Office of Procurement and Contracts
900 SW Jackson St., Room 451 South
Topeka, KS 66612

Kansas
Department of Administration

Phone: 785-296-2376
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https://admin.ks.gov/offices/procurement-contracts

Adam C. Proffitt, Secretary
Todd Herman, Director

Laura Kelly, Governor

CONTRACT AWARD

Date of Award:	May 7, 2024
Contract ID:	00000000000000000000055707
Event ID:	EVT0009267
Replace Contract:	N/A
Procurement Officer:	Bonnie L Edwards
Telephone:	785/296-3125
E-Mail Address:	bonnie.edwards@ks.gov
Web Address:	https://admin.ks.gov/offices/procurement-contracts
Item:	KanCare Medicaid & Chip Capitated Managed Care
Agency/Business Unit:	Kansas of Health and Environment and Kansas Department for Aging and Disability Services
Period of Contract:	January 1, 2025, through December 30, 2027 (With the option to renew for two (2) additional twelve-month periods)
Contractor:	Community Care Health Plan of Kansas, Inc. dba Healthy Blue 220 Virginia Ave Indianapolis, IN 46204
Vendor ID:	0000362533
FEIN:	On File
Contact Person:	Bryan Baier
E-Mail:	Bryan.baier@healthybluekansas.com
Toll Free Telephone:	833-401-1577
Local Telephone:	785-295-4834
Cell Phone Number:	785-480-0760
Fax:	866-494-2186

Payment Terms: Net 30
Political Subdivisions: Pricing is not available to the political subdivisions of the State of Kansas.
Procurement Cards: Agencies may not use a P-Card for purchases from this contract.
Administrative Fee: No Administrative Fee will be assessed against purchases from this contract.

The above referenced contract award was recently posted to Procurement and Contracts website. The document can be downloaded by going to the following website:
https://admin.ks.gov/offices/procurement-contracts

1. Terms and Conditions

1.1. Contract Documents

In the event of a conflict in terms of language among the documents, the following order of precedence shall govern:

- Form DA 146a;
- written modifications to the executed contract;
- written contract signed by the parties;
- the Bid Event documents, including any and all amendments; and
- Contractor's written offer submitted in response to the Bid Event as finalized.

1.2. Captions

The captions or headings in this contract are for reference only and do not define, describe, extend, or limit the scope or intent of this contract.

1.3. Definitions

A glossary of common procurement terms is available at http://admin.ks.gov/offices/procurement-and-contracts, under the "Procurement Forms" link.

1.4. Contract Formation

No contract shall be considered to have been entered into by the State until all statutorily required signatures and certifications have been rendered and a written contract has been signed by the contractor.

1.5. Notices

All notices, demands, requests, approvals, reports, instructions, consents or other communications (collectively "notices") that may be required or desired to be given by either party to the other shall be IN WRITING and addressed as follows:

Kansas Procurement and Contracts
900 SW Jackson, Suite 451-South
Topeka, Kansas 66612-1286
RE: Contract Number 55707

or to any other persons or addresses as may be designated by notice from one party to the other.

1.6. Statutes

Each and every provision of law and clause required by law to be inserted in the contract shall be deemed to be inserted herein and the contract shall be read and enforced as though it were included herein. If through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then on the application of either party the contract shall be amended to make such insertion or correction.

1.7. Governing Law

This contract shall be governed by the laws of the State of Kansas and shall be deemed executed in Topeka, Shawnee County, Kansas.

1.8. Jurisdiction

The parties shall bring any and all legal proceedings arising hereunder in the State of Kansas District Court of Shawnee County, unless otherwise specified and agreed upon by the State of Kansas. Contractor waives personal service of process, all defenses of lack of personal jurisdiction and forum non conveniens. The Eleventh Amendment of the United States Constitution is an inherent and incumbent protection with the State of Kansas and need not be reserved, but prudence requires the State to reiterate that nothing related to this Agreement shall be deemed a waiver of the Eleventh Amendment

1.9. Mandatory Provisions

The provisions found in Contractual Provisions Attachment (DA 146a) are incorporated by reference and made a part of this contract.

1.10. Termination for Cause

The Director of Purchases may terminate this contract, or any part of this contract, for cause under any one of the following circumstances:

the Contractor fails to make delivery of goods or services as specified in this contract;

the Contractor provides substandard quality or workmanship;

the Contractor fails to perform any of the provisions of this contract, or

the Contractor fails to make progress as to endanger performance of this contract in accordance with its terms.

The Director of Purchases shall provide Contractor with written notice of the conditions endangering performance. If the Contractor fails to remedy the conditions within ten (10) days from the receipt of the notice (or such longer period as State may authorize in writing), the Director of Purchases shall issue the Contractor an order to stop work immediately. Receipt of the notice shall be presumed to have occurred within three (3) days of the date of the notice.

1.11. Termination for Convenience

The Director of Purchases may terminate performance of work under this contract in whole or in part whenever, for any reason, the Director of Purchases shall determine that the termination is in the best interest of the State of Kansas. In the event that the Director of Purchases elects to terminate this contract pursuant to this provision, it shall provide the Contractor written notice at least 30 days prior to the termination date. The termination shall be effective as of the date specified in the notice. The Contractor shall continue to perform any part of the work that may have not been terminated by the notice.

1.12. Rights and Remedies

If this contract is terminated, the State, in addition to any other rights provided for in this contract, may require the Contractor to transfer title and deliver to the State in the manner and to the extent directed, any completed materials. The State shall be obligated only for those services and materials rendered and accepted prior to the date of termination.

In the event of termination, the Contractor shall receive payment prorated for that portion of the contract period services were provided to or goods were accepted by State subject to any offset by State for actual damages including loss of federal matching funds.

The rights and remedies of the State provided for in this contract shall not be exclusive and are in addition to any other rights and remedies provided by law.

1.13. Antitrust

If the Contractor elects not to proceed with performance under any such contract with the State, the Contractor assigns to the State all rights to and interests in any cause of action it has or may acquire under the anti-trust laws of the United States and the

State of Kansas relating to the particular products or services purchased or acquired by the State pursuant to this contract.

1.14. Hold Harmless

The Contractor shall indemnify the State against any and all loss or damage to the extent arising out of the Contractor's negligence in the performance of services under this contract and for infringement of any copyright or patent occurring in connection with or in any way incidental to or arising out of the occupancy, use, service, operations, or performance of work under this contract.

The State shall not be precluded from receiving the benefits of any insurance the Contractor may carry which provides for indemnification for any loss or damage to property in the Contractor's custody and control, where such loss or destruction is to state property. The Contractor shall do nothing to prejudice the State's right to recover against third parties for any loss, destruction, or damage to State property.

1.15. Force Majeure

The Contractor shall not be held liable if the failure to perform under this contract arises out of causes beyond the control of the Contractor. Causes may include, but are not limited to, acts of nature, fires, tornadoes, quarantine, strikes other than by Contractor's employees, and freight embargoes.

1.16. Breach

Waiver or any breach of any contract term or condition shall not be deemed a waiver of any prior or subsequent breach. No contract term or condition shall be held to be waived, modified, or deleted except by a written instrument signed by the parties thereto.

If any contract term or condition or application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, conditions, or applications which can be given effect without the invalid term, condition, or application. To this end the contract terms and conditions are severable.

1.17. Assignment

The Contractor shall not assign, convey, encumber, or otherwise transfer its rights or duties under this contract without the prior written consent of the State. State may reasonably withhold consent for any reason.

This contract may terminate for cause in the event of its assignment, conveyance, encumbrance, or other transfer by the Contractor without the prior written consent of the State.

1.18. Third Party Beneficiaries

This contract shall not be construed as providing an enforceable right to any third party.

1.19. Waiver

Waiver of any breach of any provision in this contract shall not be a waiver of any prior or subsequent breach. Any waiver shall be in writing and any forbearance or indulgence in any other form or manner by State shall not constitute a waiver.

1.20. Injunctions

Should Kansas be prevented or enjoined from proceeding with the acquisition before or after contract execution by reason of any litigation or other reason beyond the control of the State, Contractor shall not be entitled to make or assert claim for damage by reason of said delay.

1.21. Staff Qualifications

The Contractor shall warrant that all persons assigned by it to the performance of this contract shall be employees of the Contractor (or specified Subcontractor) and shall be fully qualified to perform the work required. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work under this contract.

Failure of the Contractor to provide qualified staffing at the level required by the contract specifications may result in termination of this contract or damages.

1.22. Subcontractors

The Contractor shall be the sole source of contact for the contract. The State will not subcontract any work under the contract to any other firm and will not deal with any subcontractors. The Contractor is totally responsible for all actions and work performed by its subcontractors. All terms, conditions and requirements of the contract shall apply without qualification to any services performed or goods provided by any subcontractor.

1.23. Independent Contractor

Both parties, in the performance of this contract, shall be acting in their individual capacity and not as agents, employees, partners, joint ventures or associates of one another. The employees or agents of one party shall not be construed to be the employees or agents of the other party for any purpose whatsoever.

The Contractor accepts full responsibility for payment of unemployment insurance, workers compensation, social security, income tax deductions and any other taxes or payroll deductions required by law for its employees engaged in work authorized by this contract.

1.24. Worker Misclassification

The Contractor and all lower tiered subcontractors under the Contractor shall properly classify workers as employees rather than independent contractors and treat them accordingly for purposes of workers' compensation insurance coverage, unemployment taxes, social security taxes, and income tax withholding. Failure to do so may result in contract termination.

1.25. Immigration and Reform Control Act of 1986 (IRCA)

All contractors are expected to comply with the Immigration and Reform Control Act of 1986 (IRCA), as may be amended from time to time. This Act, with certain limitations, requires the verification of the employment status of all individuals who were hired on or after November 6, 1986, by the Contractor as well as any subcontractor or sub-contractors. The usual method of verification is through the Employment Verification (I-9) Form.

The Contractor hereby certifies without exception that such Contractor has complied with all federal and state laws relating to immigration and reform. Any

misrepresentation in this regard or any employment of persons not authorized to work in the United States constitutes a material breach and, at the State's option, may subject the contract to termination for cause and any applicable damages.

Unless provided otherwise herein, all contractors are expected to be able to produce for the State any documentation or other such evidence to verify Contractor's IRCA compliance with any provision, duty, certification or like item under the contract.

1.26. Proof of Insurance

Upon request, the Contractor shall present an affidavit of Worker's Compensation, Public Liability, and Property Damage Insurance to Procurement and Contracts.

1.27. Conflict of Interest

The Contractor shall not knowingly employ, during the period of this contract or any extensions to it, any professional personnel who are also in the employ of the State and providing services involving this contract or services similar in nature to the scope of this contract to the State. Furthermore, the Contractor shall not knowingly employ, during the period of this contract or any extensions to it, any state employee who has participated in the making of this contract until at least two years after his/her termination of employment with the State.

1.28. Nondiscrimination and Workplace Safety

The Contractor agrees to abide by all federal, state, and local laws, and rules and regulations prohibiting discrimination in employment and controlling workplace safety. Any violations of applicable laws or rules or regulations may result in termination of this contract.

1.29. Confidentiality

The Contractor may have access to private or confidential data maintained by State to the extent necessary to carry out its responsibilities under this contract. Contractor must comply with all the requirements of the Kansas Open Records Act (K.S.A. 45-215 et seq.) in providing services under this contract. Contractor shall accept full responsibility for providing adequate supervision and training to its agents and employees to ensure compliance with the Act. No private or confidential data collected, maintained, or used in the course of performance of this contract shall be disseminated by either party except as authorized by statute, either during the period of the contract or thereafter. Contractor agrees to return any or all data furnished by the State promptly at the request of State in whatever form it is maintained by Contractor. On the termination or expiration of this contract, Contractor shall not use any of such data or any material derived from the data for any purpose and, where so instructed by State, shall destroy, or render it unreadable.

1.30. Environmental Protection

The Contractor shall abide by all federal, state, and local laws, and rules and regulations regarding the protection of the environment. The Contractor shall report any violations to the applicable governmental agency. A violation of applicable laws or rule or regulations may result in termination of this contract for cause.

1.31. Care of State Property

The Contractor shall be responsible for the proper care and custody of any state owned personal tangible property and real property furnished for Contractor's use in connection with the performance of this contract. The Contractor shall reimburse the

State for such property's loss or damage caused by the Contractor, except for normal wear and tear.

1.32. Prohibition of Gratuities

Neither the Contractor nor any person, firm or corporation employed by the Contractor in the performance of this contract shall offer or give any gift, money or anything of value or any promise for future reward or compensation to any State employee at any time.

1.33. Retention of Records

Unless the State specifies in writing a different period of time, the Contractor agrees to preserve and make available at reasonable times all of its books, documents, papers, records, and other evidence involving transactions related to this contract for a period of five (5) years from the date of the expiration or termination of this contract.

Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds five (5) years.

The Contractor agrees that authorized federal and state representatives, including but not limited to, personnel of the using agency; independent auditors acting on behalf of state and/or federal agencies shall have access to and the right to examine records during the contract period and during the five (5) year post contract period. Delivery of and access to the records shall be within five (5) business days at no cost to the state.

1.34. Off-Shore Sourcing

If, during the term of the contract, the Contractor or subcontractor plans to move work previously performed in the United States to a location outside of the United States, the Contractor shall immediately notify the Procurement and Contracts and the respective agency in writing, indicating the desired new location, the nature of the work to be moved and the percentage of work that would be relocated. The Director of Purchases, with the advice of the respective agency, must approve any changes prior to work being relocated. Failure to obtain the Director's approval may be grounds to terminate the contract for cause.

1.35. Indefinite Quantity Contract

This is an open-ended contract between the Contractor and the State to furnish an undetermined quantity of a good or service in a given period of time. The quantities ordered will be those actually required during the contract period, and the Contractor will deliver only such quantities as may be ordered. No guarantee of volume is made. An estimated quantity based on past history or other means may be used as a guide.

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1.36. Payment

Payment Terms are Net 30 days. Payment date and receipt of order date shall be based upon K.S.A. 75-6403(b). This Statute requires state agencies to pay the full amount due for goods or services on or before the 30th calendar day after the date the agency receives such goods or services or the bill for the goods and services, whichever is later, unless other provisions for payment are agreed to in writing by the Contractor and the state agency. NOTE: If the 30th calendar day noted above falls on a Saturday, Sunday, or legal holiday, the following workday will become the required payment date.

Payments shall not be made for costs or items not listed in this contract.

Payment schedule shall be on a frequency mutually agreed upon by both the agency and the Contractor.

1.37. Invoices

Each purchase order must be individually invoiced. Invoices shall be forwarded to the using agency in duplicate and shall state the following:

- date of invoice.
- date of shipment (or completion of work);
- purchase order number and contract number;
- itemization of all applicable charges; and
- net amount due.

1.38. Accounts Receivable Set-Off Program

If, during the course of this contract the Contractor is found to owe a debt to the State of Kansas, a state agency, municipality, or the federal government, agency payments to the Contractor may be intercepted / set off by the State of Kansas. Notice of the setoff action will be provided to the Contractor. Pursuant to K.S.A. 75-6201 et seq, Contractor shall have the opportunity to challenge the validity of the debt. The Contractor shall credit the account of the agency making the payment in an amount equal to the funds intercepted.

K.S.A. 75-6201 et seq. allows the Director of Accounts & Reports to setoff funds the State of Kansas owes Contractors against debts owed by the Contractors to the State of Kansas, state agencies, municipalities, or the federal government. Payment's setoff in this manner constitute lawful payment for services or goods received. The Contractor benefits fully from the payment because its obligation is reduced by the amount subject to setoff.

1.39. Federal, State and Local Taxes

Unless otherwise specified, the contracted price shall include all applicable federal, state, and local taxes. The Contractor shall pay all taxes lawfully imposed on it with respect to any product or service delivered in accordance with this Contract. The State of Kansas is exempt from state sales or use taxes and federal excise taxes for direct purchases. These taxes shall not be included in the contracted price. Upon request, the State shall provide to the Contractor a certificate of tax exemption.

The State makes no representation as to the exemption from liability of any tax imposed by any governmental entity on the Contractor.

1.40. Charge Back Clause

If the Contractor fails to deliver the product within the delivery time established by the contract, the State reserves the right to purchase the product from the open market and charge back the difference between contract price and open market price to the Contractor.

1.41. Debarment of State Contractors

Any Contractor who defaults on delivery or does not perform in a satisfactory manner as defined in this Agreement may be barred for up to a period of three (3) years, pursuant to K.S.A. 75-37,103, or have its work evaluated for pre-qualification purposes. Contractor shall disclose any conviction or judgment for a criminal or civil offense of any employee, individual or entity which controls a company or organization or will perform work under this Agreement that indicates a lack of business integrity or business honesty. This includes (1) conviction of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract or subcontract or in the performance of such contract or subcontract; (2) conviction under state or federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property; (3) conviction under state or federal antitrust statutes; and (4) any other offense to be so serious and compelling as to affect responsibility as a state contractor. For the purpose of this section, an individual or entity shall be presumed to have control of a company or organization if the individual or entity directly or indirectly, or acting in concert with one or more individuals or entities, owns or controls 25 percent or more of its equity, or otherwise controls its management or policies. Failure to disclose an offense may result in the termination of the contract.

1.42. Materials and Workmanship

The Contractor shall perform all work and furnish all supplies and materials, machinery, equipment, facilities, and means, necessary to complete all the work required by this Contract, within the time specified, in accordance with the provisions as specified.

The Contractor shall be responsible for all work put in under these specifications and shall make good, repair and/or replace, at the Contractor's own expense, as may be necessary, any defective work, material, etc., if in the opinion of agency and/or Procurement and Contracts said issue is due to imperfection in material, design, workmanship, or Contractor fault.

1.43. Industry Standards

If not otherwise provided, materials or work called for in this contract shall be furnished and performed in accordance with best established practice and standards recognized by the contracted industry and comply with all codes and regulations which shall apply.

1.44. Implied Requirements

All products and services not specifically mentioned in this contract, but which are necessary to provide the functional capabilities described by the specifications, shall be included.

1.45. New Materials, Supplies or Equipment

Unless otherwise specified, all materials, supplies or equipment offered by the Contractor shall be new, unused in any regard and of most current design. All materials, supplies and equipment shall be first class in all respects. Seconds or flawed items will not be acceptable. All materials, supplies or equipment shall be suitable for their intended purpose and, unless otherwise specified, fully assembled and ready for use on delivery

1.46. Inspection

The State reserves the right to reject, on arrival at destination, any items which do not conform with specification of the Contract.

1.47. Acceptance

No contract provision or use of items by the State shall constitute acceptance or relieve the Contractor of liability in respect to any expressed or implied warranties.

1.48. Ownership

All data, forms, procedures, software, manuals, system descriptions and workflows developed or accumulated by the Contractor under this contract shall be owned by the using agency. The Contractor may not release any materials without the written approval of the using agency.

1.49. Information/Data

Any and all information/data required to be provided at any time during the contract term shall be made available in a format as requested and/or approved by the State.

1.50. Certification of Materials Submitted

The Bid document, together with the specifications set forth herein and all data submitted by the Contractor to support their response including brochures, manuals, and descriptions covering the operating characteristics of the item(s) proposed, shall become a part of the contract between the Contractor and the State of Kansas. Any written representation covering such matters as reliability of the item(s), the experience of other users, or warranties of performance shall be incorporated by reference into the contract.

1.51. Transition Assistance

In the event of contract termination or expiration, Contractor shall provide all reasonable and necessary assistance to State to allow for a functional transition to another vendor.

The purpose of contract is to for Managed Care Organizations (MCOs) to provide Managed Care for the Kansas Medicaid program and Children's Health Insurance Program (CHIP), collectively referred to as "KanCare". The State of Kansas (State) has determined that delivering services through a Managed Care model and continuing to contract with multiple MCO CONTRACTORS will result in the provision of high quality, integrated, well-coordinated, and cost-effective services to improve the health outcomes of the populations currently covered by Medicaid and CHIP in Kansas. Services included in this Contract are physical health services, Behavioral Health Services, and Long-Term Services and Supports (LTSS), including nursing facility (NF) care and Home- and Community-Based Services (HCBS). These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and substance use disorder (SUD) services and seven Section 1915(c) HCBS Waiver programs.

The State intends to improve upon an already recognized, innovative Managed Care program. Requirements in this Contract are extensive, reflecting the ambitious nature of this program. The State recognizes that Contractors will bring a variety of strengths, experiences, innovations, and added value to the KanCare program, all of which has been consider in awarding of this contract.

The State of Kansas' (State's) vision for KanCare is one of collaboration and partnership between the State, CONTRACTOR(S), Members, and Providers to realize program excellence and optimal health outcomes for Members – "Partnering together to support Medicaid Members in achieving health, wellness, and independence for a healthier Kansas."

To advance this vision, the State has identified the following KanCare goals:

A. Improve Member experience and satisfaction.

    a. Educate, engage, and empower Members to personally define their health and wellness goals.

    b. Proactively solicit feedback from Members and their families to improve the health care delivery system and Member satisfaction.

B. Improve health outcomes by providing holistic care to Members that is integrated, evidence-based, and well-coordinated, and that recognizes the impact of Social Determinants of Health (SDOH).

    1. Provide integrated, whole-person health care, including physical health services, Behavioral Health Services, LTSS, and promote independence and wellness.

    c. Utilize and expand the use of strategies that address the SDOH in Medicaid to further improve Beneficiary health outcomes, reduce health disparities, and lower overall costs in Medicaid and CHIP.

    d. Expand the use of evidence-based practices and services shown to result in optimal health outcomes.

    e. Provide appropriate levels of person and family-centered Care Coordination to ensure timely access to necessary services, continuity of care, and effectiveness of services.

C. Reduce health care disparities.

    1. Provide services in a manner that is responsive to the linguistic and cultural needs and preferences of Members.

    f. Ensure Members with disabilities have equitable access to quality services.

g. Identify and remediate disparities in Member health outcomes.

D. Expand Provider network and direct care workforce capacity and skill sets.

1. Recruit and retain Providers to ensure access to all Provider types.

h. Improve Member access to services in Rural and frontier areas of the State of Kansas.

i. Increase the availability of telehealth and other technology to expand service access.

j. Expand the capacity and the skill sets of the direct care workforce.

E. Improve Provider experience and encourage Provider participation in Medicaid.

1. Reduce administrative burden for Providers, including expanding standardization of certain Provider requirements across KanCare MCOs.

k. Proactively solicit feedback from Providers to understand Provider challenges and barriers, and collaborate to improve the health care delivery system.

l. Ensure timely and accurate payment to Providers.

m. Expeditiously resolve Provider concerns and issues.

F. Increase the use of cost-effective strategies to improve health outcomes and the service delivery system.

1. Encourage and incentivize Member engagement in wellness and prevention services to adopt and maintain healthy behaviors and prevent more serious health care conditions.

n. Advance the strategic use of payment models, community reinvestments, and incentives to improve health outcomes, service delivery efficiency, Member experience, and contain the cost of health care.

G. Leverage data to promote continuous quality improvement to achieve the goals of the KanCare program.

1. Consistently and frequently examine quantitative and qualitative data and information obtained through a variety of sources (e.g., Members, Providers, and other stakeholders) to evaluate the effectiveness of the strategies employed to achieve program goals, identify opportunities for improvement, and adjust the strategies to incorporate results and lessons learned.

H. The State expects CONTRACTOR(S) to provide the expertise, experience, innovative strategies, methods of approach, and capabilities necessary to advance the KanCare vision and goals. The CONTRACTOR(S) must demonstrate congruence with the KanCare vision and goals in all aspects of its performance under this CONTRACT.

KanCare State Agencies

Presently, Kansas Medicaid services are delivered by two State agencies: the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS). KDHE and KDADS partner and closely collaborate with the Kansas Department for Children and Families (DCF), the agency responsible for overseeing the delivery of social services and the provision of care to vulnerable children and families, including foster care services.

A. KDHE is a cabinet level agency with the mission to protect and improve the health and environment of all Kansans. KDHE's Division of Health Care Finance (DHCF) is the Single State Medicaid Agency and is responsible for the Medicaid State Plan, interacting with the Centers for Medicare & Medicaid Services (CMS), drawing down Federal Financial Participation (FFP) funds, and administrating and supervising the Medicaid and CHIP programs. KDHE-DHCF is also responsible for Medicaid and CHIP eligibility determinations in Kansas. The overall oversight and management of the CONTRACTOR(S) selected for this work will be performed by the KDHE-DHCF. More information about KDHE can be found at: https://www.kdhe.ks.gov/. Additional information about KDHE-DHCF can be found at: https://www.kdhe.ks.gov/159/Medicaid-Health-Care-Finance.

B. KDADS is a cabinet level agency with the mission to foster an environment that promotes security, dignity, and independence for all Kansans. KDADS administers services to older adults; Behavioral Health Services, including mental health and addiction prevention and treatment programs; and the State's HCBS Waiver programs. KDADS also manages the four state hospitals and institutions and directs health occupations credentialing. More Information about KDADS can be found at: http://www.kdads.ks.gov.

C. The Kansas Department for Children and Families (DCF) is a cabinet level agency responsible for overseeing the delivery of social services and the provision of care to vulnerable children and their families, including foster care and adoption services. More information about DCF's services can be found at: https://www.dcf.ks.gov.

Categories of Eligibility and Populations

A majority of Medicaid and all CHIP beneficiaries will be enrolled in comprehensive, capitated, risk-based managed care. Eligibility policies, procedures and related information can be found on the KDHE website: http://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy.

A. Beneficiaries enrolled in Managed Care include:

1. Adults and children eligible under the Caretaker Medical program.
2. Certain pregnant women and children through the month of their first (1st) birthday.
3. Certain children over the age of one (1) year and through the month of their sixth (6th) birthday.
4. Certain children over the age of six (6) and through the month of their twenty-first (21st) birthday.
5. Children under the age of nineteen (19) years who are not eligible for Medicaid but are living in families with incomes less than 241% of the Federal poverty level (CHIP).
6. Aged and disabled individuals receiving supplemental security income (SSI).
7. Medically needy aged and disabled individuals (spenddown populations).
8. Employed persons with disabilities receiving coverage under the Medicaid Buy-In (Working Healthy).
9. Children and youth in foster care.
10. Children whose families receive adoption support.

11. Beneficiaries receiving long-term care, including institutional care, HCBS and Money Follows the Person.

B. Beneficiaries who are not eligible for Managed Care include:

1. Beneficiaries receiving state-funded assistance: MediKan, the KDHE Division of Public Health-run programs, and State-Only institutional care.

2. Ineligible noncitizens receiving time-limited coverage of certain Emergency Medical Conditions (SOBRA).

3. Beneficiaries who have an eligibility period that is only retroactive.

4. Persons whose only coverage is under a Medicare Savings Program.

5. Persons enrolled in the Program for All Inclusive Care for the Elderly (PACE).

C. American Indians/Alaska Natives may opt out of enrollment in managed care.

D. The Kansas Medicaid population can be divided into three (3) general groups: (1) parents, pregnant women, and children; (2) persons with disabilities (e.g., individuals with intellectual/developmental [IDD] or physical disabilities [PD], or both; and (3) the aged (65 and older). CHIP covers children under age 19. These populations are currently covered under KanCare and will continue to be covered by the successful bidders related to this CONTRACT. As of August 2023, the total Medicaid/CHIP covered population for calendar year 2023 was approximately 520,000. This includes approximately 320,000 children, 79,000 parents and pregnant women, 59,000 individuals with disabilities, and 54,000 individuals 65 and older. Kansas expects the Medicaid/CHIP population to decrease as part of the unwinding of the continuous enrollment provision, pursuant to the Consolidated Appropriations Act of 2023.

E. HCBS Waiver Populations

1. The following 1915(c) HCBS Waiver populations are currently served within the Managed Care program known as KanCare (see the KDADS website for a list of current 1915(c) Waivers and a program participation report found at https://kdads.ks.gov/kdads-commissions/long-term-services-supports/home-community-based-services-(hcbs)-programs):

o. Children with autism.

p. Children and adults with IDD.

q. People ages 16–64 with PD.

r. Medically fragile children ages 0–22 dependent on intensive medical technology (Technology Assisted or TA).

s. People ages 0–64 with brain injuries (BI).

t. People ages 65 and older who are functionally eligible for nursing facility (NF) (Frail Elderly or FE).

u. Children with a serious emotional disturbance (SED).

v. These HCBS populations receive all their physical and Behavioral Health Services, as well as LTSS, through managed care.

w. Kansas is considering adding a new community supports HCBS Waiver that would be focused on individuals with IDD who require less intensive supports than the current IDD Waiver offers.

x. One of the primary goals of this Contract is to improve integration and coordination of care for these HCBS populations, which are comprised of individuals who have multiple Chronic Conditions.

F. While managing several populations and programs allows for administrative efficiencies, CONTRACTOR(S) may be required to report separately on expenditures and utilization by population, program, and/or type of service (e.g., Behavioral Health, physical health, or HCBS).

G. Certain Medicaid Beneficiaries, including dual eligibles (Medicare and Medicaid), foster care children, and children with disabilities may be voluntarily enrolled, and may not be enrolled on a mandatory basis without a Waiver from CMS.

H. Kansas' Managed Care program will operate under State Plan and Waiver authority specified in Sections 1932(a), 1115, 1915(b), and 1915(c) of the Social Security Act (SSA).

2. SCOPE OF SERVICES

2.1 General Requirements

2.1.1 Administrative Responsibilities

A. The CONTRACTOR(S) shall:

1. Retain at all times during the period of this CONTRACT, a valid Certificate of Authority issued by the Kansas Department of Insurance.

y. Contract with the Centers for Medicare & Medicaid Services (CMS) and the Kansas Department of Health and Environment (KDHE) to provide Medicare benefits to individuals eligible for both Medicare and Medicaid (dual eligible) through a highly integrated dual eligible special needs plan (HIDE D-SNP).

   a. Except as otherwise prior approved by KDHE in writing, the CONTRACTOR(S)' HIDE D-SNP shall be in place upon implementation of this CONTRACT.

   b. The CONTRACTOR(S) must provide its HIDE D-SNP with real-time access to information that permits the dual eligible special needs plan (D-SNP) to verify eligibility of Members who are enrolled or potential D-SNP enrollees. The CONTRACTOR(S) shall validate any membership requests from other HIDE D-SNPs to ensure appropriate enrollment into a D-SNP.

   c. The CONTRACTOR(S) shall pay Medicare coinsurance and/or deductibles for Covered Services to dual eligible Members and ensure the accurate processing of crossover Claims.

   d. The CONTRACTOR(S) must provide Kansas Medicaid information (e.g., information on the Medicaid State Plan, information on Home- and Community-Based Services [HCBS] Waivers, and KDHE and Kansas Department for Aging and Disability Services [KDADS] policies) to its HIDE D-SNP and other HIDE D-SNPs.

e. Certify to the State, in accordance with Section 1932(d)(1) of the Social Security Act (SSA) 42 CFR § 438.610, that the CONTRACTOR(S) and any Subcontractors do not have any prohibited affiliations.

f. Check all required databases, as specified in 42 CFR § 455.436 and as directed by the State.

g. In accordance with the Clinical Laboratory Improvement Amendments (CLIA), obtain copies of the valid CLIA certificates from the laboratories and/or all entities providing laboratory services funded by Titles XIX and XXI of the SSA. The CONTRACTOR(S) shall provide a listing to the State of all laboratories and/or entities providing laboratory services used by the CONTRACTOR(S) and shall certify to the State that the laboratories and/or entities providing laboratory services are CLIA certified. The CONTRACTOR(S) shall update the listing and certification as laboratories and/or entities providing laboratory services are added to or dropped from the list.

h. Comply at all times with all applicable Federal and State laws and regulations related to or affecting this CONTRACT, including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990 as amended, Section 1557 of the Patient Protection and Affordable Care Act

(PPACA), and Titles XIX and XXI of the SSA. This includes existing laws and regulations as well as any laws and regulations that may be enacted during the term of this CONTRACT. It is the CONTRACTOR(S)' responsibility to remain aware of changes in existing Federal and State laws and regulations as well as the enactment of new laws and regulations as they affect the CONTRACTOR(S)' duties and responsibilities under this CONTRACT. The CONTRACTOR(S) shall implement any new or changes to Federal and State law and regulations as of the effective date specified by the law or regulation or as otherwise specified by the State.

i. Comply with all applicable Federal and State laws that pertain to Member rights and ensure that its staff and Participating Providers observe and protect those rights when furnishing services to Members.

j. Comply at all times with all State policies related to or affecting this CONTRACT. This includes existing State policies as well as any policies that may be adopted by the State during the term of this CONTRACT. It is the CONTRACTOR(S)' responsibility to remain aware of changes in existing State policies as well as adoption of new State policies that affect the CONTRACTOR(S)' duties and responsibilities under this CONTRACT. The CONTRACTOR(S) shall implement any new or changes to State policy as of the effective date specified by the State.

k. Follow the Kansas Medicaid and Children's Health Insurance Program (CHIP) State Plans. The Medicaid and CHIP State Plans with Federal and State laws and regulations are the authority that govern this CONTRACT.

l. Comply with the State's 1915(c) HCBS Waivers, including performance measures and State policies.

m. Demonstrate significant improvement in core health and life satisfaction Outcomes for Members over the full term of this CONTRACT. Savings realized by the program should be achieved by increased Care Coordination and better health Outcomes (e.g., National Outcomes Measurement System [NOMS], Healthcare Effectiveness Data and Information Set [HEDIS®], and others) rather than by significant or widespread reduction in rates to Providers, by withholding required services, or by decreasing quality of or access to any services.

n. Return CONTRACT amendments to the Department of Administration no later than ten (10) Business Days after receipt of the CONTRACT amendment.

2.1.2 Business Continuity/Disaster Recovery Plan

Within ninety (90) Calendar Days of award, the CONTRACTOR(S) shall develop and submit for State written approval, a business continuity/disaster recovery plan (BC/DR plan). The BC/DR plan shall include all Subcontractor(s)' BC/DR plans and comply with the following requirements.

A. The CONTRACTOR(S) must provide a BC/DR plan for the technology and infrastructure components, as well as for the business area operations continuity and contingency plan. The CONTRACTOR(S), together with the State, must affirm the BC/DR plan, the essential roles, responsibilities, and coordination efforts for those portions of the technical infrastructure and operations as deemed appropriate.

B. The CONTRACTOR(S) must address a wide range of infrastructure and services recovery responsibility associated with, and/or arising from partial loss of a function or of data for a brief

amount of time to a worst-case scenario in which a man-made or natural disaster, data center equipment or infrastructure failure, or total system failure may result.

C. It is the policy of Kansas Department of Health and Environment-Division of Health Care Finance (KDHE-DHCF) that a BC/DR plan is in place and maintained at all times. The BC/DR plan must contain procedures for data backup, disaster recovery including restoration of data, and emergency mode operations. The BC/DR plan must include a procedure to allow facility access in support of restoration of lost data and to support emergency mode operations in the event of an emergency. Also, access control includes procedures for emergency access to electronic information.

D. The CONTRACTOR(S)' systems and all data associated with this CONTRACT and other documents and records must be protected against hardware and software failures, human error, natural disasters, and other emergencies, which could interrupt services. The BC/DR plan must address recovery of business functions, business units, business processes, human resources, and the technology infrastructure.

E. The CONTRACTOR(S) must develop a business continuity plan that includes the following:

1. Identification of the core business processes involved in the CONTRACTOR(S)' system;

o. Plan for each core business process:

a. Identification of potential system failures for the process;

b. Risk analysis;

c. Impact analysis; and

d. Definition of minimum acceptable levels of outputs.

e. Documentation of contingency plans;

f. Definition of triggers for activating contingency plans;

g. Discussion of establishment of a business resumption team;

h. Maintenance of updated disaster recovery plans and procedures that include, but are not limited to:

a. Central computer installation and resident software are destroyed or damaged;

b. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;

c. System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system; and

d. System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system (i.e., cause unscheduled system unavailability).

e. Plan for replacement of personnel to include the following as a minimum:

a. Replacement in the event of loss of personnel before or after signing this CONTRACT;

b. Replacement in the event of inability by personnel to meet performance standards; and

c. Allocation of additional resources in the event of the CONTRACTOR(S)' inability to meet performance standards:

i. Replacement/addition of personnel with specific qualifications;

ii. Timeframes necessary for replacement;

iii. Capability of providing replacements/additions with comparable experience; and

iv. Methods for ensuring timely productivity from replacements/additions.

F. The CONTRACTOR(S) must prepare a disaster recovery plan that addresses the following:

1. Retention and storage of backup files and software;

d. Hardware backup for critical system components;

e. Facility backup;

f. Backup for telecommunications links and networks;

g. Staffing plan;

h. Backup procedures and support to accommodate the loss of online communications;

i. A detailed file backup plan and procedures, including the offsite storage of crucial transaction and master files; the plan and procedures must include a detailed frequency schedule for backing up critical files and (if appropriate to the backup media) their rotation to an offsite storage facility. The offsite storage facility must provide security of the data stored there, including protections against unauthorized access or disclosure of the information, fire, sabotage, and environmental considerations; and

j. The maintenance of current system documentation and source program libraries at an offsite location.

G. The CONTRACTOR(S) shall periodically, but no less than annually, on or before the CONTRACTOR(S)' CONTRACT anniversary, of each CONTRACT year, perform comprehensive tests of its BC/DR plan through simulated disasters, and lower-level failures in order to demonstrate to the State that it can restore system functions per the standards outlined in the CONTRACT.

H. In the event that the CONTRACTOR(S) fails to demonstrate in the tests of its BC/DR plan that it can restore system functions per the standards outlined in this CONTRACT, the CONTRACTOR(S) must submit to the State a corrective action plan (CAP) that describes how the failure will be resolved. The CAP shall be delivered within ten (10) Business Days of the conclusion of the test.

I. The disaster recovery plan and results of periodic disaster readiness simulations must be available for review by State or Federal officials on request. This report and test results must be filed annually with the KDHE-DHCF senior contract manager, and any other agency authorized by KDHE-DHCF or

the Federal government. This report and test results must be approved in writing by the KDHE-DHCF senior contract manager.

J. If the approved BC/DR plan is unchanged from the previous year, the CONTRACTOR(S) shall submit each year, a certification to the State that the prior year's BC/DR plan is still in place. This certification must be submitted on or before the CONTRACTOR(S)' contract anniversary. Changes in the BC/DR plan are due to the State within ten (10) Business Days after the change.

2.1.3 Risk Management Plan

Within ninety (90) Calendar Days of award, the CONTRACTOR(S) shall develop and submit for State written approval, a risk management plan. The risk management plan shall include all Subcontractor(s)' risk management plans and address the CONTRACTOR(S)' identified risks to ongoing operations and business continuity and their proposed solution or action to be taken to alleviate or minimize the consequences in the event that those risks become actuality. If the approved risk management plan is unchanged from the previous year, the CONTRACTOR(S) shall submit each year, a certification to the State that the prior year's risk management plan is still in place. This certification must be submitted on or before the CONTRACTOR(S)' CONTRACT anniversary. Changes in the CONTRACTOR(S)' risk management plan are due to the State within ten (10) Business Days after the change.

2.1.4 Security Management Plan

Within ninety (90) Calendar Days of award, the CONTRACTOR(S) shall develop and submit for State written approval, a security management plan (security plan). The security plan shall include all Subcontractor(s)' plans and comply with the following requirements:

A. The security plan shall document the CONTRACTOR(S)' plan to prevent unauthorized disclosure of data and information. KDHE-DHCF must initially approve the security plan and will conduct audits/evaluations of the security plan established by the CONTRACTOR(S) at least annually.

B. The security plan must include the following elements for all sites where system development will occur, will host any KDHE-DHCF data, or will be interacting with the public. The CONTRACTOR(S) is required to keep the plan up to date.

C. The security plan shall include, but not limited to, the following:

1. Comprehensive risk assessment evaluating the security risks, vulnerabilities, and threats to the system. The CONTRACTOR(S) must review and update this comprehensive risk assessment annually in coordination with KDHE-DHCF and the State chief information security officer.

k. Privacy impact analysis that identifies the data elements of the system that expose Beneficiaries to potential privacy threats and the system controls in place to mitigate private data disclosure risks.

l. Security event notification process, event evaluation, and escalation procedures, and security event response procedures.

m. Complete network diagram showing servers, printers, workstations, firewalls, intrusion prevention systems, network security device internet connections, and any other network connected device.

n. Complete list of the firewall rules for any applicable firewalls.

o. Detailed plan for system log collection and monitoring.

p. Antivirus deployment/maintenance plan.

q. Software maintenance plan, including operation systems and third-party software updates, including response procedures for critical vulnerabilities that require immediate software patching.

r. An agreement that background checks will be completed and passed by all employees prior to allowing access to KDHE-DHCF data.

s. Background checks every five (5) years after employment.

t. Procedures to limit access to information to those individuals who need such information for the performance of their job functions and ensuring that those individuals have access to only the information that is the minimum necessary for the performance of their job functions.

u. Description of how physical safety of data under its control will be protected through the use of appropriate devices and methods, including, but not limited to, alarm systems, locked files, guards, or other devices reasonably expected to prevent loss or unauthorized access to data.

v. Description of the steps taken to prevent unauthorized use of passwords, access logs, badges, or other methods designed to prevent loss of, or unauthorized access to, electronically or mechanically held data. Methods used shall include, but not be limited to, restricting system and/or terminal access at various levels, assigning personal identifiers and passwords that are tied to preassigned access rights to enter the system, restricting access to input and output documents, including a view-only access, and other restrictions designed to protect data.

w. An agreement to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules as a business associate of KDHE and KDADS.

x. Requiring that each employee, including the employees of Subcontractors or any other person to whom the CONTRACTOR(S) grants access to information under this CONTRACT, has signed a statement indicating they have been informed of, understands, and will abide by State and Federal laws, rules, statutes, guidelines, and regulations concerning confidentiality, privacy, and security. A system of sanctions for any employee, Subcontractor, officer, or director who violates the privacy and security policies shall be enforced.

y. The CONTRACTOR(S) must submit a copy of the approved User Security Agreement (initial and annually) required of all of their employees or Subcontractors who will come into contact with any secure information or data.

z. Procedures to ensure that corrective action occurs, and mechanisms are established to avoid the reoccurrence of any breach.

aa. Procedures established to recover data should it be released without authorization.

bb. A designated individual who is responsible for the implementation and monitoring of compliance with privacy and security policies and procedures.

cc. Procedures and processes for securing data access across organizational boundaries, through the internet and other leased lines, or shared with CONTRACTOR(S) and Subcontractor facilities, and all onsite and offsite data storage facilities.

dd. The CONTRACTOR(S) will engage a third party of the State's choosing, to conduct thorough system penetration testing prior to contract implementation, for their systems and Subcontractor(s)' systems. The CONTRACTOR(S) shall develop a corrective action plan for all vulnerabilities discovered during the penetration testing. The CONTRACTOR(S) will conduct additional penetration testing annually and report the results to the State.

ee. An infrastructure security plan.

2.1.5 Emergency Management Plan

A. The CONTRACTOR(S) shall develop, and implement as needed, an emergency management plan to ensure the ongoing provision of Covered Services in an emergency, including but not limited to, a declared local, State or Federal disaster, emergency or other public health emergency, natural disaster, technological disaster, or civil disorder. The CONTRACTOR(S)' emergency management plan is subject to State written approval.

B. In the event of an emergency, the CONTRACTOR(S) shall immediately notify the State of its intention to invoke its emergency management plan. The notice must include the information required by the State, including but not limited to, the nature of the emergency, the actions being taken by the CONTRACTOR(S), and the expected duration of the actions.

C. At a minimum, the CONTRACTOR(S)' emergency management plan shall include the following:

1. The names, titles, and contact information (including cell phone number and email address) for the CONTRACTOR(S)' staff who will serve as the State's point(s) of contact during the emergency, including those individuals who can be contacted twenty-four hours a day, seven days a week (24/7);

ff. The CONTRACTOR(S)' continuity of operations (COOP) plans for continuing to provide Covered Services to members during the emergency;

gg. The CONTRACTOR(S)' plans for educating Members regarding disaster preparedness, how to access Covered Services during the emergency, and any other topics specified by the State;

hh. The CONTRACTOR(S)' plans for educating Providers about any changes from normal procedures that will be in effect during the emergency and that impact Providers;

ii. At the State's direction, the CONTRACTOR(S)' plans to submit data and information to the State to support the State's response to the emergency and to facilitate the return to normal operations; and

jj. How the CONTRACTOR(S) will collaborate with the State and other KanCare Managed Care Organizations (MCOs) before and during the emergency and in returning to normal operations.

D. Depending on the nature of the emergency, the CONTRACTOR(S)' other plans to support Members and Providers, such as:

1. Providing a resource list for Members and Providers with information about where Covered Services may be accessed;

2. Developing Member-specific disaster plans for Members who are at high-risk as a result of the emergency;

kk. Identifying Members who require evacuation assistance and informing local officials of those identified;

ll. Memoranda of understanding (MOUs) with Providers (especially hospitals, dialysis Providers, and nursing facilities [NFs]) for provision of Covered Services to evacuated Members;

mm. MOUs with Provider facilities that allow evacuated Providers to render services within their facilities;

nn. Register Providers (e.g., physicians, nurses, social workers, etc.) who are willing to volunteer in State operated shelters for individuals with health care needs in the System for Emergency Response Volunteers in Kansas (SERV-KS); and

oo. Emergency contracting with Out-of-State Providers to provide Covered Services to evacuated Members.

E. The State may negotiate emergency performance from the CONTRACTOR(S) to address the immediate needs of the State, even if not contemplated under this CONTRACT.

F. After the emergency management plan has been invoked, the CONTRACTOR(S) shall continue to operate under its emergency management plan until the State provides written approval or direction for the CONTRACTOR(S)' return to normal operations.

2.1.6 Mental Health Parity and Addiction Equity Act

A. In accordance with 42 CFR § 438.905(a), CONTRACTOR(S) must comply with all Federal regulations and guidance pertaining to parity in mental health and substance use disorder (SUD) benefits, including:

1. If the CONTRACTOR(S) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third (1/3) of all medical/surgical benefits provided to Members, the CONTRACTOR(S) may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or SUD benefits.

pp. If the CONTRACTOR(S) includes an aggregate lifetime or annual dollar limit on at least two-thirds (2/3) of all medical/surgical benefits provided to Members, the CONTRACTOR(S) must either apply the aggregate lifetime or annual dollar limit to both the medical/surgical benefits to which the limit would otherwise apply and to mental health or SUD benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or SUD benefits; or not include aggregate lifetime or annual dollar limit on mental health or SUD benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

qq. If the CONTRACTOR(S) includes an aggregate lifetime limit or annual dollar amount that applies to one-third (1/3) or more but less than two-thirds (2/3) of all medical/surgical benefits provided to Members, it must either impose no aggregate lifetime or annual dollar limit on mental health or SUD benefits; or impose an aggregate lifetime or annual dollar limit on mental health or SUD benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

rr. The CONTRACTOR(S) must not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant

financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members (whether or not the benefits are furnished by the same CONTRACTOR).

ss. If a Member is provided mental health or SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or SUD benefits must be provided to the Member in every classification in which medical/surgical benefits are provided.

tt. The CONTRACTOR(S) may not apply any cumulative financial requirements for mental health or SUD benefits in a classification (inpatient, outpatient, emergency care, and prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

uu. The CONTRACTOR(S) may not impose non-quantitative treatment limitation (NQTLs) for mental health or SUD benefits in any classification unless, under the policies and procedures of the CONTRACTOR(S) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

vv. The CONTRACTOR(S) must provide documentation and reporting to establish and demonstrate compliance with 42 CFR Part 438, subpart K regarding parity in mental health and SUD benefits in a format and frequency as specified by the State.

2.1.7 Cooperation with Other Agencies

Cooperation with other State agencies and programs, is expected, and CONTRACTOR(S) must track and regularly provide evidence of the cooperation, work, and collaboration accomplished. The following is an initial list of State agencies and programs. KDHE will provide an updated list upon CONTRACT award and reserves the right to update the list throughout the term of this CONTRACT.

A. CONTRACTOR(S) shall make a reasonable effort to subcontract with any local health care Providers receiving funds from Titles V and X of the SSA. Close cooperation with these entities is expected.

B. CONTRACTOR(S) shall coordinate all cases of sexually transmitted diseases (STDs) and tuberculosis (TB) with the local health departments to ensure prevention and to limit the spread of disease. The CONTRACTOR(S) shall cooperate with the treatment plan developed by the State and local health departments. The State requires the CONTRACTOR(S) to provide language, in their subcontracts with any local health departments, regarding the coordination of care and reporting on STDs and TB to the State health department.

C. CONTRACTOR(S) shall coordinate with the Special Supplemental Food Program for Women, Infants, and Children (WIC). The State shall assure that coordination exists between WIC and CONTRACTOR(S). This coordination should include the referral of potentially eligible women, infants, and children to the WIC Program and the provision of medical information by Participating Providers to the WIC Program:

1. To be eligible for WIC benefits, a competent professional authority must diagnose a pregnant woman, a breastfeeding woman, a non-breastfeeding postpartum woman, an infant, or a child under age five (5) as being at nutritional risk. Suggested medical information for a WIC referral

include nutrition-related metabolic disease, diabetes, low birth weight, failure to thrive, premature birth, infants of alcoholic mothers, developmentally disabled infants, drug addicted or HIV positive mothers, AIDS, allergy or intolerance that affects nutritional status, and anemia.

ww. The WIC Program in Kansas is coordinated through the State and local health departments. CONTRACTOR(S) is expected to subcontract or coordinate with the local health departments in their service areas.

D. CONTRACTOR(S) shall coordinate with other Title V programs such as programs funded under the Individuals with Disabilities Education Act, the Healthy Start Home Visiting Program, and the Maternal and Infant and Family Planning Clinics as well as any other programs operated by the State and local health departments.

E. CONTRACTOR(S) shall cooperate with the justice systems in Kansas, to include but not limited to, Kansas Department of Corrections and Juvenile Justice.

F. Local Education Agencies (LEAs): The CONTRACTOR(S) is required to cooperate with LEAs for the provision of Covered Services. The State is exploring options to increase Medicaid collaboration with LEAs.

G. CONTRACTOR(S) shall coordinate with any Indian Health Service Clinics or tribally operated facilities in their service area. Documentation of such coordination is required.

H. CONTRACTOR shall cooperate and coordinate with the Department of Children and Families (DCF) and its foster care case management Providers (CMPs) in matters relating to Members in foster care.

I. The CONTRACTOR(S) shall cooperate and coordinate with KDADS and agencies conducting level of care assessments for HCBS Waivers in matters relating to Members enrolled on a 1915(c) Waiver or on a Waiver waiting list.

2.1.8 Readiness Reviews

A. In accordance with 42 CFR 438.66(d), the CONTRACTOR(S) must participate in readiness reviews for the State to assess the CONTRACTOR(S)' readiness and capability to provide services consistent with the requirements in this CONTRACT. The CONTRACTOR(S) must demonstrate to the State's satisfaction that it is able to meet the requirements in this CONTRACT prior to the Start Date of this CONTRACT.

1. The CONTRACTOR(S) must complete all readiness review activities identified by the State within the timelines established by the State. Review activities may include, but are not limited to, providing written materials to support the State's desk and onsite reviews, describing the CONTRACTOR(S)' operations, providing system demonstrations (including systems connectivity testing), and participating in interviews with State-specified staff and representatives. The scope of the readiness review may include assessing readiness to perform any of the requirements specified in this CONTRACT as determined by the State.

2. The State will not assign Members nor make payment to the CONTRACTOR(S) until the State has determined that the CONTRACTOR(S) is ready and able to meet the requirements of this CONTRACT.

B. Throughout the duration of this CONTRACT, as determined by the State, the CONTRACTOR(S) must participate in readiness reviews prior to the CONTRACTOR(S)' implementation of significant operational or program changes (e.g., change in Subcontractor, information technology system modifications), including any changes required by State policy. The CONTRACTOR(S) must demonstrate to the State's satisfaction that the CONTRACTOR(S) will continue to be able to meet the requirements in this CONTRACT prior to implementing the change.

2.1.9 Reproduction of Materials for Providers

The CONTRACTOR(S) shall reproduce and distribute information and documents provided by the State necessary for CONTRACTOR(S)' Participating Providers to fully implement the requirements of this CONTRACT at CONTRACTOR(S)' expense. Examples include, but are not limited to, forms, policy changes, and Member rosters. Information and documents will be disseminated in accordance with a reasonable timeframe as determined by the State. CONTRACTOR(S) may use mail, electronic websites or bulletin boards, secure email, facsimile (fax), or any other communication method approved by the State in writing.

2.1.10 Change in Organizational Structure

A. The CONTRACTOR(S) shall notify and obtain prior written approval from the State at least one hundred eighty (180) Calendar Days prior to the effective date of a Change in Organizational Structure that directly impacts the CONTRACTOR(S)' KanCare Medicaid operations.

B. The CONTRACTOR(S)' request for approval shall include a description of the proposed Change in Organizational Structure; the new organization's ability to meet the requirements of this CONTRACT; a detailed transition plan to ensure uninterrupted services to Members and Provider payments; and any other information requested by the State to support the CONTRACTOR(S)' request.

C. The State may approve the CONTRACTOR(S)' request with or without conditions, including, but not limited to, one (1) or more of the following: (i) executing an amendment to this CONTRACT, (ii) participating in a readiness review conducted by the State to ensure the new organization demonstrates readiness to perform under this CONTRACT, (iii) allowing for an open enrollment or Member Disenrollment without cause, or (iv) changing the auto-assignment algorithm to manage the organization's share of enrollment. The State may deny the CONTRACTOR(S)' request if the State determines that the Change in Organizational Structure is not in the best interest of the State or KanCare Members.

D. Failure to obtain prior written approval from the State or proceeding with the Change in Organizational Structure despite the State's denial of the CONTRACTOR(S)' may result in CONTRACT termination, in accordance with the terms set forth in this CONTRACT.

2.2 Enrollment, Disenrollment, and Marketing

2.2.1 Enrollment

A. Enrollment includes the following:

1. Member Enrollment/assignment: Enrollment for this CONTRACT will begin on or about November 1, 2024, and continue on an ongoing basis.

a. Medicaid and CHIP Beneficiaries aged less than nineteen (19) and Medicaid Beneficiaries who qualify as parents/caretaker relative or transitional medical will have a continuous twelve (12)-month period of eligibility.

b. Assignment for Members is effective the first Calendar Day of the eligibility start month. Assignment for CHIP Members shall begin the day eligibility is received by the Kansas Modular Medicaid System (KMMS) and is forwarded to the CONTRACTOR(S).

c. Beneficiaries eligible to enroll with the CONTRACTOR(S) may be eligible beginning the first Calendar Day of the application month, with the exception of newborns, who are eligible beginning with their date of birth (DOB).

d. Newborns of eligible mothers who were enrolled in the CONTRACTOR(S) at the time of the child's birth shall be covered under the mother's CONTRACTOR(S), unless the mother chooses a different KanCare MCO for the baby. The CONTRACTOR(S) shall receive a capitation payment for the month of birth and for all subsequent months the child remains enrolled with the CONTRACTOR(S) if the CONTRACTOR(S) provided the newborn information to the State within sixty (60) Calendar Days of the date of birth. If there is an administrative lag that is not the fault of the Member in enrolling the newborn and costs are incurred during that period, the Member shall be held harmless for those costs.

e. Neither Medicaid nor CHIP Members are subject to waiting periods or pre-existing condition clauses excluding coverage for conditions as of the effective date of their coverage. Enrollment in the Medicaid and CHIP KanCare program is the responsibility of the State and its Fiscal Agent.

f. Managed physical, behavioral, and Long-Term Services and Supports (LTSS), as well as dental services for those currently eligible for them, must be available to Members at the time of Enrollment.

g. Beneficiaries eligible for Enrollment with CONTRACTOR(S) are those encompassed by the categories listed Section 1.3 of this request for proposal (CONTRACT).

a. The State shall have the exclusive right to determine an individual's eligibility for Medicaid. The State shall have the exclusive right to determine an individual's eligibility for CHIP.

b. Such determinations are not subject to review or appeal by the CONTRACTOR(S).

c. Nothing in this section prevents the CONTRACTOR(S) from providing the State with information the CONTRACTOR(S) believes indicates that the Member's eligibility has changed.

d. For the first CONTRACT year, Members who were enrolled with a KanCare MCO that was previously contracted with the State, will be auto-assigned to that CONTRACTOR(S). Members that were previously enrolled with an MCO that is not continuing to CONTRACT with the State and newly eligible Beneficiaries will be randomly assigned to a new KanCare MCO using an auto-assignment algorithm that ensures family Members stay with the same MCO, that existing Provider-Member relationships are maintained to the extent possible, and that ultimately targets an equitable distribution of Members across the CONTRACTORS based on both numbers and acuity of Members and newly eligible Beneficiaries. The State, through its Fiscal Agent, will notify Members that they have ninety (90) Calendar Days from January 1, 2025, to choose another KanCare MCO. Along with this notification, the State, through its Fiscal Agent, will send an

enrollment packet on all available KanCare MCOs to allow Members the opportunity to make an informed choice of KanCare MCOs.

The enrollment packet will explain services, network options, and information specified in Section 2.2.1.P.5.b, including information explaining the implications of not making an active choice of a KanCare MCO, enrollment information including the ninety (90) Calendar Day without-cause Disenrollment period, and other Disenrollment rights in accordance with 42 CFR § 438.56.

The State may, at its discretion, alter the algorithm per 42 CFR § 438.54(d)(8)(ii) by considering additional criteria to conduct the default enrollment process, including the enrollment preferences of family members, previous MCO assignment of the Member, quality assurance and improvement performance, procurement evaluation elements, accessibility of Provider offices for people with disabilities (when appropriate), and other reasonable criteria related to a Member's experience with the Medicaid program. After year one (1) of the CONTRACT, the State reserves the right to adapt the auto-assignment algorithm to incorporate differential enrollment percentage targets linked to the CONTRACTOR(S)' quality improvement (QI) scores.

B. Members with enrollment questions may contact the Fiscal Agent. When the Member chooses, or is assigned a KanCare MCO, the Fiscal Agent will send the Member a letter informing them of the assigned KanCare MCO.

C. The CONTRACTOR(S) must send the Member a Member handbook or a notification on where to find the Member handbook on the CONTRACTOR(S)' website and allow the Member ten (10) Business Days to choose a Primary Care Provider (PCP). If the Member does not choose a PCP within ten (10) Business Days, the CONTRACTOR(S) shall auto-assign the Member to a PCP.

1. Members will be informed that they may request and be assigned a new PCP at any time.

e. The Member handbook will include all elements found in Section 2.10.5.

f. Additionally, the CONTRACTOR(S) shall send the Member an identification (ID) card containing at a minimum all elements found in Section 2.10.9.

D. The CONTRACTOR(S) shall maintain a permanent Member service hotline, with specially trained operators to handle calls from new Members and from Members needing assistance in obtaining services as identified further in Section 2.10.10.

E. The CONTRACTOR(S) shall also provide retroactive Medicaid coverage to Members determined eligible by the State.

1. Retroactive Medicaid coverage is defined as a period generally up to three (3) months prior to the application month. (In general, there is no retroactive coverage for CHIP Members. However, it is allowed in certain limited instances, such as for newly eligible CHIP babies, specific instances when reinstating CHIP coverage due to overdue premiums, review reconsideration periods, and the retroactive Title XXI process.)

g. When a retroactive assignment is made to the CONTRACTOR(S), the CONTRACTOR(S) is responsible for paying the historical Claims even if the Claims are past the CONTRACTOR(S)' timely filing policies. The CONTRACTOR(S) must submit for State written approval policies for authorization exceptions, which must include provisions for retroactive eligibility assignments. These policies must be in effect at the beginning of the CONTRACT.

F. The assignment adjustment process is used when a change to the existing CONTRACTOR(S)' assignment occurs. The adjustment is approved by the State. The CONTRACTOR(S) cannot change MCO assignments without written State approval and will be triggered by KMMS updates.

   1. When an assignment is removed from the CONTRACTOR(S), a recoupment of the Capitation Payment will occur for the appropriate months.

   h. When an assignment is added to the CONTRACTOR(S), a Capitation Payment will be made for the appropriate months.

G. CONTRACTOR(S) Responsibilities:

   1. The CONTRACTOR(S) shall accept, on a monthly basis, any eligible Member who selects or is assigned to the CONTRACTOR(S) in the order in which they apply or are assigned without restriction (unless authorized by CMS), up to the limits set under the CONTRACT regardless of the Member's race, color, national origin, age, sex, sexual orientation, gender identity, disability, ethnicity, language needs, or health status up to the limits set under the CONTRACT.

   i. These Members must also appear in the CONTRACTOR(S)' enrollment information. Enrollment in the CONTRACTOR(S) will occur starting with the first month of eligibility for Medicaid Members and the Calendar Day eligibility is forwarded to the CONTRACTOR(S) for CHIP Members.

   j. The CONTRACTOR(S) is responsible for obtaining any necessary signatures of medical releases.

   k. Coverage of services, including inpatient hospital care, will be the responsibility of the CONTRACTOR(S) as of the beginning of the month Enrollment becomes effective. All other (ancillary) charges, not reimbursed by the inpatient hospital payments, are the responsibility of the CONTRACTOR(S). Non-inpatient (ancillary) charges are the responsibility of the CONTRACTOR(S) if the Admission date occurs before assignment. If an Admission date occurs during the assignment to the CONTRACTOR(S), that CONTRACTOR(S) is responsible for the cost of the entire Admission regardless of assignment or eligibility.

H. CONTRACTOR(S) must have written policies and procedures for providing all Medically Necessary Covered Services to newborn children of Members effective at the time of birth.

I. CONTRACTOR(S) must agree to make available the full scope of benefits to which a Member is entitled immediately upon the effective date of Enrollment.

J. CONTRACTOR(S) must have written policies and procedures for orienting new Members and Potential Members to their benefits, rights, and features of their health plan per 42 CFR § 438.10(e). The CONTRACTOR(S) may propose alternative methods for orienting new Members and Potential Members but must be prepared to demonstrate their effectiveness. Also, refer to Section 2.10.7 for requirements regarding the Member handbook.

K. CONTRACTOR(S) must have written policies and procedures for assigning each of its Members to a PCP. The process must include at least the following features:

   1. CONTRACTOR(S) must contact the Member within ten (10) Business Days of their Enrollment and provide information on the options for selecting a PCP.

l. If a Member does not select a PCP within ten (10) Business Days of Enrollment, the CONTRACTOR(S) must make an automatic assignment, taking into consideration such factors, if known, as current Provider relationships, language need, cultural competency, and area of residence. The CONTRACTOR(S) may choose to assign new Members to a PCP immediately, notify the Member of that assignment in writing, and allow the Member to change this assignment at any time if it is not acceptable. The CONTRACTOR(S) must notify the Member in writing of their PCP's name, specialty, hospital affiliation, and office telephone number and also notify that the Member may change at any time, for any reason.

L. If a PCP is terminated from the CONTRACTOR(S), the CONTRACTOR(S) shall have written policies and procedures for Members to select or be assigned to a new PCP within fifteen (15) Calendar Days of the termination effective date.

M. Following the original assignment to the CONTRACTOR, the Member will have a ninety (90)-Calendar Day period to change to a different KanCare MCO, if desired.

1. Member choice of a KanCare MCO shall be voluntary, and neither the State nor its agents shall do anything to influence the Member's exercise of free choice.

m. Members shall be provided assurances that a decision not to enroll in the CONTRACTOR(S) shall not affect their eligibility for benefits.

N. An application for Enrollment in the program and selection of a KanCare MCO, which includes a list of KanCare MCOs, will be provided to Members. Fiscal Agent managed care Enrollment staff will be available, by calling a toll-free number or in-person to assist Members that request a change in KanCare MCO.

O. A brochure explaining the Managed Care program and CONTRACTOR(S)' services (including value-added benefits) will be provided to Members per Section 2.10.5. Members will be advised as to which KanCare MCOs offer special services that the Member may need. In addition, these materials will be offered in alternate formats to address physical and language barriers in accordance with 42 CFR § 438.10.

P. State Responsibilities:

1. The State will conduct education and enrollment activities for program Members.

n. The State will make available to the CONTRACTOR(S) on a monthly basis, an electronic roster of Members enrolled in the CONTRACTOR(S) for the entire benefit month. The roster will include information consistent with the HIPAA-compliant 834 transaction. In keeping with the State's Medicaid State Plan, Attachment 2.2a, page 10a and in accordance with 42 CFR § 438.56(g), KanCare Members that lose eligibility for a period of two (2) months or less will be automatically reenrolled in the managed care plan.

o. The State will make available to the CONTRACTOR(S) on a daily basis, an electronic roster (HIPAA 834) of Members enrolled in the CONTRACTOR(S). This roster will contain Medicaid newborn children and CHIP daily assignments.

p. The State will maintain and notify Members of the Annual Open Enrollment period, as specific to each Member, for CONTRACTOR(S) selection for the subsequent CONTRACT year.

q. The State's responsibilities at the time of the eligibility determination will include the following:

a. Educating Beneficiaries about the basic features of Managed Care consistent with the requirements in 42 CFR § 438.10(e)(2).

b. Informing Beneficiaries of available KanCare MCOs and outlining criteria that might be important when making a choice (e.g., presence or absence of the Beneficiary's existing health care Provider in a KanCare MCO' network), and that they will remain enrolled in that CONTRACTOR(S) for the following year, unless a specific "for cause" exception is met consistent with 42 CFR § 438.56 and the terms of the KanCare program.

c. Members who lose eligibility due to failure to provide eligibility information to the State on a timely basis, but those whose eligibility is subsequently re-established prior to the end of the month will be reported to the CONTRACTOR(S) on a second Member roster sent to the CONTRACTOR(S) on the daily 834 file. Capitation for those Members reported on this second roster will be made with the regular Capitation Payment for the following month.

d. No CONTRACTOR(S) will be permitted enrollment numbers that constitute more than 50% of the total eligible Medicaid and CHIP population. Should any KanCare MCO in the first (implementation) year fall below enrollment of 20% of the total Medicaid and CHIP population, the assignment algorithm will be reassessed.

2.2.2 Disenrollment

A. Disenrollment provisions apply to all Medicaid Managed arrangements per 42 CFR § 438.56.

B. Members may Disenroll as outlined in 42 CFR § 438.56(d)(2) for cause at any time and without cause during the ninety (90)-Calendar Day choice period following initial enrollment, during the Annual Open Enrollment period thereafter, after automatic re-Enrollment per 42 CFR § 438.56(g) as described in Section 2.2.1.P.2, when the State imposes intermediate sanctions on the CONTRACTOR(S) in accordance with 42 CFR § 438.e702(a)(3), and when the State terminates the CONTRACT in accordance with 42 CFR § 438.722(b).

1. Members who wish to Disenroll must submit an oral or written request to the State or its Fiscal Agent.

e. The effective date of an approved Disenrollment must be no later than the first Calendar Day of the second month following the month in which the Member or CONTRACTOR(S) files the request for Disenrollment.

f. If the State or its Fiscal Agent fails to make the determination within the timeframes specified herein, the Disenrollment is considered approved.

C. CONTRACTOR(S) Responsibilities:

1. The CONTRACTOR(S)' responsibility for Member-initiated Disenrollment shall include referring the Member to the KanCare eligibility clearinghouse to process the Disenrollment.

g. The CONTRACTOR(S) is also required to track the reason for the Disenrollments for the CONTRACTOR(S)' Quality Assessment and Performance Improvement (QAPI) process.

h. The CONTRACTOR(S) shall inform Members of their Disenrollment rights in accordance with 42 CFR § 438.56, including the ninety (90)-Calendar Day without cause Disenrollment period.

i. The CONTRACTOR(S) shall have written policies and procedures for transferring relevant patient information, including medical records and other pertinent materials, when a Member is transferred to or from another KanCare MCO. It may be necessary to transfer a Member between KanCare MCOs. As an example, the transfer may be necessary if the change is ordered as part of a Grievance resolution.

j. When a Member changes KanCare MCOs while hospitalized, the relinquishing KanCare MCO shall notify the hospital of the change prior to the transition.

   a. The relinquishing KanCare MCO shall be responsible for payment of inpatient charges for the entire hospitalization through discharge.

   b. All other non-inpatient (ancillary) charges are the responsibility of the new KanCare MCO at the beginning of the first month of Enrollment.

c. The CONTRACTOR(S) may send a request to the State for Disenrollment of a Member, but may not request Disenrollment because of a change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs (except when the Member's continued Enrollment seriously impairs the CONTRACTOR(S)' ability to furnish services to either this particular Member or other Members).

d. The CONTRACTOR(S) may not request Disenrollment for reasons other than those permitted under the CONTRACT. The State will review and must approve in writing any CONTRACTOR(S) requests for Disenrollment.

e. The CONTRACTOR(S) must also meet applicable care transition and diversion activity requirements identified in Section 2.4.12.

2.2.3 Marketing

A. Marketing means any communication, from the CONTRACTOR(S) to a Medicaid/CHIP Beneficiary who is not enrolled in that CONTRACTOR(S)' Medicaid product, that can reasonably be interpreted as intended to influence the Beneficiary to enroll in that particular CONTRACTOR(S)' Medicaid/CHIP product, or either to not enroll in, or to disenroll from, another KanCare MCO's Medicaid/CHIP product.

B. The CONTRACTOR(S) shall not influence Beneficiary Enrollment in the CONTRACTOR(S)' plan through the offer of any compensation, reward, or benefit to the Member except for additional health-related services or informational or educational services that have been approved by the State in writing.

C. The CONTRACTOR(S) must comply with the following Marketing restrictions as specified in 42 CFR § 438.104:

1. The CONTRACTOR(S) shall not conduct directly or indirectly, door-to-door, telephonic, email, texting, or other forms of "cold-call" Marketing. Cold call Marketing means any unsolicited personal contact by the CONTRACTOR(S) with a Potential Member for the purpose of Marketing as defined in paragraph A.

f. The CONTRACTOR(S) may not make any communication to a person, who is not enrolled with the CONTRACTOR(S), which can reasonably be interpreted as intended to influence the

Beneficiary to enroll in the CONTRACTOR(S), or to influence any Enrollment or Disenrollment decisions the Beneficiary might make.

D. The following requirements apply to Marketing Materials, which are defined as any materials that are produced in any medium by or on behalf of the CONTRACTOR(S) that can reasonably be interpreted as intended to market to Potential Members.

1. Marketing Materials cannot contain any assertion or statement (whether written or oral) that:

a. The Beneficiary must enroll in the CONTRACTOR(S)' plan in order to obtain benefits or in order not to lose benefits.

b. The CONTRACTOR(S) is endorsed by CMS, the Federal or State government, or similar entity.

E. The CONTRACTOR(S) shall not distribute any Marketing Materials without first obtaining the State's written approval. The material must be co-branded with the KanCare logo unless otherwise approved by the State in writing.

F. The CONTRACTOR(S) shall distribute Marketing Materials to its entire membership and service area, unless otherwise approved by the State in writing.

G. The CONTRACTOR(S) shall not offer the sale of any other type of insurance product as an enticement to Enrollment.

H. The CONTRACTOR(S) Marketing, including plans and materials, must be accurate, shall not contain false or misleading information, and does not mislead, confuse, or defraud the Beneficiaries or the State.

I. The CONTRACTOR(S) shall not seek to influence Enrollment in conjunction with the sale or offering of any private insurance. (Private insurance does not include a qualified health plan, as defined in 45 CFR § 155.20).

2.3 Covered Services

2.3.1 Covered and Non-Covered Services

A. The CONTRACTOR(S) shall assume responsibility for all physical health, Behavioral Health, and LTSS (including HCBS and NFs) to its Members.

B. The CONTRACTOR(S) shall ensure the provision of Medically Necessary Covered Services as specified in, but not limited to, those in Appendix C (Services). The CONTRACTOR(S) shall ensure that Covered Services are available twenty-four hours a day, seven days a week (24/7), as Medically Necessary.

C. The CONTRACTOR(S) shall ensure continuity, coordination, and integration of physical health, Behavioral Health, and LTSS and ensure collaboration among Providers, including community Providers.

D. The CONTRACTOR(S) shall collaborate with the State and other KanCare MCOs as needed to develop and implement new initiatives.

E. The CONTRACTOR(S) shall furnish Covered Services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same benefit/service as specified in the Kansas Medicaid Provider Manuals and Appendix C (Services).

F. Per 42 CFR § 438.210 and consistent with the requirements of this CONTRACT, the CONTRACTOR(S) may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for Utilization Management (UM) as long as the services furnished can reasonably achieve their purpose, and the limit is not in violation of the Mental Health Parity and Addiction Equity Act (MHPAEA).

G. The CONTRACTOR(S) shall cover services provided outside of the State of Kansas pursuant to 42 CFR Part 431, subpart B. This includes services that, as determined on the basis of Medical Necessity, are more readily available in other states and services needed due to an Emergency Medical Condition. The CONTRACTOR(S) shall not routinely cover any services provided outside of the continental United States.

H. This CONTRACT includes requirements to increase transparency, standardization, and accountability for pharmaceutical services. The State reserves the right to contract with a single pharmacy benefit manager (PBM) and require the CONTRACTOR(S) to contract with that PBM for the provision of pharmaceutical services. If the State elects to contract with a single PBM, the CONTRACTOR(S) shall assist the State with the transition and implementation of the single PBM and comply with the State's requirements related thereto.

2.3.2 Work Opportunities Reward Kansans (WORK) Program

A. WORK is the program through which individuals eligible for the Kansas Medicaid Buy-in program, Working Healthy, receive HCBS. Unlike other HCBS programs in Kansas, WORK is not operated under the 1915(c) HCBS Waiver authority. Instead, WORK is authorized as an alternative benefit plan. It is a Kansas Medicaid State Plan package of services targeting individuals enrolled in Working Healthy who demonstrate a need for such services.

B. WORK includes a WORK needs assessment, personal assistance services, independent living counseling, and assistive services. To receive these services, individuals must first be eligible for Working Healthy, and then demonstrate the same need for services as individuals on the HCBS Individuals with Intellectual and Developmental Disabilities (IDD), Physical Disability (PD), or Brain Injury (BI) Waivers.

C. WORK utilizes a "cash and counseling" model for the provision of personal assistance services. This model goes a step beyond Self-Direction, allowing Members to manage their funds and purchase personal assistance, providing flexibility in terms of how they purchase their services. Consumers will be given the opportunity to choose how to obtain services in the most cost-effective and innovative manner.

D. Additional information may be found in the Working Healthy program manual located at https://kancare.ks.gov/consumers/working-healthy/working-healthy/work.

E. WORK Care Coordination Administrative Standards:

1. The CONTRACTOR(S) shall provide Care Coordination services for Members that participate in the WORK program in accordance with the Working Healthy program manual and as directed by the State. If the Care Coordination section of the CONTRACT conflicts with the WORK section of

the CONTRACT or the Working Healthy program manual, the WORK section and the Working Healthy program manual shall control.

c. The CONTRACTOR(S) shall maintain written Care Coordination procedures to implement the requirements for WORK Care Coordination.

d. The CONTRACTOR(S) shall designate an individual on the CONTRACTOR(S)' staff to serve as the State's primary point of contact for all issues related to the WORK program. The CONTRACTOR(S) shall provide the State with the name and contact information for this individual, who should at a minimum be a supervisor of WORK care coordinators. This individual shall provide timely responses to all State inquiries regarding WORK program participants, coordinating as needed with the CONTRACTOR(S)' staff, including other WORK care coordinators.

F. WORK Care Coordination Staff Standards:

1. The CONTRACTOR(S) shall have an adequate number of qualified and trained care coordinators to serve WORK program participants. The CONTRACTOR(S) shall designate a limited number of care coordinators to serve WORK program participants, as directed by the State.

e. The CONTRACTOR(S) shall ensure that care coordinators serving WORK program participants meet all requirements of the CONTRACTOR(S)' care coordinators as specified in Section 2.4.7 and the training requirements specified in Section 2.4.9.

f. The CONTRACTOR(S) shall ensure that all newly hired care coordinators serving WORK program participants receive training provided by the State before starting to work with Members. Only care coordinators who receive the proper training may serve WORK participants.

g. The CONTRACTOR(S) must ensure that all care coordinators are provided with regular ongoing training on topics relevant to the Working Healthy/WORK program, including topics identified by the State. Ongoing training shall occur at a minimum annually and to the extent there are changes to the WORK program during the CONTRACT period.

h. Upon monthly notification from the State of all Members eligible for the WORK program, the CONTRACTOR(S) shall assign new Members a care coordinator among the CONTRACTOR(S) designated WORK care coordinators.

G. WORK Care Coordination General Standards:

1. The CONTRACTOR(S)' care coordinators shall provide Care Coordination for Members participating in WORK that facilitates Member understanding and use of WORK program services; accurate assessment of Member service needs; ongoing review, approval, and monitoring of individualized budgets; and referrals to other resource agencies as needed to address Member needs. See also the Working Healthy program manual.

i. In providing Care Coordination to WORK program participants, care coordinators shall actively coordinate with the WORK program manager, Working Health benefits specialists, and independent living counselors (ILCs) to ensure optimum coordination of services.

H. WORK Needs Assessment:

1. The care coordinator must complete an in-person WORK needs assessment in the Member's home within fourteen (14) Calendar Days of referral for the WORK program from KDHE-DHCF. The needs assessment and any reassessment must occur at the Member's home.

j. The Member and/or the Member's representative must be present for the WORK assessment.

k. Unless otherwise directed by the State, the CONTRACTOR(S) shall use the WORK Assessment/Allocation Tool provided by the State to conduct the WORK needs assessment.

l. The CONTRACTOR(S)' care coordinators shall use a person-centered and directed planning process to identify the Member's needs for WORK program services. To the extent possible, the care coordinator must involve the Member and/or Member representative in needs identification as well as decision making. The assessment shall be developed by the care coordinator with input from the Member/Member's representative and those individuals the Member chooses to include in the assessment process. See also the Working Healthy program manual for additional requirements regarding the WORK needs assessment.

m. After completing the needs assessment, the care coordinator shall send the needs assessment to the ILC so that the ILC can assist the Member in developing an individualized budget based on the need's assessment. The individualized budget indicates how allocated funds will be used to pay for personal and employment services.

n. The care coordinator shall review the individualized budget to ensure it:

    a. Includes all of the required elements;

    b. Meets the needs of the Member;

    c. Reflects the amount, duration, and scope of assistance identified during the WORK assessment;

    d. Ensures the emergency backup plan meets all the criteria specified on the emergency backup provided by the State; and

    e. Confirms there is no conflict of interest (COI) contained in the individualized budget.

f. The care coordinator shall refer to the Working Healthy program manual for descriptions of the amount, duration, and scope of services included in the WORK benefit package, including information about limitations.

g. The care coordinator's supervisor shall review and approve the individualized budget.

h. The care coordinator shall review all documentation received from the ILC to ensure that the Member is receiving appropriate services and that the services are being billed correctly.

i. The care coordinator shall provide ongoing management and monitoring of the Member's monthly allocation and individualized budget, including, but not limited to, temporary adjustments to the Member's monthly allocation, monitoring and management of carryover funds, obtaining PA/facilitating the request for approval of assistive services from the CONTRACTOR(S), and requesting a Member's reassessment (if needed). In performing ongoing management and monitoring functions, the care coordinator shall follow the standards described in the Working Healthy program manual.

j. Annually, the care coordinator shall reassess the Member's needs for WORK services according to the Working Healthy program manual. In addition to the annual reassessment, Members may request a reassessment at any time if the Member experiences a change in their physical condition. All reassessments must occur in the Member's home.

I. WORK Care Coordination Reporting Requirements:

1. The CONTRACTOR(S) shall comply with any reporting requirements the State determines is necessary for the WORK program.

J. Electronic Case Record Standard:

1. The CONTRACTOR(S) shall maintain an electronic case management system and ensure that a Member's electronic case record is complete and accurate.

k. The CONTRACTOR(S)' electronic case record standard must adhere to State and Federal confidentiality, privacy, and security standards, including HIPAA.

l. A Member's electronic case record must include, at a minimum:

a. Most recent WORK assessment;

b. Most recent WORK individualized budget;

c. Emergency backup plan;

d. Disenrollment from WORK information (if applicable); and

e. Any other requirements included in the Care Coordination Section 2.4.15.

K. WORK Program Disenrollment:

1. The CONTRACTOR(S) shall recommend Member Disenrollment from the WORK program to KDHE if the Member refuses to sign the WORK individualized budget.

2. A Member will be disenrolled from the WORK program based on loss of eligibility for Working Healthy.

f. If the Member has been determined ineligible for WORK, the State will notify the CONTRACTOR(S) and the Member.

g. The care coordinator shall coordinate with the WORK program manager to assist Members to return to HCBS Waivers or waiting lists as appropriate.

h. The care coordinator shall update the Member's electronic case record to reflect service closure activity, including, but not limited to:

a. Reason for the closure.

b. Whether the Member will return to an HCBS Waiver or waiting list.

L. WORK Provider Network Requirements

1. WORK Program Fiscal Management:

a. The CONTRACTOR(S) shall CONTRACT with a financial management services (FMS) organization to administer the WORK monthly allocations for the CONTRACTOR(S)' Members who are WORK program participants. The CONTRACTOR(S) shall ensure that the FMS organization for WORK program participants is capable of providing FMS for a cash and counseling program.

b. The FMS organization contracted to serve WORK program participants can be, but is not required to be, the same fiscal management organization contracted for other programs under the CONTRACT.

c. The CONTRACTOR(S) shall coordinate with the FMS organization to receive monthly allocation reports at the Member level.

d. For Members that have been determined ineligible for WORK, the CONTRACTOR(S) shall have a process for coordinating with the FMS organization to receive any portion of the monthly allocation that is unspent within ninety (90) Calendar Days of WORK services ending.

e. The CONTRACTOR(S) shall ensure that the FMS organization pays workers' compensation premiums.

f. See also the Working Healthy program manual for additional requirements for the FMS organization.

g. The CONTRACTOR(S) shall cover the cost of background checks for personal assistance services Providers.

h. The CONTRACTOR(S) shall contract with ILCs who meet the requirements/qualifications specified in the Working Healthy program manual.

M. Grievances and Appeals

1. Members participating in the WORK program have Grievances and Appeals rights as described in the Grievances, Reconsiderations, and Appeals section of this CONTRACT and Appendix D (Grievances and Appeals).

2.3.3 Supports and Training for Employing People Successfully (STEPS)

A. The CONTRACTOR(S) shall identify eligible Members who are interested in employment and refer such Members to the Supports and Training for Employing People Successfully (STEPS) program. STEPS provides supports to Members with disabilities who are motivated to seek employment to help them obtain and maintain employment.

B. The CONTRACTOR(S) shall meet all MCO requirements detailed in the STEPS manual.

C. The CONTRACTOR(S) shall contract with one (1) fiscal management services (FMS) Provider to manage the payment of STEPS services. The CONTRACTOR(S) is encouraged to work with the other KanCare MCOs to select a single FMS Provider for STEPS. The FMS Provider will directly contract with community Providers to provide STEPS services, as outlined in the STEPS manual. The FMS Provider will bill the CONTRACTOR(S) for the services rendered in accordance with the rates included in the STEPS manual. The CONTRACTOR(S) shall pay the FMS for services rendered.

D. The CONTRACTOR(S) will be reimbursed for the cost of STEPS services rendered outside of the capitation rate.

2.3.4 Value-Added Benefits

A. The CONTRACTOR(S) may offer value-added benefits to Members. Value-added benefits may be actual health care services, benefits, or positive incentives that the State determines will promote healthy lifestyles and improved health Outcomes among Members. Value-added benefits must be services not already covered under the Kansas Medicaid State Plan. Best practice approaches to delivering Covered Services are not considered value-added benefits. Value-added benefits may include anything permissible under applicable Federal Medicaid and CHIP regulations, including incentives consistent with the United States Department of Health and Human Services' (HHS') Office of the Inspector General (OIG) Special Advisory Bulletin located at https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf. State approved value-added benefits shall be provided for the duration of the CONTRACT.

B. If the CONTRACTOR(S) chooses to offer value-added benefits, they must be offered statewide and be available to all Members, as appropriate.

C. Value-added benefits must meet the CONTRACTOR(S)' Members' needs and support the goals of KanCare. In developing value-added benefits, the CONTRACTOR(S) is encouraged to consider:

1. Adult dental exams and cleanings.

i. Contingency management/incentivizing tobacco cessation.

j. Services for pregnant and postpartum women to supplement Covered Services, including, but not limited to, the following:

a. Trained non-medical professionals to provide emotional, physical, and informational support, including but not limited to doulas and peer supports;

b. Evidence-based maternal, infant, and early childhood home visiting models;

c. Breastfeeding education and lactation consultation;

d. Cribs; and

e. Transportation to pregnancy and postpartum value-added benefits and support groups.

f. Preventive behavioral health services for families with infants or toddlers at risk for behavioral health conditions.

g. Services to promote independence and address changing health care needs related to maintaining choices of housing and activities of daily living.

h. Services that support a bridge to independence and private health coverage (e.g., job counseling, appropriate clothing for job interviews, assistance with completing documentation for official forms, health literacy activities).

i. Additional transportation services (e.g., transportation to a job interview) and services that eliminate the need for transportation (e.g., home delivery).

D. Value-added benefits do not need to be consistent across KanCare MCOs.

E. Value-added benefits shall be prior approved in writing by the State. Upon approval, the value-added benefits shall become part of the CONTRACTOR(S) scope of services for the duration of the CONTRACT term unless otherwise approved in writing by the State. The State retains complete discretion regarding maintaining a value-added benefit and may without cause disallow any request for modification or discontinuation of a value-added benefit(s) prior to the end of the CONTRACT term. In seeking approval of the value-added benefit, the CONTRACTOR(S) shall submit the following information (i) within ninety (90) Calendar Days of CONTRACT award, and (ii) at least ninety (90) Calendar Days prior to the start of each calendar year.

1. Identify the category or group of Members eligible to receive the proposed value-added benefit, if it is a type of service that is not appropriate for all Members.

j. Describe any limits and/or restrictions for the value-added benefit, including, but not limited to, Prior Authorization (PA) requirements.

k. Describe how the CONTRACTOR(S) will identify the value-added benefit in Encounter Data.

l. Propose how and when the CONTRACTOR(S) will notify Providers, Beneficiaries, and Members about the availability of such value-added benefits while still meeting the requirements of 42 CFR § 438.104.

m. Describe the CONTRACTOR(S)' methods to provide continuing education and awareness to both Members and Providers throughout the year on the availability of the value-added benefits.

n. Describe how the CONTRACTOR(S)' customer service staff, and other staff as appropriate, will be trained on the value-added benefits.

F. Value-added benefits are not factored into the rate-setting process and must be provided at no additional cost to the State. However, the State considers the costs of value-added benefits that meet the definition of 42 CFR 438.3(e) to be included as incurred Claims for purposes of the CONTRACTOR(S)' medical loss ratio (MLR). The CONTRACTOR(S) shall not pass on the cost of the value-added benefits to Providers or Members.

G. The CONTRACTOR(S) must specify the conditions and parameters regarding the delivery of the value-added benefits in the CONTRACTOR(S)' Marketing Materials and Member handbook, and must clearly describe any limitations or conditions specific to the value-added benefits, including:

1. Note any limits or restrictions that apply to the value-added benefit;

o. Identify the Providers responsible for providing the value-added benefit;

p. Describe how a Member may obtain or access the value-added benefit;

q. Indicate that there are no Grievances and Appeal rights for value-added benefits; and

r. Include a statement that the CONTRACTOR(S) will provide such value-added benefit throughout the CONTRACT term.

H. The CONTRACTOR(S) shall provide a value-added benefit report in a format and frequency determined by the State.

2.3.5 In Lieu of Services

A. The CONTRACTOR(S) may provide in lieu of services, which are medically appropriate and cost-effective services or settings to those covered under the State Plan, if prior approved in writing by the State.

B. The following in lieu of services are currently approved by the State but are subject to change prior to January 1, 2025:

1. Intensive outpatient (S9480)/partial hospital psychiatric care (H0035);

s. Intermittent urinary catheters and supplies up to $150 per month;

t. Medical nutrition therapy;

u. Home infusion therapies;

v. Institutional transition assistance funding;

w. Left ventricular assist device (LVAD) as destination therapy;

x. Attendant care services (personal care services);

y. Home telehealth disease management (S0317);

z. Home-delivered meals, including preparation (S4170);

aa. Provider-directed comprehensive supports (S5135);

bb. Home modifications;

cc. Adult day care;

dd. Medication reminder services;

ee. Respite care services;

ff. Housing and tenancy supports; and

gg. Support services necessary to aid member to participate in community activities.

C. To receive approval of an additional in lieu of service, the CONTRACTOR(S) shall perform a cost-benefit analysis for any in lieu of service or setting it proposes to provide, including how the proposed service would be a medically appropriate and cost-effective substitute for a Covered Service. The CONTRACTOR(S) shall submit the proposed analysis to the State using the State's in lieu of services request form.

D. The CONTRACTOR(S) may not require a Member to receive an in lieu of service instead of a Covered Service.

E. Approved in lieu of services are offered to Members at the option of the CONTRACTOR(S).

F. A Member who is offered or utilizes an in lieu of service retains all rights and protections afforded under 42 CFR Part 438, including but not limited to the requirements in Appendix D (Grievance and Appeals).

G. If the State approves an in lieu of service, the State will consider the utilization and actual cost for the in lieu of service in rate setting, unless otherwise prohibited by Federal law.

2.4 Care Coordination

2.4.1 Care Coordination Program Overview

A. The CONTRACTOR(S) shall be responsible for Care Coordination and continuity and continuation of care. The CONTRACTOR(S)shall establish a set of person-centered, goal-oriented, culturally relevant, and logical steps to ensure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Case Management, disease management, discharge planning, and transition planning are elements of Care Coordination for Members across all Providers and settings. Care Coordination shall also identify and assist Members with addressing Social Determinants of Health (SDOH) and integration into their communities.

B. The CONTRACTOR(S) shall develop and implement a comprehensive Care Coordination program that meets the following goals and objectives:

1. Supports person-centered, whole-person, longitudinal care.

hh. Intervenes along a continuum of need from Preventive Care to addressing acute, complex, and chronic needs.

ii. Integrates services and supports to address Behavioral Health, physical health, and LTSS needs.

jj. Integrates treatment for co-occurring mental health and SUDs.

kk. Improves Members' health and other outcomes.

ll. Reduces the inappropriate use of psychotropic medication for Members in foster care and NF residents.

mm. Increases integration and employment for Members with disabilities.

nn. Identifies and addresses Members' SDOH needs and increases integration into their communities.

oo. Increases access to community-based LTSS.

pp. Maximizes access to community supports.

qq. Supplements but does not supplant natural supports.

rr. Provides for Conflict-Free Case Management/Care Coordination, service delivery and assessment as directed by Federal and State law, as well as State policy (per 42 CFR § 431.301(c)(1)(vi) and 42 CFR § 441.730(b)).

ss. Ensures that all populations, depending on their needs, receive the appropriate level of Care Coordination.

tt. Ensures appropriate in-person monitoring or telehealth, depending on the needs of the Member.

C. The CONTRACTOR(S)' Care Coordination program shall, at a minimum, include the following elements, which shall be approved by the State in writing:

1. Processes for conducting Health Screens and Health Risk Assessments (HRAs).

uu. Processes for identifying and enrolling Members into the Care Coordination program.

vv. Processes for engaging Members to participate in the Care Coordination program.

ww. Processes for conducting Needs Assessments.

xx. Processes to ensure a person-centered service planning process for the development implementation of the Person-Centered Service Plan (PCSP) or Plan of Service.

yy. Processes for monitoring and oversight of Member's services and health and welfare, including health and other outcomes.

zz. Processes for transitions of care.

aaa. Information and referral processes.

bbb. Processes for effectively communicating with the Member, their family, PCP, other Providers, and Members of the Member's interdisciplinary team.

ccc. Processes for engaging Providers in Care Coordination and building working relationships with identified Providers.

ddd. Processes for engaging Members and their physical, LTSS, and Behavioral Health Providers to ensure optimal communication and coordination.

eee. Processes to integrate services across Providers, including engaging Members and Providers to improve integration.

fff. Processes for promoting and supporting Providers treating Behavioral Health conditions in the Primary Care setting.

ggg. Processes for coordinating and maximizing Medicare services for Members who are eligible for both Medicare and Medicaid (dual eligible).

hhh. Provision of trauma-informed care and other evidence-based practices as appropriate.

iii. Processes for identifying and addressing Members' SDOH needs and increasing community integration.

jjj. Processes for engaging and contracting with community-based organizations.

kkk. Subcontracting with local entities for the provision of community Care Coordination.

lll. Processes for obtaining consent from Members to share PHI across physical health, Behavioral Health, and LTSS Providers, when such consent is required.

mmm. A process for establishing any required HIPAA and 42 CFR Part 2 compliant agreements to address PHI.

nnn. A process to assure referrals for Medically Necessary specialty, secondary, and tertiary care and a person designated as primarily responsible for coordinating the Health Care Services furnished to the Member.

ooo. A process to assure the provision of care in emergency situations, including an educational process to help assure that Members know where and how to obtain Medically Necessary care in emergency situations and disaster/emergency plans for Members, as needed.

ppp. A process for verifying compliance with the HCBS settings rule (see, e.g., 42 CFR § 441.301(c)(4)).

D. The CONTRACTOR(S)' Care Coordination model requires at a minimum that the following groups be enrolled in Care Coordination:

1. Individuals enrolled on the 1915(c) HCBS IDD Waiver.

2. Individuals enrolled on the 1915(c) HCBS Serious Emotional Disturbance (SED) Waiver.

3. Individuals enrolled on another 1915(c) HCBS Waiver, including the BI Waiver, PD Waiver, Frail Elderly (FE) Waiver, Autism Waiver, and Technology Assisted (TA) Waiver.

4. Individuals on a 1915(c) HCBS Waiver waiting list.

5. Individuals who are institutionalized in, or transitioning to the community from a NF, NFMH, ICF/IDD, hospital, psychiatric residential treatment facility (PRTF), psychiatric hospital/ State institutional alternative (SIA), State hospital, SUD residential facility, or other institution.

6. Adults with Behavioral Health needs, including mental health, SUD, and co-occurring mental health and SUD needs, and who are receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) due to a mental health and/or a SUD diagnosis or have had more than two (2) inpatient stays for mental health and/or SUD in the past five (5) years.

qqq. Youth (birth through age twenty-one [21]) with SED who are not enrolled in the 1915(c) HCBS SED Waiver.

rrr. Youth who are in an out of home placement through the foster care system with complex/high or moderate needs who are not enrolled in a 1915(c) HCBS Waiver, are not on a HCBS Waiver waiting list, and are not receiving Certified Community Behavioral Health Clinic (CCBHC) services, including youth with complex medical needs and youth who are seeing a mental health professional not employed by a CCBHC or community mental health center (CMHC).

sss. Youth who have aged out of the foster care system.

ttt. Post-adoption youth (birth through age eighteen [18]).

uuu. Houseless youth.

vvv. Justice-involved youth.

www. Adults recently released from incarceration.

xxx. Individuals participating in the WORK program, STEPS, vocational rehabilitation, or Other Employment Program.

yyy. Individuals who are pregnant or postpartum through one (1) year postpartum.

zzz. Premature babies.

aaaa. Individuals who are transplant recipients or on a transplant waiting list.

bbbb. Individuals with chronic and/or complex physical health conditions.

cccc. Individuals with SDOH needs who would benefit from Care Coordination.

dddd. Individuals who request Care Coordination.

eeee. Other individuals who the CONTRACTOR(S) determine would benefit from Care Coordination. The CONTRACTOR(S) shall submit the criteria used for determining other Members who will receive Care Coordination to the State for written approval.

E. In addition to Care Coordination provided by the CONTRACTOR(S)' staff, individuals might receive Care Coordination from Community Care Coordinators contracted with the CONTRACTOR(S) and other Care Coordination/case management entities (e.g., targeted case managements [TCM] and CCBHCs). See Appendix L (Care Coordination Matrix) for an overview of the care coordination model for each population eligible for Care Coordination from the CONTRACTOR(S), including the roles and responsibilities of the CONTRACTOR(S) and the other Care Coordination entities. The CONTRACTOR(S) is ultimately responsible for all Care Coordination activities for its Members and shall ensure Members receive the appropriate level of Care Coordination and receive the services needed to address their needs, including physical health, Behavioral Health, LTSS, and SDOH needs.

2.4.2 Health Screens, Health Risk Assessments, and Needs Assessments

A. The CONTRACTOR(S) shall have processes in place to identify and address Behavioral Health, physical health, and LTSS needs of all Members. The CONTRACTOR(S) shall implement processes to assess, monitor, and evaluate services to all subpopulations and shall ensure appropriate referrals and follow-up take place as a result of any screening or assessment activity. Please refer to Appendix K for the initial Care Coordination process workflow.

B. The CONTRACTOR(S) shall make reasonable efforts (three [3] attempts via phone and text and then follow up by mail within ten [10] Business Days from date of Enrollment for new Members) to contact Member in person, by phone, or by mail to complete a Health Screen and Health Risk Assessment (HRA). If unable to reach the Member, the CONTRACTOR(S) shall attempt screening again, at a minimum, every ninety (90) Calendar Days, or following HCBS Waiver requirements, and more frequently for hard-to-reach and high needs populations. The CONTRACTOR(S) shall use methods beyond the typical phone and mail to reach the Member, including hard-to-reach Members, but not limited to, contacting through a Provider or other community partner, contacting foster care CMPs for Members in foster care, etc. Hard-to-reach means those without a phone, identified as homeless, etc.

C. The CONTRACTOR(S) shall ensure that a Member's immediate needs are met and shall perform Health Screens, HRAs, Needs Assessment, Prior Authorizations, etc. in an expedited manner to ensure a Member's health and welfare.

D. The CONTRACTOR(S) shall operate and maintain a centralized information system necessary to conduct Health Screens, HRAs, and Needs Assessments. The system shall include the capability of

collecting and reporting short-term and intermediate Outcomes such as Member risk level and change. The system shall be able to collect and query information on individual Members as needed for follow-up and to determine intervention Outcomes, including SDOH Outcomes, and shall be capable of interfacing with the State's KMMS.

