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**State/Territory Name: KS**

**State Plan Amendment (SPA) #: 17-0005**

This file contains the following documents in the order listed:


1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES

**Division of Medicaid and Children's Health Operations**

August 11, 2017

Mike Randol, Division Director and Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900N
Topeka, KS 66612

Dear Mr. Randol:

On July 5, 2017, the Centers for Medicare & Medicaid Services (CMS) received Kansas' State Plan Amendment (SPA) transmittal #17-0005. This SPA brings the state into compliance with CMS 2348 Final Rule regarding Home Health Services.

SPA #17-0005 was approved August 09, 2017, with an effective date of July 1, 2017, as requested by the state. Enclosed is a copy of the CMS-179 summary form, as well as the approved pages for incorporation into the Kansas State Plan.

If you have any questions regarding this amendment, please contact Karen Hatcher or Michala Walker at (816) 426-5925.

Sincerely, 8/11/2017

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Sign

Enclosure

cc:
Bobbie Graff -Hendrixson
Fran Seymour-Hunter
Susan Mosier
Kim Tjelmeland

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
## FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: KS 17-005

2. STATE: Kansas

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2017

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION
CMS 2348 Final Rule,42 CFR 440.70

7. FEDERAL BUDGET IMPACT
a. FFY 2017 $5,838.00
b. FFY 2018 $23,350.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 3.1-A, #7
Attachment 3.1-A, #7.1 (new)
Attachment 3.1-A, #7.a.
Attachment 3.1-A, #7.b.
Attachment 3.1-A, #7.c., Page 1, 2
Attachment 3.1-A, #7.d.
Attachment 4.19-B, # 7 *

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

Attachment 3.1-A, #7
Attachment 3.1-A, #7.a.
Attachment 3.1-A, #7.b.
Attachment 3.1-A, #7.c., Page 1, 2
Attachment 3.1-A, #7.d.
Attachment 4.19-B, #7 *

10. SUBJECT OF AMENDMENT
CMS 2348 Final Rule Changes to Medicaid Home Health Coverage

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

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
for Michael Randol

14. TITLE
Director, Division of Health Care Finance

15. DATE SUBMITTED
July 5, 2017

16. RETURN TO
Michael Randol, Director
KDHE, Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED
July 5, 2017

18. DATE APPROVED
August 9, 2017

**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2017

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
James G. Scott

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

23. REMARKS

* Pen and Ink Changes per state email dated 7.31.17

**KANSAS MEDICAID STATE PLAN**

Attachment 3.1-A
#7

Scope of Home Health Services

1. Covered home health services include:
   (a) Skilled nursing services provided in accordance with 42 CFR 440.70;
   (b) Restorative and rehabilitative physical therapy provided in accordance with 42 CFR 440.110;
   (c) Restorative and rehabilitative occupational therapy provided in accordance with 42 CFR 440.110;
   (d) Restorative and rehabilitative speech therapy provided in accordance with 42 CFR 440.110;
   (e) Medical supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place, as defined at 42 CFR 440.70.

   Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

   Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program;
   (f) Home health aide services provided in accordance with 42 CFR 440.70;
   (g) Restorative aide services provided in accordance with 42 CFR 440.70;
   (h) Immunizations;
   (i) Kan Be Healthy (EPSDT) medical screening by a certified registered nurse or ARNP within the limitations of Attachment 3.1-A, #4.b.;
   (j) Home Telehealth services within the limitations of Attachment 3.1-A, #7.a.

2. Home Health services provided to home and community based service waiver recipients must be prior authorized.

3. Home health services must be provided to any eligible beneficiary in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound.

Scope of Home Health Services

4. Coverage of home health services cannot be contingent upon the beneficiary needing nursing or therapy services.

5. A face-to-face encounter must be conducted by a physician or an allowed non-physician practitioner for the initiation of home health services and or durable medical equipment, appliances or supplies in accordance with 42 CFR 440.70.

Home Health Nursing Limitations

1. Medically necessary skilled nursing services provided in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are home bound. Services may be provided via telehealth or interactive audio and video telecommunication systems by the registered nurse or licensed practical nurse. Skilled nursing services are those services requiring substantial and specialized nursing skills. Home telehealth services are delivered as a supplement to enhance home health services, and not as a substitute for face to face visits for the provision of on-going assessments. Home telehealth services must be ordered by a physician or an allowed non-physician practitioner and documented in the plan of care and the patients must agree to participate in the program.

   For the initiation of home health services, the face-to-face encounter must be related to the primary reason the beneficiary requires home health services and must occur within the 90 days before or within the 30 days after the start of the services.

2. DME services provided for parenteral administration of total nutritional replacements and intravenous medications in any setting in which normal life activities take place, as defined in 42 CFR 440.70 requires the participation of nursing services of a local home health agency. In areas not served by a home health agency, the services of a local health department or advanced registered nurse practitioner are required.

   State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program.

   The Medicaid agency maintains a list of preapproved medical equipment supplies and appliances. The Medicaid agency through the fiscal agent has a process and criteria for requesting medical equipment that is made available to individuals to request items not on the Medicaid Agency's list. This process has reasonable and specific criteria to assess items for coverage. When denying a request, the beneficiary is informed of the right to a fair hearing.

# KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#7.b.

## Home Health Aide Services
## Provided by a Home Health Agency - Limitations

Home health aide visits are limited to two visits per week in the absence of additional documentation to support medical necessity. Providers must submit documentation supporting the need to exceed two home health visits per week to ensure effective and efficient use and accurate reimbursement. This will be considered on a case-by-case basis. Providers may not bill more than one home health aide visit per date of service.

Home health aide services are non-covered on the same date of service as restorative aide services for the same recipient.

Home health aide visits are not contingent upon the beneficiary needing nursing or therapy services. Home health aide visits may be provided in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board. Home health services cannot be limited to services furnished to beneficiaries who are homebound.

# KANSAS MEDICAID STATE PLAN



## Home Health Services, Durable Medical Equipment, Appliances and Medical Supplies – Limitations

Durable Medical Equipment (DME) and Supplies

The equipment, appliances and supplies must be reasonable, necessary and the most economical for the treatment of the patient's illness or injury. This benefit must be initiated by a face-to-face encounter and appropriately prescribed by a qualified physician or non-physician practitioner in accordance with 42 CFR 440.70. The equipment must be appropriate for use in any setting in which normal life activities take place, as specified in 42 CFR 440.70. Medical necessity or prior authorization documentation is required for the majority of covered DME items. For the initiation of medical equipment, the face-to-face encounter must be related to the primary reason the beneficiary requires medical equipment and must occur no more than 6 months prior to the start of services.

Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program.

Supplies are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

Home Health Services, Durable Medical Equipment,
Oxygen Medical Supplies and Nutritional Replacements
And Intravenous Medications – Limitations

Oxygen

Oxygen and oxygen delivery equipment are limited and some require medical necessity documentation.

Medical Supplies, equipment, and appliances suitable for use in any setting in which normal life activities take place

1. Medical necessity or prior authorization documentation is required for provision of certain medical supplies.
2. Medical supplies must be necessary and reasonable for treatment of the patient's illness or injury.
3. Medical supplies, equipment, appliances suitable for use in any setting in which normal life activities take place, as defined at § 440.70.
4. Medical supplies provided as a home health service must be necessary for providing the home health service.

Definitions:

- Supplies are health care related items are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

- Equipment and appliances are items that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable. State Medicaid coverage of equipment and appliances is not restricted to the items covered as durable medical equipment in the Medicare program.

Nutritional Replacements and Intravenous Medications

DME services provided for parenteral administration of total nutritional replacements and intravenous medications may be provided in any setting in which normal life activities take place and requires participation from a local home health agency, physician, an allowed non-physician licensed practitioner or pharmacist.

# KANSAS MEDICAID STATE PLAN

Attachment 3.1-A
#7.d.

## Limitations of Physical Therapy, Occupational Therapy, Speech Language Pathology and Restorative Aide Services Provided by a Home Health Agency

Physical, occupational and speech therapy services must be rehabilitative and restorative in nature, provided following physical debilitation due to acute physical trauma or physical illness and must be prescribed by the attending physician or an allowed non-physician practitioner in accordance with 42 CFR 440.70. Therapy services are limited to 6 months for participants over the age of 20 (except the provision of therapy under HCBS) per injury, to begin at the discretion of the provider. Limits on therapy services may be exceeded based on medical necessity and with prior authorization. There are no time limits for participants from birth through age 20.

Restorative aide services are limited to those services provided under the direction of a registered physical therapist as prescribed by the attending physician or an allowed non-physician practitioner in accordance with 42 CFR 440.70. Restorative aide services must be rehabilitative and restorative in nature, and provided following physical debilitation due to acute physical trauma or physical illness. Restorative aide services are limited to six months' duration. Limits on restorative aid services may be exceeded based on medical necessity and with prior authorization. Restorative aide services are non-covered on the same date of service as home health aide services for the same recipient.

The above limitations do not apply to Kan Be Healthy Program Participants. Limitations of physical therapy, occupational therapy, speech language pathology and restorative aide services for Kan Be Healthy program recipients are located in the Kan Be Healthy portion of the State Plan.

**KANSAS MEDICAID STATE PLAN**

**Attachment 4.19-B**
**#7**

Home Health Services
Methods and Standards for Establishing Payment Rates

Home health services are reimbursed per unit of service provided. Kansas Medicaid establishes individual rates for the following units of service:

- Skilled nursing services
- Physical therapy services
- Occupational therapy services
- Speech therapy services
- Home health aide services
- Restorative Aide services

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of the home health services noted above. The agency's fee schedule rate was set as of March 1, 2010 and is effective for services provided on and after that date. All rates are published at
https://www.kmap-state-ks.us/Provider/PRICING/Disclaimer.asp?goto=/Provider/PRICING/HCPCSSearch.asp

Durable medical equipment and medical supplies are reimbursed on the basis of rates established by Kansas Medicaid. Payment for used equipment is limited to a maximum of 75% of the payment for new equipment.