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Whitney Howard
Research Analyst
785-296-3181
Whitney.Howard@klrd.ks.gov

Health

L-4 Medicaid Waivers in Kansas

This article provides information related to the history of Medicaid waivers in the United States and those waivers specific to Kansas.

The History of Medicaid

In the United States

Medicaid is a partnership between the federal government and the states with shared authority and financing, created by Congress in 1965 (Title XIX of the Social Security Act). The program was designed to finance health care services for low-income children, their parents, the elderly, and people with disabilities. Medicaid has become the nation's largest source of funding to provide health services to low-income people.

State participation in Medicaid is optional. However, the federal government's financial share of Medicaid financing creates an incentive for the states. To date, no state has declined to participate. All 50 states, American Samoa, the District of Columbia, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands participate and administer their own Medicaid plans. Although all states participate, eligibility varies widely because the states can choose to cover additional people and services above and beyond the federal minimum requirements.

Medicaid Expansion

Provisions of the Patient Protection and Affordable Care Act (PPACA) expanded Medicaid to all Americans under age 65 whose family income is at or below 133 percent of federal poverty guidelines by January 1, 2014. Under the provisions of the PPACA, if a state did not expand Medicaid, the state risked losing its entire federal Medicaid allotment. The Medicaid expansion provision led to challenges to the Supreme Court of the United States. On June 28, 2012, the Supreme Court ruled in *National Federation of Independent Business v. Sebelius* that Congress may not make a state's entire existing Medicaid funding contingent upon the state's compliance with the PPACA provision regarding Medicaid expansion. Consequently, Medicaid expansion is voluntary and has become a highly discussed topic in state legislatures across the country. As of November 3, 2015, 25 states and the District of Columbia have expanded Medicaid, 5 states are currently implementing expansion alternatives, and 20 states have not expanded Medicaid.

Interstate Health Care Compact

In response to federal regulation of health care, nine states (Alabama, Georgia, Indiana, Kansas, Missouri, Oklahoma, South Carolina, Utah, and Texas) have enacted and signed Interstate Health Care Compact (Compact) legislation. Utah repealed most of its Compact statute in 2014. The Compact allows Member States to establish broad health care programs that operate outside of the PPACA or other federal law. The U.S. Congress would have to consent to the Compact because it would substitute state control where federal law and regulations exist. If approved by Congress, the Compact would become effective on its adoption by at least two Member States. The Compact includes statements on the importance of the separation of powers, including federal and state authority, and the preservation of individual liberty and personal control over health care decisions. The Compact contains nine articles. For more information on the Interstate Health Care Compact, see the 2015 Briefing Book article.

KanCare: Medicaid in Kansas

Kansas participates in Medicaid, but chose not to participate in Medicaid expansion under the PPACA. Kansas administers Medicaid through the program known as KanCare. KanCare was launched in January 2013 and currently serves more than 400,000 Kansans. Under KanCare, eligible Kansans receive doctor visits and hospital care, mental health therapy, dental and eye care, medicine, non-emergency medical transportation, nursing home care, and contractor specific value-added services.

The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer the KanCare program. KDHE maintains financial management and contract oversight as the single state Medicaid agency, while KDADS administers the Medicaid waiver programs for disability services, mental health, and substance abuse; and operates the state hospitals and institutions. Additionally, Kansas contracts with three managed care organizations (MCOs) to coordinate health care for nearly all Medicaid beneficiaries. The MCOs are Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (United).

Each Medicaid consumer in the state is enrolled with one of the KanCare health plans. Consumers have the option during open enrollment once a year to change to a different KanCare health plan if they wish to do so.

Types of Medicaid Waivers Approved by CMS

Sections 1115 and 1915 of the Social Security Act give the U.S. Secretary of Health and Human Services (HHS) authority to waive provisions of the law to encourage states to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). A state must apply for and receive approval from the Centers for Medicare and Medicaid Services (CMS) in order to operate a waiver. There are three primary types of waivers and demonstration projects: Section 1115 Research and Demonstration Projects, Section 1915(b) Managed Care Waivers, and Section 1915(c) Home and Community-Based Services Waivers. Additionally, states can apply to simultaneously implement two types of waivers through the Concurrent Section 1915(b) and 1915(c) waivers.

Section 1115 Research & Demonstration Projects

Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects. The purpose of these demonstrations is to give states additional flexibility to design and improve their Medicaid programs. These demonstrations can expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, provide services not typically covered by Medicaid, and use innovative service delivery systems that improve care, increase efficiency, and reduce costs.