E. Health Screen:

1. In accordance with 42 CFR § 438.208(b)(3), the CONTRACTOR(S) shall conduct a Health Screen of all new Members, using the State-developed Health Screen and algorithm. For the initial implementation of this CONTRACT, the CONTRACTOR(S) shall develop and submit a plan to the State for conducting Health Screen for all Members within ninety (90) Calendar Days of Enrollment or as directed by State policy for HCBS Waiver and Behavioral Health Members, whichever is less. Thereafter, the CONTRACTOR(S) shall conduct a Health Screen of all new Members within ten (10) Business Days of Enrollment.

2. The CONTRACTOR(S) shall complete Health Screens for new Members telephonically or in-person.

ffff. The CONTRACTOR(S) shall complete Health Screens for existing Members using historical Claims data, telephonically, or in-person. The CONTRACTOR(S) may only complete the Health Screen via Claims data every other year.

gggg. If a Member's Health Screen indicates the need for an HRA, the CONTRACTOR(S) shall conduct an HRA (see Section F below).

hhhh. Members who are enrolled in a HCBS Waiver or on a HCBS Waiver waiting list or have an identified Behavioral Health need shall have their Health Screen completed in-person and, if indications of further Needs Assessment are present, the CONTRACTOR(S) shall complete the HRA and/or other Needs Assessments while in the home.

iiii. As part of the Health Screen, CONTRACTOR(S) shall inquire whether the Member needs any special accommodations for health appointments, for example if the Member requires interpretation services, or sedation for routine dental care. If the Member requires a special accommodation, the CONTRACTOR(S) shall provide information on how to access the accommodation and offer to assist the Member in arranging the accommodation.

jjjj. If the Health Screen does not indicate the need for an HRA, the Member shall be offered assistance in arranging an initial visit with their PCP for a baseline medical assessment and other preventive services, including an assessment or screening of the Member's potential risk, if any, for specific diseases or conditions. In addition, the CONTRACTOR(S) shall offer health education and information on Wellness services and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (for Members under age twenty-one [21]). If the Health Screen indicates a SDOH need, the CONTRACTOR(S) shall offer assistance connecting the Member to necessary resources, including tracking referrals.

kkkk. The CONTRACTOR(S) must complete the Health Screen via telephone or in-person at least every other year. The CONTRACTOR(S) may only complete the Health Screen via Claims data every other year.

llll. The CONTRACTOR(S) shall update the Health Screen at least annually through in person/phone assessment or Claims data.

mmmm. The CONTRACTOR(S) shall utilize the State-developed Health Screen and algorithm (see Appendix E, Health Screen tool and scoring methods), which includes scoring Members who are participating in a Health Screen telephonically or in-person.

F. HRAs and Needs Assessment:

1. The CONTRACTOR(S) shall conduct an in-person HRA for all Members whose Health Screen results indicate the need for an HRA. The CONTRACTOR(S)' HRA shall include the HRA elements included in Appendix F (Health Risk Assessment). Except as otherwise specified, the CONTRACTOR(S) shall conduct the HRA within thirty (30) Calendar Days of the completion of the Health Screen for Members who are enrolled in a HCBS Waiver or on a HCBS Waiver waiting list or with Behavioral Health needs, the CONTRACTOR(S) shall conduct the HRA during the same visit as the Health Screen. The HRA will determine the type of Needs Assessment warranted by the Member's health status and next steps in the process. The HRA shall be performed in-person. If the HRA cannot be performed in-person, the CONTRACTOR(S) shall submit the rationale to the State and perform the HRA in an alternative manner with State written approval.

nnnn. The CONTRACTOR(S) shall complete identified Needs Assessments as indicated by the HRA, in-person, as part of the same visit, but by no later than fourteen (14) Calendar Days of the completed HRA. (See 42 CFR § 438.210(b)(2)(iii) for requirement for LTSS.)

a. The CONTRACTOR(S) shall use the State prescribed tool designated for each HCBS Waiver program for the assessment of HCBS needs after the Member has been determined functionally eligible for the HCBS Waiver program.

b. The CONTRACTOR(S) shall use the State prescribed tool for the assessment of Behavioral Health needs.

c. The CONTRACTOR(S) shall submit additional Needs Assessments that target specific populations such as pregnant women, Children with Special Health Care Needs, etc.

d. The CONTRACTOR(S) shall reassess a Member's need for services at least every three hundred sixty-five (365) Calendar Days from the date of the last assessment or more frequently as a Member's needs change.

a. The CONTRACTOR(S)' care coordinator or the Community Care Coordinator (as applicable) shall note in the Member's record within one (1) Business Day of notification of the CONTRACTOR(S)' care coordinator or Community Care Coordinator of a Significant Change in Condition.

b. A reassessment of the Member's needs shall take place within three (3) Calendar Days of discovery or notice of Significant Change in Condition or needs. The PCSP will be dictated by State policy or HCBS Waiver, whichever is more restrictive, for HCBS Waiver Members. The reassessment can be an update to existing information in the HRA or Needs Assessment or a new assessment. The PCSP shall be updated to include any new required goals, interventions, or service authorizations for the Member and shall be signed by the Member, their Authorized Representative, Providers, and other relevant parties in accordance with PCSP requirements set forth in Section 2.4.4 or as dictated by State policy for the PCSP or the HCBS Waiver.

c. Actions taken (e.g., referrals to community agencies, authorizations of new services) by the CONTRACTOR(S) that were a result of a Significant Change in Condition will be communicated to the Member and documented in the Member's record within four (4) Business Days of the Significant Change in Condition event to ensure appropriate communication of the event or as specified in the State's policy.

d. The CONTRACTOR(S) shall implement a referral process for Care Coordination as indicated by the results of the HRA and Needs Assessments that has been approved by the State in writing.

e. Members identified as meeting Care Coordination criteria must be referred for further assessment of level acuity as well as Provider referral for services, as needed.

a. The CONTRACTOR(S) shall provide the State data derived from the Health Screen, HRA, Needs Assessment, and Plan of Service/PCSP by individual thirty (30) Calendar Days after completion. This will be provided to the State in a format prescribed by the State and will be transmitted to the State through the upload utility tool for storage in the KDHE enterprise data warehouse.

2.4.3 Long-Term Services and Supports Functional Eligibility Determinations

The CONTRACTOR(S) shall make referrals to the appropriate assessing entities to determine functional eligibility for enrollment in HCBS Waiver programs and/or Admission to any and all Adult Care Homes, including, but not limited to, NFs and/or ICF/IDDs, within two (2) Business Days of determining a possible need for LTSS. After a referral is made, the CONTRACTOR(S) must follow up with the referred entity per HCBS Waiver requirement to ensure the entity has either scheduled or completed the functional assessment.

2.4.4 Plans of Service and Person-Centered Service Planning

A. Except as otherwise specified in this CONTRACT (e.g., for Members in OneCare Kansas, WORK, and STEPS), the CONTRACTOR(S) shall develop and implement a Plan of Service for Members who receive Care Coordination but do not have a Person-Centered Service Plan (PCSP) or care plan). Members enrolled in HCBS Waiver services and Members with Behavioral Health needs who are not receiving CCBHC services shall receive Person-Centered Service Planning required in Section 2.4.4.2 – Person-Centered Service Planning. For Members in OneCare Kansas, WORK, and STEPS, the CONTRACTOR(S) shall comply with the requirements in the applicable State manual.

B. The CONTRACTOR(S) shall have an electronic signature platform to allow the use of electronic signatures as a substitute for written signatures. The CONTRACTOR(S) may use a Member's electronic signature when the Member has elected this option. The CONTRACTOR(S) may also obtain an electronic signature for other individuals (e.g., Authorized Representative or Provider) through the same platform when the individual agrees to that option.

2.4.4.1. Plans of Service

The Plan of Service is a written document that describes and records the Member's goals and service needs. The Plan of Service records the strategies to meet goals and interventions selected by the Member and team to support them in improving the Member's health and wellbeing and addressing Social Determinants of Health (SDOH).

A. The CONTRACTOR(S) shall ensure that all Members receiving Care Coordination who do not participate in the PCSP process (required for HCBS Waiver Members and Members with Behavioral Health who are not receiving services from a CCBHC) or the care planning process (for Members receiving CCBHC services) are able to participate in a Plan of Service planning process. The Plan of Service shall accurately document the Member's strengths, needs, goals, lifestyle preferences, and other preferences and outline the services and supports that will be provided to meet their identified needs through services provided or coordinated by the CONTRACTOR(S). The CONTRACTOR(S) shall also consider the availability and role of unpaid supports provided by family members and other natural supports.

B. The CONTRACTOR(S) shall provide to the State for written approval, a description of its Plan of Service process, and samples of all instruments to be used.

C. The CONTRACTOR(S) shall ensure that the Plan of Service is written in easily understood language and addresses the assessed needs of the Member by identifying all services and supports that will be provided, including those provided voluntarily by natural supports, services delivered by medical and professional staff, and by community resources or Providers.

D. The Plan of Service shall include the following components:

    1. Prioritized specific, measurable, achievable, realistic, and timely (SMART) goals and actions with timeframes for completion, and the Member's documented progress towards achieving the goals;

    b. A plan for effective and comprehensive transitions of care between care settings and levels of care, as needed by the Member; for Members transitioning from a facility, a discharge/transition plan that includes connection to community supports, including a warm hand-off from the facility to community supports;

    c. A plan for community integration that ensures compliance with the HCBS settings rule;

    d. A communication plan with the Member's PCP and other Providers, as needed, to ascertain the needs that Providers have identified for the Member, including a process to ensure the Provider's treatment plan is reflected in the Plan of Service;

    e. Identification of the Providers responsible for delivering services to the Member, identification of linkages made to specialists or other Providers, and confirmation that the Member received the needed service;

    f. Identification of any other care coordination or case management services the Member may be receiving from other programs, and a plan for coordinating with these services to avoid duplication of efforts;

    g. A provision to refer the Member, if needed, to community or social support services, assist the Member in contacting the service provision agency, and validating the Member received the needed service;

    h. A plan for continuous review and revision of the Plan of Service that includes follow-up contact, as needed, with the Member to ensure the Plan of Service is adequately monitored, including identification of gaps in care;

    i. A communication plan with the Member, including anticipated frequency and method of contacts;

j. A provision to share feedback with the Member's PCP on the Member's engagement with the Plan of Service, and for continuing to collaborate with the Member's PCP;

k. A disaster/emergency plan that considers the special needs of the Member (e.g., infant feeding for Members with infants, power back-up plan for Members using power-dependent medical equipment or devices; and

l. Care coordinator name and direct contact information along with appropriate off-hours contact information.

E. The CONTRACTOR(S) shall use a standardized Plan of Service template prior approved in writing by the State for use by all KanCare MCOs.

F. The CONTRACTOR(S) shall ensure that the Plan of Service is developed, signed by, and distributed to all relevant parties within thirty (30) Calendar Days of the Plan of Service planning meeting.

G. The CONTRACTOR(S) must develop a process by which the Plan of Service is signed and approved and must comply with the following requirements.

1. The Plan of Service must be completed with all required data elements prior to the signature process.

m. The Plan of Service must be signed by the Member, their care coordinator, their Community Care Coordinator (as applicable), and any Providers or other individuals present during the development of the Plan of Service.

n. The Plan of Service cannot be implemented until at a minimum the care coordinator's, the Community Care Coordinator's, and the Member's signature is obtained unless an extraordinary circumstance prevents signatures from being obtained as indicated by State policy.

H. The CONTRACTOR(S) shall ensure that the Plan of Service is reviewed during every contact with the Member and updated with new signatures obtained as prescribed at least annually or more often based on changes on Member's needs.

I. Members shall be provided a choice of paper or electronic Plan of Service prior to development of the plan. A completed Plan of Service must be provided to the Member prior to services beginning.

2.4.4.2. Person-Centered Service Planning

The Person-Centered Service Plan (PCSP) is a written service plan developed in accordance with the person-centered planning requirements set forth in Federal regulations and State policy using a standardized template prior approved by the State in writing for use by all KanCare MCOs. The PCSP is a written document that describes and records the Member's person-centered goals and service needs. The PCSP records the strategies to meet the goals and interventions selected by the Member and team to support them in improving the Member's health and wellness and in addressing SDOH.

A. For all Members enrolled in a HCBS Waiver and Members with Behavioral Health needs who are not receiving services from a CCBHC, the CONTRACTOR(S) shall ensure that Members are able to participate in a PCSP process that is compliant with Federal and State law and the State's PCSP policy. The CONTRACTOR(S) will ensure the PCSP includes the use of an interdisciplinary team of professionals including individuals chosen by the Member. The professionals must have adequate knowledge, training, and expertise around community living and person-centered service delivery.

The process must promote self-determination and actively engage the Member and individuals of their choice.

B. The CONTRACTOR(S) shall comply with applicable State and Federal rules (42 CFR. § 441.301(c) and K.A.R. 30-63-1 Article 63) when developing the PCSP and associated assessments. The CONTRACTOR(S) shall provide to the State for written approval a description of the PCSP process and samples of all instruments to be used.

C. The CONTRACTOR(S) must develop a process by which the PCSP is signed and approved and must comply with the following requirements.

   1. The PCSP must be completed with all required data elements prior to the signature process.

   o. The PCSP must be signed by the Member, guardian, or legal representative, CONTRACTOR(S)' care coordinator, Community Care Coordinator (as applicable), and all Providers listed on the PCSP.

   p. The PCSP cannot be implemented until, at a minimum, the care coordinator's, the Community Care Coordinator's, and the Member's signature is obtained unless an extraordinary circumstance prevents signatures from being obtained as indicated by State policy.

D. The CONTRACTOR(S) shall ensure that the PCSP is reviewed during every contact with the Member and updated at least annually or more often based on changes to Member's needs.

E. The CONTRACTOR(S) shall be responsible for approving the PCSP as well as approving the amount, scope, and duration of services contained in the PCSP within the timeframes described in Section 2.4.4.2.H.

F. The CONTRACTOR(S) shall demonstrate its processes and procedure to ensure that its care coordinator or contracted Community Care Coordinator (as applicable to the population – see Appendix L [Care Coordination Matrix]) works with the Member and their interdisciplinary team on developing the PCSP that includes recommendations regarding amount, scope, and duration of services. The care coordinator/Community Care Coordinator is also responsible for monitoring the implementation of the plan and updating it as needed.

G. The CONTRACTOR(S) shall ensure all required signatures for the PCSP are collected and are available to the State upon request.

H. The CONTRACTOR(S) shall ensure that the HCBS Needs Assessment and the development of the PCSP with signatures occurs and that the approved, signed plan is distributed to Members of the interdisciplinary team within fourteen (14) Calendar Days of the establishment of HCBS Waiver eligibility.

2.4.5 Care Coordination Stratification Levels and Contact Schedules

The CONTRACTOR(S) shall develop and implement a Care Coordination program, approved in writing by the State, that promotes person-centered care and improved health Outcomes for KanCare Members, addresses all the goals of the Care Coordination program, and includes a system of monitoring and oversight of the Care Coordination program.

As part of the Care Coordination program, each Member participating in the Care Coordination program shall have a single point of contact (e.g., CONTRACTOR(S)' care coordinator, a Community Care Coordinator, a TCM). The CONTRACTOR(S) shall provide Members a direct telephone number and

email address for contacting their CONTRACTOR(S)' care coordinator and Community Care Coordinator (as applicable) during business hours. For after hours, the Member will be directed to use the nurse line or afterhours service and provided this contact information.

The Care Coordination program shall include three (3) levels of Care Coordination based on the Member's needs as a result of the HRA and Needs Assessments. The CONTRACTOR(S) shall use the following criteria as the basis for assigning Members to a stratification level but may add additional criteria as approved by the State in writing. The three (3) levels are:

A. Level I – Short-Term/Transition of Care Needs: Members require intermittent specific assistance, including discharge planning from a short-term acute stay. Examples:

    1. Member is moved from one level of care or service to another.

    q. Discharge from hospital after a short-term stay.

B. Level II – Chronic Long-Term Needs: Members identified with chronic conditions in need of long-term Care Coordination including, but not limited to, all Members residing in the community enrolled in a HCBS Waiver program and Members on a HCBS Waiver waiting list.

C. Level III – Complex/High-Risk: Members in need of more frequent, intensive Care Coordination including individuals with complex needs or who are homeless.

D. Members in foster care, Members discharged from a long-term stay in an institutional setting shall be placed in either Level II or Level III of Care Coordination based on their individual needs.

E. The CONTRACTOR(S) shall re-evaluate the appropriateness of Member's Care Coordination level, in-person, at least annually or more often based on changes in the Member's needs or circumstances, upon request of the Member or the Member's Authorized Representative.

F. Care Coordination Contacts: The CONTRACTOR(S) shall make contacts (telephonic or in-person) with the Member based on the Member's needs and shall comply with the following minimum contact schedule based on the Member's assigned Care Coordination stratification level. If the Member has a Community Care Coordinator, the Community Care Coordinator shall comply with the following contact schedule, and the CONTRACTOR(S)' care coordinator shall conduct two (2) in-person visits per year. The CONTRACTOR(S)' care coordinator shall provide the Member's Community Care Coordinator with advance notice of the visit and invite the Community Care Coordinator to join the visit.

    1. Level I – Short-Term/Transition of Care Needs:

        a. As determined by the CONTRACTOR(S) to meet the individual's needs but includes at least one (1) in-person visit after discharge along with necessary telephonic contacts needed to ensure continuity of care. After discharge at a minimum one (1) in-person visit by the care coordinator at least annually.

        b. The CONTRACTOR(S) shall make available their contact schedule methodology upon request from the State.

    c. Level II – Chronic Long-Term Needs:

        a. At a minimum monthly telephonic contact and with a minimum of an in-person visit every three (3) months.

b. Level III – Complex/High-Risk:

   a. At minimum monthly telephonic contacts and an in-person visit every other month.

b. Contacts for all levels can be made by any member of the Member's interdisciplinary team. The results of the contact and notes about the meeting must be documented in the Member's electronic record.

2.4.6 Care Coordination Roles and Responsibilities

A. The CONTRACTOR(S) approach to Care Coordination (model of care) must contain the features of a high-performing Care Management system including, but not limited to:

   1. Person and family centeredness;

   c. Timely, proactive, and planned communication and action;

   d. The promotion of self-care and independence;

   e. Emphasis on cross continuum and system collaboration and relationships;

   f. Comprehensive consideration of physical, behavioral, and SDOH needs and community integration; and

   g. Promotion of community access and participation for Members at-risk for isolation or who encounter barriers to participating in community activity.

B. The CONTRACTOR(S) is ultimately responsible for all Care Coordination activities below and displayed in Appendix L (Care Coordination Matrix) and shall ensure the following tasks are performed:

   1. Conducting Health Screens, HRAs, and Needs Assessments.

   h. Developing, approving, implementing, updating, and monitoring PCSPs and Plans of Service.

   i. Providing choice counseling, including Provider choice and the exploration of interest/ability to move to a community setting for Members residing in institutional settings.

   j. Conducting Member contacts and home visits.

   k. Monitoring Member health and safety.

   l. Coordinating physical health, Behavioral Health, LTSS, and Transportation needs, as appropriate.

   m. Providing information on accessing Durable Medical Equipment (DME), assistive services, and home modifications and helping Members navigate the process, including obtaining bids for home modifications.

   n. Assisting Members with maintaining Medicaid eligibility, including how to maintain benefits when working.

   o. For Members residing in institutional settings:

      a. Supporting and educating the facility on pharmaceutical approaches;

b. Coordinating services external to the facility; and

c. Providing transition coordination/transition planning.

d. For Members in hospitals and other institutional settings:

a. Providing transition coordination/transition planning; and

b. Assisting in discharge planning and securing appropriate community services.

c. Providing linkage and referrals to community resources and non-Medicaid supports.

d. Providing support for education, employment, and housing, including making referrals, and follow up.

e. Education of the Member about Self-Direction of services and the Working Healthy/WORK program, STEPS and Other Employment Programs, and support of the Member who chooses to self-direct certain HCBS, WORK, or STEPS services.

f. Complying with all requirements described in K.A.R. 30-63-32 when providing Care Coordination to individuals with IDD.

g. For Members receiving TCM, coordination and collaboration with the Member's targeted case manager. See Appendix L (Care Coordination Matrix).

h. For Members receiving CCBHC services, coordination and collaboration with the CCBHC. See Appendix L (Care Coordination Matrix).

i. For Members receiving community Care Coordination, coordination and collaboration with the Community Care Coordinator. See Section 2.4.6.C below and Appendix L (Care Coordination Matrix).

j. For Members in foster care, coordination and collaboration with CMPs.

C. The CONTRACTOR(S) must Subcontract with local entities (Community Care Coordination Providers) to perform community-based Care Coordination. The Community Care Coordinators shall be located in a Member's community, have knowledge of local resources, and be the Member's primary point of contact. The CONTRACTOR(S) shall support Community Care Coordination Providers and Community Care Coordinators by:

1. Delineating responsibilities between the Community Care Coordinator and the CONTRACTOR(S) in order to avoid duplication or gaps in services.

2. Maintaining a single CONTRACTOR(S) point of contact for the Community Care Coordinator.

k. Providing necessary data, documents, and information to the Community Care Coordinator. Establishing a protocol for the transmission of required and requested data, information, and reports in a timely manner.

l. Serving as a resource for the Community Care Coordinator including, but not limited to, providing information and support for physical, Behavioral Health, and LTSS needs as well as employment, housing, and Transportation.

3. Responding to requests from the Community Care Coordinators for assistance or support in a timely manner.

m. Ensuring CONTRACTOR(S) and Community Care Coordinators meet conflict of interest requirements, as specified in Section 2.4.14.

n. Conducting joint home visits with the Community Care Coordinator.

D. The CONTRACTOR(S) shall develop a contingency plan for when there are short-term gaps in community Care Coordination capacity and must notify the State upon activation of the contingency plan. The CONTRACTOR(S) shall work to build capacity in the local community for community service coordination. The CONTRACTOR(S) shall document and make documentation available to the State upon its request, its attempts to contract with community-based organizations for the provision of community Care Coordination.

E. The CONTRACTOR(S) may use a team approach where non-clinicians may perform certain tasks, including, but not limited to, confirmation of Provider appointments, scheduling home visits, arranging Transportation, and facilitation of distribution of the Plan of Service/PCSP to the Member and Providers.

1. The CONTRACTOR(S) may provide or Subcontract with a certified peer support Provider as part of the Care Coordination team:

a. The certified peer support Provider may:

i. Help the Member develop a recovery social network for information and support from others who have been through similar experiences.

ii. Assist the Member with regaining the ability to make independent choices and to take a proactive role in treatment including discussing questions or concerns about medications, diagnoses, or treatment with their clinician.

iii. Assist the Member to identify and effectively respond to or avoid identified precursors or triggers that result in functional impairments.

b. The CONTRACTOR(S) may provide or Subcontract with a certified Positive Behavioral Support (PBS) facilitator as part of the services for the Care Coordination team:

a. The certified PBS facilitator may provide EPSDT service to anyone under age twenty-one (21) who is recommended by physician or licensed professional with Prior Authorization based on Medical Necessity.

b. The certified PBS facilitator may provide:

i. PBS Assessment: To include a functional behavior assessment, interviews, and observations in multiple settings, use of PBS tools to conduct PBS assessment based on national standards.

ii. Person-Centered Planning: A service provided by a certified PBS facilitator and driven by Member/family along with natural supports to prevent and decrease likelihood of more significant challenging behaviors. This process results in a behavioral plan that is goal and objective driven with incorporation of health, medical, and psycho/social, outlining

quality of life and independence indicators, highlighting strengths, appropriateness of environment, activities, and rate of reinforcement/or corrective feedback.

iii. PBS Treatment: A preventative service to provide goal-directed supports and solution focused interventions as set forth in PBS person-centered plan. PBS treatment is an in-person intervention with the Member present. The majority of PBS treatment must occur in community settings where the Member lives, works, and socializes. PBS interventions are prevention-based strategies which include antecedent interventions, ongoing assessment and cueing, and modeling behavior alternatives.

2.4.7 Qualifications for Care Coordinators

The CONTRACTOR(S)' care coordinators shall have experience that is appropriate to the Member's health care needs and shall perform activities within their scope of practice in accordance with applicable licensing/ credentialing rules. The CONTRACTOR(S) has the flexibility to determine the care coordinator qualifications for populations not specifically listed in this section.

CONTRACTOR(S)' care coordinators and Community Care Coordinators serving Members who are in multiple population groups, such as Members in foster care who are enrolled on a HCBS Waiver, shall be assigned a care coordinator and Community Care Coordinator most appropriate for the Member's needs and that has experience working with the populations to be served.

At minimum care coordinator and Community Care Coordinator qualifications shall include:

A. For Members with a LTSS need, the CONTRACTOR(S)' care coordinators shall:

   1. Have at least a bachelor's degree in social work, rehabilitation, nursing, psychology, special education, gerontology, or related health and human services area or be a registered nurse (RN) licensed in Kansas.

   c. Have at least one (1) year of experience working with individuals with long-term care needs, and if working with a specific HCBS Waiver population (e.g., IDD, BI, or FE), at least one (1) year of experience working directly with that population. Full-time experience in the field of developmental disabilities services may be substituted for the degree at the rate of six (6) months of full-time experience for each missing semester of college for care coordinators working with individuals with IDD. Additionally, care coordinators providing services to individuals with IDD must meets qualifications described in K.A.R. 30-63-32.

   d. Comply with additional qualifications as described in the State's HCBS Waivers.

B. For Members in a HCBS Waiver (other than the TA HCBS Waiver) or on a HCBS Waiver waiting list, the CONTRACTOR(S) shall ensure that the Member's Community Care Coordinator has (1) a minimum of six (6) months of full-time experience with the applicable population; and (2) either a bachelor's degree or additional full-time experience with the applicable population, which may be substituted for the degree at the rate of six (6) months of full-time experience for each missing semester of college.

C. For Members in the technology assisted (TA) HCBS Waiver, the CONTRACTOR(S)' care coordinator shall be an RN, licensed in Kansas. The CONTRACTOR(S) shall ensure that the Member's Community Care Coordinator meets the requirements in 2.4.7.B.

D. For Members with a Behavioral Health need, the CONTRACTOR(S)' care coordinators shall:

1. Have at least a bachelor's degree in social work, nursing, rehabilitation, psychology, or related health and human services area, or be a RN.

e. Have at least one (1) year of experience working with individuals with Behavioral Health needs and receive training in trauma-informed care.

E. For youth in custody through the foster care system with complex/high needs, the CONTRACTOR(S)' care coordinators shall:

1. Have at least a master's degree in social work, nursing, psychology, or related health and human services area or be an RN.

f. Have at least one (1) year of experience working with multi-system children.

g. Receive training in trauma-informed care.

F. For youth in custody through the foster care system with moderate needs, the CONTRACTOR(S)' care coordinators shall:

1. Have at least a bachelor's degree in social work, nursing, psychology, or related health and human services area or be a RN.

h. Have at least one (1) year of experience working with multi-system children.

i. Receive training in trauma-informed care.

2.4.8 Care Coordination Ratios

A. The CONTRACTOR(S) shall employ a methodology for assigning consistent and appropriate caseloads for CONTRACTOR(S)' care coordinators and Community Care Coordinators to ensure that Member's care needs are met timely (including timely referral and follow-up activities), Members can contact their care coordinator/Community Care Coordinator when needed and receive a timely response (within one [1] Business Day unless a shorter timeframe is required to address a health or safety concern), and the health, welfare, and safety for Members. The CONTRACTOR(S) must submit the methodology to the State for written approval and must incorporate the following factors into its caseload assignment methodology:

1. Population;

j. Acuity status mix;

k. Care coordinator/Community Care Coordinator qualifications, years of experience, and responsibilities;

l. Provision of support staff;

m. Location of care coordinator/Community Care Coordinator (e.g., community, CONTRACTOR(S)' office, Provider's office); and

n. Geographic proximity of care coordinators/Community Care Coordinators to Members (if community-based).

B. The CONTRACTOR(S) shall ensure if the CONTRACTOR's care coordinator or community care coordinator is part of a Behavioral Health team where staffing ratios are part of a fidelity model that their staffing ratio comports with the fidelity requirements

C. The CONTRACTOR(S) shall ensure there is a method to evaluate caseload assignments quarterly, including identification of circumstances that automatically trigger a review or adjustment of caseload sizes. Once evaluated, the CONTRACTOR(S) must make changes to coincide with ratio requirements.

D. The CONTRACTOR(S) shall ensure that caseload assignment provides for the name and telephone number of the Members, assigned CONTRACTOR(S)' care coordinator and Community Care Coordinator, along with an alternative number the Member may use in case their assigned care coordinator/Community Care Coordinator is in the field. For evening and weekend coverage, alternative numbers may be used with the expectation that the care coordinator/Community Care Coordinator or their designee will follow up with the Member in forty-eight (48) hours.

E. The CONTRACTOR(S) shall ensure that Members are notified via telephone or by mail of any CONTRACTOR(S)' care coordinator's or Community Care Coordinator's departure at least seven (7) Calendar Days in advance of the care coordinator's last day, if the CONTRACTOR(S) had advance notice of the care coordinator's departure, and shall provide name and number of alternative contact until a new care coordinator is assigned.

F. The CONTRACTOR(S) shall assign a new CONTRACTOR(S)' care coordinator or Community Care Coordinator and must ensure the Member is contacted within three (3) Business Days of new assignment.

G. A team approach may be used to meet Care Coordination needs as long as the Member has a single point of contact.

H. The CONTRACTOR(S) shall submit a staffing plan for the Care Coordination program that includes a description of how it will monitor Care Coordination vacancies.

I. The CONTRACTOR(S) shall provide updates to the staffing plan monthly with information about positions filled and those left open.

J. As part of its model of care description submitted to the State, the CONTRACTOR(S) must address the following:

    1. Its internal process (e.g., criteria for making assignment, notifications, information and data sharing, and training) when the CONTRACTOR(S)' care coordinator or Community Care Coordinator resigns or has an assignment change.

    o. Its turnover rates for care coordinators/Community Care Coordinators.

    p. Its average level of education for care coordinators/Community Care Coordinators.

    q. Its process for determining the appropriate size of care coordinator/Community Care Coordinator caseloads and how it monitors them.

2.4.9 Care Coordination Training Requirements

The CONTRACTOR(S) shall develop a comprehensive onboarding and training program that is completed by all CONTRACTOR(S)' care coordinators and Community Care Coordinators before they

begin providing Care Coordination services. The training program must be prior approved by the State in writing and include the following components:

A. A dedicated staff trainer who ensures that all training requirements are met.

B. A detailed Care Coordination training plan describing how the CONTRACTOR(S) will meet the initial, annual, and additional training requirements.

C. An initial training curriculum that at a minimum includes:

1. The CONTRACTOR(S)' model of care;

r. The State's HCBS Waivers, including the target population, services, HCBS settings requirements, and requirements of each HCBS Waiver, including HCBS Waiver assurance performance measures;

s. HCBS settings rule;

t. How to help Members maintain Medicaid eligibility, including how to assist Members to maintain benefits when working, including connecting Members to a Working Healthy benefits specialist;

u. Cultural competency;

v. PCSP and Plan of Service;

w. Grievance and Appeals reporting, processes, and procedures;

x. Availability of community resources in the care coordinator's respective geographic areas, including informal, non-Medicaid resources;

y. Referrals and Case Management strategies that are needed as a result of HRA (or risk assessment) and chronic care needs;

z. Care Management strategies for disease specific processes;

aa. Abuse/neglect/exploitation recognition and mandated reporter requirements, and reporting requirements and use of the State's adverse incident reporting system (AIR);

bb. Safeguards concerning restraints and restrictive interventions, including population-specific requirements and information on the different types of restraints and restrictive interventions;

cc. HIPAA;

dd. Clinical assessment and documentation;

ee. Interviewing, asking appropriate questions;

ff. Medication monitoring;

gg. Members' rights and responsibilities;

hh. Medicaid Fraud and Abuse;

ii. Trauma-informed care;

jj. SDOH and community integration;

kk. Advance Directives and legal designations (e.g., guardian, power of attorney, representative payee, etc.); and

ll. K.A.R. 30-63-1 through 30-63-32 addressing training requirements for the IDD populations.

D. An annual training curriculum that includes at a minimum:

1. Cultural competency;

mm. The State's HCBS Waivers, including HCBS Waiver assurance performance measures;

nn. HCBS settings rule;

oo. Person-centered service planning;

pp. Grievance and Appeals reporting, processes, and procedures;

qq. Abuse/neglect/exploitation recognition, mandated reporter requirements, and associated reporting requirements;

rr. Safeguards concerning restraints and restrictive interventions;

ss. HIPAA;

tt. Medicaid Fraud and Abuse;

uu. Trauma-informed care; and

vv. SDOH and community integration.

E. The CONTRACTOR(S) shall conduct an ongoing evaluation of the success of training and assessment for the need for additional training.

F. The CONTRACTOR(S) shall conduct additional training as needed based on quality monitoring results and performance measures.

2.4.10 Requirements for Specified Populations

In addition to the requirements set forth in Section 2.4 of the CONTRACT and Appendix L (Care Coordination Matrix), the CONTRACTOR(S) shall meet the following requirements for specified populations.

A. Individuals enrolled in a HCBS Waiver:

1. The CONTRACTOR(S)' care coordinators and Community Care Coordinators for Members enrolled in a HCBS Waiver shall comply with the requirements in the applicable HCBS Waiver and State policy.

ww. The CONTRACTOR(S) shall ensure that a Member's PCSP is developed using a person-centered planning process, addresses all identified needs (including physical health, Behavioral Health, LTSS, and SDOH needs), and that each Member has an individualized back-up plan and a disaster/emergency plan.

xx. The CONTRACTOR(S) shall ensure that the Member's PCSP supports full access to the greater community, including opportunities to seek employment and work in competitive integrated

settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS Waiver services.

yy. The CONTRACTOR(S) shall ensure that Members enrolled in a HCBS Waiver are residing in settings that are compliant with the HCBS settings rule.

zz. The CONTRACTOR(S) shall provide all Members receiving HCBS Waiver services with the appropriate notice for any Adverse Benefit Determination. Such notification shall be provided as required by State and Federal regulations, HCBS Waiver requirements, and applicable KDHE and KDADS policy related to timely and appropriate notice as specified in Appendix D (Grievances and Appeals).

aaa. The CONTRACTOR(S) shall notify the State when a Member is admitted to an institution within forty-eight (48) hours of becoming aware of the admission and using the process established by the State, including completing form ES-3161 (notification of HCBS changes/updates).

bbb. The CONTRACTOR(S) shall recommend timely voluntary and involuntary closure for HCBS Waiver services to the appropriate State agency using the established notification process as described by the State. Reasons for voluntary and involuntary terminations as defined by the HCBS Waiver service notification of termination policy may include, but are not limited to:

a. Member has no assessed need for services upon assessment or reassessment.

b. Client obligation is higher than the cost of service as identified in the PCSP.

c. Member has refused to pay client obligation as documented by the Provider to whom the client obligation is to be paid or the financial management services (FMS) Provider and verified by the care coordinator.

d. Member has refused services and supports identified on the PCPS as documented and signed by the Member and/or Authorized Representative.

e. Member has been institutionalized for longer than the temporary care period of time (the month of Admission and two [2] subsequent months) and is no longer eligible for services.

f. Member is unable to be located or fails to respond per requirements in Section 2.5.10.A.8, to attempts to locate for initial or annual assessment for services.

g. Member refuses to sign the PCSP.

h. Member is no longer receiving services under the HCBS Waiver.

i. Member has requested termination of services.

j. Member cannot be contacted or does not respond to reasonable attempts to contact the Member as required by the notification of termination policy.

k. Termination for the inability to contact an HCBS Waiver Member regarding initial or annual assessments for services and supports shall be documented according to the notification of closure policy. The CONTRACTOR(S) shall make three (3) attempts to contact the Member or Member’s Authorized Representative (when applicable), including a minimum of one (1) home

visit. The home visit requirement is not applicable if the visit is to be with an Authorized Representative who lives more than fifty (50) miles across the State border. All contacts shall be attempted within fourteen (14) Business Days from the date of the initial attempt to contact the Member. If unsuccessful, the CONTRACTOR(s) will notify the Member of the Grievance and Appeal process. If all attempts to contact the Member by the CONTRACTOR(S) prove unsuccessful, the CONTRACTOR(S) shall notify the appropriate State agency using the established notification process as described by the State. The State agency may intervene to attempt contact with the Member, and all recommendations by the CONTRACTOR(S) must be approved by the State in writing. The CONTRACTOR(S) shall provide the State with the appropriate notice recommendation to close the services and supports for the Member.

B. Individuals on a 1915(c) HCBS Waiver waiting list:

1. The CONTRACTOR(S) shall ensure that each Member on a 1915(c) HCBS Waiver waiting list has a Plan of Service that is developed using a person-centered planning process and includes Covered Services, EPSDT, in lieu of services, value-added benefits, and informal supports to address the Member's needs, including SDOH needs.

C. Individuals in institutional settings:

1. The CONTRACTOR(S) shall assign a care coordinator to all Members residing in institutions (e.g., NF, NFMH, hospital, ICF/IID, State hospital, psychiatric hospital/SIA, PRTF, SUD residential treatment facility). A care coordinator shall also be assigned to all individuals residing within a State correctional facility once the individual receives a Tier 1 presumptive medical determination from KDHE.

l. The CONTRACTOR(S) shall assign the Care Coordination stratification level that is most appropriate to meet the Member's needs.

m. The CONTRACTOR(S) shall participate in, at a minimum, one (1) Care Coordination meeting with the Member, their family, and the facility staff at least annually.

n. The CONTRACTOR(S) shall participate in, at a minimum, one (1) Care Coordination meeting with the Member and correctional facility staff prior to the Member's discharge/release from a State correctional facility.

o. The CONTRACTOR(S) shall at least annually evaluate if the Member's needs can be met in a less restrictive environment that includes assessing the Member's interest in and ability to transition to the community, including analyzing information from the minimum data set (MDS) for Members residing in a NF/NFMH, and determine if the Member has an interest in transitioning to a community setting. Requests for evaluations may also come from the ombudsman (KanCare or Long-Term Care), Member, or Member's Authorized Representative.

p. The CONTRACTOR(S) shall develop a transition plan to help support the transition to a less restrictive environment as appropriate. A transition plan shall also be created for Members discharging/releasing from a State correctional facility in conjunction with State corrections staff.

q. The CONTRACTOR(S) shall ensure that care coordinators initiate and participate in the institutional transition process for Members being discharged from a qualified institutional setting (e.g., NF, State Hospital, ICF/IID, or PRTF) who are eligible for the State's institutional transition process and/or the State's Money Follows the Person (MFP) program.

r. The CONTRACTOR(S) shall ensure supports are in place prior to the discharge and transition to new setting.

s. The CONTRACTOR(S) shall assist Members with accessing safe and sustainable housing and must employ a housing specialist to help support these efforts.

t. The CONTRACTOR(S) shall assist with helping the Member relocate to another facility if they express a desire to move or the quality of the current facility places a Member's health and welfare at risk and ensuring all the necessary supports are available for a successful transition.

u. The CONTRACTOR(S) shall monitor the success of the Member's community transition and ensure if enrolled in a HCBS program that the new setting is complaint with the HCBS settings rule.

v. The CONTRACTOR(S) shall comply with the requirements in Section 2.4.12, Care Transitions and Diversion Activities.

D. Adults with Behavioral Health needs:

1. For Members with Behavioral Health needs who are not receiving services from a CCBHC, the CONTRACTOR(S) shall connect the Member with a CCBHC and conduct follow up as needed to ensure the Member is receiving needed services.

2. The CONTRACTOR(S) shall be responsible for all Care Coordination activities until the Member is actively engaged with a CCBHC.

3. The CONTRACTOR(S) must ensure protocols, policies, and processes are in place for care coordinators to appropriately address Member contacts related to Behavioral Health crisis needs.

w. Protocols must include, at a minimum, how the care coordinator will refer Members to Behavioral Health Services and timeframes for updates in the PCSP that ensures the Member's health and safety needs are met.

x. The CONTRACTOR(S) must develop procedures for cross training and consultation for care coordinators and community-based Behavioral Health Providers in order to facilitate continuity of care and cost-effective use of resources.

y. The CONTRACTOR(S) shall develop policy and procedures for obtaining releases to share clinical information and providing health records to community-based Behavioral Health Providers as requested, consistent with State and Federal confidentiality requirements.

z. The CONTRACTOR(S) shall facilitate the sharing of information, including PCSPs and transitional services between the care coordinator and jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service Providers, and the PCP.

aa. The CONTRACTOR(S) shall assist individuals with accessing safe and sustainable housing and employ a housing specialist to help support these efforts.

E. Children with SED:

1. For Members with SED who are not receiving services from a CCBHC, the CONTRACTOR(S) shall connect the Member with a CCBHC and conduct follow up as needed to ensure the Member is receiving needed services.

2. The CONTRACTOR(S) shall be responsible for all Care Coordination activities until the Member is actively engaged with a CCBHC.

3. The CONTRACTOR(S) shall ensure that any care coordinator or community care coordinators working with Members with SED and their families who require intensive care coordination through wraparound facilitation comply with all training, educational, and treatment requirements required by the evidence-based practice.

bb. The CONTRACTOR(S) shall work with CCBHCs to ensure there are alternatives available to children with SED residing in PRTFs, by providing services in the least restrictive settings.

F. Youth in foster care:

1. The CONTRACTOR(S) shall have a full-time foster care coordinator who serves as the single point of contact for foster care CMPs (see Section 2.17.2.C).

cc. The CONTRACTOR(S) shall ensure care coordinators and Community Care Coordinators (for foster care youth who have a Community Care Coordinator, e.g., enrolled in the PD HCBS Waiver) working with youth in foster care have demonstrated experience working in the foster care system.

dd. The CONTRACTOR(S) shall ensure care coordinators and Community Care Coordinators who are working with youth in foster care are aware of the roles and responsibilities of CMPs versus the foster parent in making decisions on behalf of the child and shall provide specialized training, as needed.

ee. For youth in foster care with Behavioral Health needs, the CONTRACTOR(S) shall assist in connecting the Member with a CCBHC (to receive CCBHC services) or CMHC (to determine eligibility for the SED HCBS Waiver) and following up, as needed.

ff. For youth in foster care potentially eligible for a HCBS Waiver, the CONTRACTOR(S) shall assist in connecting the Member with the appropriate assessing entity for determination of eligibility and following up, as needed.

gg. The CONTRACTOR(S) shall be responsible for all Care Coordination activities unless the Member is linked and actively engaged with a CCBHC or TCM.

hh. The CONTRACTOR(S) shall assure continuity of care, including, but not limited to, continuity in the CONTRACTOR(S)' care coordinator and Community Care Coordinator for children moving from one (1) placement setting to another.

ii. The CONTRACTOR(S)' care coordinator or Community Care Coordinator shall make a home visit within forty-eight (48) hours of placement when there is a change in placement.

jj. The CONTRACTOR(S) shall ensure that an interdisciplinary team meeting (consisting of at a minimum, the care coordinator, the placement Provider, the child welfare management worker, and the treatment Provider [if one]) are held via phone or in-person within seven (7) Calendar Days of a new and/or change in placement.

kk. For Members in foster care with complex/high needs or moderate needs (as defined in Section 2.4.1.D), the CONTRACTOR's care coordinator shall be located in the Member's community.

ll. For Members in foster care with complex/high needs (as defined in Section 2.4.1.D), the CONTRACTOR's care coordinator shall have, at minimum, weekly telephonic contact with the Member and an in-person visit every other month.

mm. For Members in foster care with moderate needs (as defined in Section 2.4.1.D), the CONTRACTOR(S)' care coordinator shall have at minimum, bimonthly (twice a month) telephonic contact with the Member and an in-person visit every three (3) months.

nn. The CONTRACTOR(S) must provide in its Care Coordination model description of how they work with children with complex needs, including, but not limited to, children who have had multiple foster care placements or who are involved with multiple systems of care.

G. Individuals participating in WORK or STEPS:

1. For Members participating in WORK, the CONTRACTOR(S) shall comply with the requirements in Section 2.3.2 of this CONTRACT.

2. For Members participating in STEPS, the CONTRACTOR(S) shall comply with the requirements in Section 2.3.3 of this CONTRACT.

H. Individuals who are pregnant or postpartum:

1. For Members who are pregnant or postpartum, the CONTRACTOR(S) shall comply with the requirements in Section 2.4.11 of this CONTRACT.

I. The CONTRACTOR(S) shall ensure that the CONTRACTOR(S)' care coordinators and the community service coordinators who work with Members who fall into multiple special needs categories (e.g., foster children enrolled on a HCBS Waiver) comply with all requirements described in Section 2.4.10, as appropriate.

J. Should the CONTRACTOR(S) suspect that an inability to contact a Member is the result of any abuse, neglect, or exploitation, the CONTRACTOR(S) shall make immediate referrals to the appropriate State agency for follow-up and investigation, in accordance with Section 2.9.9 of this CONTRACT.

2.4.11 Maternity Care Coordination

In addition to the requirements set forth in Section 2.4 of the CONTRACT, the CONTRACTOR(S) shall meet the following requirements for Care Coordination for pregnant Members and postpartum Members through one (1) year postpartum (maternity Care Coordination). The CONTRACTOR(S) shall develop and implement strategies to identify Members early in their pregnancy and engage Members, particularly Members with high-risk pregnancies, in maternity Care Coordination.

A. The CONTRACTOR(S) maternity Care Coordination program shall include two (2) levels of Care Coordination based on the Member's needs. The CONTRACTOR(S) shall use the following criteria as the basis for assigning Members to a stratification level but may add additional criteria as approved by the State in writing:

1. Low-Risk Maternity: All pregnant and postpartum Members through one (1) year postpartum who do not meet the criteria for high-risk maternity.

oo. High-Risk Maternity: Pregnant and postpartum Members through one (1) year postpartum with chronic physical health conditions, with mental health conditions, with SUD, and/or with SDOH that directly impact the health and well-being of the mother and/or infant.

B. The CONTRACTOR(S) shall make contacts (telephonic or in-person) with the Member based on the Member's needs and comply with the following minimum contact schedule based on the Member's assigned Care Coordination stratification level:

1. Low-Risk Maternity: Monthly telephonic contact to ensure Member is receiving appropriate prenatal and postpartum care.

pp. High-Risk Maternity: Initial in-person visit and then monthly telephonic contact to assess Member needs, monitor the Member's Plan of Service, and provide other Care Coordination services.

C. The CONTRACTOR(S) is not required to develop a Plan of Service for Members assigned to the low-risk maternity level, but must develop a Plan of Service for Members assigned to the high-risk maternity level.

D. For Members in maternity Care Coordination, the care coordinators shall meet the following qualifications:

1. Be licensed as an RN or licensed practical nurse (LPN) in Kansas with two (2) years of qualifying experience; or

qq. Have a bachelor's degree in health, human, social work, or education services with one (1) or more years of qualifying experience with Care Coordination of individuals with complex health conditions, including Care Coordination of Behavioral Health conditions.

E. Within ten (10) Business Days of a Member being identified as pregnant or postpartum, the assigned care coordinator must initiate contact with the Member. The CONTRACTOR(S) shall make at least three (3) attempts to contact the Member, including a minimum of one (1) in-person contact for Members identified for high-risk maternity Care Coordination, within the first fourteen (14) Business Days of initial identification as pregnant or postpartum. The CONTRACTOR(S) shall document all outreach attempts.

F. Care coordinators shall ensure the provision of, at a minimum, the following:

1. Evidenced-based trimester-specific and postpartum education to promote a healthy pregnancy, delivery, and postpartum Outcomes for mother and baby, for example, prenatal vitamins, prenatal and postpartum standards of care (including American College of Obstetricians and Gynecologists [ACOG] recommendations for prenatal and postpartum visits), drug and alcohol use, tobacco cessation, nutrition, and infant Wellness visits.

rr. Assistance developing a birth plan.

ss. Assistance accessing value-added benefits relevant to Members who are pregnant or postpartum.

tt. Education about Covered Services for Members who are pregnant or postpartum, including information on Medicaid postpartum coverage.

uu. Assistance acquiring a breast pump.

vv. Assistance accessing contraceptive care based on the Member's family planning needs and preferences.

ww. Mental health and SUD screenings, and when warranted, referral to treatment. This shall include mental health/SUD screening of all pregnant and postpartum Members using a validated screening tool and, as needed, screening of pregnant and postpartum Members with mental health/SUD needs for common co-morbidities.

xx. Coordination with the Member's obstetric and other Providers, including appointment assistance, communication with Providers when Member needs are identified, and advocating on the Member's behalf when Provider assistance is needed.

yy. Coordination with home visitors, including educating Members about home visiting, referring Members to home visiting Providers, and communicating with home visiting Providers.

zz. Referrals to Covered and Non-Covered Services, including community resources that can help address the Member's SDOH needs.

aaa. Specific outreach close to the Member's delivery date to ensure postpartum supports are in place.

G. The CONTRACTOR(S) shall maintain a caseload ratio of one (1) high-risk maternity care coordinator for every forty (40) Members enrolled in high-risk maternity Care Coordination.

H. The CONTRACTOR(S) may use a team of licensed and non-licensed maternity Care Coordination staff as appropriate to meet the Member's needs. The CONTRACTOR(S) shall ensure that non-licensed staff have direct access to licensed staff for consultation and supervision.

I. The State may require the CONTRACTOR(S) to develop or provide data for the State to develop a dashboard report of prenatal and postpartum measures, including information on trends and subgroup analysis.

J. The CONTRACTOR(S) is encouraged to use Pregnancy Risk Assessment Monitoring System (PRAMS) data to inform initiatives or outreach to Members who are pregnant or postpartum.

2.4.12 Care Transitions and Diversion Activities

A. The CONTRACTOR(S) shall manage care transitions for all Members (not limited to Members receiving Care Coordination).

B. As part of its care transitions process, the CONTRACTOR(S) shall at a minimum:

1. Comply with State policies regarding transition of care, including KDHE's KanCare transition of care policy, KDADS' institutional transition policy, and KDADS' MFP policy.

2. Assign a single point of contact for hospitals and institutional facilities to contact for assistance with discharge planning and transition.

3. Develop a method for evaluating risk of Hospital Readmission in order to determine the intensity and urgency of follow-up required for the Member after the date of discharge.

bbb. Develop a method for collecting, reviewing, and using MDS Section Q data to proactively identify NF/NFMH residents who are potential candidates for transition to the community.

ccc. Ensure that timely notification and receipt of Admission dates, discharge dates, and clinical information is communicated between internal CONTRACTOR(S)' departments and between care settings, as appropriate.

ddd. Make referrals to, work with, and leverage resources from any existing transition programs as appropriate.

eee. Evaluate a Member's need for LTSS and pursue the least restrictive environment for the individual, taking into consideration the Member's preferences. The CONTRACTOR(S) shall make referrals for HCBS Waiver eligibility and/or NF placement to the appropriate entities.

fff. Participate in discharge planning activities with the facility, including making arrangements for safe discharge placement, ensuring Prescriptions have been filled prior to discharge, facilitating clinical hand-offs between the discharging facility and the CONTRACTOR(S), and ensuring adequate housing and income support are available to the Member.

ggg. For foster care youth changing placements or being discharged from an inpatient facility (e.g., hospital or PRTF), coordinating with the CMP to ensure that the Member is moved to/discharged to an appropriate placement, which does not include a CMP office.

hhh. Evaluate the need to develop or revise a Member's PCSP or Plan of Service in collaboration with the Member, Providers, caregivers, or other appropriate entities, with the Member's consent.

iii. Develop, or assist in the development of, or obtain a copy of an existing discharge/transition plan, and ensure that the transition/discharge plan and post-discharge services are integrated into the Member's PCSP or Plan of Service.

C. In addition to the requirements in State policy, the CONTRACTOR(S)' transition/discharge plan activities shall include the following elements:

1. Arranging for services specified in the discharge/transition plan and ensuring that transitional care occurs with minimal service disruption and with continuance of current Provider(s) when possible.

jjj. Assisting in securing placement and ensure the setting to which the Member is transitioning is ready for the Member's arrival.

kkk. Conducting follow up with the Member and Member's Providers within forty-eight (48) hours of discharge to ensure post discharge services have been provided.

D. When the CONTRACTOR(S) is contacted by an inpatient facility for the CONTRACTOR(S)' Member with a request for assistance with discharge planning, the CONTRACTOR(S) must initiate and implement the adequate steps to ensure discharge planning occurs for the Member.

E. As appropriate, depending on the details of the Member's transition, the CONTRACTOR(S) shall ensure that the Member has access to services consistent with the access they previously had, and is permitted to retain their current Provider for a period of time even if that Provider is not in the CONTRACTOR(S)' Provider network.

F. The CONTRACTOR(S) shall ensure the Member's new Provider(s) is able to obtain copies of the Member's medical records, as appropriate, in a manner that is compliant with Federal and State laws.

G. Upon request, the CONTRACTOR(S) may be required to submit the transition of care strategy as prescribed by the State in accordance with the requirements of 42 CFR § 438.62, for written approval.

2.4.13 Social Determinants of Health

The CONTRACTOR(S) shall develop a process for identifying SDOH needs when interacting with Members (not just Members receiving Care Coordination) and connecting them to necessary resources, including tracking referrals. Such needs could include, but not limited to, safe housing, food security, Transportation, employment and career training, and education.

2.4.14 Conflicts of Interest

For individuals enrolled in an HCBS Waiver, CONTRACTOR(S) shall not delegate or Subcontract the completion of the Needs Assessments or the development of the PCSP to any entity that is also a Provider of services or conducts components of the eligibility process to that individual, unless it can be demonstrated that the only willing and qualified entity to perform independent assessments and development of PCSPs in a geographic area is also a direct service Provider as described in 42 CFR § 431.301(c)(1)(vi) and 441.730(b). Prior to contracting with such an entity, the CONTRACTOR(S) shall document that rigorous attempts were made to contract with a conflict free, community-based organization.

THE CONTRACTOR(S) shall seek written permission from the State before contracting with the entity. The CONTRACTOR(S) must work with the entity to develop, review and approve conflict of interest protections as appropriate.

2.4.15 Electronic Care Management System

A. The CONTRACTOR(S) must have an electronic care management system that captures at a minimum:

   1. The results of the Health Screen, HRA, and Needs Assessment.

   lll. The PCSP or Plan of Service content, including goals, interventions, progress, Outcomes, and completion dates.

   mmm. Care coordinator Member touch points and outcomes.

B. Members of the Care Coordination team must have access to the care management system.

C. Members of the Care Coordination team must also have timely access to other relevant electronic data about the Member (e.g., Claims, PA data, admission discharge transfer [ADT] feeds) in order to coordinate and communicate care needs across Providers and delivery systems.

D. In order to maximize internal CONTRACTOR(S) communications (e.g., the UM reviewer is able to see the Care Coordination risk level and the name of a care coordinator for a Member) about a specific Member, the CONTRACTOR(S) must use information technology systems and processes to integrate the following data elements:

1. Enrollment data;

nnn. Care Coordination data;

ooo. Claims and Member services;

ppp. Twenty-four hours a day, seven days a week (24/7) nurse advice line information;

qqq. PA data; and

rrr. Polypharmacy review.

E. The CONTRACTOR(S)' system must also have the capability to make Care coordination data available to the Member, the PCP, and specialists, as well as interface with the State's KMMS or in the format and method specified by the State.

2.4.16 Care Coordination Reporting and Evaluation

A. The CONTRACTOR(S) shall have a system for monitoring and evaluating its Care Coordination model and shall include, at a minimum, the following in its model of care description:

1. How the CONTRACTOR(S) monitors Care Coordination.

sss. How the CONTRACTOR(S) ensures consistency of Needs Assessments across care coordinators/Community Care Coordinators.

ttt. The mechanisms by which the CONTRACTOR(S) makes process improvements.

uuu. How the CONTRACTOR(S) evaluates Members' satisfaction with Care Coordination.

B. The CONTRACTOR(S) shall report on Care Coordination measures as described in the State's KanCare Quality Management Strategy (QMS) and on HCBS Waiver assurance performance measures, including quality improvement plans issued for performance below 86%.

C. The CONTRACTOR(S) shall submit to the State Care Coordination reports as specified by the State (see Appendix H for an initial list of reports). The CONTRACTOR(S) shall comply with any additional requests from the State for Care Coordination reporting in the manner and timeframe prescribed by the State, including one-time ad hoc reporting requests.

D. The CONTRACTOR(S) shall make all Care Coordination data, inclusive of SDOH, including that which is generated by Subcontractors, available to the State upon request.

E. The CONTRACTOR(S) shall comply with any requests for data from the State's contracted External Quality Review Organization (EQRO).

F. The CONTRACTOR(S) shall comply with any requests for data from KDADS within the timeframes specified by KDADS.

2.4.17 Care Coordination Collaborative

A. The CONTRACTOR(S) shall participate in a State-chaired KanCare Care Coordination collaborative. The purpose of the collaborative is to:

1. Address questions and issues the CONTRACTOR(S) encounter in implementing the Care Coordination program.

vvv. Ensure the KanCare Care Coordination program is being implemented consistently throughout the State.

www. Share Care Coordination best practices and resources.

2.5 Provider Network

2.5.1 Credentialing and Re-Credentialing

A. The State intends to implement centralized credentialing and re-credentialing applicable to all KanCare MCOs during the term of this CONTRACT. The CONTRACTOR(S) shall assist the State with the transition and implementation of centralized credentialing and re-credentialing and comply with the State's requirements related thereto.

B. Until the State implements centralized credentialing and re-credentialing, the CONTRACTOR(S) must establish and implement a credentialing and re-credentialing process for its Participating Providers.

C. The CONTRACTOR(S)' credentialing and re-credentialing process shall comply with the following credentialing and re-credentialing requirements:

1. Continuously assess its credentialing/re-credentialing processes, obtain Provider input on its processes, and take steps to improve, simplify, and streamline the processes whenever feasible.

xxx. Utilize the State's Provider enrollment system to access all necessary applications and associated documentation within two (2) Business Days from the receipt of the daily file from the Fiscal Agent, as it will be the system of record and is intended to maximize standardization of documentation and minimize repetitive effort on the part of the Providers. The CONTRACTOR(S) shall use the State Provider enrollment system for any information to the maximum extent possible unless using information in the State Provider enrollment system would not meet National Committee for Quality Assurance (NCQA) guidelines.

yyy. Develop written policies and procedures for identification, recruitment, and retention of Participating Providers to include the establishment and implementation of a uniform credentialing and re-credentialing policy that addresses acute, primary, Behavioral Health, and LTSS Providers and meets all applicable State and CMS (42 CFR § 438.214) requirements and complies with the HCBS settings rule (42 CFR § 441.301(c)(4)).

zzz. Follow a documented process for credentialing and re-credentialing of Providers who have signed contracts or participation agreements with CONTRACTOR(S) and use the Kansas Standardized Credentialing forms. The CONTRACTOR(S) shall interface with the State's Provider enrollment system.

aaaa. Demonstrate that its Providers are credentialed and reviewed through the CONTRACTOR(S)' credentialing committee that is chaired by the CONTRACTOR(S)' chief medical officer (CMO).

bbbb. Comply with State requirements and document provisional credentialing, initial credentialing, re-credentialing, and organizational credential verification of Providers who have signed contracts or participation agreements with the CONTRACTOR(S) or have seen twenty-five (25) or more of the CONTRACTOR(S)' Members.

cccc. Credential and re-credential HCBS Providers consistent with applicable 1915(c) HCBS Waiver Provider qualification requirements and credentialing standards identified by the State for HCBS Providers and verify compliance with the HCBS settings rule (42 CFR § 441.301(c)(4)). The CONTRACTOR(S) shall provide consultation and support to its Participating Providers and any Subcontractors to demonstrate compliance with the home- and community-based settings criteria for settings in which the criteria applies. The CONTRACTOR(S) shall identify a process for achieving compliance with the HCBS settings rule as follows:

a. In the PCSP process, including expectations pertaining to employment and community integration.

b. In verifying Provider compliance with the rule when credentialing and re-credentialing HCBS Providers.

c. In its Provider agreements by including language requiring Providers to maintain compliance with the HCBS settings rule.

d. In furnishing Provider education and training on the HCBS settings rule to establish and maintain ongoing compliance.

e. Ensure 1915(c) HCBS Waiver Provider qualifications are met both initially and ongoing.

f. Provide quarterly reports to the State that demonstrate adherence to HCBS Waiver Provider requirements and all actions taken when Providers do not meet the requirements.

g. Ensure that the credentialing process provides for re-credentialing to occur every three (3) years.

h. Ensure that atypical Participating Providers (e.g., Providers of Transportation, home, and vehicle modifications, respite services) that are not assigned a National Provider Identifier (NPI) number are subject to all applicable credentialing and re-credentialing requirements as outlined in this section.

i. Verify licensure and qualifications for all Participating Providers initially and on an ongoing basis. The CONTRACTOR(S) shall submit a plan to the State ninety (90) Calendar Days before the start of the CONTRACT year that specifies the process for how Participating Provider licensure will be verified for all Provider types on an ongoing basis and the timelines for notification to the State when issues with Provider licensure and/or qualifications are identified.

j. Initiate primary source verification within five (5) Calendar Days of receipt of a completed credentialing application and, except when additional time is needed due to a delay by the primary source in providing required information, ensure that credentialing of all service Providers applying for Participating Provider status is completed within forty-five (45) Calendar Days. The start time begins when all necessary credentialing materials have been received. Completion time ends when written communication is mailed or faxed to the Provider notifying them of the CONTRACTOR(S)' decision. The CONTRACTOR(S) shall follow up with Providers as necessary to obtain any necessary information and shall provide regular updates to Providers on the status of their application.

k. Credentialed Providers must be entered/loaded into the CONTRACTOR(S)' Claims payment system within seven (7) Calendar Days of credentialing committee approval.

l. Provider selection requirements must comply with 42 CFR § 438.12.

m. The CONTRACTOR(S)' Provider selection policies and procedures must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

n. The CONTRACTOR(S) may not employ or contract with Providers excluded from participation in Federal health care programs.

o. The CONTRACTOR(S) must timely notify Providers in writing of the reason for its decision if the CONTRACTOR(S) declines to include individuals or groups of Providers in its network.

D. The CONTRACTOR(S) shall ensure that Participating Providers are eligible for payment by the CONTRACTOR(S) as a Participating Provider as of the date of the Provider's enrollment with the Kansas Medical Assistance Program (KMAP).

E. The CONTRACTOR(S) shall provide educational materials and online videos to potential Participating Providers with clear and concise information on the credentialing and Provider contracting processes, including what information must be submitted when and to whom; the types of follow-up the Provider should expect; the timeframes for decisions and notices; and whom to contact with questions. The CONTRACTOR(S) must post the educational materials and videos on the CONTRACTOR(S)' website.

F. The CONTRACTOR(S) shall require Participating Providers to comply with State policy regarding Prescription drug monitoring program (PDMP) requirements.

2.5.2 Network Development

The CONTRACTOR(S) shall develop, maintain, and monitor a network of Providers that:

A. Is supported by written agreements and is sufficient in size, scope, and types to deliver all Medically Necessary Covered Services and satisfy all service delivery requirements in this CONTRACT.

B. Delivers culturally and linguistically appropriate services as described in Section 2.5.4, including in home- and community-based settings for culturally diverse populations.

C. Offers Members a choice of Providers to the extent possible and appropriate.

D. Ensures Covered Services are as accessible to Members in terms of timeliness, amount, duration, and scope as those services that are available to non-Medicaid persons within the same service area.

E. Ensures Covered Services are provided promptly and are reasonably accessible in terms of location and hours of operation.

F. Is designed, established, and maintained by utilizing, at a minimum, the following considerations that promote the best interest and health and welfare of Members, including, but not limited to:

1. Current and anticipated enrollment and utilization of services.

p. Cultural and linguistic needs of Members considering the prevalent languages spoken, including sign language.

q. Ability of Providers to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities.

r. Each Participating Provider's panel size (as applicable) including the number of Participating Providers not accepting new referrals. For those Participating Providers who are accepting new Members, the number of additional Members that the Provider is willing and able to accommodate.

s. Availability of triage lines or screening systems, as well as the use of telehealth (e.g., Project Extension for Community Healthcare Outcomes [ECHO]), e-visits, and/or other technological solutions. The CONTRACTOR(S) should utilize Telemedicine to support an adequate Provider network in accordance with State policy. Telemedicine shall not replace Provider choice and/or Member preference for physical delivery.

t. Geographically convenient flow of Members among Participating Providers to maximize Member choice.

u. Member satisfaction survey data and quality data (e.g., HEDIS performance).

v. Member Grievance and Appeal data.

w. Issues, concerns, and requests brought forth by State agencies and other system stakeholders that have involvement with persons eligible for services under this CONTRACT.

x. Demographic data and geo-mapping data.

y. Support community integration for LTSS Members.

G. The CONTRACTOR(S) shall adhere to the following requirements for specific Provider types within its Provider network:

1. Include Osawatomie and Larned State hospitals.

2. Offer a contract to all Kansas CCBHCs, Regional Alcohol and Drug Assessment Centers (RADACs), PRTFs, and SIAs.

z. Include a sufficient number of qualified Providers to timely meet the unique needs of children in the foster care system.

aa. Include contracts with or otherwise support the graduate medical education residency training programs currently operating in the State, and to investigate opportunities for resident participation in CONTRACTOR(S) medical management and committee activities. The CONTRACTOR(S) is encouraged to contract with graduating residents and Providers that are opening new practices in, or relocating to, Kansas, especially in Rural and underserved areas.

bb. Make at least three (3) reasonable offers at or above the FFS rates to inpatient hospitals, NFs, partial hospitalization programs, and intensive outpatient programs.

cc. Make at least three (3) reasonable offers at or above the FFS rates to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and free-standing birthing centers (FBCs) and, in accordance with CMS' State Health Officials Letter #16-006, include at least one (1) FQHC, one (1) RHC, and one (1) FBC.

dd. Make at least three (3) reasonable offers at or above the FFS rates to local health departments.

ee. Include Providers that offer services to both children and adult Members moving from one (1) system of care to another system of care in order to maintain continuity of care without service disruptions or mandatory changes in service Providers for those Members who wish to keep the same Provider in accordance with State policy.

ff. Include a sufficient number of locally established, Kansas-based, independent peer/consumer and family operated/run organizations to provide support services, advocacy and training, including consumer run organizations (CROs).

gg. Ensure in-State Members receive services from in-State Providers when available at competitive rates and levels of quality, except when an Out-of-State Provider is geographically more accessible to and preferred by the Member or when a Member selects an Out-of-State Provider for telehealth services and the Provider is permitted to practice in Kansas (e.g., through an interstate licensure compact).

hh. Contract with a sufficient number of participating Behavioral Health and LTSS Providers to meet Member needs.

ii. Ensure that HCBS Providers have an adequate number of qualified direct care workers to meet the needs of Members, including coverage for workers who are no-shows, call out sick, etc., and are recruiting direct care workers, as needed. The CONTRACTOR(S) shall submit a monthly report on direct care worker capacity and no-shows/late arrivals/early departures and remediation activities.

jj. Contract with any willing Pharmacy Provider that meets requirements to participate in the CONTRACTOR(S) network.

kk. Develop incentive plans to recruit and retain Behavioral Health professionals, medical practitioners, and HCBS Providers in the local community. The CONTRACTOR(S) shall provide a quarterly report to the State documenting the CONTRACTOR(S)' efforts to recruit and retain these Providers, including, but not limited to, the Providers contacted, the incentives offered, and the outcome.

ll. Include specialty service Providers to deliver services to children, adolescents, and adults with developmental or cognitive disabilities, sexual offenders, sexual abuse victims, individuals with Behavioral Health disorders, individuals in need of dialectical behavior therapy, transitioned aged youth ages eighteen (18) to twenty-one (21), and infants and toddlers under the age of five (5) years. This includes Providers who offer sedation dentistry services for individuals who need sedation for dental care visits.

mm. Implement e-prescribing within its Provider network.

nn. Demonstrate that there are sufficient Indian Health Care Providers (IHCPs) participating in the CONTRACTOR(S)' Provider network to ensure timely access to services available under this CONTRACT from such Providers for American Indian Members who are eligible to receive services.

oo. Monitor Open Panels for LTSS services including HCBS.

H. OneCare Kansas (OCK). As directed by the 2018 Kansas Legislature, the CONTRACTOR(S) shall provide health homes for Members as identified by the State and approved by CMS. Such health homes will be known as the OneCare Kansas (OCK) program. OCK will consist of an agreement

between the CONTRACTOR(S), referred to as the Lead Entity, and a community Provider, referred to as the OCK Partner.

1. The CONTRACTOR(S) shall:

    a. Provide a statewide network of OCK Partners in partnership with community health care Provider types identified by the State.

    b. Assure the following six (6) core services, as defined in the OCK program manual, are provided to OCK participants:

        i. Comprehensive care management;

        ii. Care coordination;

        iii. Health promotion;

        iv. Comprehensive transitional care;

        v. Individual and family support; and

        vi. Referral to community supports and services.

    c. Identify and invite Members to OCK, including receiving and evaluating referrals from community Providers, using the State-defined and CMS-approved target population criteria.

    d. Assign Members to an OCK Partner, allowing Members to choose from available OCK Partners.

    e. Provide a choice of at least two (2) OCK Partners covering each county, if the CONTRACTOR(S) has an OCK Member in the county. If the CONTRACTOR(S) does not have an OCK Partner appropriate to serve a particular Member, the CONTRACTOR(S) must work with OCK Partners who are out of network, as long as the OCK Partner is in network with at least two (2) of the KanCare CONTRACTOR(S). If the CONTRACTOR(S) does not work with the OCK Partner that has been validated by the other KanCare MCOs, this will be a for cause reason for a Member to change KanCare MCOs.

    f. Receive and process requests from Members to opt in to OCK and requests to change OCK Partners.

    g. Recruit and train OCK Partners, assuring that they meet the OCK Partner and joint Lead Entity and OCK Partner requirements detailed in the State Plan and OCK program manual.

    h. Provide bidirectional methods for data sharing between the Lead Entity and OCK Partners, including clinical care alerts and population management tools.

    i. Collect quality information and report on OCK quality measures to the State.

    j. Pay OCK Partners a per member per month (PMPM) for OCK services out of the OCK PMPM the CONTRACTOR(S) (Lead Entity) is paid by KDHE, retaining no more than 8% (currently $27.09) for administrative activities.

    k. Designate an OCK manager, to serve as a State contact and participate in regular meetings with KDHE and stakeholders.

l. Meet all Lead Entity and joint Lead Entity and OCK Partner requirements detailed in the OCK State Plan amendments (SPAs) and OCK program manual.

m. Participate in the OCK learning collaborative to promote best practices and process improvement in OCK.

n. Submit Encounters to KDHE through its fiscal intermediary in order to receive an OCK PMPM for each OCK Member monthly; the PMPM will only be made if an OCK service was provided by an OCK Partner.

o. Follow all Federal and State requirements for OCK described in the Kansas Medicaid State Plan and relevant Federal statutes.

p. Not retain any of the Health Action Plan bonus payment, which must be paid to the OCK Provider if it completes the initial Health Action Plan within the first ninety (90) Calendar Days of the Member's Enrollment.

q. Not reimburse TCM for any Member receiving OCK services.

r. KDHE shall:

a. Develop the design and reimbursement for the provision of OCK through the Medicaid State Plan and amendments thereto;

b. Develop an actuarially sound and separate PMPM for OCK services to be paid to the CONTRACTOR(S) retrospectively, following provision of at least one (1) OCK service in the month;

c. Review OCK rates annually to ensure the rates are adequate for efficient and economical provision of OCK services;

d. Provide an OCK manager to provide day-to-day direction for the OCK program and receive communications from the CONTRACTOR(S) related to OCK; and

e. Annually review the provision of OCK by the CONTRACTOR(S).

l. CCBHCs. In accordance with Kansas Statutes Annotated (K.S.A.) 39-2019 and any applicable Federal authority(ies), including, but not limited to, the Medicaid State Plan and the CCBHC demonstration per Section 223 of the Protecting Access to Medicare Act of 2014 (CCBHC demonstration), the CONTRACTOR(S) shall ensure the provision of CCBHC services to eligible Members by executing the following duties and responsibilities:

1. Offering a contract to all CCBHCs certified by KDADS to deliver CCBHC services.

f. Building system capacity to efficiently collect, allocate, and track Claims submitted by CCBHCs for reimbursement including, but not limited to, ensuring TPL Claims are processed, working with CCBHCs to identify and solve billing issues, and participation in planning and trouble-shooting calls with KDADS and the CCBHCs.

g. Reimbursing the CCBHCs according to the State's prospective payment system (PPS) methodology.

h. Adhering to data and Encounter collection, submission, and reporting requirements as established by the State.

i. Complying with all CCBHC Medicaid State Plan, CCBHC demonstration, other Federal CCBHC authority, and CCBHC State regulatory or policy requirements.

J. The CONTRACTOR(S) must submit documentation to the State, in an approved format and frequency as specified by the State, that demonstrates the Provider network offers an appropriate range of preventive, primary, Behavioral Health, specialty, LTSS, and Pharmacy services that is adequate for the anticipated number of Members and maintains a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members. The CONTRACTOR(S) must submit the documentation no less frequently than the following:

1. At the time it enters into a CONTRACT with the State.

j. At any time, there is a significant change (as defined by the State) in the CONTRACTOR(S)' operation that would affect adequate capacity and services.

k. If there are changes in services, benefits, and geographic service areas.

l. If a new population is enrolled.

K. The CONTRACTOR(s) shall develop and submit an annual Provider network development and management plan and evaluation to the State for review that demonstrates the CONTRACTOR(S) maintains a network of Providers that is sufficient in number, type, capacity, and geographic distribution to meet the requirements of this CONTRACT and the needs of its Members. The CONTRACTOR(S)' Provider network development and management plan and evaluation shall be submitted in accordance with the State's reporting instructions. This submission shall be certified by the CONTRACTOR(S)' chief financial officer (CFO) or chief executive officer (CEO) or an individual who has delegated authority to sign for, and who reports directly to, the CEO or CFO. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness, and truthfulness of the information in the report.

L. The CONTRACTOR(S) shall report quarterly the number and types of Providers in its network consistent with the State's reporting requirements.

M. The CONTRACTOR(S)' documentation of network adequacy shall be signed by the CEO.

N. The CONTRACTOR(S) shall use a single source of data for its Provider directory, network adequacy reports, and any Provider information provided to the State.

2.5.3 Provider Network Adequacy Standards

A. The CONTRACTOR(S) shall comply with the State's time, distance, and other required network adequacy standards, which are available on KDHE's website. These standards include standards for receiving services from the Provider types specified in 42 CFR § 438.68. The State's standards include, but are not limited to, services from the following Provider types:

1. Primary care, adult and pediatric (pediatric standards apply to Members age zero to twenty [0–20]);

m. Obstetrics and gynecology (OB/GYN);

n. Behavioral health (mental health and SUD), adult and pediatric (pediatric standards apply to Members age zero to twenty [0–20]);

o. Specialist, adult and pediatric (pediatric standards apply to Members age zero to twenty [0–20]);

p. Hospital;

q. Pharmacy;

r. Adult and pediatric dental (pediatric standards apply to Members age zero to twenty [0–20]);

s. LTSS Provider types in which a Member must travel to the Provider to receive services;

t. LTSS Provider types that travel to the Member to deliver services or require the Member to move in order to receive services; and

u. Ancillary services.

B. See the existing network adequacy standards available at https://www.kancare.ks.gov/policies-and-reports/network-adequacy. The network adequacy standards include an exceptions process for CONTRACTOR(S) to use in the event the CONTRACTOR(S)' network cannot satisfy the network adequacy standard for a specific Provider type. The CONTRACTOR(S) must receive the State's written approval of any exception to the CONTRACTOR(S)' network adequacy standards.

2.5.4 Health Equity, Cultural Competency and Health Literacy in The Delivery of Care

A. The CONTRACTOR(S) shall:

1. Promote and participate in the State's efforts to reduce health disparities, improve Health Equity, and ensure that Covered Services are delivered in a culturally competent manner to all Members, including those with Limited English Proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

    a. Health Equity means the attainment of optimal health for all people, where everyone has a fair and just opportunity to attain their full health potential and well-being regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health Outcomes, including SDOH.

    b. Cultural competency refers to the practices and behaviors that ensure that all Members receive high-quality, effective care, irrespective of cultural background, language proficiency, socioeconomic status, and other factors that may be informed by a Member's characteristics.

    c. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand health information and services needed to make appropriate health decisions.

    d. Adhere to requirements for establishing a Provider directory as specified in Section 2.10.8 that indicates each Provider's linguistic capabilities and whether the Provider's offices, exam rooms, and equipment accommodate individuals with physical disabilities.

e. Ensure that Members are provided Covered Services without regard to race, color, national origin, sex, sexual orientation, gender identity, age, or disability and will not use any policy or

practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, age, or disability.

f. Incorporate in its policies, administration, and service practice the values of (i) honoring Member's beliefs, (ii) sensitivity to cultural diversity, and (iii) fostering in staff and Providers' attitudes and interpersonal communication styles which respect Members' cultural backgrounds. The CONTRACTOR(S) shall have specific policy statements on these topics and communicate them to Subcontractors and Participating Providers.

g. Foster and enhance Participating Providers' understanding and application of techniques to identify and address health disparities and identify and adapt to Members' cultural preferences and health literacy needs as an integrated component of service delivery. Such supports should include interactive and ongoing training, dedicated CONTRACTOR(S)' staff for Participating Providers to consult as needed, a resource library of best practices and national standards, and other resources as appropriate to evidence the importance of Health Equity, cultural competency, and health literacy in the delivery of Covered Services.

h. Permit Members to choose any Participating Provider from among the CONTRACTOR(S)' network based on cultural preference. Members may submit Grievances to the CONTRACTOR(S) and/or the State related to inability to obtain culturally appropriate care.

i. If the CONTRACTOR(S) identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its Subcontractors or Participating Providers, it shall promptly intervene and require a corrective action plan from the Subcontractor or Participating Provider.

j. Identify and address disparities in health care access, service provision, satisfaction, and health Outcomes. The CONTRACTOR(S) shall obtain data on Member demographics, stratify performance measures (including, but not limited to, HEDIS) by Member demographics (e.g., race, ethnicity, disability, and geography) to identify potential disparities; develop an annual Health Equity report card that includes stratified performance measures and post the report card, and quarterly updates/progress reports, on its website; develop and implement strategies to address identified disparities; and evaluate the impact of those strategies. The CONTRACTOR(S) shall work with the State to determine the content and format of the Health Equity report card and quarterly updates/progress reports.

B. Health Equity and cultural competency plan: Within one hundred eighty (180) Calendar Days of award, the CONTRACTOR(S) shall develop and submit for State written approval a Health Equity and cultural competency plan. The Health Equity and cultural competency plan shall be evaluated, updated, and submitted annually to the State. The Health Equity and cultural competency plan shall include, but not be limited to:

1. Description of the Health Equity and cultural competency plan development process, including the CONTRACTOR(S)' efforts to engage stakeholders in the development and assessment of the effectiveness of the plan.

k. Description of how the CONTRACTOR(S) identifies and addresses health disparities, and evaluation of the previous year's strategies.

l. Description of how the CONTRACTOR(S) identifies and addresses cultural competency needs and areas for improvement.

m. Description of how care and services are delivered equitably and in a culturally competent manner, including how this will be achieved in Rural areas of the State via telehealth strategies.

n. Description of how the CONTRACTOR(S) identifies and addresses SDOH needs.

o. Strategies to assess and respond to the health literacy needs of Members.

p. Identification of the CONTRACTOR(S)' specific staff responsible for the development and maintenance of the Health Equity and cultural competency plan.

q. At least two (2) goals for the coming year, which must be revised, updated, or replaced each year based on the current needs of Members and Providers and progress made on the previous year's goals.

r. Training and education methods utilized by the CONTRACTOR(S) to educate staff, Participating Providers, and Members about Health Equity and cultural competency, including a description of the training programs.

s. Description of how the CONTRACTOR(S) conducts regular assessments of the Provider network to ensure services are provided in a culturally competent manner to diverse populations.

2.5.5 Provider Network Access Standards

The CONTRACTOR(S) shall maintain a Provider network that can satisfy the following timely access standards to Covered Services. CONTRACTOR(S) shall not prevent or discourage its Participating Providers from contracting with other KanCare MCOs.

2.5.5.1. General Standards

CONTRACTOR(S) must adhere to the following requirements:

A. Responds to referrals twenty-four hours a day, seven days a week (24/7) and provides access to evening and weekend care.

B. Responds to routine, urgent, and emergency needs within the established timeframes in conformance with State requirements.

C. Appointment times shall be in accordance with usual and customary standards not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for Urgent Care.

D. Waiting times shall not exceed forty-five (45) minutes.

2.5.5.2. Primary Care Provider Standards

CONTRACTOR(S) must adhere to the following requirements:

A. Make available non-emergency after-hours physician services or Primary Care services.

B. Encourage the assignment of pediatricians to serve as PCPs for eligible children.

C. Offer Members freedom of choice within its network in selecting a PCP consistent with this CONTRACT.

D. Give Members a choice of at least two (2) PCPs within the applicable geographical access standards. The CONTRACTOR(S) shall not restrict PCP choice unless a Member has shown an

inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a Medically Necessary reason. In addition, the CONTRACTOR(S) shall offer contracts to primary and specialist physicians who have established relationships with Members including specialists who may also serve as PCPs to encourage continuity of Provider.

E. Ensure individuals who transition to the CONTRACTOR(S) for their physical health from another KanCare MCO and who have an established relationship with a PCP that does not participate in the CONTRACTOR(S)' Provider network, the CONTRACTOR(S) will provide, at a minimum, a six (6)-month transition period in which the individual may continue to seek care from their established PCP while the individual and the CONTRACTOR(S) finds an alternative PCP within the CONTRACTOR(S)' Provider network.

F. Offer pregnant Members a choice to be assigned a PCP that provides obstetrical care consistent with the freedom of choice requirements for selecting health care professionals so as not to compromise the Member's continuity of care.

G. Permit any American Indian Member eligible to receive services from an IHCP PCP participating as a Participating Provider, to choose that IHCP as their PCP, as long as that Provider has capacity to provide the services.

2.5.5.3. Specialty Care Standards

CONTRACTOR(S) must adhere to the following requirements:

A. Specialty care and Urgent Care: Referral appointments to specialists (e.g., specialty physician services, hospice care, home health care, rehabilitation services, etc.) shall not exceed thirty (30) Calendar Days for routine care or forty-eight (48) hours for Urgent Care.

B. Waiting times shall not exceed forty-five (45) minutes.

2.5.5.4. Emergency Care Standards

CONTRACTOR(S) must adhere to the following requirements:

A. Emergency care: All emergency care is immediate, at the nearest facility available, regardless of whether the emergency department (ED) is a Participating Provider.

B. Emergency Services must be available twenty-four hours a day, seven days a week (24/7).

2.5.5.5. Non-Emergency Medical Transportation Service Standards

The CONTRACTOR(S) shall adhere to the following requirements:

A. A Member's Transportation shall arrive at the pick-up location no later than fifteen (15) minutes after the scheduled pick-up time. Arrival later than fifteen (15) minutes after the scheduled time shall be considered a non-emergency medical transportation (NEMT) Provider no-show.

B. The NEMT Provider shall wait at least fifteen (15) minutes after the scheduled pick-up time. If the Member does not arrive within fifteen (15) minutes after the scheduled pick-up time, the CONTRACTOR(S) may consider that a Member no-show.

C. A Member's Transportation shall arrive at the Provider location:

1. No sooner than one (1) hour before the Member's appointment, but the driver shall not leave prior to the office/facility opening.

t. At least fifteen (15) minutes prior to the Member's appointment time, but the driver shall not leave prior to the office/facility opening.

D. The Member shall not wait for more than one (1) hour after the appointment for return Transportation that has not been pre-arranged.

E. NEMT Providers shall communicate with the Member regarding the approximate arrival time and shall promptly notify the Member when the Transportation Provider will arrive later than the scheduled pick-up time.

F. When returning the Member to the point of origin, NEMT Providers shall ensure return routes are efficient, do not result in unnecessary delays, and do not include scheduled or unscheduled stops during the return trip.

G. The CONTRACTOR(S) must develop and implement a quarterly performance auditing protocol to evaluate compliance with these standards.

H. The CONTRACTOR(S) may require Members to schedule Transportation at least three (3) Calendar Days prior to the appointment other than for urgent care and facility discharges and transfers, but the CONTRACTOR(S) must ensure that an exception process is in place to accommodate Members who require same day NEMT services in order to access any Medically Necessary Covered Service(s) under the CONTRACT.

I. For urgent care, facility discharges, and inter-facility transfers, the CONTRACTOR(S) shall arrange for pick-up within three (3) hours from when the request is made.

J. The CONTRACTOR(S) shall provide guidelines to Transportation Providers regarding coordinating Member pick-ups at facilities, including whom to notify regarding arrival, the method of notification, and how long to wait for the Member.

K. The CONTRACTOR(S) shall have a process for implementing requests for prescheduled Transportation to recurring appointments at the same location for the same treatment or condition (also known as standing orders) for up to six (6) months. The CONTRACTOR(S) may verify standing orders with the Member's Provider or require that standing orders be requested by the Member's Provider.

L. The CONTRACTOR(S) shall submit a monthly report on Transportation provider no-shows and remediation activities.

2.5.6 Pharmacy Provider Network

The CONTRACTOR(S) must establish, maintain, and monitor a Pharmacy Provider Network that meets the requirements in Appendix C (Services).

2.5.7 Long-Term Services and Supports Provider Network Standards

The CONTRACTOR(S) shall establish, maintain, and monitor a Provider network, including HCBS Providers and alternative residential settings (e.g., Assisted Living Facilities, Home Plus, Residential Health Care Facilities, and IDD day and residential settings) that are supported by written agreements, which is sufficient to provide all LTSS Covered Services. The CONTRACTOR(S) shall:

A. Comply with State-established Provider network standards for LTSS, including time and distance standards for LTSS Provider types in which a Member must travel to the Provider to receive services, network adequacy standards for LTSS Provider types that travel to the Member to deliver services, and Providers that require the Member to move in order to receive services.

B. Comply with additional network adequacy metrics specific to LTSS population, as identified by the State, to demonstrate timely initiation of service and ongoing service as compared to the Members' schedule for services.

C. Place a priority on supporting Members to reside or return to their own home versus having to reside in an institutional or alternative residential setting.

D. Promote person-centered care through the development of services and settings that support the mutually agreed upon PCSP or Plan of Service through all service settings.

E. Develop HCBS and settings to meet the needs of Members who have cognitive impairments, Behavioral Health needs, and other special medical needs and comply with the HCBS settings rule.

F. CONTRACTOR(S) shall directly contract with an adequate network of FMS Providers to offer choice for Members. For Members Self-Directing their services and using an FMS Provider to assist in processing Claims and payments to their direct support workers, CONTRACTOR(S) shall reimburse FMS Providers separately for administrative functions and direct service workers funds.

G. Ensure that all licensed and Medicaid-certified NFs will be offered inclusion in the CONTRACTOR(S) Provider network. The CONTRACTOR(S) can evaluate each Provider's continued network enrollment based on the assessment of quality and performance outcomes. The CONTRACTOR(S) shall request written approval from the State if it wants to terminate the CONTRACT of a NF for poor quality of care and not meeting performance outcomes. The CONTRACTOR(S) must, in their request to the State, indicate the reasons for the termination, remedial actions that have been taken, preliminary plan on where residents would be transferred, impact of the transfers on the NF and local community, and any other information that the CONTRACTOR(S) believe is relevant. Provider network agreements shall only be with NFs certified under Medicaid, but CONTRACTOR(S) will be expected to help NFs move to both Medicare and Medicaid certification to maximize use of Medicare funding.

2.5.8 Behavioral Health Provider Network Standards

The CONTRACTOR(S) shall adhere to the following requirements:

A. The CONTRACTOR(S) shall retain and recruit a sufficient number of Behavioral Health Providers to maintain network adequacy as defined for the applicable Urban, Rural, and frontier counties in the service area. The CONTRACTOR(S) shall respond to any State requests or inquiries relative to the adequacy of its Behavioral Health Provider network.

B. The availability of types of Behavioral Health programs will vary from area to area, but access problems may be especially acute in Rural and frontier areas. The CONTRACTOR(S) shall establish a program of assertive outreach and Telemedicine programming capabilities to all areas but especially to Rural and frontier areas where Behavioral Health Services may be less available than in Urban areas. The CONTRACTOR(S) shall monitor utilization in regions across the State to ensure access and availability of all Behavioral Health Services in all regions.

C. The CONTRACTOR(S) shall document, and make available upon request, waiting lists preventing Admission to treatment in the prescribed timeframes.

D. For Members presenting for SUD services:

1. For emergency needs, Members shall be referred to services immediately.

u. Members with urgent, non-emergency needs shall be assessed within twenty-four (24) hours of a request for services. Services shall be delivered within twenty-four (24) hours of the date and time of the assessment.

v. Members with routine, non-urgent needs shall be assessed within ten (10) Business Days of the date the services are requested.

w. Pregnant women who are intravenous drug users and all other pregnant substance users, regardless of Title XIX status, must receive treatment within twenty-four (24) hours of assessment. When it is not possible to admit the Member within this timeframe interim services shall be made available within forty-eight (48) hours of initial contact to include prenatal care.

x. Persons who inject drugs must receive an assessment and shall be admitted to treatment no later than ten (10) Business Days after making the request for assessment. If no program has the capacity to admit the Member within the required timeframe, interim services shall be made available to the Member no later than forty-eight (48) hours after such request. Admission to treatment must not exceed one hundred twenty (120) Calendar Days of the request for assessment.

E. For Members presenting for mental health services:

1. For emergency needs Members shall be referred to services immediately.

y. Members with urgent, non-emergency needs shall be assessed within seventy-two (72) hours of a request for services.

z. Members with routine, non-urgent needs shall be assessed within ten (10) Business Days of the date the services are requested.

aa. The CONTRACTOR(S) shall develop and maintain a comprehensive Behavioral Health crisis response network that shall include:

a. Crisis responsiveness which includes twenty-four hours a day, seven days a week (24/7), three hundred sixty-five (365) days a year emergency treatment and first response, including, when appropriate, staff going to the Member for personal intervention and for any Member that staff become aware of experiencing a crisis or other emergency.

b. Provision of or referral to psychiatric and other community services, when appropriate.

c. Assessment of any Member experiencing a Behavioral Health crisis to determine the need for inpatient, treatment, crisis services, or other community treatment services.

d. Emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating emergency services.

e. Follow up with any Member seen for or provided with any emergency service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within seventy-two (72) hours of crisis resolution.

f. In cases of discharge from inpatient care, the CONTRACTOR(S) shall work with the inpatient facility on discharge planning upon Admission and monitor Provider contact with the Member following inpatient discharge with goals of offering and encouraging Member's attendance at follow-up appointments. The timeframe begins with the day of the Member's discharge. The CONTRACTOR(S) shall ensure 85% of all contact attempts occur between twenty-four (24) to seventy-two (72) hours of discharge; 90% of contact attempts occur within one to seven (1–7) Calendar Days; and 95% of contact attempts occur within one to ten (1–10) Calendar Days. The CONTRACTOR(S) must have protocols in place to assess compliance with this CONTRACT requirement.

2.5.9 Network Management

The CONTRACTOR(S) shall:

A. Establish written Provider agreements with all Participating Providers. The Provider agreements shall contain provisions specified by the State.

B. Establish procedures to ensure that Participating Providers comply with all timely access requirements as defined by the State and specified in Sections 2.5.5, 2.5.2, and 2.5.8, and provide documentation demonstrating monitoring efforts. As network access issues arise, the CONTRACTOR(S) shall report areas of network deficiency within twenty-four (24) hours and a plan for resolution to the State within five (5) Business Days. Report must be made to KDHE-DHCF and KDADS as applicable.

C. Monitor Providers and ensure compliance with all network requirements in this CONTRACT. At a minimum, the CONTRACTOR(S) must:

1. Provide technical assistance and support to consumer and family-run organizations.

g. Conduct oversight, including site visits, to assess office hours, scheduling, physical location, and Provider quality.

h. Confirm the status of required Provider licenses, registration, certification, or accreditation.

D. Eliminate barriers that prohibit or restrict advocacy for the following:

1. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

i. Any information the Member needs in order to decide among all relevant treatment options, including the risks, benefits, and consequences of treatment or non-treatment.

j. The Member's right to participate in health care decisions including the right to refuse treatment and to express preferences about future treatment decisions.

E. Continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, Member Grievances and Appeals, quality data, quality improvement data, eligibility, utilization of services, penetration rates, Member satisfaction surveys, and demographic data requirements.

F. When feasible, develop non-financial incentive programs to increase participation in CONTRACTOR(S)' Provider network.

G. In order to improve the capacity and capabilities of the direct care workforce providing LTSS and Behavioral Health Services to Members, the CONTRACTOR(S) must:

1. Collect and analyze data and information to regularly monitor and assess the CONTRACTOR(S)' current and future workforce capacity and capabilities on at least a monthly basis.

k. Develop and implement interventions to improve workforce capacity and capability and meet Members' needs.

l. Develop and implement immediate strategies (to be implemented for up to thirty [30] Calendar Days after identifying a service gap), short-term strategies (to be implemented for up to sixty [60] Calendar Days after identifying a service gap), and long-term strategies (to be implemented within sixty [60] Calendar Days of identifying a service gap) to ensure that Members receive the services included in their PCSP or Plan of Service; strategies might include, but are not limited to, offering a special rate agreement and discussion of Self-Directed options.

m. Ensure that Participating Providers are deploying a qualified, sufficiently staffed workforce appropriate to meet the Members' needs as identified in the Member's PCSP, Plan of Service, or other service plan.

n. Provide technical assistance to Participating Providers to strengthen their workforce development programs.

o. Offer training and resources for Participating Providers to assist paid and unpaid caregivers with managing stress and burnout.

p. Collaborate with the State, other KanCare MCOs, and Providers to coordinate, plan, and implement workforce development initiatives.

q. Have a workforce development manager to lead the CONTRACTOR(S) workforce development activities.

r. Develop and submit an annual workforce development plan that is subject to State written approval and includes but is not limited to:

a. Analysis of data on workforce capacity and capabilities, including specific metrics related to direct care worker availability for adequate workforce and access;

b. Forecast of anticipated workforce capacity and capabilities;

c. Identification of geographical areas or types of services where increases in workforce capacity and/or capabilities are needed or will be needed;

d. Description of short- and long-term strategies for improving workforce capacity and capabilities, including specific initiatives and timelines;

e. Description of how implementation of the strategies will be monitored and evaluated, including an evaluation of the previous year's strategies;

f. Identification of standardized baseline workforce capacity and capability metrics to track improvement over time; and

g. Description of how stakeholders, including Providers, Members, and the general public have been involved in the development of the plan and/or strategies and will be involved in the implementation of the plan and/or strategies.

h. Present the CONTRACTOR(S)' workforce development plan and provide at least monthly progress reports on workforce development activities as requested by the State, including at stakeholder meetings.

H. The CONTRACTOR(S) shall permit Members to change Providers at any time and for any reason except as specified in Section 2.8.3.3.

I. The CONTRACTOR(S) shall conduct ongoing network management activities. The activities shall include, but not be limited to:

1. Developing a process and timeline/frequency for Provider-specific profile reports. Profile reports shall include a multi-dimensional assessment of each Provider's performance using indicators for performance that address, at a minimum, clinical quality, access, UM, and Member satisfaction. The indicators selected shall be clinically relevant, quantitatively measurable, and appropriate to the population. The CONTRACTOR(S) shall submit a copy of its Provider profile report template to the State prior to distribution to the Provider network.

2.5.10 Non-Participating Providers

The CONTRACTOR(S) shall:

A. Provide adequate, timely, and Medically Necessary Covered Services through a Non-Participating Provider if the CONTRACTOR(S)' network is unable to provide adequate and timely services required under this CONTRACT and continue to provide services by a Non-Participating Provider until a Participating Provider is available.

B. Provide documentation to the State on a quarterly basis describing the need to rely on Non-Participating Providers for the delivery of Covered Services for each Non-Participating Provider Claim paid. For purposes of this requirement "need to rely on" is defined as a Non-Participating Provider with paid Claims with dates of service for at least two (2) consecutive quarters that remains a Non-Participating Provider at the end of third consecutive quarter.

C. Coordinate with Non-Participating Providers for authorization and payment.

1. The State expects Non-Participating Providers to use the CONTRACTOR(S)' Grievance, Reconsideration, Appeal, and State Fair Hearing process to address disputes with the CONTRACTOR(S) as stated in Appendix D (Grievances and Appeals) and K.S.A. 77-501 et seq.

i. If the State determines that any CONTRACTOR(S) has a pattern of inappropriately denying payments to Non-Participating Providers, the CONTRACTOR(S) may be subject to suspension of new Enrollments, withholding of Capitation Payments, CONTRACT termination, or refusal to CONTRACT in a future time period. This applies to cases where the State has ordered payment after Appeal and also to cases where no Appeal has been made (i.e., the State is knowledgeable about abuse from other sources).

D. Negotiate and execute written single-case agreements or arrangements with Non-Participating Providers, when necessary, to ensure access to Covered Services.

E. Ensure that no Provider bills a Member for all or any part of the cost of a treatment service, except as allowed for Title XIX cost sharing, spenddown, client liability and client obligations, and non-Title-XIX sliding fee scale payments by Members. The CONTRACTOR(S) shall ensure that cost to the Member is no greater than it would be if services were provided by a Participating Provider.

F. Prior to paying Claims to a Non-Participating Provider that is not enrolled with KMAP, the CONTRACTOR(S) must, at a minimum, verify licensure and perform all Federal database checks as specified in 42 CFR § 455.436 on all Owners and managing employees.

G. Arrange for the service to be provided outside the network, if a qualified Provider is available, if a Member needs a specialized, Medically Necessary Covered Service that is not available through the network.

H. The CONTRACTOR(S) must permit American Indian Members to obtain Covered Services under this CONTRACT from non-participating IHCPs from whom the Member is otherwise eligible to receive such services.

I. The CONTRACTOR(S) must permit a non-participating IHCP to refer an American Indian Member to a Participating Provider.

J. Ensure that the CONTRACTOR(S)' Provider network adheres to the following:

    1. Provides female Members with direct access to a women's health specialist within the Provider network for covered care necessary to provide women's routine and preventive Health Care Services. This is in addition to the Member's designated source of Primary Care if that source is not a women's health specialist.

    j. Provides for a second opinion from a Participating Provider or arranges for the Member to obtain one outside the network at no cost to the Member.

    k. Demonstrates that its network includes sufficient family planning Providers to ensure timely access to Covered Services.

2.5.11 Material Change to Provider Network

A material change to the Provider network is defined as one that affects, or can reasonably be foreseen to affect, the CONTRACTOR(S)' ability to meet performance and/or Provider network standards as described in this CONTRACT, including, but not limited to, any change that would cause or is likely to cause more than 5% of Members in a service area to change the location where services are received or rendered.

A. The CONTRACTOR(S) is responsible for evaluating all Provider network changes, including unexpected or significant changes, and determining whether those changes are material changes to the CONTRACTOR(S)' Provider network.

B. All material changes to the Provider network must be approved in advance by the State in writing.

C. The CONTRACTOR(S) must submit the request for written approval of a material change to the Provider network along with a description of how the change will affect the delivery of Covered Services, the CONTRACTOR(S)' plans for maintaining the quality of Member care, and

communications to Providers and Members. The CONTRACTOR(S) must submit the request for approval within fourteen (14) Calendar Days of identifying a material change.

D. A material change in the CONTRACTOR(S)' Provider network requires thirty (30) Calendar Days advance written notice from the CONTRACTOR(S) to Members and Providers. In the event unforeseen circumstances prevent the CONTRACTOR(S) from providing thirty (30) Calendar Days advance written notice to Members and Providers, the CONTRACTOR(S) shall notify the State within one (1) Business Day of identifying the material change to the Provider network for the State's determination of notification requirements.

2.5.12 Provider-Member Communication

The CONTRACTOR(S) may not prohibit, or otherwise restrict, a Provider, acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the following:

A. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

B. Any information the Member needs to decide among all relevant treatment options.

C. The risks, benefits, and consequences of treatment or non-treatment.

D. The Member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.5.13 Avoiding and Disclosing Potential Conflicts of Interest

A. Any CONTRACTOR(S) that engages or proposes to engage in a relationship(s) with any parties that have any legal, financial, contractual, or related party interests with a Provider or group of Providers to be reimbursed through the State shall demonstrate both an organizational structure and policies and procedures that would prevent the opportunity for, or an actual practice which allows, a situation in which the CONTRACTOR(S) gains any financial benefit from any policy or practice related to network recruitment, referral, reimbursement, service authorization, monitoring and oversight, or any other practice which might bring financial gain.

B. The CONTRACTOR(S) and any Subcontractors shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of KDHE-DHCF or the State without written approval by KDHE-DHCF. Any such work that involves LTSS or Behavioral Health Providers will also need written approval from KDADS.

C. Specific situations that may be indicative of a conflict of interest include, but are not limited to, the following:

    1. A change of the distribution of referrals or reimbursement among Providers within a level of care.

    l. Referral by the CONTRACTOR(S) to only those Providers with whom the CONTRACTOR(S) shares an organizational relationship.

    m. Preferential financial arrangements by the CONTRACTOR(S) with those Providers with whom the CONTRACTOR(S) shares an organizational relationship.

n. Different requirements for credentialing, privileging, profiling, or other network management strategies for those Providers with whom the CONTRACTOR(S) shares an organizational relationship.

o. Substantiated complaints by Members of limitations on their access to Participating Providers of their choice within an appropriate level of care.

D. The CONTRACTOR(S) shall fully and completely disclose any situation that may present as a conflict of interest.

E. If the CONTRACTOR(S) is now performing or elects to perform during the term of this CONTRACT any services for any CONTRACTOR(S), Provider, or an entity owning or controlling the same, the CONTRACTOR(S) shall disclose this relationship prior to accepting any assignment involving such party.

F. Should a conflict of interest and/or preferential treatment be determined by the State at any time during the CONTRACT period, the State reserves the right to sanction the CONTRACTOR(S) or take other actions up to and including recoupment of CONTRACTOR(S) payments and terminating the Provider from the CONTRACTOR(S)' Provider network.

2.5.14 Delegation Relationships

The requirements of this section apply to any contract or written arrangement that the CONTRACTOR(S) has with any Subcontractor. If any of the CONTRACTOR(S)' activities or obligations under this CONTRACT are delegated to a Subcontractor, the CONTRACTOR(S) shall:

A. Maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its CONTRACT with KDHE-DHCF.

B. Ensure the terms of Subcontracts are subject to the applicable material terms and conditions of the CONTRACT existing between the CONTRACTOR(S) and KDHE-DHCF for the provision of Covered Services.

C. Evaluate a prospective Subcontractor's ability to perform duties to be delegated.

D. Ensure that delegated activities or obligations and related reporting responsibilities are specified in the Subcontract and that the Subcontractor agrees to perform the delegated activities and reporting responsibilities as specified in compliance with the CONTRACTOR'S obligations under this CONTRACT. All Subcontracts must contain full disclosure of all terms and conditions, including disclosure of all financial or other requested information.

E. Monitor Subcontractors' payments to Participating Providers to ensure Subcontractors are reimbursing Providers consistent with CONTRACT Section 2.5.16, Provider Payment. Subcontractors are to be compliant with changes to the State's fee schedule by the effective date of relevant fee schedules.

F. Monitor the Subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by KDHE-DHCF. As a result of the performance review, any deficiencies must be communicated to the Subcontractor in order to establish a corrective action plan. The results of the performance review and the corrective action plan shall be communicated to KDHE-DHCF upon completion.

G. Inform KDHE-DHCF in writing if a Subcontractor is non-compliant to the extent it would affect its ability to perform the duties and responsibilities of the Subcontract.

H. Ensure that the CONTRACT or other written arrangement either provides for revocation of the delegation activities or obligations, or specifies other remedies, including imposing liquidating damages, in instances where KDHE-DHCF or the CONTRACTOR(S) determine that the Subcontractor has not performed satisfactorily.

I. Not pass down compliance remedies to a Subcontractor unless the Subcontractor is responsible for the CONTRACTOR(S)' failure to meet the requirement.

J. Ensure that information specified in 42 CFR § 438.10(g)(2)(xi) about the Grievance and Appeal system is provided to all Subcontractors at the time they enter into a Subcontract.

K. Be responsible for ensuring that its Subcontractors are notified when modifications are made to State requirements, policies, and manuals.

L. Not delegate or enter into a Subcontract or a comprehensive management services agreement to perform key operational functions that are critical for integrated Health Care Service delivery, including, at a minimum:

    1. Grievance and Appeal system;

    p. Quality Management;

    q. Medical management;

    r. Provider relations;

    s. Network and Provider services contracting and oversight;

    t. Member services; or

    u. Corporate compliance.

M. Each Subcontract, and any further delegations by a Subcontractor, shall be subject to prior written approval by the State.

2.5.15 Minimum Subcontract Provisions

A. If the CONTRACTOR(S) chooses to use Subcontractors, the State encourages the CONTRACTOR(S) to use Kansas Subcontractors, including small and emerging businesses or small entrepreneurships. All Subcontracts must reference and require compliance with KDHE-DHCF minimum Subcontract provisions. Each Subcontract must contain the following:

    1. Identification of the name and address of the Subcontractor.

    v. Identification of the population, to include Member capacity, to be covered by the Subcontractor.

    w. The amount, duration, and scope of services to be provided and for which compensation will be paid. No assignment of delegation of the duties of the Subcontractor shall be valid unless prior written approval is received from the CONTRACTOR(S) and prior approved by the State in writing.

x. Full disclosure of the method and amount of compensation to be received by the Subcontractor. No payment due to the Subcontractor under the Subcontract may be assigned without the prior approval of the CONTRACTOR(S).

y. The term of the Subcontract including beginning and ending dates, methods of extension, termination, and renegotiation.

z. Include written requirements that the Subcontractor agrees to comply with all applicable Medicaid laws, State laws, policies, and regulations, including applicable sub-regulatory guidance and CONTRACT provisions.

aa. Include a requirement that any services described in the Subcontract that directly serve the State or its Members and involve access to secure or sensitive data or personal Member data shall be performed within the defined territories of the United States.

bb. Require Subcontractors to adhere to the requirements regarding disclosure of ownership and control and disclosure of information on persons convicted of crimes as outlined in 42 CFR § 438.610.

cc. Include that Participating Providers shall report all suspected Fraud, waste, or Abuse to KDHE-DHCF regardless of funding source.

dd. Include a statement that a merger, reorganization, or change in ownership of a Subcontractor of the CONTRACTOR(S) shall require a contract amendment and prior approval of KDHE-DHCF in writing.

ee. The duties of the Subcontractor relating to coordination of benefits (COB) and determination of Third-Party Liability (TPL), including timely uploading of State-provided TPL files, identifying Medicare and other TPL coverage, and seeking Medicare or TPL payment before submitting Claims to the CONTRACTOR.

ff. A description of the Subcontractor's patient, medical, and cost record keeping system, including assurances that the Subcontractor shall safeguard confidential information in accordance with Federal and State laws, regulations, policies, and HIPAA.

gg. Include requirements that the Subcontractor must retain, as applicable, Member Grievance and Appeal records, base data and audited financial reports, and data requested to support the CONTRACTOR(S)' Medical Loss Ratio (MLR) reporting requirements.

hh. A written expectation that requires compliance with KDHE-DHCF and the CONTRACTOR(S)' quality management programs, medical management programs, and shall comply with the utilization control and review procedures in conformance with CMS rules and regulations and the State's KanCare Quality Management Strategy (QMS).

ii. A provision that states KDHE-DHCF is responsible for Enrollment, re-Enrollment, and Disenrollment of the covered population and the Subcontractor must upload State-supplied Enrollment files timely.

jj. A requirement that the Subcontractor must comply with Encounter reporting and Claims submission requirements as applicable to the CONTRACTOR(S) and must upload State-supplied pricing files timely.

kk. Include written requirements that the Subcontractor develop and follow written policies and procedures for the processing of requests for initial and continuing authorization of services.

ll. A statement that compensation to individuals or entities that conduct UM and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

mm. A requirement that the Subcontractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the Member.

nn. A provision that requires the Subcontractor to assist Members in understanding their right to file Grievances and Appeals in conformance with all KDHE-DHCF Grievance and Appeal system and Member rights policies.

oo. A provision that details remediation activities if the Subcontractor fails to comply with Subcontract requirements, including, but not limited to, corrective action plans, sanctions and penalties, and Subcontract termination.

pp. Include written requirements that the Subcontractor agrees that the State, CMS, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the Subcontractor or the Subcontractor's CONTRACTOR(S) that pertain to any aspect of services and amounts payable under the CONTRACTOR(S)' CONTRACT with KDHE-DHCF. For purposes of an audit, evaluation, or inspection, the Subcontractor shall make available its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Members at no cost.

qq. Written requirements that allow the CONTRACTOR(S) to suspend, deny, and refuse to renew, or terminate any Subcontractor in accordance with the terms of the CONTRACTOR(S)' CONTRACT with KDHE-DHCF and applicable law and regulation.

rr. Require management services Subcontractors to prepare a Business Continuity/ Disaster Recovery (BC/DR) plan within ninety (90) Calendar Days of CONTRACT award.

ss. Maintain a fully executed original or electronic copy of all Subcontracts, which shall be accessible to KDHE-DHCF within five (5) Business Days of request.

B. The CONTRACTOR(S)' Subcontract with a pharmacy benefit manager (PBM) shall have an addendum that contains every requirement applicable to KanCare except that the addendum may reference definitions in another part of the Subcontract that are applicable to the KanCare addendum. All administration fees shall be line-itemed, and the Subcontract shall prohibit the sale of Prescription transaction data. When submitted to the State, no part of the PBM Subcontract, including the CONTRACTOR(S)' reimbursement of the PBM and the PBM's Claim-payment pricing methodology, shall be redacted. In addition, the CONTRACTOR(S) shall provide the State with unredacted copies of the PBM's contracts with Providers, including Pharmacy Providers, and any other agreements or contracts related to coverage of pharmaceuticals under this CONTRACT.

C. For all Subcontracts at least annually, the CONTRACTOR(S) shall provide to the State a monitoring plan for assessing and ensuring high quality Subcontractor performance.

D. Whenever any CONTRACTOR(S) has a change in any material Subcontractor, the CONTRACTOR(S) shall assign a project manager who is familiar with effective project management

techniques and tools, and shall develop and submit to the State a project plan to guide the transition to a new Subcontractor, and shall include regular reporting to the State of key timeline, milestones, accomplishments, risks, and mitigation plans associated with the transition. Examples of material Subcontractors may include, but are not limited to, dental, vision, Transportation, Pharmacy, or Behavioral Health vendors. Subcontractors fulfilling purely administrative functions shall be excluded from this requirement.

2.5.16 Provider Payment

A. Minimum reimbursement to Participating Providers: Unless the CONTRACTOR(S) has entered into a value-based purchasing (VBP) arrangement (see Section 2.7 of this CONTRACT) with a Participating Provider or has a national discount program contract, the CONTRACTOR(S) must pay Participating Providers at least the Medicaid FFS rate.

   1. Unless otherwise specified, the “Medicaid FFS rate” is the rate that the Provider would have received in the FFS Medicaid program inclusive of options for quality and outcomes incentive payments. The State will notify the CONTRACTOR(S) of updates to the Medicaid fee schedule and payment rates, and the CONTRACTOR(S) shall implement updates by the effective date specified by the State.

   2. The CONTRACTOR(S) must submit each of its national discount program contracts to the State at least ninety (90) Calendar Days prior to implementation of the discount contract for KanCare. The State reserves the right to request additional information or disapprove the discount contract for implementation for KanCare.

B. The CONTRACTOR(S)’ pharmaceutical reimbursement must follow the State’s MCO policies for pharmaceutical reimbursement for both medical and Pharmacy benefits, unless otherwise approved in writing by the State (see Appendix C, Services, for additional information).

C. The CONTRACTOR(S) shall reimburse a State hospital at least 100% of costs based on the State’s established payment process and methodology. The CONTRACTOR(S) will comply with the State’s payment adjustments to ensure that 100% of costs are covered.

D. The CONTRACTOR(S) shall reimburse critical access hospitals (CAHs) at least the Medicaid FFS rate according to the diagnosis-related group fee schedule.

E. The CONTRACTOR(S) shall reimburse NFs, NFMH, PRTFs, and ICF/IIDs, at least the Medicaid FFS rate according to the per diem rates established by the State.

   1. The CONTRACTOR(S) shall reimburse a NF 100% of the established FFS rate when a NF is sold and while the facility is being re-credentialed.

F. The CONTRACTOR(S) shall reimburse an FQHC and RHC the PPS rate in effect on the date of service for each Encounter.

G. The CONTRACTOR(S) shall reimburse a CCBHC the PPS rate in effect on the date of service for each Encounter and, upon request, cooperate with the State in conducting a reconciliation of payments to the CCBHC against the CCBHC experienced costs.

H. Unless otherwise required by Federal requirements (e.g., FQHCs, RHCs, and CCBHCs), if any Provider does not have a Provider agreement with the CONTRACTOR(S), non-Participating

Providers will receive 90% of FFS rates. This payment requirement also applies to services provided under the Prudent Layperson definition of Emergency Services.

I. The CONTRACTOR(S) shall ensure that Indian Health Care Providers (IHCPs, whether participating in the network or not, be paid for covered Medicaid or CHIP KanCare services provided to American Indian Members who are eligible to receive services from such Providers either (i) at a rate negotiated between the CONTRACTOR(S) and the IHCP, or (ii) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the Provider were not an IHCP.

J. In accordance with 42 CFR § 438.14(c)(2), the CONTRACTOR(S) shall pay the IHCP its applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS), or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology, regardless of whether the IHCP is enrolled in Medicaid as an FQHC, or participates in the CONTRACTOR(S)' network.

K. The CONTRACTOR(S) must require Participating Providers to identify Provider Preventable Conditions as a condition of payment and comply with the prohibition against payment for Provider Preventable Conditions as set forth in 42 CFR § 434.6(a)(12) and 447.26. The CONTRACTOR(S) must report all Provider Preventable Conditions in a form and frequency as specified by KDHE-DHCF.

L. The CONTRACTOR(S) shall identify Providers that are having significant billing problems and shall work with the Providers to educate and train Providers to assist in resolving billing issues. See Section 2.6.6 for related requirements.

M. The CONTRACTOR(S) shall offer all Providers the option to receive payments without any fee or cost to the Provider and shall not automatically enroll a Provider in a payment option that charges the Provider to receive payments.

N. Pay-for-performance (P4P) incentive for specified hospitals:

1. CONTRACTOR(S) shall pay a pay-for-performance (P4P) incentive in addition to negotiated rates on all inpatient and outpatient utilization at the Public Teaching Hospital and the Border Children's Hospital. To be eligible for the P4P incentive, the Large Public Teaching Hospital and Border Children's Hospital must meet or exceed the annual performance measure benchmarks on the quality metrics specified in the State directed payment preprint in accordance with 42 CFR § 438.6(c). KDHE shall be solely responsible for all review and validation of performance and for all calculations of amounts paid under this Section.

    a. CONTRACTOR(S) will receive specified payments in addition to Capitation Payments for this P4P incentive structure and the guidelines are set forth below:

        i. The P4P incentive targets have been set by KDHE, the Large Public Teaching Hospital, and the Border Children's Hospital based on hospital specific performance data. The performance targets by quality metric and hospital are specified in the State directed payment preprint in accordance with 42 CFR § 438.6(c).

        ii. The Large Public Teaching Hospital and the Border Children's Hospital must meet or exceed the performance targets for the Provider quality metrics in order to be eligible to receive the incentive payment.

iii. The Large Public Teaching Hospital and the Border Children's Hospital are eligible to receive a specified amount per measure for meeting the performance targets. The Large Public Teaching Hospital is eligible for up to the amount specified by KDHE and the Border Children's Hospital is eligible for up to the amount specified by KDHE. To the extent that the Large Public Teaching Hospital or the Border Children's Hospital do not meet one (1) or more of the performance targets in the first year of the program, no amount of the remaining annual amount will be rolled over into the second year of the program.

iv. The Large Public Teaching Hospital and the Border Children's Hospital are not required to meet all performance targets for the applicable Provider quality metrics in order to receive a P4P incentive payment. Payment will be earned for meeting any of the performance targets according to the amounts allocated to each measure.

v. The Large Public Teaching Hospital and Border Children's Hospital will each provide a mid-year report to KDHE by August 31 of each year. Within fourteen (14) Business Days of receipt of the mid-year report, KDHE will provide feedback to the Large Public Teaching Hospital and the Border Children's Hospital on any necessary corrections to the mid-year report. If corrections are necessary, the Large Public Teaching Hospital and the Border Children's Hospital will have fourteen (14) Business Days from notification by KDHE to revise the mid-year report.

vi. Within ten (10) Business Days of KDHE's receipt of satisfactory mid-year reports, an interim payment equal to 40% of the total annual incentive amounts will be paid to CONTRACTOR(S). KDHE will inform the Large Public Teaching Hospital and Border Children's Hospital of the date of the payment to the CONTRACTOR(S) and the amount due to the hospitals from the CONTRACTOR(S). CONTRACTOR(S) shall pay the Large Public Teaching Hospital and Border Children's Hospital within twenty (20) Business Days of receipt of payment from KDHE.

vii. The Large Public Teaching Hospital and the Border Children's Hospital will submit an annual report to KDHE no later than March 31 of the following calendar year.

viii. KDHE will evaluate the annual report submitted by the Large Public Teaching Hospital and the Border Children's Hospital against the performance targets. Within fourteen (14) Business Days of receipt of the annual report, KDHE will provide feedback to the Large Public Teaching Hospital and the Border Children's Hospital on any necessary corrections to the annual report. If corrections are necessary, the Large Public Teaching Hospital and the Border Children's Hospital will have fourteen (14) Business Days from notification by KDHE to revise the annual report. KDHE will calculate the total incentive payments for the Large Public Teaching Hospital and the Border Children's Hospital by the dates specified by KDHE, assuming satisfactory annual reports are received from the Large Public Teaching Hospital and the Border Children's Hospital to accommodate this timeframe.

ix. If the Large Public Teaching Hospital or the Border Children's Hospital did not achieve performance levels equivalent to the interim payment, KDHE will calculate the amount to be recouped from the Large Public Teaching Hospital or the Border Children's Hospital. After the date of notification from KDHE, CONTRACTOR(S) shall have twenty (20) Business Days to collect any recoupments from the Large Public Teaching

Hospital or the Border Children's Hospital. KDHE will inform the Large Public Teaching Hospital or the Border Children's Hospital of amount to remitted to the CONTRACTOR(S) due to unsatisfactory performance for the calendar year.

x. Any payment earned by the hospitals based on the annual report will be made to CONTRACTOR(S) within ten (10) Business Days after KDHE validates the annual report. When the CONTRACTOR(S) receives the payment from KDHE, the CONTRACTOR(S) has twenty (20) Business Days to transfer the entire amount to the Large Public Teaching Hospital and the Border Children's Hospital. KDHE will inform the Large Public Teaching Hospital or the Border Children's Hospital of the date of the payment to the CONTRACTOR(S) and the amount due.

b. No payment shall be made under this subsection without CMS' approval pursuant to 42 CFR § 438.6(c)(2).

O. The CONTRACTOR(S) shall make a directed payment to hospital Providers. KDHE will provide to the CONTRACTOR(S) the directed payment amount for each Provider. This directed payment methodology does not apply to State hospitals, the University of Kansas (KU) hospital, out-of-state hospitals, or institutions for mental disease (IMD). KDHE will be responsible for appeals from hospital Providers regarding the directed payment amount and reconciling directed payments.

P. The CONTRACTOR(S) shall make directed payments for supplemental medical education (SME) to three (3) KU Providers: KU, Kansas University Physicians Incorporated (KUPI), and Wichita Medical Practice Association (MPA). The CONTRACTOR(S) will receive specified payments in addition to Capitation Payments for the SME payments. The guidelines are set forth below. No payment shall be made under this subsection without CMS' approval pursuant to 42 CFR § 438.6(c)(2).

1. The quality measures have been set by KDHE for the KU Providers: KU, KUPI, and MPA. The performance targets by quality metric and Provider are specified in the State directed payment preprint in accordance with 42 CFR § 438.6(c).

c. The KU, KUPI, and MPA are not required to meet all performance targets for the applicable Provider quality metrics in order to receive a SME payment.

d. The KU, KUPI, and MPA will provide a mid-year report to KDHE by August 31 of each year. Within fourteen (14) Business Days of receipt of the mid-year report, KDHE will provide feedback to KU, KUPI, and MPA on any necessary corrections to the mid-year report. If corrections are necessary, the KU, KUPI, and MPA will have fourteen (14) Business Days from notification by KDHE to revise the mid-year report.

e. Within ten (10) Business Days of KDHE's receipt of satisfactory mid-year reports, an interim payment equal to 40% of the total annual amount will be paid to the CONTRACTOR(S). The CONTRACTOR(S) shall pay the KU, KUPI, and MPA within twenty (20) Business Days of receipt of payment from KDHE.

f. The KU, KUPI, and MPA will submit an annual report to KDHE no later than March 31 of the following calendar year.

g. KDHE will evaluate the annual report submitted by the KU, KUPI, and MPA against the quality targets. Within fourteen (14) Business Days of receipt of the annual report, KDHE will provide feedback to the KU, KUPI, and MPA on any necessary corrections to the annual report. If corrections are necessary, the KU, KUPI, and MPA will have fourteen (14) Business Days from

notification by KDHE to revise the annual report. KDHE will calculate the payments for the KU, KUPI, and MPA by the date specified by KDHE, assuming satisfactory annual reports are received from the KU, KUPI, and MPA to accommodate this timeframe.

h. Any payment earned by the KU, KUPI, and MPA based on the annual report will be made to the CONTRACTOR(S) within ten (10) Business Days after KDHE validates the annual report. When the CONTRACTOR(S) receives the payment from KDHE, the CONTRACTOR(S) has twenty (20) Business Days to transfer the entire amount to the KU, KUPI, and MPA. KDHE will inform the KU, KUPI, and MPA of the date of the payment to the CONTRACTOR(S) and the amount due.

2.6 Provider Services

The CONTRACTOR(S) shall:

A. Provide training that has been approved by the State in writing, for all Participating Providers, including Participating Providers that deliver HCBS Waiver services. The CONTRACTOR(S) shall offer the training to all Participating Providers at least on an annual basis. The content of the training for Participating HCBS Waiver Providers shall include, but is not limited to, accountable quality care and the unique safety and wellness issues associated with HCBS Waiver services. The training shall be tracked by the CONTRACTOR(S), to be reported on an annual basis or as requested by the State.

B. Provide in-person training at the request of Participating Providers.

C. Notify the State within thirty (30) Calendar Days of any scheduled training.

D. Provide ongoing basic billing education, both initial/orientation level and refresher level, offered to all Participating Provider staff. CONTRACTOR(S) shall develop and submit an annual schedule of Participating Provider training sessions for State written approval. The CONTRACTOR(S) shall provide this training in-person at the request of Participating Providers. The CONTRACTOR(S) shall provide an annual report to the State that reflects the completion of these training sessions over the calendar year

E. Track and trend Provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate.

F. Ensure that Provider contacts to the CONTRACTOR(S)' Provider relations staff are acknowledged within three (3) Business Days of receipt. Provider issues that can be resolved by the CONTRACTOR(S) without making updates or changes to any of the CONTRACTOR(S)' systems, must be fully resolved and communicated to the Provider within thirty (30) Business Days. Provider issues that require updates or changes in one or more of the CONTRACTOR(S)' systems, impacting more than one (1) Provider, must be added to the KanCare Claims resolution log within thirty (30) Business Days of receipt for tracking and reporting root cause, the date the system will be fixed, and the date Providers can expect Claims to be adjusted. Provider issues that require updates or changes in one or more of the CONTRACTOR(S)' systems, impacting a single Provider, must be added to the MCO unified issues log within thirty (30) Business Days of receipt for tracking and reporting root cause, the date the system will be fixed, and the date the Provider can expect Claims to be adjusted. The CONTRACTOR(S) must update Providers every thirty (30) Calendar Days of the status of their issue until it is fully resolved.

G. Hold a Provider forum no less than semi-annually. The forum must be chaired by the CONTRACTOR(S)' Administrator/CEO or designee. The purpose of the forum is to improve communication between the CONTRACTOR(S) and its Participating Providers. The forum shall not be the only venue for the CONTRACTOR(S) to communicate and participate in the issues affecting the network. Provider forum meeting agendas and minutes from the previous meeting must be approved in writing by KDHE in advance of the meeting(s).

H. Report information discussed during these forums to executive management within the organization.

I. Conduct meetings with Providers to address issues (or to provide general information, technical assistance, etc.) related to Federal and State requirements, changes in policy, reimbursement matters, PA, and other matters as identified or requested by the State.

2.6.1 Requirements for a Provider Manual

A. The CONTRACTOR(S) shall develop and submit to the State for written approval a Provider manual that:

1. Contains dated CONTRACTOR(S) policy and procedure information, including, in part, credentialing criteria, UM policies and procedures, billing and payment procedures, Provider and Member Grievance and Appeal processes, network management requirements, interpreter access procedures, and sample Provider agreements.

i. Is distributed electronically to all Participating Providers following approval of the State no later than thirty (30) Calendar Days following the CONTRACT effective date, and then to Participating Providers and Non-Participating Providers upon request thereafter.

j. Is updated regularly and distributed electronically in whole or in part to Participating Providers at least thirty (30) Calendar Days in advance of any policy or procedure change substantive revisions to the Provider manual must be submitted to the State for written approval. Changes must be posted on the CONTRACTOR(S) website and notify Providers via bulletins.

k. Is posted as an electronic version of the Provider manual to the CONTRACTOR(S)' website with hard copies made available upon request.

l. Is consistent with State Medicaid Provider manuals in regard to services covered and who can provide the services.

2.6.2 State Approval Process of Provider Materials

A. The CONTRACTOR(S) shall submit to the State for review and prior written approval all materials meant for distribution to Providers, including, but not limited to, Member handbooks, Provider Directories, any other additional, but not required, materials and information designed to educate Providers.

B. All Provider materials must be submitted to the State in electronic file media, in the format prescribed by the State. The CONTRACTOR(S)' submission shall include a plan that describes the CONTRACTOR(S)' intent for the use of the materials.

C. The State reserves the right to notify the CONTRACTOR(S) to discontinue or modify written Provider materials.

D. Except as otherwise noted written materials must be submitted for review at least forty-five (45) Calendar Days for approval before their printing and distribution. The CONTRACTOR(S) should only request expedited reviews in rare circumstances and will be monitored for potential misuse. This requirement applies to:

1. Policy letters, coverage policy statements, or other communications about Covered Services distributed to Providers;

m. All updates to the Provider handbook;

n. All bulletins;

o. All policy information changes submitted via letter;

p. All Provider agreement templates; and

q. All contracts with Subcontractors.

E. The CONTRACTOR(S) shall provide the State with advance notice of any changes made to written materials that will be distributed to Providers.

2.6.3 Electronic Specific and Website Requirements for Provider Information

A. The CONTRACTOR(S) and any Subcontractors are responsible for developing, hosting, and maintaining a public website.

B. The CONTRACTOR(S)' website and functionality shall take into consideration the Member-specific information as required in Section 2.10.

C. The CONTRACTOR(S) website shall comply with the following requirements:

1. Electronic information must be in a machine-readable file and format.

r. Allow for easy navigation.

s. Separate section each for Providers and Members.

t. Compliant with Americans with Disabilities Act (ADA) Title III website accessibility requirements and the Kansas Information Technology Office (KITO) executive council accessibility requirements. These requirements are located at the link: https://ebit.ks.gov/itec/resources/policies/policy-1210 The CONTRACTOR(S) websites will be subject to KITO's review and written approval for accessibility.

u. All information must be current and up to date.

D. The CONTRACTOR(S)' website shall include the following on their public website for Providers:

1. Prominent links to the electronic Provider handbooks.

v. CONTRACTOR(S)' contact information.

w. Frequently asked questions (FAQs).

x. Benefit information and links to KMAP policies as appropriate.

y. Information on oral translation services and how to obtain those services.

z. Links to other related websites, including the KDHE-DHCF Medicaid and KDADS websites.

aa. Information about the CONTRACTOR(S)' Formulary:

a. Which medications are covered, including both brand and generic names; and

b. What tier each medication is on.

c. Provider directory as required per Section 2.10.8.

d. Historical repository of bulletins.

e. Authorization necessity check and links to the authorization request tool or form.

f. The following must be accessible from the CONTRACTOR(S)' website with specific links:

a. Sign in for KMAP enrollment and credentialing tool;

b. Sign in for KMAP Member eligibility verification tool;

c. Any other forms and Provider newsletters; and

d. CONTRACTOR(S)' Provider training.

e. The CONTRACTOR(S)' Health Equity and cultural competency plan.

f. The CONTRACTOR(S)' non-discrimination policy.

g. Links to all Subcontractor websites.

h. Links to definitions of Claim denial or remark codes.

i. Maps with Provider representative regions outlined and full name/contact information for Provider representatives.

E. The CONTRACTOR(S) shall maintain a secure area within their website for Providers (a Provider portal) that shall be available free of charge to Providers.

1. The CONTRACTOR(S)' Provider portal shall include:

a. Information regarding the CONTRACTOR(S)' records for the inquirer.

b. Ability to submit Claims (individual or batch) and supporting documentation, correct Claims, and check Claim status (e.g., received, pended, paid, denied), including notification of any additional information needed and reasons for denials.

c. Ability to identify and resolve credit balance issues.

d. Electronic copy of explanation of benefits (EOBs)/remittance advices that detail Claim service payment or denials and include dates of service, procedure codes, amount billed, amount allowed, amount paid, and patient liability.

e. Ability to determine which services require an authorization.

f. Ability to have Providers submit Prior Authorizations as specified in Section 2.14.2 of this CONTRACT.

g. Ability to check Member's eligibility and Enrollment status and download and print a Member's identification (ID) card.

h. Members' TPL information (see Section 2.15.2).

i. Ability to receive Provider-specific reports, including gaps in care.

j. Ability to access Provider-specific reports.

k. Ability to initiate an online discussion ("chat") with a Provider representative.

l. The CONTRACTOR(S) is encouraged to include the following functionality in its Provider portal:

a. Ability to see a Member's Claims history for all Providers/services.

b. Ability to access information for Care Coordination, including results of the Member's Health Screen, HRA, Needs Assessments, and the Member's Plan of Service/PCSP.

c. Ability to update the Provider's demographic information.

d. Ability to initiate an Appeal.

2.6.4 Written Provider Materials Requirements

A. All written Provider materials must follow the requirements in Section 2.6 above.

B. Any significant policy or process change with Provider impact requires a Provider bulletin.

C. State policy changes shall be communicated using the official KDHE-DHCF policy related to the Provider bulletin publication process:

1. Bulletin will be supplied by the State to the CONTRACTOR(S).

e. CONTRACTOR(S) shall publish/distribute the State's bulletin.

f. Bulletin will be on the CONTRACTOR(S) website and distributed via email in advance of policy effective date.

g. CONTRACTOR(S) will notify KDHE-DHCF's policy team when the publication process is complete.

D. Any bulletins that are not related to a State policy change must be reviewed and approved by the State in writing prior to publication.

E. Bulletins should be emailed through an email distribution list, posted on the CONTRACTOR(S) public website, and mailed to Providers as appropriate.

F. The CONTRACTOR(S) shall not distribute any Marketing Materials without first obtaining the State's written approval. The material must be co-branded with the KanCare logo unless otherwise approved in writing by the State.

2.6.5 Customer Service Center – Provider Assistance

A. The CONTRACTOR(S) shall staff, operate, and maintain a customer and Provider service center that is responsible for handling and responding to questions, concerns, inquiries, and complaints received by telephone, fax, written, in-person, or electronic means concerning the KanCare program.

B. The CONTRACTOR(S) must operate a toll-free telephone service, for use by Members, Potential Members, Providers, community-based service organizations, and other public or private agencies from 8:00 am–5:00 pm Central Time Monday through Friday, except for holidays approved by the State in writing. The CONTRACTOR(S) is responsible for providing sufficient in-bound toll-free lines to meet the performance standards outlined below.

   1. Automated voice response system (AVRS) may be incorporated into the customer service plan. If an AVRS is used, separate queues must be available for English and Spanish calls.

   h. The AVRS must be capable of providing specific information such as the fax number, hours of operation, etc., as well as allowing the caller to access a call center representative.

   i. The AVRS shall provide an option in initial menu to allow Providers to contact a call center representative immediately.

   j. The CONTRACTOR(S)' call center shall be staffed with personnel who are knowledgeable about the CONTRACTOR(S)' program and Covered Services, including services provided by Subcontractors, and services covered outside the CONTRACT.

C. The CONTRACTOR(S) shall immediately (within one [1] hour) notify the State if there is an interruption or failure of the CONTRACTOR(S)' call center.

D. The customer service center shall be a separate, identifiable, and centralized unit which is staffed with a sufficient number of trained staff to fulfill the functions of this unit. The staff answering calls must receive appropriate training, including, but not limited to, benefits and services, enrollment process, Grievance, Reconsideration, and Appeal processes, and logging and documenting calls.

E. The CONTRACTOR(S) shall research, resolve, and respond to all inquiries made by Providers and other parties.

F. The CONTRACTOR(S) shall submit a call center representative training plan, evaluation standards, and tools to the State for written approval ninety (90) Calendar Days after CONTRACT award.

G. The CONTRACTOR(S) must provide language assistance and translation services necessary to ensure meaningful access at no cost to LEP Members.

H. The CONTRACTOR(S) must have dedicated Provider lines with sufficient staffing to meet CONTRACT standards.

I. The CONTRACTOR(S) must have a specific Provider line dedicated to Pharmacy issues.

J. The CONTRACTOR(S) must record all calls (inbound and outbound, including voicemails) that are directed to the CONTRACTOR(S)' primary published Provider services.

K. The CONTRACTOR(S) must provide a system to track and document all phone contacts, including incoming calls, outgoing calls, incoming email, outgoing email, web-based contacts, and voice

messages. The call tracking system shall have the capability to generate statistical reports regarding, for example, call volumes, length of time to answer, abandonment rates, length of the calls, nature of the contact, and who answered the contact.

L. The CONTRACTOR(S) shall submit a call center report to the State using State specifications and definitions. Reasons for the call shall be standardized between KanCare MCOs, and all statistics must be submitted as required by the State. The CONTRACTOR(S)' customer service center shall maintain reporting systems with the capability to track all statistics necessary to address performance requirements listed in Section 2.10.10.L.

M. Customer service performance standards: The CONTRACTOR(S) and their Subcontractors shall meet the following requirements for customer service:

1. 100% of incoming and outgoing calls must be documented and recorded.

k. 99% of calls must be answered by an individual or an electronic device without receiving a busy signal.

l. 90% of all calls answered within thirty (30) seconds.

m. Average abandonment rate of less than 5%.

n. 85% of calls answered by a live voice within thirty (30) seconds.

o. A minimum of 70% of calls resolved during the initial call. Warm Transfers to the appropriate department, including Grievance and Appeals, will be recognized as resolved during the initial call.

p. 100% of received phone calls are recorded and the recordings maintained.

q. 100% of calls left on voicemail during or after working hours are retrieved and returned within one (1) Business Day.

r. 100% of all inquiries shall be resolved within fifteen (15) Business Days.

N. The CONTRACTOR(S) shall use data and monitor customer service center requirements by obtaining information from the Members and Providers, resolving issues, identifying, and addressing trends. If deficiencies are identified, the CONTRACTOR(S) must report such findings to the State and perform corrective action until compliance is met.

O. The CONTRACTOR(S), through customer services, shall facilitate the development of Warm Transfers from help lines when the caller's crisis cannot be addressed by the help lines. The State will consider options other than use of Warm Transfers for coordination of help line services that are proposed by the CONTRACTOR(S), as long as the other requirements of this section are met.

P. The CONTRACTOR(S) must provide a voicemail system that allows messages to be left during and after business hours.

Q. The CONTRACTOR(S) must provide email customer service support with sufficient capacity to handle the incoming volume.

R. Toll-free fax line: The CONTRACTOR(S) must provide a toll-free HIPAA compliant, secure fax system with sufficient capacity to handle the incoming volume.

S. Fax service performance standards: The CONTRACTOR(S) shall meet the following requirements for fax line service:

   1. 98% of the time, fax lines shall meet customer demand.

   s. 95% of all inquiries shall be resolved within two (2) Business Days of receipt.

   t. 98% of all inquiries shall be resolved within five (5) Business Days.

   u. 100% of all inquiries shall be resolved within fifteen (15) Business Days.

T. The CONTRACTOR(S) shall have, maintain, and publish the availability of a HIPAA-compliant email system to receive secure materials from Providers electronically.

U. All fax, written communication, and similar documents received shall be imaged/scanned into electronic files for documentation and retrieval purposes and stored using HIPAA-compliant methods.

2.6.6 Provider Representatives

A. In addition to the customer service center specifications outlined in Section 2.6.5 above, the CONTRACTOR(S) shall have a sufficient number of dedicated Provider representatives located throughout the State who shall provide individual training to Providers in-person or virtually.

B. Provider representatives shall train Providers on Claim billing, Medicaid benefits, authorization requirements, Grievance, Appeal, and State Fair Hearing rights and procedures, recoupments, EOBs, Claim reconsiderations, and Claim payment/denial.

C. CONTRACTOR(S) shall post on the website the contact information for the Provider representatives, and a State map showing the regions covered by each representative.

D. Provider representatives must have prior customer service experience and insurance Claim experience with training in billing.

E. The CONTRACTOR(S) shall submit the names of the Provider representatives and full list of all Provider contacts with a brief description of the contact to the State for review on a quarterly basis.

F. The CONTRACTOR(S) shall submit any changes or vacancies from the Provider representative unit to the State within ten (10) Calendar Days of any changes.

G. The CONTRACTOR(S) shall ensure Provider representatives provide one-on-one assistance to Providers and the Provider's clearinghouse(s) as needed to help Providers submit clean and accurate Claims and minimize Claim denials. The CONTRACTOR(S) shall establish the criteria for providing one-on-one assistance, subject to State written approval. At a minimum, the CONTRACTOR(S) shall contact a Provider if the CONTRACTOR(S) has or will deny 25% or more of the Provider's Claims within a rolling ninety (90) Calendar Day period, and review each error and the reason for denial and advise how the Provider/Provider's clearinghouse can correct the error for resubmission (as applicable) and avoid the error/reason for denial in the future.

H. The CONTRACTOR(S) shall ensure that all Provider offices receive one (1) contact from the CONTRACTOR(S) (via phone call, or in-person contact) at a minimum semi-annually (twice per calendar year). Email communication is only acceptable to fulfill this section if there is documentation that the Provider specifically requests email to be the only method of communication.

Some larger facilities/clinics may require more frequent contact. Providers may communicate to the CONTRACTOR(s) their preferred frequency of contact and if documented and met per Provider request, will meet the requirement for those Providers. If the CONTRACTOR(S) makes three (3) attempts to contact the Provider with no response, then the CONTRACTOR(S) shall be allowed to count this as a contact for the purposes of this requirement. Email may only be utilized to satisfy this requirement if the CONTRACTOR(S) has documentation from the Provider indicating their preference for email contact. This documentation must be supplied to the State upon request.

I. The CONTRACTOR(S) shall ensure that Provider representatives attend all major Provider association meetings.

J. The CONTRACTOR(S) shall ensure that all Provider representatives attend at least one (1) all-CONTRACTOR(S) Provider training.

K. The CONTRACTOR(S) shall work with other MCOs to create and present Provider training that has been approved by the State in writing at minimum quarterly in locations throughout the State.

2.7 Value-Based Purchasing Strategies

A. The State encourages the CONTRACTOR(S) to use value-based payment (VBP) strategies to advance the State's vision and goals or otherwise improve the KanCare program for Providers and Members.

B. When entering into a VBP arrangement with a Participating Provider, the CONTRACTOR(S) must use alternative payment models (APMs) as described in the Health Care Payment Learning and Action Network (LAN) APM framework, as appropriate for the capacity of the Provider to participate in such VBP arrangements.

C. If a Participating Provider requests a VBP arrangement, the CONTRACTOR(S) shall make a good faith effort to enter into a VBP arrangement with the Provider.

D. The CONTRACTOR(S) must submit each of its proposed VBP arrangements to the State at least ninety (90) Calendar Days prior to implementation of the arrangement. The State reserves the right to request additional information about a proposed VBP arrangement, request changes to a proposed or implemented VBP arrangement, and disapprove a proposed or implemented VBP arrangement.

E. To promote effective implementation of VBP strategies and reduce Provider abrasion concerns, the State may require a VBP arrangement be standardized across CONTRACTOR(S).

F. For each proposed VBP arrangement, the CONTRACTOR(S) must address the elements described in Table 1.

TABLE 1

Framework for Value-Based Purchasing Arrangement Proposals	
1. Description of arrangement and objectives	Provide a detailed description of the arrangement, including the applicable LAN APM model, how it differs from traditional payments, and the goals and objectives the CONTRACTOR(S) seeks to achieve through the arrangement. The CONTRACTOR(S) should describe how these goals and objective align with the KanCare vision and goals or otherwise improve the KanCare program for Providers or Members.
2. Identify specific populations and services/Providers included in the arrangement	Include all populations (including geographically isolated populations) and services/Providers that would be included in the arrangement. The proposal may be limited to certain services, specified populations and/or subpopulations, and/or other categories as appropriate for the VBP arrangement.
3. Identify role of Care Coordination strategies, as applicable	The CONTRACTOR(S) should indicate how the proposed arrangement relies on Care Coordination strategies. For example, potential synergies may exist at the local levels that address Care Coordination, SDOH, and covered physical, Behavioral Health, or LTSS services.
4. Identify role of Health Information Technology/Health Information Exchange (HIT/HIE), as applicable	In consideration of the information provided in Section 2.15.1 regarding HIT/HIE, the CONTRACTOR(S) should identify what HIT/HIE components are necessary for successful implementation of the arrangement.
5. Coordination and collaboration with existing value-based purchasing and quality Initiatives	The CONTRACTOR(S) should include in their proposals how they will coordinate and collaborate with existing relevant value-based purchasing and quality initiatives in the State, such as the Kansas Healthcare Collaborative, the Rural Health Initiative, Project ECHO, or others.

Framework for Value-Based Purchasing Arrangement Proposals	
6. Identify if the model would be implemented statewide or would be a pilot proposal and if the CONTRACTOR(S) has existing experience with the initiative in Kansas or in another state	Identify Providers that are participating (if this model is already implemented) or if the CONTRACTOR(S) has identified interested Providers. If the arrangement has already been implemented by the CONTRACTOR(S) in another market, include a description of outcomes associated with the existing model. The proposal should also include a stakeholder engagement strategy for areas where the model will be implemented.
7. Identify the proposed metrics, outcomes, or other measurements that the CONTRACTOR(S) will use to (i) determine the payment methodology, if applicable; and (ii) evaluate the effectiveness of the arrangement	Metrics, outcomes, or other measurements should be readily available to Providers, the CONTRACTOR(S), and the State and should not be administratively burdensome. However, the CONTRACTOR(S) must describe why the specific metrics/measures were selected and how they relate to the model. The CONTRACTOR(S) should also describe how they will monitor Provider performance and the impact on Members. Additionally, describe how the CONTRACTOR(S) will provide the data, outcomes, and evaluation to the State. If the model could skew any performance measures otherwise reported, the CONTRACTOR(S) should identify the interdependencies for State consideration. Proposals should also describe a stakeholder engagement plan for receiving input in the development of performance metrics.
8. Identify the total number of Members expected to participate in the arrangement, the projected expenditures, and when the arrangement is expected to start	Projections are best estimates by the CONTRACTOR(S). The description should include a proposed implementation timeline that addresses research, development, Provider engagement and/or enrollment in the model, and roll-out (including phase-in and staggered deployment), but such timeline must assume full deployment within twelve (12) months of the implementation date of the CONTRACT.

G. It is the intent of the State that measures, including any standardized measures and reports for VBP arrangements, be primarily based on nationally accepted measure sets (e.g., HEDIS and NOMS)

and not be self-defined in nature. This is intended to align health and other measures in the State with national standards, to minimize the impact of reporting on the Provider, and to allow for common data across the enterprise.

H. Reporting requirements:

1. The State will require CONTRACTOR(S) to provide reports to document and evaluate the effectiveness and outcomes of VBP arrangements implemented under the CONTRACT.

v. The State will review proposed metrics included in submitted strategies and may select some or all of those metrics as well as potentially include additional metrics as part of the reporting requirements.

2.8 Utilization Management

2.8.1 Utilization Management Program Description

A. The CONTRACTOR(S) shall have a comprehensive integrated UM program that reviews services for Medical Necessity and assessed needs. A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the CONTRACTOR(S) and entities to which the CONTRACTOR(S) delegates or Subcontracts UM activities. The UM program description shall include at a minimum:

1. The UM program will be under the direct oversight of an applicable Kansas licensed professional with the chief medical officer (CMO) having complete oversight of the UM program and activities.

2. The UM program shall include an integrated approach, where the Member record is one (1) record, housed in one (1) documentation system.

3. The description of UM services and which services require a PA, a registration, or some other type of CONTRACTOR(S) notification.

4. The procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes, and the process used to review and approve the provision of medical services.

5. The manner in which a Provider or a Member may request services.

6. The timeframes from the point of a request to the decision including both oral and written notification, where indicated and in accordance with 42 CFR § 438 Subpart F, 1915(c) Waivers, State policy, and Appendix D (Grievances and Appeals).

7. Description of the staff members' licensure and credentials to manage any areas within the UM operations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by an individual who has appropriate expertise in addressing the Member's medical, Behavioral Health, or LTSS needs.

8. Assurance that compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services or services for an assessed need to any Member.

B. The CONTRACTOR(S) and Subcontractors (e.g., PBMs) must primarily utilize Kansas-licensed physicians and Pharmacists and dentists to render any adverse determination regarding service requests. However, CONTRACTOR(S) may utilize a non-Kansas licensed physician or Pharmacist

or dentist for such determinations on a short-term basis in cases of temporary absence or business disruption so long as the use of this option is reported to the State on a per-use basis; the non-Kansas licensed physician and Pharmacist and dentist is of equal licensure as the person for whom they are substituting; the non-Kansas licensed physician and Pharmacist and dentist is familiar with the KanCare program and has an existing relationship with the CONTRACTOR(S) or an affiliated health plan; and the absence or disruption does not exceed ten (10) Business Days or as otherwise approved by KDHE in writing. If CONTRACTOR(S) or Subcontractor intends to utilize the short-term option, the CONTRACTOR(S) shall first provide KDHE a description of how it will be structured and implemented.

C. The CONTRACTOR(s) shall notify and receive written approval by the State for any UM activities that would be managed by a Subcontractor.

2.8.2 Utilization Management Program Evaluation

A. The CONTRACTOR(S) shall monitor and evaluate on an ongoing basis the appropriateness of care and services. The evaluation shall be a fluid document that is updated as UM services are evaluated on a monthly, quarterly, semi-annually, and annual basis. The UM plan and evaluation results must be submitted at least annually to the State for review. The program evaluation shall:

1. Identify and describe the mechanisms to detect services that are the drivers of utilization cost and the services that are identified as being underutilized.

w. Identify rationale and evidence to support the decision to apply Prior Authorization to certain services.

x. Include analysis validating compliance with the MHPAEA.

2.8.3 Utilization Management Activities

A. All UM activities shall function in a comprehensive integrated manner, utilizing evidence-based practices guiding policy and procedure. The CONTRACTOR(S) shall demonstrate integrated operations and shall coordinate with Providers to ensure integrated care in any setting. The CONTRACTOR(S) shall include Preventive Care within the UM program and activities.

B. The CONTRACTOR(S) must demonstrate how it complies with State policy and how the needs of the KanCare population will be identified and addressed.

C. The CONTRACTOR(S) shall ensure timely access to all services that are available through this CONTRACT.

D. For pharmaceuticals, the CONTRACTOR(S) shall comply with the State's Medical Necessity and appropriateness criteria and Prior Authorization requirements. See Appendix C (Services).

E. The CONTRACTOR(S) shall use the American Society for Addiction Medicine (ASAM) criteria for SUD services.

F. Unless prior approved by the State in writing, the CONTRACTOR(S) must use the State's Medicaid Medical Necessity and appropriateness criteria where it is established.

G. In the absence of State Medicaid Medical Necessity and appropriateness criteria, the CONTRACTOR(S) must use evidence-based Medical Necessity and appropriateness criteria (e.g., InterQual® or MCG®).

H. In the absence of State Medicaid Medical Necessity and appropriateness criteria or evidence-based Medical Necessity and appropriateness criteria, the CONTRACTOR(S)' Medical Necessity criteria must be based on current evidence in widely used treatment guidelines or clinical literature.

I. The CONTRACTOR(S) must submit to the State for written approval any Prior Authorization requirements for mileage, lodging, and meal reimbursement.

J. The State reserves the right to review the CONTRACTOR(S)' Prior Authorization and utilization review requirements and direct the CONTRACTOR(S) to remove requirements in consideration of Provider and Member friction and/or low value.

K. The CONTRACTOR(S) shall require Providers to use a standardized Prior Authorization (PA) form(s)/submission elements for PA requests. Unless a specific PA form is required by the State (e.g., for certain pharmaceuticals) the CONTRACTOR(S) shall work with the other KanCare MCOs, the State, and Providers to develop the standardized PA forms/submission elements, which must be prior approved by the State in writing. The CONTRACTOR(S) shall implement standardized PA forms/submission elements by no later than the beginning of the second year of this CONTRACT.

L. Except for Prior Authorizations required by the State, the CONTRACTOR(S) shall review opportunities to reduce Participating Provider burden by waiving the CONTRACTOR(S)' PA requirements if Providers have demonstrated high reliability practice. High reliability practice may be exhibited through meeting the CONTRACTOR(S)' defined thresholds of PA approval rates or by utilizing a clinical decision support functionality that has rendered the use of PA as a management tool unnecessary, as determined by the CONTRACTOR(S). The CONTRACTOR(S) may also waive the CONTRACTOR(S)' PA requirements as part of the CONTRACTOR(S)' VBP arrangements.

M. The CONTRACTOR(S) shall collaborate with other KanCare MCOs, the State, and Providers to develop and implement policies and procedures to standardize and streamline service authorization processes in accordance with Federal requirements and State direction.

N. The CONTRACTOR(S) shall collaborate with other KanCare MCOs, the State, Providers, and Members to develop and implement policies and procedures to standardize and streamline the process for accessing DME, assistive services, and home modifications, and to make the process more transparent. This includes but is not limited to having clear, standardized, and streamlined forms, supporting documentation requirements, and billing procedures; providing clear and consistent information to Providers and Members regarding the requirements and review criteria; and assisting Providers and Members with the submission, approval, and reimbursement processes.

O. The CONTRACTOR(S) must provide educational materials and webinars to Providers concerning obtaining PA for services, Medical Necessity criteria for services, and required timelines to ensure smooth delivery of services.

P. The CONTRACTOR(S) shall educate Providers on Medical Necessity principles and provide reference information and directed education on specific criteria, authorization policies, procedures, and practice guidelines that are within the scope of a Provider's practice. The CONTRACTOR(S) may also target individualized education based on concerns, questions, or evidence of practices not adherent to current treatment guidelines or clinical literature.

Q. The CONTRACTOR(S) shall provide a forum to receive Provider suggestions for policies and procedures at least annually and shall document all changes made subsequent to Provider input.

R. The CONTRACTOR(S) shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

S. When processing authorization for services, the CONTRACTOR(S) shall offer peer-to-peer consultation and consult with requesting Providers when appropriate. The CONTRACTOR(S) must ensure that individuals conducting peer-to-peer consultations are Providers with expertise in treating the Member's condition and in the same specialty/subspecialty as the requesting/ordering Provider. The CONTRACTOR(S) must offer a peer-to-peer consultation within a mutually agreed upon time within twenty-four (24) hours of a Provider's request for a peer-to-peer consultation.

T. The CONTRACTOR(S) shall disclose all criteria it uses for UM, submit the policies, procedures, and any applicable practice guidelines, including any revisions, to the State for written approval prior to implementation.

U. The CONTRACTOR(S)' UM policies, procedures, and practice guidelines shall be:

1. Based on valid and reliable clinical evidence or a consensus of Providers in the particular field.

y. Consider the needs of the Members.

z. Adopted in consultation with Participating Providers.

aa. Reviewed and updated periodically as appropriate.

V. The CONTRACTOR(S) shall ensure that decisions for UM, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

W. In accordance with 42 CFR § 438.26, the CONTRACTOR(S) shall disseminate practice guidelines to all affected Providers and, upon request, to Members and Potential Members.

X. The State may require the CONTRACTOR(S) to develop or provide data for the State to develop a dashboard report of authorization metrics, including, for example, authorization turnaround timeframes, denial rates by type of service, Appeals, and Appeal overturn rates.

2.8.3.1 Emergency Department Protocol

A. The CONTRACTOR(s) shall develop an emergency department (ED) protocol based on evidence-based guidelines with the goal of reducing unnecessary ED visits and that assures integrated services for behavioral and physical health needs. For example, assurance that acute physical health needs are identified and treated prior to transferring Members for a Behavioral Health service, and assurances that Members admitted to a medical-surgical unit with Behavioral Health needs receive appropriate Behavioral Health consultation and services.

2.8.3.2 Emergency and Post-Stabilization Services

The CONTRACTOR(S) may not deny payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR § 438.114(a)(i-iii) of the definition of Emergency Medical Condition and/or a representative of the CONTRACTOR(S) instructs the Member to seek Emergency Services.

A. The CONTRACTOR(S) may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

B. The CONTRACTOR(S) may not refuse to cover Emergency Services based on the ED Provider, hospital, or Fiscal Agent not notifying the Member's PCP, MCO, or applicable State entity of the Member's screening and treatment within ten (10) Calendar Days of presentation for Emergency Services.

C. A Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.

D. The attending emergency physician, or the Provider actually treating the Member, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CONTRACTOR(S) as responsible for coverage and payment.

E. Post-Stabilization Care Services are Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition. The CONTRACTOR(S) shall comply with the Post-Stabilization Care Services rules set forth at 42 CFR § 422.113(c).

F. The CONTRACTOR(S) shall cover and pay for Post-Stabilization Care Services in accordance with provisions set forth at 42 CFR § 422.113(c). The CONTRACTOR(S) is financially responsible for Post-Stabilization Care Services obtained within or outside the CONTRACTOR(S) MCO that are pre-approved by a Participating Provider or other CONTRACTOR(S) representative.

G. The CONTRACTOR(S) is financially responsible for Post-Stabilization Care Services obtained within or outside the CONTRACTOR(S)' MCO that are not pre-approved by a Participating Provider or other CONTRACTOR(S) representative but administered to maintain the Member's stabilized condition within one (1) hour of a request to the CONTRACTOR(S) for pre-approval of further Post-Stabilization Care Services.

H. CONTRACTOR(S) is financially responsible for Post-Stabilization Care Services obtained within or outside the CONTRACTOR(S)' MCO that are not pre-approved by a Participating Provider or other CONTRACTOR(S) representative, but administered to maintain, improve, or resolve the Member's stabilized condition if the CONTRACTOR(S) does not respond to a request for pre-approval within one (1) hour; the CONTRACTOR(S) cannot be contacted; or the CONTRACTOR(S) representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, the CONTRACTOR(S) must give the treating physician the opportunity to consult with a Participating Provider who is a physician, and the treating physician may continue with care of the Member until a plan physician is reached or one (1) of the criteria of 42 CFR § 422.113(c)(3) is met.

I. CONTRACTOR(S) must limit charges to Members for Post-Stabilization Care Services to an amount no greater than what the CONTRACTOR(S) would charge the Member if they had obtained the services through the CONTRACTOR(S).

J. CONTRACTOR(S)' financial responsibility for Post-Stabilization Care Services that it has not pre-approved ends when:

    1. A plan physician with privileges at the treating hospital assumes responsibility for the Member's care.

    bb. A plan physician assumes responsibility for the Member's care through transfer.

cc. CONTRACTOR(S) representative and the treating physician reach an agreement concerning the Member's care.

dd. The Member is discharged.

2.8.3.3 Administrative Lock-In

A. The CONTRACTOR(S) shall have in place an administrative Lock-In system for the situations described below. The CONTRACTOR(S)' Lock-In system shall be consistent with State and Federal regulations. The CONTRACTOR(S) must notify the State at a frequency defined by KDHE-DHCF when a Member has been placed in administrative Lock-In and if a Member in Lock-In transfers to FFS or another KanCare MCO.

B. Situations in which CONTRACTOR(S) may place a Member in administrative Lock-in include:

1. Persistent non-compliance: Member persistently refuses to follow prescribed treatments or comply with the CONTRACTOR(S) requirements.

ee. Abusive or threatening conduct: Member engages in abusive or threatening conduct.

ff. Fraud/Abuse: Member is found to be committing Fraud or Abuse of medical benefits.

gg. Overutilization: Member utilizes Medicaid services at a frequency or amount that is not Medically Necessary.

C. The CONTRACTOR(S) shall provide education to the Member regarding their behavior prior to placing a Member in administrative Lock-In.

1. If the Member has a SUD, mental health, or disability diagnosis related to the persistent non-compliant behavior, the CONTRACTOR(S) will work with Behavioral Health and disability Providers to help the Member change behavior prior to placing the Member in administrative Lock-In.

hh. The CONTRACTOR(S)' attempts to educate and change the Member's behavior shall be documented.

ii. During the Lock-In period, the Member may be required to use one (1) Pharmacy, one (1) hospital, and one (1) PCP.

jj. The Member has the right to Appeal their placement into administrative Lock-In.

kk. The Member must be given notice of opportunity for a State Fair Hearing before placement into administrative Lock-In.

D. The CONTRACTOR(S) must ensure that the Member has reasonable access (taking into account geographic location and reasonable travel time) to Medicaid services.

1. Restrictions must not apply to Emergency Services furnished to the Member.

E. CONTRACTOR(S) may review all ED, inpatient, and outpatient Claims of Locked-In Members.

2.8.4 KanCare HCBS Waiver Populations

A. In the event that the Member receiving HCBS Waiver services has complied with the CONTRACTOR(S) requests for re-evaluation prior to expiration, continues to demonstrate need for services at the appropriate scope, duration and frequency, and expresses a desire to retain the current Provider and service array, the CONTRACTOR(S) shall ensure that HCBS services are reauthorized prior to the expiration of current authorizations in order to ensure continuity of care and stability for Members and Providers regarding those services. If an authorization expires, and the Member has complied with re-evaluations, the designated entity has offered impartial choice timely, and the chosen Provider has complied with requested documentation submission, HCBS shall be considered as authorized consistent with the previous authorization until the pending reauthorization is fully operational. Claims for services provided between authorizations shall be adjudicated consistent with the Claims adjudication requirements as reflected elsewhere in this CONTRACT and Appendices hereto.

B. The CONTRACTOR(S) shall conduct Prior Authorization for those Members receiving HCBS services in a manner that assesses both the medical and functional needs of the Member, and considers whether the denial of equipment, supplies, or services would inhibit a Member's community access, or the progression of the Member's PCSP, if denied.

C. Once the CONTRACTOR(S) has authorized HCBS, Claims for the fully authorized service shall be adjudicated in accordance with the Claims processing guidelines and applicable Member due process rights as expressed in this CONTRACT.

D. The CONTRACTOR(S) shall ensure that HCBS initial authorizations are electronically entered for delivery and billing in a timely fashion. This includes:

    1. Except as otherwise provided in this section, the CONTRACTOR(S) must notify providers of 99% of HCBS initial authorizations at least fourteen (14) Business Days prior to the first date of service delivery. This requirement does not apply in circumstances in which notice cannot be provided within that timeframe, including: continuity of care for Members transitioning from one KanCare MCO to another; Members with gaps in eligibility that have been restored; Members who have been emergently placed by Adult Protective Services (APS) or other State or law enforcement agency in service on a non-Business Day; Members who have incurred a material change in condition necessitating a change in services overnight, weekend, or holiday, or other similar circumstance in which retroactive authorizations may be necessary to address the needs of the Member; institutional transitions into the community; and delays in coding or correct coding as it relates to level of care. The CONTRACTOR(S) shall contact the appropriate State entity when aware of delays in level of care coding.

    ll. Except as otherwise provided in this section, the CONTACTOR(S) must enter 95% of HCBS initial authorizations into the CONTRACTOR(S)' authorization/Electronic Visit Verification (EVV) system one (1) Calendar Day prior to the first date of service delivery. This standard does not apply in circumstances in which services must start immediately or retroactive authorizations may be necessary to address the needs of the Member, including: Members transitioning from one KanCare MCO to another; Members with gaps in eligibility that have been restored; Members who have been emergently placed by APS or other State or law enforcement agency in service on a non-Business Day; Members who have incurred a material change in condition necessitating a change in services overnight, weekend, or holiday; institutional transitions into the community; and delays in coding or correct coding as it relates to level of care. The

CONTRACTOR(s) shall contact the appropriate State entity when aware of delays in level of care coding.

mm. 100% of approved PCSP authorizations must be provided to Provider and Member prior to services beginning.

2.9 Quality Assessment and Performance Improvement

2.9.1 General Requirements

A. The State's QMS: The CONTRACTOR(S) shall comply with the State's KanCare Quality Management Strategy (QMS). The QMS includes, among other things, details on the State's expectations and requirements for quality activities and timeliness. The QMS is reviewed annually, at a minimum, and may be revised based on such review. If significant changes occur that impact quality activities or threaten the potential effectiveness of the QMS, as determined by the State, the QMS may be reviewed and revised more frequently. The CONTRACTOR(S) shall comply with any revisions to the QMS.

B. The CONTRACTOR(S) shall develop an annual QAPI program description, work plan, and evaluation. The CONTRACTOR(S) shall complete an annual evaluation, and the evaluation shall review the effectiveness and outcomes of the QAPI program description and work plan. The recommendations and findings from each annual evaluation should inform the writing and goals of the QAPI program description and work plan.

1. The CONTRACTOR(S) shall include assessment of all interventions outlined in the QAPI program description and work plan in the annual evaluation.

nn. The CONTRACTOR(S) shall address all opportunities for improvement and proposed interventions identified in the evaluation in the subsequent year's QAPI program description or work plan, as applicable.

oo. The CONTRACTOR(S) shall include interventions to address unmet performance measure goals in each subsequent annual work plan.

C. The CONTRACTOR(S) shall establish, document, and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to Members which, at a minimum, includes the following elements:

1. Performance improvement projects (PIPs) that focus on clinical and non-clinical areas. Section 2.9.5 for additional PIP requirements.

2. Collection and reporting performance measurement data, including performance measures relating to quality of life, rebalancing, and community integration activities for Members receiving LTSS.

3. Mechanisms to detect both underutilization and overutilization of services.

4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs, as defined in the State's QMS.

5. Mechanisms to assess the quality and appropriateness of care furnished to Members receiving LTSS, including assessment of care between care settings.

6. Mechanisms to compare services and supports received with those set forth in the Member's treatment/service plan/PCSP for individuals enrolled in LTSS, including HCBS Waivers.

7. Participate in efforts by the State to prevent, detect, and remediate Critical Incidents that are based, at a minimum, on the requirements for the State for HCBS Waiver, Behavioral Health and institutional programs. The CONTRACTOR(S) shall identify, track, and review Critical Incidents to address potential and actual quality of care and/or health and safety issues.

D. The CONTRACTOR(S) shall monitor and review each HCBS Waiver performance measure on an annual basis using a statistically valid sample for each HCBS Waiver and shall identify and address any deficiencies and document its activities in the QAPI.

E. The CONTRACTOR(S) shall monitor and review to ensure that HCBS Waiver Members are receiving services authorized in their PCSP and take action to remedy any gaps in service, including gaps due to inability to find a direct care worker or direct worker no-shows. The CONTRACTOR(S) shall track and report on this measure as part of its QAPI.

F. The CONTRACTOR(S) shall develop and implement mechanisms and include a description of the process to identify Members who are enrolled in HCBS Waivers but who are not receiving any Waiver services. This process shall be in accordance with Section 2.4.10.A, Individuals Enrolled in a HCBS Waiver.

G. The CONTRACTOR(S) shall develop and implement mechanisms to identify and address Behavioral Health Service needs of Members. The CONTRACTOR(S) shall ensure the Member receives all identified State approved Behavioral Health Services for any unmet service needs.

H. The CONTRACTOR(S) shall report to the State on the results of efforts to support community integration for Members using LTSS.

I. The CONTRACTOR(S) shall develop a process to evaluate the impact and effectiveness of its QAPI.

J. Structure and staffing: The CONTRACTOR(S) shall ensure the following requirements are met:

1. Establish a QAPI unit within its organizational structure that is separate and distinct.

pp. Employ sufficient, qualified staff and utilize appropriate resource to achieve quality outcomes.

qq. Ensure the chief medical officer (CMO), or other physician designee, is responsible for oversight of the CONTRACTOR(S) QAPI program.

rr. Establish a quality committee structure from the board of directors down to the local health plan that includes, at a minimum:

a. Committees to address quality management and quality improvement, service, delegation oversight, credentialing and re-credentialing, peer review, and Member advisory.

b. Subcommittees to address children or other special populations, as appropriate.

c. All committees should have a clearly defined charter outlining the role, responsibility, membership, and meeting frequency. As appropriate and based on the role of each committee, membership should include an appropriate mix of community Providers,

Members, and caregivers reflective of the services delivered and populations served under the CONTRACT.

d. Develop an annual QAPI work plan outlining the requirements and timeline in which the CONTRACTOR(S) will complete all QAPI activities.

e. Develop an annual evaluation process to be completed within the first quarter of each year from which findings and recommendation will be used to shape the annual QAPI program description and QAPI work plan. For all areas evaluated as part of the QAPI program, report the findings in the annual evaluation. The QAPI evaluation should assess the extent to which the CONTRACTOR(S) met its goals and objectives and should include recommendations for continuous quality and service improvement. The CONTRACTOR(S) shall outline both completed and ongoing QI activities in each annual QAPI program description and work plan.

f. Integrate quality management processes in all areas of the CONTRACTOR(S)' organization.

g. Demonstrate improvement in the quality of care provided to Members through established quality management and performance improvement processes.

h. Regularly, and as requested, disseminate Subcontractor and Provider quality improvement information including performance measures, dashboard indicators, and Member Outcomes to the State and key stakeholders, including Members and family members.

i. Develop and maintain mechanisms to solicit feedback and recommendations from key stakeholders, Subcontractors, Members, and family members to monitor service quality and to develop strategies to improve Member Outcomes and quality improvement activities related to the quality of care and system performance.

2.9.2 State and Federal Monitoring

The CONTRACTOR(S) shall ensure its Subcontractors and delegates comply with all requirements for State and Federal monitoring found at 42 CFR § 438.230 and as contained within this section.

A. The CONTRACTOR(S) shall cooperate with any State or Federal monitoring of its performance under this CONTRACT, which may include but is not limited to External Quality Reviews (EQRs), operational reviews, performance audits, and evaluations.

B. The CONTRACTOR(S) must identify, collect, and provide any data, medical records, or other information requested by the State or its representative or the Federal agency or its authorized representative in the format or process specified by the State/Federal agency or its authorized representative. The CONTRACTOR(S) shall ensure that the requested data, medical records, and other information is provided at no charge and submitted in the required timeframe to the State/Federal agency or its authorized representative.

C. If requested, the CONTRACTOR(S) shall provide, at no cost, an adequate workspace at the CONTRACTOR(S)' local offices for the State/Federal agency or its authorized representative to review requested data, medical records, or other information.

D. Federal law (Section 1902(a)(30)(C) of Title XIX of the SSA) requires entities which are external to and independent of the State and its CONTRACTOR(S) and Subcontractors to perform, on an annual basis, a review of the quality of Medicaid Managed Care services furnished by each such CONTRACTOR(S). Requirements relating to the EQR are further defined and described in

42 CFR Part 438. The CONTRACTOR(S) shall cooperate and participate in EQR activities in accordance with protocols identified under 42 CFR Part 438, Subpart E and the requirements of this CONTRACT.

1. The EQRO will conduct annual, external, independent reviews of the quality Outcomes, timeliness of, and access to the services covered in this CONTRACT.

j. The CONTRACTOR(S) shall collaborate with the EQRO to develop studies, surveys, and other QAPI activities to access the quality of care and services provided to Members and to identify opportunities for CONTRACTOR(S)' improvement. The CONTRACTOR(S) must also work collaboratively with the State and the EQRO to annually measure identified performance measures.

k. The CONTRACTOR(S) shall respond to recommendations made by the EQRO within the timeframe established by the EQRO.

l. The CONTRACTOR(S) shall implement recommendations by the EQRO within the timeframe established by the State and the EQRO.

m. For the purposes of this CONTRACT, these requirements shall apply to all Medicaid and CHIP Managed Care services.

2.9.3 Quality Assessment and Performance Improvement Goals and Objectives

A. The CONTRACTOR(S) shall adopt the following goals and integrate these goals into the QAPI program, its organization, and its delegates and Subcontractors:

1. Promote an organizational culture focused on continuous quality improvement, innovation, and service excellence at all levels of quality program design and implementation.

n. Empower staff excellence through hiring staff who are experienced and knowledgeable in Medicaid and investing in their development through relevant ongoing training, education, and mentorship.

o. Harness data from information systems and engage data analytic approaches to produce actionable information that is consistent, timely, valid, and reliable and supports evidence-based decision making.

p. Utilize Rapid-Cycle Process Improvement methods to quickly identify, analyze, and resolve operational inefficiency to improve the Member experience, Provider experience, and quality of care.

q. Focus on achieving year-over-year quantitative and qualitative improvements.

r. Implement a system of measurement and monitoring that assures the health, safety, and welfare of Members.

s. Pursue innovative approaches to expand access to quality care and services.

t. Develop a transparent and collaborative environment with Members, Providers, and other stakeholders to promote best in class Health Care Service delivery to Members and improve access to care, the quality of care, and Member Outcomes.

u. Employ strategies to evaluate the ongoing efficiency and effectiveness of its Participating Providers and adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and services to all Members.

v. Improve the delivery of holistic, person-centered, and culturally appropriate care.

w. Maximize the quality of life of all Members by addressing SDOH through delivery of culturally appropriate, integrated, holistic, and evidenced-based care and services.

x. Promote the highest level of independence, dignity, productivity, community inclusion, and individuality based on Member and representative choice, rights, and goals of care.

y. Increase employment and independent living supports to increase independence and health Outcomes for Members.

z. Use person-centered models to collaborate with Members, caregivers, and family to achieve the highest level of Member self-actualization and success.

aa. Improve the overall health and safety of Members.

B. The CONTRACTOR(S) shall adopt, at a minimum, the following objectives through which the CONTRACTOR(S) shall meet the established QAPI goals.

1. Collect complete and accurate data on Members and Providers regarding service processes and outcomes furnished through robust collection, analysis, and reporting of data.

bb. Maintain staff with the capacity and capability to provide and describe Kansas specific data at every level of collection, analysis, and reporting by the CONTRACTOR(S) as well as Participating Providers and Subcontractor(s).

cc. Develop capacity to analyze data, make information actionable, and implement interventions to demonstrate improved results.

dd. Deploy Rapid-Cycle Process Improvement principles throughout the organization.

ee. Develop strong Provider peer review mechanisms to evaluate the quality, appropriateness, and cost effectiveness of care delivered.

ff. Adopt strategies to collect and integrate experience of care and satisfaction data from Members, caregivers, Participating Providers, and other network partners into the QAPI program.

gg. Drive collaboration and innovation internally, across business units and externally with Members, caregivers, Participating Providers, stakeholders, and community-based entities.

2.9.4 Performance Measures

A. The CONTRACTOR(S) shall collect, aggregate, control, validate, and use performance measure data to improve the delivery of care and services. The CONTRACTOR(S) must use performance measure data in a rapid-cycle fashion to (i) improve the integration of physical, behavioral, and LTSS service delivery, and (ii) improve access and availability of LTSS and Behavioral Health Providers. The CONTRACTOR(S) must also use data to improve the quality of care and services delivered to all populations under the KanCare program.

B. The CONTRACTOR(S) shall comply with the requirements in the State's QMS regarding performance measures for medical, Behavioral Health, and LTSS. The CONTRACTOR(S) shall use the methodology established by the State for all performance measures specified in the QMS.

C. The CONTRACTOR(S) shall report on the measures included in the Adult and Child Core Sets specified by CMS using the methodology specified by CMS.

D. The CONTRACTOR(S) shall report on the HCBS Waiver assurance measures (performance measures) included in Kansas' HCBS Waivers.

E. At any time, CMS or the State may specify performance measures to be included in this CONTRACT. In addition to complying with the performance measures specified by the State, the CONTRACTOR(S) shall comply with any performance measures required by CMS or other Federal authority.

F. If the CONTRACTOR(S) contract with a vendor to calculate a measure, the CONTRACTOR(S) shall require the vendor to work with the CONTRACTOR(S)' and State staff to address any discrepancies or errors identified by the State.

2.9.5 Performance Improvement Projects

A. The CONTRACTOR(S) shall conduct performance improvement projects (PIPs) that focus on clinical and non-clinical areas.

B. Each PIP must adopt principles of Rapid-Cycle Process Improvement and be designed to achieve significant improvement, sustained over time, in health Outcomes and Member satisfaction, and must include the following elements:

1. Measurement of performance using objective quality indicators.
2. Implementation of interventions to achieve improvement in the access to and quality of care.
3. Evaluation of the effectiveness of interventions based on established performance measures.
4. Planning and initiation of activities for increasing or sustaining improvement.

C. The CONTRACTOR(S) shall report the status and results of each PIP to the State on an annual basis, or more frequently as requested by the State or EQRO.

D. The CONTRACTOR(S) shall perform at least three (3) PIPs that are approved by the State in writing. Clinical PIPs include but are not limited to projects focusing on prevention and care of acute and Chronic Conditions, high-risk populations, high-volume services, high-risk services, and continuity and coordination of care. Non-clinical PIPs include but are not limited to projects focusing on availability, accessibility, and cultural competency of services, Claims payment timeliness, interpersonal aspects of care, Grievances and Appeals, and other complaints.

E. One (1) of the PIPs shall be a non-clinical PIP in the area of long-term care approved by the State in writing.

F. One (1) of the PIPs shall be a PIP on EPSDT screening and community outreach plans when overall CMS 416 rates are below 85%.

G. One (1) of the PIPs shall be a non-clinical PIP proposed by the CONTRACTOR(S) and approved by the State in writing.

H. The CONTRACTOR(S) shall incorporate Rapid-Cycle Process Improvement principles into all PIP activities.

I. The CONTRACTOR(S) shall use the State-specified PIP template to document and report all PIP activities.

J. The CONTRACTOR(S) shall ensure that CMS EQR protocols for PIPs are followed and that all steps outlined in the CMS protocols for PIPs are documented.

K. The CONTRACTOR(S) shall identify benchmarks and set achievable performance goals for each of its PIPs. The CONTRACTOR(S) shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

L. The CONTRACTOR(S) shall report on PIPs as required in by the State.

M. After three (3) years, the CONTRACTOR(S) shall, using evaluation criteria established by KDHE-DHCF or its designee, determine if one (1) or more of the CONTRACTOR's PIPs should be continued. Prior to discontinuing a PIP, the CONTRACTOR(S) shall identify a new PIP (if required by KDHE-DHCF) and must receive KDHE-DHCF's written approval to discontinue the previous PIP and perform the new PIP.

N. The State reserves the right to tie PIP requirements to P4P indicators where the CONTRACTOR(S) has failed to meet the benchmark or improvement standard.

2.9.6 Peer Review

A. The CONTRACTOR(S) shall implement a peer review process that addresses the requirements below and includes a process to collect and analyze data to evaluate the appropriateness of care and services rendered by Participating Providers. The CONTRACTOR(S) shall use data from the peer review process to improve the delivery of care and services and integrate the data into the CONTRACTOR(S)' program integrity processes.

B. The CONTRACTOR(S) shall have a peer review process that includes:

1. Review of a Participating Provider's practice methods and patterns, including quality outcomes, prescribing patterns, morbidity/mortality rates, and all Grievances filed against the Participating Provider relating to medical treatment.

hh. Evaluation of the appropriateness of care and service rendered by Participating Providers.

ii. Implementation of corrective action(s) when the CONTRACTOR(S) deems it necessary to do so.

jj. Development of policy recommendations to maintain or enhance the quality of care and service provided to Members.

kk. Reviews that include the appropriateness of diagnosis and subsequent treatment, maintenance of a Participating Provider's medical/case records, adherence to standards generally accepted by a Participating Provider's peers and the process and Outcome of a Participating Provider's care.

ll. Appointment of a peer review committee, as a subcommittee to the QM/QI committee, to review Participating Provider performance when appropriate. The CMO or a physician designee shall

chair the peer review committee and all decisions made by the peer review committee shall not be over-turned by the credentialing committee or other committee without the knowledge or consensus approval of the peer review committee.

mm. Membership in the committee shall be drawn from the Provider network and include peers of the Participating Provider being reviewed.

nn. Receipt and review of all written and oral allegations of inappropriate or aberrant service by a Participating Provider.

oo. Education to Members, the Member advocate(s), QM, and other CONTRACTOR(S)' staff, about the peer review process, so that Members and the CONTRACTOR(S)' staff can make referrals to the peer review committee of situations or problems relating to Participating Providers. The CONTRACTOR(S) shall include in its QAPI program documentation, a description of how Members and Member advocates are educated on the CONTRACTOR(S)' process for reviewing its reported quality of care concerns, including potential peer review. Peer review shall be defined. Description of how staff are educated on the peer review process shall also be included.

2.9.7 National Committee for Quality Assurance Accreditation

A. The CONTRACTOR(S) shall obtain NCQA Health Plan accreditation and Health Equity Accreditation/Health Equity Accreditation Plus of at least "accredited" and LTSS distinction status within twenty-four (24) months of the onset of delivering care to KanCare Members. The State may authorize an extension of this deadline for good cause.

B. Failure to obtain NCQA accreditation or distinction by the date specified above or an extension prior approved in writing by the State and failure to maintain accreditation/distinction thereafter may be considered a breach of this CONTRACT and result in termination of this CONTRACT in accordance with the terms set forth in this CONTRACT. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) Calendar Days of receipt of notification from NCQA.

C. The CONTRACTOR(S) must submit the final hard copy NCQA Health Plan accreditation, Health Equity accreditation, and distinction status report for each accreditation/distinction cycle within ten (10) Calendar Days of receipt of the report from NCQA. Updates of accreditation status based on annual HEDIS scores must also be submitted within ten (10) Calendar Days of receipt.

2.9.8 Health Care Effectiveness Data and Information Set, and Consumer Assessment of Health Care Providers & Systems

A. The CONTRACTOR(S) shall conduct HEDIS data collection as required in the State's QMS and as specified by NCQA.

B. HEDIS data collection shall be conducted at a minimum annually and upon the State's request. At a minimum, the CONTRACTOR(S) shall complete all HEDIS measures designated by NCQA as relevant to Medicaid.

C. The CONTRACTOR(S) shall report population-specific HEDIS measures as specified by the State (e.g., comprehensive diabetes care measure rates for all Members, IDD/Serious and Persistent Mental Illness [SPMI] populations and HCBS populations) and stratify measure by Member demographics (e.g., race, ethnicity, or geography) as specified by the State.

D. The CONTRACTOR(S) shall contract with an NCQA-certified HEDIS auditor to validate the processes of the CONTRACTOR(S) in accordance with NCQA requirements. Audited HEDIS results shall be submitted to KDHE-DHCF, NCQA, and KDHE-DHCF's EQRO annually by August 15 of each calendar year.

E. The CONTRACTOR(S) shall utilize the hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing hybrid specifications as identified by NCQA. In the event the CONTRACTOR(S) fails to pass the medical record review for any given standard and NCQA mandates administrative data must be submitted instead of hybrid, the administrative data may be used.

F. The CONTRACTOR(S) shall submit to KDHE-DHCF by August 15 of each calendar year a detailed explanation for any Medicaid HEDIS measure marked as "not reported".

G. The CONTRACTOR(S) shall conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys at the frequency required in the QMS. When conducting the CAHPS, the CONTRACTOR(S) shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The CONTRACTOR(S)' vendor shall perform the CAHPS adult survey, CAHPS child survey, and the CAHPS children with Chronic Conditions survey using the most current CAHPS version specified by NCQA. The CAHPS survey shall include a statistically valid sample frame to stratify by Title XIX and Title XXI populations and results shall be reported by population stratification. Survey results shall be reported to KDHE separately for each required CAHPS survey and stratification level listed above. Survey results shall be submitted to KDHE-DHCF, NCQA, and KDHE's EQRO annually by August 15 of each calendar year in which the CAHPS survey was conducted.

2.9.9 Adverse Incident Reporting and Management System

A. The CONTRACTOR(S) shall integrate data from the adverse incident reporting and management system, and use that information along with Grievance data to improve the care and services delivered by Participating Providers, decrease incidents of abuse, neglect, and exploitation, and prevent future incidents.

B. The CONTRACTOR(S) shall utilize KDADS adverse incident reporting and management system to comply with State law and KDADS "HCBS Adverse Incident Reporting and Management" policy.

C. Incidents shall be classified as adverse incidents when the event or incident brings harm or creates the potential for harm to any Member being served by a KDADS HCBS Waiver program, the Older Americans Act, the Senior Care Act, or the Behavioral Health Services programs.

D. The CONTRACTOR(S) shall report all adverse incidents within twenty-four (24) hours of becoming aware of the incident or event.

E. If any member of the CONTRACTOR(S)' staff or the staff of a Subcontractor that is not a Provider has reasonable cause to believe that a Member has been abused, mistreated, neglected, or financially exploited, or has knowledge of the occurrence of other adverse incidents, the CONTRACTOR(S) shall report such incidents to the State by direct entry into the State's web-based adverse incident reporting (AIR) system.

   1. The CONTRACTOR(S) shall make reports of any abuse, neglect, exploitation, and fiduciary abuse to the DCF as required by DCF and KDADS complaint hotline for Adult Care Homes and "HCBS Adverse Incident Reporting and Management" policy for HCBS.

pp. The CONTRACTOR(S) shall investigate and follow up on any Behavioral Health adverse incidents reported in compliance with Behavioral Health guidelines. The CONTRACTOR(S) shall only permit use of restraints and seclusions for members on the IDD and SED Waivers, and such use must comply with the State's HCBS Waiver requirements and policy. Any use of physical or chemical restraint, isolation, or seclusion in either Waiver is considered an adverse incident and must be reported via the AIR system within twenty-four (24) hours.

F. The CONTRACTOR(S) shall cooperate with KDHE-DHCF, KDADS and any investigating agency in documenting, investigating, and addressing actual and suspected adverse incidents.

G. The CONTRACTOR(S) shall collect and analyze data regarding adverse incidents and track and identify trends, as outlined in KDADS "HCBS Adverse Incident Reporting and Management" policy.

2.9.10 Member Satisfaction Surveys

A. The CONTRACTOR(S) shall conduct Member satisfaction surveys as required in the State's QMS. The CONTRACTOR(S) shall comply with all Federal and State confidentiality law in conducting Member satisfaction survey(s).

B. Upon request by the State, the CONTRACTOR(S) shall make available the results of the Member satisfaction surveys to Providers, the State, Members, and families/caregivers.

C. The CONTRACTOR(S) shall provide the results of the Member satisfaction survey(s) data in a form that allows seamless integration with the State's enterprise data warehouse.

D. The CONTRACTOR(S) shall incorporate results of the Member satisfaction survey(s) in its QAPI program to improve care for Members.

E. The CONTRACTOR(S) shall conduct a sampling methodology that includes a statistically significant sample for both the HCBS and Behavioral Health populations.

F. The CONTRACTOR(S) shall annually conduct a member satisfaction survey with the KanCare SUD population and shall incorporate questions, as needed, into their survey instrument as instructed by KDADS or KDHE. For example, questions to meet the requirements of the SUD demonstration.

1. The SUD survey must at a minimum:

    a. Comply with requirement in Section 2.9.10.E to include a statistically significant sample in order to generalize the results to the KanCare SUD population.

    b. Include information about whether the survey can be submitted confidentially and the procedure for this process.

    c. Utilize mutually agreed upon methods that are approved by the State in writing, for administering the survey by all KanCare MCOs.

    d. Include steps that will be taken to increase responses if/when the CONTRACTOR(S) determines that the number of completed surveys is not adequate to generalize the results to the KanCare SUD population.

    e. Include steps taken to address the recommendations for future action from the previous survey and feedback from the EQRO and State.

f. An annual summary shall be provided to the State and other interested parties which, at a minimum:

a. Reports sampling methodology that was used to determine statistically significant sample size.

b. Validates the sample size and response rate were adequate for generalizability to the KanCare SUD population.

c. Documents statistical testing performed per question and composite

d. Includes a recommendation(s) for future actions section. Action plan to include follow-up steps to address specific outcomes/issues identified in the survey findings and processes.

2.9.11 Provider Satisfaction Surveys

A. Annually, the CONTRACTOR(S) shall provide a Provider satisfaction survey, a Provider satisfaction survey methodology, and a Provider satisfaction survey result report to the State for written approval. The purpose of the Provider satisfaction survey is to assess Provider satisfaction with the performance of the CONTRACTOR(S) and KanCare and identify strengths and areas for improvement. The Provider satisfaction survey shall be a KanCare-specific survey with KanCare-specific Providers and must have a confidence level of 95% and a 5% margin of error to determine sample size to ensure generalizability of results to the KanCare Provider populations.

B. The CONTRACTOR(S) shall comply with the requirements in the QMS regarding Provider satisfaction survey(s).

C. The Provider satisfaction survey methodology must be submitted annually to the State for review a minimum of sixty (60) Calendar Days prior to the survey implementation. The Provider satisfaction survey methodology must include, at a minimum:

1. Survey instrument to be utilized. Questions must be specific to the CONTRACTOR(S) and its KanCare network and not relative to other KanCare MCOs, other insurance plans, or other products.

e. Justification for the instrument choice: how will this choice in instrument best meet the objective of the survey.

f. Sample size, sample frame, minimum response rate, and Provider types.

g. The CONTRACTOR(S) shall conduct a sampling methodology that includes a statistically significant sample for PCPs, specialists, HCBS, and Behavioral Health Provider populations.

h. Timelines for implementing each step in an action plan for administration of the survey.

i. Administration plan (e.g., phone, email, web-based, number of attempts to receive a response, etc.).

j. Process to eliminate from sample those Providers with inaccurate or out-of-date contact information.

k. Information about whether the survey can be submitted confidentially and the procedure for this process.

l. Steps that will be taken to increase responses if/when the CONTRACTOR(S) identifies the number of completed surveys may be inadequate (also include in timeline).

m. Steps taken to address the recommendations for future action from the previous survey feedback from the EQRO and State.

D. Within ninety (90) Calendar Days of reaching the minimum number of completed surveys, the CONTRACTOR(S) shall annually submit a Provider satisfaction survey result report to the State and interested parties. The Provider satisfaction survey result report shall include, at a minimum:

1. An executive summary.

n. Instrument, implementation, and analysis must comply with the most recent CMS EQR survey protocol requirements.

o. Information regarding tracking respondents and non-respondents; reasons for non-respondents and ineligibles; and plan for improving this process in future surveys, when applicable.

p. Report must stratify results by each group: PCPs, specialists, HCBS, and Behavioral Health Providers.

q. Report the sampling methodology that was used to determine statistically significant sample sizes of PCPs, specialists, HCBS, and Behavioral Health Providers.

r. Validation that the sample size and response rate were adequate for generalizability to the KanCare Provider network.

s. Any changes made to the initial methodology approved by the State in writing and reasons for making the changes.

t. Document statistical testing performed per question and composite.

u. A recommendation(s) for future actions section. Action plan to include follow-up steps to address specific outcomes/issues identified in the survey findings and processes.

E. The CONTRACTOR(S) shall incorporate results of the Provider satisfaction survey(s) in its QAPI program to improve care for Members and CONTRACTOR(S)' service to its Participating Providers.

F. The CONTRACTOR(S) shall conduct a sampling methodology that includes a statistically significant sample for both the HCBS and Behavioral Health Provider populations. The CONTRACTOR(S) shall include reference for the sampling methodology in its QAPI program documentation.

2.9.12 Clinical and Medical Records

A. The CONTRACTOR(S) shall maintain, and shall require Participating Providers and Subcontractors to maintain, clinical and medical records in a manner that is current, detailed, and organized and that permits effective and confidential patient care and quality review, administrative, civil, and/or criminal investigations and/or prosecutions.

B. The CONTRACTOR(S) shall have clinical and medical record keeping policies and practices which are consistent with 42 CFR § 456 and current NCQA standards as well as all other related State and Federal laws for medical record documentation. The CONTRACTOR(S) shall distribute these policies to practice sites. At a minimum, the policies and procedures shall address:

1. Confidentiality of clinical medical records: CONTRACTOR(S) and Subcontractors must maintain the confidentiality of clinical and medical record information and release the information only in the following manner:

    a. All clinical and medical records of Members shall be confidential and shall only be released in compliance with HIPAA and other applicable record-protection laws.

    b. Written consent of the Member is only required for the transmission of clinical and medical record information of a former enrolled Member for “sensitive conditions” or as otherwise specified by HIPAA and other applicable record-protection laws. Authorization is not required when the CONTRACTOR(S) is transitioning care to another KanCare MCO.

    c. The extent of clinical or medical record information to be released in each instance shall be based upon tests of Medical Necessity and a “need to know” on the part of the Provider requesting the information.

    d. All releases of information for SUD specific clinical or medical records must meet Federal guidelines at 42 CFR Part 2.

    e. Clinical and medical record documentation standards: The CONTRACTOR(S) shall maintain a system of access to clinical and medical records. The CONTRACTOR(S) must have in effect arrangements which provide for access to the clinical and medical records and clinical and medical record-keeping systems which include a complete record for each Member in accordance with provisions set forth in the CONTRACT. CONTRACTOR(S) shall include sufficient information to comply with the provisions of 42 CFR § 456.111 and § 456.211 regarding utilization review. The State, or its designated agent, and the Federal government shall be allowed access to this system.

C. Records retention: The CONTRACTOR(S) shall retain, preserve, and make available upon request all records relating to the performance of its obligations under the CONTRACT, including clinical and medical records and Claim forms, for a period of not less than ten (10) years from the date of termination of the CONTRACT. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of such litigation, if the litigation is not terminated within the normal retention period. The timeframe for retention shall be documented in the CONTRACTOR(S)’ Provider manual. Electronic copies of documents contemplated herein may be substituted for the originals with the prior written consent of the State, provided that the microfilming procedures are approved by the State in writing as reliable, and are supported by an effective retrieval system. Upon expiration of the ten (10) year retention period, unless the subject of the records is under litigation, the subject records may be destroyed or otherwise disposed of without the prior written consent of the State.

2.10 Member Services

2.10.1 Member Services General Requirements

A. The CONTRACTOR(S) shall convey information to Members and Potential Members via written materials, telephone, internet, and in-person communications, and shall allow Members to submit questions and to receive responses from the CONTRACTOR(S).

B. The CONTRACTOR(S) shall ensure that the informational materials disseminated to all Members and Potential Members accurately identify differences among the categories of eligible persons.

C. The CONTRACTOR(S) shall provide Members with at least thirty (30) Calendar Days written notice of any significant change in policies concerning Members' Disenrollment rights, right to change PCPs, or any significant change to any of the items listed in Member rights and responsibilities regardless of whether the State or the CONTRACTOR(S) caused the change to take place.

D. Per 42 CFR § 438.10, information such as the Member handbook, Provider directory, or other electronic Member information must be available in paper form without charge upon request within five (5) Business Days.

E. All Member information under Section 2.10.3.D will be posted electronically on the CONTRACTOR(S) website and in such a format that can easily be printed by the Member.

F. If the CONTRACTOR(S) elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, then consistent with 42 CFR § 438.10 CONTRACTOR(S) must furnish information about the services it does not cover as follows:

   1. To the State whenever it adopts the policy during the term of the CONTRACT.

   f. To Potential Members before and during Enrollment.

   g. To Members at least thirty (30) Calendar Days before the effective date of the policy with respect to any particular service.

G. The CONTRACTOR(S) shall provide interpretation services, including oral interpretation and American Sign Language (ASL), free of charge to the Member twenty-four hours a day, seven days a week (24/7). This includes providing phone-based or in-person interpretation services when a Member is receiving services from a Provider. The CONTRACTOR(S) is encouraged to contract with Participating Providers to provide interpretation services when a Member is receiving services from the Provider. CONTRACTOR(S) shall ensure each Member who requires interpretation services knows how to access them, and shall assist the Member in arranging interpretation services if the Member requests assistance. The CONTRACTOR(S) shall not require advance notice to schedule interpretation services provided telephonically or virtually. The CONTRACTOR(S) may require advance notice for in-person interpretation services; however, if no advance notice is provided, the CONTRACTOR(S) shall make a good faith effort to arrange an in-person interpreter when one (1) is requested.

2.10.2 Advance Directives

A. CONTRACTOR(S) shall comply with the requirements set forth in 42 CFR § 438.3(j) and 42 CFR § 422.128 for maintaining written policies and procedures for Advance Directives.

   1. The CONTRACTOR(S) shall maintain written policies and procedures respecting Advance Directives with respect to all adult Members receiving medical care by or through CONTRACTOR(S) as set forth in 42 CFR § Part 489, subpart I.

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

B. CONTRACTOR(S) shall provide written information to each Member with respect to the following:

1. Their rights under the law of Kansas to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulation of Advance Directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. Changes in State law must be provided as soon as possible, but no later than ninety (90) Calendar Days after the effective date of the change in State law. Applicable State law may be found in the Kansas Natural Death Act, K.S.A. 65–28,101 et seq. and the Kansas Durable Power of Attorney for Health Care Decisions, K.S.A. 58–625 et seq.

b. The Member's right to file complaints concerning non-compliance with the Advance Directive requirements with the State survey and certification agency.

c. The CONTRACTOR(S)' written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the CONTRACTOR(S) cannot implement an Advance Directive as a matter of conscience. At a minimum, this statement must do the following:

   a. Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.

   b. Identify the State legal authority (K.S.A. 65–28,107 or K.S.A. 58–625) permitting such objection.

   c. Describe the range of medical conditions or procedures affected by the conscientious objection.

C. Provide the information specified in Section 2.10.7 and its subsections and Section 2.10.10 to each Member at the time of initial Enrollment. If a Member is incapacitated at the time of initial Enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not they have executed an Advance Directive, the CONTRACTOR(S) may give Advance Directive information to the Member's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated Member or to a surrogate or other concerned persons in accordance with State law. The CONTRACTOR(S) is not relieved of its obligation to provide this information to the Member once they are no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the Member directly at the appropriate time.

D. CONTRACTOR(S) shall document in a prominent part of the Member's current medical record whether or not the Member has executed an Advance Directive.

E. CONTRACTOR(S) shall not condition the provision of care or otherwise discriminate against a Member based on whether or not the Member has executed an Advance Directive.

F. CONTRACTOR(S) shall ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding Advance Directives.

G. CONTRACTOR(S) shall provide for education of staff concerning its policies and procedures on Advance Directive.

H. CONTRACTOR(S) shall provide for community education regarding Advance Directives that may include material required herein, either directly or in concert with other Providers or entities. Separate community education materials may be developed and used, at the discretion of the

CONTRACTOR(S). The same written materials are not required for all settings, but the material should define what constitutes an Advance Directive emphasizing that an Advance Directive is designed to enhance an incapacitated individual's control over medical treatment and describe applicable State law concerning Advance Directives. The CONTRACTOR(S) must be able to document its community education efforts upon request by the State or applicable agents of the Federal government.