CMS uses general criteria to determine whether Medicaid or CHIP program objectives are met.

These criteria include whether the demonstration will:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to service Medicaid and low-income populations in the state;
- Improve health outcomes for Medicaid and other low-income populations in the state; or
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

In general, Section 1115 demonstrations are approved for a five-year period and may be renewed typically for an additional three years. Demonstrations must be "budget neutral" to the federal government, which means that during the course of the project, federal Medicaid expenditures will not be more than federal spending without the waiver.

Currently, there are 29 states and the District of Columbia that have approved Section 1115 waivers with CMS. Those states are: Alabama, Arkansas, Colorado, Delaware, Florida, Hawaii, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Washington, Wisconsin, and Wyoming. Additionally, several states have Section 1115 waivers that are pending approval with CMS.

Section 1915(b) Managed Care Waivers

A Section 1915(b) waiver is necessary if a state would like to enter into managed care contracts because of the transfer of risk from the state to a MCO. Under the 1915(b) waiver, states have the following four options:

- 1915(b)(1): implement a managed care delivery system that restricts the types of providers people can use to get Medicaid benefits;
- 1915(b)(2): allow a county or local government to act as a choice counselor or enrollment broker in order to help people pick a manage care plan;
- 1915(b)(3): use the savings the state realizes from a managed care delivery system to provide additional services; and
- 1915(b)(4): restrict the number or type of providers who can provide specific Medicaid services (such as disease management or transportation).

Thus, the 1915(b) waivers allows the state to provide Medicaid services through managed care delivery systems, effectively limiting the consumer's choice of providers. The following states and the District of Columbia currently have Section 1915(b) waivers approved by CMS: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.

Section 1915(c) Home and Community Based Services Waivers

The Medicaid Home and Community Based Services (HCBS) waiver program is authorized under Section 1915(c) of the Social Security Act. Through the HCBS waiver, states can assist Medicaid beneficiaries by providing a wide range of services that permit individuals to live in their homes or communities and avoid institutionalization. Programs can provide a combination of standard medical services and non-medical services. Standard medical services include, but are not limited to: case management, home health aide, personal care, adult day health services, and respite care. States can propose other services that may assist in diverting or transitioning individuals from institutional settings to their homes or communities.

Currently, 47 states and the District of Columbia have 1915(c) waivers approved with CMS. The only states that currently do not have an approved

1915(c) waiver with CMS are Arizona, Rhode Island, and Vermont.

Medicaid Waivers in Kansas

Current Medicaid Waivers

KanCare allows the state to provide all HCBS through managed care. Currently, Kansas operates seven separate 1915(c) waivers alongside a 1115 waiver. The seven 1915(c) waivers are: Autism, Frail Elderly (FE), Intellectual and Developmental Disabilities (I/DD), Physical Disabilities (PD), Serious Emotional Disturbance (SED), Technology Assisted (TA), and Traumatic Brain Injury (TBI). Specific information for each of the seven 1915(c) waivers follows.

Autism

The Autism Waiver provides services to children from the time of diagnosis of Autism Spectrum Disorder (ASD), Asperger's Syndrome, or Pervasive Developmental Disorder–Not Otherwise Specified (PDD-NOS) until the child's sixth birthday. Autism services are limited to three years; however, an additional year may be submitted for approval. To qualify for an additional year of service, the child must meet eligibility based on the Level of Care assessment at the annual review on the third year of services and data collected by the Autism Specialist must document continued improvement.

To apply for the waiver, a parent or guardian must complete an application. The application contains two sections. Section 1 requests basic information about the child and the child's family. Section 2 requires the parent or guardian to indicate the screening tool used in the child's diagnosis. This section also requires documentation of Autism Spectrum diagnosis or a signature of a licensed medical doctor or psychologist. The completed application can be submitted one of three ways: faxed, hand delivered to a local KDADS office, or mailed.

In addition to submitting a completed application, the child must be financially eligible to participate in the waiver. Only the child's personal income and resources are considered; the parents' income and resources are not considered for this waiver. Additionally, any personal income of the child over $727 per month must be contributed toward the cost of care.

If a child meets the criteria for the waiver, the child will receive a letter from the Autism Program Manager informing him or her of placement on the Proposed Recipient List and of the numerical position on the list. When a position becomes available, the Program Manager contacts the family and offers them the potential position. There were 241 proposed recipients on the Proposed Recipient List as of August 31, 2015.