I. The CONTRACTOR(S) is not required to:

1. Provide care that conflicts with an Advance Directive.

d. Implement an Advance Directive if, as a matter of conscience, the CONTRACTOR(S) cannot implement an Advance Directive. State law allows any health care Provider or any agent of the Provider to conscientiously object.

J. While a Provider or agent of the Provider may object, State law requires that the Member be transferred to another physician. K.S.A. 65–28,107(a) requires transfer of a Member to another physician if the attending physician refuses to comply with the declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition of a qualified Member.

2.10.3 State Approval Process of Member Materials

A. The CONTRACTOR(S) shall submit to the State for review and prior written approval all materials meant for distribution to Members, including but not limited to, Member handbooks, Provider directories, Member identification (ID) cards and, upon request, any other additional, but not required, materials and information provided to Members designed to promote health and/or educate Members.

B. All materials must be submitted to the State in electronic file media, in the format prescribed by the State. The CONTRACTOR(S) shall include a plan that describes the CONTRACTOR(S)' intent for the use of the materials.

C. The State reserves the right to notify the CONTRACTOR(S) to discontinue or modify written materials.

D. Materials after approval: Except as otherwise noted written materials must be submitted for review at least forty-five (45) Calendar Days before their printing and distribution. The CONTRACTOR(S) should only request expedited reviews in rare circumstances and will be monitored for potential misuse. This requirement applies to:

1. All Enrollment materials distributed to all Members including the Member handbook.

e. Policy letters, coverage policy statements, and other communications about Covered Services distributed to Members.

f. Standard letters and notifications, such as the notice of Enrollment, the notice of redetermination, and the notice of Disenrollment.

E. The CONTRACTOR(S) shall submit to the State for written approval any changes made to written materials that will be distributed to all Members.

F. The CONTRACTOR(S) must maintain, and provide to the State upon request, documentation verifying that the Member handbook is reviewed and updated at least once a year.

2.10.4 Electronic Specific and Website Requirements for Member Information

A. The CONTRACTOR(S) and any Subcontractors are responsible for developing, hosting, and maintaining a public website.

B. The CONTRACTOR(S)' website and functionality shall take into account the Provider-specific information as required in Section 2.6.3.

C. The CONTRACTOR(S)' website shall comply with the following requirements:

1. Electronic information must be in a machine-readable file and format.

g. Allow for easy navigation.

h. Separate section each for Providers and Members.

i. Member materials must be worded at or below a sixth grade reading level, unless otherwise approved in writing by the State.

j. Member materials must be available online in both English and Spanish. Links to other prevalent language translations should be available. CONTRACTOR(S) is responsible for assuring accuracy and cultural appropriateness of the translations.

k. Compliant with the Americans with Disabilities Act (ADA) Title III website accessibility requirements and the Kansas Information Technology Office (KITO) executive council accessibility requirements. These requirements are located at the link: https://ebit.ks.gov/itec/resources/policies/policy-1210. The CONTRACTOR(S)' websites will be subject to KITO's review and written approval for accessibility.

l. All information must be kept current and up to date.

D. The CONTRACTOR(S) shall include the following on their public website:

1. Prominent links to the electronic Member handbooks;

m. CONTRACTOR(S)' contact information;

n. FAQs;

o. Benefit information and links to KMAP policies as appropriate;

p. Information on oral translation services and how to obtain those services;

q. Links to other related websites, including the KDHE-DHCF Medicaid and KDADS websites;

r. Information about the CONTRACTOR(S)' Formulary:

a. Which medications are covered, including both brand and generic names; and

b. What tier each medication is on;

c. Provider directory as required per Section 2.10.8;

d. Posting of the Health Equity and cultural competency plan;

e. Posting of non-discrimination policy; and

f. Links to all Subcontractor websites.

E. For Members, the CONTRACTOR(S) shall maintain a secure area within their website that:

1. Enables an authorized inquirer to request an electronic copy of explanation of benefits (EOB) that detail Claim service payment or denials. Dates of service, procedure codes, amount billed, amount allowed, amount paid, and patient liability are all required on the EOBs from the CONTRACTOR(S) and Subcontractors.

g. Provides the ability to obtain Claim or authorization status information.

h. Provides information regarding the CONTRACTOR(S)' records for the inquirer.

2.10.5 Written Member Materials Requirements

A. All written Member materials must follow the requirements in 2.10.3 and 2.10.4 above.

B. All written Member materials must be worded at or below a sixth grade reading level, unless otherwise approved in writing by the State.

C. All written Member materials shall be clearly legible with a minimum font size of twelve (12) point.

D. All written Member material must be available in alternative formats, through the provision of auxiliary aids and services and in an appropriate manner that takes into consideration the special needs of Members or Potential Members with disabilities. All Members must be informed of (1) how to request auxiliary aids and services; (2) that information is available in alternative formats at no cost; and (3) how to access those formats. As stated in 42 CFR § 438.10(d)(3), the CONTRACTOR(S) must include taglines in the Prevalent non-English languages in the State, as well as conspicuously-visible font size, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and teletypewriter telephone/text telephone (TTY/TDY) telephone number of the CONTRACTOR(S)' Member/customer service unit. Conspicuously-visible font size means printed in a font no smaller than eighteen (18) point.

E. All written Member materials must be printed with the assurance of non-discrimination.

F. All written Member materials shall be available in English, Spanish, and any additional Prevalent non-English language.

1. The CONTRACTOR(S) is responsible for ensuring the translation is accurate and culturally appropriate.

i. With the request for approval, the CONTRACTOR(S) shall submit a certification to the State that the translation of the information into different languages has been reviewed by a qualified individual for accuracy and that the materials are available in each Prevalent non-English language. See Section 2.10.3 for approval timeframes.

G. All written Member materials shall notify Members that oral interpretation is available for any language at no expense to the Member and instructions for accessing oral interpretation.

H. The CONTRACTOR(S) must make a good faith effort to give written notice of termination of a Participating Provider to each Member who received their Primary Care from, or was seen on a regular basis by, the terminated Provider. The CONTRACTOR(S) must provide notice to the

Member by the later of thirty (30) Calendar Days prior to the effective date of the termination, or fifteen (15) Calendar Days after receipt or issuance of the termination notice.

2.10.6 Member Enrollment Material Requirements

A. The CONTRACTOR(S) shall provide information to the State for written approval and then the CONTRACTOR(S) shall print information to be included with the welcome packet per State printing specifications for Members and Potential Members in accordance with 42 CFR § 438.10(e) that includes the following:

1. Authorization requirements and how to obtain an authorization;

j. Populations which are subject to mandatory Managed Care enrollment;

k. Service area of the CONTRACTOR(S);

l. Covered Services (including those covered by the State) and non-Covered Services;

m. Provider directory and Formulary (this information must be posted on the website and printed versions to be provided upon request within five [5] Business Days);

n. Network adequacy/access;

o. Care Coordination responsibilities of the CONTRACTOR(S);

p. To the extent available, CONTRACTOR(S)' quality and performance indicators including Member satisfaction;

q. Website location for Member handbook;

r. Information on how to request paper versions of Member materials;

s. Notification to all Members of their right to request and obtain Member handbook information at least once a year;

t. Notification to all Members, at the time of Enrollment, of the Member's rights to change Providers or Disenroll for cause;

u. Listing of value-added benefits; and

v. Rights and responsibilities form, for those Members enrolling for HCBS services.

B. CONTRACTOR(S) must provide Enrollment materials to all Members within ten (10) Calendar Days of initial notification of Enrollment.

C. Within the Enrollment materials, the CONTRACTOR(S) shall provide to all Members a link to the online location of the State-approved Member handbook and other written materials with information on how to access services. Paper versions of the Member handbook will be mailed to Members upon request within five (5) Business Days.

2.10.7 Member Handbook Requirements

A. When there are program changes, the CONTRACTOR(S) shall provide notification to the affected Members at least thirty (30) Calendar Days before implementation.

B. The Member handbook and any updates shall be submitted to the State for written approval. The CONTRACTOR(S) shall make modifications in handbook language if requested by the State.

C. Annually, the CONTRACTOR(S) shall summarize and submit to the State all Member handbook changes by noting the pages changed and a brief description of the content changed. The CONTRACTOR(S) shall also submit a “clean” current electronic copy of the Member handbook each year.

D. The electronic version of the Member handbook shall be contained within one (1) electronic file (rather than separate files for each chapter) for ease of searching and printing of the handbook.

E. The content of the Member handbook must include the following:

1. A table of contents.

w. A glossary, where all CONTRACTOR(S) shall use the State definitions for managed care terminology, including the terminology specified at 42 CFR § 438.10(c)(4)(i).

x. Online location of the Provider directory, and features of the Provider directory. Instructions on how to request a paper copy of the Provider directory.

y. Appointment procedures.

z. Availability upon request any physician incentive plans in place as set forth in 42 CFR § 438.3(i).

aa. A description of all available Covered Services, value-added benefits, an explanation of any service limitations or exclusions from coverage, and a notice stating that the CONTRACTOR(S) will be liable only for those services authorized by the CONTRACTOR(S).

bb. What to do in case of an emergency and instructions for receiving advice on getting care in case of any emergency, including how to access the CONTRACTOR(S)’ twenty-four (24) hour toll-free number. Information should also distinguish between an emergency using the Prudent Layperson standard and Urgent Care. In a life-threatening situation, the Member handbook should instruct Members to use the emergency medical services available or to activate emergency medical services by dialing 9-1-1. The CONTRACTOR(S) shall not require the Member to call the CONTRACTOR(S) or PCP prior to going to the emergency department for Prior Authorization in accordance with Section 1932(b)(2) of the SSA.

cc. Description to the extent to which after-hours care is provided.

dd. How to obtain emergency Transportation and NEMT.

ee. How to obtain Behavioral Health Services.

ff. How to obtain value-added benefits.

gg. How to obtain ILOS, and the Member’s rights and protections related to ILOS.

hh. Information regarding out-of-county and out-of-state moves.

ii. Informing the Member that if they have a worker’s compensation Claim, or a pending personal injury or medical malpractice lawsuit, or have been involved in an auto accident, to immediately contact the KDHE-DHCF Medicaid unit, TPL manager.

jj. Contributions the Member can make toward their own health, Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CONTRACTOR(S) or the State.

kk. The CONTRACTOR(S)' policy regarding Copayments and charges to Members. Any cost sharing imposed on Members must be in accordance with 42 CFR § 447.50 through 42 § 447.56.

ll. The CONTRACTOR(S)' procedures for notifying Members about terminations and/or changes in benefits, services, or delivery dates.

mm. Information regarding Advance Directives in accordance with 42 CFR § 438.3(j), including a description of State law as found in K.S.A. 65–28,101 and supporting documentation as specified in Section 2.10.2.

nn. Benefits provided by the CONTRACTOR(S).

a. In the case of a counseling or referral service that the CONTRACTOR(S) does not cover because of moral or religious objections, the CONTRACTOR(S) must inform Members that the service is not covered by the CONTRACTOR(S). The CONTRACTOR(S) must inform Members how they can obtain information from the State about how to access these non-Covered Services.

b. The amount, duration, and scope of benefits available under the CONTRACT in sufficient detail to ensure that Members understand the benefits to which they are entitled. The information provided must address the EPSDT benefit and how to access component services for Members under age twenty-one (21).

c. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Member's PCP.

d. The extent to which, and how, after-hours and emergency coverage are provided, including: what constitutes an Emergency Medical Condition and Emergency Services with reference to the definitions in 42 CFR § 438.114(a); definition of Post-Stabilization Care Services; and the CONTRACTOR(S)' responsibility for coverage; and locations which can provide Emergency and Post-Stabilization Care Services.

e. Any restrictions on the Member's freedom of choice among Participating Providers.

f. A list of services not covered by the CONTRACTOR(S) but covered by the State, see Appendix C (Services).

g. The extent to which, and how, Members may obtain benefits, including family planning services and supplies from Non-Participating Providers. This includes an explanation that the CONTRACTOR(S) cannot require a Member to obtain a referral before choosing a family planning Provider.

h. Member rights and responsibilities, including the elements specified in 42 CFR § 438.100.

i. The process of selecting and changing the Member's PCP.

j. Member's rights to change Providers or Disenroll for cause.

k. Grievance, Reconsideration, Appeal, and State Fair Hearing procedures and timeframes, consistent with 42 CFR § 438 subpart F, in a State-developed or a description approved by the State in writing, see Appendix D (Grievances and Appeals). Such information must include: the right to file Grievances, Reconsiderations, and Appeals; the requirements and timeframes for filing a Grievance or Appeal; the availability of assistance in the filing process; the right to request a State Fair Hearing after the CONTRACTOR(S) has made a determination on a Member's Appeal which is adverse to the Member; the fact that, when requested by the Member, benefits that the CONTRACTOR(S) seeks to reduce or terminate will continue if the Member files an Appeal or a request for State Fair Hearing within the timeframes specified for filing, and that the Member may, consistent with State policy, be required to pay the cost of services furnished while the Appeal or State Fair Hearing is pending if the final decision is adverse to the Member.

l. How to access auxiliary aids and services, including additional information in alternative formats or languages.

m. The toll-free telephone number for Member services, medical management, and any other unit providing services directly to Members.

n. Information on how to report suspected Fraud or Abuse.

o. How to access services during a transition of care in accordance with the State's transition of care policy in Section 2.4.12.

p. Any other content required by the State.

NOTE: Some of this information may be included as inserts to the handbook.

2.10.8 Provider Directory

A. The CONTRACTOR(S) shall develop and maintain a Provider directory, which shall be made available to all Members in the formats specified in this section and in accordance with 42 CFR § 438.10(h). The directory attributes specified in paragraph B of this section must be present in the directories for each of the Provider types covered under the CONTRACT, including, but not limited to, the following:

1. Physicians, including specialists;

q. Vision;

r. Dental;

s. Sedation dental Providers;

t. Hospitals;

u. Pharmacies;

v. Behavioral health Providers; and

w. LTSS Providers.

B. The following types of information are required elements for each Participating Provider listing within the Provider directory. If this information is not available, the element must be listed in the directory with an indication that the details are unavailable:

1. Complete name;

x. Address for all office locations, including street, city, county, and zip code;

y. Phone number, including teletypewriter (TTY) phone line;

z. Provider type;

aa. Specialty/services provided;

bb. Ages served;

cc. Group affiliations (i.e., affiliations through which the Participating Provider delivers services);

dd. Hours of operation;

ee. After-hours contact information;

ff. Website uniform resource locator (URL);

gg. Whether the Participating Provider will accept new Members;

hh. Cultural and linguistic capabilities, including languages spoken (e.g., Spanish, ASL) by the Participating Provider or a skilled medical interpreter at the Participating Provider's office;

ii. Whether the Participating Provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment; and

jj. Link to an interactive map with directions available.

C. The following types of information are optional elements for each Participating Provider listing within the Provider directory and represent elements the State believes may increase Member choice of Provider:

1. Customer rating;

kk. Insurance plans accepted;

ll. Licensure/accreditation status;

mm. Service area listing;

nn. Special needs accommodations available; and

oo. Whether public Transportation is available in the service area.

D. The text of the directories shall be in the format approved by the State in writing. The Provider information used to populate the Provider directories shall be submitted in a format specified by the State.

E. Within ten (10) Calendar Days of the Member Enrollment notification, the CONTRACTOR(S) shall notify the Member within the Enrollment packet of the availability of the online Provider directory and how to access the online Provider directory, including a website address that takes the Member directly to the online Provider directory. The notice shall also notify the Member of their right to request a hard copy of the Provider directory and instructions for doing so, including the telephone

number of the Member services information line. Annually thereafter, the CONTRACTOR(S) shall notify Members of their right to request a hard copy of the Provider directories and instructions for doing so.

F. The CONTRACTOR(S) shall post the Provider directory on the CONTRACTOR(S)' website according to the following specifications:

1. The online version of the Provider directory shall be searchable according to the required elements in paragraph B of this section; searchable by user information, to include at a minimum user address and distance from user location; accessible by users with special needs; and available to print, download, and email.

pp. The online version of the Provider directory shall be updated daily and no later than two (2) Business Days after the CONTRACTOR(S) receives updated Provider information.

qq. The online Provider directory shall contain a disclaimer that the online Provider directories are updated more frequently than the printed directory.

rr. The following features of the electronic Provider directory are optional:

a. A customizable directory listing based upon user specifications which could be downloaded.

b. Ability to compare multiple Participating Providers' information at one time through user filter selections.

c. Ability for directory users to report incorrect Participating Provider listing information.

G. The CONTRACTOR(S)' online Provider directory shall comply with 42 CFR § 438.242 regarding a publicly-accessible standard-based application programming interface (API).

H. Upon request, Members shall receive a hard copy of the Provider directory free of charge. With the Member's permission, the CONTRACTOR(S) may individualize the fields that are included in the paper directory mailed to the Member. The CONTRACTOR(S) may obtain Member permission either verbally, over the phone, in writing or in-person, and must document the request. The directory shall be mailed to Members within five (5) Business Days of the request. Members receiving a hard copy of the Provider directory shall be advised that the CONTRACTOR(S)' network may have changed since the directories were printed, and how to access current information regarding the CONTRACTOR(S)' Participating Providers.

I. The hard copy of the Provider directories shall be updated at least monthly and all updates shall be implemented by the fifth Calendar Day of each month.

J. Upon request, the CONTRACTOR(S) shall provide information on the participation status of any Provider and the means for obtaining more information about Participating Providers.

2.10.9 Member Identification Cards

A. The CONTRACTOR(S) shall provide each Member an identification (ID) card within ten (10) Calendar Days of the Member's Enrollment date. For Members in foster care, the CONTRACTOR(S) shall send a copy of the Member ID card to both the Member's foster care family and the Member's CMP.

B. The CONTRACTOR(S) shall automatically re-issue a Member ID card for Members who are newly coded as foster care and send the Member ID card to both the Member's foster care family and the Member's CMP.

C. The CONTRACTOR(S) shall re-issue a Member ID card within ten (10) Calendar Days of notice if a Member reports a lost card or if information on the Member ID card needs to be changed.

D. The Member ID cards shall not be overtly different in design from the ID card the CONTRACTOR(S) issues to its non-Medicaid Members.

E. The ID cards shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), comply with all State and Federal requirements and, at a minimum, include:

1. Phone numbers for the CONTRACTOR(S)' toll-free Member services information line, nurse advice/nurse triage line, Pharmacy services call center, and any other key numbers;

d. Descriptions of procedures to be followed for Emergency Services;

e. The Member's identification number;

f. The Member's name (first and last name and middle initial);

g. The Member's date of birth;

h. The Member's effective date of Enrollment;

i. The Member's Copayment information for Covered Services;

j. Phone numbers for Pharmacy, vision, and dental call centers; and

k. Toll-free phone number twenty-four (24) hours a day, three hundred sixty-five (365) days a year to assist Members needing immediate assistance if it is different than the regular customer service toll-free number.

2.10.10 Customer Service Center – Member Assistance

A. The CONTRACTOR(S) shall staff, operate, and maintain a customer and Provider service center that is responsible for handling and responding to questions, concerns, inquiries, and complaints received by telephone, fax, written, in-person, or electronic means concerning the KanCare program.

B. The CONTRACTOR(S) must operate a toll-free telephone service, for use by Members, Potential Members, Providers, community-based service organizations, and other public or private agencies from 8:00 am–5:00 pm Central Time Monday through Friday, except for holidays approved by the State in writing. The CONTRACTOR(S) is responsible for providing sufficient in-bound toll-free lines to meet the performance standards outlined in Section 2.10.10.M below, including the following:

1. AVRS may be incorporated into the customer service plan. If an AVRS is used, separate queues must be available for English and Spanish calls.

l. The AVRS must be capable of providing specific information such as the fax number, hours of operation, etc., as well as allowing the caller to access a call center representative.

m. The AVRS shall provide an option in the initial menu to allow Members to contact a call center representative immediately.

n. The CONTRACTOR(S)' call center shall be staffed with personnel who are knowledgeable about the CONTRACTOR(S)' program, Covered Services, including services provided by Subcontractors, and services covered outside the CONTRACT.

C. The CONTRACTOR(S) shall immediately (within one [1] hour) notify the State if there is an interruption or failure of the CONTRACTOR(S)' call center.

D. The customer service center shall be a separate, identifiable, and centralized unit which is staffed with a sufficient number of trained staff to fulfill the functions of this unit. The staff answering calls must receive appropriate training including, but not limited to, benefits and services, Enrollment process, Grievance and Appeal processes, and logging and documenting calls.

E. The CONTRACTOR(S) shall research, resolve, and respond to all received inquiries made by Members and other parties.

F. The CONTRACTOR(S) shall submit a call center representative training plan, evaluation standards, and tools to the State for written approval ninety (90) Calendar Days after CONTRACT award.

G. The CONTRACTOR(S) shall provide language assistance and translation services necessary to ensure meaningful access at no cost to the LEP Members.

H. The CONTRACTOR(S) must have dedicated Member lines with sufficient staffing to meet CONTRACT standards.

I. The CONTRACTOR(S) must have a specific Member line dedicated to Pharmacy issues.

J. The CONTRACTOR(S) must record all calls (inbound and outbound, including voicemails) that are directed to the CONTRACTOR(S)' primary published Member services.

K. The CONTRACTOR(S) must provide a system to track and document all phone contacts, including incoming calls, outgoing calls, incoming email, outgoing email, web-based contacts, and voice messages. The call tracking system shall have the capability to generate statistical reports regarding, for example, call volumes, length of time to answer, abandonment rates, length of the calls, nature of the contact, and who answered the contact.

L. The CONTRACTOR(S) shall submit a call center report to the State using State specifications and definitions. Reasons for the call shall be standardized between KanCare MCOs, and all statistics will be submitted as required by the State. The customer service center will maintain reporting systems with the capability to track all statistics necessary to address performance requirements listed in Section 2.10.10.N.

M. Customer service performance standards: The CONTRACTOR(S) and their Subcontractors shall meet the following requirements for customer service:

1. 100% of incoming and outgoing calls must be documented and recorded.

o. 99% of calls must be answered by an individual or an electronic device without receiving a busy signal.

p. 90% of all calls must be answered within thirty (30) seconds.

q. Average abandonment rate of less than 5%.

r. 85% of calls answered by a live voice within thirty (30) seconds.

s. A minimum of 70% of calls resolved during the initial call. Warm Transfers to the appropriate department, including Grievance and Appeals, will be recognized as resolved during the initial call.

t. 100% of received phone calls are recorded and the recordings maintained.

u. 100% of calls left on voicemail during or after working hours will be retrieved and returned within one (1) Business Day.

v. 100% of all inquiries shall be resolved within fifteen (15) Business Days.

N. The CONTRACTOR(S) shall use data and monitor customer service center requirements by obtaining information from the Members and Providers, resolving issues, identifying and addressing trends. If deficiencies are identified the CONTRACTOR(S) must report such findings to the State and perform corrective action until compliance is met.

O. The CONTRACTOR(S), through customer services, shall facilitate the development of Warm Transfers from help lines when the caller's crisis cannot be addressed by the help lines. The State will consider options other than use of Warm Transfers for coordination of help line services that are proposed by the CONTRACTOR(S), as long as the other requirements of this section are met.

P. The CONTRACTOR(S) must provide a voicemail system that allows messages to be left during and after business hours.

Q. The CONTRACTOR(S) must provide email customer service support with sufficient capacity to handle the incoming volume.

R. Toll-free fax line: The CONTRACTOR(S) must provide a toll-free HIPAA compliant, secure fax system with sufficient capacity to handle the incoming volume.

S. Fax service performance standards: The CONTRACTOR(S) shall meet the following requirements for fax line service:

1. 98% of the time, fax lines shall meet customer demand.

w. 95% of all inquiries shall be resolved within two (2) Business Days of receipt.

x. 98% of all inquiries shall be resolved within five (5) Business Days.

y. 100% of all inquiries shall be resolved within fifteen (15) Business Days.

T. The CONTRACTOR(S) shall have, maintain, and publish the availability of a HIPAA-compliant email system to receive secure materials from Members and Providers electronically.

U. All fax, written communication, and similar documents received shall be imaged/scanned into electronic files for documentation and retrieval purposes and stored using HIPAA-compliant methods.

2.10.11 Member Crisis Assistance

A. The CONTRACTOR(S) must operate a toll-free phone number twenty-four (24) hours a day, three hundred sixty-five (365) day a year to respond to Members needing immediate assistance.

B. The toll-free number must be published in the Member handbook, the Member ID card, and associated materials. The services of this help line shall include:

1. Telephone crisis intervention.

z. Risk assessment.

aa. Referral and consultation to callers which may include caregivers, family members, and other community agencies seeking assistance with Behavioral Health issues.

bb. Kansas-specific information of community resources such as contact information to the Member's local RADAC, social detoxification unit, certified gambling counselor, or CMHC or CCBHC shall be provided.

C. The CONTRACTOR(S) shall develop and maintain a comprehensive Behavioral Health crisis response network that shall include:

1. Crisis responsiveness which includes twenty-four hours a day, seven days a week (24/7), three hundred sixty-five (365) days a year emergency treatment and first response, including, when appropriate, staff going to the individual for personal intervention, for any Member staff become aware of experiencing a crisis or other emergency.

cc. Provision of or referral to psychiatric and other community services, when appropriate.

dd. Assessment of any Member experiencing a Behavioral Health crisis to determine the need for inpatient treatment, crisis services, or other community treatment services.

ee. Emergency consultation and education when requested by law enforcement officers, other professionals or agencies, or the public for the purposes of facilitating Emergency Services.

ff. Follow up with any Member seen for or provided with any Emergency Service and not admitted for inpatient care and treatment to determine the need for any further services or referral to any services within seventy-two (72) hours of crisis resolution.

gg. In cases of discharge from inpatient care, the CONTRACTOR(S) shall work with the inpatient facility on discharge planning upon Admission and monitor Provider contact with the Member following inpatient discharge with goals of offering and encouraging Member's attendance at follow-up appointments. The timeframe begins with the day of the Member's discharge. The CONTRACTOR(S) shall ensure 85% of all contact attempts occur between twenty-four (24) to seventy-two (72) hours of discharge, 90% of contact attempts occur within one to seven (1-7) Calendar Days, and 95% of contact attempts occur within one to ten (1-10) Calendar Days. The CONTRACTOR(S) must have protocols in place to assess compliance with this CONTRACT requirement.

hh. CONTRACTOR(S) agrees that there will be no requirements for pre-authorization for Emergency Services or treatment for a Behavioral Health crisis.

2.10.12 Member Rights and Protections

A. The CONTRACTOR(S) must have written policies regarding the Member rights specified in this section. The CONTRACTOR(S) must comply with any applicable Federal and State laws that pertain to Member rights and ensure that its staff and affiliated Providers take those rights into account when furnishing services to Members. All Members shall be guaranteed the following rights and protection:

1. Information requirements. Each Member shall receive information in accordance with 42 CFR § 438.10.

ii. Dignity and privacy. Each Member is guaranteed the right to be treated with respect and with due consideration for their dignity and privacy.

jj. Receive information on available treatment options. Each Member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

kk. Participate in decisions. Each Member is guaranteed the right to participate in decisions regarding their health care, including the right to refuse treatment.

ll. Free from restraint or seclusion. Each Member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

mm. Copy of medical records. Each Member is guaranteed the right to request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR § 164.

nn. Free exercise of rights. Each Member is free to exercise their rights, and that the exercise of those rights does not adversely affect the way the CONTRACTOR(S) and its Providers or the State treat the Member.

oo. Compliance with other State and Federal laws and regulations. CONTRACTOR(S) must comply with all Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Titles II and III of the ADA and Section 1557 of the PPACA. CONTRACTOR(S) must comply with any other applicable Federal and State laws (e.g., Title VI of the Civil Rights Act of 1964, etc.) and other laws regarding privacy and confidentiality.

B. The CONTRACTOR(S) must comply with any applicable Federal and State laws that pertain to Member rights and ensure that its staff and affiliated Providers take those rights into account when furnishing services to Members.

C. Members shall not be held liable for the CONTRACTOR(S)' debts in the event of insolvency; not be held liable for the Covered Services provided to the Member for which the State does not pay the CONTRACTOR(S); not be held liable for Covered Services provided to the Member for which the State or the CONTRACTOR(S) do not pay the Provider that furnishes the services; and not be held liable for payments of Covered Services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the Member would owe if the CONTRACTOR(S) provided the services directly.

D. The CONTRACTOR(S) will maintain a mechanism to gain Member input into their process and system of care. The CONTRACTOR(S) shall create and maintain a Member advisory committee(s), which must be representative of the Membership being served, including LTSS and Behavioral Health Members.

   1. A plan for the Member advisory committee(s) shall be submitted annually by the CONTRACTOR(S) and subject to written approval by the State.

   pp. The plan shall include procedures for implementing the committee, including meeting at least quarterly, and details on how the CONTRACTOR(S) will ensure meaningful representation from all Member stakeholder groups.

   qq. The CONTRACTOR(S) shall submit an annual meeting calendar for the Member advisory committee to the State with dates, times, and meeting places for each meeting. At least two (2) weeks prior to each meeting the CONTRACTOR(S) shall send a meeting agenda and other materials for the meeting to both committee members and the State.

   rr. The CONTRACTOR(S) shall include Health Equity as an agenda topic for at least two (2) meetings of the Member advisory committee per year; this topic shall include reviewing the CONTRACTOR(S)' Health Equity and cultural competency plan and the CONTRACTOR(S)' Health Equity report card.

   ss. Quarterly, the CONTRACTOR(S) shall submit a written report to KDHE-DHCF. The report shall contain information about meeting(s) held in the past quarter, how the CONTRACTOR(S) is addressing previous issues raised by the Member advisory committee, and who attended meetings. The CONTRACTOR(S) shall designate an employee to present this report and answer related questions to groups as identified by KDHE-DHCF.

E. The CONTRACTOR(S) will be prohibited from restricting a Provider from advising or advocating on behalf of a Member.

2.11 Grievances and Appeals

See Appendix D, Grievances, Reconsiderations, Appeals, and State Fair Hearings, for all requirements related to those processes.

2.12 Program Integrity

2.12.1 Program Integrity and Disclosure Requirements

A. The CONTRACTOR(S) and any Subcontractors with responsibility for coverage of services and payment of Claims must establish arrangements or procedures that include, at a minimum the elements required in 42 CFR § 438.608(a)(1), specifically:

   1. Written policies, procedures, and standards of conduct that articulate the CONTRACTOR(S)' commitment to comply with all applicable requirements and standards under the CONTRACT, and all applicable Federal and State requirements.

   tt. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the CONTRACT and who reports directly to the CEO and the board of directors.

uu. The establishment of a regulatory compliance committee on the board of directors and at the senior management level charged with overseeing the CONTRACTOR(S)' compliance program and its compliance with the requirements under the CONTRACT.

vv. A system for training and education for the compliance officer, the CONTRACTOR(S)' senior management, and the CONTRACTOR(S)' employees for the Federal and State standards under the CONTRACT.

ww. Effective lines of communication between the compliance officer and the CONTRACTOR(S)' employees.

xx. Enforcement of standards through well-publicized disciplinary guidelines.

yy. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the CONTRACT.

B. The CONTRACTOR(S) shall coordinate any and all program integrity efforts with KDHE-DHCF personnel and the Kansas' Medicaid fraud control unit (MFCU), located within the Kansas Attorney General's Office. For LTSS and Behavioral Health Services program integrity issues, coordination is also required with KDADS. At a minimum, CONTRACTOR(S) shall:

1. Meet monthly, and as required, with KDHE-DHCF staff and MFCU staff to coordinate reporting of all instances of credible allegations of Fraud, as well as all recoupment actions taken against Providers.

zz. Provide any and all documentation or information upon request to KDHE-DHCF, MFCU, CMS and its contractors, the Medicaid Inspector General's Office located within the Kansas Attorney General's Office, or HHS OIG related to any aspect of this CONTRACT, including but not limited to policies, procedures, Subcontracts, Provider agreements, Claims data, Encounter Data, and reports on recoupment actions and receivables.

aaa. Per 42 CFR § 438.608(a)(7), report within two (2) Business Days to the KDHE-DHCF, MFCU, and any appropriate legal authorities any evidence indicating the possibility of Fraud, waste, or Abuse by any Participating Provider or Non-Participating Provider. If the CONTRACTOR(S) fails to report any suspected Fraud, waste or Abuse, KDHE-DHCF may invoke any penalties allowed under this CONTRACT including, but not limited to, suspension of payments or termination of the CONTRACT. Furthermore, the enforcement of penalties under the CONTRACT shall not be construed to bar other legal or equitable remedies which may be available to the KDHE-DHCF or MFCU for non-compliance with this section.

bbb. Provide KDHE-DHCF with a quarterly update of investigative activity, including corrective actions taken.

ccc. Provide KDHE-DHCF an annual program integrity work plan which outlines the CONTRACTOR(S) program integrity/Fraud, waste, and Abuse focus for the coming year.

ddd. Hire and maintain a full-time staff person in Kansas whose duties shall be 100% devoted to the oversight and management of the program integrity efforts required under this CONTRACT.

This person shall be designated as the program integrity manager. The program integrity manager have open and immediate access to all Claims, Claims processing data, and any other electronic or paper information required to assure that program integrity activity of the CONTRACTOR(S) is sufficient to meet the requirements of KDHE-DHCF. The duties shall include, but not be limited to, the following:

a. Oversight of the program integrity function under this CONTRACT.

b. Liaison with the State in all matters regarding program integrity.

c. Development and operations of a Fraud control program within the CONTRACTOR(S) Claims payment system.

d. Liaison with Kansas' MFCU.

e. Assure coordination of efforts with KDHE-DHCF and other agencies concerning program integrity issues.

f. Employ a full-time special investigation unit (SIU) investigator dedicated to Kansas Medicaid 100% of the time. This investigator must reside in the State.

g. Hire additional qualified staff to assist the program integrity manager as appropriate based on the number of reviews/audits and investigations occurring.

C. The CONTRACTOR(S) shall ensure that all Participating Providers are enrolled with KDHE-DHCF as Medicaid Providers consistent with the Provider disclosure, screening, and enrollment requirements of 42 CFR § Part 455, subparts B and E as incorporated in 42 CFR § 438.608(b) prior to executing a Provider agreement. Prior to paying Claims to a Non-Participating Provider that is not enrolled with Kansas Medicaid, the CONTRACTOR(S) shall, at a minimum, verify licensure and perform all Federal database checks as specified at 42 CFR § 455.436 on all Owners and managing employees.

D. The CONTRACTOR(S) shall diligently safeguard against the potential for, and promptly investigate reports of, suspected Fraud and Abuse by employees, Subcontractors, Providers, and others with whom the CONTRACTOR(S) does business. The CONTRACTOR(S) shall provide the State with its policies and procedures on handling issues of suspected Fraud and Abuse.

E. The CONTRACTOR(S) shall make a good faith effort to complete a full review of Provider Fraud or Abuse cases within twelve (12) months. Documentation of such efforts shall be sent to the State program integrity team on a rolling twelve (12) month basis.

F. The CONTRACTOR(S) shall comply with all Federal and State laws and regulations related to program integrity and disclosure requirements.

G. The State, or any agent including the State's Fiscal Agent or other contractor, has the right to review, audit, and recover from Participating Providers. CONTRACTOR(S) and Subcontractors have a duty to cooperate with reviews and audits and must respond to State requests.

H. The CONTRACTOR(S) shall comply with 42 CFR § 438.608(a)(3) by promptly reporting (within five [5] Business Days) to KDHE-DHCF any information received about changes to a Member's circumstances that may affect the Member's eligibility, including changes in the Member's residence, the death of the Member, or other information specified by KDHE-DHCF.

I. The CONTRACTOR(S) shall notify the State, on a monthly basis, as to any adverse action that has been taken against a Participating Provider's participation in the program as specified in an adverse action report. The CONTRACTOR(S) shall report CONTRACTOR(S) and all Subcontractor Fraud and Abuse information on the schedule identified by and in the report template format prescribed by the State. In addition, the CONTRACTOR(S) shall comply with 42 CFR § 438.608(a)(4) by notifying KDHE-DHCF when the CONTRACTOR(S) receives information about a change in the Participating Provider's circumstances that may affect the Participating Provider's eligibility to participate in KanCare, including the termination of the Provider agreement with the CONTRACTOR(S). The CONTRACTOR(S) shall immediately (within one [1] Business Day) notify the State if the CONTRACTOR(S) terminates a Provider due to concerns related to Member health or safety.

J. Terminated Providers: The CONTRACTOR(S) shall terminate Provider agreements with any Participating Provider whose Medicaid Provider agreement has been terminated for cause by the State. Such Provider agreement termination shall be effective on the date specified within the notification from the State. The CONTRACTOR(S) shall provide written notice of the Participating Provider termination to the Members as specified in Section 2.10.5 of this CONTRACT and work to ensure any Member assigned to such Participating Provider is transitioned to another Participating Provider. The CONTRACTOR(S) shall not enter into a Provider agreement nor pay a Non-Participating Provider terminated for cause by the State. The Federal financial participation (FFP) is not available for amounts expended for Providers excluded by Medicare, Medicaid, or CHIP, except for Emergency Services. In addition, CONTRACTOR(S)' Subcontractors, and Members of CONTRACTOR(S)' or Subcontractor's Participating Providers are prohibited from employing or contracting with persons or entities that State has terminated from participation in the Kansas Medicaid program.

K. Inactivated Providers: The CONTRACTOR(S) shall terminate Participating Provider agreements with any Participating Provider whose Medicaid Provider agreement has been inactivated by the State. Such Participating Provider contract termination shall be effective on the date of inactivation by the State. The CONTRACTOR(S) is not prohibited from entering into a single case agreement or other arrangement for Non-Participating Provider payment for such Providers.

L. The CONTRACTOR(S) shall conduct an annual risk assessment of both CONTRACTOR(S)' and each Subcontractors' Fraud and Abuse/program integrity procedures (for those Subcontractors that are delegated to adjudicate Claims on behalf of the CONTRACTOR(S), such as dental, vision, Pharmacy, or Transportation). The assessment shall include a listing of the top five (5) vulnerable areas and outline action to mitigate risks in each area. The assessment shall be provided to the State by March 1 of each year.

M. The CONTRACTOR(S) shall be entitled to retain Overpayment recoveries, including Overpayments due to Fraud, waste or Abuse that were first identified by the CONTRACTOR(S).

    1. The CONTRACTOR(S) shall, when directed by KDHE-DHCF, recover established Overpayments made to a Provider by the State for performance or non-performance of activities not governed by this CONTRACT. When funds are recovered, CONTRACTOR(S) shall promptly notify KDHE-DHCF of any amount recovered and, as directed by KDHE-DHCF, CONTRACTOR(S) will immediately provide the amount recovered to KDHE-DHCF, or KDHE-DHCF will withhold the amount recovered from a payment otherwise owed to CONTRACTOR(S). In the event the Overpayment is not recoverable, CONTRACTOR(S) shall promptly notify KDHE-DHCF and provide an explanation as to the reason the Overpayment is not collectible.

h. KDHE-DHCF and any agent, including the State's Fiscal Agent or other contractors not a KanCare MCO, may discover and identify an Overpayment to be recovered from a Participating Provider or Non-Participating Provider that was made by the CONTRACTOR(S), and the CONTRACTOR(S) shall be entitled to retain Overpayment recoveries, including Overpayments due to Fraud, waste, or Abuse, that were first identified by the CONTRACTOR(S). The CONTRACTOR(S) is not entitled to any recovery under this section when KDHE-DHCF and any agent, including the State's Fiscal Agent or other agent, identifies and pursues Overpayments, false Claims, or fraudulent Claims paid by the CONTRACTOR(S) to a Provider.

i. The CONTRACTOR(S) shall require and have a mechanism for Participating Providers and Non-Participating Providers to report when it has received an Overpayment, to return the Overpayment to the CONTRACTOR(S) within sixty (60) Calendar Days after the date on which the Overpayment was identified, and to notify the CONTRACTOR(S) in writing of the reason for the Overpayment.

j. The CONTRACTOR(S) shall conduct credit balance audits of Providers to determine if an Overpayment exists. This shall be done no less than quarterly to ensure prompt identification and collection of any Overpayments.

k. The CONTRACTOR(S) shall comply with 42 CFR § 438.608(c)(3) by reporting to KDHE-DHCF, within sixty (60) Calendar Days of identification, Capitation Payments, or other payment in excess of amounts specified in the CONTRACT.

l. The CONTRACTOR(S) shall comply with 42 CFR § 438.608(a)(2) by promptly reporting (within thirty [30] Calendar Days) all Overpayments identified or recovered, specifying the Overpayments due to potential Fraud, to KDHE-DHCF.

m. The annual report on CONTRACTOR(S)' recoveries and any information or documentation related to recoveries that were retained by the CONTRACTOR(S) or the State will be used by the State for purposes of developing actuarially sound capitation rates.

N. The CONTRACTOR(S) shall have in place a method to verify, on a regular basis, whether services reimbursed by the CONTRACTOR(S) were furnished to Members as billed by Participating Providers.

O. The CONTRACTOR(S) and any Subcontractors shall comply with 42 CFR § 455.23 by suspending all payments to a Provider after KDHE-DHCF determines that there is a credible allegation of Fraud for which an investigation is pending under the Medicaid program against an individual or entity unless KDHE-DHCF has identified in writing a good cause reason for not suspending payments or to suspend payments only in part. The CONTRACTOR(S) and any Subcontractors shall resume payments if KDHE-DHCF determines good cause for a payment suspension to be lifted prior to the conclusion of an investigation.

1. The CONTRACTOR(S) or Subcontractor(s) shall issue a notice of payment suspension that comports in all respects with the obligations set forth in 42 CFR § 455.23(b) and maintain the suspension for the durational period set forth in 42 CFR § 455.23(c). In addition, the notice of payment suspension shall state that payments are being withheld in accordance with 42 CFR § 455.23(g).

n. The CONTRACTOR(S) and Subcontractor(s) shall maintain all materials related to payment suspensions for a minimum of five (5) years in compliance with the obligations set forth in 42 CFR § 455.23(g).

P. The CONTRACTOR(S) shall report ownership and control information in accordance with 42 CFR § 438.608(c)(2):

1. The CONTRACTOR(S) shall disclose the following:

a. The name and address of any person (individual or corporation) with an ownership or control interest in the CONTRACTOR(S). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

b. The date of birth (DOB) and Social Security number (in the case of an individual).

c. Other tax identification number (TIN) (in the case of a corporation) with an ownership or control interest in the CONTRACTOR(S) or in any Subcontractor in which the CONTRACTOR(S) has a 5% or more interest.

d. Whether the person (individual or corporation) with an ownership or control interest in the CONTRACTOR(S) is related to another person with ownership or control interest in the CONTRACTOR(S) as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

e. The name of any other disclosing entity in which an Owner of the CONTRACTOR(S) has an ownership or control interest.

f. The name, address, date of birth, and Social Security number of any managing employee of the CONTRACTOR(S).

g. Disclosures from the CONTRACTOR(S) are due:

a. Upon the CONTRACTOR(S) submitting the proposal in accordance with the State's procurement process.

b. Upon the CONTRACTOR(S) executing a CONTRACT with the State.

c. Upon renewal or extension of the CONTRACT.

d. Within thirty-five (35) Calendar Days after any change in ownership of the CONTRACTOR(S).

e. All disclosures must be provided to KDHE-DHCF.

f. FFP is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by law.

Q. Pursuant to 42 CFR § 455.106, upon execution of the CONTRACT and prior to renewal of the CONTRACT, or at any time upon written request by KDHE-DHCF, the CONTRACTOR(S) must disclose to KDHE-DHCF the identity of any person who:

1. Has ownership or control interest in the CONTRACTOR(S) or is an agent or managing employee of the CONTRACTOR(S).

g. Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or CHIP since the inception of those programs.

R. The CONTRACTOR(S) shall implement in its Provider enrollment processes the obligation of Providers to disclose the identity of any person described in 42 CFR § 1001.1001(a)(1). The CONTRACTOR(S) shall forward such disclosures to KDHE-DHCF. CONTRACTOR(S) shall abide by any direction provided to the CONTRACTOR(S) by KDHE-DHCF, pursuant to 42 CFR § 1002.3, on whether or not to permit the applicant to be a Participating Provider. Specifically, the CONTRACTOR(S) shall not permit the Provider to become a Participating Provider if KDHE-DHCF or the CONTRACTOR(S) determines that any person who has ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or CHIP, or if KDHE-DHCF or the CONTRACTOR(S) determine that the Provider did not fully and accurately make any disclosure required pursuant to 42 CFR § 1001.1001(a)(1).

S. Prohibited relationships 42 CFR § 438.610:

1. The CONTRACTOR(S) and Subcontractor may not knowingly have a relationship with the following:

a. An individual or entity who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation, of an individual or entity described in Section 2.12.1.S.1.a.

c. "Relationship", for purposes of prohibited affiliations, is defined as follows:

a. A director, officer, or partner of the CONTRACTOR(S) or Subcontractor.

b. A Subcontractor of the CONTRACTOR(S) or Subcontractor.

c. A person with beneficial ownership of 5% or more of the CONTRACTOR(S)' or Subcontractor's equity.

d. A Participating Provider or person with an employment, consulting, or other arrangement with the CONTRACTOR(S) or Subcontractor for the provision of items and services that are significant and material to the CONTRACTOR(S)' or Subcontractor's obligation under its CONTRACT with the State.

e. The CONTRACTOR(S) or Subcontractor may not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the SSA.

f. The CONTRACTOR(S) must provide written disclosures of any prohibited affiliation under 42 CFR § 438.610.

g. Any Participating Provider or Provider entity, CONTRACTOR(S), or Subcontractor, that receives or makes $5 million in annual payments from KDHE-DHCF, must comply with Section 1902(a)(68) of the SSA and 42 CFR § 438.608(a)(6) as a condition of receiving payment. The $5 million amount will be based on paid Claims, net of any adjustments to those Claims. It will be the responsibility of Providers or Provider entities, CONTRACTOR(S), or Subcontractor to make the determination as to whether they meet the $5 million threshold. To comply with Section 1902(a)(68) of the SSA and 42 CFR § 438.608(a)(6), the CONTRACTOR(S) must ensure that it has implemented all of the following requirements:

    a. Must establish written policies that provide detailed information about the Federal laws identified in Section 1902(a)(68) of the SSA and any State laws imposing civil or criminal penalties for false Claims and statements or providing whistleblower protections under such laws.

    b. In addition to the detailed information regarding the Federal and State laws, the written policies must contain detailed information regarding the CONTRACTOR(S) policies and procedures to detect and prevent Fraud, waste, or Abuse in Federal health care programs, including the Medicare and Medicare Advantage programs.

    c. The CONTRACTOR(S) must provide a copy of its written policies to all of its employees, contractors, and agents of the vendor.

    d. If the CONTRACTOR(S) maintains an employee handbook, the CONTRACTOR(S) must include in its employee handbook a specific discussion of the Federal and State laws described in its written policies, the CONTRACTOR(S)' policies and procedures for detecting and preventing Fraud, waste, or Abuse, and the right of its employees to be protected from discharge, demotion, suspension, threat, harassment, discrimination, or retaliation in the event the employee files a claim pursuant to the Federal False Claims Act or otherwise makes a good faith report alleging Fraud, waste, or Abuse in a Federal health care program, including the Medicare and KDHE-DHCF programs, to the CONTRACTOR(S) or Provider or to the appropriate authorities.

e. Cost recovery and cost avoidance tracking and reporting. The CONTRACTOR(S) must submit a quarterly payment integrity report to KDHE-DHCF detailing, for the reporting period, the dollar amounts cost avoided through front end edits and other cost avoidance efforts, and the dollar amounts identified and recovered through Fraud, waste, or Abuse detection efforts. These reports must be in a format approved by KDHE-DHCF in writing.

f. Other Requirements:

    a. The CONTRACTOR(S) must use the unique identifier provided by the State's Fiscal Agent for each individual Participating Provider.

    b. The CONTRACTOR(S) shall report Fraud and Abuse information to KDHE-DHCF quarterly. The report will include the information as indicated on the report template approved by KDHE-DHCF in writing.

    c. The CONTRACTOR(S) shall document that safeguards at least equal to Federal safeguards (at 41 U.S.C. 423) are in place.

    d. The CONTRACTOR(S) and Subcontractor shall conduct program integrity data analytics specific to Kansas data.

e. Denial or termination of CONTRACT:

i. KDHE-DHCF may refuse to enter into or renew a CONTRACT with the CONTRACTOR(S) if any person who has an ownership or control interest in the CONTRACTOR(S), or who is an agent or managing employee of the CONTRACTOR(S), has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or CHIP.

ii. KDHE-DHCF may refuse to enter into or may terminate the CONTRACT(S) if it determines that the CONTRACTOR(S) did not fully and accurately make any disclosure required under this section.

T. The CONTRACTOR(S) shall report to KDHE and, upon request, to the Secretary of HHS, the Inspector General of HHS, and the Comptroller General, a description of transactions between the CONTRACTOR(S) and a party in interest (as defined in Section 1318(b) of the Public Health Service Act), including the following transactions: (i) Any sale or exchange, or leasing of any property between the CONTRACTOR(S) and such a party; (ii) Any furnishing for consideration of goods, services (including management services), or facilities between the CONTRACTOR(S) and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; (iii) Any lending of money or other extension of credit between the CONTRACTOR(S) and such a party. The CONTRACTOR(S) shall make any reports of transactions between the CONTRACTOR(S) and parties in interest that are provided to KDHE, or other agencies, available to Members upon request.

2.12.2 Member Fraud and Abuse

A. The CONTRACTOR(S) shall notify the State of Members suspected of participating in fraudulent or abusive activities. Notification must be in written format with supporting documentation attached. The Members may be identified through UM, chart review, or by referral from Participating Providers. The CONTRACTOR(S) shall report to the State suspected fraudulent activities as directed by State policy or regulation. The CONTRACTOR(S) shall make a good faith effort to complete a full review of Member Fraud or Abuse cases within twelve (12) months. Documentation of such efforts shall be sent to the State program integrity team on a rolling twelve (12) month basis.

B. The CONTRACTOR(S) is expected to provide Member education in an attempt to correct abusive behavior. Abusive behavior may include, but is not limited to:

1. Concurrently obtaining services from two (2) or more Providers of the same specialty, not in the same group practice, with no referrals.

f. Using two (2) or more emergency facilities for non-emergency diagnosis.

g. Concurrently using two (2) or more prescribing physicians to obtain drugs from the same therapeutic class of medication.

h. Two (2) or more occurrences of having Prescriptions for the same therapeutic class of medication filled two (2) or more times on the same or subsequent Calendar Day by the same or different Providers.

i. Concurrently using two (2) or more Pharmacies to obtain quantity of drugs from the same therapeutic class of medication which exceed the manufacturer's maximum recommended dosage as approved by the United States Food and Drug Administration (FDA).

j. Report of Member using the medical card to purchase drugs on a forged Prescription.

k. Report of Member loaning a card to another individual to obtain Medicaid reimbursed services.

l. Consistently seeking/obtaining medical services which are not supported by diagnosis or medical records/documentation.

m. On request or recommendation of State legal or KDHE-DHCF for cause.

2.13 Financial Management

2.13.1 Disclosure of Financial Records

A. The CONTRACTOR(S) shall establish and maintain an accounting system in accordance with generally accepted accounting principles, and the revenues and expenses properly applicable to this CONTRACT shall be readily ascertainable.

B. The CONTRACTOR(S) and any Subcontractors shall make available to the State, the State's authorized agents, and appropriate representatives of the HHS, any financial records of the CONTRACTOR(S) or Subcontractors which relate to the CONTRACTOR(S)' capacity to bear the risk of potential financial losses, or to the services performed and amounts paid or payable under this CONTRACT. Accounting procedures, policies, and records shall be completely open to State and Federal audit at any time during the CONTRACT period and for ten (10) years thereafter.

C. All financial submissions shall be certified by the CONTRACTOR(S)' chief financial officer (CFO) or CEO or an individual who has delegated authority to sign for, and who reports directly to, the CEO or CFO. The certification must attest that, based on best information, knowledge, and belief, the information submitted in the reports is current, complete, accurate, and truthful. The statement should include the CONTRACTOR(S) name, reporting period, preparer information, and signatures.

D. The CONTRACTOR(S) shall file with the State all financial reports in a format and frequency as specified by the State.

E. The CONTRACTOR(S) shall provide a written assurance stating the required performance bond will be submitted not later than forty-five (45) Calendar Days after CONTRACT signing.

F. The CONTRACTOR(S) shall provide an insolvency plan documenting arrangement made which protect its subscribers in the event of insolvency. The plan must include provisions for dividing the cash reserves, capital, and surplus requirements among Participating Providers in the event of insolvency. The CONTRACTOR(S) shall hold harmless its Members in the event of insolvency and the CONTRACTOR(S)' Participating Providers shall not charge Members any portion of the costs associated with the provision of services under this CONTRACT.

G. The CONTRACTOR(S)' statutory reporting and other reporting requirements shall solely reflect the results of the KanCare program, except as otherwise required by the National Association of Insurance Commissioners (NAIC) requirements.

H. The CONTRACTOR(S) shall provide a copy of each letter of credit held.

I. The CONTRACTOR(S) shall notify the State in writing of any person or corporation that has 5% or more ownership or controlling interest in the entity. The CONTRACTOR(S) shall submit financial statements for all Owners with interest of 5% or greater.

J. The CONTRACTOR(S) shall submit audited financial reports specific to the Medicaid CONTRACT on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards to be defined by the State in accordance with 42 CFR § 438.3(m).

2.13.2 Payment to Contractor(s)

A. Actuarially sound capitation rates: The State's actuaries will calculate a blended statewide actuarially sound capitation rate per Rate Cell to cover all Medicaid eligible populations, services, and regions in accordance with generally accepted actuarial principles and in conformance with 42 CFR § 438.3(c)(1)(ii), § 438.4, § 438.5, § 438.7, and any Federal guidance governing actuarially sound capitation rates for Medicaid managed care programs.

B. Risk adjustment: The final actuarially sound capitation rates will be subject to a risk adjustment methodology that is developed, documented, and approved in accordance with 42 CFR § 438.5(g) and 42 CFR § 438.7(b)(5). The approved risk adjustment methodology will be applied in a budget neutral manner, as defined in 42 CFR § 438.5(a).

C. The State will reduce Capitation Payments for Member patient liability for nursing facility (NF) and share of cost for HCBS. Capitation rates will be net of third-party liability recoveries.

D. Amendment process: Rates for succeeding CONTRACT years (January 1 through December 31) shall be set annually by the KDHE-DHCF and their actuaries. These rates shall be adjusted annually from the preceding year for emerging experience, trend, utilization, and policy changes and must be approved by CMS.

E. For purposes of developing actuarially sound capitation rates, the CONTRACTOR(S) shall submit validated Encounter Data and audited financial reports in accordance with 42 CFR § 438.5(c). The CONTRACTOR(S) shall also complete a Medicaid reporting template in a format designed by the State and its actuaries.

F. Monthly Capitation Payments calculated in accordance with the CONTRACT will be paid by the State and the CONTRACTOR(S) may only retain Capitation Payments for Medicaid eligible Members. The CONTRACTOR(S) has sixty (60) Calendar Days from the date in which the CONTRACTOR(S) discovers an Overpayment to return such Overpayment to the State.

G. Capitation Payments made by the State to CONTRACTOR(S), including any amounts earned by the CONTRACTOR(S) under a withhold arrangement as required in 42 CFR § 438.6(b)(3), constitute full and complete payment to CONTRACTOR(S) for all goods and services provided by CONTRACTOR(S) to the State for the time period covered by such Capitation Payments. The State will not make payments to Participating Providers unless required by Federal law as specified in 42 CFR § 438.60 The State may recover CONTRACTOR(S)' monthly Capitation Payments if the Member is subsequently determined to be ineligible for the month in question when the CONTRACTOR(S) actually provided service. Consideration may be given in instances where the CONTRACTOR(S) has paid for services.

H. The CONTRACTOR(S) has the right to audit case mix information and the supporting medical records and to recommend adjustments/corrections to that data; however, the State retains ultimate authority in deciding whether to implement those adjustments. The CONTRACTOR(S) must request any adjustment affecting the case mix from the State no later than thirty (30) Calendar Days prior to

the rate effective date. The CONTRACTOR(S) will provide documentation and details relative to how it will audit case mix data.

I. In instances where Enrollment is disputed between two (2) KanCare MCOs, the State will be the final arbitrator of CONTRACTOR(S)' membership and reserves the right to recover an inappropriate Capitation Payment. The State also reserves the right to recover other types of inappropriate Capitation Payments, including, but not limited to, untimely notice from the CONTRACTOR(S) to the Fiscal Agent or KanCare eligibility clearinghouse, as applicable, of a Member's request to Disenroll.

J. Should any part of the scope of work under this CONTRACT relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn Federal authority, or which is the subject of a legislative repeal), the CONTRACTOR(S) must do no work on that part after the effective date of the loss of program authority. The State will adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the CONTRACTOR(S) works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the CONTRACTOR(S) will not be paid for that work. If the State paid the CONTRACTOR(S) in advance to work on a no-longer-authorized program or activity and under the terms of this CONTRACT the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the State. However, if the CONTRACTOR(S) worked on a program or activity prior to the date legal authority ended for that program or activity, and the State included the cost of performing that work in its payments to the CONTRACTOR(S), the CONTRACTOR(S) may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

K. Any and all recoveries from risk corridor/quality measure calculations for withhold arrangements will be subtracted from the PMPM payment in the following month(s). If no further PMPM payments are due, the CONTRACTOR(S) will issue a check payable to KDHE-DHCF.

L. Medical Loss Ratio:

1. The CONTRACTOR(S) shall calculate and report an MLR consistent with the requirements specified in 42 CFR § 438.8 for the MLR reporting year for purposes of reporting to the State so that the State may report to CMS. This will be referred to as the Reported MLR. The expenses reported should capture any costs associated with community health workers (CHWs) employed by CONTRACTOR(S). The MLR should include expenses for State-directed payments (SDPs) in the numerator, and revenue received for SDPs in the denominator, in accordance with CMS reporting guidelines. The MLR should exclude any expenses and revenue related to the STEPS program OneCare Kansas health home program, and any non-risk payments.

n. The CONTRACTOR(S) shall submit the MLR report within eight (8) months of the close of the MLR reporting year.

o. The CONTRACTOR(S) shall pay a remittance to the State if the difference of the Pricing MLR from the capitation rates, outlined below and consistent with 42 CFR § 438.8, minus the Reported MLR for the MLR reporting year, is equal to or greater than 3%. The Pricing MLR will also account for any profit, risk contingency, and/or underwriting gain included prospectively within the capitation rates. The details of the terms of the remittance are outlined below:

p. Pricing MLR

a. Pricing Numerator

i. The Pricing Numerator will be the CONTRACTOR(S)-specific projected medical portion of the capitation rates, as well as Care Coordination and community health workers, after risk and region adjustments for the KanCare program for each twelve (12) month contract period, net of Member patient liability for nursing facility and share of cost for HCBS, on an aggregate PMPM basis. It will also include the projected amount for State-directed payments (SDPs), including those paid as separate payment terms. The projected PMPM will be a blend of the applicable portion of the capitation rates in effect from January to December each year, considering any changes to the capitation rates during that time. If multiple sets of rates are effective during that time, a blended PMPM will be calculated using actual plan-specific membership during each period for the blend. This includes all Rate Cells and delivery case rate, and the aggregate PMPM will be calculated based on the CONTRACTOR(S)' specific mix of membership and case rate volume.

ii. The amount of Member patient liability for NF and share of cost for HCBS will be removed based on the projected amount that was included prospectively in the capitation rates. This will be the same amount for both the Numerator and Denominator.

iii. The Pricing Numerator includes all components required and allowable under CFR § 438.8.

b. Pricing Denominator

i. The Pricing Denominator will be the CONTRACTOR(S)-specific projected capitation rates and case rates after risk and region adjustments for the KanCare program for each twelve (12) month contract period, net of Member patient liability for NF and share of cost for HCBS, on an aggregate PMPM basis. It will also include the projected amount for State-directed payments (SDPs), including those paid as separate payment terms. The projected PMPM will be a blend of the rates in effect from January to December each year, considering any changes to the capitation rates during that time. If multiple sets of rates are effective during that time, a blended PMPM will be calculated using actual plan-specific membership during each period for the blend. This includes all Rate Cells and delivery case rate, and the aggregate PMPM will be calculated based on the CONTRACTOR(S)' specific mix of membership and case rate volume.

ii. The amount of Member patient liability for NF and share of cost for HCBS will be removed based on the projected amount that was included prospectively in the capitation rates. This will be the same amount for both the Numerator and Denominator.

iii. The Pricing Denominator includes all components required and allowable under 42 CFR § 438.8.

c. Formula

i. The Pricing MLR will be calculated as the Pricing Numerator PMPM divided by the Pricing Denominator PMPM. The result will be used for the remittance calculation, outlined below in Section 2.13.2.L.5.

d. Remittance calculation

a. The remittance will be calculated as follows:

i. The Pricing MLR will be calculated as noted above.

ii. The Reported MLR will be collected from the CONTRACTOR(S) per the requirements of 42 CFR § 438.8.

iii. The difference of the Pricing MLR minus the Reported MLR will be calculated, referred to as “Difference”.

iv. If the Difference is equal to or greater than 3%, the CONTRACTOR(s) will owe a remittance to the State as follows:

1. The numerator PMPM from the Reported MLR will be divided by the Pricing MLR, referred to as the Minimum Pricing PMPM.

2. The difference between the Pricing Denominator PMPM and the Minimum Pricing PMPM will be applied to total membership for each month of the contract period used to calculate the Pricing MLR, resulting in calculation of a total annual remittance amount due for the twelve (12) month contract period.

3. The resulting dollar amount will be the remittance owed by CONTRACTOR(S) to the State, and will be considered as a revenue adjustment for purposes of recalculating the MLR.

b. Remittance timing

a. A final reconciliation calculation will be performed after eight (8) months of Claims runout following the MLR period.

b. The remittance is due to the State within thirty (30) Calendar Days of notification from the State that a remittance is owed. The requirement to pay the remittance survives the termination of this CONTRACT.

c. The parties agree that in the event of a dispute concerning the Target Pricing MLR, Reported MLR, or remittance calculation, the parties will engage in good faith discussions and negotiations to resolve such dispute within twelve (12) months of the CONTRACTOR(S)’ receipt of the final reconciliation calculation as determined by KDHE’s actuaries. If no resolution can be reached within that twelve (12) month period, the KDHE Medicaid Director and the CONTRACTOR(S) will each submit written arguments on the matter to the KDHE Secretary for a final decision, which shall be issued in writing and served on the CONTRACTOR(S) within sixty (60) Calendar Days or as soon thereafter as practicable. Any such final decision by the Secretary is final agency action and shall be subject to judicial review in accordance with the provisions of K.S.A. 77-601 et seq.

M. Community reinvestment requirements

1. The CONTRACTOR(S) must demonstrate a commitment to improving health outcomes in local communities in which it operates through community reinvestment activities.

d. The CONTRACTOR(S) must contribute 3% of its annual after-tax profit to community reinvestment. The State may require the CONTRACTOR(S) to increase the percentage of community reinvestment contributions in future years of the CONTRACT.

e. The CONTRACTOR(S) must work with the State and community stakeholders to identify community reinvestment priority areas and activities. The CONTRACTOR(S) is encouraged to

work with other KanCare MCOs to maximize the collective impact of community reinvestment activities.

f. The CONTRACTOR(S) must not use community reinvestment funding to pay for Covered Services, value-added benefits, or CONTRACTOR(S)' administrative expenses.

g. The CONTRACTOR(S) must submit an annual community reinvestment plan to the State for written approval. The community reinvestment plan shall detail the CONTRACTOR(S)' community reinvestment priority areas and activities. Following the CONTRACTOR(S)' initial submission, each subsequent community reinvestment plan shall describe and quantify the impact of the prior year's community reinvestment plan.

N. Coverage of high-cost rare disease drugs

1. KDHE-DHCF will pay for some high-cost, rare disease physician-administered drugs and handling fees outside of capitation rates, as a non-risk payment. See Appendix C (Services).

O. Pay for Performance

1. The State will implement a 3% quality improvement withhold that the CONTRACTOR(S) can earn back based on its performance on the quality improvement targets in the State's QMS.

2. The State will implement a HCBS P4P withhold that the CONTRACTOR(S) can earn back based on its performance on filling personal care service (PCS) and specialized medical care (SMC) included on Members' PCSPs. The withhold amount (percentage at risk) will be determined by the State in its sole discretion. The State anticipates that this withhold will be up to 1% of total Capitation Payments. For year one (1) of this CONTRACT, the CONTRACTOR(S) will be able to earn back the withhold by submitting required reports to the State. For each subsequent year, the State will establish a withhold for PCS and a withhold for SMC. The CONTRACTOR(S) will be required to meet metrics for each withhold to earn back the applicable withhold. In the first year and subsequent years, the State will require the CONTRACTOR(S) to substantiate reductions in expected authorized hours and/or utilization. The CONTRACTOR(S) shall not reduce authorized hours for the purpose of meeting the HCBS P4P metrics.

2.14 Claims Management

2.14.1 Timely Claims Processing

A. The CONTRACTOR(S) must pay all Claims timely and accurately. The CONTRACTOR(S) is responsible for submitting information about services rendered and reimbursed in the HIPAA-required formats specified in the 837 Institutional Claim and Encounter Transactions, the 837 Professional Services Claim and Encounter Transactions companion guides, the 837 Dental Services Claim and Encounter Transactions, and National Council for Prescription Drug Programs (NCPDP) standards, all of which can be found under Publications, HIPAA Companion Guides, at this website: https://www.kmap-state-ks.us/.

B. The CONTRACTOR(S) shall implement the Claims processing requirements set out in Appendix I (KanCare Claims Processing Requirements).

C. A Claim is defined below:

1. Claim means (i) a bill for services, (ii) a line item of service, or (ii) all services for one Member within a bill.

h. Clean Claim means one that can be processed without obtaining additional information from the Provider of the service or from a third party. It does not include a Claim from a Provider who is under investigation for Fraud or Abuse, or a Claim under review for Medical Necessity.

D. The CONTRACTOR(S) shall meet the following payment requirements:

1. 100% of all Clean Claims including adjustments must be processed and paid or processed and denied within thirty (30) Calendar Days of receipt.

i. 99% of all non-clean Claims including adjustments must be processed and paid or processed and denied within sixty (60) Calendar Days of receipt.

j. 100% of all Claims including adjustments must be processed and paid or processed and denied within ninety (90) Calendar Days of receipt.

E. The CONTRACTOR(S) shall abide by the following specifications:

1. The date of receipt is the date the CONTRACTOR(S) receives the Claim, as indicated by its date stamp on the Claim.

k. The CONTRACTOR(S) and each Subcontractor shall upon receipt identify each Claim and its attachments, adjustment, and financial transaction with a unique internal control number (ICN). The CONTRACTOR(S) shall submit to the State a description of its ICN structure including ICN descriptions for each of its Subcontractors and resubmit such description(s) whenever there is a change.

l. Note: The ICN is alphanumeric, has a maximum field length of sixteen (16) bytes and includes at a minimum the date of Claim receipt. Additional identifiers could include the batch number, sequence of Claim within the batch, and an indicator of the type of Claim submission.

m. If the ICN does not contain the date of receipt, the CONTRACTOR(S) or Subcontractor must have other methods of obtaining the date of receipt information. Documentation explaining this must be submitted to the State for written approval. The CONTRACTOR(S) must provide the date of receipt on all Claims inquires. The CONTRACTOR(S) shall update appropriate business practice manuals with this information and submit the manuals to the State for written approval.

n. The date of payment is the date on the check or other form of payment.

F. The CONTRACTOR(S) shall provide technical assistance to Providers for Claims submission.

G. The CONTRACTOR(S) must track and report separately the number of submitted, paid, and denied Claims, and adjustments each month.

H. Nursing Facilities

1. For Nursing Facilities (NFs), the CONTRACTOR(S) shall:

a. Edit Claims and Claims systems based on patient liability deductions.

b. When, and as directed by KDHE-DHCF/KDADS, process recovery and recoupment of Claims for quality care assessment delinquencies, and provide the amount recovered to KDHE-DHCF/KDADS.

c. Pay 90% of Clean Claims within fourteen (14) Calendar Days and 99.5% of Clean Claims within twenty-one (21) Calendar Days. The CONTRACTOR(S) will also provide technical assistance to NF Providers for Claims submission.

d. Exception: The CONTRACTOR(S) and its Providers may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Provider agreement.

I. Reports: The CONTRACTOR(S) shall report on Claims payments.

J. The CONTRACTOR(S) shall collaborate with other KanCare MCOs to provide consistent practices, such as online billing, for Claims submission to simplify Claims submission and ease administrative burdens for Providers in working with multiple KanCare MCOs.

1. The CONTRACTOR(S) shall automatically reprocess Claims when a CONTRACTOR(S)' system issue has resulted in an incorrect processing of the Claim. In those instances, the CONTRACTOR(S) shall not require Providers to resubmit Claims or file Appeals; and these Claims will be exempted for timely filing purposes and reported as such by CONTRACTOR(S).

e. The CONTRACTOR(S) shall adopt and implement standardized timely filing requirements, applying a one hundred eighty (180) Calendar Day filing limit for all Claims for all services, and a three hundred sixty-five (365) Calendar Day limit for any correction or rebilling of a timely filed Claim, unless the Provider agrees through their Provider agreement to an alternate timely filing timeframe.

f. The CONTRACTOR(S) shall process Provider Claim adjustments and corrected billings the same as other Claims received.

g. The CONTRACTOR(S) shall be responsible for routing all electronic data interchange (EDI) and paper Claims received by the CONTRACTOR(S) to its Subcontractors as appropriate and ensuring that Claims are tracked appropriately for timely Claims processing.

K. The CONTRACTOR(S) shall, when directed by KDHE-DHCF, recover established Overpayments made to a Provider by the State for performance or non-performance of activities not governed by this CONTRACT. When funds are recovered, the CONTRACTOR(S) shall promptly notify KDHE-DHCF of any amount recovered and, as directed by KDHE-DHCF, the CONTRACTOR(S) must immediately provide the amount recovered to KDHE-DHCF, or KDHE-DHCF will withhold the amount recovered from a payment otherwise owed to the CONTRACTOR(S). In the event the Overpayment is not recoverable, the CONTRACTOR(S) shall promptly notify KDHE-DHCF and provide an explanation as to the reason the Overpayment is not collectable.

L. KDHE and any agent, including the State's Fiscal Agent or other contractors not a KanCare MCO, may discover and identify an Overpayment to be recovered from a KanCare Provider for an Overpayment made by the CONTRACTOR(S) (KanCare MCO), and recovery will be the property of the State. The CONTRACTOR(S) is not entitled to any recovery under this section when KDHE and any agent, including the State's Fiscal Agent or other contractors not a KanCare MCO, identifies and pursues Overpayments, false Claims, or fraudulent Claims paid by the CONTRACTOR(S) to a Provider.

M. Pursuant to requirements in Appendix C (Services), the CONTRACTOR(S) must provide all Claims information to the State on drugs dispensed or administered to Members, within forty-five (45) Calendar Days after the end of each quarterly rebate period.

2.14.2 Post-Pay Recovery, Third-Party Liability, and Coordination of Benefits

A. Post-pay recovery and third-party liability: Third-party liability (TPL) refers to any individual, entity, or program that may be liable for all or part of a Member's health coverage. Under Section 1902(a)(25) of the SSA, the State is required to take all reasonable measures to identify legally liable Third-Parties and treat verified TPL as a resource of the Medicaid Member. The CONTRACTOR(S) shall also follow all Federal regulations and all State statutes and regulations for TPL and medical Subrogation. The CONTRACTOR(S) shall have procedures in place to collect TPL funds when primary coverage is identified after payment has been made.

B. The CONTRACTOR(S) must identify and pursue TPL for its Members. The CONTRACTOR(S) must identify and coordinate with all Third Parties against whom Members may have a claim for payment or reimbursement for Health Care Services. These Third Parties may include Medicare; any other group insurance, trustee, union, welfare, or employer organization; employee benefit organization including preferred Provider organizations or similar type organizations; any coverage under governmental programs; and any coverage required to be provided for by State law. The CONTRACTOR(S) shall have processes to identify Members newly eligible for Medicare or other payers and to recover Provider payments, as applicable, for services rendered for any period in which the Member was later found to have Medicare and/or other coverage. The CONTRACTOR(S) shall have processes to coordinate among departments to educate Members regarding Medicare eligibility and/or have the ability to refer the Member to appropriate Medicare resources or experts.

C. Coordination of Benefits:

1. Medicaid is secondary to all other Third Parties with the exception of Special Health Services, Vocational Rehabilitation, Indian Health Services, and Crime Victim's Compensation Funds. As Capitated Payments made to the CONTRACTOR(S) are from Medicaid funds, the CONTRACTOR(S) are secondary payers to all other Third Parties not listed above.

h. The State has adjusted the CONTRACTOR(S)' Capitation Payment equal to the State's TPL recoveries for Members. In lieu of this offset to Capitation Payments, CONTRACTOR(S) will retain its TPL recoveries.

i. The CONTRACTOR(S) shall perform data matches with Medicare and with private health insurance companies to ensure that it maintains a full and accurate list of primary insurance. The CONTRACTOR(S) shall also participate in the Defense Enrollment Eligibility Reporting System (DEERS) data match and the Public Assistance Reporting Information System (PARIS) data match.

j. The CONTRACTOR(S) must track its TPL cost avoidance and recovery for all Members and report this recovery amount to the State according to the format and schedule specified by the State in the payment integrity report.

k. Data transfer of TPL information on any Member shall occur according to the format and schedule specified by the State.

l. The State shall transfer to the CONTRACTOR(S) any new TPL information for any Member that comes to the State's attention, and the CONTRACTOR(S) and any Subcontractor(s) shall upload the State-supplied TPL information on a timely basis.

m. The CONTRACTOR(S) will coordinate with the State to comply with any information requests regarding child support birth expenses within ten (10) Business Days

n. Claims for preventive pediatric care, including EPSDT, shall be paid at the time presented for payment by the Provider and CONTRACTOR(S) shall bill the responsible Third Party.

o. The CONTRACTOR(S) will make available to Providers, through their website, all TPL information on file for Members.

p. The CONTRACTOR(S) will follow TPL and Medicare pricing rules as established by Kansas Medicaid policy.

q. The CONTRACTOR(S) shall transfer to the State, in the form, frequency, and manner prescribed by the State, valid and verified new TPL lead information for all Members.

D. The CONTRACTOR(S) will participate in the Coordination of Benefits Agreement (COBA) Medicare crossover process. The CONTRACTOR(S) will accept and process Medicare crossover Claims for all assigned Members and maintain HIPAA compliance and follow State COBA policy and process.

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

2.14.3 Encounter Data and Other Data Requirements

A. The CONTRACTOR(S) shall collect service information in standardized formats approved by the State in writing and must make all collected data available to the State after it is tested for accuracy, completeness, logic, and consistency in accordance with 42 CFR § 438.242. The CONTRACTOR(S) shall ensure its Subcontractors' Encounter Data is built according to State specifications and accurately reflects actual Claims adjudication prior to data for submission to the State including accurately identifying the Provider who delivers any services.

B. The CONTRACTOR(S) shall certify data including, but not limited to, all documents specified by the State, Enrollment information, Encounter Data, and other information contained in this CONTRACT and the CONTRACTOR(S) proposal. The certification must attest, based on best knowledge, information and belief as to the accuracy, completeness, and truthfulness of the documents and data. The CONTRACTOR(S) must submit the certification concurrently with the certified data and documentation. Data must be certified by one of the following:

1. The CONTRACTOR(S)' CEO.

r. The CONTRACTOR(S)' CFO.

s. An individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR(S)' CEO or CFO.

C. The CONTRACTOR(S) shall comply with the requirements in Appendix J (Encounter Data Requirements).

2.15 Information Systems

2.15.1 Health Information Technology and Health Information Exchange

A. HIT and HIE are two of the cornerstones of efforts in Kansas to improve the coordination and delivery of Health Care Services. They are also central to Federal efforts to improve the quality and effectiveness of Health Care Services.

1. HIT refers to electronic systems that make it possible for health care Providers to better manage patient care through secure use and sharing of health information. HIT includes the use of Electronic Health Records (EHRs) instead of paper medical records to maintain people's health information.

t. HIE refers to the electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.

B. KDHE-DHCF's vision and strategy for implementing HIT initiatives is to pursue initiatives that encourage the adoption of certified EHR technology, promote health care quality, and advance HIE capacity in Kansas. KDHE-DHCF's mission for HIT in Kansas is to:

1. Transform health care in Kansas through the deployment, coordination, and use of HIT and HIE.

C. Currently, there are four (4) State-certified health information organizations (HIOs) providing technology services in Kansas:

1. The Kansas Health Information Network (KHIN) is a nonprofit organization operated by Konza, Inc. that serves the majority of Kansas Providers.

u. The Lewis and Clark Health Information Exchange (LACIE) is a nonprofit organization in partnership with Tiger Institute serving hospitals and Providers in northeast Kansas and northwest Missouri.

v. Velatura is a nonprofit organization operating in Missouri, as well as other states, and providing information on Members that receive care on the Kansas/Missouri border.

w. CyncHealth is a nonprofit organization operating in Nebraska and Iowa and providing information on Members that receive care on the Kansas/Nebraska border.

D. HIT/HIE requirements for the CONTRACTOR(S): The CONTRACTOR(S) shall submit a plan to the State that details how it will use HIT and HIE to improve coordination and integration of care, promote prevention and Wellness, and improve quality through appropriate sharing of clinical and administrative data among Providers and to the State. This plan, at a minimum, will:

1. Demonstrate how the CONTRACTOR(S) will accept and utilize data from certified EHR technology.

x. Demonstrate how the CONTRACTOR(S) will promote the use (as defined) of EHRs among its Participating Providers.

y. Demonstrate how the CONTRACTOR(S) will utilize HIE and EHR Data for reporting where appropriate.

E. As directed by the State, the CONTRACTOR(S) shall submit a plan to the State that details how it will use HIT to improve coordination and integration of care, promote prevention and Wellness, interoperability, and improve quality through appropriate sharing of clinical and administrative data among Providers and to the State. This plan, at a minimum, must:

1. Specify how the CONTRACTOR(S) will work within the framework outlined by KDHE-DHCF to facilitate electronic exchange of health information between Providers and the CONTRACTOR(S), and between the CONTRACTOR(S) and the State using standard based protocols.

z. Demonstrate how the CONTRACTOR(S) will work with Providers to assist in their acquisition and use of certified EHR technology in accordance with the Kansas State Medicaid HIT plan (SMHP).

aa. Demonstrate how the CONTRACTOR(S) will accept and use data from certified EHR technology.

bb. Demonstrate how the CONTRACTOR(S) will assist Providers in developing registries of Members with Chronic Conditions to help improve Care Management/Care Coordination.

cc. Demonstrate how the CONTRACTOR(S) will use its HIT system to provide information on areas including, but not limited to, utilization, Grievances and Appeals, and Disenrollment for any reason other than a loss of Medicaid eligibility.

dd. Demonstrate how the CONTRACTOR(S) will collect data on Member and Provider characteristics, as specified by the State and on services furnished to Members through an Encounter Data system and other methods as may be specified by the State.

F. The CONTRACTOR(S) shall work with the State and other relevant CONTRACTOR(S) to develop a joint plan to move HIT and EHR forward in Kansas.

G. The CONTRACTOR(S) shall comply with the requirements in Section 2.7 of Appendix C (Services), regarding pharmaceuticals.

H. The CONTRACTORS(S) shall operate and maintain a fully functional Prior Authorization (PA) system to support both automated and manual PA determinations and responses, at minimum, capable of:

1. Gathering and applying appropriate decision criteria needed to make an automated authorization decision.

ee. Receiving and sending PA requests electronically in HIPAA-compliant transaction formats.

ff. Providing a detailed reporting package.

gg. Generating and distributing PA denial letters to Members and applicable Providers.

hh. Communicating the decision clearly and quickly to the Provider as per State policy.

ii. Updating internal records in adjudication/Claims systems and call tracking systems in conjunction with Claims adjudication.

I. The CONTRACTOR(S) shall provide the Provider community with the ability to automate the PA process through a HIPAA-compliant, web-based Provider portal (see Section 2.6.3) which shall, at minimum, be capable of:

1. Minimizing the burden on the Provider community while driving appropriate utilization.

jj. Supplying access to EHRs to health care Providers via a secure login process.

kk. Electronically and securely submit Pharmacy and non-Pharmacy PA requests for automated and manual review by examining up to twenty-four (24) months of administrative data; for example, Member-specific Pharmacy, medical, and Encounter Claims and applying evidence-based guidelines to determine prescribing appropriateness (administrative data includes, but is not

limited to, Pharmacy, hospitalizations, length of stay, ED utilization, eligibility, paid/denied Claims, Provider, etc.).

ll. Providing authorized users with access to:

a. Member profile information;

b. Member prescriber information;

c. Member PA history;

d. PA questions;

e. Automated PA/authorization criteria check;

f. Authorization approval and denial outcomes;

g. Ability to attach applicable medical record data to PA submissions; and

h. Ability to request reconsideration of denial outcomes electronically.

J. The State will provide an Electronic Visit Verification (EVV) application that will be available to the CONTRACTOR(S), Providers, and caregivers at no charge. The State has selected a Providers' choice model whereby Providers have the option to use third-party EVV applications, once the application is authorized by the State. The CONTRACTOR(s) shall have the following responsibilities for all Claims for services requiring EVV:

1. EVV is required for HCBS, Personal Care Services (PCS), and Home Health Care Services (HHCS) Claim submissions. The CONTRACTOR(S) shall not process Claims without an approved and validated EVV transaction. This includes:

a. All home health visits, including nursing, home health aide, and rehabilitative therapy services.

b. Services requiring an in-home visit, or an alternative to an in-home visit, or provision of a device as an alternative to an in-home visit.

c. The CONTRACTOR(S) shall ensure on at least a daily basis that all submitted Claims are subjected to review/edit and responses are given in standard HIPAA transaction formats with a process to manage corrections and any necessary resubmissions. Copies of 835 transactions for EVV services shall be provided in a weekly upload.

d. The CONTRACTOR(S) shall transmit authorization for services requiring EVV to the State's EVV vendor, including the Member identification number, service codes, units, start and end date, and specified Provider after the development of the PCPS/Plan of Service/care plans (hereinafter plans of care).

e. The CONTRACTOR(S) shall update the authorization in the event an update plan of care requires a change. If an authorization no longer applies, the CONTRACTOR(S) must cancel the authorization by submitting a new end date.

f. The CONTRACTOR(S) shall issue a new authorization in the event the Provider rejects an authorization.

g. The CONTRACTOR(S) shall be able to receive and take action on email and/or text alerts triggered by critical observations entered by the caregiver during a visit.

h. The CONTRACTOR(S) shall monitor and use information from the EVV system to verify that services are provided as specified in the PCSP and Plan of Service, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized Provider/worker so that the Member or Member's care coordinator may immediately address service gaps, including late and missed visits. The CONTRACTOR(S) shall monitor Covered Services anytime a Member is receiving services, including after the CONTRACTOR(S)' regular business hours.

i. The CONTRACTOR(S) shall ensure continuity of care for Members transitioning between KanCare MCOs by ensuring authorizations for current services are submitted to the EVV vendor and cover but do not exceed the ninety (90) Calendar Day transition period and that a new authorization is submitted to the EVV vendor within five (5) Business Days before the scheduled service start date.

j. The CONTRACTOR(S) must use EVV-provided data to identify and address any service gaps or suspected Fraud, waste, or Abuse, including any incidents noted by the caregiver during the visit. The CONTRACTOR(S) must demonstrate to KDHE how the analysis will be performed and the results reported for action.

k. The CONTRACTOR(S) shall comply with the State's EVV policy and 21st Century Cures Act requirements for HCBS, PCS, and HHCS visits.

2.15.2 Use of and Safeguarding Data

In addition to the provisions of Appendix J (Encounter Data Requirements), and Appendix M (Other Systems Data Processing and Reporting Requirements), the CONTRACTOR(S) must comply with the following:

A. The CONTRACTOR(S) must meet all Federal requirements identified under HIPAA and the Health Information Technology for Economic and Clinical Health (HITECH) Act. The CONTRACTOR(S) shall ensure all Subcontractors that have access to PHI comply with HIPAA and HITECH requirements.

B. Data files: Data files and data contained therein shall be and remain the property of the State and shall be returned to the State by CONTRACTOR(S) upon the termination of this CONTRACT. State data shall not be utilized by CONTRACTOR(S) for any purpose other than that of rendering services to the State under this CONTRACT, nor shall State data or any part thereof be disclosed, sold, assigned, leased, or otherwise disposed of to third parties by CONTRACTOR(S) unless there has been prior written State approval. The State shall have the right of access and use of any data files retained or created by CONTRACTOR(S) for systems operation under this CONTRACT.

C. Safeguarding data: The CONTRACTOR(S) shall establish and maintain at all times reasonable safeguards against the destruction, loss, or alteration of the program data and any other data in the possession of the CONTRACTOR(S) necessary to the performance of operations under this CONTRACT.

D. Confidentiality of data and records:

1. The CONTRACTOR(S) shall comply with 45 CFR § 205.50, and 42 CFR Part 2, Safeguarding Information for the Financial Assistance and Social Service Program, 42 CFR Part 431 Subpart F, as well as 41 U.S.C. § 423. The CONTRACTOR(S) must comply with any other applicable Federal and State laws (e.g., Title VI of the Civil Rights Act of 1964) and other laws regarding privacy and confidentiality. As deemed necessary, the State or its designated agent, and the Federal government shall be allowed access to this data. All information, except as noted above, as to personal facts and circumstances obtained by the CONTRACTOR(S) shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the State and the written consent of the Member, or their attorney, or their responsible parent or guardian.

l. Data and information received by the CONTRACTOR(S) and maintained in the CONTRACTOR(S)' database shall be used only for health policy decisions and research. Persons or agencies making requests for data or information from the CONTRACTOR(S)' database shall be directed to the State.

m. Appropriate administrative, technical, procedural, and physical safeguards shall be established by CONTRACTOR(S) to protect the confidentiality of the data and to prevent unauthorized access to it. The State reserves the right to approve or disapprove of CONTRACTOR(S)' security procedures. Any approval or disapproval shall be in writing.

n. Security of facilities: The CONTRACTOR(S) shall provide all reasonable security procedures at any place where services are performed by CONTRACTOR(S) under this CONTRACT. The CONTRACTOR(S)' personnel shall comply with the rules of the State with respect to access to State offices, data files and data.

o. Rights in data and disclosure of information:

    a. The State operates under the Open Records Act. The State may duplicate, use, or disclose in any manner and for any purpose whatsoever all data, reports, and documentation delivered to the State under this CONTRACT. This obligation is not subject to any limitation in any respect except as provided under State or Federal laws. The CONTRACTOR(S) hereby grants to the State, a royalty-free, non-exclusive, and irrevocable license to publish, reproduce, deliver, and to authorize others to do so, all such data, reports, and documentation.

    b. It is recognized by the parties that certain information or financial data pertaining to the CONTRACTOR(S) may be exempted from public disclosure under both State and Federal law. Such data, which the CONTRACTOR(S) does not want disclosed, will be prominently identified by the CONTRACTOR(S).

    c. If the State receives a request for disclosure of such information which the CONTRACTOR(S) has marked as proprietary, the State, as an accommodation to the CONTRACTOR(S), before releasing the same will give the CONTRACTOR(S) notice orally or in writing at least forty-eight (48) hours before the release, in order that the CONTRACTOR(S) may immediately seek any relief available to it under State or Federal law. Failure to give timely notice shall not be a basis for a cause of action against the State, their employees, agents, and representatives.

d. Notification and discussion of potential system changes:

a. The CONTRACTOR(S) shall notify the State of the following changes to systems within its span of control at least ninety (90) Calendar Days before the projected date of the change. If so directed by the State, the CONTRACTOR(S) shall discuss the proposed change with the applicable State staff and submit testing and implementation plans, where applicable. This includes:

   i. Software release updates of core transaction systems: Claims processing, eligibility and Enrollment processing, service authorization management, Provider enrollment and data management.

   ii. Conversions of core transaction management systems.

   iii. New system implementations.

   iv. Infrastructure upgrade.

2.16 Reporting and Data Collection

The State has a data centric system that collects, integrates, and analyzes data from a variety of sources, including data feeds (as specified in the KanCare Guide or Appendix M) and required self-reporting (see Appendix H for an initial list of reports). This approach enables the State to project risk, enhance Care Coordination, mitigate service gaps, and promote quality, access, and efficiencies. During the course of this CONTRACT, the State may add or delete reports and may require the CONTRACTOR(S) to submit additional data, including to the State's data warehouse.

A. The CONTRACTOR(S) shall provide data and reports, including data and reports from Subcontractors, in a format and frequency determined by the State (see the KanCare Guide and Appendix M for data requirements and Appendix H for an initial list of reports) and also perform ad hoc analysis and reporting as requested and within prescribed timeframes established by the State.

B. When ad-hoc data and/or reporting requests are made by the State, the CONTRACTOR(S) shall affirm in writing its understanding of the request, the State-prescribed methodology to be used, and the required timelines for submission.

C. The CONTRACTOR(S) shall be responsible for ensuring that data elements contained within its system(s) map appropriately to the State-defined data elements for inclusion in the State's data warehouse. During the course of this CONTRACT, the State may add or delete reports and may require the CONTRACTOR(S) to submit data to the State's data warehouse.

D. The CONTRACTOR(S) shall provide the State a description of their technical expertise for the team that supports data and reporting by describing their staffing model in this area, along with information about staffing capabilities, including job titles and brief job descriptions.

E. The CONTRACTOR(S) must provide oversight and quality assurance of its Subcontractor(s)' systems to ensure all required data complies with State requirements. The CONTRACTOR(S) remains solely responsible for meeting all reporting and data requirements set forth by the State. Issues discovered by the State will be communicated to the CONTRACTOR(S) for resolution; the State will not interact with Subcontractors to resolve any issues, answer questions, or provide technical assistance; this is the responsibility of the CONTRACTOR(S). Ad-hoc queries issued by the State must be addressed by the CONTRACTOR(S) in the timeframes specified by the State and must include Subcontractor data where appropriate.

F. The CONTRACTOR(S) shall provide the State flowchart(s) depicting how data enters their system(s), how it interacts and relates to other internal systems, and how data is generated from the system(s) and exchanged with external trading partners. This includes interactions CONTRACTOR(S) has with any Subcontractors that provide EDI functions.

G. The CONTRACTOR(S) shall demonstrate that quality control checkpoints are in place by submitting to the State quality control procedures and processes that include tracking, trending, reporting, process improvement, and monitoring of data submissions to include revisions and methodology to eliminate duplicate data. Submitted documentation must show that coding of data is consistent throughout all records and data sources. The CONTRACTOR(S) must provide:

   1. Description of change control processes for implementing change in data content and structure including feedback mechanisms to improve data accuracy, timeliness, and completeness.

   b. Documentation describing the tools and methodologies used to determine compliance with data submissions.

   c. A flow chart and narrative description of data flows between internal systems and external organizations.

   d. Documentation of employment of a technical staff with expertise to support all data and reporting functionality.

H. The CONTRACTOR(S) must participate in all data validation activities required by the State. The CONTRACTOR(S)' data submissions, including data provided by Subcontractors, must meet adequacy requirements per State guidelines. Data must be validated for accuracy and completeness prior to submission. Report templates, along with process requirements for the submission of data and reports, will be detailed in the contracting process. On an ongoing basis, the State may require responses from the CONTRACTOR(S) regarding their data submissions, including resolution to questions and change requests that arise regarding data content, completeness, and reporting.

I. The CONTRACTOR(S) shall receive amended standards with advance notice and make any changes or corrections to any systems, processes, or data transmission formats as needed to comply with data quality standards. The CONTRACTOR(S) shall be held responsible for errors or non-compliance resulting from its own actions or the actions of an agent authorized to act on its behalf.

J. The CONTRACTOR(S) shall comply with the following:

   1. Have an effective process to ensure accurate, timely, and complete data and reporting submissions.

   e. Have effective procedures for quality control, coding consistency, and consistency across data sources.

   f. Have effective mechanisms for tracking, trending, monitoring data submissions, and revisions.

   g. Have an effective process for implementing timely corrective actions.

   h. Have effective tools and methodologies to determine compliance.

2.16.1 Data, Reports and Audits

A. The State's procedures for monitoring and oversight of the CONTRACTOR(S)' compliance with the CONTRACT include an annual CONTRACT review, additional audits, and review of reports and data.

B. The State will periodically, but no less frequently than once every three (3) years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the Encounter and financial data submitted by, or on behalf of, the CONTRACTOR(S) in accordance with Federal regulations. The CONTRACTOR(S) must submit information and documents in accordance with a reasonable timeframe as determined by the State.

C. General reporting procedures: The CONTRACTOR(S) shall comply with all the reporting requirements established by the State and listed in the KanCare Guide, Appendix M, or the KanCare reporting system (Appendix H includes an initial list of reports that will be included in the KanCare reporting system). The CONTRACTOR(S) shall be informed by the State of any report additions or changes to existing reports when these additions or changes are made. The State may modify reports, specifications, templates, or timetables as necessary during the CONTRACT. The CONTRACTOR(S)' changes to the format must be approved by the State in writing prior to implementation and must not disrupt the continuity or comparability of the data reported. The CONTRACTOR(S) must maintain a health information system that collects, analyzes, integrates, and reports data. The CONTRACTOR(S) shall provide data and create reports using the formats, including electronic formats, instructions, and timetables as specified by the State, at no cost to the State. All reports must be stratified as directed by the State. All reports must be accurate and auditable. Report output must be clear and easily understandable to the end user. The CONTRACTOR(S) shall, upon request of the State, generate any additional data or reports at no additional cost to the State, within a time period prescribed by the State.

D. The CONTRACTOR(S) must take the following steps to ensure that data received from Participating Providers is accurate and complete: Verify the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency; and collect utilization data in standardized formats as requested by the State.

E. As part of its QAPI program, the CONTRACTOR(S) shall review all reports submitted to the State to identify instances and/or patterns of non-compliance, determine and analyze the reasons for non-compliance, identify and implement actions to correct instances of non-compliance and to address patterns of non-compliance, and identify and implement quality improvement activities to improve performance and ensure compliance going forward.

F. The CONTRACTOR(S) shall transmit and receive all transactions and code sets in the appropriate standard formats as specified under HIPAA. The CONTRACTOR(S) shall submit all reports electronically and in a manner and format prescribed by the State. Standards applied for determining adequacy of required reporting are as follows:

    1. Timeliness: Reports or other required data shall be received on or before scheduled due dates.

    i. Accuracy: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or State defined standards.

    j. Completeness: All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

k. Fees: The CONTRACTOR(S) is prohibited from charging additional fees for any data or report requested by the State.

G. Reporting requirements: The CONTRACTOR(S) shall provide reports to the State in the frequency specified by the State, following the format(s) developed by the State or approved by the State in writing. Initial reporting formats must be developed and approved prior to the implementation of this CONTRACT. Ongoing and additional reporting issues and formats are subject to development and revision as necessary across the time span of this CONTRACT, and each such report must be consistent with the criteria described above and presented to/approved by the State in writing prior to use. The CONTRACTOR(S) agrees to furnish information, as required, from its records to the State and the State's authorized agents and to provide an assessment of identified deficiencies, including but not limited to, the following:

1. Additional data and reports: Upon request by the State, the CONTRACTOR(S) shall submit additional data or reports, including Behavioral Health and LTSS data and reports.

l. Ad Hoc reports: Upon request, the CONTRACTOR(S) shall provide ad hoc data and reports, including for LTSS and Behavioral Health data and reports, within the timeframes specified by the State.

H. General audit procedures: The CONTRACTOR(S), the CONTRACTOR(S)' parent company, and all Subcontractors that are affiliated and not affiliated with CONTRACTOR(S), must provide the results of an annual audit performed by an independent certified public accountant and authorize the CONTRACTOR(S) to share this information with the State. The CONTRACTOR(S) shall authorize the independent accountant to allow representatives of the State, upon written request, to verify the audit report.

I. Throughout the duration of the CONTRACT, and for a period of ten (10) years after termination of the CONTRACT or from the date of completion of the audit, in accordance with 42 CFR § 438.3(h), the CONTRACTOR(S) and any Subcontractors shall provide duly authorized representatives of the State or Federal government, access to all records and material, including financial records, relating to the CONTRACTOR(S)' provision of and reimbursement for activities contemplated under the CONTRACT. Such access shall include the right to inspect, audit, and reproduce all such records and material and to verify reports furnished in compliance with the provisions of the CONTRACT.

J. The CONTRACTOR(S) shall allow duly authorized agents or representatives of the State and Federal government, during normal business hours, access to the CONTRACTOR(S)' premises or the CONTRACTOR(S)' Subcontractor's premises, and networks/data sources, to inspect, audit, monitor, or otherwise evaluate the performance of the CONTRACTOR(S)' or Subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit.

K. In the event right of access is requested under this section, the CONTRACTOR(S) or Subcontractor shall upon request provide and make available leadership and non-leadership staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort. In practice, the State notifies any entity audited well before the actual audit occurs. A pre-entrance conference is scheduled to inform the CONTRACTOR(S) about the process. Audits are generally scheduled at a mutually agreed upon time. However, there may be unusual circumstances which require that the State perform an audit with minimal notice. These circumstances would include alleged failure to comply with the CONTRACT.

L. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of CONTRACTOR(S)' or Subcontractor's activities. The CONTRACTOR(S) shall be given ten (10) Business Days, or an amount of time agreed upon by the State and the CONTRACTOR(S), to respond to any findings of an audit before the State shall finalize its findings in Federal reporting. All information so obtained will be accorded confidential treatment as provided under applicable law.

M. Adverse findings or findings of non-compliance relating to performance under this CONTRACT must be remediated by the CONTRACTOR(S) in a timeframe and manner that considers the nature of the deficiency and that limits the severity of the impact of the non-compliance.

1. The CONTRACTOR(S) shall develop and report the following information to the State related to the finding(s):

a. The source of the finding/how the finding was identified;

b. A summary of the finding;

c. The proposed corrective action plan (CAP) and associate timeframes to address the finding(s); and

d. The CONTRACTOR(S)' plan to monitor ongoing performance to ensure compliance.

e. Nothing in this requirement shall prohibit the State from imposing one (1) or more of the compliance remedies specified in Section 2.18, Compliance Remedies, when the State determines that the CONTRACTOR(S) has failed to comply with the requirements in this CONTRACT.

N. Identification of patients for purposes of calculating Disproportionate Share Hospital (DSH) payments: The CONTRACTOR(S) shall provide to the State information necessary to determine the hospital services provided under the CONTRACT (and the identity of hospitals providing such services) for purposes of calculating Disproportionate Share Hospital payments.

O. Record keeping requirements: The CONTRACTOR(S) must retain, at a minimum, all data, information, and documentation specified in 42 CFR § 438.3(u) and as directed by the State for a minimum of ten (10) years.

2.17 Staffing

2.17.1 Contractor(s) Staffing Requirements

A. The CONTRACTOR(S) shall have in place the organization, management, and administrative systems necessary to fulfill all contractual requirements of this CONTRACT. The CONTRACTOR(S) shall demonstrate to KDHE-DHCF's satisfaction that it has the necessary dedicated, non-delegable Kansas staffing, by function and qualifications, to fulfill its obligations under this CONTRACT.

B. The CONTRACTOR(S) is responsible for maintaining a level of staffing necessary to perform and carry out all of the functions, requirements, roles, and duties as contained herein, regardless of the level of staffing specified in this CONTRACT. The information provided in this section is not intended to define the overall staffing levels needed to meet CONTRACT requirements.

C. Upon State request, the CONTRACTOR(S) shall identify a staff person to be the State's designated contact for specific activities such as annual contract audits or PIPs.

D. Staffing plan: The CONTRACTOR(S) shall submit to the State for written approval a staffing plan for this CONTRACT. The staffing plan shall outline how the CONTRACTOR(S) will achieve consistent, dependable service regardless of changes that may directly influence work volume. The staffing plan shall also provide a description of the number, type, and functions or position descriptions, and qualifications of the CONTRACTOR(S)' staff, including any requirements as required in Section 2.17.2. In addition, the CONTRACTOR(S) shall:

1. Report Key Personnel departures to State staff no later than five (5) Business Days of learning of the intended departure, to the extent possible.

f. Report Key Personnel role changes to the State within five (5) Business Days of learning of the change, to the extent possible.

g. Notify the State at least thirty (30) Calendar Days in advance of any plans to change, hire, or reassign designated Key Personnel.

h. Develop a system and training program to ensure that knowledge is transferred from an employee leaving a position to a new employee to the extent possible.

i. Fill key positions on an interim basis within fifteen (15) Calendar Days of departure (notifying the State of the interim person and a summary of their qualifications), and on a permanent basis within ninety (90) Calendar Days of departure, unless a different timeframe is approved by the State in writing. The replacement be a qualified individual approved by the State in writing.

j. Always identify a minimum staffing level defined over time and maintain that defined minimum staffing level during designated business hours.

E. The CONTRACTOR(S)' must submit a back-up personnel plan to the State, including a discussion of the staffing contingency plan for:

1. The process for replacement of personnel in the event of the loss of Key Personnel or other personnel before or after signing a CONTRACT.

k. Allocation of additional resources to this CONTRACT in the event of inability to meet a performance standard.

l. Replacement of staff with key qualifications and experience and new staff with similar qualifications and experience.

m. The timeframes necessary for obtaining replacements.

n. Method of bringing replacements or additions up to date regarding this CONTRACT.

F. In keeping with Kansas values of a strong work ethic and the understanding that work builds self-esteem and provides financial security and that people with disabilities who are ready, willing, and able to work are healthier when they do, it is vitally important that people with disabilities are employed in integrated settings in the workplace. Therefore, the CONTRACTOR(S) shall hire people with disabilities and shall be able to demonstrate what percentage of its workforce helps it to meet this requirement. The CONTRACTOR(S) shall adopt hiring practices that establish a preference for considering employment opportunities for individuals with disabilities. The plan for hiring practices must be approved by the State in writing.

1. The CONTRACTOR(S) shall develop an individuals with disabilities hiring plan and adopt practices to ensure at least 5% of its Kansas based staff are comprised of individuals with disabilities by the end of the first year of operation.

o. Each subsequent CONTRACT year the CONTRACTOR(S) shall increase its hiring of individuals with disabilities by a minimum of 1% or until it has reached 10% of its total Kansas-based staff.

p. In accordance with K.S.A. 75-3317 through 75-3322, “The Kansas Use Law”, the CONTRACTOR(S) are encouraged to purchase goods and services from Kansas Use Law vendors, and doing so shall contribute to meeting the CONTRACTOR(S) goal for hiring individuals with disabilities, as required in Section 2.17.1.F (e.g., CONTRACTOR(S) is encouraged to utilize mail room service by a qualified Kansas State Use vendor).

q. Within sixty (60) Calendar Days of CONTRACT award the CONTRACTOR(S) shall develop an individuals with disabilities hiring plan that outlines the CONTRACTOR(S)’ activities to meet the State established goal and how it will ensure the expansion of employment opportunities for individuals with disabilities.

r. The individuals with disabilities hiring plan shall be evaluated on an annual basis and made available to the State and stakeholders upon request and shall address barriers to attaining specific goals as well as interventions to be placed to meet the required goals.

s. The CONTRACTOR(S) shall use the conditions contained in the Americans with Disabilities Act as the guideline for development of its disability hiring plan.

2.17.2 Contractor(s) Key Personnel

A. This section identifies designated Key Personnel and certain other staff where specific requirements for the position shall be met by the CONTRACTOR(S). Individuals filling Key Personnel positions must be approved by the State in writing. The CONTRACTOR(S) may request exceptions to the Key Personnel positions listed below. Such exception requests shall clearly identify the reason for the exception and the value the change results into Kansas and the population served under the KanCare program and must be approved by the State in writing.

B. The minimum Key Personnel positions are listed below. If a full-time staff person is required, that means that one (1) person shall perform that function (as opposed to multiple persons equaling a full-time equivalent). If a full-time staff person is not specified, the position does not require a full-time staff person.

C. All Key Personnel are to be exclusively dedicated to the KanCare CONTRACT, be physically based in Kansas, and have Kansas licensure as appropriate.

D. Key Personnel include:

1. A full-time senior executive/project director who has clear authority over the general administration and day-to-day business activities of this CONTRACT.

t. A full-time chief operating officer (COO) who is responsible for the overall operations of this CONTRACT and serves as the primary point of contact for all operational issues. The COO shall manage the daily operations of the CONTRACTOR(S) to ensure compliance with Federal and State laws, rules, and regulations and the performance standards set forth in this CONTRACT. The COO shall establish systems for robust reporting of operations and oversee the collection of

information necessary for performance monitoring. The COO shall ensure communication and collaboration with key stakeholders.

u. A full-time senior executive finance officer responsible for accounting and finance operations, including all audit activities.

v. A full-time compliance officer responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this CONTRACT and serving as a liaison between the CONTRACTOR(S) and the State regarding compliance. The compliance officer shall report directly to the CEO and the board of directors. The compliance officer's responsibilities shall include but not be limited to the following:

    a. Providing documentation/demonstration requests (not limited to the following: walkthrough, case records, or policy and procedures);

    b. Securing and coordinating necessary resources;

    c. Receiving and responding to all inquiries and requests made by the State in the times and formats specified;

    d. Attending and participating in annual contract review meetings or conference calls;

    e. Making best efforts to resolve any issues identified; and

    f. Meeting with the State at the time and place requested by the State, if non-compliance is identified.

g. A full-time medical director or CMO who is board certified and a licensed physician in Kansas. The CMO shall be responsible for all clinical activities, including but not limited to, the proper provision of Covered Services to Members; UM activities, and developing clinical practice standards and clinical policies and procedures. The CMO shall act as a champion supporting continuous quality improvement efforts to improve the care and services delivered to all populations covered under this CONTRACT and shall work directly with all other medical officers and department and business unit leads to promote excellence in care and service delivery.

h. A full-time LTSS clinical officer/medical director (LTSS CO/MD) who is board certified in geriatrics or a gerontological nurse practitioner, licensed in Kansas, and who has at least five (5) years of experience in directing health care services for frail elderly or individuals of any age with physical, intellectual, and/or developmental disabilities. The LTSS CO/MD shall oversee and be responsible for all primary and physical and Behavioral Health Services provided to individuals receiving LTSS, and to comparable populations enrolled in KanCare, and all clinical activities pertaining to the operation of LTSS programs and services, including Preventive Care and the management and coordination of Chronic Conditions and physical health needs, and the integration and coordination of primary and other physical health services for Members receiving LTSS. The LTSS CO/MD shall also be responsible for working with the CMO, Behavioral Health CMO (BH-CMO), Pharmaceutical director and the behavior supports director to ensure the integration of physical and Behavioral Health Services and supports and LTSS, as applicable, for individuals in each of these populations and to oversee the CONTRACTOR(S)' quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations.

i. A full-time LTSS director/manager dedicated to the KanCare LTSS initiatives including Care Coordination efforts, housing, employment, Transportation, and community integration activities required for a high performing LTSS system. This position will work closely with the medical officers, quality director, and other clinical partners to provide direction to improve coordination and implement community-based and institutional initiatives (e.g., programs designed to address transitions from long-term institutional settings or SDOH).

j. A full-time Behavioral Health medical officer/medical director (BH-CMO) who is a board certified psychiatrist and addictionologist (or addictions experience approved by the State in writing), is a licensed physician in Kansas, and who has at least five (5) years combined experience in mental health and SUD services. This person shall oversee and be responsible for all Behavioral Health activities, including oversight of coordination activities with KDADS and shall work closely with the behavior supports director and other medical officers to ensure the delivery of holistic and integrated person-centered care. KDADS must provide written approval of staffing of this position in advance of an offer being extended.

k. A full-time behavior supports director who is a Kansas licensed psychologist or board certified psychiatric mental health nurse practitioner or clinical nurse specialist with an advanced practice nursing (APN) degree and experience with Applied Behavior Analysis (ABA) and directing behavior support services. The behavior supports director shall oversee and be responsible for behavior support services provided to individuals receiving LTSS and comparable populations. The behavior supports director shall be responsible for working with the BH-CMO to oversee the ongoing management of behavior crisis prevention, intervention, and stabilization services and shall be responsible for working with the other medical officers and the Pharmaceutical director to ensure the integration of physical and Behavioral Health Services and supports and LTSS, as applicable, for individuals in each of these populations, and to oversee the CONTRACTOR(S)' quality improvement initiatives regarding behavior supports and the appropriate use of psychotropic medications in each of these populations.

l. A full-time Pharmaceutical director who is a licensed Pharmacist in Kansas and oversees Pharmaceuticals, Supplies, and Devices coverage through the pharmacy and medical benefits. The Pharmaceutical director must oversee the CONTRACTOR(S)' process to ensure that drug coverage on both the pharmacy and medical benefit follows State policy and guidance. The Pharmaceutical director shall be responsible for all clinical and administrative Pharmacy activities, including but not limited to, proper provision of pharmaceutical services to Members and developing and maintaining policies and procedures that comply with the State's policy and guidance. This position shall interface with the medical director/officers, the behavior supports director, the reporting team, the Prior Authorization team, and other CONTRACTOR(S)' staff to ensure integration of pharmaceutical data into the integration, management, and quality improvement efforts of the CONTRACTOR(S). This position must peer review the CONTRACTOR(S)' Member and Provider drug program related documents, prior to submission of such documents to the State. The CONTRACTOR(S)' Pharmaceutical director may delegate responsibilities to another designee who is a Kansas-licensed Pharmacist dedicated to the KanCare contract. However, the Pharmaceutical director is ultimately responsible for ensuring compliance with the above contract requirements.

m. A full-time quality management (QM) director with at least five (5) years of experience performing HEDIS data collection, integrating Rapid-Cycle Process Improvement principles in an organization, and utilizing study design and evaluation approaches to improve quality of care and service delivery. This position is responsible for executing the QAPI requirements found in

Section 2.9 in accordance with the State's KanCare Quality Management Strategy (QMS) and for infusing continuous quality improvement approaches throughout the organization.

n. A full-time program integrity manager as described in Section 2.12 (Program Integrity).

o. A full-time chief data analytics coordinator with a minimum of three (3) years of experience aggregating disparate data sets and analyzing data with the intent of identifying trends and opportunities for improvement. In addition to reviewing data across populations and programs, including data from vendors such as Behavioral Health, Pharmacy, Transportation etc., this position is responsible for facilitating and responding to ad hoc data requests from the State and internal business units, coordinating, reviewing, and validating all data and reports sent to the State, and acting as a resource to ensure appropriate data and data analytic support and services are available to support Rapid-Cycle Process Improvement efforts across the CONTRACTOR(S)' enterprise and to meet all reporting and quality improvement efforts under this CONTRACT. This position shall work closely with the QM director and the information systems director/manager.

p. A full-time Member services director/manager who shall be responsible for Member services, including, among others, the Member services call center, and the CONTRACTOR(S)' health literacy, health education and cultural competency efforts. This individual shall oversee the Member advocates and work closely with other business units to ensure member-centric service delivery.

q. A full-time health services director/manager who responsible for all UM activities, including but not limited to, overseeing PAs. This person shall be under the direct supervision of the CMO and shall ensure that UM staff have appropriate clinical licensure and experience in order to make UM decisions. This person will also be responsible for coordinating with the Behavioral Health and LTSS medical officers, Pharmaceutical director and behavior supports director, and other network staff to ensure delivery of holistic, integrated, and person-centered care.

r. A full-time Care Coordination director/manager responsible for all Care Coordination activities, within the Care Coordination program for all KanCare Members. The Care Coordination director shall be a Kansas licensed clinician with at least five (5) years of Case Management and Care Management experience and who is knowledgeable about all KanCare HCBS Waiver programs and who will provide oversight or the CONTRACTOR(S)' quality improvement initiatives regarding Care Coordination, SDOH, and health Outcomes. This position will work closely with the behavior supports director and the health services director to provide integrated, holistic care for all KanCare populations covered under this CONTRACT.

s. A full-time Provider relations director/manager who responsible for Provider services and Provider relations, Provider payment issues, Provider education, development, and execution of Provider training as described in Section 2.6 and who shall act as the single point of contact to the State to address escalated Provider issues.

t. The CONTRACTOR(S) shall identify one (1) or more dedicated Pharmaceutical, LTSS and Behavioral Health Provider representatives for Pharmaceutical, LTSS and Behavioral Health Providers. Pharmaceutical, LTSS, and Behavioral Health Provider representative(s) shall be responsible for internal representation of Providers' interests including, but not limited to, contracting, service authorizations, Claims processing and, other Pharmaceutical, LTSS, and Behavioral Health Provider needs.

a. The Pharmaceutical, LTSS, and Behavioral Health Provider representatives shall conduct ongoing communications with Pharmaceutical, LTSS, and Behavioral Health Providers through Provider forums, webinars, dedicated toll-free Provider telephone lines, and other means to ensure resolution of issues that include but are not limited to: Enrollment/eligibility determinations; credentialing issues; authorization issues; and Claims processing/payment disputes.

b. A full-time network management and contracting director/manager who is responsible for all network development staff, developing and implementing the Provider network development and management plan and evaluation described in Section 2.5.2 and assessing network adequacy and availability including expanding use of Telemedicine and innovative strategies to improve network access and availability.

c. The CONTRACTOR(S) shall identify at least one (1) staff member to be responsible for oversight and coordination of all Subcontractors and delegated entities. This person shall be responsible for coordinating the delegation oversight (sub)-committee, coordinating annual audits, facilitating joint operational meetings between the CONTRACTOR(S) and its Subcontractor(s), and interfacing with other internal business units impacted by the Subcontractor(s).

d. A full-time transition of care coordinator with demonstrated expertise in facilitating and coordinating care transitions across the continuum of care settings and throughout the Member's life-span. This position should report to the Care Coordination director/manager and is responsible for working across internal business units and directly coordinating with Care Coordination staff, external community entities, and Participating Providers to provide advice and support for complex transition of care cases.

e. A full-time staff person exclusively dedicated to overseeing housing services and supports for LTSS and Behavioral Health programs and services. This person shall have at least three (3) years' experience in assisting the elderly or persons with disabilities to secure accessible, affordable housing through Federal (e.g., U.S. Housing and Urban Development [HUD], Shelter Plus Care, Substance Abuse and Mental Health Services Administration [SAMHSA], and Department of Agriculture [USDA]), as well as, local programs. The housing specialist shall work under the Housing First model, honoring Member choice. The housing specialist shall be responsible for working with the aforementioned housing agencies and other housing programs to help develop and access affordable housing services for Members receiving LTSS, educating and assisting care coordinators regarding affordable housing services for KanCare Members, and liaison with KDADS housing coordinators and housing specialists within each CMHC on Kansas' broader housing strategy and initiatives. The housing specialist will work with KDADS to ensure that community Providers are trained and achieving fidelity in evidence-based practices (i.e., Housing First model).

f. A full-time employment services and supports coordinator responsible for overseeing employment services and supports for LTSS programs and services. This person shall have at least three (3) years' experience in developing employment services and supports for persons with disabilities in integrated settings, which shall include at least one (1) year experience directing such programs and services; or other significant and relevant employment services expertise as approved by KDADS in writing. The employment services and supports coordinator shall be responsible for coordination with the Working Healthy/WORK program, STEPS, the Kansas Workforce Centers, Kansas Rehabilitation Services, and the Kansas Departments of

Education, to assist the State in increasing competitive integrated employment of youth and adults with disabilities. The CONTRACTOR(S) shall also assist the State with any new employment initiatives the State may implement and provide ongoing leadership of employment services and supports for the CONTRACTOR(S)' staff and Participating Providers. A staff person in this position must successfully complete Association of Community Rehabilitation Educators (ACRE) professional level employment training, as well as, be an SSI/Social Security disability insurance Outreach, Access, and Recovery (SOAR) certified specialist with KDADS and the Social Security Administration either prior to or during the first year of employment. A staff person in this position must be familiar with the Individual Placement and Supports (IPS) supported employment model, and any other evidence-based employment models used by the CMHCs.

g. A designated workforce development director/manager who is qualified by training and experience to be the single point of accountability to coordinate and oversee the CONTRACTOR(S)' workforce development activities.

h. A designated OneCare Kansas (OCK) manager, to serve as a State contact and participate in regular meetings with the KDHE and stakeholders.

i. A designated oral health director/manager who is a dentist licensed in Kansas. This position shall oversee and be responsible for all oral health activities related to this CONTRACT, including developing and implementing strategies to expand Member access to oral health services and increase utilization of preventive services, and shall serve as the main point of contact for the State regarding oral health services.

j. A full-time EPSDT coordinator responsible for all KAN Be Healthy services and related issues, including but not limited to, all KAN Be Healthy activities and EPSDT screening events. This position shall interface and coordinate with the foster care coordinator, director of Care Coordination, oral health director, the Member advocates, and other internal staff to ensure the delivery of all preventive screenings and to ensure delivery of appropriate treatment and follow up based on identified diagnoses.

k. A full-time foster care coordinator responsible for working with DCF and KDADS who has demonstrated experience working in the foster care system to help CONTRACTOR(S) staff, Members, and families navigate through and coordinate with various programs and systems of care.

l. A full-time Grievance and Appeal director/manager responsible for managing Member Grievances, Member Appeals, and Member State Fair Hearings. The Grievance and Appeals director/manager must have experience with Member Grievances, Appeals, administrative hearings, or other legal processes. The Grievance and Appeal director/manager shall coordinate with the CONTRACTOR(S)' legal services and other internal staff to ensure compliance with Appendix D (Grievances and Appeals) and other relevant provisions of this CONTRACT and to ensure delivery of accurate, complete, and timely State Fair Hearing documentation. Minimum requirements for processing of State Fair Hearings are education as a legal assistant or paralegal or comparable education or employment experience.

m. A full-time Provider Grievance and Appeal director/manager responsible for managing Provider Grievances, Reconsiderations, Appeals, External Independent Third-Party Reviews, and State Fair Hearings. The Grievance and Appeals director/manager must have experience with Claims and Provider payments, administrative hearings, or other legal or payment processes. The

Provider Grievance and Appeal director/manager shall coordinate with the CONTRACTOR(S)' legal services and other internal staff to ensure compliance with Appendix D (Grievances and Appeals) and other relevant provisions of this CONTRACT and to ensure delivery of accurate, complete, and timely State Fair Hearing documentation. Minimum requirements for processing of State Fair Hearings are education as a legal assistant or paralegal or comparable education or employment experience.

n. At least two (2) full-time Member advocates (one [1] for LTSS and one [1] for Behavioral Health), who have at least two (2) years of experience in a health care related field with requisite experience working with either LTSS or Behavioral Health populations, preferably working with low-income populations, and have demonstrated expertise in topics related to LTSS, resiliency and recovery, and cultural competency. The Member advocates shall be responsible for the following activities:

    a. Act as the single point of contact between the State and the CONTRACTOR(S) for escalated Member concerns and questions.

    b. Investigate and resolve access and cultural sensitivity issues identified by CONTRACTOR(S) staff, State staff, Providers, advocate organizations, or Members.

    c. Monitor Grievances with Grievance personnel to look at trends or major areas of concern.

    d. Work with care coordinators to help link Members to necessary services and supports.

    e. Coordinate with the schools, community agencies, and State agencies, with special emphasis on foster children and providing services to Members.

    f. Recommend policy procedural changes to the CONTRACTOR(S)' management including those needed to ensure/improve Member access to care and quality of care (changes can be recommended for both internal administrative policies and Provider requirements).

    g. Identify a staff person to function as a primary contact for Member advocacy groups and work with these groups to identify and correct Member access barriers.

    h. Participate in local community organizations to acquire knowledge and insight regarding the special health care needs of Members.

    i. Analyze systems functions through meetings with staff.

    j. Organize and provide training and educational materials for CONTRACTOR(S)' staff and Providers to enhance their understanding of the values and practices of all cultures with which the CONTRACTOR(S) interact.

    k. Provide input to CONTRACTOR(S)' management on how Provider changes will affect Member access and quality/continuity of care and develop/coordinate plans to minimize any potential problems.

    l. Review all informational material to be distributed to Members.

    m. Assist Members and Member representatives in obtaining medical records.

n. A designated Health Equity director/manager qualified by training and experience. The Health Equity director/manager shall lead and manage the CONTRACTOR(S)' efforts to identify and

address health disparities, improve Health Equity, and ensure Covered Services are delivered in a culturally competent manner to all Members. This shall include supervising staff, informing the CONTRACTOR(S)' policies and operations, and coordinating and collaborating with stakeholders.

o. A full-time staff information systems director/manager responsible for all CONTRACTOR(S) information systems supporting this CONTRACT who is trained and experienced in information systems, data processing, and data reporting as required to oversee all information systems functions supporting this CONTRACT including, but not limited to, establishing and maintaining connectivity with KanCare information systems and providing necessary and timely reports to KanCare.

p. A full-time Claims/operations manager who is qualified by training and experience to oversee Claims and Encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness, and completeness of processing payment and reporting.

2.17.3 Staff Training and Education

A. The CONTRACTOR(S) shall provide an initial orientation and training as well as ongoing training, including training targeted to different types of staff, to ensure that all staff and the staff of its Subcontractors and delegates can fulfill the requirements of the positions they hold and to ensure competency and compliance with this CONTRACT. The CONTRACTOR(S) shall use the most appropriate training methods, which may include instructor-led and web-based trainings.

B. The CONTRACTOR(S) shall submit an annual staff training and education plan for KDHE-DHCF written approval that details the CONTRACTOR(S)' staff training and education activities, including the frequency of training, training topics, and targeted staff audience. In addition, the CONTRACTOR(S) shall report on the status of the staff training and education plan activities on a quarterly basis.

C. The staff training and education plan must include a specific training and education plan for the CONTRACTOR(S)' Care Coordination staff, including delegated Care Coordination (see Section 2.4.9).

D. The CONTRACTOR(S) shall have a staff training coordinator who is responsible for developing, overseeing, and evaluating the CONTRACTOR(S)' staff training and education plan.

E. Staff training may include any topic that the CONTRACTOR(S) deems relevant, but shall include the following minimum requirements:

1. Continuous QI principles and the Rapid-Cycle Process Improvement approach.

q. Advance Directives.

r. Member rights.

s. Health Equity and cultural competency.

t. Concepts in community integration and independent living, including:

a. Functional limitations and/or chronic illnesses that impact individuals living or working in the community.

b. SDOH.

c. Early identification of LTSS Members who may be candidates for NF diversion.

d. Compliance with HIPAA and other State and Federal rules and regulations.

e. Topics related to the Pharmaceutical benefit.

f. The identification and reporting of adverse incidents and Member Grievances.

g. Behavioral health topics, including co-occurring disorders.

h. The WORK program, STEPS, and Other Employment Programs and how to assist all Members with connecting to employment and volunteer opportunities.

i. Transition of care processes for Members as they move throughout the continuum of care settings.

j. The role of the Member advocates and how to make referrals for assistance.

k. The identification and reporting of Fraud, waste, and Abuse.

l. Any additional training topics as determined by the State.

F. The CONTRACTOR(S) shall verify and document that it has met the training requirements in this section of the CONTRACT. The CONTRACTOR(S) must make this documentation available for the State's review upon request.

G. The CONTRACTOR(S) shall develop and implement a process to evaluate the effectiveness and outcomes of the training provided and document that it has met this requirement.

H. Community partnership: The CONTRACTOR(S) shall build partnerships with community-based organizations, trade associations, faith-based organizations, and other community entities to provide guidance, direction, and support to the CONTRACTOR(S) and the CONTRACTOR(S)' staff in the form of technical assistance, training, and education to support the delivery of person-centered, culturally competent, and integrated care to all Members.

2.17.4 Facilities and Equipment

A. The CONTRACTOR(S) shall maintain a Kansas facility within a two (2)-hour drive of the city limits of Topeka, Kansas. This facility shall meet the requirements of the ADA and appropriate fire code. The CONTRACTOR(S) shall limit access to its facilities to appropriate and authorized personnel only and provide the State with a copy of its security plan. Security from threats and hazards must meet security guidelines specified in 45 CFR § 95.621(f).

B. The facility shall serve as the base location for the CONTRACTOR(S)' Member advocates, Provider relations, network management, Care Coordination, and QM functions, and staff working in these areas shall be located at this facility, unless the position is considered a field-based staff position. In addition, Key Personnel must be based at this facility. The CONTRACTOR(S) may perform some development functions outside of Kansas but within the continental United States, and Kansas health data must never leave the continental United States. The CONTRACTOR(S)' team is generally expected to perform 100% of its work onsite in its Kansas facility except as otherwise proposed by the CONTRACTOR(S) and agreed to and approved by the State in writing. The CONTRACTOR(S)' proposal must clearly explain which positions and functions will be located in the

Kansas facility and which are proposed to be located outside the Kansas facility. If out-of-state (not located in Kansas) services are proposed, then the proposal shall include appropriate coordination activities necessary to manage and coordinate all out-of-state activity.

C. The CONTRACTOR(S) must limit access to any out-of-state facilities included in the operation, including storage facilities, and must provide the State with a copy of its planned security procedures for all facilities. The State reserves the right to perform physical security checks at the State's discretion.

D. Generally, the State will **not** provide any facilities or equipment for the CONTRACTOR(S). The State will provide one (1) cubicle for visiting CONTRACTOR(S)' staff in its downtown Topeka offices.

2.18 Compliance Remedies

A. General requirements

1. The State may impose compliance remedies described in this CONTRACT, or available under State or Federal law, against the CONTRACTOR(S) if the CONTRACTOR(S) fails to comply with the terms of this CONTRACT. While the compliance remedies below reflect progressive levels of severity, the State will determine the most appropriate compliance remedy to address CONTRACTOR(S)' non-compliance at its sole discretion and is not bound to exhaust lower-level remedies. Additionally, compliance remedies are not exclusive, meaning that the State's imposition of any particular compliance remedy does not preclude the State from taking additional compliance remedies available under this CONTRACT and State or Federal law.

m. The CONTRACTOR(S) shall monitor compliance with the terms of this CONTRACT and take immediate action to correct non-compliance it identifies. The CONTRACTOR(S)' correction of non-compliance shall not be dependent upon the State's identification of non-compliance or impositions of compliance remedies. The CONTRACTOR(S) shall disclose non-compliance and the action taken to correct non-compliance to the State within forty-eight (48) hours of discovering the non-compliance.

n. The CONTRACTOR(S) is singularly responsible for fully complying with the terms of this CONTRACT, regardless of delegation to Subcontractors of Providers. Compliance remedies will be applied to the CONTRACTOR(S). The CONTRACTOR(S) shall not pass down compliance remedies to its Subcontractors or Providers unless the Subcontractor/Provider is responsible for the CONTRACTOR(S)' failure to meet the requirement.

B. Compliance remedies

1. If the State determines that the CONTRACTOR(S) is not in compliance with one (1) or more requirements in this CONTRACT, the State may impose one (1) or more of the following compliance remedies. Failure of the CONTRACTOR(S) to achieve compliance within the timeframe specified by the State or approved by the State in writing may result in the escalation of compliance remedies as provided in this section.

2. Informal remediation plan: The State may notify the CONTRACTOR(S) informally (e.g., by email) of non-compliance and allow the CONTRACTOR(S) to correct the non-compliance within a State-defined time period.

o. Notification of non-compliance: The State may issue a written notification of non-compliance to the CONTRACTOR(S) identifying contractual non-compliance and the State's expectations for

correcting non-compliance. A notification of non-compliance will also be used by the State to communicate any compliance remedies to be imposed by the State.

p. Corrective Action Plan: The State may require the CONTRACTOR(S) to develop and submit a proposed corrective action plan (CAP) to the State as specified in the notification of non-compliance. The CONTRACTOR(S)' proposed CAP and time period for correcting the non-compliance is subject to the State's written approval.

q. Directed Corrective Action Plan: When the State determines the specific action the CONTRACTOR(S) must implement to correct non-compliance, the State may require the CONTRACTOR(S) to comply with a State-developed corrective action plan, or "DCAP", within a State-defined time period.

r. Liquidated damages: The State may assess liquidated damages when CONTRACTOR(S) fails to meet one (1) or more performance requirements specified in Appendix G (Liquidated Damages).

s. Enrollment suspension: The State may suspend the CONTRACTOR(S)' right to new Enrollment under this CONTRACT when the CONTRACTOR(S) fails to correct non-compliance within the defined time period or sooner than the defined time period if the State finds that Members' health or welfare is jeopardized. The suspension period may be for any length of time specified by the State or may be indefinite. The suspension period may extend to the expiration of this CONTRACT.

t. Suspension or recoupment of Capitation Payment: The State may suspend or recoup a Capitation Payment paid for any month for any Member who was denied the full extent of Covered Services meeting the standards set forth by this CONTRACT, or who received or is receiving substandard services.

u. Suspension of Capitation Payments: The State may suspend the CONTRACTOR(S)' Capitation Payments under this CONTRACT when the CONTRACTOR(S) fails to correct non-compliance within the defined time period. Suspension of Capitation Payments may continue until the State is satisfied that the non-compliance has been corrected and is not likely to recur.

v. Intermediate sanctions: The State may take intermediate sanctions as specified in 42 CFR Part 438, subpart I. In accordance with 42 CFR §§ 438.710 and 438.722, before imposing an intermediate sanction, the State will provide the CONTRACTOR(S) a written notice that explains the basis and nature of the sanction, and any appeal rights that the State elects to provide.

w. Termination of CONTRACT: In accordance with 42 CFR §§§ 438.708, 438.710 and 438.722, the State has the authority to terminate the CONTRACTOR(S)' CONTRACT and enroll the CONTRACTOR(S)' Members with other KanCare MCOs or provide the Members' Medicaid benefits through other options included in the State Plan, if the State determines that the CONTRACTOR(S) has failed to do either of the following: (a) Carry out the substantive terms of its contract; (b) Meet applicable requirements in Sections 1932, 1903(m), and 1905(t) of the SSA. Before terminating the CONTRACTOR(S)' CONTRACT, the State will provide the CONTRACTOR(S) a pre-termination hearing. The State will provide the CONTRACTOR(S) a written notice that contains the State's intent to terminate, the reason for termination, and the time and place of the hearing. After the hearing the CONTRACTOR(S) will be given the written notice of the decision affirming or reversing the proposed termination of the contract and, for an

affirming decision, the effective date of termination. For an affirming decision, the CONTRACTOR(S)' members will be given notice of the termination and information consistent with 42 CFR § 438.10, on their options for receiving Medicaid services following the effective date of termination and will be allowed to Disenroll immediately without cause.

C. Request for reconsideration

1. The CONTRACTOR(S) may request reconsideration of the compliance remedies in this section imposed by the State with the exception of the following: notification of non-compliance with no other associated compliance remedy; informal remediation plan; CAP; and DCAP. The CONTRACTOR(S) may not use the request for reconsideration process to dispute the State's decision to terminate the CONTRACT for non-compliance; the CONTRACTOR(S) shall follow the pre-termination hearing process outlined above in this section.

x. The CONTRACTOR(S)' request for reconsideration must be submitted in accordance with the following procedure:

   a. The CONTRACTOR(S) must submit a request for reconsideration in writing to the State no later than ten (10) Business Days after the date the CONTRACTOR(S) receives the written notification of non-compliance from the State.

   b. The CONTRACTOR(S)' request for reconsideration, at a minimum, must identify the proposed compliance remedy, provide a detailed description of the basis for the request for reconsideration, and provide all supporting documentation.

   c. The State will issue a final written decision within thirty (30) Business Days following the receipt of the CONTRACTOR(S)' request for reconsideration, subject to the sufficiency of the information provided by the CONTRACTOR(S) or need for additional time to render a final decision. In the event the State needs additional information from the CONTRACTOR(S) or time for rendering a decision, the State will notify the CONTRACTOR(S) in writing.

   d. If the State approves the CONTRACTOR(S)' request for reconsideration in whole, the State will rescind the associated compliance remedy.

   e. If the State approves the CONTRACTOR(S)' request for reconsideration in part, the State, at its sole discretion, may rescind or reduce the associated compliance remedy.

   f. If the State denies the CONTRACTOR(S)' request for reconsideration in whole, the State will take the compliance remedy outlined in the original notification of non-compliance.

g. Nothing in this section prevents the State from immediately imposing a compliance remedy required in 42 CFR 438, Subpart I.

2.19 KDHE-DHCF Additional Terms and Conditions

2.19.1 Business Associate Agreement

The CONTRACTOR(S) shall be required to complete and sign a Business Associate agreement as noted below. The language below is provided for the CONTRACTOR(S) preliminary review. The actual agreement will be provided upon contract award.

THIS AGREEMENT is made and entered into by and between the Kansas Department of Health and Environment (hereinafter referred to as “KDHE”) and _____(hereinafter referred to as “Business Associate”).

Notwithstanding Section V of this Business Associate Agreement (hereinafter referred to as “BAA”), the term of this BAA shall run concurrently with the Underlying Contract between the parties and shall have the same effective date and termination date as the Underlying Agreement.

RECITALS

The Parties to this BAA have a relationship whereby KDHE may provide Business Associate access to Protected Health Information (hereinafter referred to as “PHI”), which may include electronic Protected Health Information, that Business Associate will use to fulfill its contractual obligations to KDHE.

KDHE and Business Associate acknowledge that each party has certain obligations under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as amended, including those provisions of the American Recovery and Reinvestment Act of 2009 (“ARRA”), specifically the Health Information Technology for Economic and Clinical Health Act (“HITECH”), and the statutes implementing regulations to maintain the privacy and security of PHI, and the parties intend this BAA to satisfy those obligations including, without limitation, the requirements of 45 CFR § 164.504(e).

KDHE is a Hybrid Entity under HIPAA, specifically the Division of Health Care Finance within KDHE containing the covered entity functions. Therefore, Business Associate is not permitted to use or disclose health information in ways that KDHE could not. This protection continues as long as the data is in the hands of Business Associate. Business Associate acknowledges that for the purposes of this BAA, Business Associate is a “business associate” as that term is defined in 45 CFR § 160.103, and therefore the requirements of HIPAA apply to Business Associate in the same manner that they apply to KDHE pursuant to 42 U.S.C § 17931(a).

NOW THEREFORE, in consideration of the mutual promises below and other good and valuable consideration the parties agree as follows:

I. DEFINITIONS

A. “Administrative Safeguards” shall mean the administrative actions, policies and procedures to manage the selection, development, implementation and maintenance of security measures to protect PHI and to manage the conduct of Business Associate’s workforce in relation to the protection of that PHI.

B. “Business Associate” shall have the same meaning as the term “Business Associate” as defined in 45 CFR § 160.103.

C. “Data Aggregation Services” shall mean, with respect to PHI created or received by Business Associate in its capacity as a Business Associate of KDHE, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities, as defined in 45 CFR § 164.501 and as such term may be amended from time to time in this cited regulation.

D. “Designated Record Set” shall mean a group of records maintained by or for KDHE that consists of the following: (a) medical records and billing records about Individuals maintained by or for a health care Provider; (b) enrollment, payment, Claims adjudication, and case or medical management record systems maintained by or for a health plan; or (c) records used in whole or in part, by or for

KDHE to make decisions about Individuals. For these purposes, the term “record” means any item, collection, or group of information that includes PHI and is maintained, collected, used, or disseminated by or for KDHE.

E. “Disclosure” shall mean the release, transfer, provision of, access to, or divulging in any other manner of PHI outside the entity holding the information.

F. “HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, the implementation regulations promulgated thereunder by the U.S. Department of Health and Human Services, the HITECH (as defined below), and any future regulations promulgated thereunder, all as may be amended from time-to-time.

G. “HITECH Act” shall mean the Health Information Technology for Economic Clinical Health Act, Title VIII of Division A and Title VI of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L.111-5).

H. “Individual” shall have the same meaning as the term “individual” as defined in 45 CFR § 160.103, and any amendments thereto, and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

I. “Physical Safeguards” shall mean the physical measures, policies and procedures to protect KDHE’s electronic information systems and related buildings and equipment from natural and environmental hazards and unauthorized intrusion.

J. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR § Part 160 and Part 164.

K. “Protected Health Information” shall have the same meaning as the term “protected health information”, as defined in 45 CFR § 160.103 and any amendments thereto, limited to the information created or received by Business Associate from or on behalf of KDHE.

L. “Required by Law” shall have the same meaning as the term “required by law” in 45 CFR § 164.103.

M. “Secretary” shall mean the Secretary of the United States Department of Health and Human Services or their designee.

N. “Security Incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

O. “Security Rule” shall mean the Standards for Security of Electronic Protected Health Information at 45 CFR § Parts 160, 162 and 164.

P. “Technical Safeguards” shall mean the technology and the policy and procedures for its use that protect PHI and control access to it.

Q. “Underlying Contract” means the contract with which this agreement is associated.

R. “Unsecure Protected Health Information (PHI)” means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of Public Law 111-5.

S. “Use” shall mean, with respect to PHI, the sharing, employment, application, utilization, examination, or analysis of such information within any entity that maintains such information.

T. Capitalized terms used, but not otherwise defined, in this BAA shall have the same meaning ascribed to them in HIPAA, the Privacy Rule, the Security Rule, or HITECH or any future regulations promulgated, or guidance issued by the Secretary.

II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

A. Use and Disclosure. Business Associate agrees to not use or disclose PHI other than as permitted or required by this BAA or as Required by Law.

B. Safeguards to be in Place. Business Associate agrees to use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this BAA. Additionally, Business Associate shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of KDHE as required by the Security Rule.

C. HIPAA Training. Business Associate agrees to ensure all members of its workforce, including subcontractor workforce members, which will or potentially will provide services pursuant to the Underlying Agreement will be appropriately trained on the requirements of HIPAA.

D. Duty to Mitigate. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this BAA or the Privacy Rule and to communicate in writing, such procedures to KDHE.

E. Business Associate’s Agents and Subcontractors. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of KDHE agrees, in writing in the form of a Business Associate Agreement, to the same restrictions and conditions that apply through this BAA to Business Associate with respect to such information, including implementation of reasonable and appropriate safeguards to protect PHI. Business Associate agrees that it is directly liable for any actions of its subcontractors that results in a violation of this Agreement. Business Associate also agrees to make available to KDHE any contracts or agreements Business Associate has with any subcontractors Business Associate provides PHI under this BAA.

F. Duty to Provide Access. To the extent Business Associate has PHI in a Designated Record Set, Business Associate agrees to provide access, at the request of KDHE, to the PHI in the Designated Record Set to KDHE or, as directed by KDHE, to the Individual, in order to meet the requirements under 45 CFR § 164.524. Any denial by Business Associate of access to PHI shall be the responsibility of, and sufficiently addressed by, Business Associate, including, but not limited to, resolution of all appeals and/or complaints arising therefrom.

G. Amendment of PHI. Business Associate agrees to make any amendment(s) to PHI in its possession contained in a Designated Record Set that KDHE directs or agrees to pursuant to 45 CFR § 164.526 at the request of KDHE or an Individual, and within a reasonable time and manner.

H. Duty to Make Internal Practices Available. Business Associate agrees to make its internal practices, books and records, including policies and procedures relating to the use and disclosure of PHI, and any PHI received from, or created or received by Business Associate on behalf of KDHE, available

to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining KDHE's compliance with the Privacy Rule.

I. Documenting Disclosures/Accounting. Business Associate agrees to document any disclosures of PHI and information in its possession related to such disclosures as would be required for KDHE to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Business Associate agrees to provide to KDHE information collected in accordance with Section II(H) of this BAA, to permit KDHE to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

J. Reporting Disclosures to KDHE. In addition to the duty to mitigate under Section II(D), Business Associate agrees to report to KDHE any unauthorized use or disclosure of unsecure PHI not provided for by this BAA or the Privacy Rule of which it or its officers, employees, agents or subcontractors discover, including any breach of unsecure PHI of which it becomes aware, as soon as practicable but no longer than five (5) Business Days after the discovery of such disclosure. Notice to KDHE shall consist of notifying the KDHE Privacy Officer by phone or email of the occurrence of an unauthorized use, disclosure, or security incident.

K. Notification of Breach. Business Associate shall notify KDHE within five (5) Business Days after it, or any of its employees, subcontractors, or agents, discovers that a breach of unsecured PHI as defined by 45 CFR § 164.402 may have occurred, irrespective of any occurrence or non-occurrence of harm. Notice to KDHE shall consist of notifying the KDHE Privacy Officer by phone or email of the occurrence of a Breach or suspected occurrence of a Breach. Business Associate shall exercise reasonable diligence to become aware of whether a breach of unsecured PHI may have occurred and, except as stated to the contrary in this Section, shall otherwise comply with 45 CFR § 164.410 in making the required notification to KDHE. Business Associate shall cooperate with KDHE in the determination as to whether a breach of unsecured PHI has occurred and whether notification to affected individuals of the breach of unsecured PHI is required by 45 CFR § 164.400 et seq., including continuously providing KDHE with additional information related to the suspected breach as it becomes available. In the event that KDHE informs Business Associate that (i) KDHE has determined that the affected individuals must be notified because a breach of unsecured PHI has occurred and (ii) Business Associate is in the best position to notify the affected individuals of such breach, Business Associate shall immediately provide the required notice (1) within the timeframe defined by 45 CFR § 164.404(b), (2) in a form and containing such information reasonably requested by KDHE, (3) containing the content specified in 45 CFR § 164.404(c), and (4) using the method(s) prescribed by 45 CFR § 164.404(d). In addition, in the event that KDHE indicates to Business Associate that KDHE will make the required notification, Business Associate shall promptly take all other actions reasonably requested by KDHE related to the obligation to provide a notification of a breach of unsecured PHI under 45 CFR § 164.400 et seq. Business Associate shall indemnify and hold KDHE harmless from all liability, costs, expenses, claims or other damages that KDHE, its related corporations, or any of its or their directors, officers, agents, or employees, may sustain as a result of a Business Associate's breach, or Business Associate's subcontractor or agent's breach, of its obligations under this Agreement.

III. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

A. General Use and Disclosure Provision: Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI on behalf of, or to provide services to, KDHE for the purposes set forth in III (B), if such use or disclosure of PHI would not violate the Privacy Rule if done by KDHE.

B. Specific Use and Disclosure Provisions:

1. Business Associate may use and disclose PHI to perform services for KDHE, including specific services, as set out in the Underlying Agreement, and any additional services necessary to carry out those specific services in the Underlying Agreement.

h. Business Associate may use PHI in its possession for the proper management and administration of Business Associate and to carry out the legal responsibilities of Business Associate.

i. Business Associate may disclose PHI in its possession for the proper management and administration of Business Associate, provided that disclosures are required by Law.

j. Business Associate may only de-identify PHI in its possession obtained from KDHE with KDHE's prior written consent, in accordance with all de-identification requirements of the Privacy Rule.

k. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1). KDHE shall be furnished with a copy of all correspondence sent by Business Associate to a Federal or state authority.

l. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation Services to KDHE.

m. Any use or disclosure of PHI by Business Associate shall be in accordance with the minimum necessary policies and procedures of KDHE and the regulations and guidance issued by the Secretary on what constitutes the minimum necessary for Business Associate to perform its obligations to KDHE under this Agreement and the Underlying Agreement.

IV. OBLIGATIONS OF COVERED ENTITY

A. KDHE shall notify Business Associate of any limitation(s) in its Notice of Privacy Practices of KDHE in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

B. KDHE shall notify Business Associate in a timely manner of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent that such change may affect Business Associate's permitted or required use or disclosure of PHI.

C. KDHE shall notify Business Associate in a timely manner of any restriction to the use and/or disclosure of PHI, which the KDHE has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

D. KDHE shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by KDHE.

V. TERMINATION

A. Term. The term of this Agreement shall run concurrently with the Underlying Contract with KDHE and shall terminate upon termination of the Underlying Contract and when all of the PHI provided by KDHE to Business Associate, or created or received by Business Associate on behalf of KDHE, is destroyed or returned to KDHE, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with the termination provisions of Section (V)(c)(2).

B. Termination for Cause. Upon either party's knowledge of a material breach by the other party, such party shall either:

1. Provide an opportunity for the breaching party to cure the breach, end the violation, or terminate this Agreement if the breaching party does not cure the breach or end the violation within five (5) Business Days.

n. Immediately terminate the Agreement if the breaching party has breached a material term of this Agreement and cure is not possible.

o. If neither termination nor cure is feasible, the non-breaching party shall report the violation to the Secretary.

C. Effect of Termination.

1. Except as provided in paragraph V(c)(2) of this Agreement, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from KDHE or created or received by Business Associate on behalf of KDHE. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

p. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to KDHE notification in writing of the conditions that make return or destruction infeasible. Upon verification that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. If it is infeasible for Business Associate to obtain, from a subcontractor or agent, any PHI in the possession of the subcontractor or agent, Business Associate must provide a written explanation to KDHE and require the subcontractors and agents to agree to extend any and all protections, limitations and restrictions contained in this Agreement to the subcontractors' and/or agents' use and/or disclosure of any PHI retained after the termination of this Agreement, and to limit any further uses and/or disclosures to the purposes that make the return or destruction of the PHI infeasible.

D. Judicial or Administrative Proceedings. Notwithstanding any other provision herein, KDHE may terminate the applicable Underlying Agreement, effective immediately, upon a finding or stipulation that Business Associate violated any applicable standard or requirement of the Privacy Rule or the Security Rule or any other applicable laws related to the security or privacy of PHI, relating to the Underlying Agreement, in any criminal, administrative or civil proceeding in which the Business Associate is a named party.

VI. MISCELLANEOUS

A. Regulatory References. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended and for which compliance is required.

B. Amendment. No change, amendment, or modification of this Agreement shall be valid unless set forth in writing and agreed to by both parties, except as set forth in Section VI(l) below.

C. Indemnification. Subject to the terms of the underlying CONTRACT, Business Associate shall indemnify KDHE for any and all claims, inquiries, costs or damages, including but not limited to any

monetary penalties, that KDHE incurs arising from a violation by Business Associate, or a subcontractor or agent of Business Associate, of its obligations hereunder.

D. Survival. The respective obligations of Business Associate under this Agreement shall survive the termination of this Agreement.

E. Interpretation. Any ambiguity or inconsistency in this Agreement shall be resolved in favor of a meaning that permits KDHE to comply with the Privacy Rule, the Security Rule, and the ARRA.

F. No Third-Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than KDHE and its respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

G. Notices. Any notices to be given to either party under this Agreement shall be made in writing and delivered via email at the address given below:

1. Business Associate: _____

q. KDHE: Michael Smith, mailto:Michael.Smith@ks.gov

H. Headings. The section headings are for convenience only and shall not be construed to define, modify, expand, or limit the terms and provisions of this Agreement.

I. Governing Law and Venue. This Agreement shall be governed by, and interpreted in accordance with, the internal laws of the State of Kansas, without giving effect to its conflict of law provisions.

J. Binding Effect. This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective permitted successors and assigns.

K. Effect on Underlying Agreement. If any portion of this Agreement is inconsistent with the terms of the Underlying Agreement, the terms of this Agreement shall prevail. Except as set forth above, the remaining provisions of the Underlying Agreement are ratified in their entirety.

L. Modification. The parties acknowledge that state and Federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to ensure compliance with such developments. The parties specifically agree to take such action as may be necessary to implement the standards and requirements of HIPAA and other applicable state and Federal laws relating to the security or confidentiality of PHI as determined solely by KDHE.

1. In the event that a Federal or State law, statute, regulation, regulatory interpretation or court/agency determination materially affects this Agreement, as is solely determined by KDHE, the parties agree to negotiate in good faith any necessary or appropriate revisions to this Agreement. If the parties are unable to reach an agreement concerning such revisions within the earlier of sixty (60) days after the date of notice seeking negotiations or the effective date of the change in law or regulation, or if the change in law or regulation is effective immediately, the KDHE, in its sole discretion, may unilaterally amend this Agreement to comply with the change in law upon written notice to Business Associate.

VII. OBLIGATIONS OF BUSINESS ASSOCIATE PURSUANT TO HITECH

A. Access to PHI in an Electronic Format. If Business Associate uses or maintains PHI in an Electronic Health Record, Business Associate must provide access to such information in an electronic format if so requested by an Individual. Any fee that Business Associate may charge for such electronic

copy shall not be greater than Business Associate's labor costs in responding to the request. If an Individual makes a direct request to Business Associate for access to a copy of PHI, Business Associate will promptly inform the KDHE in writing of such request.

B. Prohibition on Marketing Activities. Business Associate shall not engage in any marketing activities or communications with any individual unless such marketing activities or communications are allowed by the terms of the Underlying Agreement and are made in accordance with HITECH or any future regulations promulgated thereunder. Notwithstanding the foregoing, any payment for marketing activities should be in accordance with HITECH or any future regulations promulgated thereunder.

C. Application of the Security Rule to Business Associate. Business Associate shall abide by the provisions of the Security Rule and use all appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement. Without limiting the generality of the foregoing sentence, Business Associate shall:

1. Adopt written policies and procedures to implement the same administrative, physical, and technical safeguards required of the KDHE.

r. Abide by the most current guidance on the most effective and appropriate technical safeguards as issued by the Secretary.

s. If Business Associate violates the Security Rule, it acknowledges that it is directly subject to civil and criminal penalties.

VIII.ADDITIONAL OBLIGATIONS OF BUSINESS ASSOCIATE

Business Associate shall not receive any remuneration, directly or indirectly, in exchange for any PHI, unless so allowed by the terms of the Underlying Agreement and in accordance with HITECH and any future regulations promulgated thereunder.

IX. ENFORCEMENT

Business Associate acknowledges that, in the event it, or its subcontractor or agent, violates any applicable provision of the Security Rule or any term of this Agreement that would constitute a violation of the Privacy Rule, Business Associate will be subject to and will be directly liable for any and all civil and criminal penalties that may result from such violation.

IN WITNESS WHEREOF, and intending to be legally bound, the parties have executed this Agreement as of the date reflected below.

Kansas Department of Health and Environment:

_____ _____

Janet Stanek, MBA Date
Secretary

Business Associate:

_____ _____

[Insert MCO CEO] Date

2.19.2 Retention and Production of Records

Unless the State specifies in writing a different period of time, the CONTRACTOR(S), and any Subcontractor(s), agrees to preserve, make available and upon request produce all of its books, documents, papers, records, and other evidence involving transactions related to this CONTRACT for a period of no less than ten (10) years from the date of the expiration or termination of this CONTRACT.

Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds five (5) years.

The CONTRACTOR(S), and any Subcontractor(s), agrees that authorized Federal and State representatives, including but not limited to, personnel of the using agency; independent auditors acting on behalf of State and/or Federal agencies shall have access to and the right to examine records and access the physical premises of the CONTRACTOR(S), and any Subcontractor(s), during the CONTRACT period, and during the ten (10) years post CONTRACT period or ten (10) years from the date of completion of any audit, whichever is later. Delivery of and access to the records shall be within five (5) Business Days. In the event this CONTRACT is no longer in effect, the delivery of and access to the records shall be provided to the State within fifteen (15) Business Days at no cost to the State.

2.19.3 Termination at Expiration and/or Termination of Contract

A. A transition period shall begin in the event of termination of this CONTRACT, prior to the end of the term of this CONTRACT, if the State and the CONTRACTOR(S) do not execute a new CONTRACT, or upon notice that the State does not intend to exercise an option to renew this CONTRACT for any additional year. During the transition period, the CONTRACTOR(S) must work cooperatively with the State and any MCO with whom the State may CONTRACT for similar services. The length of the transition period shall, in the State's sole discretion be no less than three (3) months but no more than six (6) months in duration. The costs relating to the transfer of materials and responsibilities must be paid by the CONTRACTOR(S) without additional compensation or reimbursement of expenses from the State. The CONTRACTOR(S) must be responsible for the provision of necessary information to the State and any MCO during the transition period to ensure a smooth transition of responsibility, including but not limited to, Prior Authorized Covered Services to the Member's new MCO and comply fully and timely with the new MCO's requests for historical utilization data including the Member Plans of Service and Person-Centered Service Plans (PCSPs) for Care Coordination. The CONRACTOR(S) shall abide by transitions in care requirements as set forth in Section 2.4.12 of this CONTRACT.

2.19.4 Turnover Plan

The CONTRACTOR(S) shall deliver to KDHE a proposed turnover plan, subject to KDHE's written approval, by the date specified by KDHE.

A. The CONTRACTOR(S) shall address procedures related to turnover at CONTRACT end.

B. The CONTRACTOR(S) is expected to be a full partner in the turnover process and ensure that the State's Managed Care program continues to operate smoothly during and after the turnover process. The CONTRACTOR(S) shall designate a local staff member as the CONTRACTOR(S)' single point of contact responsible for coordinating the CONTRACTOR(S)' turnover activities. The single point of contact shall be available to KDHE for at least three (3) months following the official

turnover date to address concerns by KDHE. The CONTRACTOR(S)' single point of contact shall have access to other knowledgeable individuals within the CONTRACTOR(S)' organization to assist with issue resolution in the event the contact person cannot provide an adequate response.

C. The CONTRACTOR(S)' turnover plan must provide for an orderly transition at the end of this CONTRACTOR(S) should the CONTRACTOR(S) be replaced by another entity.

D. The CONTRACTOR(S) shall take no action(s) that will hinder the orderly transition of duties and responsibilities from the CONTRACTOR(S) to another, separate CONTRACTOR(S) or the State upon termination of this CONTRACT.

E. Six (6) months prior to the expiration date/termination of this CONTRACT, the CONTRACTOR(S) shall provide, at no extra charge, assistance in turning over the operations performed under this CONTRACT to KDHE and all designated agents assigned by KDHE. The CONTRACTOR(S) shall update its turnover plan and incorporate all provisions of the KanCare turnover work schedule, which will be provided to the CONTRACTOR(S) by KDHE. The CONTRACTOR(S) updated turnover plan shall include, but is not limited to the following:

   1. Proposed approach to transition operations to another contractor or the State;

   2. Notification of Member and Providers;

   3. Identification and release of KDHE owned data and documents;

   4. Turnover of all records and other necessary data to the new CONTRACTOR(S) or other entity specified or approved by KDHE in writing, in the format specified or approved by KDHE in writing;

   5. Schedule for submission of all outstanding reports and deliverables;

   6. Designation of the single point of contact who will be available on a daily basis to assist KDHE during the transition and turnover process;

   7. Proposed timeline delineating the turnover process; and

   8. Incorporating and operationalizing all provisions of the KanCare turnover work schedule provided by KDHE.

F. The CONTRACTOR(S) shall organize, and box all records for shipment to the new CONTRACTOR(S), unless otherwise instructed by the KDHE. Boxed materials must be labeled on the outside with a list of contents and include an inventory list on each box that clearly indicates the type and date of materials. The CONTRACTOR(S) shall receive specific instructions from KDHE regarding boxing, labeling, and shipment of all records utilized under this CONTRACT.

G. The CONTRACTOR(S) shall release all documents and records necessary to complete the transfer of operations and will provide a final report documenting all such actions. At the option of KDHE, the CONTRACTOR(S) shall arrange for the removal of hardware and software, or the transfer of documents, equipment, or software leases, where applicable.

H. In the event the CONTRACTOR(S) is non-compliant or non-cooperative with the approved turnover plan, the KDHE shall hold the CONTRACTOR(S) responsible for all expenses associated with the delay of the transition.

2.19.5 Post-Contract Obligations and Procedures

A. CONTRACT termination shall not extinguish or prejudice the State's right to enforce its rights and remedies under this CONTRACT or State and Federal law and regulation, including but not limited to the right to recover damages for breach of CONTRACT.

B. Continuing obligations: Termination or expiration of this CONTRACT shall not discharge the CONTRACTOR(S) of obligations with respect to services or items furnished prior to termination or expiration, including retention of records and verification of Overpayments or underpayments. Termination or expiration shall not discharge the State's payment obligations, as allowed by law, to the CONTRACTOR(S) or the CONTRACTOR(S)' payment obligations to its Subcontractors and Providers with respect to Covered Services furnished prior to termination or expiration. Upon any termination or expiration of this CONTRACT, in accordance with the provisions in this section, the CONTRACTOR(S) must:

   1. Provide the State with any and all information deemed necessary by the State within the timeframe and in the format specified by the State. Failure to provide this information is subject to 2.19.5.A of this CONTRACT referencing the State's right to recover damages post-CONTRACT termination.

   t. Be financially responsible for Claims with dates of service through 11:59 pm Central Time on the day of termination, except as otherwise provided in this section of the CONTRACT, including those submitted within established time limits after the day of termination, including Claims subject to dispute or Appeal.

   u. Provide the State with all Encounter Data for Claims paid by the CONTRACTOR(S) under this CONTRACT, within the timeframes specified in this CONTRACT.

   v. Be financially responsible for hospitalized Members through the date of discharge or fifteen (15) Calendar Days after termination or expiration of this CONTRACT, whichever is earlier.

   w. Be financially responsible for the results of Member Appeals of Adverse Benefit Determinations rendered by the CONTRACTOR(S) concerning treatment or services requested prior to termination or expiration that would have been provided but for the denial prior to termination or expiration, which are subsequently overturned at a Grievance, Appeal, or State Fair Hearing proceeding.

   x. Arrange for the orderly transition of Member care and Member records to those Providers who will be assuming care for the Member, in accordance with this CONTRACT.

   y. Maintain the confidentiality of all Member's protected health information (PHI) as required by law and the provisions of this CONTRACT.

C. Notice to Members: In the event that this CONTRACT is terminated or expires without the State and the CONTRACTOR(S) executing a new CONTRACT, the CONTRACTOR(S) must notify all Members in writing of such termination or such expiration at least thirty (30) Calendar Days in advance of the effective date of termination or expiration. Notice must be made available in an accessible format for individuals with visual impairments and in the relevant language for Members with Limited English Proficiency. For Members who are undergoing treatment for an acute condition, the CONTRACTOR(S) must describe in the notice the process for obtaining a complete transition of care plan in accordance with Section 2.4 of this CONTRACT to ensure the continuation of care prior

to termination or expiration of this CONTRACT. The Member notice language and process must be prior approved by KDHE in writing prior to distribution.

D. Notice to Providers: In the event that this CONTRACT is terminated or expires without the State and the CONTRACTOR(S) executing a new CONTRACT, the CONTRACTOR(S) must notify all Participating Providers in writing of such termination or such expiration at least thirty (30) Calendar Days in advance of the effective date of termination or expiration. The notice must include processes for continuing authorizations. The Provider notice language and process must be prior approved by KDHE in writing prior to distribution.

E. Termination or expiration requirements: If the State or the CONTRACTOR(S) provides written notice of termination or expiration, the State may withhold up to 20% of one (1) month's Capitation Payment due to the CONTRACTOR(S). Once the State determines that the CONTRACTOR(S) has substantially complied with the termination or expiration requirements in this section, the withheld portion of the Capitation Payment will be paid to the CONTRACTOR(S). The State will not unreasonably delay or deny a determination that the CONTRACTOR(S) substantially complied with the termination or expiration requirements. The State will share with the CONTRACTOR(S) a determination on compliance with the termination or expiration requirements by the first day of the second month after the CONTRACT ends. If the State determines that the CONTRACTOR(S) has not substantially complied, the State will share a subsequent determination by the first day of each subsequent month. If the State subsequently determines that the CONTRACTOR(S) has substantially complied with termination or expiration requirements, it will promptly pay the withheld portion of the Capitation Payment.

Contractual Provisions Attachment

DA-146a Rev. 07/19

Important

The Provisions found in Contractual Provisions Attachment (Form DA-146a, Rev. 07-19), which is attached hereto, are hereby incorporated in this contract, and made a part thereof. The parties agree that the following provisions are hereby incorporated into the contract to which it is attached and made a part thereof, said contract being the _____ day of _____, 20____.

Terms Herein Controlling Provisions

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

Kansas Law and Venue

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

Termination Due to Lack of Funding Appropriation

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

Disclaimer of Liability

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

Anti-Discrimination Clause

The contractor agrees: (a) to comply with the Kansas Act Against Discrimination (K.S.A. 44 1001, et seq.) and the Kansas Age Discrimination in Employment Act (K.S.A. 44-1111, et seq.) and the applicable provisions of the Americans With Disabilities Act (42 U.S.C. 12101, et seq.) (ADA), and Kansas Executive Order No. 19-02, and to not discriminate against any person because of race,

color, gender, sexual orientation, gender identity or expression, religion, national origin, ancestry, age, military or veteran status, disability status, marital or family status, genetic information, or political affiliation that is unrelated to the person's ability to reasonably perform the duties of a particular job or position; (b) to include in all solicitations or advertisements for employees, the phrase "equal opportunity employer"; (c) to comply with the reporting requirements set out at K.S.A. 44-1031 and K.S.A. 44-1116; (d) to include those provisions in every subcontract or purchase order so that they are binding upon such subcontractor or vendor; (e) that a failure to comply with the reporting requirements of (c) above or if the contractor is found guilty of any violation of such acts by the Kansas Human Rights Commission, such violation shall constitute a breach of contract and the contract may be cancelled, terminated or suspended, in whole or in part, by the state agency or the Kansas Department of Administration; (f) Contractor agrees to comply with all applicable state and federal anti-discrimination laws and regulations; (g) Contractor agrees all hiring must be on the basis of individual merit and qualifications, and discrimination or harassment of persons for the reasons stated above is prohibited; and (h) if it is determined that the contractor has violated the provisions of any portion of this paragraph, such violation shall constitute a breach of contract and the contract may be canceled, terminated, or suspended, in whole or in part, by the contracting state agency or the Kansas Department of Administration.

Acceptance of Contract

This contract shall not be considered accepted, approved or otherwise effective until the statutorily required approvals and certifications have been given.

Arbitration, Damages, Warranties

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

Representative's Authority to Contract

By signing this contract, the representative of the contractor thereby represents that such person is duly authorized by the contractor to execute this contract on behalf of the contractor and that the contractor agrees to be bound by the provisions thereof.

Responsibility for Taxes

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

Insurance

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

Information

No provision of this contract shall be construed as limiting the Legislative Division of Post Audit from

having access to information pursuant to K.S.A. 46-1101, et seq.

The Eleventh Amendment

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

Campaign Contributions / Lobbying

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

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APPENDIX A: DEFINITIONS & ACRONYMS

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

A

Abuse – For purposes of program integrity, Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid and Children's Health Insurance Program (CHIP) or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Beneficiary/Member practices that result in unnecessary cost to the Medicaid and CHIP program (see 42 CFR § 455.2).

Access – As it pertains to External Quality Review (EQR), the Member's ability to receive timely Covered Services to achieve optimal Outcomes, as evidenced by the CONTRACTOR(S) successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR § 438.68 (network adequacy standards) and 42 CFR § 438.206 (availability of services).

Action – The denial, in whole or in part, of a payment for a service to a Provider.

Admission – Entry into a facility for the purpose of receiving inpatient medical treatment.

Adult Care Home – As defined in K.S.A 39-923, Adult Care Homes are "any nursing facility, nursing facility for mental health, intermediate care facility for people with intellectual disability, assisted living facility, residential health care facility, home plus, boarding care home and adult day care facility, all of which are classifications of adult care homes and are required to be licensed by the secretary of aging and disability services."

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

Adverse Benefit Determination – As defined in 42 CFR § 438.400, as related to a Member:

(1) The denial or limited authorization of a requested service, including the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "Clean Claim" is not an Adverse Benefit Determination.

(4) The failure to provide services in a timely manner, as defined by the State.

(5) The failure of the CONTRACTOR(S) to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.

(6) For a resident of a Rural area with only one (1) managed care organization (MCO, the denial of a

Member's request to exercise their right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of a Member's request to dispute a financial liability, including cost sharing, Copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Annual Open Enrollment – The period designated by the State when Members can elect to transfer from one (1) KanCare MCO to another KanCare MCO without good cause.

Appeal – A review by the CONTRACTOR(S) of an Adverse Benefit Determination for a Member or an Action for a Provider.

Authorized Representative – Any person or entity acting on behalf of the Member or Provider with the written consent of the Member or Provider. A Provider may be an Authorized Representative of a Member.

Automated Information Management System – A comprehensive data set of demographics, client status, and Encounter Data for the mental health consumers served by local Community Mental Health Centers (CMHCs) in Kansas.

B

Behavioral Health – Mental health and substance use disorder (SUD).

Behavioral Health Services – Mental health and SUD Covered Services.

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

Business Days – Monday through Friday, except for State of Kansas holidays.

C

Calendar Days – All seven (7) days of the week, including State of Kansas holidays.

Capitation Payment –Payment the State makes periodically to a CONTRACTOR(S) on behalf of each Member enrolled under the CONTRACT and based on the actuarially sound capitation rate for the provision of Covered Services. The State makes the payment regardless of whether the particular Member receives services during the period covered by the payment.

Care Coordination – Name used in KanCare for the comprehensive, holistic, integrated approach to coordinating and monitoring all of an individual's care (e.g., behavioral health, physical health, Long-Term Services and Supports [LTSS], and Social Determinants of Health [SDOH]) through direct support, Provider referrals, and linkages to community resources.

Care Management – Applies systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage an individual's comprehensive behavioral health, physical health, and LTSS conditions more effectively. The goal of Care Management is to achieve an optimal level of wellness and improve coordination of care while addressing SDOH.

Case Management – A collaborative process of assessment, planning, facilitation, service coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs (e.g., behavioral health, physical health, and LTSS) through communication and referral to available resources to ensure needs are met. Additionally, Case Management addresses SDOH that include but are not limited to housing, domestic violence, and food assistance.

Centers for Medicare & Medicaid Services – Division within the Federal Department of Health and Human Services (HHS) which administers Medicare and oversees the State's administration of Medicaid.

Certified Community Behavioral Health Clinic – An organization that has been provisionally or fully certified by the Kansas Department for Aging and Disability Services (KDADS) to provide, directly or through formal contract with a designated collaborating organization (DCO), the following Certified Community Behavioral Health Clinic (CCBHC) services: Crisis services; screening, assessment and diagnosis, including risk assessment; person-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring of key indicators of health risks; targeted case management (TCM); psychiatric rehabilitation services; peer support and family supports; medication assisted treatment (MAT); assertive community treatment; and community-based mental health care for veterans and those in the armed services. CCBHCs must also provide care coordination with other health and social service providers in the spirit of integrated physical health, behavioral health, and supportive services.

Change in Organizational Structure – The acquisition, change in ownership, merger, or reorganization involving the CONTRACTOR(S).

Children's Health Insurance Program – The operated by the State under Title XXI of the Social Security Act (SSA), and related State and Federal rules and regulations for children up to age nineteen (19) who will receive all Medically Necessary services covered by the State's CHIP State Plan.

Children with Special Health Care Needs – Young persons with disabilities or diseases which require specialty care and who qualify for services under the Kansas Special Health Care Needs (SHCN) program, Title V, through the Kansas Department of Health & Environment's Bureau of Family Health, and are enrolled in KanCare.

Chronic Condition – A condition or disease that is persistent or otherwise long-lasting (usually longer than three [3] months) in its effects or a disease that comes with time, such as, but not limited to arthritis, asthma, cancer, chronic obstructive pulmonary disease, diabetes, and viral diseases, such as Hepatitis C and HIV/AIDS.

Claim – (1) a bill for services, (2) a line item of service, or (3) all services for one (1) Member within a bill.

Clean Claim – Claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It does not include a Claim from a Provider who is under investigation for Fraud or Abuse or a Claim under review for Medical Necessity.

Clinical Laboratory Improvement Amendments – A set of standards issued by the Centers for Medicare & Medicaid Services (CMS) to ensure consistency of laboratory services.

Community Care Coordination Provider – A conflict-free entity that is under contract with the CONTRACTOR(S) to perform specific care coordination activities described in Appendix L (Care Coordination Matrix). These conflict-free entities may not be the same entities that provide Home- and Community-Based Services (HCBS) Waiver services, per 42 CFR 441.301(c)(1)(vi). See CONTRACT Section 2.3.13, Conflicts of Interest, for more information.

Community Care Coordinator – A care coordinator who is employed by a Community Care Coordination Provider that is under contract with the CONTRACTOR(S) to perform specific Care Coordination activities described in Appendix L (Care Coordination Matrix) and who is based in the Member's community.

Conflict-Free Case Management – When the individual providing Care Coordination is not employed by, does not have a financial interest in, nor is affiliated to any degree with the Participating Provider of services. The exception being when the State determines that only one (1) entity in a geographic area is willing and qualified to provide Case Management and/or develop Person-Centered Service Plans (PCSP). In these cases, the State must develop conflict of interest protections, including separation of entity and Participating Provider functions within Participating Provider entities, which must be approved by the CMS. (42 CFR § 441.301(c) (1) (vi) and § 441.730(b)).

Consumer Assessment of Healthcare Providers and Systems – Surveys that ask consumers to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of Participating Providers and ease of access to health care services.

CONTRACTOR(S) – The MCO who has entered into a contract with the State to provide KanCare Covered Services to a Member.

Coordination of Benefits – Provision regulating payments to eliminate duplicate coverage when a Member is covered by multiple issuers.

Copayment – A fixed dollar amount that a Member must pay when they receive a particular Covered Service, as specified by the State.

Covered Services – All Medicaid and CHIP Health Care Services, Pharmaceuticals, Supplies, and Devices provided by the CONTRACTOR(S) in any setting, including, but not limited to, medical care, behavioral health care, and LTSS.

Critical Incident – Critical Incidents shall include, but not be limited to, the following incidents:

(1) Unexpected death of a Member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended to by a physician.

(2) Suspected physical, mental, or sexual mistreatment, abuse, and/or neglect of a Member.

(3) Suspected theft or financial exploitation of a Member.

(4) Severe injury sustained by a Member.

(5) Medication error involving a Member.

(6) Inappropriate/unprofessional conduct by a Participating Provider involving a Member.

D

Day – Except where the term Business Day is expressly used, all references to “days” in this CONTRACT shall be construed as Calendar Days.

Disenrollment – The removal of a Member from the CONTRACTOR(S)’ roster which results in a cessation of services for that Member from that CONTRACTOR(S).

Durable Medical Equipment – Equipment that meets these conditions:

(1) Withstands repeated use.

(2) Is not generally useful to a person in the absence of an illness or injury.

(3) Is primarily and customarily used to serve a medical purpose.

(4) Is appropriate for use in the home.

(5) Is rented or purchased as determined by the State.

E

Early and Periodic Screening, Diagnostic, and Treatment – The federally required Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, as defined in Section 1905(r) of the SSA and 42 CFR Part 441, Subpart B for Members under the age of twenty-one (21). It includes periodic screening and diagnostic services to determine health care needs as well as the provision of all Medically Necessary services listed in Section 1902(a) of the SSA even if the service is not available under Kansas’ Medicaid State Plan. The Kansas EPSDT program is called KAN Be Healthy Program.

Electronic Health Record – A record in digital format that is a systematic collection of electronic health information. Electronic Health Records (EHRs) may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

Electronic Protected Health Information – Protected health information that is transmitted by or maintained in electronic media.

Electronic Visit Verification – State authorized system used for verification that HCBS are performed and submitted as Claims to the CONTRACTOR(S).

Eligibility Broker – An individual or entity that performs choice counseling.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are as follows:

(1) Furnished by a Provider that is qualified to furnish these services.

(2) Needed to evaluate or stabilize an Emergency Medical Condition.

Encounter – When a Member receives services from a Provider.

Encounter Data – The information relating to the receipt of any item(s) or service(s) by a Member under the CONTRACT that is subject to the requirements of 42 CFR § 438.242 and 42 CFR § 438.818.

Enrollment – The assignment of a Beneficiary into a CONTRACTOR(S).

External Quality Review – The analysis and evaluation by an External Quality Review Organization (EQRO), of aggregated information on quality, timeliness, and Access to the Health Care Services that a CONTRACTOR(S) (described in 42 CFR § 438.310(c)(2)), or their CONTRACTOR(S) furnish to Medicaid Beneficiaries.

External Quality Review Organization – An organization that meets the competence and independence requirements set forth in 42 CFR § 438.354, and performs mandatory External Quality Review (EQR), other EQR-related activities as set forth in 42 CFR § 438.358, or both.

F

Federally Qualified Health Center – An entity that is receiving a grant under Section 330 of the Public Health Service Act, is designated by the Federal Health Resources and Services Administration (HRSA) as a Federally Qualified Health Center (FQHC) look-alike, or is an outpatient health program/facility operated by a tribe or tribal organization (under the Indian Self-Determination Act) or by an Urban Indian Organization (under Title V of the Indian Health Care Improvement Act).

Fee-For-Service – The payment method by which the State reimburses Providers for each Covered Service rendered to a Beneficiary.

Fiscal Agent –The organization contracted by the State to operate the Kansas Modular Medicaid System (KMMS).

Formulary – The complete list of Pharmaceuticals, Supplies, or Devices that are covered by the State and must be covered by the CONTRACTOR(S).

Fraud – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes Fraud under applicable Federal and State laws and regulations.

G

Grievance – An expression of dissatisfaction about any matter other than an Adverse Benefit Determination or an Action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member’s rights regardless of whether remedial action is requested. Grievance includes a Member’s right to dispute an extension of time proposed by the CONTRACTOR(S) to make a Service Authorization decision.

H

Habilitation Services and Devices – Habilitation Services and Devices refer to Health Care Services and devices that help a person maintain, learn, or improve skills and functioning for daily living.

HCBS Waiver – A Home- and Community-Based Waiver of Medicaid provisions for specified groups authorized under Section 1915(c) of the Social Security Act.

Healthcare Effectiveness Data and Information Set – A tool used by more than 90% of health plans to measure performance on important dimensions of care and service. The tool is managed by the National Committee for Quality Assurance (NCQA).

Health Care Services – All Medicaid/CHIP services provided by the CONTRACTOR(S) under this CONTRACT in any setting, including but not limited to medical care, behavioral health care, and LTSS.

Health Equity – The attainment of optimal health for all people, where everyone has a fair and just opportunity to attain their full health potential and well-being regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes, including SDOH.

Health Information Exchange – Refers to the electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.

Health Information Technology – Refers to electronic systems that make it possible for Providers to better manage Member care through secure use and sharing of health information.

Health Risk Assessment – An extensive health questionnaire, conducted by a care coordinator using a person-centered approach, to evaluate a Member's health risks, quality of life, SDOH, and available services and supports. The Health Risk Assessment determines the appropriate needs assessment that should be conducted for the Member.

Health Screen – An initial, brief, health questionnaire for all Members, conducted by a care coordinator or Member of the Care Coordination team, to determine the appropriate next course of action for care, including the need for a Health Risk Assessment.

Home- and Community-Based Services – Provides opportunities for Members to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses and are authorized under the State's 1915(c) HCBS Waivers.

Home Health Care – Home Health Care is medical care provided to a Member in their home or non-institutional setting by a registered nurse (RN), home health aide, occupational therapist, physical therapist, or other skilled medical professionals. Home Health Care is often prescribed as part of a care plan following a Hospitalization or a significant change in health status.

Hospice – Hospice care is a comprehensive set of services, identified and coordinated by an interdisciplinary group of medical professionals to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. It is compassionate comfort care (as opposed to curative care) for people facing a terminal illness with a prognosis of six (6) months or less based on their physician's estimate if the disease runs its course as expected.

Hospitalization – Hospitalization is a period of confinement (episode of care) in a hospital that begins with a patient's admission and ends with discharge

Hospital Readmission – The subsequent admission of a Member as an inpatient into a hospital within thirty (30) Calendar Days of discharge as an inpatient from the same (transfers from an acute care bed to a psychiatric bed in the same hospital or transfers between hospitals are not considered readmissions).

I

Indian Health Care Provider – A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

J

K

KAN Be Healthy – The name of the federally mandated EPSDT program in Kansas.

Kansas Modular Medicaid System – The system that processes Fee-For-Service (FFS) claims and Encounter Data related to Managed Care as well as providing several operational, administrative, and data supports to the KanCare program. Kansas Modular Medicaid System (KMMS) is the State's name for its Medicaid Management Information System.

KDHE-DHCF – The Kansas Department of Health and Environment, Division of Health Care Finance. KDHE-DHCF is the single-state Medicaid agency for Kansas and the State agency responsible for the administration and management of the KanCare Medical Assistance (Medicaid) program and CHIP.

Key Personnel – The CONTRACTOR(S)' chief executive officer (CEO) and other personnel as designated in Section 2.17 of the CONTRACT.

L

Limited English Proficient – Potential Members and Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

Lock-In – The restriction, through limitation of the use of the medical identification card to designated medical Participating Providers, Pharmacy, and/or hospitals, of a Member's access to medical services because of Abuse.

Long-Term Services and Supports – Services and supports provided to Members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the individual's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

M

Managed Care – A system of managing and financing health care techniques and concepts to ensure that services provided to Members are necessary, efficiently provided, and appropriately priced. The Managed Care program in Kansas is referred to as KanCare.

Managed Care Organization – As defined at 42 CFR § 438.2, a Managed Care Organization (MCO) is either a federally qualified health maintenance organization or any other public or private entity this is organized primarily for the purpose of providing health care services, makes the services it provides to its Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other members within the area served by the entity, and meets the solvency standards of 42 CFR § 438.116.

Marketing – Any communication, from the CONTRACTOR(S) to a Beneficiary who is not enrolled in that CONTRACTOR(S), that can reasonably be interpreted as intended to influence the Beneficiary to enroll in that particular CONTRACTOR(S)' product, or either to not enroll in or to disenroll from another KanCare MCO's product. Marketing does not include communication to a Beneficiary from the issuer of a qualified health plan, as defined in 45 CFR § 155.20, about the qualified health plan.

Marketing Materials – Materials that are produced in any medium, by or on behalf of the CONTRACTOR(S) and can reasonably be interpreted as intended to market the CONTRACTOR(S) to potential Members.

Medicaid – The medical assistance program operated by the State under Title XIX of the SSA, and related State and Federal rules and regulations.

Medicaid Management Information System – The system, known as the Kansas Modular Medicaid System () in Kansas, which processes FFS Claims and Encounter Data related to Managed Care as well as providing several operational, administrative, and data supports to the KanCare program.

Medicaid Provider Manuals or State Provider Manuals – Service specific documents created by the Kansas Medicaid Fiscal Agent to describe policies and procedures applicable to the program generally and that service specifically.

Medical Necessity – Defined in K.A.R. 30-5-58 and the State will reference this citation in any discussion regarding the definition of Medical Necessity. In addition, The CONTRACTOR(S) is responsible for covering services related to the following:

(1) The prevention, diagnosis, and treatment of health impairments.

(2) The ability to achieve age-appropriate growth and development.

(3) The ability to attain, maintain, or regain functional capacity.

Medical Supplies – Items that meet these conditions:

(1) Are not generally useful to a person in the absence of illness or injury.

(2) Are prescribed by a physician.

(3) Are used in the home and certain institutional settings.

MediKan Program – A State-funded program for the indigent that is both time-limited and limited in scope of services designed to serve adults with some level of disability that does not meet the SSA definition of disability.

Member – A Beneficiary who has been certified by the State as eligible to enroll under this CONTRACT, and whose name appears on the CONTRACTOR(S)' Enrollment information which the State will transmit to the CONTRACTOR(S) in accordance with an established notification schedule. Member includes the Member's Authorized Representative.

Must – A term, like "shall," that is used throughout the KanCare CONTRACT that means the requirement(s) is mandatory.

N

National Association of Insurance Commissioners – The United States' standard setting and regulatory support organization created and governed by the chief insurance regulators from the fifty (50) states, the District of Columbia, and five (5) United States territories. Through the National Association of Insurance Commissioners (NAIC), State insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of State regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, forms the national system of State-based insurance regulation in the United States.

Needs Assessment – A process, conducted by a care coordinator, to assess a Member's need for services and supports (including but not limited to, physical health, behavioral health, and LTSS) and the gaps that exist in addressing identified needs.

Non-Covered Services – Services for which Medicaid or CHIP will not provide reimbursement, including services that have been denied due to the lack of Medical Necessity.

Non-Participating Provider – Any Provider that has not entered into a Provider agreement with the CONTRACTOR(S) or Subcontractor(s) to serve Members.

O

Occupational Therapy – The provision of treatment by an occupational therapist registered with the American Occupational Therapy association. The treatment shall meet these requirements:

(1) Be rehabilitative and restorative in nature.

(2) Be provided following physical debilitation due to acute physical trauma or physical illness.

(3) Be prescribed by the attending physician.

Offer Point – The rate, within the State initial actuarially sound capitation rate range, after accounting for all additional payment components (e.g., projected quality incentives earned), at which the State is willing to contract with any bidder willing to accept this rate. The Offer Point is only employed if the initial cost proposals submitted by the bidders are not acceptable to the State. If the State employs the Offer Point, the State has the option of either: 1) selecting a different Offer Point for each winning bidder based upon the relative position of their submitted statewide blended rate within the State initial actuarially sound capitation rate range, or 2) selecting the same Offer Point for all winning bidders. The

initial agreed upon rate will be determined between the State and the bidders after all proposals are submitted which may or may not include the use of an Offer Point and/or best and final offer(s). If the State updates the State initial actuarially sound capitation rate range to incorporate more recent information, the initial agreed upon rate will remain at the same position in the State final actuarially sound capitation rate range relative to the State initial actuarially sound capitation rate range.

Open Panel – A Provider who is accepting new Medicaid/CHIP patients/clients.

Other Employment Programs – Programs such as Individual Placement and Supported Employment, which is an evidence-based approach to supported employment for people who have a mental illness. Individual Placement and Support (IPS) supports people in their efforts to achieve steady, meaningful employment in mainstream competitive jobs, either part-time or full-time. This stands in contrast to other vocational rehabilitation approaches that employ people in sheltered workshops and other set-aside jobs. IPS has been extensively researched and proven to be effective.

Outcomes – Changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services.

Out-of-State Provider – Any Provider that is physically located more than fifty (50) miles beyond the border of Kansas, except those providing services to children who are wards of the State.

In addition, the following shall be considered Out-of-State Providers if they are physically located beyond the border of Kansas:

(1) Nursing facilities.

(2) Intermediate care facilities.

(3) CMHCs.

(4) Partial hospitalization service Participating Providers.

(5) Alcohol and drug program Participating Providers.

Outpatient Treatment – Services provided by the outpatient department of a hospital, a facility that is not under the administration of a hospital, or a physician’s office.

Overpayment – Any payment made to a Participating Provider or Non-Participating Provider by the CONTRACTOR(S) to which the Participating Provider or Non-Participating Provider is not entitled to under Title XIX or Title XXI of the SSA or any payment to the CONTRACTOR(S) by the State to which the CONTRACTOR(S) is not entitled.

Owner – Sole proprietor, member of a partnership, or a corporate stockholder with 5% or more interest in the corporation. The term “owner” shall not include minor stockholders in publicly held corporations.

P

Participating Provider – Any Provider that has entered into a Provider agreement with the CONTRACTOR(S) or a Subcontractor(s) to serve Members and receives Medicaid or CHIP funding directly or indirectly from the CONTRACTOR(S) to order, refer, or render Covered Services. A Participating Provider is not a Subcontractor by virtue of the Provider agreement.

Person-Centered Service Plan – A written service plan developed jointly with a Member (and/or the Member's Authorized Representative) that reflects the services and supports that are important for the Member to meet the needs identified through a Needs Assessment, what is important to the Member with regard to preferences for the delivery of such services and supports and the Providers of the services and supports. (42 CFR § 441.725(a) and (b)).

Pharmaceutical, Supply, or Device – Refers to the following:

(1) Any article recognized in the official United States pharmacopoeia, another similar official compendium of the United States, an official national formulary, or any supplement of any of these publications.

(2) Any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings.

(3) Any article intended to affect the structure or any function of the bodies of human beings.

(4) Any article intended for use as a component of any article specified in 1, 2, or 3 above.

Pharmacist – Any person duly licensed or registered to practice pharmacy by the State board of pharmacy or by the regulatory authority of the State in which the person is engaged in the practice of pharmacy.

Pharmacy – The premises, laboratory, area, or other place meeting these conditions:

(1) Where drugs are offered for sale, the profession of pharmacy is practiced, and Prescriptions are compounded and dispensed.

(2) That has displayed upon it or within it the words "pharmacist", "pharmaceutical chemist", "pharmacy", "apothecary", "drugstore", "druggist", "drugs", "drug sundries", or any combinations of these words or words of similar import.

(3) Where the characteristic symbols of Pharmacy or the characteristic prescription sign "Rx" are exhibited. The term "premises" as used in this subsection refers only to the portion of any building or structure leased, used, or controlled by the registrant in the conduct of the business registered by the board at the address for which the registration was issued.

Pharmacy Provider Network – A network of pharmacies qualified to participate in the Kansas Medical Assistance Program (KMAP) pharmacy program that are willing to comply with the CONTRACTOR(S)' payment rates and terms and to adhere to quality standards established by the CONTRACTOR(S).

Physical Therapy – Treatment that meets these criteria:

(1) Is provided by a physical therapist registered in the jurisdiction where the service is provided or by the Kansas board of healing arts.

(2) Is rehabilitative and restorative in nature.

(3) Is provided following physical debilitation due to acute physical trauma or physical illness.

(4) Is prescribed by the attending physician.

Plan – In accordance with 42 CFR § 438.10, for consistency of information provided to Members, Plan is the Member's health plan; may also be called a managed care organization (MCO).

Plan of Service – A written document that describes and records the Member's goals and service needs. The Plan of Service records the strategies to meet goals and interventions, selected by the Member and their team to support them in improving the Member's health and wellbeing and addressing SDOH.

Positive Behavioral Support – A set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment.

Post-Stabilization Care Services – Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR § 438.114(e), to improve or resolve the Member's condition.

Potential Member – A Beneficiary who is subject to mandatory Enrollment or may voluntarily elect to enroll in KanCare, but is not yet a Member of a specific KanCare MCO.

Preferred Drug List – A subset of the Formulary that is further managed to encourage the use of safe, effective, and affordable products. The Preferred Drug List (PDL) applies to products billed on both the medical and pharmacy benefits.

Prescribed – The issuance of a Prescription order by a person authorized by law to administer, prescribe, and use Prescription-only drugs in the course of professional practice.

Prescription – Refer to either of the following:

(1) A Prescription order.

(2) A Prescription medication.

Prescription Product – Any Pharmaceutical, Supply, or Device that is dispensed according to a Prescription order. If indicated by the context, the term "Prescription Product" may include the label and container of the Pharmaceutical, Supply, or Device.

Prevalent – A non-English language determined to be spoken by a significant number or percentage of potential Members and Members that are Limited English Proficient.

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

Primary Care – All Health Care Services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist (OB/GYN), pediatrician, or other licensed practitioner as authorized by the State, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Prior Authorization – Member's request to the CONTRACTOR(S) for the provision of a service. This is also known as a Service Authorization.

Protected Health Information – Shall have the same meaning as the term "Protected Health Information" in 45 CFR § 160.103 and is individually identifiable information in any medium pertaining to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, that CONTRACTOR(S) receives from Kansas Department of Health & Environment or that CONTRACTOR(S) creates or receives on behalf of Kansas Department of Health & Environment. The term "Protected Health Information" applies to the original data and to any health data derived or extracted from the original data that has not been de-identified.

Provide – To furnish directly, or authorize and pay for the furnishing of, a Covered Service to a Member.

Provider – Any individual or entity that is engaged in the delivery, ordering, or referring of Covered Services, and is legally authorized to do so by the state in which it delivers the Covered Services. This term may be used when referring to both Participating Providers and Non-Participating Providers.

Provider Preventable Conditions – The minimum set of conditions, including infections and events, which have been identified for non-payment according to the State's Medicaid State Plan.

Prudent Layperson – A person who possesses an average knowledge about health, health care, and medicine.

Psychiatric Residential Treatment Facility – Any non-hospital facility with a Provider agreement with a State Medicaid agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of twenty-one (21) (psychiatric under twenty-one [21] benefit).

Q

R

Rapid-Cycle Process Improvement – An iterative quality improvement process that uses a four-stage approach often referred to as the Plan-Do-Study-Act model, each iteration of the process should occur in a rapid sequential fashion that takes less than three (3) months to complete.

Rate Cell – A set of mutually exclusive categories of Members that is defined by one (1) or more characteristics for the purpose of determining the capitation rate and making a Capitation Payment; such characteristics may include age, gender, eligibility category, and region or geographic area.

Reconsideration – A review by the CONTRACTOR(S) of an Action.

Regional Alcohol & Drug Assessment Center (Heartland RADAC) – A private, 501(c) 3, non-profit organization, incorporated in 1998 as a licensed alcohol and drug treatment program that provides assessment and referral services, as well as care coordination and case management services for individuals seeking substance abuse services.

Risk – The possibility of monetary loss or gain by the CONTRACTOR(S) resulting from service costs exceeding or being less than Capitation Payments made to it by the State.

Rural – An area identified as Rural by the United States Census Bureau as an area that is not Urban.

Rural Health Clinic – An entity that has been determined by CMS to meet the requirements of Section 1861(aa)(2) of the SSA and 42 CFR Part 491 and has an agreement with CMS to provide Rural Health Clinic services under Medicare.

S

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

Serious and Persistent Mental Illness – An individual meets the definition of an adult with a Serious and Persistent Mental Illness (SPMI) if they meet the criteria for a dimension I diagnosis of:

(1) SPMI.

(2) Schizophrenia or other psychotic disorder (Diagnostic and Statistical Manual of Mental Disorders [DSM] diagnosis of 295.xx, 297.xx, 298.xx).

(3) Major depressive disorder or bipolar disorder (DSM diagnosis of 296.xx, severe, recurrent, not in full remission).

(4) Anxiety disorder, personality disorder, or a combination of mental disorders sufficiently disabling to meet criteria of functional disability.

Service Authorization – Member's request to the CONTRACTOR(S) for the provision of a Covered Services.

Shall – A term, like "must," that is used throughout the KanCare CONTRACT that means the requirement(s) is mandatory.

Significant Change in Condition – A change in an individual's health status as the result of factors including, but not limited to, loss of caregiver, Hospitalization, institutionalization, change in residence, fall, or other incident, warranting a reassessment of need for services and supports to safely support the individual.

Single State Medicaid Agency – Kansas Department of Health & Environment, Division of Health Care Finance, which is legally authorized and responsible for administering the provisions of the State Plan for Medical Assistance (Medicaid) and the administration of CHIP on a statewide basis.

Social Determinants of Health – Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks *(Healthy People 2030).*

Start Date – The date the CONTRACT for services becomes effective.

State – The State of Kansas, including, but not limited to, any entity or agency of the State.

State Fair Hearing – An administrative hearing involving the presentation of evidence and argument before a presiding officer from the Kansas Office of Administrative Hearings concerning an Adverse Benefit Determination or an Action. The presiding officer will hear the matter, determine the result, and issue a decision.

State Plan – Plan approved by CMS governing the Kansas Medicaid program.

Subcontract – Any written agreement between the CONTRACTOR(S) and a Subcontractor.

Subcontractor – An individual or entity with a Subcontract with the CONTRACTOR(S) that relates directly or indirectly to the performance of the CONTRACTOR(S)' obligations under the CONTRACT. A Participating Provider is not a Subcontractor by virtue of a Provider agreement with the CONTRACTOR(S).

Subrogation – Procedure where an insurance company recovers from a Third-Party when the action resulting in medical expense (e.g., auto accident) was the fault of another person.

T

Telemedicine – The delivery of Health Care Services or consultations while the patient is at an originating site and the health care Provider is at a distant site. Telemedicine will be provided by means of real-time, two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, that facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Also referred to as telehealth.

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

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

Title XXI – The provisions of Title XXI of the SSA (the Children's Health Insurance Program), which provides health insurance coverage to uninsured children from low-income families, who are not Title XIX eligible.

Transportation – A Covered Service available for the purpose of transporting a Member to a Provider providing Covered Services.

U

Urban – An area identified as Urban by the United States Census Bureau.

Urgent Care –Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe it requires Emergency Services.

Utilization Management – Evaluation of necessity and appropriateness of Covered Services according to set guidelines.

Utilization Report – A report that provides information regarding evaluation of necessity and appropriateness of Health Care Services according to set guidelines.

V

W

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

Warm Transfer – As it relates to the CONTRACTOR(S)' customer service center and help lines, a telecommunications mechanism in which the person answering the call facilitates the transfer to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.

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

Will – A term, like "shall," that is used throughout the KanCare CONTRACT that means the requirement(s) is mandatory.

WORK Program – A State Plan package of benefits that provides personal services, as well as other services, for employed persons with disabilities.