Once a child is referred by the Program Manager for assessment, the Functional Eligibility Specialist has five working days to schedule a home visit and complete a functional eligibility assessment to determine if the child meets the established criteria. If the child meets the criteria, the Functional Eligibility Specialist assists the family in completing a Medicaid application and referring them to an Autism Specialist. The Autism Specialist then has five working days to contact the family and begin the development of the Individualized Behavioral Plan or Plan of Care.

The waiver allows individuals to receive early intensive intervention treatment and allows primary caregivers to receive needed support through respite services. Services and supports provided under this waiver include intensive individual supports, respite care, consultative clinical and therapeutic services, family adjustment counseling, interpersonal communication therapy, and parent support and training (peer-to-peer). As of September 16, 2015, there were 61 individuals eligible to receive services under this waiver.

Frail Elderly

The Home and Community Based Services Frail Elderly (HCBS/FE) Waiver provides home and community-based services to Kansas seniors as an alternative to nursing facility care. The waiver serves those individuals 65 and older who choose HCBS and are functionally eligible for nursing

facility care. The individual's personal income and resources are considered when determining eligibility for the waiver. Income over $727 per month must be contributed toward the cost of care.

An individual is required to reach out to the local Aging and Disability Resource Center (ADRC) if interested in the HCBS/FE waiver. The ADRC can conduct the functional assessment needed to determine eligibility for the program, as well as provide community and state options for services. If the individual selects HCBS/FE services, the ADRC will send notification to the Department for Children and Families (DCF) to process a Medicaid application. During the Medicaid application process, the individual selects the Managed Care Organization (MCO) of his or her choice or a MCO is assigned if the individual does not select a particular MCO. The MCO will then assign a Care Coordinator to the consumer. The Care Coordinator meets with the consumer and develops the Plan of Care to establish the number of hours for services required to meet the individual's needs. The Care Coordinator can assist with locating providers in the individual's area if assistance is needed.

Services and supports included under the HCBS/FE Waiver are: adult day care, assistive technology, attendant care, comprehensive support, financial management, medication reminder, nursing evaluation visit, oral health, personal emergency response, sleep cycle support, and wellness monitoring. As of September 16, 2015, there were 5,068 individuals eligible to receive services without the Money Follows the Person (MFP) program, and 53 individuals eligible under the MFP program. The MFP program is a federal demonstration grant given to help individuals currently living in institution settings to choose to transition into community-based services. Individuals must qualify for Medicaid and also qualify for either the HCBS/FE, HCBS/PD, HCBS/I/DD, or TBI waivers to participate in the program.

Intellectual and Developmental Disability

The Home and Community Based Services Intellectual and Development Disability (HCBS I/DD) Waiver provides services to individuals 5 years of age and older with intellectual disabilities and developmental disabilities. To qualify for this waiver, the individual must meet the definition of intellectual disability, have a developmental disability, or be eligible for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). Only the individual's personal income and resources are considered. For individuals under the age of 18, parents' income and resources are not counted. However, personal income over $727 per month must be contributed to the cost of care.

The point of entry into the HCBS I/DD Waiver is an individual's local Community Developmental Disability Organization (CDDO). The CDDO will help determine the individual's eligibility and will work with the person and his or her family to access services. As of September 16, 2015, there were 3,332 individuals on the HCBS I/DD waiting list.

Services and supports under the HCBS I/DD Waiver can include day support, overnight respite care, personal assistant, residual supports, supported employment, assistive services, medical alert, sleep cycle support, specialized medical care, and supportive home care. As of September 16, 2015, there were 8,753 individuals eligible to receive services without the MFP program, and 33 individuals eligible under the MFP program.

Physically Disabled

The Home and Community Based Services Physically Disabled (HCBS/PD) Waiver provides services to individuals who are at least 16 years of age, and no older than 65 years. The individual must be determined disabled by the Social Security Administration, needs assistance to perform normal rhythm of the day, and meet the Medicaid nursing facility threshold. To qualify for this waiver, only the individual's personal income and resources will be considered. If the individual is under age 18, the parents' income and resources will not be considered. However, personal income over $727 per month must be contributed toward the cost of care.

The point of entry for the HCBS/PD Waiver is an individual's local ADRC. As of September 16,

2015, there were 1,769 individuals on the HCBS/PD waiting list. The following services and supports can be provided under the HCBS/PD Waiver as long as those services are approved by the MCO: personal services, assistive services, sleep cycle support, and Personal Emergency Response Systems (PERS) and installation. As of September 16, 2015, there were 5,480 individuals eligible to receive services without the MFP program, and 160 individuals eligible under the MFP program.