X

Y

Z

Acronym	Definition
A	
ABA	Applied Behavior Analysis
ACIP	Advisory Commission on Immunization Practices
ADA	Americans with Disabilities Act
ADAP	AIDS Drug Assistance Program
ADT	Admission Discharge Transfer
AIMS	Automated Information Management System
AIR	Adverse Incident Reporting System
AMA	American Medical Association
API	Active Pharmaceutical Ingredient
APM	Alternative Payment Model
APN	Advanced Practice Nursing
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARRA	American Recovery and Reinvestment Act
ASAM	American Society of Addiction Medicine
AVRS	Automated Voice Response System
B	
BAA	Business Associate Agreement
BC-DR	Business Continuity/Disaster Recovery
BH-CMO	Behavioral Health Medical Officer/Medical Director
BI	Brain Injury
BSRB	Behavioral Sciences Regulatory Board
C	
CAH	Critical Access Hospital
CAHPS®	Consumer Assessment of Healthcare Providers and Systems (the acronym “CAHPS” is a registered trademark of the Agency for Healthcare Research and Quality)
CAP	Corrective Action Plan
CARC	Claim Adjustment Reason Codes
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease and Control
CDDO	Community Developmental Disability Organization
CDT	Code on Dental Procedures and Nomenclature
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CHR	Community Health Representative
CHW	Community Health Worker

Acronym	Definition
CLIA	Clinical Laboratory Improvement Amendments
CMHC	Community Mental Health Center
CMO	Chief Medical Officer
CMP	Foster Care Case Management Provider
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COI	Conflict of Interest
COO	Chief Operating Officer
CPST	Community Psychiatric Support and Treatment
CPT	Current Procedure Terminology
CRD	Chronic Renal Disease
CRNA	Certified Registered Nurse Anesthetists
CRO	Consumer Run Organization
CYSHCN	Children and Youth with Special Health Care Needs
D	
DCF	Department of Children and Families
DD	Developmental Disability
DEERS	Defense Enrollment Eligibility Reporting System
DHCF	Division of Health Care Finance
DME	Durable Medical Equipment
DOB	Date of Birth
DSH	Disproportionate Share Hospital
D-SNP	Dual Eligible Special Needs Plan
DUR	Drug Utilization Review or Report
E	
EBP	Evidence-Based Practices
ED	Emergency Department
EDI	Electronic Data Interface
EHR	Electronic Health Record
EMC	Electronic Media Claims
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ESRD	End State Renal Disease
EVV	Electronic Visit Verification
F	
FAQ	Frequently Asked Questions
FBC	Free Standing Birth Center

Acronym	Definition
FDA	United States Food and Drug Administration
FE	Frail Elderly
FEB	Front End Billing
FFP	Federal Financial Participation
FFS	Fee-For-Service
FMS	Financial Management Services
FQHC	Federally Qualified Health Center
G	
GAR	Grievance and Appeals Report
GTG	Good to Go Report (WORK)
H	
HCBS	Home- and Community-Based Services
HCPCS	Health Care Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Economic Clinical Health Act
HIV	Human Immunodeficiency Virus
HRA	Health Risk Assessment
HUD	United States Housing and Urban Development
I	
ICD	International Classification of Diseases
ICF	Intermediate Care Facility
ICF/IDD	Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities
ICN	Internal Control Number
IDD	Individuals with Intellectual and Developmental Disabilities
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan
IFSP	Independent Family Services Plan
IHCPs	Indian Health Care Providers
ILC	Independent Living Counselor (WORK Program)
IMD	Institution for Mental Diseases
IPS	Individual Placements and Supports

Acronym	Definition
J	
K	
KAPA	Kansas Administrative Procedures Act
K.A.R.	Kansas Administrative Regulations
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KHIN	Kansas Health Information Network
KID	Kansas Insurance Department
KMAP	Kansas Medical Assistance Program
KMMS	Kansas Modular Medicaid System
K.S.A	Kansas Statutes Annotated
L	
LACIE	Lewis and Clark Health Information Exchange
LEAs	Local Education Agencies
LEP	Limited English Proficient
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
M	
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MDL	Maintenance Drug List
MDS	Minimum Data Set
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person Grant
MHPAEA	Mental Health Parity and Addiction Equity Act
MLR	Medical Loss Ratio
MTM	Medication Therapy Management
N	
NAIC	National Association of Insurance Commissioners
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NDC	National Drug Codes
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NFMH	Nursing Facility for Mental Health
NOMS	National Outcomes Measurement System
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limitation
O	
OB/GYN	Obstetrics and Gynecology

Acronym	Definition
OCK	OneCare Kansas
OIG	HHS Office of the Inspector General
	P
P4P	Pay for Performance
PA	Prior Authorization
PACE	Program for All-Inclusive Care for the Elderly
PAD	Physician-Administered Drug
PARIS	Public Assistance Reporting Information System
PBM	Pharmacy Benefit Manager
PBS	Positive Behavior Support
PCP	Primary Care Provider
PCS	Personal Care Services
PCSP	Person-Centered Service Plan
PD	Physical Disability
PDL	Preferred Drug List
PHI	Protected Health Information
PIP	Performance Improvement Project
PMPM	Per Member Per Month
PNC	Procurement Negotiating Committee
POS	Point of Sale or Place of Service, depending on the context
PPACA	Patient Protection and Affordable Care Act
PPS	Prospective Payment System
ProDUR	Prospective Drug Utilization Review
PRTF	Psychiatric Residential Treatment Facility
	Q
QAPI	Quality Assessment & Performance Improvement
QI	Quality Improvement
QM	Quality Management
QMB	Qualified Medicare Beneficiary
QMS	KanCare Quality Management Strategy
	R
RA	Remittance Advices
RADAC	Regional Alcohol and Drug Assessment Center
RARC	Remittance Advice Remark Codes
CONTRACT	Request for Proposal
RHC	Rural Health Clinic
RN	Registered Nurse
	S
SAMHSA	Substance Abuse and Mental Health Services Administration

Acronym	Definition
SBIRT	Screening Brief Intervention and Referral to Treatment
SDOH	Social Determinants of Health
SDP	State-Directed Payment
SED	Serious Emotional Disturbance
SFTP	Secured File Transfer Protocol
SIA	State Institution Alternative
SMHP	State Medicaid HIT Plan
SOBRA	Sixth Omnibus Budget Reconciliation Act
SPMI	Serious and Persistent Mental Illness
SSA	Social Security Act
SSI	Supplemental Security Income
SSN	Social Security Number
ST	Speech Therapy
STC	Specific Therapeutic Class
STD	Sexually Transmitted Diseases
STEPS	Supports and Training for Employing People Successfully
SUD	Substance Use Disorder
T	
TA	Technology Assisted
TAT	Turnaround Time
TB	Tuberculosis
TCM	Targeted Case Management
TIN	Tax Identification Number
Title XIX	Of the Social Security Act – Federal Funds Source for Medicaid
Title XXI	Of the Social Security Act – Federal funds source for health insurance for low- income children (CHIP)
TPL	Third-Party Liability
TTY/TDD	Teletypewriter/Telecommunications Device
U	
UM	Utilization Management
UR	Utilization Review
URL	Universal/Uniform Resource Locator
U.S.	United States
USDA	United States Department of Agriculture
V	
VBP	Value-Based Purchasing
W	
WIC	Special Supplemental Food Program for Women, Infants, and Children
X	
Y	

Acronym	Definition
Z	

APPENDIX B: [RESERVED]

APPENDIX C: SERVICES

1.0 Overview of Services

1.1 The CONTRACTOR(S) shall assume responsibility for the provision of Medically Necessary services to the populations included in KanCare except those services specifically excluded below in Section 6. The CONTRACTOR(S) shall ensure the provision of Medically Necessary services as specified below, subject to all terms, conditions, and definitions of the CONTRACT. The Covered Services shall be available statewide through the CONTRACTOR(S) or its Subcontractor(s).

1.2 The CONTRACTOR(S) shall agree to assume responsibility for all physical health, Behavioral Health, and Long-Term Services and Supports of each Member as of the effective date of coverage under this CONTRACT. The CONTRACTOR(S) shall ensure the provision of Medically Necessary services as specified below, subject to all terms, conditions, and definitions of this CONTRACT. The CONTRACTOR(S) shall ensure the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The CONTRACTOR(S) shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely for cost savings or because of the diagnosis, type of illness, or condition. Except as otherwise provided in this CONTRACT (e.g., for Pharmaceuticals), the CONTRACTOR(S) may place appropriate limits on a service on the basis of criteria such as Medical Necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose and any limits are in compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). Any and all disputes relating to the definition and presence of Medical Necessity shall be resolved in favor of the State.

1.3 The CONTRACTOR(S) shall maintain a benefit package and procedural coverage for Members at least as comprehensive as the Medicaid Fee-for-Service (FFS) plan, including, but not limited to, the State's Medicaid State plan, 1915(b) Waiver, 1915(c) Home- and Community-Based Services (HCBS) Waivers, 1115 demonstration(s), and Kansas Medicaid Provider Manuals.

1.4 Experimental surgery and procedures are not covered under the State Medicaid and Children's Health Insurance Plans (CHIP). The CONTRACTOR(S) may cover experimental surgery and procedures but shall not require Members to undergo experimental surgery or procedures.

1.5 For a complete list of services covered by Kansas Medicaid FFS, please refer to the Kansas Medicaid Provider Manuals located at https://portal.kmap-state-ks.us/PublicPage/Public/ProviderManuals.

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

2.0 Medical Services

The following services and scope of these services as described in the Medicaid

Provider Manuals and defined in State policy are reflective of current State FFS limitations and must be covered under the terms of this CONTRACT. Covered Services include but are not limited to the following:

2.1 Inpatient hospital services based on Medical Necessity, including but not limited to:

2.1.1 Acute medical detoxification providing twenty-four (24)-hour availability of non-surgical medical treatment for acute intoxication and/or life-threatening conditions, under the direction of a physician in a hospital or other suitably equipped medical setting, with continuous services to persons afflicted with an alcohol and/or drug related crisis. See the KDADS Licensing Standards https://kdads.ks.gov/docs/librariesprovider17/survey-certification-and-credentialing-commission/behavioral-health-licensing/sud-facilities/standards.pdf?sfvrsn=51439ee_2 and Kansas Medical Assistance Program Substance Use Disorder Provider Manual https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/SUD_manual_21273_19109.pdf for eligibility and service requirements.

2.1.2 Maternity services.

2.1.3 Outpatient hospital services.

2.1.4 Inpatient psychiatric services.

2.2 Emergency services based on the prudent layperson standard for Emergency Medical Conditions.

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

2.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): The CONTRACTOR(S) must provide EPSDT screenings to all Medicaid Members under twenty-one (21) years of age and all CHIP Members under nineteen (19) years of age.

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

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

2.4.3 Reporting as specified by Federal regulations and in Appendix H (Reports).

2.4.4 The CONTRACTOR(S) must implement outreach, monitoring, and evaluation strategies for EPSDT. The CONTRACTOR(S) must conduct Provider education activities that increase Member awareness and access to EPSDT services. The CONTRACTOR(S) must conduct specific outreach activities designed to increase education on the EPSDT program and Member participation in the EPSDT program, and measures that will be used to monitor success.

2.5 Other Preventive Screening including but not limited to:

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

2.5.2 Maternal depression screening.

2.6 The CONTRACTOR(s) shall cover routine patient cost for items and services as defined in Section 1905(gg)(1) of the Social Security Act (SSA) that are furnished in connection with participation in a qualified clinical trial.

2.7 Pharmaceuticals, Supplies, and Devices Covered on the Pharmacy Benefit and Physician Administered Drugs (PADs) Covered on the Medical Benefit

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

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

2.7.1.2 Kansas Medicaid makes exceptions to the drugs subject to restriction when determined to be Medically Necessary, as specified in State policy.

2.7.1.3 The PDL is a subset of drugs from the Formulary. The PDL includes drugs that are preferred and non-preferred. Non-preferred drugs require a Prior Authorization (PA) to be approved for use.

2.7.1.3.1 The PDL applies to medications on both the pharmacy and the medical benefit (PADs).

2.7.1.3.2 The PDL includes provisions that allow access to all non-preferred drugs that are on the Formulary through the structured PA process used by the FFS program.

2.7.1.3.3 The CONTRACTOR(S) must follow the State’s PDL, including PA, step edit, and utilization edit criteria.

2.7.2 Resource Files: These files are used for obtaining and maintaining the Kansas Medicaid Formulary. These files are loaded to the Secure File Transfer Portal (SFTP), for the CONTRACTOR(S) to access.

2.7.2.1 Resource files include but are not limited to:

2.7.2.1.1 The FFS Covered Outpatient Drug (COD) file identifies rebate eligible drugs by National Drug Code (NDC) and includes PDL drug designation.

2.7.2.1.1.1 The CONTRACTOR(S) must only cover rebate eligible drugs unless coverage by the CONTRACTOR(S) is otherwise approved by the State Pharmaceutical Program Manager and listed in State policy or they are value-added benefits approved by the State.

2.7.2.1.2 The Active Pharmaceutical Ingredient (API) file contains active Pharmaceutical ingredients and excipients for compounding.

2.7.2.1.3 A Diagnosis Restrictions File and a Procedure Restrictions file.

2.7.2.2 See the KanCare Guide for additional resource file information. The CONTRACTOR(S) must implement these and any other drug coverage related State file updates within three (3) Business Days of the file posting.

2.7.3 The CONTRACTOR(S) must have Kansas Medicaid-only billing codes (bank identification number [BIN]/processor control number [PCN]/Group) for Point-of-Sale (POS) pharmacy Claims. There must be separate billing codes for the CONTRACTOR(S) as the primary payor and for when the CONTRACTOR(S) is not the primary payor, for Claims processing.

2.7.3.1 No change (addition/removal/update) to the POS billing codes (BIN/ PCN/Group) can be implemented until a ninety (90)-Calendar Day notice has been given to the Providers and to KDHE, regarding the upcoming change. This notice requires prior review by the State, per the standard CONTRACTOR(S) document review process.

2.7.4 Quantity Limitations: The CONTRACTOR(S) may establish quantity limitations for covered Pharmaceuticals, Supplies, or Devices. These limitations must be based on the maximum recommended dose or supply according to the manufacturer. If there are no published limitations available, the CONTRACTOR(S) may establish reasonable limits based on appropriate use and standards of quality care. If the State has limitations in place for a covered Pharmaceutical, Supply, or Device, the CONTRACTOR(S) must implement the designated State limitation.

2.7.5 Day Supply Limitation: The CONTRACTOR(S) may establish a day's supply limitation for Prescription Products; however, the limitation may not be less than thirty-one (31) Calendar Days and must not conflict with the ninety (90) Calendar Day maintenance drug list (MDL) policy, or other State Calendar Day supply limitations.

2.7.6 Early Refill Edit: The CONTRACTOR(S) may establish an early refill edit for Prescription Claims. The CONTRACTOR(S)' edit may not be less restrictive than FFS. The current early refill edit for Kansas Medicaid FFS claims is 80% for non-controlled medications (e.g., 80% of the original Prescription must be used prior to a refill being covered for the Member). Some medications, such as opioids for pain use, have a 90% early refill edit.

2.7.7 CONTRACTOR(S)' Pharmacist Duties: The CONTRACTOR(S) must have a Pharmaceutical Director as specified in Section 2.17.2 (Key Personnel).

2.7.8 Prior Authorization (PA): Consistent with all applicable laws the CONTRACTOR(S) must implement a PA program for medication use that mirrors the Medicaid FFS Drug

Utilization Review (DUR) Board approved PA program. This requirement applies to drugs billed on the pharmacy and the medical benefits.

2.7.8.1 The CONTRACTOR(S) may submit clinical Medical Necessity criteria for PA for a given drug to the State for consideration for review by the State Mental Health Medication Advisory Committee, the DUR Board, and the PDL Committee.

2.7.8.2 The CONTRACTOR(S) must use the FFS DUR Board approved PA criteria and PA forms. The CONTRACTOR(S) may not use other Medical Necessity criteria, in place of FFS criteria or when there is no State PA criteria in place. A blanket requirement for chart notes is not to be required for PA review, but information from the chart may be needed for the PA form submission.

2.7.8.3 The CONTRACTOR(S) must use a Kansas specific customer service representative for PA request reviews.

2.7.8.4 In accordance with 42 CFR § 438.3(s)(6), the CONTRACTOR(S) must provide a response to a request for PA for a covered outpatient drug by telephone or other telecommunication device within twenty-four (24) hours of the request. The request can be approved, denied, or needs more information. The clock stops while waiting for documentation and starts when documentation has been received. This applies to drugs on both the pharmacy and medical benefits. See policy E2015-129 including its addendums and attachments, for additional PA direction.

2.7.8.5 When medications are needed without delay (emergent situations) and PA is not available, a seventy-two (72) hour supply for non-mental health medications or a five (5)-day supply for mental health medications must be authorized, until a PA can be secured. The Provider is to call the CONTRACTOR(S)' pharmacy customer service center – Provider assistance line for a one-time override.

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

2.7.8.7 Pharmaceuticals with PA requirements on the medical benefit must have edits in place on the Healthcare Common Procedure Code System (HCPCS) codes, for both drug-specific HCPCS codes and Not Otherwise Classified (NOC)/Not Otherwise Specified (NOS) HCPCS codes, per State policy.

2.7.8.8 If the CONTRACTOR(S) use an electronic PA (ePA) vendor for drug PA processing, the ePA questionnaire must follow the same general format and use the same questions that are found on the PA forms posted on the KDHE Pharmaceutical Program website.

2.7.9 PA Appeals: A general PA Appeal for Pharmaceuticals is to be responded to within the timeframe specified in Appendix D (Grievances and Appeals).

2.7.10 Access:

2.7.10.1 The CONTRACTOR(S) must ensure that the Pharmacy Provider Network is sufficient to provide access to medications and is consistent with the access standards for

delivery networks. Network adequacy must meet the time and distance standards determined by the State.

2.7.10.2 The CONTRACTOR(S) is not required to ensure that Pharmacies within the Provider network provide home delivery service; however, this is encouraged. The CONTRACTOR(S) must ensure Members have access to medications twenty-four hours a day, seven days a week (24/7).

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

2.7.10.4 The CONTRACTOR(S) must allow Pharmacies to fill Prescriptions for covered drugs ordered by any licensed Provider regardless of network participation.

2.7.11 Drug/Product Recalls: In the event of a drug/product recall by the United States Food and Drug Administration (FDA), the CONTRACTOR(S) shall be responsible for identifying and notifying Members and Providers affected by the recall.

2.7.11.1 Specialty drugs: The CONTRACTOR(S) shall reimburse all drugs that could be deemed to be a specialty drug using the same reimbursement methodology as drugs not deemed to be a specialty drug, for that benefit plan (pharmacy or medical).

2.7.11.2 If a drug has limited distribution set forth by the manufacturer, such as that the drug must be received from a specialty Pharmacy, the CONTRACTOR(S) must provide a list of specialty Pharmacies from which the item can be ordered, allowing the Member/Provider to choose from the list.

2.7.11.3 The CONTRACTOR(S) must not require Members to receive medications through a specific specialty pharmacy program except for manufacturer limited-distribution Pharmaceuticals.

2.7.11.4 Provider or Member “steering” or pushing of particular medications to CONTRACTOR(S)/Pharmacy Benefit Manager (PBM)-owned (affiliated) Pharmacies is not allowed. Members must have free access to any Provider participating in the CONTRACTOR(S) network (except in cases where the Member is in the administrative Lock-In program) without any form of steering. The CONTRACTOR(S) is not allowed to steer Members and/or Providers to utilize specific Participating Providers including specialty Pharmacies.

2.7.11.5 The CONTRACTOR(S) shall reimburse for medications listed on the Non-Risk Payment for High-Cost Rare Disease Drug Spend policy, according to that policy.

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

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

2.7.12.2 MTM services should include Comprehensive Medication Reviews, Targeted Medication Reviews, and Gaps in Care Reviews. Targeted Medication Reviews and Gaps in Care services must be approved by the State in writing, if there is not a State policy regarding MTM services. If there is a State MTM policy, State policy is to supersede the CONTRACTOR(S)' MTM program. MTM services do not include prospective drug utilization review (ProDUR) Pharmacist dispensing functions, such as a review of drug interactions, therapeutic duplication, and appropriate drug dosing, which is to be addressed at the time of filling a Prescription. (See ProDUR section of this Appendix).

2.7.12.3 MTM services must be provided by a licensed Kansas Pharmacist, and the CONTRACTOR(S) must allow any willing participating Pharmacy Provider to provide MTM services.

2.7.12.4 The CONTRACTOR(S) agrees that billing for MTM services will be done by the Provider through the medical benefit using the appropriate MTM billing HCPCS codes provided in State policy, when such a time there is a State policy regarding MTM services and billing of those services.

2.7.12.5 The CONTRACTOR(S) must notify the Members of eligibility in the MTM program.

2.7.12.6 All MTM services must be conducted in-person or telephonically.

2.7.13 Drug Utilization Review (DUR):

2.7.13.1 Prospective DUR (ProDUR): The CONTRACTOR(S) is responsible for ensuring POS pharmacy Claims processing and ProDUR is provided by Pharmacies within the Pharmacy Provider network. The ProDUR services include, but are not limited to, a review of drug therapy and counseling prior to dispensing of the Prescription. The review should include at a minimum a screening to identify potential drug therapy problems including therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect dosage, incorrect duration of therapy, drug-allergy interactions, underutilization (adherence), and over-utilization or abuse. Coverage of covered outpatient drugs should be appropriate, Medically Necessary, and not likely to result in adverse medical events.

2.7.13.1.1 The CONTRACTOR(S) must require POS intervention and outcomes codes for severity level one (1) intervention notifications. Claims cannot be bypassed or overridden without the use of standard National Council for Prescription Drug Programs (NCPDP) intervention codes. A non-NCPDP override code cannot be used to bypass this edit. The Pharmacist must address all level one (1) severity intervention messages and enter the reason for service, professional service provided, and result of service intervention codes into their Claims adjudication system. The CONTRACTOR(S) must conduct a quarterly analysis of the Pharmacists' interventions and semi-annual auditing for verification of information submitted. If interventions cannot be substantiated by Pharmacist documentation, Claim payment is to be recouped. The DUR program must comply with the requirements of Section 1927(g) of the SSA as specified in 42 CFR § 438.3(s)(4).

2.7.13.2 Retrospective DUR: The CONTRACTOR(S) is required to collaborate with the State in retrospective DUR and to include an academic detailing component. The CONTRACTOR(S) shall perform Provider and drug use analyses for profiling and

education with specific intent to decrease frequency of patterns of Fraud, Abuse, gross overuse, or inappropriate or medically unnecessary care when such patterns have been identified in the retrospective DUR analysis.

2.7.13.3 In order to comply with the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, the CONTRACTOR(S) shall implement the following requirements for covered outpatient drugs, according to State policy:

2.7.13.3.1 Prospective safety on subsequent fills of opioid prescriptions, as specified by the State, which may include edits to address Calendar Days' supply, early refills, duplicate fills, and quantity limitations for clinical appropriateness. (Section 1902(a)(85) of the SSA and Section 1004 of the SUPPORT Act and 08/05/2019 CMS Center for Medicaid and CHIP Services Informational Bulleting [CIB])

2.7.13.3.2 Prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids Prescriptions to limit the daily MME. (Section 1902(a)(85) of the SSA and Section 1004 of the SUPPORT Act and 08/05/2019 CIB)

2.7.13.3.3 Retrospective reviews on opioid Prescriptions exceeding above limitations on an ongoing basis. (Section 1902(a)(85) of the SSA and Section 1004 of the SUPPORT Act and 08/05/2019 CIB)

2.7.13.3.4 Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing basis. (Section 1902(a)(85) and Section 1004 of the SUPPORT Act and 08/05/2019 CIB)

2.7.13.3.5 Review of antipsychotic agents for appropriateness for all children eighteen (18) and under including foster children based on approved indications and clinical guidelines. (Section 1902(a)(85) of the SSA and Section 1004 of the SUPPORT Act and 08/05/2019 CIB)

2.7.13.3.6 The DUR program to have an established process that identifies potential Fraud and Abuse of controlled substances by enrolled individuals, health care Providers, and Pharmacies. (Section 1902(a)(85) of the SSA and Section 1004 of the SUPPORT Act and 08/05/2019 CIB)

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

2.7.14 Utilization Data: Pursuant to requirements of 42 CFR § 438.3(s)(2) and (3), the CONTRACTOR(S) must provide to the State (via Kansas Modular Medicaid System [KMMS] as Encounter Data) all Claims information on drugs dispensed or administered to Members, within forty-five (45) Calendar Days after the end of each quarterly rebate period. Utilization data is to be by date of service. Any adjustments to the Claims data previously submitted must also be referenced by the date of service.

2.7.15 Reports: See Appendix H (Reports) for Pharmaceutical program reports required by the State.

2.7.15.1 Ad hoc Claims data reports may be requested by the State in preparation for State quarterly Pharmaceutical meetings.

2.7.15.2 The CONTRACTOR(S) must be able to efficiently provide (i.e., within fourteen [14] Calendar Days of request) ad hoc reports related to information contained in Prior Authorization (PA) request data bases.

2.7.15.3 The CONTRACTOR(S) must be able to provide to the State (or the State's designee) additional Claims-related information on drugs with PA, that were dispensed or administered to Members. Examples include, but are not limited to, laboratory results, clinical assessments, clinical outcome measures, or other outcomes- or performance-related measures. This Claims-related information must be provided within forty-five (45) Calendar Days after the end of each quarterly rebate period.

2.7.16 Timely Claims payment: See CONTRACT Section 2.14.1.D for Pharmacy Claims payment time requirements.

2.7.17 Website: The CONTRACTOR(S)' website must include links to the KDHE Pharmaceutical Program page for PA criteria and PA forms and links to the Kansas Medical Assistance Program (KMAP) NDC and HCPCS look-up tools.

2.7.17.1 See CONTRACT Sections 2.6.3 and 2.10.4 for additional website requirements.

2.7.18 Rebate Processing and Resolution: The CONTRACTOR(S) must process and resolve rebate Claim disputes according to the State's KanCare Guide. Rebate resolution is to be completed within sixty (60) Calendar Days of the dispute notice from the State Fiscal Agent rebate team.

2.7.18.1 Any drug Claims found to be disputed, that were due to an incorrect billing by a Provider, will require front end Claims editing within one hundred twenty (120) Calendar Days of the dispute notice, to prevent future rebate disputes of the same nature.

2.7.18.2 The CONTRACTOR(S) is responsible for resolving rebate disputes regardless of the date of service of the Claim.

2.7.19 Rebate Collection: Neither the CONTRACTOR(S), nor their PBM or another Subcontractor may collect rebates for Kansas Medicaid Pharmaceutical utilization. Rebates means any price concession or discount received by the CONTRACTOR(S) or by its PBM, regardless of who pays the rebate or discount.

2.7.20 Reimbursement:

2.7.20.1 The CONTRACTOR(S) shall reimburse Pharmacy Providers the State-mandated Pharmacy dispensing fee. For multiple ingredient compounds, the CONTRACTOR(S) may pay a higher dispensing fee, but the rate must be prior approved by the State in writing. Compounds billed with only one (1) ingredient are not considered a compound and cannot be billed as a compound. The State will provide at least ninety (90) Calendar Day notice of changes in dispensing fees, which the CONTRACTOR(S) will be required to implement by the effective date specified by the State.

2.7.20.2 The CONTRACTOR(S) must reflect the actual amount paid to Pharmacy Providers on the Encounter claims according to the NCPDP Basis of Value codes per State policy. The amount paid for Pharmaceuticals on the medical benefit should be the actual amount paid to the Provider and should be reflected in the Encounter Data.

2.7.20.3 The CONTRACTOR(S)' Pharmaceutical reimbursement must follow the State's Managed Care Organization (MCO) policies for Pharmaceutical reimbursement for both medical and pharmacy benefits, unless otherwise approved by the State in writing. Capitation rate calculations for Pharmaceuticals will reflect the amount allowed in policy.

2.7.20.4 KDHE-DHCF will pay for some high-cost, rare disease PADs and handling fees outside of capitation rates, as a non-risk payment. These drugs are not included in the capitation rate cells. This non-risk payment will apply to all drugs described in KDHE-DHCF Policy No. E2022-057, MCO Non-Risk Payment for High-Cost Rare Disease Drug Spend. KDHE-DHCF will reimburse the CONTRACTOR(S) quarterly, based upon the guidance described in KDHE-DHCF Policy No. E2022-057. The CONTRACTOR(S) may only reimburse for the lesser of (1) actual cost to the CONTRACTOR(S), (2) actual cost to CONTRACTOR(S)' PBM, or (3) actual cost paid for the Pharmaceutical.

2.7.20.5 The CONTRACTOR(S) may only pay the patient responsibility amount up to the maximum Medicaid rate.

2.7.20.6 The CONTRACTOR(S) or the CONTRACTOR(S)' PBM may not subject Pharmacies to post-adjudication penalties, direct and indirect remuneration (DIR) fees, clawbacks, or other financial adjustments of paid Claims.

2.7.21 340B:

2.7.21.1 The CONTRACTOR(S) will receive a Public Health Service (PHS) file from the State Fiscal Agent, designating which Providers' Claims do not require information in the NDC loop on medical Claims, for the following claims quarter.

2.7.21.2 The State Fiscal Agent will identify and exclude 340B Claims per State policy, on behalf of the CONTRACTOR(S), for rebate invoicing purposes. The CONTRACTOR(S) must submit all Claims to the State for Encounter processing.

2.7.21.3 The CONTRACTOR(S) must reimburse all Pharmaceutical Claims according to the State's MCO policies for Pharmaceutical reimbursement.

2.7.22 Document submissions: All CONTRACTOR(S)' document submissions (Member, Provider, Subcontractor) related to the CONTRACTOR(S)' Pharmaceutical program to the State must show tracked changes when the version submitted is not the same as the previously approved version.

2.7.22.1 All Provider and Member notices related to the Pharmaceutical program must be submitted and approved by the State in writing prior to distribution to a Provider and/or Member.

2.7.23 Claims: When Encounters for separately billed Pharmaceuticals are denied, the CONTRACTOR(S) must seek correction/resolution of the Claim, when applicable. The supplemental Encounter reporting will not be allowed for denied Encounters, if the Encounter is for a rebate eligible drug.

2.7.23.1 The CONTRACTOR(S) must use the current NCPDP Claims edit processing guidance version approved by the NCPDP, per State policy effective date.

2.7.23.2 Claims must reject at the POS, when the Claim submission is not NCPDP compliant.

2.7.24 Bulletins: The CONTRACTOR(S) must default to the State policy Provider notification, when a policy update is the same for FFS and the CONTRACTOR(S), unless a separate notice otherwise is approved or requested by the State in writing.

2.7.25 For Provider education initiatives resulting from drug utilization profiling, the CONTRACTOR(S) must provide a goal and success markers to gauge whether the initiative was successful. A summary of each initiative and results must be sent to the State's Pharmaceutical Program Manager and include other initiatives by the CONTRACTOR(S) that impact the area of the initiative.

2.7.26 Health Information Technology and Health Information Exchange: The CONTRACTOR(S) shall provide the following for Pharmaceutical services:

2.7.26.1 Operate and maintain a fully functional PA system to support both automated and manual PA determinations and responses, at minimum, capable of:

2.7.26.1.1 Examining up to twenty-four (24) months of administrative data; for example, patient specific pharmacy, medical, and Encounter Data from both FFS and CONTRACTOR(S) and applying evidence-based guidelines to determine prescribing appropriateness (administrative data includes but is not limited to Pharmacy, hospitalizations, length of stay, emergency department utilization, eligibility, paid/denied Claims, Providers, etc.). This is considered a retrospective DUR.

2.7.26.1.2 Applying the appropriate decision criteria that was approved by the FFS DUR Board and State policy, which is needed to make an automated authorization or precertification decision.

2.7.26.1.3 Integrating with the POS Claims processor and all corresponding processing applications and providing an automated decision during the POS transaction with the CONTRACTOR(S)' POS system in accordance with NCPDP mandated response times with 95% of electronic PA system transactions completing in less than one (1) second.

2.7.26.1.4 Submitting PA requests electronically in Health Insurance Portability and Accountability Act (HIPAA) compliant transaction formats and in the NCPDP D.0 format or the most recent NCPDP version, at no additional charge to the Pharmacy/Provider.

2.7.26.1.5 Providing a detailed reporting package.

2.7.26.1.6 Generating and distributing PA approval and denial letters to Members and applicable health care Providers.

2.7.26.1.7 Communicating the decision clearly and quickly to the health care Provider as per State policy.

2.7.26.1.8 Updating internal records in adjudication/Claims systems and call tracking systems in conjunction with Claims adjudication.

2.7.26.1.9 Providing continuity of care contingencies consistent with State policies and guidelines for the Pharmaceutical specific standards as required upon the implementation of new PDL and State PA program changes.

2.7.26.1.10 Providing capability of exempting all medications prescribed for a Member with a specific disease state.

2.7.26.1.11 Providing capability to utilize a prescriber's specialty code in rendering an automated PA determination.

2.7.26.2 Allowing for low impact and quick turnaround maintenance of PDL and PA criteria through table driven criteria as opposed to hard coded criteria.

2.7.26.3 Possessing documented experience in the Medicaid arena (five [5] or more Medicaid clients) with a comprehensive library of effective criteria to leverage and expand the PA portfolio, used to support development of State policy.

2.7.26.4 Providing documented administrative and drug savings through previous experience.

2.7.26.5 Providing measurable outcomes for quality improvement reports.

2.7.26.6 Offering back-up system redundancy to provide for business continuity with uninterrupted twenty-four hours a day, seven days a week (24/7) production support and service three hundred sixty-five (365) days a year.

2.7.26.7 Establishing technology platform that provides technology support, including demonstrated success in provision of web-based portals with appropriate security features that allow Providers to verify Member eligibility and submit Claims for services rendered.

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

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

2.10 Durable Medical Equipment (DME) as ordered by a qualified health plan Provider.

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

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

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

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

2.14.1 Hearing aids and repairs.

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

2.16 Ambulance services.

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

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

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

2.20 Mid-level practitioners' services.

2.20.1 Advanced Practice Registered Nurse (APRN) – Qualified APRNs are not required to collaborate with a supervising physician to provide care to patients, prescribe medications, and DME.

2.20.2 Psychiatric nurse practitioner.

2.20.3 Certified Registered Nurse Anesthetists (CRNA).

2.20.4 Nurse midwives (Federal guidelines permit Members to access this service outside the CONTRACTOR(S)' plan if the Member desires to receive this service from a nurse midwife; the CONTRACTOR(S) is responsible for payment for this service).

2.20.5 Physician assistants.

2.20.6 Pharmacists.

2.21 Vision services, including but not limited to:

2.21.1 Eye exams and glasses including for post cataract surgery.

2.21.2 Contact lenses and replacements.

2.21.3 Artificial eyes.

2.22 Hospice services when ordered by a Participating Provider and a diagnosis of a terminal illness defined as having a prognosis of six (6) months or less if the disease runs its normal course in accordance with 42 CFR § 418.

2.23 Podiatry services for Members under twenty-one (21) years of age.

2.24 Prenatal health promotion/risk reduction enhanced social work services.

2.25 Postpartum/newborn home visit.

2.26 Screening, diagnosis, and treatment of sexually transmitted infections.

2.27 HIV testing and counseling.

2.28 Dietitian services as Medically Necessary for members under twenty-one (21) years of age.

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

2.29.1 CONTRACTOR(S) must maintain on file a copy of the verification from the Social Security Administration stating this Member is not entitled to Medicare, a Medicare denial, and explanation of benefits, or a copy of the Medicare card. If a Member did not have self-dialysis training in the first three (3) months of maintenance dialysis, the Encounter Data should be accompanied by a Provider's evaluation of the Member for self-dialysis training.

2.30 Vaccinations.

2.30.1 Members (ages zero–eighteen [0–18]) in the Title XIX and Title XXI program receive their vaccines from the Vaccines for Children Program. The Advisory Commission on

Immunization Practices (ACIP) schedule should be followed. The CONTRACTOR(S) should encourage their Providers to become Vaccines for Children Providers.

2.30.2 Vaccine counseling – Vaccine counseling for all EPSDT immunizations.

2.30.3 COVID-19 vaccines and treatment – COVID-19 vaccines and treatment is provided to all eligibility groups covered by the State, including the optional individuals eligible for family planning services, individuals with Tuberculosis (TB), and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage group for which medical assistance consists only of payment of premiums; and

2.30.3.1 Is provided to Beneficiaries without cost sharing pursuant to Section 1916(a)(2)(H) and Section 1916A(b)(3)(B)(xii) of the SSA; reimbursement to qualified Providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the State plan.

__X__ Applies to the State's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to Section 1937(b)(8)(A) of the SSA.

__X__ The State provides coverage for any Medically Necessary COVID-19 vaccine counseling for children under the age of twenty-one (21) pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the SSA.

__X__ The State assures compliance with the United States Department of Health and Human Services (HHS) COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the Providers that are considered qualified to prescribe, dispense, administer, deliver, and/or distribute COVID-19 vaccines.

2.31 Ventilator services.

2.31.1 The purpose of the Nursing Facility (NF) ventilator program is to provide twenty-four (24) hours a day treatment and care for mechanical ventilator dependent residents. Mechanical ventilation is defined as a life support system designed to replace and/or support normal ventilator lung function. There is currently one (1) NF providing ventilator care in the Kansas Medicaid program. The facility has a licensed bed capacity of forty-four (44) with twenty-three (23) unduplicated persons served in the ventilator program in fiscal year 2017.

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

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

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

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

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

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

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

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

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

2.33 Abortions are only covered in the instances that:

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

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

2.34 Long-Term Care (LTC) services.

2.34.1 Nursing Facility (NF) services.

2.34.2 HCBS.

2.34.3 Head Injury rehabilitation services.

2.34.4 Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IDD).

2.35 Dental services for eligible populations.

2.36 Non-emergency medical transportation (NEMT) to Medically Necessary services listed in State policy and State Provider manuals, in compliance with all Federal regulations, including but not limited to:

2.36.1 Mileage reimbursement to Medically Necessary services.

2.36.2 Lodging and meals for the Member and one (1) attendant when the receipt of medical services necessitates an overnight stay.

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

2.37 All HCBS Waiver services listed in this Section 5.0 of this Appendix.

2.38 In addition, Medically Necessary services shall include services as defined elsewhere in the CONTRACT, including services to treat mental illness, Substance Use Disorder (SUD), HCBS, and LTC.

2.39 Bariatric surgery.

2.40 Transplant services.

2.41 Telemedicine.

2.42 Certified community health workers.

2.43 Child behavior interventionist.

3.0 SUD Services

At a minimum, the CONTRACTOR(S) must provide access to Medically Necessary substance use disorder (SUD) treatment services as provided under the State's Medicaid FFS program. The CONTRACTOR(S) shall use the Kansas definition of Medical Necessity and the American Society of Addiction Medicine (ASAM) criteria as included in the State Approved Assessment Tool when determining the need for SUD services. The CONTRACTOR(S) may place appropriate limits on a service on the basis of criteria applied under the State plan, such as the Kansas definition of Medical Necessity, ASAM criteria as included in the State Approved Assessment Tool, and best practice guidelines, provided that the services furnished can reasonably be expected to achieve their purpose.

3.1 Court referred treatment.

3.1.1 The CONTRACTOR(S) shall work with the Provider network for placement for Medically Necessary, court-ordered, or court-referred treatment of Covered Services for Members, including but not limited to, as cited in K.S.A 8-1567.

3.2 Please see the Kansas Medical Assistance Program Substance Use Disorder Provider Manual for covered SUD services. https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/SUD_manual_21273_19109.pdf.

3.2.1 For all modalities of care, the duration of treatment should be determined by the Member's needs and their response to treatment.

3.2.2 More details on all modalities of care are available in the Licensing Standards for Kansas. https://kdads.ks.gov/docs/librariesprovider17/survey-certification-and-credentialing-commission/behavioral-health-licensing/sud-facilities/standards.pdf?sfvrsn=51439ee_2.

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

3.3 ASAM Levels of Care.

3.3.1 Level 0.5, which is called Early Intervention. Early intervention can consist of assessment and education for people at risk of developing a SUD, or programs like driving under the influence (DUI) classes for people arrested for driving under the influence. The goal of 0.5 services is to intervene before a person develops a SUD.

3.3.2 Level 1 outpatient treatment consists of treatment for substance use that is less than nine (9) hours a week. Level 1 is appropriate for people with less severe disorders, or as a step-down from more intensive services.

3.3.3 Level 2.1 is intensive outpatient services consisting of at least nine (9) and no more than twenty (20) hours per week of treatment. These programs typically offer medical care 24 hours a day by phone or within seventy-two (72) hours in-person.

3.3.4 Level 2.5 is partial hospitalization, which is at least twenty (20) hours a week but is less than twenty-four (24)-hour care. This level of care provides structure, and daily oversight for people who need daily monitoring, but not twenty-four hours a day, seven days a week (24/7) care.

3.3.5 Level 3.1 is clinically managed low-intensity residential treatment. Residential services at this level consist of a setting, such as a group home, where people live. However, treatment is only required to be five (5) hours per week, which helps people with such topics as relapse management.

3.3.6 Level 3.3 is clinically managed high-intensity and population-specific services. These programs are targeted for providing treatment designed to move at a slower pace, for people with cognitive functioning issues, including people with traumatic brain injuries, the elderly, or people with developmental disabilities.

3.3.7 Level 3.5 is clinically managed residential services. These services are designed for people with serious psychological or social issues who need twenty-four (24)-hour oversight and are at risk of imminent harm.

3.3.8 Level 3.7 is medically managed high-intensity inpatient treatment. These services are for people who need intensive medical or psychological monitoring in a twenty-four (24)-hour setting but do not need daily physician interaction.

3.3.9 Level 4 provides twenty-four (24)-hour nursing care and daily physician visits. People in this level of care need daily physician monitoring, along with twenty-four (24)-hour oversight.

3.4 Auxiliary services.

3.5 Substance use assessment and referral.

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

3.6 Case management.

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

3.7 Peer support.

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

3.8 Medication assisted treatment (MAT).

3.8.1 MAT combines the use of FDA-approved medications with evidence-based counseling and behavioral therapies to treat substance use disorders, primarily alcohol use and opioid use disorders.

3.8.2 SUD provider network and MAT:

3.8.2.1 The CONTRACTOR(S) shall ensure coordination of care for individuals with SUDs to include the provision of other treatment and recovery services concurrent with MAT when medically indicated. The CONTRACTOR(S) shall improve and expand the network of MAT Providers. The CONTRACTOR(S) shall educate Members and Providers on the prevention and treatment of SUDs and evidence-based MAT practices.

3.8.2.2 The CONTRACTOR(S) must establish a network of Providers that is supported by written contracts, to ensure availability of the services listed above for both adults and youth. A full continuum of SUD services must be available statewide in accordance with this CONTRACT.

4.0 Mental Health Services

The CONTRACTOR(S) shall provide all Medically Necessary services to Members accessing care through the mental health service system or as directed by any changes to the State plan or policy. All services will be provided in accordance with service definitions and operational limits as approved by the State. All service provided shall be practice-research based or evidence-based and consistent with fidelity to a model.

Please see the Kansas Medical Assistance Program Mental Health Provider Manual for covered mental health services: https://portal.kmap-state-ks.us/Documents/Provider/Provider%20Manuals/Mental_Health_23167_23091.pdf

4.1 Initial admission evaluation and assessment.

4.2 Medication management.

4.3 Outpatient therapy services.

4.4 Community psychiatric support and treatment (CPST).

4.5 Psychosocial rehabilitation.

4.6 Peer support.

4.7 Parent/family peer support service that involves the participation of a non-Medicaid eligible is for the direct benefit of the Beneficiary.

4.8 Mobile crisis response.

4.9 Basic crisis intervention.

4.10 Intermediate crisis intervention.

4.11 Advanced crisis intervention.

4.12 Community integration – Supportive housing services in a frequency, support, and duration that supports and maintains the individual's opportunity to remain in their home and community.

4.13 Targeted case management (TCM).

4.14 Screening and assessment for risk of inpatient care.

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

4.16 Attendant care.

4.17 Case conference.

4.18 Early childhood mental health assessment services.

4.19 Psychological testing/assessment.

4.20 Inpatient psychiatric treatment.

4.21 Mental Health Provider Network.

4.21.1 The CONTRACTOR(S) must establish a network of Providers that is supported by written contracts, to ensure availability of the services listed above for both adults and youth. A full continuum of mental health services must be available statewide in accordance with this CONTRACT.

4.21.2 Psychiatric Residential Treatment Facilities (PRTFs):

4.21.2.1 PRTF services must provide active treatment in a structured therapeutic environment for children and youth with a Behavioral Health diagnosis. The CONTRACTOR(S) shall offer a contract to all Kansas PRTFs in its Provider network.

4.21.2.2 Certified Community Behavioral Health Clinics (CCBHCs):

4.21.2.2.1 CCBHC services must meet Federal criteria and be certified by KDADS. CCBHCs are described elsewhere in the CONTRACT, but the CONTRACTOR(S) shall offer a contract to all Kansas CCBHCs.

4.21.3 State institution alternatives (SIAs):

4.21.3.1 SIAs are State institution alternatives that provide emergency acute inpatient psychiatric hospital services. The CONTRACTOR(S) shall offer a contract to all Kansas SIAs.

4.21.4 Crisis intervention centers (CICs):

4.21.4.1 CICs are crisis intervention centers that provide emergency crisis stabilization and detoxification services. Most CICs will be connected to a CCBHC, but some in the future may operate separately or independently of a CCBHC. The CONTRACTOR(S) will be encouraged to help expand CIC coverage around the State.

5.0 HCBS

HCBS Waivers are Medicaid programs designed to provide services to a person in their community instead of an institution, such as a nursing facility or State hospital. Presently, there are seven (7) 1915(c) HCBS Waivers in Kansas which serve different target populations. In Kansas, KDHE-DHCF is the Single State Medicaid Agency while KDADS serves as the operating agency for HCBS programs. All HCBS services are to be delivered in compliance with the current, approved Waiver or other CMS-approved requirements and applicable State policies. Detailed information about the HCBS Waivers in Kansas can be found at https://kdads.ks.gov/kdads-commissions/long-term-services-supports/home-community-based-services-(hcbs)-programs.

HCBS codes can be found on the KMAP website: https://www.kmap-state-ks.us/Public/Provider.asp

5.1 Intellectual/developmentally disabled (I/DD) HCBS Waiver services.

5.2 Physical disability (PD) HCBS Waiver services.

5.3 Technology assisted (TA) HCBS Waiver services.

5.4 Autism HCBS Waiver services.

5.5 Brain injury (BI) HCBS Waiver services.

5.6 Frail elderly (FE) HCBS Waiver services.

5.7 Serious emotional disturbance (SED) HCBS Waiver services.

6.0 Services Not Included

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

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

6.2 State institution services:

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

6.3 School-based services, early intervention services ordered through an Individual Education Plan (IEP) or Independent Family Services Plan (IFSP) Local Education Agencies (LEAs), Head Start facilities, Part C of the Individuals with Disabilities Education (IDEA) Act.

6.4 Laboratory services performed by the KDHE laboratories.

7.0 Other Activities to be Addressed

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

7.2 During the term of the CONTRACT, the CONTRACTOR(S) shall propose for review and State written approval special new treatment services and programs for Members for which the CONTRACTOR(S) may need to adapt its Provider network. These new treatment services or programs could include evidence-based practices (EBP), Self-Direction, or services to help a Member with employment and/or housing supports.

7.3 The CONTRACTOR(S) shall perform a cost-benefit analysis for any new service or programs it proposes to develop under Section 2.2 of this Appendix, including how the proposed service will not impact the Title XIX capitation rates, once approved by the State and CMS (as necessary).

APPENDIX D: GRIEVANCES, RECONSIDERATIONS, APPEALS, AND STATE FAIR HEARINGS

1.0 Scope

1.1 This Appendix details the contractual requirements for the Grievance, Reconsideration, Appeal, External Independent Third-Party Review, and State Fair Hearing processes available to Members and Providers participating in KanCare, the Kansas Medical Assistance Program's managed care program. KanCare is administered through the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE- DHCF), the Single State Medicaid Agency. The Grievance, Reconsideration, External Independent Third-Party Review, Appeal and State Fair Hearing processes together are known as the KanCare Grievance and Appeal System. The KanCare Grievance and Appeal System is the exclusive means of dispute resolution for Members and Providers submitting a Grievance, disputing an Adverse Benefit Determination or disputing an Action by a KanCare CONTRACTOR(S), as "Adverse Benefit Determination" and "Action" are defined in this Appendix.

1.1.1 The CONTRACTOR(S) shall develop, implement, and maintain a Member Grievance and Appeal System that complies with the requirements in applicable Federal and State laws and regulations including, but not limited to, the Code of Federal Regulations (CFR) at 42 CFR Part 431, Subpart E and Part 438, Subpart F, "Grievance and Appeal System," Kansas Statutes Annotated (K.S.A.) 77-501 et seq., "Kansas Administrative Procedures Act" (KAPA), Kansas Administrative Regulations (K.A.R.), and applicable provisions of Kansas Statute 40-3228 relating to Grievance procedures.

1.1.2 The Member Grievance and Appeal System shall include a Grievance process, an Appeal process, and access to the State's Fair Hearing system. All Grievance and Appeal System requirements apply to all three (3) components of the Grievance and Appeal System, not just to the Grievance and Appeal process. The CONTRACTOR(S) shall inform the Member of its requirement for the Member to first complete the CONTRACTOR(S)' Member Appeal process through a standard or expedited appeal process before making a request for a State Fair Hearing. Failure to complete the Appeal process is a basis for dismissal of the Member's request for a State Fair Hearing. The CONTRACTOR(S)' Member Appeal process shall be consistent with other KanCare Managed Care Organizations (MCOs) and shall be the same for all Members. The CONTRACTOR(S) shall ensure that all Members are informed of the Member Grievance and Appeal System processes and timelines in writing via the Member Handbook and on its website. Modifications to the Member Grievance and Appeal System must be submitted for the State's written approval prior to implementation and cannot supplant, delay, or hinder the Grievance, Appeal, and State Fair Hearing process.

1.1.3 The CONTRACTOR(S) shall develop, implement, and maintain a Provider Grievance and Appeal System that complies with the requirements in applicable Federal and State laws and regulations including, Kansas Statute Annotated (K.S.A.) 77-501 et seq., "Kansas Administrative Procedures Act" (KAPA), K.S.A. 39-709, and Kansas Administrative Regulations (K.A.R.).

1.1.4 The Provider Grievance and Appeal System shall include a Grievance process, an optional Reconsideration process, a required Appeal process, an optional External Independent Third-Party Review process, and access to the State's Fair Hearing System. All Grievance and Appeal System requirements apply to all five (5) components of the Grievance and Appeal System, not just to the Grievance and Appeal process. If a Participating Provider or an equivalently treated Non-Participating Provider disputes an Action by the CONTRACTOR(S), the CONTRACTOR(S) shall inform the Participating Provider or an equivalently treated Non-Participating Provider of its requirement to complete the Provider Appeal process before making a request for a State Fair Hearing. Failure to complete the Appeal process is a basis for dismissal of the Provider's request for a State Fair Hearing. The CONTRACTOR(S)' Provider Grievance and Appeal System shall be consistent with other KanCare MCOs and shall be the same for all Providers with the exception of State-approved Provider agreements that contain timeframes that are different from those established in this Appendix. The CONTRACTOR(S) shall ensure that all Providers are informed of the Provider Grievance and Appeal System processes and timelines in writing and on its website. Modifications to the Provider Grievance and Appeal System must be submitted for the State's written approval prior to implementation and cannot supplant, delay or hinder the Grievance, Reconsideration, Appeal, External Independent Third-Party Review, and State Fair Hearing processes. Review, and State Fair Hearing processes.

2.0 Definitions

2.1 *Action* is defined as the denial, in whole or in part, of payment for a service to a Provider. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an Action.

2.2 *Adverse Benefit Determination* is defined in federal regulation 42 CFR § 438.400 as related to a Member:

2.2.1 The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

2.2.2 The reduction, suspension, or termination of a previously authorized service;

2.2.3 The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" is not an Adverse Benefit Determination;

2.2.4 The failure to provide services in a timely manner, as defined by the State;

2.2.5 The failure of the CONTRACTOR(S) to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals;

2.2.6 For a resident of a rural area with only one CONTRACTOR(S), the denial of a Member's request to exercise their right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network; or

2.2.7 The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

2.3 *Appeal* is defined as a review by the CONTRACTOR(S) of an Adverse Benefit Determination, as "Adverse Benefit Determination" is defined in this Appendix, or an Action, as "Action" is defined in this Appendix.

2.4 *Authorized Representative* is defined as any person or entity acting on behalf of the Member or Provider with the written consent of the Member or Provider. A Provider may be an Authorized Representative of a Member.

2.5 *Claim* is defined as (1) a bill for services, (2) a line item of service, or (3) all services for one (1) beneficiary within a bill.

2.6 *Clean claim* is defined as a claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

2.7 *Continuation of Benefits* is defined as the continuation of previously authorized services or course of treatment during the pendency of an Appeal or State Fair Hearing concerning an Adverse Benefit Determination terminating, suspending, or reducing the Member's benefits from KanCare.

2.8 *CONTRACTOR(S)* is defined as the MCO(s) that has entered into a contract with the State to provide KanCare Covered Services to a Member.

2.9 *Covered Services* means all Medicaid and CHIP services, Pharmaceuticals, Supplies, and Devices provided by the CONTRACTOR(S) in any setting, including but not limited to medical care, Behavioral Health care, and long-term services and supports.

2.10 *Equivalent Due Process Treatment* means treating Participating and Non-Participating Providers in an equivalent manner in terms of processing a Grievance, Reconsideration, Appeal, External Independent Third-Party Review, or State Fair Hearing. This does not include or apply to reimbursement differences between Participating and Non-Participating Providers.

2.11 *Expedited Appeal* is defined as the accelerated review process for Appeals when the CONTRACTOR(S) determines that taking the time for a standard resolution of the Appeal could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. See 42 CFR §§ 438.408 and 438.410.

2.12 *Expedited Appeal Request* is defined as a request by a Member to use an accelerated review process for Appeals when the CONTRACTOR(S) determines that taking the time for a standard resolution of the Appeal could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. See 42 CFR §§ 438.408 and 438.410.

2.13 *Expedited State Fair Hearing* is defined as a State Fair Hearing, as defined in this Appendix, and in accordance with the accelerated timeframes and criteria as specified in 42 CFR §§ 431.224 and 431.244 and applicable State laws and regulations.

2.14 *Expedited State Fair Hearing Request* is defined as a request by a Member for a State Fair Hearing in which final administrative action is made as expeditiously as the Member's health condition requires and no later than three (3) business days after the Office of Administrative Hearings (OAH) receives from the CONTRACTOR(S) the case information for any Appeal of a denial of a service that meets the criteria for expedited resolution as set forth in 42 CFR § 438.410(a), but was not resolved within the timeframe for expedited resolution or was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the Member.

2.15 *External Independent Third-Party Review* is defined as a request by a Participating Provider or a Non-Participating Provider for a review of the CONTRACTOR(S)' Adverse Benefit Determination or Action by a third-party reviewer that is unaffiliated with the CONTRACTOR(S).

2.16 *Grievance* is defined as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination, as "Adverse Benefit Determination" is defined in this Appendix, or an Action, as "Action" is defined in this Appendix. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, and failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by the CONTRACTOR(S) to make a Service Authorization decision.

2.17 *HCBS Waiver* is defined as a Home- and Community-Based waiver of Medicaid provisions for specified groups authorized under Section 1915(c) of the Social Security Act.

2.18 *KDHE-DHCF* is defined as the Kansas Department of Health and Environment, Division of Health Care Finance. KDHE-DHCF is the single-state Medicaid Agency for Kansas and the State Agency responsible for the administration and management of the KanCare medical assistance program and CHIP.

2.19 *Member* is defined as a Title XIX or Title XXI Beneficiary who has been certified by the State as eligible to enroll under this CONTRACT, and whose name appears on the CONTRACTOR(S)' enrollment information which the State will transmit to the CONTRACTOR(S) every month in accordance with an established notification schedule. Member includes the Member's Authorized Representative, as "Authorized Representative" is defined in this Appendix.

2.20 *New Health Care Service* is defined as a service that the CONTRACTOR(S) has not previously authorized or a service that the CONTRACTOR(S) has previously authorized, but the authorization period for that service has expired at the time of the request for additional services. A new health care service is the only health care service that qualifies for review by the External Independent Third-Party Reviewer.

2.21 *Non-Participating Provider* is defined as a Provider that has not entered into a provider agreement with the CONTRACTOR(S) or Subcontractor(s) to serve Members.

2.22 *Notice of Action* is defined as a written document sent by the CONTRACTOR(S) to a Provider that provides notice of an Action and meets the format and timing requirements specified in this Appendix and any additional requirements in Kansas Administration Regulation.

2.23 *Notice of Adverse Benefit Determination* is defined as a written document sent by the CONTRACTOR(S) to a Member that provides notice of an Adverse Benefit Determination and meets the requirements of 42 CFR § 438.404 and any additional requirements in Kansas Administration Regulation.

2.24 *Notice of Expedited Appeal Resolution* is defined as a written document sent by the CONTRACTOR(S) to a Member that provides notice of resolution of an Expedited Appeal of an Adverse Benefit Determination and meets the format requirements of 42 CFR § 438.408(d)(2) and timing requirements specified in this Appendix.

2.25 *Notice of External Review Decision* is defined as a written document sent by the CONTRACTOR(S) to the Provider requesting an External Independent Third-Party Review and to the affected Member that provides notice of the decision of the external reviewer and meets the content and timing requirements specified in this Appendix.

2.26 *Notice of Member Appeal Resolution* is defined as a written document sent by the CONTRACTOR(S) to a Member that provides notice of resolution of an Appeal of an Adverse Benefit Determination and meets the format requirements of 42 CFR § 438.408(d)(2) and timing requirements specified in this Appendix.

2.27 *Notice of Member Grievance Resolution* is defined as a written document sent by the CONTRACTOR(S) to a Member that provides notice of resolution of a Grievance and meets the format requirements of 42 CFR § 438.408(d)(1) and timing requirements specified in this Appendix.

2.28 *Notice of Provider Appeal Resolution* is defined as a written document sent by the CONTRACTOR(S) to a Provider that provides notice of resolution of an Appeal of an Action and meets the format and timing requirements specified in this Appendix.

2.29 *Notice of Provider Grievance Resolution* is defined as a written document sent by the CONTRACTOR(S) to a Provider that provides notice of resolution of a Grievance and meets the requirements specified in this Appendix.

2.30 *Notice of Reconsideration Resolution* is defined as a written document sent by the CONTRACTOR(S) to a Provider that provides notice of resolution of a Reconsideration of an Action and meets the format and timing requirements specified in this Appendix.

2.31 *Notification E-mail* is defined as an e-mail sent by the CONTRACTOR(S) to a Member that alerts the Member an electronic notice has been posted at the CONTRACTOR(S)' website.

2.32 *Participating Provider* is defined as any Provider that has entered into a provider agreement with the CONTRACTOR(S) or a Subcontractor(s) to serve Members and receives Medicaid or CHIP funding directly or indirectly from the CONTRACTOR(S) to order, refer, or render Covered Services. A Participating Provider is not a subcontractor by virtue of the provider agreement.

2.33 *Prior Authorization* is defined as a Member's request to the CONTRACTOR(S) for the provision of a service. This is also known as a service authorization.

2.34 *Provider* is defined as any individual or entity that is engaged in the delivery, ordering, or referring of Covered Services and is legally authorized to do so by the state in which it delivers the Covered Services. When used in this Appendix, Provider refers to both Participating and Non-Participating Providers. Provider includes the Provider's

Authorized Representative, as “Authorized Representative” is defined in this Appendix.

2.35 *Reconsideration* is defined as a review by the CONTRACTOR(S) of an Action, as “Action” is defined in this Appendix.

2.36 *Send* means to deliver by mail or in electronic format as specified in 42 CFR § 431.201.

2.37 *Service Authorization* means a Member’s request to the CONTRACTOR(S) for the provision of a Covered Service.

2.38 *State* is defined as the State of Kansas, including, but not limited to, any entity or agency of the State.

2.39 *State Fair Hearing* is defined as an administrative hearing involving the presentation of evidence and argument before a presiding officer from the Kansas Office of Administrative Hearings concerning an Adverse Benefit Determination or an Action as “Adverse Benefit Determination” and “Action” are defined in this Appendix. The presiding officer will hear the matter, determine the result, and issue a decision.

2.40 *Subcontract* means any written agreement between the CONTRACTOR(S) and a Subcontractor.

2.41 *Subcontractor* is defined as an individual or entity with a Subcontract with the CONTRACTOR(S) that relates directly or indirectly to the performance of the CONTRACTOR(S)’ obligations under the CONTRACT. A Participating Provider is not a Subcontractor by virtue of a provider agreement with the CONTRACTOR(S).

3.0 Principles

3.1 Continuation of Benefits for a Member

When a Member requests an Appeal or a State Fair Hearing concerning the termination, suspension, or reduction of a previously authorized service, the Member may receive continuation of those previously authorized services or benefits during the pendency of the Appeal or State Fair Hearing. The timing and extent of the continued services or benefits shall follow the procedure described for Members in this Appendix.

3.2 Equivalent Due Process Treatment of Participating and Non-Participating Provider

In dealing with Non-Participating Providers, the CONTRACTOR(S) may assume that the Non-Participating Provider seeks Equivalent Due Process Treatment as a Participating Provider when the Non-Participating Provider requests a review using the Provider Grievance, Provider Reconsideration, Provider Appeal, Provider External Independent Third-Party Review and Provider State Fair Hearing processes.

3.3 Reimbursement Is Not Included Under the Equivalent Due Process Treatment of Participating and Non-Participating Provider

To encourage a Provider to seek affiliation with a CONTRACTOR(S), the principle of Equivalent Due Process Treatment does not extend to reimbursement. A Participating Provider may be treated more favorably than a Non-Participating Provider in terms of payment of submitted claims. Participating pharmaceutical Providers must be reimbursed in accordance with State policy.

3.4 **A Federally Banned Provider**

If a Participating Provider or a Non-Participating Provider is banned by Federal authorities controlling the Medicaid or Medicare programs, that Provider shall be banned from participation in the Kansas Medical Assistance Program. If the State notifies the CONTRACTOR(S) of such a ban concerning a Participating Provider, the CONTRACTOR(S) shall remove the Provider from the CONTRACTOR(S)' list of Participating Providers.

3.5 **Computing Period of Time**

In computing any period of time prescribed by this Appendix, the day the designated period of time starts shall not be included. In computing any period of time to determine timeliness of a submission, the date the submission is received by the CONTRACTOR(S) shall be used.

4.0 Member Grievances, Appeals and State Fair Hearings

4.1 **Member Grievance System**

The CONTRACTOR(S) shall establish a Grievance and Appeal System, including written policies and procedures that meet the following requirements:

4.1.1 Provides Members reasonable assistance in completing forms and other procedural steps, not limited to auxiliary aids and services upon request, such as providing interpreter services and a toll- free number with Teletypewriter/Telecommunications Device (TTY/TDD) and interpreter capability.

4.1.2 Acknowledges receipt of each Grievance.

4.1.3 Ensures that individuals who make decisions on Grievances are individuals:

4.1.3.1 Who were neither involved in previous levels of review or decision-making nor a subordinate of any such individual.

4.1.3.2 Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the Member's condition or disease:

4.1.3.2.1 A Grievance regarding denial of expedited resolution of an Appeal; or

4.1.3.2.2 Any Grievance involving clinical issues.

4.1.4 Provides the Grievance procedures and timeframes to all Providers and Subcontractor(s) at the time they enter into a provider agreement or Subcontract.

4.1.5 Includes the Member's right to submit Grievances and their requirements and timeframes for filing.

4.1.6 Includes the availability of assistance in filing a Grievance.

4.1.7 Includes the toll-free number to submit oral Grievances.

4.1.8 Includes a toll-free facsimile number to submit written Grievances.

4.1.9 Ensures the CONTRACTOR(S) maintains records of all Grievances received.

4.2 **Member Grievance Process**

4.2.1 The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving Grievances by Members through the Grievance process administered by the CONTRACTOR(S). The Grievance process shall ensure the following:

4.2.1.1 The Grievance process shall be the same for all Members.

4.2.1.2 The Member may submit a Grievance either orally or in writing. The CONTRACTOR(S) cannot require a written form from the Member for a Grievance.

4.2.1.3 A Member may submit a Grievance at any time.

4.2.1.4 The CONTRACTOR(S) shall acknowledge each oral or written Grievance received from a Member in writing within ten (10) Calendar Days of receipt. For Grievances resolved the same day of receipt, the CONTRACTOR(S) is not required to send an acknowledgement but shall acknowledge receipt of the Grievance in the Notice of Member Grievance Resolution. The CONTRACTOR(S) shall acknowledge 100% of Grievances within ten (10) Calendar Days from the date the Grievance is received.

4.2.1.5 The CONTRACTOR(S) shall resolve each Grievance as expeditiously as the Member's health condition requires and not later than thirty (30) Calendar Days from the day the CONTRACTOR(S) receives the Grievance.

4.2.1.6 The CONTRACTOR(S) may extend the thirty (30) Calendar Day resolution period by up to fourteen (14) Calendar Days if the Member requests the extension or the CONTRACTOR(S) shows (to the satisfaction of the State agency, upon its request) that there is need for additional time to resolve the Grievance and how the delay is in the Member's interest. This request for additional time to resolve the Grievance shall be made two (2) Business Days in advance of the thirty (30) Calendar Day deadline to the State.

4.2.1.7 If the CONTRACTOR(S) extends the timeframe not at the request of the Member, the CONTRACTOR(S) shall make reasonable efforts to give the enrollee prompt oral notice of the delay and within two (2) Calendar Days send a written notice to the Member with the reason for the decision to extend the timeframe. The written notice of the extension shall inform the Member of a right to file a Grievance if the Member disagrees with that decision to extend the timeframe. The CONTRACTOR(S) shall resolve the Grievance as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.2.1.8 The CONTRACTOR(S) shall resolve 98% of Grievances and send a Notice of Member Grievance Resolution as specified in this Appendix within thirty (30) Calendar Days from the date the Grievance is received. If the Member's request was made orally or telephonically, the date of the oral or telephonic request shall be used as the start of this period. If the Member's request was made in writing, the date of receipt of the written request shall be used as the start of this resolution period.

4.2.1.9 The CONTRACTOR(S) shall resolve 100% of Grievances within sixty (60) Calendar Days from the date the Grievance is received and send a Notice of Member Grievance Resolution as specified in this Appendix.

4.2.1.10 All notices containing the Member Grievance Resolution shall meet the requirements of 42 CFR § 438.408(d) and shall be in writing. The notice shall include a description of

the Grievance, date the CONTRACTOR(S) received the Grievance, the date of Grievance resolution, and the resolution of the Grievance by the CONTRACTOR(S). It shall use easily understood language of no more than a 5.9 grade level and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Notice of Member Grievance Resolution shall be available in the State-established Prevalent non-English languages. All Members shall be informed that information is available in alternative formats and how to access those formats.

4.2.1.11 The CONTRACTOR(S) shall also inform Members how to submit a Grievance directly with the State, once the Member has completed the CONTRACTOR(S)' Grievance process, if they are unable to obtain culturally appropriate care.

4.2.1.12 The CONTRACTOR(S) shall designate an employee of the CONTRACTOR(S) who has primary responsibility for ensuring that Grievances are resolved in compliance with written policy and within the required timeframe. The CONTRACTOR(S) shall have policies and procedures in place outlining the designated employee's role in a Member's Grievance. The designated employee must have a significant role in monitoring, investigating, and hearing Grievances. The CONTRACTOR(S) shall have a routine process to detect patterns of Grievances. Management, supervisory, and quality improvement staff shall be involved in developing policy and procedure improvements to address the Grievances.

4.2.1.13 The CONTRACTOR(S)' Grievance procedures shall be provided to Members in writing and through oral interpreter services. A written description of the CONTRACTOR(S)' Grievance procedure shall be available in the Prevalent non-English languages identified by the State, at no more than a 5.9 grade reading level.

4.2.1.14 The CONTRACTOR(S) shall include a written description of the Grievance process in the Member handbook and website. The CONTRACTOR(S) shall maintain and publish in the Member handbook and website at least one (1) toll-free telephone number with TTY/TDD and interpreter capabilities for filing Grievances.

4.2.1.15 The CONTRACTOR(S)' Grievance process shall allow for electronic submission of Grievances and shall require that every Grievance received in person, by telephone, voice mail, e-mail, or in writing from a Member shall be acknowledged, recorded in a written record and logged with the following details:

4.2.1.15.1 Date the Member filed the Grievance;

4.2.1.15.2 Identification of the individual filing the Grievance;

4.2.1.15.3 Date received by the CONTRACTOR(S);

4.2.1.15.4 Date acknowledgement letter was sent;

4.2.1.15.5 Identification of the individual recording the Grievance;

4.2.1.15.6 Nature of the Grievance;

4.2.1.15.7 How the CONTRACTOR(S) resolved the Grievance;

4.2.1.15.8 Corrective action required;

4.2.1.15.9 Date resolved; and

4.2.1.15.10 Date Notice of Member Grievance Resolution was sent to the Member.

4.2.1.16 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Member for making a Grievance.

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

4.2.1.18 The CONTRACTOR(S) shall cooperate with the State's fiscal agent and the State, or designees of either, to resolve all Member Grievances. Such cooperation may include, but is not limited to, providing internal Member Grievance information or assistance to the State.

4.3 **Timeframe for Notice of Member Grievance Resolution**

4.3.1 The CONTRACTOR(S) shall send the Notice of Member Grievance Resolution to the Member within thirty (30) Calendar Days of the date the CONTRACTOR(S) receives the Grievance.

4.4 **Notice of Adverse Benefit Determination for Members**

4.4.1 **Notice of Adverse Benefit Determination System for Members**

The CONTRACTOR(S) shall develop, implement, and maintain a system for sending a notice to a Member for an Adverse Benefit Determination, as that term is defined by this Appendix, made by the CONTRACTOR(S) against the Member. The CONTRACTOR(S) shall send a Notice of Adverse Benefit Determination notifying the Member, in accordance with Kansas statutes and federal regulations, when the CONTRACTOR(S) issues an Adverse Benefit Determination to the Member. The Notice of Adverse Benefit Determination shall meet the requirements of 42 CFR § 438.404 and shall be in writing. It shall use easily understood language of no more than a 5.9 grade level and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. The Notice of Adverse Benefit Determination shall be available in the State-established Prevalent non-English languages. All Members shall be informed that information is available in alternative formats and how to access those formats. The CONTRACTOR(S) shall notify the affected Provider and Member, in writing, of any decision by the CONTRACTOR(S) to deny a Service Authorization request, to authorize a service in an amount, duration or scope that is less than requested or to terminate, suspend or reduce previously authorized services.

4.4.2 **Content of Notice of Adverse Benefit Determination for Members**

4.4.2.1 The CONTRACTOR(S)' notice to the Member shall, at a minimum, include any information required by Kansas statute that relates to the CONTRACTOR(S)' Notice of Adverse Benefit Determination and any information required by 42 CFR § 438.404, including but not limited to:

4.4.2.1.1 Dates, types, and amount of service requested (if the Adverse Benefit Determination pertains to a Service Authorization request);

4.4.2.1.2 Date of the Notice of Adverse Benefit Determination;

4.4.2.1.3 Date the Notice of Adverse Benefit Determination was sent. In lieu of a sent date, the CONTRACTOR(S) may add language stating the Member may consider the sent date to be the date of the notice;

4.4.2.1.4 Adverse Benefit Determination the CONTRACTOR(S) has made or intends to make;

4.4.2.1.5 Reasons for the Adverse Benefit Determination, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

4.4.2.1.6 Date the Adverse Benefit Determination was made or will be made;

4.4.2.1.7 The Member's right to request an Appeal of the CONTRACTOR(S)' Adverse Benefit Determination, including information on exhausting the CONTRACTOR(S)' one (1) level of Appeal described at 42 CFR § 438.402(b) and the right to request a State Fair Hearing consistent with 42 CFR § 438.402(c);

4.4.2.1.8 If the Adverse Benefit Determination is based upon a statute, regulation, policy or procedure, the CONTRACTOR(S) shall provide the statute, regulation, policy or procedure supporting the Adverse Benefit Determination;

4.4.2.1.9 The circumstances under which an Appeal process can be expedited and how to request it;

4.4.2.1.10 An explanation of the Member's right to request an Appeal through the CONTRACTOR(S)' Appeal process immediately following receipt of the CONTRACTOR(S)' Notice of Adverse Benefit Determination. The explanation shall include the Member's right to request an Appeal within sixty (60) Calendar Days of the date of the Notice of Adverse Benefit Determination, plus an additional three (3) Calendar Days to allow for sending of the notice. The Notice of Adverse Benefit Determination shall include the address and contact information for submission of the Appeal;

4.4.2.1.11 The procedures by which the Member may Appeal the CONTRACTOR(S)' Adverse Benefit Determination;

4.4.2.1.12 The circumstances under which a Member may continue to receive benefits pending resolution of the Appeal or State Fair Hearing, the procedures by which the Member may request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;

4.4.2.1.13 The Member's right to represent themselves or be represented by an Authorized Representative when requesting an Appeal through the CONTRACTOR(S) or requesting a State Fair Hearing;

4.4.2.1.14 A toll-free number that the Member can call to request the assistance of a Member representative, submit an Appeal, or request a State Fair Hearing;

4.4.2.1.15 A toll-free facsimile number that the Member may use to submit an Appeal or request a State Fair Hearing;

4.4.2.1.16 The specific change in Federal or State law that requires the Adverse Benefit Determination; and

4.4.2.1.17 An explanation of the Member's right to a State Fair Hearing and the procedures by which the Member may request it, or in cases of an Adverse Benefit Determination based on a change in law, the circumstances under which a State Fair Hearing will be granted, if applicable.

4.4.3 **Notice of Adverse Benefit Determination for Service Authorization Denials**

4.4.3.1 The CONTRACTOR(S) shall notify the requesting Provider and send the Member written notice of any decision by the CONTRACTOR(S) to deny a Service Authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice must meet the requirements of 42 CFR § 438.404.

4.4.3.2 If a Member's Person-Centered Service Plan (PCPS) or Plan of Service does not include a Covered Service requested by the Member or includes an amount and/or frequency of a Covered Service that is less than the amount/frequency requested by the Member, the CONTRACTOR(S) shall provide the member with a Notice of Adverse Benefit Determination. The Member may agree to accept some or all of the services on the PCSP or Plan of Service pending the outcome of an Appeal.

4.4.3.3 If a Member's PCSP or Plan of Service includes an amount and/or frequency of a Covered Service that is less than the amount/frequency currently authorized for the Member and/or terminates a currently authorized Covered Service, the CONTRACTOR(S) shall provide the member with a Notice of Adverse Benefit Determination and comply with requirements regarding Continuation of Benefits.

4.4.4 **Timeframe for Notice of Adverse Benefit Determination for Standard Service Authorization Denials**

4.4.4.1 The CONTRACTOR(S) shall send written notice as expeditiously as the Member's health condition requires, which may not exceed seven (7) Calendar Days following receipt of the request for service, with a possible extension of up to fourteen (14) additional Calendar Days, if the Member or the Provider requests an extension or the CONTRACTOR(S) shows (to the satisfaction of the State agency, upon its request) that there is a need for additional information and how the extension is in the Member's interest.

4.4.4.2 If the CONTRACTOR(S) extends the timeframe, the CONTRACTOR(S) shall send the Member written notice of the reason to extend the timeframe and inform the Member of the right to submit a Grievance if they disagree with that decision. The CONTRACTOR(S) shall carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.4.5 **Timeframe for Notice of Adverse Benefit Determination for Expedited Service Authorization Denials**

4.4.5.1 For cases in which a Provider indicates, or the CONTRACTOR(S) determines, that following the standard timeframe could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, the CONTRACTOR(S) shall make an expedited authorization decision and send written Notice of Adverse Benefit Determination as expeditiously as the Member's health

condition requires and no later than seventy-two (72) hours after receipt of the request for service. The CONTRACTOR(S) may extend the seventy-two (72)-hour time period by up to fourteen (14) Calendar Days if the Member requests an extension, or if the CONTRACTOR(S) shows (to the satisfaction of the State agency, upon its request) a need for additional information and how the extension is in the Member's interest.

4.4.5.2 If the CONTRACTOR(S) extends the timeframe, the CONTRACTOR(S) shall send the Member written notice of the reason to extend the timeframe and inform the Member of the right to submit a Grievance if they disagree with that decision. The CONTRACTOR(S) shall carry out its determination as expeditiously as the Member's health condition requires and send notice no later than the date the extension expires.

4.4.6 **Timeframe for Notice of Adverse Benefit Determination for Untimely Service Authorization Decisions**

4.4.6.1 If Service Authorization decisions are not reached within the timeframes for either standard or expedited service authorizations, including extended timeframes, such untimely service authorizations constitute a denial and are Adverse Benefit Determinations. The CONTRACTOR(S) shall send notice no later than the date that the timeframes expire.

4.4.7 **Notice of Adverse Benefit Determination for Termination, Suspension or Reduction of Services**

4.4.7.1 The CONTRACTOR(S) shall notify the requesting Provider and send the Member written notice of any decision by the CONTRACTOR(S) to terminate, suspend or reduce previously authorized services. The CONTRACTOR(S) must send the notice within the timeframes specified below. The notice must meet the requirements of 42 CFR § 438.404.

4.4.8 **Timeframe for Notice of Adverse Benefit Determination for Termination, Suspension or Reduction of Services**

4.4.8.1 The CONTRACTOR(S) shall send written notice at least ten (10) Calendar Days before the effective date of the Adverse Benefit Determination when the Adverse Benefit Determination is a termination, suspension, or reduction of previously authorized Covered Services, except:

4.4.8.1.1 If the State has facts indicating that action should be taken because of probable fraud and abuse by the Member, and those facts have been verified, the period of advanced notice is shortened to five (5) Calendar Days before the effective date of the Adverse Benefit Determination.

4.4.8.1.2 If one (1) of the following events occurs, the period of advanced notice is shortened to the day of the Adverse Benefit Determination:

4.4.8.1.2.1 The State has factual information confirming the death of a Member;

4.4.8.1.2.2 The State receives a signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where the Member indicates that they understand this shall be the result of supplying the information);

4.4.8.1.2.3 The Member is admitted to an institution where they are ineligible for further services;

4.4.8.1.2.4 The Member's address is unknown, and mail directed to them has no forwarding address;

4.4.8.1.2.5 The Member has been accepted for Medicaid services by another local jurisdiction or state; or

4.4.8.1.2.6 The Member's physician prescribes the change in the level of care.

4.5 **Member Standard Appeals**

4.5.1 **Member Standard Appeals System**

4.5.1.1 The CONTRACTOR(S) shall establish a Member Appeal System, including written policies and procedures that meet the following requirements:

4.5.1.1.1 Provides Members reasonable assistance in completing forms and other procedural steps, not limited to providing auxiliary aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

4.5.1.1.2 Acknowledges receipt of each Appeal.

4.5.1.1.3 Ensures that individuals who make decisions on Appeals are individuals:

4.5.1.1.3.1 Who were neither involved in previous levels of review or decision-making nor a subordinate of any such individual.

4.5.1.1.3.2 Who, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the Member's condition or disease if any of the following apply:

4.5.1.1.3.2.1 An Appeal of an Adverse Benefit Determination based on lack of medical necessity; or

4.5.1.1.3.2.2 Any Appeal involving clinical issues.

4.5.1.1.3.3 Who take into account all comments, documents, records, and other information submitted by the Member without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

4.5.1.1.4 Provides that oral inquiries seeking to Appeal an Adverse Benefit Determination are treated as Appeals.

4.5.1.1.5 Provides the Member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The CONTRACTOR(S) must inform the Member of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified in 42 CFR § 438.408(b) and (c) in the case of expedited resolution.

4.5.1.1.6 Provides the Member and their Authorized Representative access to the Member's case file, including medical records, other document and records, and any new or additional evidence considered, relied upon, or generated by the CONTRACTOR(S) (or at the direction of the CONTRACTOR(S)) in connection with the Appeal of the Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals as specified in 42 CFR § 438.408(b) and (c).

4.5.1.1.7 Includes as parties to the Appeal:

4.5.1.1.7.1 The Member and their Authorized Representative; or

4.5.1.1.7.2 The legal representative of a deceased Member's estate.

4.5.1.1.8 Provides the Appeal procedures and timeframes to all Providers and Subcontractor(s) at the time they enter into a provider agreement or Subcontract.

4.5.1.1.9 Includes the Member's right to submit Appeals and their requirements and timeframes for filing.

4.5.1.1.10 Includes the availability of assistance in filing.

4.5.1.1.11 Includes the toll-free number to submit oral Appeals.

4.5.1.1.12 Includes the toll-free facsimile number to submit written Appeals.

4.5.1.1.13 Includes the Member's right to request Continuation of Benefits as defined in 42 CFR § 438.420(b)(1) and this Appendix during an Appeal or State Fair Hearing, and whether the Member may be liable for the cost of any continued benefits if the CONTRACTOR(S)' Adverse Benefit Determination is upheld in a State Fair Hearing.

4.5.1.1.14 Ensures the CONTRACTOR(S) maintains records of all Appeals received.

4.5.2 **Member Standard Appeals Process**

4.5.2.1 The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving Appeals by Members through the Appeal process administered by the CONTRACTOR(S). The Appeal process shall ensure the following:

4.5.2.1.1 The Appeal procedure shall be the same for all Members.

4.5.2.1.2 The Member may submit an Appeal either orally or in writing. The CONTRACTOR(S) cannot require a written form from the Member for an Appeal.

4.5.2.1.3 When a Member requests review of an Adverse Benefit Determination either orally or in writing, the CONTRACTOR(S) shall regard this as a request to Appeal an Adverse Benefit Determination.

4.5.2.1.4 The timeframe within which a Member must submit a request for an Appeal with the CONTRACTOR(S) shall be sixty (60) Calendar Days from the date of the Notice of Adverse Benefit Determination, plus an additional three (3) Calendar Days to allow for sending of the notice.

4.5.2.1.5 The CONTRACTOR(S) shall acknowledge each oral or written Appeal received from a Member in writing within five (5) Calendar Days of the earliest request for an Appeal. If the Member's request was made orally or telephonically, the date of the oral or telephonic request shall be used as the start of this period. If the Member's request was made in writing, the date of receipt of the written request shall be used as the start of this period. For Expedited Appeal Requests, the CONTRACTOR(S) is not required to send an acknowledgement but shall acknowledge receipt of the expedited Appeal request in the Notice of Expedited Appeal Resolution. The CONTRACTOR(S) shall acknowledge 100% of Appeals within five (5) Calendar Days from the date the Appeal is received.

4.5.2.1.6 The CONTRACTOR(S) shall resolve each Appeal and send notice as expeditiously as the Member's health condition requires and no later than thirty (30) Calendar Days from the date the CONTRACTOR(S) receives the Appeal.

4.5.2.1.7 The CONTRACTOR(S) may extend the thirty (30) Calendar Day resolution period by up to fourteen (14) Calendar Days, if the Member requests the extension or the CONTRACTOR(S) shows (to the satisfaction of the State agency, upon its request) that there is need for additional time to resolve the Appeal and how the delay is in the Member's interest. This request for additional time to resolve the Appeal shall be made two (2) Business Days in advance of the thirty (30) Calendar Day deadline to the State.

4.5.2.1.8 If the CONTRACTOR(S) extends the timeframe not at the request of the Member, the CONTRACTOR(S) shall make reasonable efforts to give the Member prompt oral notice of the delay and within two (2) Calendar Days send a written notice to the Member with the reason for the decision to extend the timeframe. The written notice of the extension shall inform the Member of the right to file a Grievance if the Member disagrees with that decision to extend the timeframe. The CONTRACTOR(S) must resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

4.5.2.1.9 The CONTRACTOR(S) shall resolve 100% of Appeals within thirty (30) Calendar Days of the date the CONTRACTOR(S) receives the request for an Appeal from the Member, unless it is an Appeal requiring expedited resolution, and send Notice of Member Appeal Resolution of the CONTRACTOR(S)' decision. If the Member's request was made orally or telephonically, the date of the oral or telephonic request shall be used as the start of this resolution period. If the Member's request was made in writing, the date of receipt of the written request shall be used as the start of this resolution period.

4.5.2.1.10 The CONTRACTOR(S) shall designate an employee of the CONTRACTOR(S) who has primary responsibility for ensuring that Appeals are resolved in compliance with written policy and within the required timeframe. The CONTRACTOR(S) shall have policies and procedures in place outlining the designated employee's role in a Member's Appeal of an Adverse Benefit Determination. The designated employee must have a significant role in monitoring, investigating, and hearing Appeals. The CONTRACTOR(S) shall have a routine process to detect patterns of Appeals. Management, supervisory, and quality improvement staff shall be involved in developing policy and procedure improvements to address the Appeals.

4.5.2.1.11 The CONTRACTOR(S) shall provide a reasonable opportunity to present evidence, and allegations of fact or law, in person, as well as in writing. The CONTRACTOR(S) shall allow the Member and the Member's representative the opportunity, before and during the Appeal process, to examine the Member's case file, including clinical records, and any other documents and records considered during the Appeal process. The CONTRACTOR(S) shall inform the Member of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

4.5.2.1.12 The CONTRACTOR(S)' Appeal procedures shall be provided to Members in writing and through oral interpreter services. A written description of the Appeal procedures must be available in the Prevalent non-English languages identified by the State, at no more than a 5.9 grade reading level.

4.5.2.1.13 The CONTRACTOR(S) shall include a written description of the Appeals process in the Member handbook and website. That description shall include the CONTRACTOR(S)'

requirement for the Member to complete the CONTRACTOR(S)' Appeal process before making a request for a State Fair Hearing. The CONTRACTOR(S) shall maintain and publish in the Member handbook and website at least one (1) toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Appeal of an Adverse Benefit Determination.

4.5.2.1.14 The CONTRACTOR(S)' Appeal process shall allow for electronic submission of Appeals and shall require that every Appeal received in person, by telephone, voice mail, e-mail or in writing from a Member shall be acknowledged, recorded in a written record and logged with the following details:

4.5.2.1.14.1 Date of the Notice of Adverse Benefit Determination;

4.5.2.1.14.2 Date notice was sent;

4.5.2.1.14.3 Effective date of the Adverse Benefit Determination;

4.5.2.1.14.4 Date the Member requested the Appeal;

4.5.2.1.14.5 Date received by the CONTRACTOR(S);

4.5.2.1.14.6 Date acknowledgement letter was sent;

4.5.2.1.14.7 Identification of the individual filing the Appeal;

4.5.2.1.14.8 Identification of the individual recording the Appeal;

4.5.2.1.14.9 Nature of the Appeal;

4.5.2.1.14.10 How the CONTRACTOR(S) resolved the Appeal;

4.5.2.1.14.11 Corrective action required;

4.5.2.1.14.12 Date resolved;

4.5.2.1.14.13 Date of the Notice of Member Appeal Resolution; and

4.5.2.1.14.14 Date the Notice of Member Appeal Resolution was sent.

4.5.2.1.15 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Member or their representative for filing an Appeal.

4.5.2.1.16 Continuation of Benefits for Members Receiving Non-HCBS Waiver Services and Benefits: In accordance with 42 CFR § 438.420(a) and (b), the CONTRACTOR(S) shall continue the Member's previously authorized non-HCBS Waiver services and benefits including the benefit that is the subject of the Appeal, if all of the following criteria are met:

4.5.2.1.16.1 The Member or their Authorized Representative (excluding a Provider) requests an Appeal timely and Continuation of Benefits, with timely defined as on or before the later of the following: within ten (10) Calendar Days of the CONTRACTOR(S) sending the Notice of Adverse Benefit Determination or the intended effective date of the CONTRACTOR(S)' proposed Adverse Benefit Determination. If a Member has chosen to receive notices electronically, the date of the notification email shall be the date the CONTRACTOR(S) sent the Notice. If the electronic Notice includes a sending date that is later than the date of the notification email, the sending date in the Notice shall be used.

4.5.2.1.16.2 The Appeal request involves the termination, suspension, or reduction of a previously authorized course of treatment.

4.5.2.1.16.3 The services were ordered by an authorized Provider.

4.5.2.1.16.4 The original period covered by the authorization has not expired.

4.5.2.1.16.5 The Member timely files for continuation of the benefits.

4.5.2.1.17 For a Member receiving non-HCBS Waiver services and benefits, and who requests an Appeal and Continuation of Benefits with the CONTRACTOR(S), the services and benefits continued pending the outcome of the Appeal shall end ten (10) Calendar Days following the sending date of the Notice of Member Appeal Resolution concerning the termination, suspension or reduction of previously authorized services and benefits unless a Member requests a State Fair Hearing. The Notice of Member Appeal Resolution shall advise the Member that the Appeal decision may be reviewed through a request for a State Fair Hearing. If a Member submits a request for a State Fair Hearing and Continuation of Benefits within ten (10) Calendar Days of the sending date of the Notice of Member Appeal Resolution, services and benefits shall be continued through the date of the decision in the State Fair Hearing.

4.5.2.1.18 For a Member receiving non-HCBS Waiver services and benefits, and in accordance with 42 CFR § 438.420(d), if the final resolution of the Appeal or State Fair Hearing is adverse to the Member, and upholds the CONTRACTOR(S)' Adverse Benefit Determination, then to the extent that the services and benefits were furnished to the Member while the Appeal or State Fair Hearing was pending to comply with the Continuation of Benefits requirements, the CONTRACTOR(S) may recover such costs from the Member.

4.5.2.1.19 For a Member receiving non-HCBS Waiver services and benefits, if the CONTRACTOR(S) continues or reinstates the Member's services and benefits while the Appeal is pending at the CONTRACTOR(S) or pending the State Fair Hearing decision, the services and benefits shall be continued until one (1) of the following occurs:

4.5.2.1.19.1 The Member withdraws the Appeal or State Fair Hearing request;

4.5.2.1.19.2 The Member does not request Continuation of Benefits within ten (10) Calendar Days of the CONTRACTOR(S) sending the Notice of Adverse Benefit Determination; or

4.5.2.1.19.3 A State Fair Hearing officer issues a State Fair Hearing decision adverse to the Member.

4.5.2.1.20 Continuation of Benefits for Members Receiving HCBS Waiver Services and Benefits: The CONTRACTOR(S) shall continue the Member's HCBS Waiver services and benefits currently received by the Member, including the services and benefits that are the subject of the Appeal, if all of the following criteria are met:

4.5.2.1.20.1 The Member requests an Appeal timely, with timely defined as on or before sixty (60) Calendar Days from the date of the CONTRACTOR(S)' Notice of Adverse Benefit Determination, plus an additional three (3) Calendar Days to allow for sending of the notice that terminates, suspends or reduces the previously authorized services and benefits;

4.5.2.1.20.2 The Appeal involves the termination, suspension or reduction of a previously authorized course of treatment;

4.5.2.1.20.3 The services were ordered by an authorized Provider; and

4.5.2.1.20.4 The original period covered by the authorization has not expired.

4.5.2.1.21 For a Member receiving HCBS Waiver services and benefits, the previously authorized HCBS Waiver services and benefits shall be continued for sixty-three (63) Calendar Days from the date of the Notice of Adverse Benefit Determination that terminates, suspends or reduces the previously authorized HCBS Waiver services and benefits. If the Member requests an Appeal within those sixty-three (63) Calendar Days, the Member's current HCBS Waiver services and benefits shall continue through the sent date of the Notice of Member Appeal Resolution. If a Member has chosen to receive notices electronically, the date of the notification email shall be the date the CONTRACTOR(S) sent the Notice. If the electronic Notice includes a sent date that is later than the date of the notification email, the sent date in the Notice shall be used.

4.5.2.1.22 For a Member receiving HCBS Waiver services and benefits, the services and benefits continued pending the outcome of the Appeal shall be continued for one hundred twenty (120) Calendar Days, plus an additional three (3) Calendar Days to allow for sending of the notice from the sent date of the Notice of Member Appeal Resolution concerning the termination, suspension, or reduction of previously authorized services. The Notice of Member Appeal Resolution shall advise the Member that the Appeal decision may be reviewed through a request for a State Fair Hearing. If a Member submits a request for a State Fair Hearing within one hundred twenty-three (123) Calendar Days from the sent date of the Notice of Member Appeal Resolution, services and benefits shall be continued through the date of the decision in the State Fair Hearing.

4.5.2.1.23 For a Member receiving HCBS Waiver services and benefits, and at the request of the Member, the previously authorized HCBS Waiver services and benefits may be terminated and replaced with other HCBS Waiver services and benefits.

4.5.2.1.23.1 If the replacement HCBS Waiver services and benefits begin within sixty (60) Calendar Days, plus an additional three (3) Calendar Days to allow for sending of the Notice of Adverse Benefit Determination terminating the previously authorized HCBS Waiver services and benefits, the services and benefits of the previously authorized HCBS Waiver shall be continued only until the replacement HCBS Waiver's services and benefits begin. If the replacement HCBS Waiver's services and benefits do not begin within sixty-three (63) Calendar Days from the date of the Notice of Adverse Benefit Determination terminating the previously authorized HCBS Waiver services and benefits, the services and benefits of the previously authorized HCBS Waiver shall be continued for sixty-three (63) Calendar Days from the date of the Notice of Adverse Benefit Determination terminating the previously authorized HCBS Waiver services and benefits.

4.5.2.1.23.2 If the replacement HCBS Waiver services and benefits begin within one hundred twenty (120) Calendar Days, plus an additional three (3) Calendar Days to allow for sending of the notice from the date of the Notice of Member Appeal Resolution that upholds the termination of the previously authorized HCBS Waiver services and benefits, the services and benefits of the previously authorized HCBS Waiver shall be

continued only until the replacement HCBS Waiver's services and benefits begin. If the replacement HCBS Waiver's services and benefits do not begin within one hundred twenty-three (123) Calendar Days from the date of the Notice of Member Appeal Resolution, the services and benefits of the previously authorized HCBS Waiver shall be continued for one hundred twenty-three (123) Calendar Days from the date of the Notice of Member Appeal Resolution that upholds the termination of the previously authorized HCBS Waiver services and benefits.

4.5.2.1.24 For a Member receiving HCBS Waiver services and benefits, if the CONTRACTOR(S) continues or reinstates the Member's HCBS Waiver services and benefits while the Appeal is pending at the CONTRACTOR(S) or pending the State Fair Hearing decision, the services and benefits shall be continued until one (1) of the following occurs:

4.5.2.1.24.1 The Member withdraws the Appeal or State Fair Hearing request;

4.5.2.1.24.2 The Member does not request an Appeal within sixty-three (63) Calendar Days, from the date of the CONTRACTOR(S)' Notice of Adverse Benefit Determination or request a State Fair Hearing within one hundred twenty-three (123) Calendar Days from the date of the Notice of Member Appeal Resolution;

4.5.2.1.24.3 A State Fair Hearing officer issues a State Fair Hearing decision adverse to the Member; or

4.5.2.1.24.4 The Member requests that the previously authorized HCBS Waiver services and benefits be terminated and replaced with another HCBS Waiver services and benefits that will begin during the sixty-three (63) Calendar Days from the date of the CONTRACTOR(S)' Notice of Adverse Determination or that will begin during the one hundred twenty-three (123) Calendar Days from the date of the CONTRACTOR(S)' Notice of Member Appeal Resolution.

4.5.2.1.25 If the final resolution of the Appeal or State Fair Hearing is adverse to the Member receiving HCBS Waiver services and benefits, and upholds the CONTRACTOR(S)' Adverse Benefit Determination, then to the extent that the HCBS Waiver services and benefits were furnished to the Member while the Appeal or State Fair Hearing was pending to comply with the Continuation of Benefits requirements, the Member will not have to pay the CONTRACTOR(S) for HCBS Waiver services and benefits provided during the Appeal or State Fair Hearing unless fraud has occurred.

4.5.2.1.26 The CONTRACTOR(S) shall inform Providers and Subcontractor(s), at the time they enter into a provider agreement or Subcontract, of the Member's right to request Continuation of Benefits during an Appeal or State Fair Hearing, and whether the Member may be liable for the cost of any continued benefits if the CONTRACTOR(S)' decision is upheld.

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

4.5.2.1.28 The CONTRACTOR(S) shall consider the Member, the Member's Authorized Representative or an estate representative of a deceased Member as a party to the

Appeal. A Member may seek a State Fair Hearing if the Member is not satisfied with the CONTRACTOR(S)' decision in response to an Appeal.

4.5.2.1.29 If the CONTRACTOR(S) reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the CONTRACTOR(S) must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date it reverses the determination.

4.5.2.1.30 If the CONTRACTOR(S) reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, the CONTRACTOR(S) shall pay for those services.

4.5.2.1.31 If a Member makes a request for disenrollment, the CONTRACTOR(S) shall give the Member information on the disenrollment process and direct the Member to the State's fiscal agent. If the request for disenrollment is denied by the State, the CONTRACTOR(S) shall advise the Member of their right to request a State Fair Hearing in lieu of an Appeal to the CONTRACTOR(S).

4.5.2.1.32 The CONTRACTOR(S) shall ensure that punitive action is not taken against a Provider who requests an Appeal on the Member's behalf or supports a Member's Appeal request.

4.5.2.1.33 The CONTRACTOR(S) shall cooperate with the State, the State's fiscal agent, and/or designees of either, to resolve all Member Appeals. Such cooperation may include, but is not limited to, providing internal Member Appeal information to the State.

4.5.3 **Content of Notice of Member Appeal Resolution**

4.5.3.1 The written Notice of Member Appeal Resolution shall include:

4.5.3.1.1 Date of the Notice of Member Appeal Resolution.

4.5.3.1.2 Date the Notice of Member Appeal Resolution was sent. In lieu of a sent date, the CONTRACTOR(S) may add language stating the Member may consider the sent date to be the date of the notice.

4.5.3.1.3 Date the CONTRACTOR(S) received the Appeal.

4.5.3.1.4 The results of the resolution process and the date of the Appeal resolution.

4.5.3.1.5 For decisions not wholly in the Member's favor:

4.5.3.1.5.1 The right to request a State Fair Hearing within one hundred twenty (120) Calendar Days of the date of the CONTRACTOR(S)' Notice of Member Appeal Resolution, plus an additional three (3) Calendar Days to allow for sending of the notice;

4.5.3.1.5.2 How to request a State Fair Hearing;

4.5.3.1.5.3 The right to request to continue to receive benefits, pursuant to 42 CFR § 438.420 and this Appendix, pending a State Fair Hearing;

4.5.3.1.5.4 How to request the Continuation of Benefits in a timely manner;

4.5.3.1.5.5 Notice that if the CONTRACTOR(S)' Adverse Benefit Determination is upheld in a State Fair Hearing, whether the Member may be liable for the cost of any continued benefits;

4.5.3.1.5.6 That in the State Fair Hearing the Member may represent themselves or use legal counsel, a relative, a friend, or a spokesperson;

4.5.3.1.5.7 An explanation of the individual's right to a State Fair Hearing, or in cases of an Adverse Benefit Determination based on change in law, the circumstances under which a State Fair Hearing will be granted; and

4.5.3.1.5.8 Any other information required by Kansas statute or regulation that relates to a managed care organization's notice of disposition of an Appeal.

4.5.4 **Timeframe for Notice of Member Appeal Resolution**

4.5.4.1 The CONTRACTOR(S) shall send the Notice of Member Appeal Resolution to the Member within thirty (30) calendar days of the date the CONTRACTOR receives the Appeal.

4.6 **Member Expedited Appeals**

4.6.1 **Member Expedited Appeal System**

4.6.1.1 The CONTRACTOR(S) shall establish a Member Expedited Appeal System, including written policies and procedures that meet the following requirements:

4.6.1.1.1 Provides Members reasonable assistance in completing forms and other procedural steps, not limited to providing auxiliary aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

4.6.1.1.2 Acknowledges receipt of each Appeal in the Notice of Expedited Appeal Resolution.

4.6.1.1.3 Ensures that individuals who make decisions on Appeals are individuals:

4.6.1.1.4 Who were neither involved in previous levels of review or decision-making nor a subordinate of any such individual.

4.6.1.1.5 Who, if deciding any of the following, are individuals who have the appropriate clinical expertise in treating the Member's condition or disease if any of the following apply:

4.6.1.1.5.1 An Appeal of a denial based on lack of medical necessity; or

4.6.1.1.5.2 Any Appeal involving clinical issues.

4.6.1.1.6 Provides the Appeal procedures and timeframes to all Providers and Subcontractor(s) at the time they enter into a provider agreement or Subcontract.

4.6.1.1.7 Includes an explanation regarding the Member's right to an Expedited Appeal and the circumstances under which the Member or Provider may request it.

4.6.1.1.8 Includes an explanation regarding the circumstances under which the Member may make an Expedited State Fair Hearing Request from the CONTRACTOR(S), how to obtain an Expedited State Fair Hearing, and the right to representation at an Expedited State Fair Hearing.

4.6.1.1.9 Includes the requirements and timeframes for filing an Expedited Appeal and an Expedited State Fair Hearing Request.

4.6.1.1.10 Includes the availability of assistance in filing.

4.6.1.1.11 Includes the toll-free number to submit an oral Expedited Appeal or an oral Expedited State Fair Hearing Request.

4.6.1.1.12 Includes the toll-free number to submit a written Expedited Appeal or a written Expedited State Fair Hearing Request by facsimile.

4.6.1.1.13 Includes the Member's right to request Continuation of Benefits as defined in 42 CFR § 438.420(b)(1) and this Appendix during an expedited Appeal or expedited State Fair Hearing and whether the Member may be liable for the cost of any continued benefits if the CONTRACTOR(S)' Adverse Benefit Determination is upheld in a State Fair Hearing.

4.6.1.1.14 Ensures the CONTRACTOR(S) maintains records of all Expedited Appeal Requests.

4.6.2 **Member Expedited Appeal Process**

4.6.2.1 The CONTRACTOR(S) shall establish and maintain an Expedited Appeal process that complies with 42 CFR § 438.410, when the CONTRACTOR(S) determines (for a request from a Member) or the Provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CONTRACTOR(S) must follow all Appeal requirements for standard Member Appeals as set forth in this Appendix and applicable federal and State regulations, except where differences are specifically noted.

4.6.2.2 The Expedited Appeal process shall be the same for all Members.

4.6.2.3 The Member may submit an Expedited Appeal either orally or in writing. The CONTRACTOR(S) cannot require a written form from the Member for an Expedited Appeal.

4.6.2.4 The CONTRACTOR(S) shall inform the Member that they must complete the CONTRACTOR(S)' Expedited Appeal process before making a request for an Expedited State Fair Hearing.

4.6.2.5 After the CONTRACTOR(S) receives the Expedited Appeal Request, it shall resolve 100% of Expedited Appeals, notify the Member of the receipt of the Expedited Appeal Request, and send a Notice of Member Appeal Resolution as expeditiously as the Member's health condition requires and no later than seventy-two (72) hours from the date the CONTRACTOR(S) receives the request.

4.6.2.6 For an Expedited Appeal, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to fourteen (14) Calendar Days if the Member requests an extension or the CONTRACTOR(S) shows (to the satisfaction of the State, upon its request) that there is a need for additional information and how the delay is in the Member's interest. If the CONTRACTOR(S) extends the timeframe not at the request of the Member, the CONTRACTOR(S) shall make reasonable efforts to provide oral notice of the delay and send a written notice to the Member with the reason for the delay within two (2) Calendar Days and inform the Member of the right to file a Grievance if the Member disagrees with that decision.

4.6.2.7 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Member for requesting an Expedited Appeal. The CONTRACTOR(S) must ensure that punitive action is not taken against a Provider who requests an Expedited Appeal or supports a Member's request.

4.6.2.8 If the CONTRACTOR(S) denies an Expedited Appeal Request, it shall:

4.6.2.8.1 Transfer the Appeal to the standard thirty (30) Calendar Day resolution timeframe for an Appeal, and

4.6.2.8.2 Make reasonable efforts to give the Member prompt oral notice of the denial of the Expedited Appeal Request and send a written notice to the Member within two (2) Calendar Days.

4.6.2.9 The decision to deny an Expedited Appeal Request does not constitute an Adverse Benefit Determination or require a Notice of Adverse Benefit Determination. The Member may submit a Grievance in response to this decision.

4.6.2.10 If the CONTRACTOR(S)' decision is adverse to the Member, the CONTRACTOR(S) shall send the Notice of Member Appeal Resolution described above. The CONTRACTOR(S) shall notify the Member of their right to request an Expedited State Fair Hearing from OAH. The CONTRACTOR(S) shall provide documentation to OAH and the Member indicating how the decision was made prior to OAH's Expedited State Fair Hearing.

4.6.2.11 The CONTRACTOR(S) shall designate an employee of the CONTRACTOR(S) who has primary responsibility for ensuring that Expedited Appeals are resolved in compliance with written policy and within the required timeframe. The CONTRACTOR(S) shall have policies and procedures in place outlining the designated employee's role in a Member's Expedited Appeal of an Adverse Benefit Determination. The designated employee must have a significant role in monitoring, investigating and hearing Appeals. The CONTRACTOR(S) shall have a routine process to detect patterns of Expedited Appeals. Management, supervisory, and quality improvement staff shall be involved in developing policy and procedure improvements to address the Expedited Appeals.

4.6.2.12 The CONTRACTOR(S) shall inform the Member of the limited time available for the Member to present evidence and allegations of fact or law, in person and in writing, in the case of an Expedited Appeal.

4.6.2.13 The CONTRACTOR(S)' Expedited Appeal procedures shall be provided to Members in writing and through oral interpreter services. A written description of the Expedited Appeal procedures must be available in the Prevalent non-English languages identified by the State, at no more than a 5.9 grade reading level.

4.6.2.14 The CONTRACTOR(S) shall include a written description of the Expedited Appeals process in the Member handbook and website. The CONTRACTOR(S) shall maintain and publish in the Member handbook and website at least one (1) toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Expedited Appeal Request of an Adverse Benefit Determination.

4.6.2.15 The CONTRACTOR(S)' Expedited Appeal process shall allow for electronic submission of Appeals and shall require that every Expedited Appeal received from a Member shall be acknowledged, recorded in a written record and logged with the following details:

4.6.2.15.1 Date of the Notice of Adverse Benefit Determination;

4.6.2.15.2 Date notice was sent;

4.6.2.15.3 Effective date of the Adverse Benefit Determination;

4.6.2.15.4 Date the Member requested the Expedited Appeal;

4.6.2.15.5 Date received by the CONTRACTOR(S);

4.6.2.15.6 Identification of the individual filing the Expedited Appeal;

4.6.2.15.7 Identification of the individual recording the Expedited Appeal;

4.6.2.15.8 Nature of the Expedited Appeal;

4.6.2.15.9 How the CONTRACTOR(S) resolved the Expedited Appeal;

4.6.2.15.10 Corrective action required;

4.6.2.15.11 Date resolved; and

4.6.2.15.12 Date the Notice of Member Appeal Resolution was sent.

4.6.2.16 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Member or their representative for filing an Expedited Appeal.

4.6.2.17 Continuation of Benefits for Members Receiving Non-HCBS Waiver and HCBS Waiver Services and Benefits: In accordance with 42 CFR § 438.420(b) and this Appendix, the CONTRACTOR(S) shall continue the Member's previously authorized non-HCBS Waiver and HCBS Waiver services and benefits, including the benefit that is the subject of the expedited Appeal, according to the procedures in the Member Appeal section of this Appendix, subject to the exceptions below:

4.6.2.17.1 Continuation of Benefits only applies to the termination, suspension, or reduction of previously authorized services. A request for future services is not included within Continuation of Benefits; and

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

4.6.2.18 If the final resolution of the Expedited Appeal or Expedited State Fair Hearing is adverse to the Member receiving non-HCBS Waiver services and benefits, and upholds the CONTRACTOR(S)' Adverse Benefit Determination, then to the extent that the non-HCBS Waiver services and benefits were furnished to the Member while the Expedited Appeal or Expedited State Fair Hearing was pending to comply with the Continuation of Benefits requirements, the Member may have to pay the CONTRACTOR(S) for non-HCBS Waiver services and benefits provided during the Expedited Appeal or Expedited State Fair Hearing.

4.6.2.19 If the final resolution of the Expedited Appeal or Expedited State Fair Hearing is adverse to the Member receiving HCBS Waiver services and benefits, and upholds the CONTRACTOR(S)' Adverse Benefit Determination, then to the extent that the HCBS Waiver services and benefits were furnished to the Member while the Appeal or State Fair Hearing was pending to comply with the Continuation of Benefits requirements, the Member will not have to pay the CONTRACTOR(S) for HCBS Waiver services and benefits provided during the Appeal or State Fair Hearing unless fraud has occurred.

4.6.2.20 The CONTRACTOR(S) shall inform Providers and Subcontractor(s), at the time they enter into a provider agreement or Subcontract, of the Member's right to request Continuation of Benefits during an Expedited Appeal or Expedited State Fair Hearing, and whether the Member may be liable for the cost of any continued benefits if the CONTRACTOR(S)' decision is upheld.

4.6.2.21 The CONTRACTOR(S) shall consider the Member, an Authorized Representative, or an estate representative of a deceased Member as a party to the Expedited Appeal. A Member may seek a State Fair Hearing if the Member is not satisfied with the CONTRACTOR(S)' decision in response to an Expedited Appeal.

4.6.2.22 If the CONTRACTOR(S) reverses a decision to deny, limit, or delay services that were not furnished while the Expedited Appeal was pending, the CONTRACTOR(S) must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date it reverses the determination.

4.6.2.23 If the CONTRACTOR(S) reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, the CONTRACTOR(S) shall pay for those services.

4.6.2.24 The CONTRACTOR(S) shall ensure that punitive action is not taken against a Provider who requests an Expedited Appeal on the Member's behalf or supports a Member's Expedited Appeal Request.

4.6.2.25 The CONTRACTOR(S) shall cooperate with the State, the State's fiscal agent, and/or designees of either, to resolve all Member Expedited Appeals. Such cooperation may include, but is not limited to, providing internal Member Expedited Appeal information to the State.

4.6.3 **Timeframe for Notice of Member Expedited Appeal Resolution**

4.6.3.1 The CONTRACTOR(S) shall send the Notice of Member Expedited Appeal Resolution to the Member within seventy-two (72) hours following the date of receipt of the Expedited Appeal Request.

4.6.4 **Deemed Exhaustion of the Member Appeal Process**

4.6.4.1 Failure of the CONTRACTOR(S) to adhere to the notice and timing requirements in this Appendix and as specified in 42 CFR part 438, subpart F, means that the Member is deemed to have exhausted the CONTRACTOR(S)' Appeals process and the Member may initiate a State Fair Hearing.

4.7 **Electronic Member Notice System**

4.7.1 The CONTRACTOR(S) shall develop, implement, and maintain a system for providing a Member a choice to receive the notices in this Appendix in electronic format or by mail. The Electronic Member Notice System shall be consistent with the requirements of 42 CFR § 438.10 and shall meet the following requirements:

4.7.1.1 Provide Members with an opportunity to change the choice of format for receipt of notices from the CONTRACTOR(S).

4.7.1.2 For Members choosing to receive notices from the CONTRACTOR(S) electronically, the CONTRACTOR(S) shall:

4.7.1.2.1 Ensure the Member's election to receive notices electronically is confirmed by mail.

4.7.1.2.2 Inform the Member of the right to change the election and receive notices by mail at no charge to the Member.

4.7.1.2.3 Post notices to the Member's electronic account within one (1) Business Day of notice generation.

4.7.1.2.4 Send an email or other electronic communication alerting the Member that a notice has been posted to the Member's account. The CONTRACTOR(S) shall ensure no confidential information is included in the email or electronic alert.

4.7.1.3 Send a notice by mail within three (3) Business Days of the date of a failed email or electronic communication if an email or electronic communication is undeliverable.

4.7.1.4 Log the date the CONTRACTOR sends the email or other electronic communication and the date the Member opens the email or other electronic communication or, in the event the delivery of the email or electronic communication fails, the date of the failure, and the date the CONTRACTOR(S) sends a paper copy of the notice.

4.7.1.5 At the Member's request, and free of charge, send by mail any notice that has been posted to a Member's electronic account within five (5) Business Days of the date the CONTRACTOR(S) receives the request.

4.7.1.6 Ensure the format of the notices is accessible and the notices are placed in a location on the CONTRACTOR(S)' website that is prominent and accessible.

4.7.1.7 Ensure the electronic notice can be electronically retained and printed.

4.8 Member State Fair Hearings

4.8.1 Member State Fair Hearing System

4.8.1.1 The CONTRACTOR(S) shall establish a Member State Fair Hearing System, including written policies and procedures that meet the following requirements:

4.8.1.2 Provides Members reasonable assistance in completing forms and other procedural steps, not limited to providing auxiliary aids and services upon request, such as interpreter services and a toll-free number with TTY/TDD and interpreter capability.

4.8.1.3 Provides the State Fair Hearing procedures and timeframes to all Providers and Subcontractor(s) at the time they enter into a provider agreement or Subcontract.

4.8.1.4 Includes the Member's right to submit a State Fair Hearing and the requirements and timeframes for filing.

4.8.1.5 Informs Members that they have the right to access the State Fair Hearing process following receipt of the CONTRACTOR(S)' Notice of Member Appeal Resolution. In the case of an Expedited State Fair Hearing process, the CONTRACTOR(S) must inform the Member that they must first complete the CONTRACTOR(S)' Expedited Appeal process before requesting an Expedited State Fair Hearing.

4.8.1.6 Informs Members that they may be represented by an Authorized Representative in the State Fair Hearing process.

4.8.1.7 Includes the availability of assistance in filing.

4.8.1.8 Includes the availability of a toll-free number to submit oral requests for State Fair Hearings.

4.8.1.9 Includes the Member's right to request Continuation of Benefits as defined in 42 CFR § 438.420 and this Appendix during a State Fair Hearing and whether the Member may be liable for the cost of any continued benefits if the CONTRACTOR(S)' Adverse Benefit Determination is upheld in a State Fair Hearing.

4.8.1.10 Includes the establishment of a process by the CONTRACTOR(S) to research State Fair Hearing requests that includes analysis of the dispute and compilation of State Fair Hearing evidence in compliance with Section 5.8 of this Appendix.

4.8.1.11 Ensures the CONTRACTOR(S) maintains records of all State Fair Hearing requests received.

4.8.2 **Member State Fair Hearing Process**

4.8.2.1 The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, and reporting State Fair Hearings, including requests for expedited State Fair Hearings, submitted by Members. The State Fair Hearing process shall ensure the following:

4.8.2.1.1 The State Fair Hearing process shall be the same for all Members.

4.8.2.1.2 The Member may request a State Fair Hearing either orally or in writing. The CONTRACTOR(S) cannot require a written form from the Member for a request for a State Fair Hearing or use the lack of a written or signed form from the Member as a basis for refusal to process the request.

4.8.2.1.3 The timeframe within which a Member must submit a request for a State Fair Hearing with the CONTRACTOR(S) or OAH shall be one hundred and twenty (120) Calendar Days from the date of the Notice of Member Appeal Resolution, plus an additional three (3) Calendar Days to allow for sending of the notice.

4.8.2.1.4 The CONTRACTOR(S) shall forward all requests received from Members for a State Fair Hearing to the OAH within one (1) Business Day of the Member's request for a State Fair Hearing.

4.8.2.1.5 A Member must request Continuation of Benefits during a State Fair Hearing in accordance with the procedures in the Member Appeal section of this Appendix.

4.8.2.1.6 The CONTRACTOR(S) shall designate an employee of the CONTRACTOR(S) who has primary responsibility for ensuring that State Fair Hearing requests are processed in compliance with written policy and within the timeframes required by the State. The CONTRACTOR(S) shall have policies and procedures in place outlining the designated employee's role in processing a Member's State Fair Hearing request. The designated employee must have a significant role in monitoring, investigating and processing State Fair Hearing requests. The CONTRACTOR(S) shall have a routine process to detect and record patterns of State Fair Hearings. Management, supervisory, and quality improvement staff shall be involved in developing policy and procedure improvements to address Member State Fair Hearing requests.

4.8.2.1.7 The CONTRACTOR(S)' State Fair Hearing process shall be provided to Members in writing and through oral interpreter services. A written description of the

CONTRACTOR(S)' State Fair Hearing process shall be available in the Prevalent non-English languages identified by the State, at no more than a 5.9 grade reading level.

4.8.2.1.8 The CONTRACTOR(S) shall include a written description of the State Fair Hearing process in the Member handbook and website. The CONTRACTOR(S) shall maintain and publish in the Member handbook and website at least one (1) toll-free telephone number with TTY/TDD and interpreter capabilities for filing a request for a State Fair Hearing.

4.8.2.1.9 The CONTRACTOR(S)' State Fair Hearing process shall allow for electronic submission of requests for State Fair Hearings and shall require that every State Fair Hearing request received in person, by telephone, voice mail, e-mail or in writing from a Member shall be recorded in a written record and logged with the following details:

4.8.2.1.9.1 Date of the Notice of Adverse Benefit Determination;

4.8.2.1.9.2 Date notice was sent;

4.8.2.1.9.3 Effective date of the Action;

4.8.2.1.9.4 Date the Member requested the State Fair Hearing;

4.8.2.1.9.5 Date forwarded to OAH;

4.8.2.1.9.6 Identification of the individual filing the request for a State Fair Hearing;

4.8.2.1.9.7 Identification of the individual recording the request;

4.8.2.1.9.8 Nature of the State Fair Hearing;

4.8.2.1.9.9 Resolution of the State Fair Hearing;

4.8.2.1.9.10 Corrective action required; and

4.8.2.1.9.11 Date resolved.

4.8.2.1.10 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Member, or Authorized Representative, for filing a State Fair Hearing request.

4.8.2.1.11 The CONTRACTOR(S) shall follow the directions of the State concerning:

4.8.2.1.11.1 The preparation of and the contents for the Agency Summary (see applicable K.A.R. as a guide), including notification to the Member that both the CONTRACTOR(S) and the State will be appearing at the State Fair Hearing, with names of those who will be appearing;

4.8.2.1.11.2 The sending of the Agency Summary and any addendums;

4.8.2.1.11.3 The identification of CONTRACTOR(S)' witnesses to testify at the State Fair Hearing;

4.8.2.1.11.4 The motions for extensions of time to submit necessary documents;

4.8.2.1.11.5 The motions to dismiss, if any; and

4.8.2.1.11.6 Other State Fair Hearing matters as needed.

4.8.2.1.12 The CONTRACTOR(S) shall cooperate with the State, the State's fiscal agent, and/or designees of either, to resolve all Member State Fair Hearings. Such cooperation may

include, but is not limited to, providing internal Member State Fair Hearing information to the State.

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

4.8.2.1.13.1 Standard resolution: Within ninety (90) Calendar Days of the date the Member submitted the Appeal with the CONTRACTOR(S) (excluding the calendar days the Member took to subsequently file for a State Fair Hearing).

4.8.2.1.13.2 Expedited resolution (the Appeal was heard first through the CONTRACTOR(S)' Appeal process): As expeditiously as the Member's health condition requires and no later than three (3) Business Days after OAH receives, from the CONTRACTOR(S), the case file and information for any Appeal of a denial of a service that the CONTRACTOR(S) indicates:

4.8.2.1.13.2.1 Meets the criteria for an expedited Appeal process as set forth in 42 CFR § 438.410(a), but was not resolved within the CONTRACTOR(S)' timeframe for an Expedited Appeal, or

4.8.2.1.13.2.2 Was resolved within the CONTRACTOR(S)' timeframe for expedited resolution but was resolved wholly or partially adversely to the Member.

4.8.2.1.14 The State is a party to the State Fair Hearing. The State will be designated as the respondent in a State Fair Hearing for cases involving CONTRACTOR(S) decisions appealed to a State Fair Hearing by a Member or Provider. The State Medicaid Agency or a State Agency authorized to administer that portion of the Kansas Medicaid Program will be designated as the respondent in those cases involving their area of administrative delegation. The parties to the State Fair Hearing include the CONTRACTOR(S). The CONTRACTOR(S) may be noted as the contractual agent of the State. The Member or the Member's estate is also a party and will be designated as the appellant. The Member or the Member's estate may be represented.

4.8.2.1.15 The Fair Hearings Manager or an attorney for the respondent will represent the State at all State Fair Hearings. The CONTRACTOR(S) shall participate in or be present at the State Fair Hearings.

4.8.2.1.16 The respondent or appellant to the State Fair Hearing may Appeal the decision of the Initial Order issued by the Presiding Officer to the State Appeals Committee (SAC). SAC will review the Initial Order and issue a Final Order. If neither the respondent nor appellant requests a review of the Initial Order by SAC, the Initial Order will become the Final Order. The respondent or appellant may Appeal the Final Order to a district court. The respondent or appellant also may request a Reconsideration of the Final Order by the Secretary of KDHE-DHCF. There are filing time limits that are strictly enforced. The Initial and Final Orders specify those time limits.

4.8.2.1.17 If the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the State Fair Hearing was pending, the CONTRACTOR(S) must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination.

4.8.2.1.18 If the State Fair Hearing officer reverses a decision to deny authorization of services, and the Member received the disputed services while the State Fair Hearing was pending, the CONTRACTOR(S) must pay for those services.

4.8.2.1.19 If a Member makes a request for disenrollment, the CONTRACTOR(S) shall give the Member information on the disenrollment process and direct the Member to the State's fiscal agent. If the request for disenrollment is denied by the State, the CONTRACTOR(S) shall advise the Member of their right to request a State Fair Hearing.

4.8.2.1.20 The CONTRACTOR(S) shall ensure that punitive action is not taken against a Provider who requests a State Fair Hearing on the Member's behalf or supports a Member's State Fair Hearing request.

4.8.2.1.21 The CONTRACTOR(S) shall cooperate with the State, the State's fiscal agent, and/or designees of either to process or resolve all Member State Fair Hearing requests. Such cooperation may include, but is not limited to, providing internal Member State Fair Hearing information to the State.

5.0 Provider Grievances, Reconsiderations, Appeals, External Independent Third-Party Reviews and State Fair Hearings

5.1 Provider Grievance System

5.1.1 The CONTRACTOR(S) shall establish a Provider Grievance and Appeal System, including written policies and procedures that meet the following requirements:

5.1.1.1 Ensures that individuals who make decisions on Grievances are individuals:

5.1.1.1.1 Who were neither involved in previous levels of review or decision-making nor a subordinate of any such individual;

5.1.1.2 Provides the Grievance procedures and timeframes in writing to all Providers and Subcontractor(s) at the time they enter into a provider agreement or Subcontract;

5.1.1.3 Includes the Provider's right to submit Grievances and their requirements and timeframes for filing;

5.1.1.4 Includes the toll-free number to submit oral Grievances; and

5.1.1.5 Ensures the CONTRACTOR(S) maintains records of all Grievances received as noted below.

5.2 Provider Grievance Process

5.2.1 The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving Grievances by Providers through the Grievance process administered by the CONTRACTOR(S). The Grievance process shall ensure the following:

5.2.1.1 The Grievance procedure shall be the same for both Participating and Non-Participating Providers.

5.2.1.2 The Provider may submit a Grievance either orally or in writing. The CONTRACTOR(S) cannot require a written form from the Provider for a Grievance.

5.2.1.3 The timeframe within which a Provider must submit a Grievance with the CONTRACTOR(S) is one hundred and eighty (180) Calendar Days of the date of the incident being grieved.

5.2.1.4 The CONTRACTOR(S) shall resolve each Grievance and send Notice of Provider Grievance Resolution.

5.2.1.5 The CONTRACTOR(S) shall resolve 98% of Grievances within thirty (30) Calendar Days from the date the Grievance is received. If the Provider's request was made orally or telephonically, the date of the oral or telephonic request shall be used as the start of this period. If the Provider's request was made in writing, the date of receipt of the written request shall be used as the start of this Grievance resolution period.

5.2.1.6 The CONTRACTOR(S) shall resolve 100% of the Grievances within sixty (60) Calendar Days from the date the Grievance is received.

5.2.1.7 All notices containing the Grievance resolution decisions shall be in writing. The notice shall include a description of the Grievance, date the CONTRACTOR(S) received the Grievance, the date of Grievance resolution, and the resolution of the Grievance by the CONTRACTOR(S).

5.2.1.8 The CONTRACTOR(S) shall designate an employee of the CONTRACTOR(S) who has primary responsibility for ensuring that Grievances are resolved in compliance with written policy and within the required timeframe. The CONTRACTOR(S) shall have policies and procedures in place outlining the designated employee's role in a Provider's Grievance. The designated employee must have a significant role in monitoring, investigating and hearing Grievances. The CONTRACTOR(S) shall have a routine process to detect patterns of Grievances. Management, supervisory, and quality improvement staff shall be involved in developing policy and procedure improvements to address the Grievances.

5.2.1.9 The CONTRACTOR(S)' Grievance procedures shall be provided in writing to Providers in the Provider handbook and on its website. Upon request, the CONTRACTOR(S) shall provide a copy of the Grievance procedures to a Non-Participating Provider or direct the Non-Participating Provider to the CONTRACTOR(S)' website. The CONTRACTOR(S) shall maintain and publish in the Provider handbook and website at least one (1) toll-free telephone number for requesting Grievances.

5.2.1.10 The CONTRACTOR(S)' Grievance process shall allow for electronic submission of Grievances and shall require that every Grievance received in person, by telephone, voice mail, e-mail or in writing from a Provider shall be acknowledged, recorded in a written record and logged with the following details:

5.2.1.10.1 Date the Provider requested the Grievance;

5.2.1.10.2 Identification of the individual filing the Grievance;

5.2.1.10.3 Date received by the CONTRACTOR(S);

5.2.1.10.4 Identification of the individual recording the Grievance;

5.2.1.10.5 Nature of the Grievance;

5.2.1.10.6 How the CONTRACTOR(S) resolved the Grievance;

5.2.1.10.7 Corrective action required;

5.2.1.10.8 Date resolved; and

5.2.1.10.9 Date Notice of Provider Grievance Resolution was sent.

5.2.1.11 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Provider for making a Grievance.

5.2.1.12 The CONTRACTOR(S) will cooperate with the State's fiscal agent and the State, or designees of either, to resolve all Provider Grievances. Such cooperation may include, but is not limited to, providing internal Provider Grievance information or assistance to the State.

5.2.1.13 In no event shall the CONTRACTOR(S) allow a Provider who has been barred from participation in the Kansas Medical Assistance Program to request a Grievance.

5.2.2 Timeframe for Notice of Provider Grievance Resolution

5.2.2.1 The CONTRACTOR(S) shall send the Notice of Provider Grievance Resolution to the Provider within five (5) Business Days following the date of resolution of the Grievance.

5.3 **Notice of Action for Providers**

5.3.1 **Notice of Action System for Providers**

The CONTRACTOR(S) shall develop, implement, and maintain a system for sending a Notice of Action to a Provider, for Actions taken by the CONTRACTOR(S) against the Provider. The CONTRACTOR(S) shall send a Notice of Action notifying the Provider in accordance with this Appendix and applicable State regulations when the CONTRACTOR(S) issues an Action to the Provider. The notice shall be in writing and contain the elements noted below. The notice may be in the form of a letter or Remittance Advice.

5.3.2 **Content of Notice of Action for Providers**

5.3.2.1 The CONTRACTOR(S)' notice to the Provider shall include the following elements:

5.3.2.1.1 Date of the Notice of Action;

5.3.2.1.2 Date the Notice of Action was sent. If the notice is in the form of a Remittance Advice, the sent date may be represented by the date on the Remittance Advice that indicates it is available electronically. If the notice is in the form of a letter, in lieu of a sent date, the CONTRACTOR(S) may add language stating the Provider may consider the sent date to be the date of the notice;

5.3.2.1.3 The Action the CONTRACTOR(S) has made or intends to make;

5.3.2.1.4 The reasons for the Action;

5.3.2.1.5 The date the Action was made or will be made;

5.3.2.1.6 If the Action is based upon a determination that the service is not medically necessary, the CONTRACTOR(S) shall provide an explanation of the medical basis for the decision, application of policy or accepted standards of medical practice to the individual's medical circumstances, in its notice to the Provider;

5.3.2.1.7 If the Action is based upon a statute, regulation, policy or procedure, the CONTRACTOR(S) shall provide the statute, regulation, policy or procedure supporting the Action;

5.3.2.1.8 An explanation of the Provider's right to request either a Reconsideration or an Appeal through the CONTRACTOR(S)' Reconsideration process or Appeal process following receipt of the CONTRACTOR(S)' notice containing the adverse decision;

5.3.2.1.9 An explanation of the optional nature of the CONTRACTOR(S)' Reconsideration process and the CONTRACTOR(S)' requirement for the Provider to complete the CONTRACTOR(S)' Appeal process before requesting a State Fair Hearing;

5.3.2.1.10 An explanation of the Provider's right to submit a Reconsideration within one hundred twenty (120) Calendar Days of the date of the Notice of Action and the Provider's right to submit an Appeal request within sixty (60) Calendar Days of the date of the Notice of Action, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice. The notice shall include the address and contact information for submission of the Reconsideration and submission of the Appeal;

5.3.2.1.11 An explanation of the Provider's right to terminate the Reconsideration process and submit an Appeal request to the CONTRACTOR(S) within sixty (60) Calendar Days of the date of the Notice of Action, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice. Submission of the Appeal request is not dependent upon completion of the process or receipt of a Notice of Reconsideration Resolution;

5.3.2.1.12 An explanation that if a Provider chooses to submit a Reconsideration, and wait until receipt of the Notice of Reconsideration Resolution, that a Provider has the right to submit an Appeal request to the CONTRACTOR(S) within sixty (60) Calendar Days of the date of the Notice of Reconsideration Resolution, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice. If a Provider fails to submit an Appeal request within sixty-three (63) Calendar Days and has submitted a Reconsideration Request, the Provider must wait until receipt of the Notice of Reconsideration Resolution. See Section 5.4.1.2.6 of this Appendix;

5.3.2.1.13 The procedures by which the Provider may request a Reconsideration or an Appeal regarding the CONTRACTOR(S)' Action, including the address and contact information for submission of the Reconsideration and submission of an Appeal through the CONTRACTOR(S);

5.3.2.1.14 An explanation of a review process available to the Provider after receipt of the CONTRACTOR(S)' administrative denial of payment due to the Provider's failure to timely submit an authorization request or notification. The explanation shall include the Provider's right to submit evidence of extenuating circumstances with the Provider's Appeal. The explanation shall include the Provider's right to have clinical documentation submitted with the Provider's Appeal reviewed for medical necessity if the CONTRACTOR(S) determines the Provider has submitted sufficient evidence of extenuating circumstances;

5.3.2.1.15 The Provider's right to represent themselves or be represented by legal counsel or another spokesperson when requesting a Reconsideration or an Appeal through the CONTRACTOR(S);

5.3.2.1.16 The specific change in Federal or State law that requires the Action; and

5.3.2.1.17 The Provider's right to a State Fair Hearing following completion of the Provider Appeal Process or, in cases of an Action based on a change in law, the circumstances under which a State Fair Hearing will be granted.

5.3.3 **Timeframe for Notice of Action to Providers**

5.3.3.1 The CONTRACTOR(S) shall send a written Notice of Action to the Provider within one (1) Business Day following the date of Action affecting the claim.

5.4 **Provider Reconsiderations**

5.4.1 **Provider Reconsideration System**

5.4.1.1 The CONTRACTOR(S) shall establish a Provider Reconsideration System, including written policies and procedures, that allows a provider to dispute a claim payment determination prior to requesting an Appeal and that is not required as a precursor to the submission of an Appeal. The Provider Reconsideration System shall meet the following requirements:

5.4.1.1.1 Provides the Reconsideration procedures and timeframes in writing to all Providers and Subcontractor(s) at the time they enter into a contract;

5.4.1.1.2 Includes the Provider's right to submit Reconsiderations and their requirements and timeframes for filing; and

5.4.1.1.3 Ensures the CONTRACTOR(S) maintains records of all Reconsiderations received.

5.4.2 **Provider Reconsideration Process**

5.4.2.1 The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving Reconsiderations by Providers through the Reconsideration process administered by the CONTRACTOR(S). The Provider Reconsideration process shall ensure the following:

5.4.2.1.1 The Reconsideration procedure shall be the same for all Providers with the exception of State approved provider agreements that contain timeframes that are different from those established in this Appendix.

5.4.2.1.2 A Provider may submit a request for Reconsideration orally or in writing.

5.4.2.1.3 The Provider has the option to submit either a Reconsideration request or an Appeal request to the CONTRACTOR(S) following receipt of the CONTRACTOR(S)' Notice of Action.

5.4.2.1.4 The timeframe within which a Provider may submit a request for Reconsideration with the CONTRACTOR(S) shall be one hundred twenty (120) Calendar Days of the date of the Notice of Action, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice. The Provider's rights to Appeal are preserved throughout the Reconsideration process.

5.4.2.1.5 If a Provider chooses to request a Reconsideration, a Provider may terminate the Reconsideration process and submit an Appeal request with the CONTRACTOR(S) within sixty (60) Calendar Days of the date of the Notice of Action, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice. If a

Provider does not submit an Appeal request within sixty-three (63) Calendar Days of the date of the Notice of Action, the Provider must wait to receive the Notice of Reconsideration resolution before filing an Appeal. The Provider must submit a request for an Appeal with the CONTRACTOR(S) within sixty-three (63) Calendar Days of the date of the Notice of Reconsideration Resolution.

5.4.2.1.6 The CONTRACTOR(S) shall resolve 100% of Reconsiderations and send a Notice of Reconsideration Resolution within the timeframe indicated in this Appendix. The notice may be in the form of a letter or Remittance Advice.

5.4.2.1.7 The Provider's right to represent themselves or be represented by legal counsel or another spokesperson when requesting a Reconsideration or an Appeal through the CONTRACTOR(S).

5.4.2.1.8 The CONTRACTOR(S) shall designate an employee of the CONTRACTOR(S) who has primary responsibility for ensuring that Reconsiderations are resolved in compliance with this Appendix, written policy and within the required timeframe. The CONTRACTOR(S) shall have policies and procedures in place outlining the designated employee's role in a Reconsideration of an Action. The designated employee must have a significant role in monitoring, investigating, and hearing Reconsiderations. The CONTRACTOR(S) shall have a routine process to detect patterns of Reconsiderations. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Reconsiderations.

5.4.2.1.9 The CONTRACTOR(S) shall provide a reasonable opportunity to present evidence, and allegations of fact or law, in person, as well as in writing. The CONTRACTOR(S) shall allow the Provider the opportunity, before and during the Reconsideration process, to examine the case file, including clinical records, and any other documents and records considered during the Reconsideration process. The CONTRACTOR(S) shall inform the Provider of the time available for providing this information.

5.4.2.1.10 The CONTRACTOR(S)' Reconsideration procedures shall be provided in writing to Providers in the Provider handbook and on its website. Upon request, the CONTRACTOR(S) shall provide a copy of the Reconsideration procedures to a Non-Participating Provider or direct the Non-Participating Provider to the CONTRACTOR(S)' website.

5.4.2.1.11 The CONTRACTOR(S) shall provide the Reconsideration procedures in writing to all Providers and Subcontractor(s) at the time they enter into a provider agreement or Subcontract.

5.4.2.1.12 The CONTRACTOR(S)' Reconsideration process shall allow for electronic submission of Reconsiderations and shall require that every Reconsideration received in person, by telephone, voice mail, e-mail or in writing from a Provider shall be recorded in a written record, and logged with the following details:

5.4.2.1.12.1 Date of the Notice of Action;

5.4.2.1.12.2 Date notice was sent;

5.4.2.1.12.3 Effective date of the Action;

5.4.2.1.12.4 Date the Provider requested the Reconsideration;

5.4.2.1.12.5 Date received by the CONTRACTOR(S);

5.4.2.1.12.6 Identification of the individual filing the Reconsideration;

5.4.2.1.12.7 Identification of the individual recording the Reconsideration;

5.4.2.1.12.8 Nature of the Reconsideration;

5.4.2.1.12.9 How the CONTRACTOR(S) resolved the Reconsideration;

5.4.2.1.12.10 Corrective action required;

5.4.2.1.12.11 Date resolved; and

5.4.2.1.12.12 Date the Notice of Reconsideration Resolution was sent to Provider.

5.4.2.1.13 The CONTRACTOR(S) shall consider the Provider or Provider's Authorized Representative as a party to the Reconsideration.

5.4.2.1.14 If the CONTRACTOR(S) or State Fair Hearing officer reverses a decision to deny payment, the CONTRACTOR(S) shall authorize or provide the disputed payment promptly but no later than seventy-two (72) hours from the date it reverses the determination.

5.4.2.1.15 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Provider, or their representative, for filing a Reconsideration.

5.4.2.1.16 The CONTRACTOR(S) shall cooperate with the State, the State's fiscal agent, and/or designees of either, to resolve all Provider Reconsiderations. Such cooperation may include, but is not limited to, providing internal Provider Reconsideration information to the State.

5.4.2.1.17 In no event shall the CONTRACTOR(S) allow a Provider who has been barred from participation in the Kansas Medical Assistance Program to request a Reconsideration.

5.4.3 **Content of Notice of Reconsideration Resolution**

5.4.3.1 The CONTRACTOR(S)' written Notice of Reconsideration Resolution to the Provider shall include the following elements:

5.4.3.1.1 Date of Notice of Reconsideration Resolution;

5.4.3.1.2 Date the Notice of Reconsideration Resolution was sent. If the notice is in the form of a Remittance Advice, the sent date may be represented by the date on the Remittance Advice that indicates it is available electronically;

5.4.3.1.3 The Action the CONTRACTOR(S) has made or intends to make;

5.4.3.1.4 The results of the resolution process;

5.4.3.1.5 The date of the Reconsideration Resolution;

5.4.3.1.6 If the Action is based upon a determination that the service is not Medically Necessary, the CONTRACTOR(S) shall provide an explanation of the medical basis for the decision, application of policy or accepted standards of medical practice to the individual's medical circumstances, in its notice to the Provider;

5.4.3.1.7 If the Action is based upon a statute, regulation, policy or procedure, the CONTRACTOR(S) shall provide the statute, regulation, policy or procedure supporting the Action;

5.4.3.1.8 An explanation of the Provider's right to submit an Appeal request to the CONTRACTOR(S) immediately following receipt of the Notice of Reconsideration Resolution within sixty (60) Calendar Days of the date of the notice, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice. The notice shall include the address and contact information for submission of the Appeal;

5.4.3.1.9 The procedures by which the Provider may request an Appeal regarding the CONTRACTOR(S)' Action;

5.4.3.1.10 The Provider's right to represent themselves or be represented by legal counsel or another spokesperson when requesting an Appeal through the CONTRACTOR(S);

5.4.3.1.11 The specific change in Federal or State law that requires the Action;

5.4.3.1.12 The Provider's right to a State Fair Hearing following completion of the Provider Appeal Process or, in cases New edit by Dorothy of an Action based on a change in law, the circumstances under which a State Fair Hearing will be granted; and

5.4.3.1.13 Any other information required by Kansas statute or regulation that relates to the CONTRACTOR(S)' Notice of Reconsideration Resolution.

5.4.4 **Timeframe for Notice of Reconsideration Resolution to Providers**

5.4.4.1 The CONTRACTOR(S) shall send the Notice of Reconsideration Resolution to the Provider within five (5) Business Days following the date of resolution of the Reconsideration.

5.5 **Provider Appeals**

5.5.1 **Provider Appeal System**

5.5.1.1 The CONTRACTOR(S) shall establish a Provider Appeal System, including written policies and procedures, that allows a Provider to dispute a claim payment determination and that is required as a precursor to requesting a State Fair Hearing. The Provider Appeal System shall meet the following requirements:

5.5.1.1.1 Acknowledges receipt of each Provider Appeal;

5.5.1.1.2 Provides the Appeal procedures and timeframes in writing to all Providers and Subcontractors at the time they enter into a provider agreement or Subcontract;

5.5.1.1.3 Includes the Provider's right to submit Appeals and their requirements and timeframes for filing;

5.5.1.1.4 Ensures the CONTRACTOR(S) completes a review of extenuating circumstances when a Provider submits an Appeal following the CONTRACTOR(S)' administrative denial of payment. The CONTRACTOR(S)' review shall determine whether the Provider's Appeal documents show evidence of extenuating circumstances that contributed to a Provider's failure to timely submit an authorization request or notification to the CONTRACTOR(S);

5.5.1.1.5 Ensures the CONTRACTOR(S) completes a review of medical necessity when a Provider submits an Appeal with clinical documents following the CONTRACTOR(S)'

administrative denial of payment. The CONTRACTOR(S)' medical necessity review shall be completed for Provider Appeals the CONTRACTOR(S) has determined show sufficient evidence of extenuating circumstances; and

5.5.1.1.6 Ensures the CONTRACTOR(S) maintains records of all Appeals received.

5.5.2 **Provider Appeals Process**

5.5.2.1 The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving Appeals by Providers through the Appeal process administered by the CONTRACTOR(S). The Provider Appeal Process shall ensure the following:

5.5.2.1.1 The Appeal procedure shall be the same for all Providers with the exception of State-approved Provider agreements that contain timeframes that are different from those established in this Appendix.

5.5.2.1.2 A Provider must submit an Appeal in writing.

5.5.2.1.3 The timeframe within which a Provider must submit a request for an Appeal with the CONTRACTOR(S) shall be sixty (60) Calendar Days of the date of the Notice of Action, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice.

5.5.2.1.4 The CONTRACTOR(S) shall acknowledge 100% of Appeals received from a Provider in writing within ten (10) Calendar Days of the date the CONTRACTOR(S) receives the Appeal request.

5.5.2.1.5 The CONTRACTOR(S) shall resolve 98% of Provider Appeals within thirty (30) Calendar Days of the date the CONTRACTOR(S) receives the Appeal request and send a Notice of Reconsideration Resolution within the timeframe indicated in this Appendix. The notice may be in the form of a letter or Remittance Advice.

5.5.2.1.6 The CONTRACTOR(S) shall resolve 100% of Provider Appeals within sixty (60) Calendar Days of the date the CONTRACTOR(S) receives the Appeal request and send a Notice of Reconsideration Resolution within the timeframe indicated in this Appendix. The notice may be in the form of a letter or Remittance Advice.

5.5.2.1.7 The Provider's right to represent themselves or be represented by legal counsel or another spokesperson when requesting an Appeal through the CONTRACTOR(S).

5.5.2.1.8 The CONTRACTOR(S) shall designate an employee of the CONTRACTOR(S) who has primary responsibility for ensuring that Provider Appeals are resolved in compliance with written policy and within the required timeframe. The CONTRACTOR(S) shall have policies and procedures in place outlining the designated employee's role in a Provider's Appeal of an Action. The designated employee must have a significant role in monitoring, investigating, and hearing Appeals. The CONTRACTOR(S) shall have a routine process to detect patterns of Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Appeals.

5.5.2.1.9 The CONTRACTOR(S) shall provide a reasonable opportunity to present evidence, and allegations of fact or law, in person, as well as in writing. The CONTRACTOR(S) shall allow the Provider and the Provider's representative the opportunity, before and

during the Appeal process, to examine the case file, including clinical records, and any other documents and records considered during the Appeal process. The CONTRACTOR(S) shall inform the Provider of the time available for providing this information.

5.5.2.1.10 The CONTRACTOR(S)' Appeal procedures shall be provided in writing to Providers in the Provider handbook and on its website. Upon request, the CONTRACTOR(S) shall provide a copy of the Appeal procedures to a Non-Participating Provider or direct the Non-Participating Provider to the CONTRACTOR(S)' website.

5.5.2.1.11 The CONTRACTOR(S) shall provide the Appeal procedures and timeframes in writing to all Providers and Subcontractor(s) at the time they enter into a provider agreement or a Subcontract.

5.5.2.1.12 The CONTRACTOR(S)' Appeal process shall allow for electronic submission of Appeals and may require that every Appeal be submitted by written communication or through the CONTRACTOR(S)' secure web portal. Every Provider Appeal received shall be acknowledged, recorded in a written record, and logged with the following details:

5.5.2.1.12.1 Date of the Notice of Action;

5.5.2.1.12.2 Date notice was sent;

5.5.2.1.12.3 Effective date of the Action;

5.5.2.1.12.4 Date the Provider requested the Appeal;

5.5.2.1.12.5 Date received by the CONTRACTOR(S);

5.5.2.1.12.6 Date acknowledgement letter was sent;

5.5.2.1.12.7 Identification of the individual filing the Appeal;

5.5.2.1.12.8 Identification of the individual recording the Appeal;

5.5.2.1.12.9 Nature of the Appeal;

5.5.2.1.12.10 How the CONTRACTOR(S) resolved the Appeal;

5.5.2.1.12.11 Corrective action required;

5.5.2.1.12.12 Date resolved; and

5.5.2.1.12.13 Date Notice of Provider Appeal Resolution was sent to the Provider.

5.5.2.1.13 The CONTRACTOR(S) shall consider the Provider or Provider's Authorized Representative as a party to the Appeal. A Provider may seek a State Fair Hearing if the Provider is not satisfied with the CONTRACTOR(S)' decision in response to an Appeal.

5.5.2.1.14 If the CONTRACTOR(S) or State Fair Hearing officer reverses a decision to deny payment, the CONTRACTOR(S) shall authorize or provide the disputed payment promptly but no later than seventy-two (72) hours from the date it reverses the determination.

5.5.2.1.15 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Provider, or their representative, for filing an Appeal.

5.5.2.1.16 The CONTRACTOR(S) shall cooperate with the State, the State's fiscal agent, and/or designees of either, to resolve all Provider Appeals. Such cooperation may include, but is not limited to, providing internal Provider Appeal information to the State.

5.5.2.1.17 In no event shall the CONTRACTOR(S) allow a Provider who has been barred from participation in the Kansas Medical Assistance Program to request an Appeal.

5.5.3 **Content of Notice of Provider Appeal Resolution**

5.5.3.1 The CONTRACTOR(S)' written Notice of Provider Appeal Resolution to the Provider shall include the following elements:

5.5.3.1.1 Date of Notice of Provider Appeal Resolution;

5.5.3.1.2 Date the Notice of Provider Appeal Resolution was sent. If the notice is in the form of a Remittance Advice, the sent date may be represented by the date on the Remittance Advice that indicates it is available electronically. If the notice is in the form of a letter, in lieu of a sent date, the CONTRACTOR may add language stating the Provider may consider the sent date to be the date of the notice;

5.5.3.1.3 The results of the resolution process and the date of the Appeal resolution;

5.5.3.1.4 Date the CONTRACTOR(S) received the Appeal;

5.5.3.1.5 For decisions not wholly in the Provider's favor;

5.5.3.1.5.1 A statement that the Provider's Appeal rights within the CONTRACTOR(S)' Appeal process have been exhausted;

5.5.3.1.5.2 A statement that the Provider is entitled to an External Independent Third-Party Review;

5.5.3.1.5.3 The requirements to request an External Independent Third-Party Review;

5.5.3.1.5.4 An explanation of the Provider's right to request a State Fair Hearing following receipt of the CONTRACTOR(S)' Notice of Provider Appeal Resolution;

5.5.3.1.5.5 The procedures by which a Provider may request a State Fair Hearing;

5.5.3.1.5.6 An explanation that the Provider must submit the request for State Fair Hearing within one hundred twenty (120) Calendar Days of the Notice of Provider Appeal Resolution, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice;

5.5.3.1.5.7 The address and contact information for submission of the State Fair Hearing request;

5.5.3.1.5.8 That in the State Fair Hearing the Provider may represent themselves or use legal counsel, a relative, a friend, or a spokesperson;

5.5.3.1.5.9 An explanation of the Provider's right to request a State Fair Hearing, or in cases of an Action based on change in law, the circumstances under which a State Fair Hearing will be granted; and

5.5.3.1.5.10 Any other information required by Kansas statute or regulation that relates to the CONTRACTOR(S)' Notice of Provider Appeal Resolution.

5.5.4 **Timeframe for Notice of Provider Appeal Resolution**

5.5.4.1 The CONTRACTOR(S) shall send the Notice of Provider Appeal Resolution to the Provider within five (5) Business Days following the date of resolution of the Appeal.

5.6 **External Independent Third-Party Review**

5.6.1 **External Independent Third-Party Review System**

5.6.1.1 The CONTRACTOR(S) shall establish an External Independent Third-Party Review System pursuant to K.S.A. 39-709i and State policy. The System shall include written policies and procedures that allow a Provider to dispute a denial of a claim payment or a denial of a new health care service following completion of the CONTRACTOR(S)' Appeal process. The External Independent Third-Party Review System shall meet the following requirements:

5.6.1.1.1 Includes the requirements and timeframes for filing an External Independent Third-Party Review in the Notice of Provider Appeal Resolution:

5.6.1.1.1.1 Payment of a penalty fee to the requesting Provider for each Notice of Provider Appeal Resolution that does not comply with K.A.R. 129-9-9, as determined by the State.

5.6.1.1.2 Acknowledgement of receipt by the CONTRACTOR(S) of each request for External Independent Third-Party Review;

5.6.1.1.3 Transfers of Provider Appeal documentation to the State;

5.6.1.1.4 Reversals of the CONTRACTOR(S)' adverse decision if the CONTRACTOR(S) fails to comply with the timeliness requirements of K.S.A. 39-709i;

5.6.1.1.5 Sending of a Notice of External Review Decision by the CONTRACTOR(S) to the requesting Provider and to the affected Member, if related to the denial of a new health care service;

5.6.1.1.6 Payment to the external review contractor of the cost of reviews for decisions that reverse the CONTRACTOR(S) adverse decision, including payment for partial reviews begun prior to the CONTRACTOR(S) reversing its adverse decision;

5.6.1.1.7 Provides the External Independent Third-Party Review procedures and timeframes in writing to all Providers and Subcontractors at the time they enter into a provider agreement or Subcontract; and

5.6.1.1.8 Maintains records of all requests received for External Independent Third-Party Review.

5.6.2 **External Independent Third-Party Review Process**

5.6.2.1 The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and processing requests for External Independent Third-Party Review. The External Independent Third-Party Review Process shall ensure the following:

5.6.2.1.1 The External Independent Third-Party Review Process shall be the same for all Providers.

5.6.2.1.2 A Provider shall submit a request for External Independent Third-Party Review in writing.

5.6.2.1.3 The timeframe within which a Provider must submit a request for External Independent Third-Party Review to the CONTRACTOR(S) shall be sixty (63) Calendar Days of the date of the Notice of Provider Appeal Resolution.

5.6.2.1.4 The CONTRACTOR(S) shall send a written acknowledgement of each request for External Independent Third-Party Review to the requesting Provider and to the affected Member, if related to the denial of a new health care service, within five (5) Business Days of receipt of the request. If the CONTRACTOR(S) does not send an acknowledgement of receipt to the Provider, send a copy of the acknowledgement to the State, and a copy of the acknowledgement to the affected Member, if applicable, pursuant to the five (5)-day requirements of K.S.A. 39-709i, the CONTRACTOR(S) shall reverse the adverse decision that is the issue in the request. The CONTRACTOR(S) is not required to reverse the adverse decision that is the issue in the request if the requesting Provider fails to comply with the requirements of K.S.A 39-709i, as determined by the State.

5.6.2.1.5 The CONTRACTOR(S) shall send the State a copy of the Provider's request for External Independent Third-Party Review, a copy of the Notice of Provider Appeal Resolution, and a coversheet within five (5) business days of receipt of the request for External Independent Third-Party Review.

5.6.2.1.6 The CONTRACTOR(S) shall send the Provider Appeal documentation submitted by a Provider during the CONTRACTOR(S)' Appeal process, including any medical necessity criteria applied, to the State within fifteen (15) Business Days of receipt of a Provider's request for External Independent Third-Party Review. If the CONTRACTOR(S) does not comply with all of the fifteen (15)-day requirements of K.S.A. 39-709i, the CONTRACTOR(S) shall reverse the adverse decision that is the issue in the request. The CONTRACTOR(S) is not required to reverse the adverse decision that is the issue in the request if the requesting Provider fails to comply with the requirements of K.S.A 39-709i, as determined by the State.

5.6.2.1.7 The CONTRACTOR(S) shall process 100% of requests for External Independent Third-Party Review and send a Notice of External Review Decision within the timeframe indicated in this Appendix.

5.6.2.1.8 If the affected Member completes the CONTRACTOR(S)' Appeal process for a denial of the same new health care service involved in a Provider's Appeal, the CONTRACTOR may waive the requirement for the Provider to complete the CONTRACTOR'S Appeal process. This exception applies when the CONTRACTOR(S) is unable to comply with the State's requirement for a different Appeal reviewer, as required in 4.4.1.1.3.1. If a review of the Provider's Appeal documentation is waived, the CONTRACTOR(S) shall forward the documentation submitted by the Member, the documentation submitted by the Provider, and the CONTRACTOR(S)' Appeal decision documentation to the State. The Provider's Notice of Provider Appeal Resolution shall reference the CONTRACTOR(S)' determination made during the Member's Appeal review and shall state that the CONTRACTOR(S)' Provider Appeal process is deemed to be exhausted.

5.6.2.1.9 The CONTRACTOR(S) shall send a Notice of External Review Decision to the requesting Provider and affected Member, if related to the denial of a new health care service following receipt of the external reviewer's decision letter.

5.6.2.1.10 The CONTRACTOR(S) shall provide payment or authorization of a new health care service within five (5) Business Days for decisions by the external reviewer that reverse the CONTRACTOR(S)' adverse decision.

5.6.2.1.11 The CONTRACTOR(S) shall notify the State of the need for an extension of the agency summary due date or a continuation of a scheduled hearing if the requesting Provider or affected Member requests a State Fair Hearing regarding a denial that is the issue in a pending decision by the external reviewer.

5.6.2.1.12 The CONTRACTOR(S) shall process State Fair Hearing requests that are submitted by a Provider or the affected Member following a decision by the external reviewer to uphold the CONTRACTOR(S)' decision. The CONTRACTOR(S) shall include in the agency summary copies of the Appeal documents provided to the external reviewer, the CONTRACTOR(S)' Notice of Provider Appeal Resolution, the Provider's request for an External Independent Third-Party Review, the external reviewer's decision letter and supporting documentation, and the CONTRACTOR(S)' Notice of External Review Decision.

5.6.3 **Content of Notice of External Review Decision**

5.6.3.1 The CONTRACTOR(S)' written Notice of External Review Decision to the provider shall include the following elements:

5.6.3.1.1 Date of the Notice of External Review Decision;

5.6.3.1.2 Date the CONTRACTOR(S) received the decision of the external reviewer;

5.6.3.1.3 The decision of the external reviewer;

5.6.3.1.4 For external reviewer decisions that reverse the CONTRACTOR(S)' decision, a statement that the CONTRACTOR(S) will provide authorization or payment within five (5) Business Days of the date of the Notice of External Review Decision;

5.6.3.1.5 For external reviewer decisions not wholly in the Provider's favor:

5.6.3.1.5.1 An explanation of the Provider's right and the affected Member's right to request a State Fair Hearing regarding the denial that was the issue in the request for External Independent Third-Party Review following receipt of the CONTRACTOR'S Notice of External Review Decision;

5.6.3.1.5.2 The procedures by which a Provider or Member may request a State Fair Hearing;

5.6.3.1.5.3 An explanation that if the Provider or Member wants the decision of the external reviewer to be reviewed in a State Fair Hearing, that the Provider or Member must submit the request for State Fair Hearing within thirty (30) Calendar Days of the date of the Notice of External Review Decision, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice;

5.6.3.1.5.4 The address and contact information for submission of the State Fair Hearing request;

5.6.3.1.5.5 That in the State Fair Hearing the Provider or Member may represent themselves or use legal counsel, a relative, a friend, or a spokesperson; and

5.6.3.1.5.6 Any other information required by Kansas statute or regulation that relates to the CONTRACTOR(S) Notice of External Review Decision.

5.6.4 **Timeframe for Notice of External Review Decision**

5.6.4.1.1 The CONTRACTOR(S) shall send a Notice of External Review Decision to the requesting Provider and to the affected Member, if related to the denial of a new health care service, within ten (10) Business Days of receipt of the external reviewer's decision. The CONTRACTOR(S) shall send a copy of the Notice to the State at the time the Notice is sent to the Provider and Member.

5.7 **Provider State Fair Hearing**

5.7.1 **Provider State Fair Hearing System**

5.7.1.1 The CONTRACTOR(S) shall establish a Provider State Fair Hearing System, including policies and procedures that meet the following requirements:

5.7.1.1.1 Provides the State Fair Hearing procedures and timeframes to all Providers and Subcontractor(s) at the time they enter into a provider agreement or Subcontract;

5.7.1.1.2 Includes the Provider's right to a State Fair Hearing and the requirements and timeframes for filing;

5.7.1.1.3 Informs Providers that they have the right to access the State Fair Hearing process immediately following receipt of the CONTRACTOR(S)' Notice of Provider Appeal Resolution or Notice of External Review Decision and how to obtain a State Fair Hearing;

5.7.1.1.4 Informs Providers that they may be represented by an Authorized Representative in the State Fair Hearing process;

5.7.1.1.5 Includes the availability of a toll-free number to submit oral requests for State Fair Hearings;

5.7.1.1.6 Includes the establishment of an internal process to research State Fair Hearing requests that includes analysis of the dispute and compilation of State Fair Hearing evidence in compliance with Section 5.8 of this Appendix; and

5.7.1.1.7 Ensures the CONTRACTOR(S) maintains records of all State Fair Hearing requests received.

5.7.2 **Provider State Fair Hearing Process**

5.7.2.1 The CONTRACTOR(S) shall have written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, and reporting State Fair Hearings submitted by Providers. The State Fair Hearing process shall ensure the following:

5.7.2.1.1 The State Fair Hearing process shall be the same for all Providers.

5.7.2.1.2 The Provider may request a State Fair Hearing either orally or in writing. The CONTRACTOR(S) may require a written form from the Provider for a request for a State Fair Hearing.

5.7.2.1.3 The timeframe within which a Provider must submit a request for a State Fair Hearing with the CONTRACTOR(S) or OAH shall be one hundred twenty (120) Calendar Days from the date of the Notice of Action, plus an additional three (3) Calendar Days to allow for sending of the CONTRACTOR(S)' notice.

5.7.2.1.4 The CONTRACTOR(S) shall forward all requests received from Providers for a State Fair Hearing to the OAH within one (1) Business Day of the Provider's request for a State Fair Hearing.

5.7.2.1.5 The CONTRACTOR(S) shall designate an employee of the CONTRACTOR(S) who has primary responsibility for ensuring that State Fair Hearing requests are processed in compliance with written policy and within the timeframes required by the State. The CONTRACTOR(S) shall have policies and procedures in place outlining the designated employee's role in processing a Provider's State Fair Hearing request. The designated employee must have a significant role in monitoring, investigating and processing State Fair Hearing requests. The CONTRACTOR(S) shall have a routine process to detect and record patterns of State Fair Hearings. Management, supervisory, and quality improvement staff shall be involved in developing policy and procedure improvements to address Provider State Fair Hearing requests.

5.7.2.1.6 The CONTRACTOR(S)' State Fair Hearing procedures shall be provided in writing to Providers in the Provider handbook and on its website. Upon request, the CONTRACTOR(S) shall provide a copy of the State Fair Hearing procedures to a Non-Participating Provider or direct the Non-Participating Provider to the CONTRACTOR(S)' website. The CONTRACTOR(S) shall maintain and publish in the Provider handbook and website at least one (1) toll-free telephone number for requesting a State Fair Hearing, if oral requests are permitted by the CONTRACTOR(S).

5.7.2.1.7 The CONTRACTOR(S)' State Fair Hearing process shall allow for electronic submission of requests for State Fair Hearings and shall require that every State Fair Hearing request received in person, by telephone, voice mail, e-mail or in writing from a Provider shall be recorded in a written record and logged with the following details:

5.7.2.1.7.1 Date of Notice of Action;

5.7.2.1.7.2 Date notice was sent;

5.7.2.1.7.3 Effective date of the Action;

5.7.2.1.7.4 Date the Provider requested the State Fair Hearing;

5.7.2.1.7.5 Date forwarded to OAH;

5.7.2.1.7.6 Identification of the individual filing the request for a State Fair Hearing;

5.7.2.1.7.7 Identification of the individual recording the request;

5.7.2.1.7.8 Nature of the State Fair Hearing;

5.7.2.1.7.9 Resolution of the State Fair Hearing;

5.7.2.1.7.10 Corrective action required; and

5.7.2.1.7.11 Date resolved.

5.7.2.1.8 The CONTRACTOR(S) is prohibited from discriminating or taking punitive action against a Provider for filing a State Fair Hearing request.

5.7.2.1.9 The CONTRACTOR(S) shall follow the directions of the State concerning:

5.7.2.1.9.1 The preparation of and the contents for the Agency Summary (see applicable K.A.R. as a guide), including notification to the Provider that both the CONTRACTOR(S) and the State will be appearing at the State Fair Hearing, with names of those who will be appearing;

5.7.2.1.9.2 The sending of the Agency Summary and any addendums;

5.7.2.1.9.3 The identification of CONTRACTOR(S)' witnesses to testify at the State Fair Hearing;

5.7.2.1.9.4 The motions for extensions of time to submit necessary documents;

5.7.2.1.9.5 The motions to dismiss, if any; and

5.7.2.1.9.6 Other State Fair Hearing matters as needed.

5.7.2.1.10 The CONTRACTOR(S) shall cooperate with the State, the State's fiscal agent, and/or designees of either, to resolve all Provider State Fair Hearings. Such cooperation may include, but is not limited to, providing internal Provider State Fair Hearing information to the State.

5.7.2.1.11 In no event shall the CONTRACTOR(S) allow a Provider who has been barred from participation in the Kansas Medical Assistance Program to request a State Fair Hearing.

5.7.2.1.12 The State OAH is responsible for the State Fair Hearing.

5.7.2.1.13 The State is a party to the State Fair Hearing. The State will be designated as the respondent in a State Fair Hearing for cases involving CONTRACTOR(S) decisions appealed to a State Fair Hearing by a Provider. The State Medicaid Agency or a State Agency authorized to administer that portion of the Kansas Medicaid Program will be designated as the respondent in those cases involving their area of administrative delegation. The parties to the State Fair Hearing include the CONTRACTOR(S). The CONTRACTOR(S) may be noted as the contractual agent of the State. The Provider is also a party and will be designated as the appellant. The provider may be represented.

5.7.2.1.14 The Fair Hearings Manager or an attorney for the respondent will represent the State at all State Fair Hearings. The CONTRACTOR(S) shall participate in or be present at the State Fair Hearings.

5.7.2.1.15 For State Fair Hearings in which the appellant is represented by an attorney, the CONTRACTOR(S) shall provide legal counsel who will participate in the entire State Fair Hearing process. The CONTRACTOR(S)' legal counsel shall be designated as Second Chair. The State shall be designated as First Chair.

5.7.2.1.16 The respondent or appellant to the State Fair Hearing may Appeal the decision of the Initial Order issued by the Presiding Officer to the State Appeals Committee (SAC). SAC will review the Initial Order and issue a Final Order. If neither the respondent nor appellant requests a review of the Initial Order by SAC, the Initial Order will become the Final Order. The respondent or appellant may Appeal the Final Order to a district court. The respondent or appellant also may request a Reconsideration of the Final Order by the Secretary of KDHE-DHCF. There are filing time limits that are strictly enforced. The Initial and Final Orders specify those time limits.

5.7.2.1.17 If the CONTRACTOR(S) or State Fair Hearing officer reverses a decision to deny payment, the CONTRACTOR(S) must authorize or provide the disputed payment promptly but no later than seventy-two (72) hours from the date the CONTRACTOR(S) receives notice reversing the determination.

5.7.2.1.18 The CONTRACTOR(S) shall ensure that punitive action is not taken against a Provider who requests a State Fair Hearing on the Member's behalf or supports a Member's State Fair Hearing request.

5.7.2.1.19 The CONTRACTOR(S) shall cooperate with the State, the State's fiscal agent, and/or designees of either to process or resolve all Provider State Fair Hearing requests. Such cooperation may include, but is not limited to, providing internal Provider State Fair Hearing information to the State.

5.8 **Additional Requirements for CONTRACTOR(S)' Member and Provider Grievance, Appeal, State Fair Hearings and Provider Reconsideration Tracking and Staff Training**

5.8.1 The tracking systems for Member Grievances (4.2.1 of this Appendix), Member Appeals (4.4.2.1), Member State Fair Hearings (4.7.2.1), Provider Grievances (5.2.1), Provider Reconsiderations (5.4.2.1), Provider Appeals (5.5.2.1), External Independent Third-Party Reviews (5.6.2.1), and Provider State Fair Hearings (5.7.2.1) must have functionality to create database extract files or other files, as determined by the State, that can be imported into the State's Grievance, Reconsideration, Appeal and State Fair Hearing database or other reporting software.

5.8.2 Appropriate functioning in all areas of Member and Provider Grievance, Appeal and State Fair Hearing, Provider Reconsideration and Provider External Independent Third-Party Review support shall include training of all new staff and ongoing training for current staff, in all areas of CONTRACTOR(S)' organization where staff are involved in the aforementioned processes, as well as staff with direct Member contact such as call center and Member outreach staff, to achieve the following minimum competencies:

5.8.2.1 Understand State and CONTRACTOR(S)' policies and procedures applicable to Member and Provider Grievance, Appeal, and State Fair Hearing requests, Provider Reconsideration requests, and Provider External Independent Third-Party Review requests;

5.8.2.2 Understand Federal and State statutes and regulations applicable to Member and Provider Grievance, Appeal and State Fair Hearing Requests, Provider Reconsideration requests, and Provider External Independent Third-Party Review requests;

5.8.2.3 Apply knowledge of State and CONTRACTOR(S)' policies and procedures, as well as State and Federal statutes and regulations and associated documents, to comply with all processing, issuing of all required notices to Members and Providers (e.g., initial and resolution notices), and tracking requirements pertaining to the disposition of Member and Provider Grievance, Appeal and State Fair Hearing requests, Provider Reconsideration requests, and Provider External Independent Third-Party Review requests as specified in this Appendix;

5.8.2.4 Apply knowledge of State and Federal statutes and regulations to ensure relevant statute or regulation is included in State Fair Hearing documents;

5.8.2.5 Accurately identify the dispute involved in each Member and Provider Grievance, Appeal and State Fair Hearing request, Provider Reconsideration request, and Provider External Independent Third-Party Review requests;

5.8.2.6 Ensure all potential witnesses, CONTRACTOR(S) and agency representatives are listed in each agency summary for State Fair Hearings;

5.8.2.7 Research State Fair Hearing requests to determine the source of the dispute, analyze data from multiple sources, and involve the appellant and key departments within the State or CONTRACTOR(S), when necessary, to achieve resolution of the dispute prior to a State Fair Hearing, when possible;

5.8.2.8 Compile relevant documentation for State Fair Hearings for agency summaries and dismissal requests that complies with the applicable K.A.R. and as directed by the State;

5.8.2.9 Summarize the arguments presented by the appellant and the State/CONTRACTOR(S) in agency summaries for State Fair Hearings to ensure the dispute and actions by the appellant and State/CONTRACTOR(S) are clearly identified. Accurately state the legal basis upon which dismissal requests are based and include regulations or statutes in support; and

5.8.2.10 Ensure timely delivery to the appellant, the State, and its designee, the OAH, of State Fair Hearing documentation as required by the State and the State's designee, the OAH.

APPENDIX E: HEALTH SCREEN TOOLS AND SCORING METHODOLOGY

The CONTRACTOR(S) shall use the Health Screen questions and scoring methodology as included in this Appendix to identify Members that may need Care Coordination. The questions may be embedded within the CONTRACTOR(S)' documentation system and should be set up in a manner where the questions and answers are able to be reported.

There are two tools based upon the age of the Member. There is a pediatric tool for Members under the age of 18, and an adult tool for Members ages 18 and over. Some of the questions are informational and are not weighted questions or automatic triggers. If a Member responds in a manner that activates an automatic trigger, that Member must receive a Health Risk Assessment (HRA). The CONTRACTOR(S) should complete the Health Screen even after an automatic trigger is activated in order to gain the fullest picture of the Member's health possible.

Pediatric Tool – Ages 17 and under

Introductory statement indicating all questions may not apply to your child

Questions	Response	Scoring
Health Status		
1) Do you feel your child's health is:	Excellent	0
	Very good	0
	Fair	1
	Poor	2
	Refused to answer	0
	Disconnected call	0
2) Has your child seen a primary care provider (PCP) (e.g., a doctor, nurse, or clinic that your child sees for check-ups and routine care) in the last twelve (12) months?	Yes	0
	No	1
	Unsure	1
	Refused to answer	0
	Disconnected call	0
3) Does your child have a specialist(s), for example an allergy doctor or a heart doctor, that they see on an ongoing basis?	Yes	Auto Trigger
	No	0
	Refused to answer	0

Questions	Response	Scoring
	Disconnected call	0
4) Over the past two (2) weeks, how often has your child shown little interest or pleasure in doing things?	Not at all	0
	Several days	1
	More than half the days	3
	Nearly every day	Auto Trigger
	Refused to answer	0
	Disconnected call	0
5) Over the past two (2) weeks, how often has your child appeared to be feeling down, depressed, or hopeless?	Not at all	0
	Several days	1
	More than half the days	3
	Nearly every day	Auto Trigger
	Refused to answer	0
	Disconnected call	0
6) How many emergency room (ER) visits has your child had in the past six (6) months?	0 visits	0
	1-2 visits	2
	3-4 visits	3
	5 or more visits	Auto Trigger
	Refused to answer	0
	Disconnected call	0
7) How many unplanned hospitalizations has your child had in the last twelve (12) months?	0 visits	0
	1-2 visits	2
	3-4 visits	Auto Trigger
	5 or more visits	Auto Trigger
	Refused to answer	0
	Disconnected call	0
8) Has your child seen a dentist in the last twelve (12) months? (ages 12 months and above)	Yes	0
	No	1

Questions	Response	Scoring
	Unsure	1
	N/A	0
	Refused to answer	0
	Disconnected call	0
9) Has your child had a flu shot in the last twelve (12) months? (ages 6 months and above)	Yes	0
	No	1
	Unsure	1
	N/A	0
	Refused to answer	0
	Disconnected call	0
10) Is your child up to date on their immunizations?	Yes	0
	No	1
	Unsure	1
	Refused to answer	0
	Disconnected call	0
11) Has your child had an eye exam in the last twelve (12) months? (ages 3 and above)	Yes	0
	No	1
	Unsure	1
	N/A	0
	Refused to answer	0
	Disconnected call	0
Health Conditions		
12) Does your child have any physical or behavioral health conditions where they are under the care of a doctor or told that they should be under the care of a doctor?	Yes	Auto Trigger
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
13) Does your child have two or more chronic conditions such as heart conditions, diabetes, asthma, conduct disorder, attention deficit/hyperactivity disorder (ADHD), autism,	Yes	Auto Trigger
	No	0

Questions	Response	Scoring
autoimmune disorders, or seizures?	Unsure	1
	Refused to answer	0
	Disconnected call	0
14) In the last seven (7) days has your child complained of pain? How would you rate their pain on a scale of zero (0) to ten (10), with zero (0) being no pain to ten (10) being excruciating pain?	Rating of 0	0
	Rating of 1	0
	Rating of 2	0
	Rating of 3	0
	Rating of 4	1
	Rating of 5	1
	Rating of 6	2
	Rating of 7	3
	Rating of 8	3
	Rating of 9	4
	Rating of 10	Auto Trigger
	Refused to answer	0
	Disconnected call	0
15) Does your child take four (4) or more prescription medications on a regular basis?	Yes	Auto Trigger
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
16) Does your child take their medications as prescribed and instructed by their doctor?	Yes	0
	No	2
	Unsure	1
	Refused to answer	0
	Disconnected call	0
17) Do you have any concerns about your child’s medicines?	Yes	1
	No	0
	Unsure	1

Questions	Response	Scoring
	Refused to answer	0
	Disconnected call	0
18) Does your child use any medical equipment currently? (e.g., wheelchair, walker, crutches, nebulizer, diabetic supplies)	Yes	1
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
19) Does your child need more help with activities of daily living than other children their age? (e.g., bathing, medication, dressing, feeding)	Yes	1
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
20) What is your child's current weight?	Enter weight	0
21) What is your child's current height in inches?	Enter height	0
22) Has a doctor or specialist recommended your child gain or lose weight?	Yes	Auto Trigger
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
23) In the past 12 months has your child ever threatened or talked about harming themselves or others?	Yes	Auto Trigger
	No	0
	Refused to answer	1
	Disconnected call	0
24) Is your child pregnant or do you suspect that they are pregnant? (females age 8 and above)	Yes	Auto Trigger
	No	0
	N/A	0
	Refused to answer	0
	Disconnected call	0

Questions	Response	Scoring
Health Lifestyle		
25) Does your child currently use tobacco, electronic cigarettes, vaping, or smokeless tobacco products?	Yes	1
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
26) Does your child spend time with anyone who uses cigarettes or other tobacco products?	Yes	1
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
27) How often does your child consume alcohol?	Never	1
	Less than monthly	1
	Monthly	2
	Weekly	Auto Trigger
	Daily or almost daily	Auto Trigger
	Unsure	1
	Refused to answer	0
	Disconnected call	0
28) Does your child regularly wear a seatbelt or ride in a car seat?	Yes	0
	No	1
	Unsure	2
	Refused to answer	0
	Disconnected call	0

Questions	Response	Scoring
29) For children ages six and above who are capable of physical activity: In the past week, on how many days has your child done a total of thirty (30) minutes or more of physical activity, that was enough to raise their heart rate and breathing rate? (This may include sports, exercise, and brisk walking or cycling for recreation or to get to and from places.)	7 days	0
	6 days	0
	5 days	0
	4 days	1
	3 days	1
	2 days	2
	1 days	2
	0 days	3
	Unsure	1
	Not Applicable	0
	Refused to answer	0
	Disconnected call	0
30) In the past twelve (12) months has your child used recreational drugs?	Yes	Auto Trigger
	No	0
	Unsure	1
	Refused to answer	1
	Disconnected call	0
31) Has your child had a well child exam or Kan Be Healthy screening in the past twelve (12) months?	Yes	0
	No	1
	Unsure	1
	Refused to answer	0
	Disconnected call	0
32) Because difficult relationships can cause health problems, we are asking all of our members the following question: Does a partner, or anyone at home, hurt, hit, or threaten your child?	Yes	Auto Trigger
	No	0
	Refused to answer	1
	Disconnected call	0

Questions	Response	Scoring
Home/Employment		
33) Does your child have a regular, safe place to sleep and store their things?	Yes	0
	No	Auto Trigger
	Refused to answer	1
	Disconnected call	0
34) What is your child's employment status?	Employed	0
	Unemployed, actively seeking employment	1
	Unemployed, not seeking employment	0
	Unemployed, but may want to seek employment	1
	Too young to be employed	0
	Refused to answer	0
	Disconnected call	0
35) Does your child have a Social Security disability determination?	Yes	2
	No	0
	Refused to answer	0
	Disconnected call	0
36) Does your child have any current legal problems, or on probation/parole?	Yes	0
	No	0
	Unsure	0
	N/A	0
	Refused to answer	0
	Disconnected call	0
37) How often do you as the parent or guardian need to have someone help you when you read instructions, pamphlets, or other written material from your child's doctor or pharmacy?	Never	0
	Sometimes	1
	Usually	2
	Always	3
	Refused to answer	0

Questions	Response	Scoring
	Disconnected call	0
38) Is your family currently receiving supports for healthy eating? (Supplemental Nutrition Assistance Program [SNAP], Food Stamps, Special Supplemental Food Program for Women, Infants, and Children [WIC], etc.)	No	0
	Yes	1
	No, but would like to	2
	Don't know	2
	Refused to answer	0
	Disconnected call	0
39) Does your family worry about paying bills?	Yes	0
	No	0
	Unsure	0
	N/A	0
	Refused to answer	0
	Disconnected call	0
40) What is your child's highest level of education?	Has not yet entered school	0
	Is making satisfactory progress	0
	Has or is at risk of failing or dropping out	0
	Has earned a high school diploma or GED	0
41) At how many addresses has your child lived in the past twelve (12) months?	Enter number	0
	Refused to answer	0
	Disconnected call	0
42) If employed, do you feel that your child is employed adequately based on their skills and knowledge?	Yes	0
	No	0
	Unsure	0
	N/A	0
	Refused to answer	0
	Disconnected call	0

Questions	Response	Scoring
43) Within the past thirty (30) days, where has your child been living? (may select multiple options)	Owned or rented home	0
	Stayed at someone else's home	0
	Homeless	0
	Group home setting	0
	Transitional living facility or temporary emergency shelter	0
	Hotel	0
	Other	0
	Refused to answer	0
	Disconnected call	0

Pediatric Health Screen Tool Scoring Triggering HRA
A total score of twenty-three (23) or more
Q1 through Q11 – (Health Status) A score of nine (9) or more
Q12 through Q24 – (Health Conditions) A score of five (5) or more
Q25 through Q32 – (Health Lifestyle) A score of six (6) or more
Q33 through Q38 – (Home/Employment) A score of four (4) or more

Adult Tool – Ages 18 and over

Questions	Response	Scoring
Health Status		
1) Do you feel your health is:	Excellent	0
	Very good	0
	Fair	1
	Poor	2
	Refused to answer	0
	Disconnected call	0
2) Have you seen a primary care provider (PCP) (e.g., a doctor, nurse, or clinic that you see for check-ups and routine care) in the last twelve (12) months?	Yes	0
	No	1
	Unsure	1
	Refused to answer	1
	Disconnected call	0
3) Do you have a specialist(s), for example an allergy doctor or a heart doctor, that you see on an ongoing basis?	Yes	Auto Trigger
	No	0
	Refused to answer	0
	Disconnected call	0
4) Over the past two (2) weeks, how often have you been bothered by having little interest or pleasure in doing things?	Not at all	0
	Several days	1
	More than half the days	2
	Nearly every day	3
	Refused to answer	0
	Disconnected call	0
5) Over the past two (2) weeks, how often have you been bothered by feeling down, depressed, or hopeless?	Not at all	0
	Several days	1
	More than half the days	2
	Nearly every day	3
	Refused to answer	0

Questions	Response	Scoring
	Disconnected call	0
6) How many emergency room (ER) visits in the past six (6) months?	0 visits	0
	1-2 visits	2
	3-4 visits	3
	5 or more visits	Auto Trigger
	Refused to answer	0
	Disconnected call	0
7) How many unplanned hospitalizations in the last twelve (12) months?	0 visits	0
	1-2 visits	2
	3-4 visits	3
	5 or more visits	Auto Trigger
	Refused to answer	0
	Disconnected call	0
8) Have you seen a dentist in the last twelve (12) months?	Yes	0
	No	1
	Unsure	1
	Refused to answer	0
	Disconnected call	0
9) Have you had a flu shot in the last twelve (12) months?	Yes	0
	No	1
	Unsure	1
	Refused to answer	0
	Disconnected call	0
10) Are you up-to-date on your immunizations?	Yes	0
	No	1
	Unsure	1
	Refused to answer	0
	Disconnected call	0

Questions	Response	Scoring
11) Have you had an eye exam in the last twelve (12) months?	Yes	0
	No	1
	Unsure	1
	Refused to answer	0
	Disconnected call	0
Health Conditions		
12) For childbearing females: Are you pregnant or do you suspect that you are pregnant? (Age 55 and under)	Yes	Auto Trigger
	No	0
	N/A	0
	Refused to answer	0
	Disconnected call	0
13) Do you have any physical or behavioral health conditions where you are, or were told that you should be under the care of a doctor?	Yes	Auto Trigger
	No	0
	Unsure	0
	Refused to answer	0
	Disconnected call	0
14) Do you have two or more chronic conditions such as heart disease, arthritis, diabetes, asthma, dementia, bi-polar disorder, schizophrenia?	Yes	Auto Trigger
	No	0
	Unsure	0
	Refused to answer	0
	Disconnected call	0
15) In the last seven (7) days how would you rate your pain on a scale of zero (0) to ten (0) with zero (0) being no pain to ten (10) being excruciating pain?	Rating of 0	0
	Rating of 1	0
	Rating of 2	0
	Rating of 3	0
	Rating of 4	1
	Rating of 5	1
	Rating of 6	1
	Rating of 7	2
	Rating of 8	2

Questions	Response	Scoring
	Rating of 9	3
	Rating of 10	Auto Trigger
	Refused to answer	0
	Disconnected call	0
16) Do you take four (4) or more prescription medications on a regular basis?	Yes	Auto Trigger
	No	0
	Unsure	0
	Refused to answer	0
	Disconnected call	0
17) Do you take your medications as prescribed and instructed by your doctor?	Yes	0
	No	2
	N/A	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
18) Do you have any concerns about your medicines?	Yes	1
	No	0
	N/A	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
19) Do you use any medical equipment currently? (excluding cane, walker, crutches, nebulizer, diabetic supplies)	Yes	1
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
20) Do you need help with activities of daily living? (e.g., bathing, medication, eating)	Yes	1
	No	0
	Unsure	1

Questions	Response	Scoring
	Refused to answer	0
	Disconnected call	0
21) What is your current weight?	Enter weight	0
22) What is your current height in inches?	Enter height	0
Current body mass index (BMI) - below 18 and above 30 scoring one point	Enter BMI	0
23) In the past twelve (12) months have you ever thought about harming yourself or others?	Yes	Auto Trigger
	No	0
	Refused to answer	0
	Disconnected call	0
24) Do you currently use tobacco, electronic cigarettes, or vaping products?	Yes	1
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
25) Have you used smokeless tobacco products in the last thirty (30) days?	Yes	1
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
26) How often do you have (six [6] for women/eight [8] for men) or more drinks in a single occasion?	Never	0
	Less than monthly	1
	Monthly	2
	Weekly	Auto Trigger
	Daily or almost daily	Auto Trigger
	Refused to answer	0
	Disconnected call	0
27) Do you regularly wear a seatbelt?	Yes	0
	No	1
	Unsure	1

Questions	Response	Scoring
	Refused to answer	0
	Disconnected call	0
28) In the past week, on how many days have you done a total of thirty (30) minutes or more of physical activity, which was enough to raise your heart rate and breathing rate? (This may include sport, exercise, and brisk walking or cycling for recreation or to get to and from places but should not include housework or physical activity that may be part of your job.)	7 days	0
	6 days	0
	5 days	0
	4 days	1
	3 days	1
	2 days	2
	1 day	2
	0 days	3
	Refused to answer	0
	Disconnected call	0
29) In the past twelve (12) months have you used recreational drugs?	Yes	1
	No	0
	Unsure	1
	Refused to answer	0
	Disconnected call	0
30) Have you had a well woman/well man exam in the past twelve (12) months?	Yes	0
	No	1
	Unsure	1
	Refused to answer	0
	Disconnected call	0
31) Because difficult relationships can cause health problems, we are asking all of our members the following question: Does a partner, or anyone at home, hurt, hit, or threaten you?	Yes	Auto Trigger
	No	0
	Refused to answer	0
	Disconnected call	0
Home/Employment		
32) Do you have a regular, safe place where you sleep and store your things?	Yes	Auto Trigger
	No	0

Questions	Response	Scoring
	Refused to answer	0
	Disconnected call	0
33) What is your employment status?	Employed	0
	Unemployed, actively seeking employment	1
	Unemployed, not seeking employment	0
	Unemployed or retired, but may want to seek employment	1
	Retired	0
	Refused to answer	0
	Disconnected call	0
34) Do you have a Social Security disability determination?	Yes	2
	No	0
	Refused to answer	0
	Disconnected call	0
35) Do you have any current legal problems, or are you currently on probation or parole?	Yes	0
	No	0
	Unsure	0
	N/A	0
	Refused to answer	0
	Disconnected call	0
36) How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	Never	0
	Sometimes	1
	Usually	2
	Always	3
	Refused to answer	0
	Disconnected call	0

Questions	Response	Scoring
37) Are you currently receiving supports for healthy eating? (Supplemental Nutrition Assistance Program [SNAP], Food Stamps, Special Supplemental Food Program for Women, Infants, and Children [WIC], etc.)	Yes	1
	No, but would like to	2
	Don't know	2
	Refused to answer	0
	Disconnected call	0
38) What is your highest level of education?	Some high school	0
	High school diploma	0
	Trade school	0
	Some college	0
	College degree	0
	More than a college degree	0
	Refused to answer	0
	Disconnected call	0
39) Within the past thirty (30) days, where have you been living? (may select multiple options)	Owned or rented home	0
	Stayed at someone else's home	0
	Homeless	0
	Group home setting	0
	Transitional living facility or temporary emergency shelter	0
	Hotel	0
	Other	0
	Refused to answer	0
40) How many addresses did you have in the past twelve (12) months?	Enter number	0
	Refused to answer	0
	Disconnected call	0

Questions	Response	Scoring
41) If employed, do you feel that you are employed adequately based on your skills and knowledge?	Yes	0
	No	0
	N/A	0
	Unsure	0
	Refused to answer	0
	Disconnected call	0
42) Do you worry about paying bills?	Yes	0
	No	0
	N/A	0
	Unsure	0
	Refused to answer	0
	Disconnected call	0
43) Would you like to learn more about available financial assistance programs?	Yes	0
	No	0
	N/A	0
	Unsure	0
	Refused to answer	0
	Disconnected call	0

Adult Health Screen Tool Scoring Triggering HRA
A total score of twenty-three (23) or more
Q1 through Q11 – (Health Status) A score of nine (9) or more
Q12 through Q23 – (Health Conditions) A score of five (5) or more
Q24 through Q31 – (Health Lifestyle) A score of six (6) or more
Q32 through Q37 – (Home/Employment) A score of four (4) or more

APPENDIX F: KANCARE HEALTH RISK ASSESSMENT (HRA)

Demographics	**Response**
Member Name	
ID #	
Primary Language	
Is an interpreter needed?	
Date of Birth	
Identified Gender	
Ethnicity (African American, Asian, Caucasian, Hispanic, Native American, Other)	
Do you practice a religion?	
Address	
Phone Number	
Emergency Contact Name	
Emergency Contact Phone Number	
List anyone present during Heath Risk Assessment (HRA)	
Does the member have an Advance Directive?	
Does the member have a Power of Attorney?	
Does the member have a living will?	
Service Providers	**Response**
Primary Care Provider/Physician Name and Phone Number	
Dentist Name and Phone Number	
Obstetrics and Gynecology (OB/GYN) (for Women) Name and Phone Number	
Optometrist Name and Phone Number	
Other Specialists, including any alternative medicine providers, Name and Phone Number	
Other	
Other	
Other	
Last Appointment with Provider	**Response**
Primary Care Provider/Physician	
Dentist	
OB/GYN (for Women)	
Optometrist	
Other Specialists	
Other	
Other	
Other	

Next Appointment with Providers	**Response**
Primary Care Provider/Physician	
Dentist	
OB/GYN (for Women)	
Optometrist	
Other Specialists	
Other	
Other	
In General, how would you rate your health (Excellent, very good, good, fair, poor)	
Last Date of Health Screenings	**Response**
Mammogram (Female over 50)	
Cervical/PAP (Female)	
Colonoscopy (Over 50)	
Immunizations	
Last Tetanus Shot	
Flu Shot	
Prostrate exam (Male)	
Height	
Weight	
Current Medical Conditions	**Response**
Anxiety	
Asthma	
Bipolar Disorder	
Bleeding Problems/Anemia	
Cancer	
Chronic Obstructive Pulmonary Disease/Emphysema	
Coronary Heart Disease/Congestive Heart Failure	
Dementia	
Depression	
Developmental Disorder/Learning Disorder	
Diabetes	
Headaches	
Hepatitis	
High Blood Pressure	
Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome HIV/AIDS	
Kidney Disease	
Organ Failure	
Other Cardiac Problems	
Pregnancy	
Renal Failure	
Schizophrenia	

Current Medical Conditions	Response
Seizures	
Sickle Cell	
Surgery	
Other	
Illicit Substance Use	
Substance Use	
Substance	
Amount	
Frequency	
Last Use	
Substance Use	
Substance	
Amount	
Frequency	
Last Use	
Substance Use	
Substance	
Amount	
Frequency	
Last Use	
Hearing Problem	
Vision Problem	
Medications, Start Date, Name, Dose, and Frequency	**Response**
How often do you take medications?	
How many medications do you take?	
Do you find that you sometimes have to choose between buying groceries or medications?	
Have you had any abnormal test results?	**Response**

Hospitalization and Emergency Room	Response
In the past three (3) months, how many times did you go to the Emergency Room?	
In the past six (6) months, how many times have you had unplanned hospitalizations stays as a patient in a hospital?	
Dates, Facility & Diagnosis of Hospitalization(s) in the past two (2) years	
Home Evaluation/Safety	**Response**
How many addresses did you have in the past twelve (12) months?	
Home Evaluation/Safety	**Response**
Who all lives in the home? Names and relationship.	
Are there pets in the home?	
Are there throw carpets present?	
Are there steps to the get inside the house?	
Are there steps inside the house?	
Is there adequate access to the bathroom?	
Is the water running, electricity and gas available?	
Is there a stove and refrigerator present and working?	
Does the member use an assistance device/ current Durable Medical Equipment?	
Any observed safety concerns?	
Socio-Economic	**Response**
What transportation do you use?	
Do you belong to a church, a club, etc.?	
Do you ever choose not to seek medical care because of religious or personal beliefs?	
If employed, do you feel that you are employed adequately based on your skills and knowledge?	
How many people are employed that live in your home?	
Do you attend school? If yes, name of school and grade	
Are there any current problems at school?	
What is the highest grade or level of school you completed?	
Do you want to pursue more education than you have today?	
Have you ever been arrested?	
If so, have you been convicted?	

Socio-Economic	Response
Do you have any current legal problems, or on probation/parole?	
Do you worry about paying bills?	
Do you have childcare or concerns regarding childcare?	
How often do you go to a grocery store in a typical month?	
Where do you do most of your food shopping?	
Do you exercise regularly or take part in a physical exercise program?	
Have you fallen in the past six (6) months? (A fall is when your body goes to the ground without being pushed.)	
Has your doctor recently told you that you need to lose weight?	
Are you on a special diet recommended by your doctor (low sodium, low cholesterol, low fat)?	
In the past seven (7) days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup)	
In the past two (2) weeks, have you experienced a change in the amount you normally eat, either poor appetite or overeating?	
When was the last time you smoked or used any tobacco products? (Cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)	
Are you interested in quitting?	
In the past two (2) weeks, have you felt stressed or anxious?	
In the past two (2) weeks, have you had little interest or pleasure in doing things that you normally like to do?	
In the past two (2) weeks, have you been feeling downhearted, depressed or “blue” more than usual?	
Have you ever thought you should cut down your drug or alcohol use?	
Have you ever felt annoyed when people have commented on your drug or alcohol use?	
Have you ever felt guilty or badly about your drug or alcohol use?	
Have you ever used drugs to ease withdrawal symptoms, or to avoid feeling low after using drugs or alcohol?	
Have you ever been treated for drug or alcohol abuse?	

Socio-Economic	Response
In the past four (4) weeks, how much body pain have you had?	
During the past four (4) weeks, how much did pain interfere with your normal activities?	
During the past four (4) weeks, how has your health impacted your ability to work or caused you to be absent from activities you enjoy?	
Do you need help doing the following?	
Standing from a sitting position?	
Walking in the house?	
Walking outside of the house?	
Preparing a meal?	
Eating a meal?	
Getting dressed?	
Shower/Bathing?	
Using the toilet?	
Doing Laundry?	
Organizing your day?	
Driving or getting to places?	
How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?	
In the past two (2) weeks, have you experienced a significant change in the amount you normally sleep, either trouble getting to sleep or sleeping too much?	
If you answered “Yes” to any of the above questions, do you have someone who can assist you?	
Which ones apply to you: (Strongly Agree, Agree, Disagree, Strongly Disagree)	
My health is important to me.	
It is important for me to take an active role in my health care.	
I am confident I can prevent or reduce problems associated with my health.	
I am confident I know when I need to seek medical care and when I am able take care of myself.	
I am confident I can talk to my doctor about my health concerns even when he or she does not ask.	
I am confident I can follow through on medical treatments I may need to do at home.	
Other Problems or Concerns	**Response**
Any other problems or concerns that have not need discussed?	

APPENDIX G: LIQUIDATED DAMAGES

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

Liquidated damage assessments are linked to performance of system implementation or operational responsibilities. Where an assessment is defined as a "not to exceed" amount, the dollar value shall be set at the discretion of the State.

The State will provide a written notification of non-compliance to the CONTRACTOR(S) identifying each unmet performance requirement herein subject to the liquidated damage assessment(s). The imposition of liquidated damages is not in lieu of any other remedy available to the State.

The State may elect not to impose a liquidated damage in a particular instance. This decision shall not be construed as a waiver of the State's right to impose liquidated damages in the future related to that or any other unmet performance requirement. For each performance requirement, unless specified otherwise, the identified liquidated damage amount is for the first time the State imposes a liquidated damage for that performance requirement. Thereafter, each time the State imposes a liquidated damage again for that specific performance requirement, the amount of liquidated damage will increase by 25% of the original liquidated damage amount. For example, if the amount of liquidated damage is $1,000, that is the amount which will be imposed by the State for the first time the liquidated damage option is utilized. The second time that performance requirement is not met and the State utilizes the liquidated damage option, the amount imposed by the State will be $1,250. The third time, the amount imposed will be $1,500, and so on with 25% increases each time the option is utilized by the State, through the life of this CONTRACT.

The CONTRACTOR(S) is singularly responsible for fully complying with the terms and performance requirements of this CONTRACT, regardless of delegation to Subcontractors or Providers. Liquidated damages will be applied to the CONTRACTOR(S). The CONTRACTOR(S) shall not pass down liquidated damages to its Subcontractors or Providers unless the Subcontractor or Provider is responsible for the CONTRACTOR(S)' failure to meet the requirement.

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

Request for Reconsideration: The CONTRACTOR(S) may request the State to reconsider the imposition of a liquidated damage as set forth in CONTRACT Section 2.18.

Performance Requirements/Liquidated Damages

	Performance Area	Description of Non-Compliance	Liquidated Damages
1.	Covered Services	Failure to meet the Preferred Drug List (PDL) adherence targets established by the State, including but not limited to targets for particular pharmaceutical classes.	The amount of the liquidated damage for each PDL adherence target not met will be calculated annually as follows: a. The number of Claims outside the target multiplied by the average differential in net cost between a preferred product and a non-preferred product.
2.	Covered Services	Failure to adhere to the State's coverage provisions for pharmaceuticals, including but not limited to step therapy, quantity limit, and Prior Authorization edits and clinical criteria.	As determined by the State: a. $500 per occurrence, per Member; or b. Liquidated damages equal to the total number of Claims identified that failed to adhere to the State's coverage provisions multiplied by the average increase in cost to the KanCare program as a result of the CONTRACTOR(S) failure to adhere to the State's coverage provisions. The average increase in cost shall be calculated by averaging the increase in cost between the Claims that adhered to the coverage provisions and the Claims that failed to adhere to the coverage provisions.
3.	Covered Services	Failure to provide medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for Members under the age of twenty-one (21), as specified in Section 2.4 of Appendix C (Services).	$2,500 per occurrence/per Member

	Performance Area	Description of Non-Compliance	Liquidated Damages
4.	Care Coordination	Failure to complete Member Health Screens as required and in the timeframe specified in Section 2.4.2.E, Health Screen, for at least 80% of the Members that the CONTRACTOR(S) was able to contact.	$10,000 per quarter
5.	Care Coordination	Failure to complete and distribute a Plan of Service or Person-Centered Service Plan (PCSP) within the timeframes specified in Section 2.4.4.1, Plans of Service, and Section 2.4.4.2, Person-Centered Service Planning.	$500 per occurrence, per Member
6.	Care Coordination	Failure to initiate the services identified and authorized in the Member's Plan of Service or PCSP as required in Section 2.4.6, Care Coordination Roles and Responsibilities.	$500 per service, per Calendar Day, per Member
7.	Care Coordination	Failure to meet the transition of care standards for Members transitioning in one or more of the circumstances specified in Section 2.4.12, Care Transitions and Diversion Activities, and State policy, including KDHE's transition of care policy, KDADS' institutional transition policy, and KDADS' Money Follows the Person policy.	$5,000 per transition, per Member
8.	Provider Network	Failure to meet the Provider time and distance standards (geo-access standards) for each Provider type established by the State, in the absence of a State-approved exception, as described in Section 2.5.3, Provider Network Adequacy Standards and specified in the KanCare network adequacy standards available on the KanCare website.	$25,000 per quarter for any of the geo-access standards not met
9.	Provider Network	Failure to meet standards to provide timely access to Primary Care, Specialty Care, Long-Term Services and Supports, Emergency Care, and Behavioral Health service Providers to meet the routine, urgent, and emergent needs for Members as specified in Section 2.5.5, Provider Network Access Standards, Section 2.5.7, Long-Term Services and	$500 per occurrence, per Member

	Performance Area	Description of Non-Compliance	Liquidated Damages
		Supports, and Section 2.5.8, Behavioral Health Provider Network Standards.	
10.	Provider Network	Failure to meet the following Non-Emergency Medical Transportation service standards to transport Members to and from Provider service locations, as specified in Section2.5.5.5, Non-Emergency Medical Transportation Service Standards: • Pick up no more than fifteen (15) minutes after the scheduled time to travel to or from the Member's appointment. • Drop off at the Provider service location no sooner than one (1) hour before, but at least fifteen (15) minutes prior to (or at the time the Provider's office opens), the Member's appointment time. • Wait time for return Transportation after the appointment not to exceed one (1) hour, if no pre-arranged time for pick up. • Urgent care Transportation within three (3) hours of the request.	$1,000 for each scheduled driver no show occurrence, per Member $500 for all other failures to meet Transportation standards listed, per occurrence, per Member
11.	Provider Network	Failure to meet the following credentialing standards as specified in Section 2.5.1, Provider Credentialing and Re-credentialing: • Complete provider credentialing and notify Providers applying for Participating Provider status within forty-five (45) Calendar Days from the date the CONTRACTOR(S) receives all necessary credentialing materials. • Enter/load the Credentialed Provider information into the CONTRACTOR(S)' Claims payment system within seven (7) Calendar Days of Credentialing Committee approval.	$500 per standard, per occurrence, per Provider
12.	Provider Services	Failure to meet the following call center performance standards as specified in Section 2.6.5, Customer Service Center – Provider Assistance:	$10,000 per standard/per month

	Performance Area	Description of Non-Compliance	Liquidated Damages
		a. 90% of calls answered within thirty (30) seconds. b. Abandonment rate of less than 5%. c. 85% of calls are answered by a live voice within thirty (30) seconds. d. A minimum 70% of all calls to the customer service center are resolved during the first call.	
13.	Utilization Management	Failure to meet timeliness requirements for making Service Authorization decisions, as specified in Section 2.8.1, Utilization Management Program Description and Appendix D (Grievances, and Appeals).	$500 per Service Authorization request, per Member
14.	Utilization Management	Failure to meet the following timeliness standards for making Service Authorization decisions, as specified in Section 2.8.1, Utilization Management Program Description: a. 100% of expedited Service Authorizations completed within the required decision timeframe. b. 98% of standard Service Authorizations completed within the required decision timeframe.	$10,000 per month, per standard
15.	Utilization Management	Failure to use a health care professional with clinical expertise in treating the Member's condition and in the same specialty/subspecialty as the requesting/ordering Provider to perform Utilization Management peer-to-peer consultations, as specified in Section 2.8.3, Utilization Management Activities.	$5,000 per occurrence
16.	Member Services	Failure to meet the following call center performance standards as specified in Section 2.10.10, Customer Service Center – Member Assistance: a. 90% of calls answered within thirty (30) seconds. b. Abandonment rate of less than 5%. c. 85% of calls are answered by a live voice within thirty (30) seconds.	$10,000 per standard/per month

	Performance Area	Description of Non-Compliance	Liquidated Damages
		d. A minimum 70% of all calls to the customer service center are resolved during the first call.	
17.	Member Services	Failure to ensure the Provider directory posted on the CONTRACTOR(S)' website demonstrates at least a 90% accuracy rate of required elements for Participating Providers listed within the Provider Directory, as specified in Section 2.10.8, Provider Directory.	$25,000 per month
18.	Grievances and Appeals	Failure to send timely and content-compliant notices listed below to Members and/or Providers, as applicable, as specified in Appendix D, Grievances, Reconsiderations, Appeals, External Independent Third-Party Reviews, and State Fair Hearings. • Notice of Action. • Notice of Adverse Benefit Determination. • Notice of External Review Decision. • Notice of Member Appeal Resolution. • Notice of Provider Appeal Resolution. • Notice of Expedited Appeal Resolution. • Notice of Member Grievance Resolution. • Notice of Provider Grievance Resolution. • Notice of Provider Reconsideration Resolution.	$500 per occurrence, per Member or Provider, as applicable
19.	Grievances and Appeals	Failure to meet the following Member Grievance and Appeal performance standards (except in those instances when the Member has requested or the State has granted a written extension) related to the required resolution timeframes specified in Appendix D, Grievances, Reconsiderations, Appeals, External Independent Third-Party Reviews, and State Fair Hearings: • Resolve at least 98% of Member Grievances within thirty (30) Calendar Days.	$10,000 per month, per standard

	Performance Area	Description of Non-Compliance	Liquidated Damages
		• Resolve 100% of Member Grievances within sixty (60) Calendar Days. • Resolve 100% of Member Standard Appeals within thirty (30) Calendar Days. • Resolve 100% of Member Expedited Appeals within seventy-two (72) hours.	
20.	Grievances and Appeals	Failure to meet the performance standards for the completeness, accuracy, and timely provision of Member and Provider State Fair Hearing documentation to the Office of Administrative Hearings, as specified in Appendix D, Grievances, Reconsiderations, Appeals, External Independent Third-Party Reviews, and State Fair Hearings.	$500 per occurrence
21.	Grievances and Appeals	Failure to meet Member and Provider State Fair Hearing requirements as specified in Appendix D, Grievances, Reconsiderations, Appeals, External Independent Third-Party Reviews, and State Fair Hearings, as evidenced by two (2) or more years of annual contract audits resulting in a finding of “partially met” or below during the five (5)-year contract period. The two (2) years do not need to be consecutive years.	$10,000 for each year in which annual contract audits result in a finding of “partially met” or below
22.	Program Integrity	Failure to notify the State within the timeframe and process established by the State of the need for closure of HCBS Waiver services for a Member as specified in Section 2.4.10.A, Individuals Enrolled in a HCBS Waiver.	$100 per Member, per Calendar Day
23.	Program Integrity	Failure to notify the State when a Member is admitted to an institution within the timeframe and using the process established by the State as specified in Section 2.4.10.A, Individuals Enrolled in a HCBS Waiver.	$5,000 per month, per Member
24.	Claims Management	Failure to meet the following Claims processing requirements as specified in	$10,000 per standard, per month

	Performance Area	Description of Non-Compliance	Liquidated Damages
		Section 2.14.1, Timely Claims Processing: • Process and pay or deny 90% of clean claims within thirty (30) Calendar Days of receipt. • Process and pay or deny 99% of all Claims (including adjustments) within ninety (90) Calendar Days of receipt.	
25.	Claims Management	Failure to submit complete, accurate, and timely Encounter Data as specified in Section 2.14.3, Encounter Data and Other Data Requirements and Section 1.4 of Appendix J (Encounter Data Requirements).	$50,000 per month
26.	Reporting and Data Collection	Failure to provide reports or data submissions that are accurate, complete, produced in the format and media required or approved by the State in writing, and within the timeframe specified by the State, as specified in Section 2.16.1, Data, Reports and Audits.	$1,000 per report/data submission requirement, per Calendar Day
27.	General Compliance	Failure to comply with any standard in this CONTRACT that is not identified above as a standard subject to liquidated damages.	Up to $500 for each occurrence of non-compliance. The liquidated damage may be assessed per Member, per Provider, and/or per Calendar Day as determined by the State.