Serious Emotional Disturbance

This Serious Emotional Disturbance (SED) Waiver provides services to individuals ages 4-21 who are experiencing a serious emotional disturbance. The State of Kansas no longer accepts children and youth into its state mental health hospital. If a family should choose an inpatient psychiatric facility rather than HCBS, the state will enter into a contract with an out-of-state provider to provide services for that child or youth. The waiver provides for the traditional Medicaid financial criteria to be waived and for children to be assessed for Medicaid financial eligibility based solely on the child's income and resources and not that of the household.

The Community Mental Health Center (CMHC) serves as the functional assessor for the SED Waiver. Services and supports under this waiver include attendant care, independent living and skills building, short-term respite care, parent support and training, professional resource family care and wraparound facilitation. As of September 16, 2015, there were 2,934 individuals eligible to receive services under this waiver.

Technology Assisted

The Technology Assisted (TA) Waiver provides services for children under the age of 21 who are chronically ill or medically fragile and dependent on intensive technology. The individual is determined TA program eligible if he or she is 0-21 years of age, meets the definition of medical fragility, requires the use of primary medical technology on a daily basis (*i.e.* a ventilator, Trach, G-tube feeding), and meets the medical and nursing acuity threshold for the specified age group. Only the individual's personal income and resources are considered. The parents' personal income and resources are not counted for eligibility purposes but are counted for the purpose of determining a family participation fee.

Private agencies serve as the point of entry to the TA Waiver. Services and supports under this waiver can include financial management services, health maintenance monitoring, intermittent intensive medical care service, specialized medical care, long-term community care attendant, medical respite care, and home modification services. As of September 16, 2015, there were 446 individuals eligible to receive services under this waiver.

Traumatic Brain Injury

The Traumatic Brain Injury (TBI) Waiver provides services to individuals ages 16-65 who have sustained a traumatic non-degenerative brain injury resulting in residual deficits and disabilities. The TBI Waiver is not considered a long-term care program and is designed to be a rehabilitative program. The brain injury must be traumatically-acquired, *i.e.* caused by an external physical force. The common injuries resulting in trauma to the brain include, but are not limited to: falls, which involve a forceful blow to the head, not generally consistent with concussion or minor injury; motor vehicle accidents with resulting head trauma; struck by or against, including collision with a moving or stationary object; and assaults involving repeated blows to the brain.

Thus, in order to qualify for the waiver, the individual must have a traumatic brain injury, be 16 to 65 of age, meet the criteria for TBI rehabilitation hospital placement (which is determined by the screening), and meet the financial guidelines to qualify for Medicaid. Only the individual's personal income and resources are considered for eligibility. For individuals under the age of 18, parents' income and resources are not counted toward eligibility. Personal income over $727 must be contributed toward the cost of care.

The individual's local ADRC is the point of entry to the TBI program. Services and supports

under this waiver may include personal services, assistive services, rehabilitation, home delivered meals, medication reminder, and transitional living skills. As of September 16, 2015, there were 504 individuals eligible to receive services without the MFP program, and 11 individuals eligible under the MFP program.

Current Proposal — Waiver Integration

The State of Kansas is seeking to fully integrate the seven 1915(c) waivers into the 1115 waiver. Entrance to HCBS will remain the same, but services will fall into two broader categories: Children's Services and Adults' Services. The new integrated waiver would be called KanCare CommunityCare and, if approved by CMS, would begin on January 1, 2017.

KDHE and KDADS officials indicate state waiver integration is intended to create parity for the populations served through HCBS and offer a broader array of services to individuals participating in the KanCare program. The core features of waiver integration include: eligibility requirements and processes will remain the same, children will continue to be entitled to all medically necessary services identified through Early Periodic Screening Diagnosis and Treatment (EPSDT), all members will continue to be entitled to medically necessary state plan services that are part of KanCare, and services will be authorized through personalized plans of care.

For more information, please contact:

Whitney Howard, Research Analyst
Whitney.Howard@klrd.ks.gov

Amy Deckard, Assistant Director for Information Management
Amy.Deckard@klrd.ks.gov

Iraida Orr, Principal Research Analyst
Iraida.Orr@klrd.ks.gov

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181
Fax: (785) 296-3824