APPENDIX H: INITIAL LIST OF REPORTS

The reporting requirements included in this Appendix reflect the reports in the Kansas reporting system for KanCare 2.0 and an initial list of additional reports that will be required under this CONTRACT. During the course of this CONTRACT, the State may add or delete reports and may require the CONTRACTOR(S) to submit additional data, including data to the State's data warehouse. This Appendix is provided for convenience only regarding the initial set of reports and does not limit the CONTRACTOR(S)' responsibility to provide all data and reports required by the State in the format and frequency specified by the State.

Number	Report	Description	Reference	Frequency
1.	5% Ownership Report	The CONTRACTOR(S) shall notify the State in writing of any person or corporation that has 5% or more ownership or controlling interest in the entity. The CONTRACTOR(S) shall submit financial statements for all owners with interest of 5% or greater.	CONTRACT Section 2.13.1.I	Annually
2.	Advanced Medical Hold Manual Review Report	For newly-released medications that will appear before the Drug Utilization Review (DUR) Board, an advanced medical hold manual review Prior Authorization (PA) may be implemented that allows coverage of the drug only pursuant to a manual review process based on the Advanced Medical Hold Manual Review (AMHMR) PA criteria approved by the DUR Board to pre-manage newly United States Food and Drug Administration (FDA)-approved drugs prior to a permanent PA being placed upon a drug. As medications become FDA approved, the KDHE Pharmacy Team will notify the Fiscal Agent Pharmacy Team, the Fiscal Agent Medical Policy Team, the KDHE Policy Team, the KDHE MCO report manager, and the Managed Care Pharmaceutical Directors via e-mail (with the AMHMR policy number as reference) to place the specific medications on medical hold and require a manual PA review. This report provides a summary of cost avoidance for new drugs that have an AMHMR PA requirement.	Per State Request	Monthly

Number	Report	Description	Reference	Frequency
3.	Annual Core Measures	Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) HEDIS Technical Specifications for Health Plans	CONTRACT Section 2.9.4 and QMS	Annually
4.	Annual MCO Evaluation Report	The MCO must prepare a written report, detailing the annual review of the QAPI program. The report must include a summary and review of completed and continuing quality improvement activities that address the quality of clinical care and services; trending and analysis of measures to assess performance in quality of clinical care and services; any corrective actions which are recommended, implemented, or in progress, as well as modifications made to the QAPI program.	CONTRACT Section 2.9.1	Annually
5.	Annual QAPI Program Description	Brief description of annual quality assessment/performance improvement plans. Findings and recommendations from the QAPI annual evaluation process will be used to shape the annual QAPI program description.	CONTRACT Section 2.9.1; 42 CFR § 438.33	Annually
6.	Business Continuity/Disaster Recovery Plan	At a minimum, the plan must address the elements listed in the CONTRACT. If the approved plan is unchanged from previous year, the MCO must submit a certification that the prior year's plan is still in place.	CONTRACT Section 2.1.2	Annually
7.	Business Continuity/Disaster Recovery Results	Results of Business Continuity/Disaster Recovery (BC/DR) testing.	CONTRACT Section 2.1.2	Annually
8.	CAHPS Report	The MCO must submit a report of audited Consumer Assessment of Healthcare Providers and Systems (CAHPS) results. The MCO must analyze CAHPS data and provide an analysis summary with this report and track and trend all aspects of the survey and take corrective action as needed to improve performance.	CONTRACT Section 2.9.8.G	Annually
9.	Children and Youth with Special Health Care Needs	The report consists of the name, date of birth (DOB), and policy (ID) number for every child in the Children and Youth Special Health Care Needs (CYSHCN) program that receives Medicaid coverage. The MCO then takes those names and matches them up with their	Per State Request	Monthly

Number	Report	Description	Reference	Frequency
		Members and identifies children who require a health care plan (HCP). The report contains a field that indicates whether or not KDHE/Bureau of Family Health (BFH) has an HCP for CYSHCN, the HCP is then forwarded to the MCO. MCOs share the status of the child's KAN Be Healthy screens with KDHE/BFH.		
10.	Claim/Encounter Review Attestation	Monthly MCO attestation to review of Claims/Encounter Data.	CONTRACT Section 2.14.3 and Appendix J (Encounter Data Requirements)	Monthly
11.	Claims Overview Report	CONTRACT standard Claims processing. • Claims and percentage denied by category. • Turnaround times (TATs) for Claims processing by category. • Top ten (10) denials reason by category with dollar values (with and without duplicate Claims). • Report of Claims that have been adjusted and tracking number of adjustments by category of service.	Per State Request	Monthly
12.	Collaborative PIP–Annual	Annual submission of collaborative performance improvement project (PIP) from MCO joint performance improvement projects.	CONTRACT Section 2.9.5 and QMS	Annually
13.	Community Reinvestment Plan	Detail the MCO's community reinvestment priority areas and activities, and evaluation of previous year's plan.	CONTRACT Section 2.13.2.M	Annually (by end of the first quarter for the first year and then annually)
14.	Credentialing/ Re-Credentialing Timeframes	This report will be used to verify the MCO's compliance with the measurements in Section 2.5.1. Credentialing and Re-Credentialing.	Per State Request	Monthly
15.	Customer Service Report, Member Services and Provider Services Phone Line Report, Telephone and Internet Activity Report, Call Center Access and Responsiveness Report	The MCO must monitor Member services, Provider services, nurse/triage nurse advice, and utilization management lines. Data in the report must be recorded weekly and include the detailed rate calculations. The report must provide information on total calls received, calls abandoned within thirty (30) seconds, percentage abandoned, average talk time, average speed of answer, and percentage answered within thirty (30) seconds by month (summarized quarterly and annually).	CONTRACT Section 2.10.10.L	Monthly

Number	Report	Description	Reference	Frequency
		The report must also contain the original contact resulting in a formal grievance or appeal with a resolution of "sent to grievances and appeals process." Each telephone and internet activity report must include but not be limited to the following: call volume, e-mail volume, average call length, average hold time, abandoned call rate, content of call or email and resolution and blocked call rate. By Member and by Provider, the average speed of answer, call abandonment percentage, number of busy signals, and hold time in seconds.		
16.	Direct Care Worker Report	Direct care worker capacity and no-shows/late arrivals/early departures and remediation activities.	CONTRACT Section 2.5.2.G	Monthly
17.	Drug Clinical-PDL PA Management	Summary of drugs that had a PA requested for the month the data represents: the total number of PA requests, and the number of PA requests that were denied, and the twenty-four (24) hour turnaround time (TAT) compliance numbers.	Per State Request	Monthly
18.	Employment Specialist Referral Report	The Employment Specialist Referral Report captures data relevant to MCO employment specialist referrals to employment services.	Per State Request	Quarterly
19.	EPSDT PIP	Performance improvement project to increase EPSDT participation rates.	CONTRACT Section 2.9.5 and QMS	Annually
20.	EPSDT Report	EPSDT MCO service approvals that are not State Plan covered. These are reported as paid Claims.	Per State Request	Monthly
21.	Extraordinary Funding	The MCOs must report extraordinary funding to the State on the State-approved report, which will include status of the persons served who have services reimbursed with extraordinary funding, authorizations for extraordinary funding, review date, approvals and denials including reasons for denials, and dates of communication to the community service provider of the status of extraordinary funding. The report will be required each quarter and due by the fifteenth Calendar Day of the month following the end of each quarter. Periods covered for each quarter shall be January through March; April through June; July through September; and October through December.	Per Policy M2016-44	Quarterly

Number	Report	Description	Reference	Frequency
22.	Final Independently Audited Financial Statements	The MCO shall submit to the State annual Audited Financial Statements specific to the KanCare CONTRACT. The MCO shall submit to the Kansas Insurance Department (KID) the results of an annual audit performed by an independent Certified Public Accountant and to authorize the KID to share this information with other State agencies as required. The MCO shall authorize the independent accountant to allow representatives of the State, including the KID, upon written request, to verify the audit report. The MCO, the MCO's parent company, and all non-provider Subcontractors that are not affiliated with the MCO will provide the results of an annual audit performed by an independent Certified Public Accountant and to authorize the MCO to share this information with the State. The MCO shall authorize the independent certified public accountant (CPA) to allow representatives of the State, upon written request, to verify the audit report.	CONTRACT Section 2.13.1.J and 2.16.1.H	Annually
23.	Financial Package – Monthly Edition	Financial Package – Monthly Edition	Per State Request	Monthly
24.	Fraud and Abuse Report – Member and Provider	The report must include the following (to the extent such information is available): • Number of complaints of fraud and abuse made to KDHE that warrant preliminary investigation. • For each complaint that warrants investigation: name and ID, complaint source, Provider type, nature of complaint, approximate dollars involved, and the legal and administrative disposition of the case. The report must include corrective actions taken.	CONTRACT Section 2.12.1 and 2.12.2	Quarterly
25.	Geographic Mapping Reports (Geo-Access)	Geographic mapping reports detailing single and multiple Provider locations by the following categories: urban/suburban, densely settled, and rural/frontier. The Medicaid Geo-Access report is combined with the density report to provide network access information. The report is broken out by modality and region. Detail by county will be provided if out of access.	Per State Request	Quarterly

Number	Report	Description	Reference	Frequency
26.	Grievance, Appeal, Reconsideration and State Fair Hearing (GAR)	The monthly reporting requirements require data of Member grievances, appeals, and State Fair Hearing requests, including those related to physical and Behavioral Health, Long-Term Services and Supports (LTSS), and Pharmaceutical services. The monthly reporting requirements must include Provider Grievance, Reconsideration, Appeal, and State Fair Hearing data. Data reporting requirements include: 1) Compliance data regarding timely issuing of Notices of Action, Notices of Adverse Benefit Determinations, Notices of Appeal Resolutions, and Notices of Reconsideration Resolutions. 2) Compliance data regarding resolution of Member and Provider Grievances, including detailed narratives of Member and Provider Grievance resolutions. 3) Compliance data regarding resolution of Provider Reconsiderations, including detailed narratives of Claim resolutions. 4) Compliance data regarding resolution of Member and Provider Appeals, including detailed narratives of Member and Provider Appeal resolutions. 5) Compliance data regarding processing of Member and Provider State Fair Hearings, including detailed information of the issue involved in the hearing request and disposition of each request.	Per State Request	Monthly
27.	HCBS Member Satisfaction	Most recent Home- and Community-Based Services (HCBS) Member satisfaction data.	CONTRACT Section 2.9.10	Quarterly
28.	HCBS PCSP Report	Increases and decreases in Person-Centered Service Plans (PCSPs)/Plans of Service by specified programs for Members and units by year.	Per State Request	Quarterly
29.	HCBS P4P	PCSPs and PCSP data, including units of personal care services (PCS) and specialized medical care (SMC) authorized and filled.	CONTRACT Section 8.13.2.O.2	Monthly
30.	HCBS Waiver Performance Measures	Report on the performance measures for each HCBS Waiver.	CONTRACT Section 2.9.4	As specified in each HCBS Waiver

Number	Report	Description	Reference	Frequency
31.	HCBS Waiver Provider Requirements	Demonstrate adherence to HCBS Waiver Provider requirements and actions taken when Providers do not meet the requirements.	CONTRACT Section 2.5.1.C.8	Quarterly
32.	Health Equity and Cultural Competency Plan	The report must include, at a minimum, the elements specified in CONTRACT Section 2.5.4.B.	CONTRACT Section 2.5.4.B	Annual
33.	Health Equity Report Card	Stratified performance measures.	CONTRACT Section 2.5.4.A	Annual
34.	Health Information Technology Plan	Health Information Technology Plan	Per State Request	Annually
35.	Health Screen and Health Risk Assessments Report	Number of outreach attempts and completed Health Screens and Health Risk Assessments (HRAs). Report for new Members to include: • Number of new Members. • Number and percent of new Members (a) identified for a Health Screen via telephone and (b) identified for Health Screen in-person. • Number and percent of new Members the MCO attempted to contact for a Health Screen, by screening mode (telephone or in-person), within ten (10) business days of enrollment/after ten (10) business days of enrollment, and the average number of attempted contacts per timeframe. • Number and percent of new Members the MCO was unable to contact, by screening mode. • Number and percent of new Members contacted who declined participation, by screening mode. • Number and percent of new Members screened, by screening mode. • Number and percent of new Members screened within ten (10) business days of enrollment/after ten (10) Business Days of Enrollment. • Number and percent of new Members whose Health Screen indicated the need for an HRA. • Number and percent of new Members identified for a HRA the MCO attempted to contact to conduct the HRA within thirty (30)	CONTRACT Section 2.4.2	Quarterly

Number	Report	Description	Reference	Frequency
		Calendar Days of completion of the Health Screen/after thirty (30) Calendar Days of completion of the Health Screen. • Number and percent of new Members identified for an HRA the MCO was unable to contact. • Number and percent of new Members contacted who declined participation. • Number of new Members with an HRA completed within thirty (30) Calendar Days of completion of the Health Screen/after thirty (30) Calendar Days of completion of the Health Screen. • Number and percent of new Members with an HRA completed who were referred for a Needs Assessment. • Number and percent of new Members the MCO was unable to contact. • Number and percent of new Members contacted who declined participation. • Number and percent of new Members assessed within fourteen (14) Calendar Days of completed HRA/after fourteen (14) Calendar Days of completed HRA. • Number and percent of new Members with a completed HRA and/or Needs Assessment who were referred for Care Coordination. Report for current Members to include: • Number and percent of current Members due for an updated Health Screen, HRA, or Needs Assessment. • Number and percent of current Members due for a Health Screen who were screened, by screening mode (telephone, in-person, or Claims data) within one (1) year of previous Health Screen/after one (1) year. • Number and percent of current Members whose updated Health Screen indicated the need for an HRA, the number and percent of those Members for whom an initial HRA was completed within thirty (30) Calendar Days of completion of the Health Screen/after thirty (30) Calendar Days of completion of the Health Screen, the number and percent of those Members who		

Number	Report	Description	Reference	Frequency
		were referred for a Needs Assessment, the number and percent of those Members who were assessed within fourteen (14) Calendar Days of completed HRA/after fourteen (14) Calendar Days of completed HRA, and the number and percent of Members with a completed HRA or assessment who were referred for Care Coordination. • Number of Members due for an annual re-assessment who had an assessment completed within one (1) year/after one (1) year of previous assessment. • Number of Members due for an as needed re-assessment who had an assessment completed within three (3) Calendar Days of discovery of significant change/after three (3) Calendar Days of discovery of significant change.		
36.	HEDIS Annual Reporting	The report submitted should be an Excel file with a tab for an audit review table and then separate tabs with the results of all HEDIS measures designated by NCQA as relevant to Medicaid. These results shall be validated by a NCQA-certified HEDIS auditor. The CONTRACTOR(S) shall utilize the hybrid methodology (i.e., gathered from administrative and medical record data) as the data collection method for any Medicaid HEDIS measure containing Hybrid Specifications as identified by NCQA. In the event the CONTRACTOR(S) fails to pass the medical record review for any given standard and NCQA mandates administrative data must be submitted instead of hybrid, the administrative data may be used. For any Medicaid HEDIS measure marked as "Not Reported" shall include a detailed explanation. Please also include an attestation.	CONTRACT Section 2.9.8.	Annually
37.	HIPAA Monthly Summary	KDHE will need to be notified of all impermissible HIPAA uses and disclosures including those that do not arise to the level of a HIPAA breach that requires notification of the individual and HHS. "For HIPAA breaches and significant releases the MCO should notify KDHE as quickly as possible as outlined within the contract and BAA. For the incidents that are impermissible uses and disclosures that do not arise to the level of a HIPAA breach, like a misdirected fax to the wrong Provider, the MCO's may detail these incidents in a monthly report to KDHE."	Per State Request	Monthly

Number	Report	Description	Reference	Frequency
38.	IDDKKMAR	The IDD implementation KanCare key management activities report (KKMAR) includes operational issues (service plan changes, IDD Care Coordination levels and details, Community Developmental Disability Organization (CDDO) affiliation, IDD Provider directory and compliance with HCBS setting rule).	Per State Request	Monthly
39.	In Lieu of Services Report	Month/year incurred, Medicaid ID, Waiver Member (drop down by HCBS Waiver name), provided procedure code, provided procedure code description, per unit value, total units used this month, value of service, avoided service procedure code, avoided service procedure description, avoided units, cost avoided, rationale for approval of in lieu of service (ILOS).	Per State Request	Monthly
40.	Insolvency Plan	The CONTRACTOR(S) shall provide an insolvency plan documenting arrangements made which protect its subscribers in the event of insolvency. The plan must include provisions for dividing the cash reserves, capital, and surplus requirements among Participating Providers in the event of insolvency. The CONTRACTOR(S) shall hold harmless its Members in the event of insolvency and the CONTRACTOR(S)' Participating Providers shall not charge Members any portion of the costs associated with the provision of services under this CONTRACT.	CONTRACT Section 2.13.1.F	Annually
41.	KanCare LTSS Oversight Report	Report includes hiring status of Care Coordination positions, caseloads, LTSS enrollment, Care Coordination contacts for new/transition/ongoing Members, annual reviews, Money Follows the Person Grant (MFP) referrals.	Per State Request	Monthly
42.	MCO Annual Timeliness Report	MCO compliance with the timely access standards in Section 2.5.5 of the CONTRACT.	Per State Request	Annually
43.	MCO Completed Provider Trainings Report	This report contains a listing of the Provider trainings that the MCO has completed during the previous year.	CONTRACT Section 2.6.	Annually
44.	MCO Provider Training Plan	This report contains a listing of the proposed Provider trainings that the MCO will hold during the current year.	CONTRACT Section 2.6	Annually
45.	Medication Therapy Management (MTM) Report	Summary of medication therapy management (MTM) CMS and targeted medication review (TMR) cases created and completed by the Pharmacist. The report needs to include a detailed list of the Gaps in Care and TMRs provided by the Pharmacists/pharmacy	Per State Request	Semi-Annually

Number	Report	Description	Reference	Frequency
		interns. These interventions in totality will be billed on the medical benefit.		
46.	Member Advisory Committee Annual Meeting Plan	Member advisory committee plan, timeframes, and topics for the upcoming calendar year.	CONTRACT Section 2.10.12.D.	Annually
47.	Member Advisory Committee Meeting Minutes	Meeting minutes and stakeholder feedback are to be sent to KDHE using the KanCare Report Administration after each Member advisory committee meeting. Minutes should be a summary of what was discussed at the meeting and do not take the place of the quarterly report.	CONTRACT Section 2.10.12.D.	Quarterly
48.	Member Advisory Committee Quarterly Report	A quarterly report to KDHE using the KanCare Report Administration. The quarterly report should detail MCO follow up items to what was discussed and if (and how) the MCO plans to address the feedback.	CONTRACT Section 2.10.12.D.	Quarterly
49.	Member Handbook Updates	Summary of Member handbook updates/new Member handbook. The MCO must maintain documentation verifying that the Member handbook is reviewed and updated at least once a year.	CONTRACT Section 2.10.7.C	Annually
50.	Member Outreach and Educational Offerings Report	Description of activity and number of attendees at outreach activities and educational offerings for Members. Cumulative reports by fiscal year must show outreach activities such as meetings, presentations, coalition involvement, recovery focused events and tip sheets. Outreach must also be shown for priority populations.	Per State Request	Quarterly
51.	Member SUD Satisfaction Survey	Annual substance use disorder (SUD) Member satisfaction survey.	CONTRACT Section 2.9.10.F and QMS	Annually
52.	MLR Annual Report	Medical loss ratio (MLR) reporting template to comply with 42 CFR 438.8.	CONTRACT Section 2.13.2.L	Annually
53.	Network Adequacy (Provider Network Report)	The MCO must provide separate reports for Medicaid and CHIP populations. These electronic reports must be in Excel and list each Primary Care Provider (PCP), hospital, and Pharmacy per county. The PCPs must have an indicator for open/closed panels and include the number of Members assigned to each Provider and that Provider's maximum caseload. This will be a full file replacement	Per State Request	Quarterly

Number	Report	Description	Reference	Frequency
		each month. Must also include documentation describing the use and need to rely on Non-Participating Providers.		
54.	OneCare Kansas (OCK) (Health Homes) CMS Core Set Measures	Core set of Health Care Quality Measures for Medicaid Health Home Programs (Health Home Core Set)	CONTRACT Section 2.5.2.H	Annually
55.	OCK KKMAR	OneCare Kansas key management activities: • Member and Provider feedback service issues/concerns • Claims – TAT, service volume/dollars, denials • Clinical management • Provider relations • Network adequacy	CONTRACT Section 7.5.2.H	Monthly
56.	Online Provider Directory File	Machine-readable file of the MCO's online Provider directory.	CONTRACT Section 2.10.8	Ad-Hoc
57.	Organizational Charts	Organization charts with changes noted, focus on key positions, and Care Coordination.	Per State Request	Quarterly
58.	Overview of Corporate Compliance Department Activity	Cumulative data regarding routine Medicaid Claim verification audits and overpayment reasons pre- and post-appeal. Report must be separated by programs as specified by the State.	Per State Request	Quarterly
59.	Pay for Performance	Pay for Performance (P4P) reports.	Per State Request	Annually
60.	Pay for Performance Reporting	Summary of MCO performance on physical health, Behavioral Health, HCBS, LTSS, and operational measures reported overtime for evaluation of improvement to meet payment-based outcomes.	Per State Request	Quarterly
61.	Payment Integrity Report	The MCO must report the money saved and costs avoided through front end edits and recipient lock-in and other cost avoidance efforts, and the amount recovered through fraud, waste, or abuse detection efforts.	Per State Request	Quarterly
62.	Performance Bond	The CONTRACTOR(S) shall provide a written assurance stating the required performance bond will be submitted not later than forty-five (45) Calendar Days after CONTRACT signing. Once each bond continuation and CONTRACT renewal period to cover any turnover period.	CONTRACT Section 2.13.1.E	Annually

Number	Report	Description	Reference	Frequency
63.	Performance Improvement Projects	The MCO must submit new data on at least one (1) PIP annually to the State. This does not mean one (1) new PIP a year. PIP must be submitted to and approved by the State in writing prior to implementation. PIPs must include the following: • Measurement of performance using objective quality indicators. • Implementation of system interventions to achieve improvement in quality. • Evaluation of the effectiveness of the interventions. • Planning and initiation of activities for increasing or sustaining improvement. • Reporting the status and results of each project to the State on an annual basis.	CONTRACT Section 2.9.5	Annually
64.	Program Integrity Risk Assessment	The CONTRACTOR(S) shall conduct an annual risk assessment of both CONTRACTOR(S)' and each Subcontractors' fraud and abuse/program integrity procedures (for those Subcontractors that are delegated to adjudicate Claims on behalf of the CONTRACTOR(S), such as dental, vision, Pharmacy, or transportation). The assessment shall include a listing of the top five (5) vulnerable areas and outline action to mitigate risks in each area. The assessment shall be provided to the State within thirty (30) Calendar Days of its completion each year.	CONTRACT Section 2.12.1.L	Annually
65.	Provider Manual Updates	Summary of Provider manual updates/new Provider manual.	CONTRACT Section 2.6.1.A	Annually
66.	Provider Network Development and Management Plan and Evaluation	Demonstrates the CONTRACTOR(S) maintains a network of Providers that is sufficient in number, type, capacity, and geographic distribution to meet the requirements of this CONTRACT and the needs of its Members.	CONTRACT Section 2.5.2.K	Annually
67.	Provider Participation – Adverse Actions Taken Against Providers	The MCO must notify the State as to any adverse action that has been taken against a Provider's participation in the program, including when it denies credentialing/contracting for fraud-related concerns.	CONTRACT Section 2.12.1.I	Monthly
68.	Provider Recruitment Report	Documentation of efforts to recruit and retain Providers.	CONTRACT Section 2.5.2.G	Quarterly

Number	Report	Description	Reference	Frequency
69.	Provider Rep Report	MCO shall submit the names of Provider representatives and full list of all Provider contacts with a brief description of the contact to the State for review on a quarterly basis.	CONTRACT Section 2.6.6 E	Quarterly
70.	Provider Satisfaction Survey	The CONTRACTOR(S) shall provide a Provider Satisfaction Survey Methodology and a Provider Satisfaction Survey Result Report to the State for written approval. The purpose of the Provider Satisfaction Survey is to assess Provider satisfaction with the performance of the CONTRACTOR(S) and KanCare and identify strengths and areas for improvement. The Provider Satisfaction Survey shall be a KanCare-specific survey with KanCare-specific Providers and must have a confidence level of 95% and a 5% margin of error to determine sample size to ensure generalizability of results to the KanCare Provider populations.	CONTRACT Section 2.9.11	Ad-Hoc
71.	Psychiatric Residential Treatment Facility/ Children's State Institution Alternative Utilization	Complete the report and detail tab for Members that were discharged from either a Psychiatric Residential Treatment Facility (PRTF) or State Institution Alternative (SIA) in the reporting.	Per State Request	Monthly
72.	Quality Assessment and Performance Improvement Work Plan	Detailed summary of annual quality assessment/performance improvement efforts and results of those efforts. These submissions should have an executive summary that highlights all changes, providing the substantive nature of each and the impetus of each (e.g., responsive to a review finding, update to an NCQA standard, etc.); and should then separately provide substantive updates on each area of the QAPI plan.	CONTRACT Section 2.9.1	Semi-Annually
73.	Quarterly KID NAIC Financial Report	The MCO shall file with the State, a Quarterly Financial Report. These reports shall be on the form prescribed by the NAIC for health maintenance organizations and shall be submitted to the State on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year) and November 15 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the MCO's quarterly and year-to-date revenues earned, and expenses incurred as a result of the MCO's participation in the KanCare program. The second quarterly report (submitted on August 15) shall include the MLR	Per State Request	Quarterly

Number	Report	Description	Reference	Frequency
		report completed on an accrual basis that includes an actuarial certification of the Claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with NAIC guidelines. The MCO shall also submit a reconciliation of the MLR report to the second quarterly NAIC report. Statement of Financial Position — Assets – Total Cash, Total Reimbursement Funds, Total Investments, Total Other Assets, Total Current Assets, Net Fixed Assets, Liabilities and Equity – Total Current Liabilities, Total Liabilities, Total Equity. Quarterly Financial Statements. For Providers licensed as MCOs by the KID: Copies of financial reports and financial solvency reports as to be submitted to the KID pursuant to the T-XIX Managed Care Interagency Agreement as well as any additional reports or information required by KDHE-DHCF or its sister agency, the KID. For non-MCO licensed Providers and for those providing services for T-XXI Members, income and expense statements specific to the contracted program(s) will be required semi-annually, for the six (6) month period of January to June, and July to December of each contract period. Income and Expense Statement (Unaudited) – Statement of Revenue, Administrative Services Revenue, Expenses, Net Income (Loss).		
74.	Required Staff and Diversity Hiring Report	The CONTRACTOR(S) shall hire people with disabilities and shall be able to demonstrate what percentage of its workforce helps it to meet this requirement. The CONTRACTOR(S) shall adopt hiring practices that establish a preference for considering employment opportunities for individuals with disabilities. The plan for hiring practices must be approved by the State in writing.	CONTRACT Section 2.17.1.F	Quarterly
75.	Risk Management Plan	The MCO’s plan to address identified risks to ongoing operations and business continuity. If the approved plan is unchanged from the previous year, the MCO must submit a certification that the prior year’s plan is still in place.	CONTRACT Section 2.1.3	Annually

Number	Report	Description	Reference	Frequency
76.	Screening, Brief Intervention and Referral to Treatment (SBIRT) Summary Billing Report	Screening, brief intervention and referral to treatment (SBIRT) summary billing reporting.	Per State Request	Quarterly
77.	Security Plan Updates	The CONTRACTOR(S) shall limit access to its facilities to appropriate and authorized personnel only and provide the State with a copy of its security plan. The CONTRACTOR(S) must limit access to any out-of-state facilities included in the operation, including storage facilities, and must provide the State with a copy of its planned security procedures for all facilities.	CONTRACT Section 2.1.4.3 and 2.17.4	Annually
78.	Staffing Contingency Plan Updates	The MCO must deliver a back-up personnel plan, including a discussion of the staffing contingency plan including but not limited to: • The process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the CONTRACT; • Allocation of additional resources in the event of inability to meet any performance standard; • Replacement of staff with key qualifications and experience with new staff with similar qualifications and experience; • Discussion of timeframes necessary for obtaining replacements; • MCO capabilities to provide, in a timely manner, replacements/additions with comparable experience; and • The method of bringing replacements/additions up to date regarding the Kansas CONTRACT must be emphasized.	CONTRACT Section 2.17.1.E	Annually
79.	STC Quarterly Report	CMS Quarterly 1115 special terms and conditions (STC) Report	1115 Waiver STC	Quarterly
80.	Step Therapy Policy	Tracking of utilization of drugs impacted by step therapy policy changes, including cost avoidance.	Per State Request	Monthly
81.	System Penetration Testing Results	Results of system penetration testing.	CONTRACT Section 2.1.4	Annually
82.	Technology Assisted Waiver for Specialized Medical Care	Specialized medical care units for technology assisted (TA) HCBS Waiver participants.	TA Waiver	Monthly

Number	Report	Description	Reference	Frequency
83.	Title XXI Vaccine Report	Reporting of vaccines paid by the MCO for any Title XXI children by age range by vaccine type with totals.	Per State Request	Quarterly
84.	Transportation Provider No-Show Report	Report with information on transportation Provider no-shows and remediation activities.	CONTRACT Section 2.5.5.L	Monthly
85.	Utilization Management BH Annual	Utilization Management (UM) reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend analysis. There will be a final report that is due after the end of the year to allow for one hundred eighty (180) day lag/Claim adjustments.	CONTRACT Section 2.8.2	Annually
86.	Utilization Management HCBS Annual	UM reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend analysis. There will be a final report that is due after the end of the year to allow for one hundred eighty (180) day lag/Claim adjustments.	CONTRACT Section 2.8.2	Annually
87.	Utilization Management NEMT Annual	UM reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend analysis. There will be a final report that is due after the end of the year to allow for one hundred eighty (180) day lag/Claim adjustments.	CONTRACT Section 2.8.2	Annually
88.	Utilization Management Physical Health Annual	UM reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State	CONTRACT Section 2.8.2	Annually

Number	Report	Description	Reference	Frequency
		so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend analysis. There will be a final report that is due after the end of the year to allow for one hundred eighty (180) day lag/Claim adjustments.		
89.	Utilization Management SUD Annual	UM reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend analysis. There will be a final report that is due after the end of the year to allow for one hundred eighty (180) day lag/Claim adjustments.	CONTRACT Section 2.8.2	Annually
90.	Utilization Management – BH	UM reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend analysis. By service, unduplicated number of Members receiving services, mean hours per Member, mean service units per Member, and mean reimbursement per Member. Data is reported by catchment area and statewide and by ages zero to seventeen (0-17) and eighteen (18)+.	CONTRACT Section 2.8.2	Quarterly
91.	Utilization Management – HCBS	Utilization Management – HCBS	CONTRACT Section 2.8.2 and Per State Request	Quarterly
92.	Utilization Management – NEMT	UM reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend	CONTRACT Section 2.8.2	Quarterly

Number	Report	Description	Reference	Frequency
		analysis. By service, unduplicated number of Members receiving services, mean hours per Member, mean service units per Member, and mean reimbursement per Member. Data is reported by catchment area and statewide and by ages zero to seventeen (0-17) and eighteen (18)+.		
93.	Utilization Management – Phys Health	UM reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend analysis. By service, unduplicated number of Members receiving services, mean hours per Member, mean service units per Member, and mean reimbursement per Member. Data is reported by catchment area and statewide and by ages zero to seventeen (0-17) and eighteen (18)+.	CONTRACT Section 2.8.2	Quarterly
94.	Utilization Management – SUD/9a Higher LOC & 10a Lower LOC	UM reports must include an analysis of data and identification of opportunities for improvement and follow-up of the effectiveness of the intervention. Utilization data must be reported based on Claim data and include specific data elements that are defined by the State so all MCOs are reporting on common data set. The MCO must submit UM report on utilization patterns and aggregate trend analysis. By service, unduplicated number of Members receiving services, mean hours per Member, mean service units per Member, and mean reimbursement per Member. Data is reported by catchment area and statewide and by ages zero to seventeen (0-17) and eighteen (18)+.	CONTRACT Section 2.8.2	Quarterly
95.	Value-Added Benefits	Summary of the utilization by Member population type of the MCO's benefits that are offered beyond the State Plan services.	CONTRACT Section 2.3.4	Monthly
96.	Verification of Services Provided	Tracking of MCO follow-up on service received verification letter to Members.	Per State Request	Monthly
97.	Value-Based Purchasing – Provider Pay for Performance	Active and terminated value-based purchasing programs are to be reported quarterly. The same report template is it to be used quarterly so any changes to the value-based purchasing programs can be identified. One additional field, number of Providers by TIN	CONTRACT Section 2.7	Quarterly

Number	Report	Description	Reference	Frequency
		that received an incentive in the previous calendar year, is required to be reported in the first quarter of each calendar year only.		
98.	WORK Allocation Report	WORK report which contains one line per participant listing the participant's monthly allocation amount as showing in the PPL Web Portal and include Participant PPL ID number; Participant Medicaid number; Participant First Name; Participant Last Name; Month Start Date; Month End Date; Monthly Allocation; Unallocated Amount; Allocated Amount; Total Spent Amount including Total spent on PA services, Total spent on alternative services, Total reimbursements; Total Swept Amount; Monthly Allocation Balance.	CONTRACT Section 2.3.2	Monthly
99.	WORK Enrollment End Date Report	WORK report which contains one line for each participant in the program and list the enrollment start and end dates (if applicable) that have been entered by the participant's ILC or Case Manager into the PPL Web Portal and include: Participant PPL ID; Participant First Name; Participant Last Name; Enrollment Begin Date; Enrollment End Date.	CONTRACT Section 2.3.2	Monthly
100.	WORK Good to Go (GTG) Report	WORK status report, which contains one line for each participant/Provider association in the Web Portal and include: Participant PPL ID; Participant First Name; Participant Last Name; Participant GTG Status; Provider PPL ID; Provider Name; Provider First Name; Provider Last Name; Provider Type; Provider GTG Status; Participant Provider Checklist Status; Independent Living Counselor (ILC) First Name; ILC Last Name; Assessment Contractor First Name; Assessment Contractor Last Name.	CONTRACT Section 2.3.2	Monthly
101.	WORK ILC Billing Audit File	KDHE is requesting ILC billing documentation submitted by the following ILCs during the reporting quarter.	CONTRACT Section 2.3.2 and Per State Request	Quarterly
102.	WORK Open Member Data	Report is overview of Member demographics, HCBS Waiver/waiting list status, MCO contacts, and ILC contacts.	CONTRACT Section 2.3.2 and Per State Request	Ad-Hoc
103.	WORK Participant Funds Summary Reports	WORK report which contains one line per participant summarizing their monthly allocations for the month(s) the report is run for and the participant's carryover and overflow information. The reports are	CONTRACT Section 2.3.2	Quarterly

Number	Report	Description	Reference	Frequency
		cumulative and include: Participant PPL ID; Participant Medicaid number; Participant First Name; Participant Last Name; Sum of Monthly Allocations; Total Unallocated; Total Allocated; Total Spent (Total spent on PA services, Total spent on alternative services, Total reimbursements); Total Swept; Total Monthly Allocations Balance; Carryover Budget; Carryover Unallocated; Carryover Allocated; Carryover Spent; Carryover Balance; Overflow Budget; Overflow Unallocated; Overflow Allocated.		
104.	Workforce Development Plan	See CONTRACT Section 2.5.9.G	CONTRACT Section 2.5.9.G	Annually
105.	Workforce Development Plan Progress Reports	Progress reports on implementation of workforce initiatives.	CONTRACT Section 2.5.9.G	Monthly

APPENDIX I: KANCARE CLAIMS PROCESSING REQUIREMENTS

1.0 Claims and Claim Corrections

1.1 Entry and Control

1.1.1 Maintain control over all transactions during their entire processing cycle.

1.1.2 Provide accurate and complete audit trails of all processing.

1.1.3 Monitor the location of all Claims at all times.

1.1.4 All input and output transmissions and formats must be Health Insurance Portability and Accountability Act (HIPAA) compliant. The CONTRACTOR(S)' system must be adapted to meet any new HIPAA requirements for transactions and transmissions.

1.2 Inputs

The CONTRACTOR(S)' system accepts, controls, processes, and reports separately, Claims for KanCare. Inputs include the following Claim forms (in both paper and electronic formats) and attachments:

1.2.1 UB-04 Claim forms from Providers, in both paper and HIPAA-required electronic media format.

1.2.2 The Centers for Medicare & Medicaid Services (CMS) 1500 Claim forms from Providers, in both paper and HIPAA-required electronic media format.

1.2.3 Pharmacy, in both paper and HIPAA-required electronic media format.

1.2.4 Dental (American Dental Association format), in both paper and HIPAA-required electronic media format.

1.2.5 Attachments required for Claims adjudication, including; but not limited to:

1.2.5.1 Third-Party Liability (TPL) and Medicare Explanation of Benefits (EOBs).

1.2.5.2 Sterilization and abortion consent forms.

1.2.5.3 Dental x-rays.

1.3 Processing Requirements

1.3.1 Identify, upon receipt, each Claim and its attachments, adjustment, and financial transaction with a unique Internal Control Number (ICN).

Note: The ICN is alphanumeric, has a maximum field length of sixteen (16) bytes and includes, at a minimum, the date of Claim receipt. Additional identifiers could include the batch number, sequence of Claim within the batch, and an indicator of the type of Claim submission. If the ICN does not contain the date of receipt, the CONTRACTOR(S) or Subcontractor must have other methods of obtaining the date of receipt information. Documentation explaining this must be submitted to the State for review and written approval. The CONTRACTOR(S) is responsible for providing the date of receipt on all Claims inquires. The appropriate business practice manuals must include this information and submitted to the State for review and written approval.

1.3.2 Maintain an optical image of all Claims, attachments, adjustment requests, and other paper documents.

1.3.3 Retrieve optical images by ICN and other user-defined keys.

1.3.4 Maintain inventory control and an audit trail for all Claims and other transactions entered into the system to ensure processing through completion.

1.3.5 Edit to prevent duplicate entry of Claims.

1.3.6 Maintain an audit trail record with each Claim and adjustment record that shows each stage of processing, the date each stage the Claim was entered, the processor ID, and any error codes posted at each step-in processing.

1.3.7 Maintain online inquiry to Claims, adjustments, and financial transactions, from data entry through to payment, with access by Kansas Medical Assistance Program (KMAP) ID or Social Security Number (SSN), provider ID number, and ICN to include pertinent Claim data and Claim status.

1.3.8 Accept Claims received via paper or electronic media from Providers, billing services, and Medicare carriers and intermediaries.

1.3.9 CONTRACTOR(S) must offer Providers the ability to submit Claim attachments electronically or via fax, in addition to being able to submit them as a paper attachment.

1.4 Electronic Media Claims (EMC)

1.4.1 Accept Claims from both participating and non-participating Providers.

1.4.2 Develop and implement a testing process to verify Providers' readiness for EMC participation.

1.4.3 Accept and adjudicate Medicare crossover Claims.

1.4.4 Perform logic and consistency editing to screen Claims before acceptance by the CONTRACTOR(S)' system, including, at a minimum:

1.4.4.1 Claim filing is within time limit for filing.

1.4.4.2 Logical dates of services (e.g., valid dates, not future dates).

1.4.4.3 Service consistency with place of service/type of service.

1.4.4.4 Units/number of services performed is consistent with the span of time for the procedure.

1.5 Front End Billing (FEB) Requirements

The FEB process was developed to assist in reducing Provider administrative overhead and allowing Providers to continue to bill in the same manner as they submit Kansas Medicaid Claims. It also provides KDHE-DHCF a mechanism for data management. Claims will be split and forwarded to the appropriate KanCare managed care organization (MCO) by the Beneficiary's assignment on the earliest Claim date of service.

Front end editing will be applied to all Claims sent to the MCOs based upon Strategic

National Implementation Process (SNIP) levels one (1) through four (4) compliance and validity editing. Electronic Claims submitted to the Fiscal Agent will be forwarded to the MCO for processing via a daily 837 and National Council for Prescription Drug Programs (NCPDP) transactions. The CONTRACTOR(S) will be responsible for forwarding the appropriate Claim types to their Subcontractors, for example; vision, dental, Behavioral Health, and Non-Emergency Medical Transportation (NEMT).

1.5.1 Related Files Data Exchange Requirements and File Listing:

1.5.1.1 The CONTRACTOR(S) shall receive and process FEB files daily.

1.5.1.2 The CONTRACTOR(S) shall process and respond within twenty-four (24) hours of receipt.

1.5.1.3 The CONTRACTOR(S) shall send a 999 file acknowledgement and 277CA response by the end of the next Business Day.

1.5.1.4 The CONTRACTOR(S) shall report to the Fiscal Agent any files that are pending over twenty-four (24) hours, excluding weekends.

1.5.1.5 FEB Related Files List:

1.5.1.5.1 837 Health Care Claims (Institutional, Professional and Dental)

1.5.1.5.2 NCPDP D.0 Pharmacy

1.5.2 Claims Front End Billing Rejections:

1.5.2.1 The CONTRACTOR(S) shall receive FEB files and rejection reports daily.

1.5.2.2 The CONTRACTOR(S) shall process and respond by close of business on the following Business Day.

1.5.3 Adjudicated Claim Copies (Pharmacy/NEMT Claims)/Pre-adjudicated Claim Copies. A copy of all electronic and paper Claims received directly by the CONTRACTOR(S) from the Provider or other clearinghouses must be sent to the Fiscal Agent.

1.5.3.1 The CONTRACTOR(S) shall send a complete copy of all electronic and paper Claims received directly by the CONTRACTOR(S).

1.5.3.2 Claim copies should be sent the same Calendar Day the Claim is received.

1.5.3.3 Note: Exception for NEMT and pharmacy Claims. NEMT and pharmacy Claim copies should be received the Calendar Day before the Encounter Data are submitted.

1.5.4 FEB Rejections:

1.5.4.1 The CONTRACTOR(S) shall review the FEB related ASC X12N 277 Claims Status Response and respond to the State within forty-eight (48) hours of file production on any anomalies. The CONTRACTOR(S) shall work with the State and Fiscal Agent to determine how these should be addressed.

1.5.4.2 Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the CONTRACTOR(S) and the State and/or its agent(s), the CONTRACTOR(S) shall notify the applicable State staff via phone, fax, and/or electronic mail within one (1) hour of such discovery. In its notification, the

CONTRACTOR(S) shall explain in detail the impact to critical path processes such as Claims submission processes.

1.5.5 System Modifications: Notification and discussion of potential system changes shall apply regarding all system modifications that could impact FEB. The CONTRACTOR(S) shall notify the State of the following changes to systems within its span of control at least ninety (90) Calendar Days before the projected date of the change. If so directed by the State, the CONTRACTOR(S) shall discuss the proposed change with the applicable State staff. This includes:

1.5.5.1 Decisions regarding system or process modifications that impact FEB will need to be made in conjunction with the State regarding FEB editing/denials, Claim routing (splitting), or data needs.

1.5.5.2 Implementation date shall be agreed upon by both parties.

1.5.6 Reporting - Rejected and Accepted Claims:

1.5.6.1 The CONTRACTOR(S) and their Subcontractors shall report monthly the number of FEB Claims that were accepted and rejected per week.

1.5.6.2 At a minimum, the report should contain but not limited to:

1.5.6.3 Claim type.

1.5.6.4 Plan/Subcontractor.

1.5.6.5 Number of Claims accepted.

1.5.6.6 Number of Claims rejected.

1.5.6.7 Total number of Claims.

1.5.6.8 Percentage of Claims accepted.

1.5.6.9 Percentage of Claims rejected.

1.5.6.10 Subtotals of all the above columns.

1.5.7 Acceptance of FEB Related Files:

Monthly, the CONTRACTOR(S) and their Subcontractor shall forward to the State a report indicating when the FEB related files were loaded into their system. The CONTRACTOR(S) will work with the State regarding the required format and data elements.

1.6 Point of Sale (POS)

1.6.1 Process a majority of pharmacy Claims in real-time via POS technology.

1.6.2 Provide a POS system, which includes at a minimum the following capabilities:

1.6.2.1 Transmission and online real-time processing of pharmacy Claims.

1.6.2.2 Access to Member and Provider eligibility information.

1.6.2.3 Prior approval processing.

1.6.2.4 TPL processing and response.

1.6.2.5 Notification of Copayment requirements.

1.6.2.6 Reversal of Claims.

1.6.2.7 Compound drug Prescriptions.

1.6.2.8 Accept and process override codes from the Pharmacy or help desk to permit overrides for emergencies, life-threatening illnesses, and other situations defined by the State.

1.6.3 Provide appropriate staff to support both technical and informational aspects of this function.

1.7 Outputs

The outputs for the Claims and Claim Adjustments and Control function include control and audit trail reports produced during various stages of the Claims processing cycle and Claim, adjustment, and financial transaction data. They consist of:

1.7.1 Inventory management analysis by Claim type, processing location, and age.

1.7.2 Input type control listings.

1.7.3 Records of non-processable Claims.

1.7.4 Exception reports of Claims in suspense in a particular processing location for more than a user-specified number of Calendar Days.

1.7.5 Inquiry screens to include pertinent header and detail Claim data and status.

1.7.6 Electronic submission statistics as defined by the State.

1.7.7 Reports of unsuccessful transmissions of Claims and Claim adjustments errors or rejections.

1.7.8 These reports shall be available to the State.

1.7.8.1 Formatted Claim records for input into the Claims processing cycle.

1.7.8.2 Pharmacy POS response messages to Providers.

1.8 CONTRACTOR(S) Responsibilities

1.8.1 The CONTRACTOR(S) shall process all Claims completely, timely and accurately.

1.8.2 The CONTRACTOR(S) shall automatically reprocess Claims when a CONTRACTOR(S)' system issue has resulted in an incorrect processing of the Claim. In those instances, the CONTRACTOR(S) shall not require Providers to resubmit Claims or file Appeals; and these Claims shall be exempted for timely filing purposes and reported as such by the CONTRACTOR(S).

1.8.3 The CONTRACTOR(S) must submit for State written approval policies for timely filing exceptions. The policies must include provisions for retroactive eligibility assignments and the timely filing exceptions specified in Federal and State regulations, including 42 CFR § 447.45(d) and K.A.R. § 129-5-65. These policies must be in effect at the beginning of the CONTRACT.

1.8.4 The CONTRACTOR(S) shall review CMS mandated modifications and perform periodic reviews of Claims data and provide written recommendations for possible changes to make data collection more efficient.

1.8.5 Establish controls to ensure no mail, Claims, Claim attachments, or checks are misplaced after receipt by the CONTRACTOR(S).

1.8.6 Batch electronic Claims upon receipt and assign a unique ICN.

1.8.7 Record Claims, accompanying documentation, and electronic transmittal documents on optical media.

1.8.8 Provide retrieval capability for optical documents by ICN and other user defined keys.

1.8.9 Establish reconciliation procedures to ensure control within the CONTRACTOR(S)' system processing cycles.

1.8.10 Maintain standard Claim control and tracking standards for all Claims submitted.

1.8.11 Reconcile all Claims (paper and electronic) entered into the system to batch processing cycle input and output figures.

1.8.12 Produce online and hard-copy reconciliation and control reports according to State specifications.

1.8.13 Produce policies and guidelines Providers shall follow for Claims submission.

1.8.14 Perform data entry of all paper Claims.

1.8.15 Process Claim corrections (adjustments).

1.8.16 Load electronically submitted Claims.

1.8.17 Perform validity editing on all entered Claims against Provider, Member, and reference data.

1.8.18 Produce all Claims entry statistics reports and deliver to the State, in a format conducive to assessing performance compliance.

1.8.19 Respond to State requests for Claim copies, Member and Provider information, and reports.

1.8.20 Make all reports available to the State.

1.9 Performance Expectations

1.9.1 Assign a unique ICN to every Claim, attachment, and adjustment within one (1) Business Day of receipt at the CONTRACTOR(S)' site.

1.9.2 Return paper Claims missing required data to Providers within three (3) Business Days of receipt.

1.9.3 Optically image every Claim and attachment within one (1) Business Day of receipt at the CONTRACTOR(S)' site.

1.9.4 Respond to State requests for Claim copies, Member and Provider information, and reports within three (3) Business Days of receiving the request.

1.9.5 Provide online response notifications to Providers within five (5) minutes of receipt of incoming electronic Claim transactions in 95% of cases and 100% in ten (10) minutes.

2.0 Pricing and Financial

2.1 Processing Requirements

2.1.1 Identify the allowable reimbursement for Claims according to the date-specific pricing data and reimbursement methodologies contained on applicable Provider, Member, or reference files for the date of service on the Claim.

2.1.2 Edit billed charges for reasonableness (low and high variances) and flag any exceptions, including the ability to vary the parameters of this edit by Provider type, Claim type, and edit disposition.

2.1.3 Identify and calculate payment amounts according to the fee schedules, per diems, diagnosis related group rates, capitation rates, case management fees, and global rates established by the State.

2.1.4 Deduct Member responsibility amounts (patient liability, client obligations, and spenddown) according to State guidelines when pricing Claims.

2.1.4.1 Note: Please refer to the “Patient Liability, Client Obligation and Spenddown Comparison Chart” in the KanCare Guide.

2.1.5 Price TPL and Medicare crossover Claims at the lesser of the KMAP/MCO contracted rate or Medicare allowed amount on paper and electronic media.

2.1.6 Price using a unique Qualified Medicare Beneficiary (QMB) rate.

2.1.7 Price using other payment methodologies as determined by the State, depending on Beneficiary program eligibility or type of Claim.

2.1.8 Price services billed with procedure codes with multiple modifiers in conformance with standard State requirements.

2.1.9 Price Claims according to the policies of the program the Member is enrolled in at the time of service and edit for concurrent program Enrollment.

2.2 Financial

2.2.1 Generate provider Remittance Advices (RAs) in paper media or electronic HIPAA-approved format.

2.2.2 Provide the flexibility to suppress check generation as requested by the State.

2.2.3 Update Claims history with all appropriate financial records and reflect in subsequent reporting, including TPL Claim-specific recoveries.

2.3 CONTRACTOR(S) Responsibilities

2.3.1 Make recommendations on any area in which the CONTRACTOR(S) thinks improvements can be made.

2.3.2 Price Claims in accordance with KMAP policy, benefits, and limitations as defined by the State unless the service or pharmaceutical provided is approved by the State as part of the CONTRACTOR(S) value added or in lieu of service.

2.4 Performance Expectations

2.4.1 The State will provide Beneficiary Claims history. The CONTRACTOR(S) will use the Claims history files for Claims processing and reporting.

3.0 Adjudication

3.1 Edit/Audit Processing Requirements

In order to perform all of the required edit/audit checks during processing, and be able to pass the Claims on to subsequent processing, the CONTRACTOR(S)' system must have the capabilities to:

3.1.1 Perform all edit processing cycles and audit processing cycles.

3.1.2 Edit each data element of the Claim record for required presence, format, consistency, reasonableness, and allowable values.

3.1.3 Sequence the edits and audits to ensure that as many error conditions as possible are identified before the Claim requires manual intervention or is returned to the Provider.

3.1.4 Establish dollar and frequency thresholds for key procedures or services and identify any Member or Provider whose activity exceeds the thresholds during the history audit cycle and suspend the Claim for review prior to payment.

3.1.5 Identify all applicable error codes for Claims that fail daily processing edits.

3.1.6 Identify and hierarchically assign status and disposition of Claims (suspend or deny) which fail edits, based on the edit disposition file.

3.1.7 Identify potential and existing TPL (including Medicare) and deny or pay and report the Claim, depending on the edit, if it is for a Covered Service under a Third-Party resource, for applicable Claim types and covered periods.

3.1.8 Edit to ensure that TPL including Medicare and Medicare inpatient Part-B payments, have been coordinated with and applied to Claims.

3.1.9 Randomly validate via post payment review of TPL Claim audits that Providers have the EOB on file as required, when the Claim is submitted electronically.

3.1.10 Edit to ensure all required attachments, per the reference files or edits, have been received, and maintained for audit purposes.

3.1.11 Edit for and suspend Claims requiring Provider or Member prepayment review.

3.1.12 Edit, suspend, and/or process newborn Claims submitted under the mother's KMAP identification number (ID) according to State policy.

3.1.13 Maintain a function to process Claims against an edit/audit criteria file or table and an error disposition file to provide flexibility in edit and audit processing (including system parameters) based on KMAP Benefit grid.

3.1.14 Edit to ensure that diagnosis, revenue, and procedure codes and modifiers are present on all Claims including Medicare crossovers.

3.1.15 Edit for Member eligibility on date(s) of service.

3.1.16 Retain the KMAP identification number (ID) throughout Claims processing and adjudication to support Member and Provider customer service, reporting, and discrepancy resolution.

3.1.17 Edit for valid Member using the KMAP ID, SSN or Date of Birth (DOB), and any combination of characters of the first and last name, including cross-checking against previous Member names on file.

3.1.18 Edit for Member participation in special programs against program services and restrictions, such as Lock-in and newborn eligibility.

3.1.19 Edit Provider eligibility to perform type of service rendered on date of service, including editing of the Provider's Clinical Laboratory Improvement Amendments (CLIA) identification number, if necessary.

3.1.20 Edit for Provider participation as a member of the billing group under an appropriate Provider type, as appropriate.

3.1.21 Edit Nursing Facility (NF), State mental health hospital, Nursing Facility for Mental Health (NFMH), Psychiatric Residential Treatment Facility (PRTF), Intermediary Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Home- and Community-Based Services (HCBS) Waiver program Claims against Member level of care, admit/discharge information, and program guidelines.

3.1.22 Edit for Prior Authorization (PA) requirements and that the Claim matches to an active PA for the date of service.

3.1.23 Maintain edit disposition to deny Claims for services that require PA if no PA is identified or active.

3.1.24 Update the PA record to reflect the service(s) paid and to update the number of services or dollars still remaining to be used on the record.

3.1.25 Perform automated cross-checks and relationship edits on all Claims.

3.1.26 Perform automated audit processing using history Claims, suspended Claims, in-process Claims, and same cycle Claims.

3.1.27 Edit for potential and exact duplicate Claims, including cross-references between group and rendering Providers, multiple Provider locations, and across Provider and Claim types and categories of service.

3.1.28 Perform automated edits using potential duplicate and exact duplicate criteria to validate against all other Claims in the system.

3.1.29 Edit each Claim record as completely as possible during edit or audit cycle, rather than ceasing the edit process when an edit failure is encountered.

3.1.30 Identify and track all edits and audits posted to the Claim in a single cycle.

3.1.31 Provide, for each error code, a resolution code, an override indicator, and the date that the error was resolved, overridden, or denied; all Claims shall carry the ID of the operator to provide a complete online audit trail of processing.

3.1.32 Maintain a record of services needed for audit processing where the audit criteria cover a period longer than thirty-six (36) months (e.g., once-in-a-lifetime procedures).

3.1.33 Utilize software to perform automated edits to identify splitting or unbundling of panel or bundled type services.

3.1.34 Track long-term care (LTC) (i.e., NF, NFMH, PRTF, and ICF/IID) Member leave days (hospital and therapeutic).

3.1.35 Edit Member LTC information against authorized Member and Provider level-of-care information.

3.1.36 Report drug utilization data necessary for the State to bill manufacturers for rebates within forty-five (45) days of the end of each quarterly rebate period. The utilization data must include, at minimum, the total number of units of each dosage form, strength, and package size by the National Drug Code (NDC) of each covered outpatient drug billed on the pharmacy and medical benefit (physician-administered drugs [PDAs]). Utilization data should be based on date of service instead of payment date.

3.2 Adjustments

3.2.1 Process additional types of adjustments including but not limited to spenddown, TPL, etc.

3.2.2 Retroactively reprocess NF, NFMH, State mental health hospital, PRTF, and ICF/IID Claims to identify and correct any erroneous payments resulting from changes in patient liabilities or facility specific rates.

3.3 Spenddown Requirements

3.3.1 Apply spenddown accurately and timely, every hour, at a minimum, using the Spenddown Web Service.

3.3.2 Review and research the Spenddown Adjustment Reports, which includes accessing the Kansas Modular Medicaid System (KMMS) to determine which Claims applied to spenddown should be adjusted.

3.3.3 Reconcile spenddown discrepancies for the Claims applied to spenddown based on the spenddown amount reported on the encounter as compared to the spenddown amount submitted through the Spenddown Web Service.

3.3.4 Establish a process to return monies timely to Members when spenddown is over applied as identified through the Spenddown Adjustment Reports.

3.3.5 Establish a process to notify the State on any spenddown discrepancies and monies returned to Members.

3.3.6 Check the hourly Spenddown Proprietary File to confirm the Member’s remaining spenddown balance is greater than zero (0), before submitting to the Spenddown Web Service.

3.3.7 Apply calculated charges to spenddown. Apply denied Claims to spenddown based upon the pre-emptive indicator.

Note: Services that are considered “Spenddown Pre-emptive” are not applied toward the Member’s spenddown.

3.3.8 Apply Claims with TPL and Medicare payments correctly to spenddown.

3.3.9 Complete KMMS training to use in researching spenddown issues. The CONTRACTOR(S) must maintain internal staff to provide ongoing KMMS spenddown training for the CONTRACTOR(S)' staff and Subcontractors.

3.3.10 Pharmacy Benefit Manager must develop a process to timely notify Pharmacy Providers of the amount applied to spenddown based on the Spenddown Web Service Response File.

3.3.11 Comply with spenddown policy related to QMB and AIDS Drug Assistance Program (ADAP).

3.4 Suspense Resolution Processing Requirements

3.4.1 Completely re-edit corrected Claims.

3.4.2 Identify discrepancies such as reported death, DOB, and others identified by the State.

3.4.3 Provide the capability to hold for payment, for a time period determined by the State, all Claims, or Claims for one (1) or more Provider types or individual Providers, by billing or rendering status.

3.5 CONTRACTOR(S) Responsibilities

3.5.1 Propose necessary and desirable edit and audit criteria.

3.5.2 Propose for State approval prepayment and medical review criteria.

3.5.3 Review and resolve any Claims that suspend for any of the edits and audits as determined by the State.

3.5.4 Process "special" Claims, including late billing, Member retroactive eligibility, out-of-state emergency, and any other State-defined situation, in accordance with State instructions.

3.5.5 Make recommendations on any area in which the CONTRACTOR(S) thinks improvements can be made.

3.5.6 Maintain a method to process for payment any specific Claim(s), as directed by the State, on an exception basis and maintain an audit trail.

4.0 History, Inquiry, and Reporting

4.1 Processing Requirements

4.1.1 Maintain thirty-six (36) months of adjudicated (paid and denied) Claims history and all Claims for lifetime procedures on a current, active Claims history file for use in audit processing, online inquiry and update, and printed Claims inquiries, including, at a minimum:

4.1.1.1 Diagnosis codes at both the header and detail level, as defined by HIPAA format requirements.

4.1.1.2 Multiple procedure code modifiers per line, as defined by HIPAA.

4.1.1.3 All billing, supervising, rendering, furnishing, ordering, prescribing, referring, and other Providers eligible to provide services under the State Plan at the correct header and detail levels based on the type of service.

4.1.1.4 PA number at header or detail level based on the type of service.

4.1.1.5 Billed, allowed, and paid amounts.

4.1.1.6 MCO, TPL, and Medicare payment data including allowed amounts, payment amounts, deductible, Copayments, co-insurance, paid date, denied date, Claim Adjustment Reason Codes/Remittance Advice Remark Codes (CARCs/RARCs).

4.1.1.7 Beneficiary HCBS client obligation and NF patient liability, as applicable.

4.1.1.8 Procedure, drug, or other service codes, including revenue codes and procedure code modifiers.

4.1.1.9 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service indicator.

4.1.1.10 Date of service, date of adjudication, and date of payment.

4.1.2 Maintain the original Claim and the results of adjustment transactions in Claims history; link all Claims and subsequent adjustments to the original Claim number.

4.1.3 Maintain a record of any services that, due to State policy, are required for processing for a longer span of time than that covered by the active Claims history (e.g., once-in-a-lifetime procedures) on active Claims history for audit processing.

4.1.4 Maintain thirty-six (36) months of member-centric service authorization history related to all Claims including the following fields at a minimum:

4.1.4.1 PA Number.

4.1.4.2 Member ID.

4.1.4.3 Effective Start Date.

4.1.4.4 Effective End Date.

4.1.4.5 MCO Payor ID.

4.1.4.6 PA Line Item.

4.1.4.7 Additional fields as required by the State.

4.2 Outputs

4.2.1 Inventory management analysis by Claim type, processing location, and Claim age.

4.2.2 Claims inventory trend reports.

4.2.3 Suspense file summary and detail reports.

4.2.4 Edit/audit override analysis by Claim type, edit/audit, and operator ID.

4.2.5 Reports of “specially handled” or manually processed Claims.

4.2.6 Advance Pay Collection Referral Report.

4.3 CONTRACTOR(S) Responsibilities

4.3.1 Provide training to State staff in the use of the CONTRACTOR(S)’ Claims.

4.3.2 Processing and related ancillary systems, initially and on an ongoing basis, as requested by the State.

4.3.3 Produce all required Claims operations reports and deliver to the State.

4.3.4 Provide Claims payment data to the State.

4.3.5 Produce HIPAA-compliant remittance advices (paper and electronic) and deliver to Providers.

4.3.6 Ensure all EOB codes sent on an 835 RA are HIPAA compliant. If necessary, provide supplemental training material for Providers to understand the root cause of the denial when the HIPAA reason does not provide specific detail.

4.3.7 Report all error codes on the RA.

4.3.8 Provide online access to State staff to all history and financial information.

4.3.9 Support all Claims reporting functions, files, and data elements necessary to meet the requirements of this CONTRACT.

5.0 Maintenance and Modification Changes

5.1 System/Software Modifications

System and software modifications may result when the State or the CONTRACTOR(S) determines that an additional requirement needs to be met which results in a change to existing file structures or current processing logic. Examples of modification tasks include:

5.1.1 Implementation of capabilities neither specified in this CONTRACT nor agreed to during the design task.

5.1.2 Implementation of edits and audits not defined in the operational system accepted by the State.

5.1.3 Changes to established report, screen, or file formats and new data elements or report items.

5.1.4 Acceptance of a new input form.

5.2 CONTRACTOR(S) Responsibilities

Where a maintenance activity is determined to be necessary: Identify the business impact and work in conjunction with State staff to resolve the deficiency.

5.3 Problem Notification

Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information, including any problems affecting scheduled exchanges of data between the CONTRACTOR(S) and the State and/or its agent(s), the CONTRACTOR(S) shall notify the applicable State staff via phone, fax, and/or electronic mail within one (1) hour of such discovery.

5.3.1 In its notification, the CONTRACTOR(S) shall:

5.3.1.1 Explain in detail the impact to critical path processes such as Enrollment management and Claims submission processes.

5.3.1.2 Submit an MCO Problem Notification Form by the end of the next Business Day after discovery of a system deficiency is identified.

5.3.1.3 Submit weekly updates to KDHE on the status of the problem through the KanCare Claims Resolution Log, Unified Log, and Encounter Data Resolution Log.

APPENDIX J: ENCOUNTER DATA REQUIREMENTS

1.0 Encounter Data

The CONTRACTOR(S) shall collect service information in the federally mandated Health Insurance Portability and Accountability Act (HIPAA) transaction formats and code sets, and submit this data in a standardized format approved by the State in writing. The CONTRACTOR(S) must make all collected data available to the State after it is tested for compliance, accuracy, completeness, logic, and consistency. The CONTRACTOR(S) shall follow the Encounter Data protocol provided in this Appendix and the KanCare Guide located in the Bidder's Library. Periodically, updates to the KanCare Guide will be made. When updates are made to the KanCare Guide, the changes may need to take effect immediately, i.e., schedules that need to be updated periodically or annually, information that needs to be corrected or clarified and communication that needs to occur due to program changes.

1.1 Compliance with HIPAA-Based Code Sets

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

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

1.1.2 CPT codes – The CPT-4 codes are used to describe medical procedures and physicians' services and is maintained and distributed by the AMA. For more information on the CPT-4 codes, please contact the AMA.

1.1.3 ICD-10 is the International Classification of Diseases, Tenth Revision, (ICD-10-CM) is the diagnosis coding system and is maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the United States Department of Health and Human Services (HHS).

1.1.4 ICD-10 is the International Classification of Diseases, Tenth Revision, Clinical Modification and Procedure Coding System (ICD-10-PCS) for inpatient surgical codes, is maintained by CMS, and is used to report procedures for inpatient hospital services.

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

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

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

1.1.8 Claim Adjustment Reason Codes (CARC) explain why a Claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient. The CONTRACTOR(S) shall provide documentation that the CONTRACTOR(S) and any Subcontractors are compliant with this requirement.

1.1.9 Remittance Advice Remark Codes (RARC) are used by the Kansas Modular Medicaid System (KMMS) using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP). The CONTRACTOR(S) shall provide documentation that the CONTRACTOR(S) and any Subcontractors are compliant with this requirement.

NOTE – Institutional, professional, and dental Claims contain CARC and RARC codes, while pharmacy Claims contain NCPDP reject codes. RARCs are used in conjunction with CARCs to further explain a payment decision or to relay additional information. NCPDP reject codes are used to document denial reasons for pharmacy Claims.

1.2 Compliance with Other Code Sets

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

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

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

1.3 Electronic Data Submission Standards

1.3.1 The CONTRACTOR(S) shall have a comprehensive automated and integrated Encounter Data system capable of meeting the requirements below:

1.3.1.1 All CONTRACTOR(S)' Encounter Data (encounters) shall be submitted to the State or the State's Fiscal Agent in the standard HIPAA transaction formats, namely the ASC X12N 837 transaction formats (P – Professional, I – Institutional, and D – Dental) and, for pharmacy services, in the NCPDP format. The CONTRACTOR(S)' paid amounts shall be provided.

1.3.1.2 The CONTRACTOR(S) shall collect, and submit to the State's Fiscal Agent, Member service level Encounter Data for all covered services. The CONTRACTOR(S) shall be held responsible for errors or non-compliance resulting from their own actions or the actions of an agent authorized to act on their behalf.

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

1.3.2.1 Batch transaction types:

1.3.2.1.1 ASC X12N 820 Premium Payment

1.3.2.1.2 ASC X12N 834 Benefit Enrollment and Maintenance

1.3.2.1.3 ASC X12N 835 Claims Payment Remittance Advice

1.3.2.1.4 ASC X12N 837I Health Care Claim: Institutional

1.3.2.1.5 ASC X12N 837P Health Care Claim: Professional

1.3.2.1.6 ASC X12N 837D Health Care Claim: Dental

1.3.2.1.7 NCPDP D.0 Pharmacy Claim

1.3.2.2 Online transaction types:

1.3.2.2.1 ASC X12N 270/271 Eligibility Coverage or Benefit Inquiry/Response

1.3.2.2.2 ASC X12N 274 Healthcare Provider Information

1.3.2.2.3 ASC X12N 276/277 Health Care Claim Status Inquiry/Response

1.3.2.2.4 ASC X12N 278 Health Care Services Review Inquiry/Response

1.3.2.2.5 NCPDP D.0 Pharmacy Claim

1.3.3 The CONTRACTOR(S) shall convert all information that enters its Claims system via hard copy paper Claims or other proprietary formats to Encounter Data to be submitted in the appropriate HIPAA-compliant formats. The transaction and code sets can be found at www.cms.gov.

1.4 Encounter Data Completeness, Accuracy, Timeliness, and Error Resolution

The CONTRACTOR(S) shall provide complete and accurate Encounter Data to the State. The CONTRACTOR(S) shall implement review procedures to validate Encounter Data. The following standards are hereby established:

1.4.1 Completeness

The CONTRACTOR(S) must submit encounters that represent at least 98% of the Covered Services provided by the CONTRACTOR(S)' participating and non-participating Providers. The CONTRACTOR(S) shall strive to achieve a 100% complete submission rate. All data submitted by the Providers to the CONTRACTOR(S) must be included in the Encounter Data submissions.

1.4.2 Accuracy

1.4.2.1 Transaction type (X12): 98% of the records in the CONTRACTOR(S)' batch submission pass X12 electronic data interchange (EDI) compliance edits and repairable compliance edits. The X12 EDI compliance edits are established through Strategic National Implementation Process (SNIP) levels one (1) through four (4). Repairable edits that report exceptions are defined in the KanCare Guide.

1.4.2.2 Transaction type (NCPDP): 98% of the records in the CONTRACTOR(S)' Encounter Data batch submission pass NCPDP compliance edits and repairable compliance edits. The NCPDP compliance edits are described in the National Council for Prescription Drug Programs Telecommunications Standard Guides. Repairable edits that report exceptions are defined in the KanCare Guide.

1.4.3 Timeliness

1.4.3.1 Encounter Data shall be submitted within thirty (30) Calendar Days of Claim payment. All encounters must be submitted, both paid and denied Claims. The paid Claims must include the CONTRACTOR(S)' allowed and paid amount.

1.4.3.2 Complete Spenddown Adjustment Reports and send a response to the Fiscal Agent within thirty (30) Business Days from the receipt date of the Spenddown Adjustment Report.

1.4.4 Error resolution

1.4.4.1 For all encounters submitted after the submission start date, including historical and ongoing Claims, if the State or its Fiscal Agent notifies the CONTRACTOR(S) of:

1.4.4.1.1 Encounters failing X12 EDI compliance edits,

1.4.4.1.2 Repairable compliance edits,

1.4.4.1.3 Encounter build errors,

1.4.4.1.4 Denied encounters that need to be corrected and voided and replaced (reconciliation), or

1.4.4.1.5 All encounters that need to be voided and replaced (i.e., post implementation or other reasons).

1.4.4.1.6 The CONTRACTOR(S) shall remediate all such encounters within thirty (30) Calendar Days after such notice.

1.4.4.2 Encounters cannot be adjusted; therefore, they must be updated through the Void and Replacement process. (See process described in the KanCare Guide.) Encounters must be voided and a replacement sent within thirty (30) Calendar Days of identifying that the original encounter was in error.

1.4.4.3 When the CONTRACTOR(S) is notified that Claims need to be reprocessed or encounters need to be voided and replaced, the CONTRACTOR(S) shall submit an attestation that documents the date the activity was completed.

1.4.5 The CONTRACTOR(S) shall participate in State-sponsored workgroups directed at continuous improvements in Encounter Data quality and operations. For additional information regarding Encounter Data submissions, please reference the KanCare Guide.

1.5 Encounter Data – Staffing Requirements

1.5.1 The CONTRACTOR(S) shall designate sufficient resources to perform these Encounter Data functions as determined by generally accepted best industry practices.

1.6 Data Certifications

Data submitted by the CONTRACTOR(S) including, but not limited to, all documents specified by the State, Enrollment information, Encounter Data, and other information required as a deliverable in the CONTRACT, must be certified. The Attestation Form shall include the following:

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

1.6.1.1 CONTRACTOR(S)' chief executive officer;

1.6.1.2 CONTRACTOR(S)' chief financial officer; or

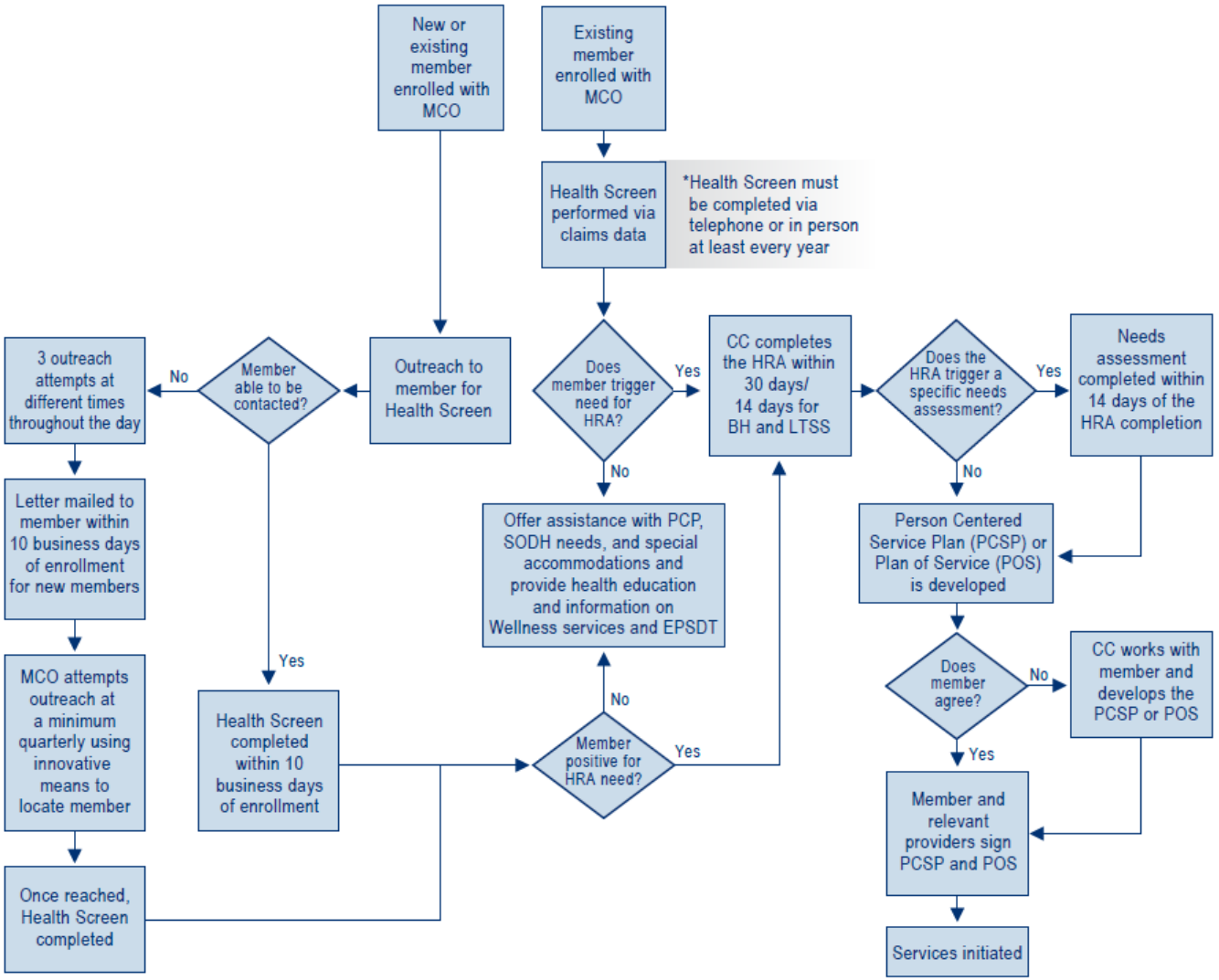
1.6.1.3 An individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR(S)' chief executive officer or chief financial officer.

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

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

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

APPENDIX K: KANCARE INITIAL CARE COORDINATION PROCESS WORKFLOW



APPENDIX L: CARE COORDINATION MATRIX

	Population	Care Coordination Model	MCO Responsibilities	CCC/TCM/CCBHC/Other Care Coordinator Responsibilities
1.	Intellectual/ Developmental Disability (IDD) HCBS Waiver	Targeted case management (TCM) with MCO Care Coordination	• Completion of Health Screen, Health Risk Assessment (HRA), and Needs Assessments • Development, approval, and monitoring of the Person-Centered Service Plan (PCSP), including incorporation of the person-centered support plan and behavior support plan developed by the TCM • Education about self-direction • Member contacts and home visits, including coordinating visits with the TCM • Health and safety monitoring, in coordination with the TCM • Physical health, Behavioral Health. Long-Term Services and Supports (LTSS), and Transportation coordination • Linkage and referral to community resources and non-Medicaid supports, in coordination with the TCM • Resource for the TCM to provide support for education, employment, and housing, including making referrals and following up • Sharing information and coordinating with the community developmental disability organization (CDDO) and the TCM	<u>TCM</u> • Primary point of contact for the member • Development, implementation, and monitoring of the member's person-centered support plan and behavior support plan (included in the PCSP, which is approved by the MCO) • Member contacts and home visits, including attending MCO care coordinator visits • Health and safety monitoring (also MCO) • Linkage and referral to community resources and non-Medicaid supports (also MCO) • Support for education, employment, and housing, including making referrals and following up (with MCO as a resource for the TCM) • Sharing information and coordinating with the MCO <u>CDDO</u> • Choice counseling (HCBS vs. institution, option for self-direction, and choice of provider)
2.	Serious Emotional Disturbance (SED) HCBS Waiver	TCM with MCO Care Coordination	• Completion of Health Screen, HRA, and Needs Assessments • Development, approval, and monitoring of the PCSP, including incorporation of the plan of care developed by the TCM • Choice counseling (choice of institution or HCBS Waiver) • Member contacts and home visits, including coordinating visits with the TCM	<u>TCM</u> • Primary point of contact for the member • Development, implementation, and monitoring of the member's plan of care (included in the PCSP, which is developed and approved by the MCO) • Assistance with choice of services • Member contacts and home visits, including attending MCO care coordinator visits • Health and safety monitoring (also MCO)

	Population	Care Coordination Model	MCO Responsibilities	CCC/TCM/CCBHC/Other Care Coordinator Responsibilities
			• Health and safety monitoring, in coordination with the TCM • Physical health, Behavioral Health, LTSS, and Transportation coordination • Linkage and referral to community resources and non-Medicaid supports, in coordination with the TCM • Support for education, employment and housing, including making referrals and following up, in coordination with the TCM • Sharing information and coordinating with the TCM	• Linkage and referral to community resources and non-Medicaid supports (also MCO) • Support for education, employment, and housing, including making referrals and following up (also MCO) • Sharing information and coordinating with the MCO
3.	Brain Injury (BI) HCBS Waiver Physical Disability (PD) HCBS Waiver Frail Elderly (FE) HCBS Waiver Autism HCBS Waiver Technology Assisted (TA) HCBS Waiver	Community Care Coordination (CCC) with MCO Care Coordination	• Completion of Health Screen and HRA • Choice counseling (choice of institution or HCBS Waiver) • Education about self-direction (also CCC) • Approval of Person-Centered Service Plan • Member contacts and home visits, in coordination with CCC • Health and safety monitoring, in coordination with CCC • Physical health, Behavioral Health, and Transportation coordination • Linkage and referral to community resources and non-Medicaid supports, in coordination with CCC • Support for education, employment and housing, including making referrals and following up, in coordination with CCC • Sharing information and coordinating with CCC	<u>CCC</u> • Primary point of contact for the member • Completion of needs assessments • Development, implementation, and monitoring of PCSP • Service/provider choice counseling • Member contacts and home visits, including attending MCO care coordinator visits • Health and safety monitoring (also MCO) • Linkage and referral to community resources and non-Medicaid supports (also MCO) • Support for education, employment and housing, including making referrals and following up (also MCO) • Education about self-direction (also MCO) • Sharing information and coordinating with the MCO
4.	Individuals on a 1915(c) HCBS Waiver waiting list	TCM with MCO Care Coordination for those on waiting list for the IDD HCBS Waiver	• Completion of Health Screen and HRA • Choice counseling (choice of institution or HCBS Waiver) • Education about self-direction (also CCC) • Approval of Plan of Service	<u>CCC</u> • Primary point of contact for the member • Completion of needs assessments • Development, implementation, and monitoring of Plan of Service • Service/provider choice counseling

	Population	Care Coordination Model	MCO Responsibilities	CCC/TCM/CCBHC/Other Care Coordinator Responsibilities
		CCC with MCO Care Coordination for those on other waiting lists (e.g., PD HCBS Waiver)	• Member contacts and home visits, in coordination with CCC • Health and safety monitoring, in coordination with CCC • Physical health, Behavioral Health, and Transportation coordination • Linkage and referral to community resources and non-Medicaid supports, in coordination with CCC • Support for education, employment and housing, including making referrals and following up, in coordination with CCC • Sharing information and coordinating with CCC	• Member contacts and home visits, including attending MCO care coordinator visits • Health and safety monitoring (also MCO) • Linkage and referral to community resources and non-Medicaid supports (also MCO) • Support for education, employment and housing, including making referrals and following up (also MCO) • Education about self-direction (also MCO) • Sharing information and coordinating with the MCO
5.	Nursing facility (NF)/Nursing facility for mental health (NFMH) /intermediate care facility-individuals with intellectual disability (ICF/IDD)/hospital/ Psychiatric Residential Treatment Facility (PRTF)/other institution	MCO Care Coordination	All care coordination functions, including requirements specific to this population.	NA
6.	Behavioral Health (Adults)	Certified Community Behavioral Health Clinic (CCBHC) with MCO Care Coordination	For members receiving CCBHC services: • Ensuring completion of Health Screen, HRA, and Needs Assessments by the CCBHC • Documenting the member's care plan • Providing resources to the CCBHC for choice counseling • Supporting the CCBHC, including providing resources and coordinating with the CCBHC as needed, including with member contacts, health and safety monitoring,	<u>CCBHC</u> • Single point of contact for the member • Completion of Health Screen, HRA, and Needs Assessments • Development, implementation, and monitoring of the care plan • Service/provider choice counseling (with MCO support and resources) • Member contacts and home visits (with MCO support)

	Population	Care Coordination Model	MCO Responsibilities	CCC/TCM/CCBHC/Other Care Coordinator Responsibilities
			service coordination, linkage and referrals to community resources and non-Medicaid supports, and support for education, employment, and housing • Providing technical assistance and support to the CCBHC for members who have complex physical health conditions, as needed If a member is not connected with a CCBHC, the MCO shall perform all care coordination functions, including connecting the member with a CCBHC and ensuring continuity of care.	• Health and safety monitoring (with MCO support) • Physical health, Behavioral Health, LTSS, and Transportation coordination (with MCO support and resources) • Linkage and referral to community resources and non-Medicaid supports (with MCO support and resources as needed) • Support for education, employment and housing, including making referrals and following up (with MCO support and resources)
7.	Children with SED, including transition age youth	CCBHC with MCO Care Coordination	Same as Adults with Behavioral Health Needs.	Same as Adults with Behavioral Health Needs.
8.	Foster Care with Complex/High or Moderate Needs who do not meet the criteria for a HCBS Waiver or SED	MCO Care Coordination	All Care Coordination functions, including requirements specific to this population.	NA
9.	Youth who have aged out of the foster care system	MCO Care Coordination	All Care Coordination functions.	NA
10.	Post-adoption youth	MCO Care Coordination	All Care Coordination functions.	NA
11.	Houseless youth	MCO Care Coordination	All Care Coordination functions.	NA
12.	Justice-involved youth	MCO Care Coordination	All Care Coordination functions.	NA
13.	Adults recently released from incarceration	MCO Care Coordination	All Care Coordination functions.	NA

	Population	Care Coordination Model	MCO Responsibilities	CCC/TCM/CCBHC/Other Care Coordinator Responsibilities
14.	Individuals participating in WORK, STEPS, Vocational Rehab, or Other Employment Program	Current care coordination with MCO Care Coordination	All Care Coordination functions unless the member is participating in WORK or STEPS. If the member is participating in WORK or STEPS, MCO responsibilities as outlined in the Section 2 of the CONTRACT and the WORK or STEPS manual.	As outlined in the WORK or STEPS manual.
15.	Individuals who are pregnant or postpartum	MCO Care Coordination	All Care Coordination functions, including requirements specific to this population.	NA
16.	Premature babies	MCO Care Coordination	All Care Coordination functions.	NA
17.	Individuals who are transplant recipients or on a transplant waiting list	MCO Care Coordination	All Care Coordination functions.	NA
18.	Individuals with chronic and/or complex physical health conditions	MCO Care Coordination unless OneCare Kansas	All Care Coordination functions unless the member is in OneCare Kansas (OCK); if member is in OCK, MCO responsibilities as outlined in Section 2 of the CONTRACT and the OCK manual.	For members enrolled in OneCare Kansas, the OCK provider is responsible for care coordination functions.
19.	Individuals with Social Determinants of Health (SDOH) needs	MCO Care Coordination	All Care Coordination functions.	N/A
20.	Individuals who request Care Coordination	MCO Care Coordination	All Care Coordination functions.	N/A
21.	Other individuals identified by the MCO	MCO Care Coordination but MCO may offer CCC	All Care Coordination functions unless the member selects CCC.	If the member selects CCC, the roles and responsibilities should be similar to other CCC populations, but MCO to define.

APPENDIX M: OTHER SYSTEMS DATA PROCESSING AND REPORTING REQUIREMENTS

1.0 **Other Systems Data Processing Requirements**

1.1 Eligibility and Enrollment Data Exchange Requirements

1.1.1 CONTRACTOR(S) Roster

The CONTRACTOR(S) shall receive a Member roster once per month with daily updates. The format that will be used is the ASC X12 834 transaction. The CONTRACTOR(S) shall update its eligibility/Enrollment databases within twenty-four (24) hours after receipt of files. The CONTRACTOR(S) shall transmit to the State or its agent, in a periodicity schedule, format and data exchange method to be determined by the State, specific data it may garner from a Member, including Third-Party liability data.

1.2 Information Management and Systems

The following system requirements shall be met by the CONTRACTOR(S):

1.2.1 Availability of Critical Systems Functions

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

1.2.2 Availability of Data Exchange Functions

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

1.2.3 Availability of Other Systems Functions

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

1.2.4 Problem Notification

1.2.4.1 Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the CONTRACTOR(S) and the State and/or its agent(s), the CONTRACTOR(S) shall notify the applicable State staff via phone, fax and/or electronic mail within one (1) hour of such discovery. In its notification, the

CONTRACTOR(S) shall explain in detail the impact to critical path processes, such as Enrollment management and Claims submission processes.

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

1.2.5 Recovery from Unscheduled System Unavailability

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

1.2.6 Exceptions to System Availability Requirement

The CONTRACTOR(S) shall not be responsible for the availability and performance of systems and infrastructure of information technologies outside of the CONTRACTOR(S)' span of control.

1.2.7 Notification, Discussion, and Documentation of Potential System Changes

The CONTRACTOR(S) shall notify the State of the following changes to systems within its span of control at least ninety (90) Calendar Days before the projected date of the change. If so directed by the State, the CONTRACTOR(S) shall discuss the proposed change with the applicable State staff and provide supporting initial and ongoing documentation as specified by the State, including at a minimum:

1.2.7.1 Summary of the system change;

1.2.7.2 Description of impacts caused by the system change on other entities (Fiscal Agent, State, etc.);

1.2.7.3 Communication plan for Providers and/or Members impacted by the system change;

1.2.7.4 Project timeline/Cutover schedule;

1.2.7.5 Testing Plan (especially if testing with the Fiscal Agent is needed);

1.2.7.6 Weekly updates (project phase, accomplishments, upcoming tasks, etc.) using the reporting method specified by the State and certified by the CONTRACTOR(S) in accordance with Section 1.4.5 of this Appendix;

1.2.7.7 Production validation documentation as specified by the State and certified by the CONTRACTOR(S) in accordance with Section 1.4.5 of this Appendix below.

1.2.7.8 Software release updates of core transaction systems: Claims processing, eligibility and Enrollment processing, Service Authorization management, Provider enrollment and data management;

1.2.7.9 Conversions of core transaction management systems; and

1.2.7.10 New system implementations.

1.2.8 Response to State Reports of Systems Problems Not Resulting in System Unavailability

The CONTRACTOR(S) shall respond to State reports of system problems not resulting in system unavailability according to the following timeframes:

1.2.8.1 Within seven (7) Calendar Days of receipt, the CONTRACTOR(S) shall respond in writing to notices of system problems.

1.2.8.2 Within twenty (20) Calendar Days, the correction shall be made or a requirements analysis and specifications document will be due.

1.2.8.3 The CONTRACTOR(S) shall correct the deficiency by an effective date to be determined by the State.

1.2.9 Valid Window for Certain System Changes

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

1.2.10 Testing

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

1.3 Other Systems Documentation Requirements

1.3.1 Types of Documentation

The CONTRACTOR(S) shall develop, prepare, print, maintain, produce, and distribute distinct system process and procedure manuals, user manuals, and quick-reference guides, and any updates thereafter, for the State and other applicable State staff. The CONTRACTOR(S) shall provide this documentation in outline form electronically for written approval by the State.

1.3.2 Content of System Process and Procedure Manuals

The CONTRACTOR(S) shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

1.3.3 Content of System User Manuals

The system user manuals shall contain information about and instructions for using applicable system functions and accessing applicable system data.

1.3.4 Changes to Manuals

When a system change is subject to the State's written approval, the CONTRACTOR(S) shall draft revisions to the appropriate manuals prior to State approval of the change. Updates to the electronic version of these manuals shall occur

in real time.

1.3.5 Availability of/Access to Documentation

All of the aforementioned manuals and reference guides shall be available electronically and on-line. If so prescribed, the manuals will be published in accordance with the appropriate State and/or state standard. Additionally, the documentation shall be provided in printed form upon request.

1.4 Data Processing Requirements

The CONTRACTOR(S) shall cooperate with State requirements regarding data submission and data exchange, including as specified herein or in the KanCare Guide.

1.4.1 Methods for Data Exchange

The CONTRACTOR(S) and the State and/or its agent shall make predominant use of secure file transfer protocol (SFTP) and electronic data interchange (EDI) in their exchanges of data, including X12 transactions.

1.4.2 For data exchange, the CONTRACTOR(S) must remain in compliance with Health Insurance Portability and Accountability Act (HIPAA) transaction standards, including SNIP level edits, National Council for Prescription Drug Programs versions, and X12 transaction versions. Updates for compliance must be made timely and in coordination with the State and/or its agent.

1.4.3 State-Based Formatting Standards and Methods

CONTRACTOR(S) systems shall exchange the following data with the State and/or its agent in a format to be jointly agreed upon by the CONTRACTOR(S) and the State:

1.4.3.1 Provider network data: The CONTRACTOR(S) shall submit Provider information electronically to the Fiscal Agent in a Provider roster format approved by the State in writing. This information will be updated monthly by the CONTRACTOR(S) and will be a full file replacement each month.

1.4.3.2 Case management fees, if applicable.

1.4.3.3 Payments

1.4.3.4 Member and services data: The CONTRACTOR(S) must report separately on those Members receiving care for chronic Behavioral Health conditions (e.g., Serious and Persistent Mental Illness [SPMI], substance use disorder [SUD]), disabilities (e.g., intellectual or developmental disabilities, physical disabilities, or brain injury), long-term care services, and physical health services. The CONTRACTOR(S) must also report separately on services, including but not limited to, outpatient Behavioral Health Services and inpatient Behavioral Health Services.

1.4.3.5 Pharmaceutical Report: The CONTRACTOR(S) shall provide all requested drug utilization review (DUR) reports, including but not limited to Claims summary reports, annual DUR Board meeting program summary report, and the CMS annual DUR survey.

1.4.3.6 Mental Health Outcomes Data: The CONTRACTOR(S) (and/or their Subcontractors) shall report all mental health outcomes data in compliance with the Automated

information Management System (AIMS) data collection requirements. The CONTRACTOR(S) shall also provide summary and detail reports on data completeness and accuracy, as defined in the AIMS manual.

1.4.3.7 Daily Claims Data File Submissions

1.4.3.7.1 In addition to the Claims and Encounter file submissions, the CONTRACTOR(S) are required to send daily Claims data files to the State in the standard HIPAA formats and must include all Claims that have been received and are pending any further action, including routing to internal departments, financial updating for check number and date, etc. These daily files will be used for multiple purposes by the State including reporting, error resolution, and matching to Encounters. The CONTRACTOR(S) must also connect directly to the Kansas Modular Medicaid System (KMMS), the State's data collection and reporting system, and send a variety of data according to State specifications. Once interface development with KMMS is complete, the daily claims data file submissions will be eliminated.

1.4.4 Substance Use Disorder (SUD) Data System Requirements

The CONTRACTOR(S) shall work with the KDADS in promoting SUD Provider use of the Kansas SUD specific data system/data collection tool. The CONTRACTOR(S) must use the American Society of Addiction Medicine (ASAM) criteria in making SUD Service Authorization decisions. The State will monitor both the CONTRACTOR(S)' application and documentation of the Kansas definition of Medical Necessity and the ASAM criteria through ongoing reviews including, but not limited to, external audits. The CONTRACTOR(S) shall document all authorizations and any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than the request in the CONTRACTOR(S)' records, and that documentation shall reference the Kansas Medical Necessity definition and ASAM criteria. The CONTRACTOR(S) shall develop a process by which they can verity SUD Providers are submitting Federally required information in the Kansas SUD specific data system used by Providers in Kansas. The CONTRACTOR(S) shall ensure that it as well as Participating Providers use the required Kansas Medical Necessity definition and ASAM criteria for determination of level of service, even when Prior Authorization from the CONTRACTOR(S) is not required.

1.4.5 Data Certifications

Data submitted by the CONTRACTOR(S) including, but not limited to, all documents specified by the State, Enrollment information, Encounter Data, and other information required as a deliverable in the CONTRACT, must be certified. The Attestation Form shall include the following:

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

1.4.5.1.1 CONTRACTOR(S)' chief executive officer.

1.4.5.1.2 CONTRACTOR(S)' chief financial officer.

1.4.5.1.3 An individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR(S)' chief executive officer or chief financial officer.

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

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

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