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Health and Social Services

F-3 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 federal 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 U.S. Supreme Court. 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 October 7, 2016, 25 states and the District of Columbia have expanded Medicaid, six states currently are implementing expansion alternatives, and 19 states have not participated in expansion.

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 415,000 Kansans. Some of the services provided under KanCare include: doctor's office visits and hospital care, behavioral health services, dental and vision care, medicine, non-emergency medical transportation, nursing facility services, weight-loss surgery, 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., Sunflower State Health Plan, and UnitedHealthcare Community Plan of Kansas.

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 four primary types of waivers and demonstration projects: Section 1115 Research and Demonstration Projects, Section 1915(b) Managed Care Waivers, Section 1915(c) Home and Community Based Services Waivers, and 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 can be renewed typically for an additional three years. Demonstrations must be "budget neutral" to the federal government, which means during the

course of the project, federal Medicaid expenditures cannot be more than federal spending without the waiver.

Currently, there are 26 states and the District of Columbia that have approved Section 1115 waivers with CMS. Those states are: Alabama, Arkansas, Arizona, California, Colorado, Delaware, Florida, Hawaii, Iowa, Kansas, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Pennsylvania, Utah, Virginia, Washington, Wisconsin, and Wyoming. Additionally, several states have Section 1115 waivers that are pending approval with CMS.

Section 1915(b) Managed Care Waivers

Section 1915(b) waivers are one of several options available to states that allow the use of managed care in the Medicaid program. 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. Currently, there are 35 states and the District of Columbia that have approved Section 1915(b) waivers with CMS. Those states are: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

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.

Concurrent Section 1915(b) and 1915(c) Waivers

States can apply to simultaneously implement 1915 (b) and 1915(c) waivers to provide a continuum of services to the elderly and the disabled, as long as the federal requirements for both programs are met.

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).

To participate in a 1915(c) waiver, the individual requiring services must be financially and functional eligible for Medicaid. Individuals with income above $747.00 a month must share in the cost of care, called the "client obligation." The client obligation is paid to a medical provider, not to the State of Kansas or to a KanCare MCO. Additional 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, Asperger's Syndrome, or Pervasive Developmental Disorder–Not Otherwise Specified 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 an Autism 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.

The Autism Program Manager prescreens for the Autism diagnosis and places the child on the Proposed Recipient List. As of August 31, 2016, there were 283 children on the Proposed Recipient List. Once a position becomes available, the Program Manager sends a referral to KVC, a contractor, to conduct the functional eligibility determination and communicate program eligibility to KDHE. As of September 13, 2016, there were 62 children eligible to receive services under this waiver.

The waiver allows children to receive early intensive intervention treatment and allows primary caregivers to receive needed support through respite services. Kansas received direction from CMS to move three services from the Autism Waiver to the Medicaid State Plan Amendment. These services are: consultative clinical and therapeutic services (Autism Specialist), intensive individual supports, and interpersonal communication therapy. The three services that will continue to be part of the Autism Waiver are: respite care, family adjustment counseling, and parent support and training. The Autism Waiver and State Plan Amendments will be submitted to CMS for approval.

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 functional eligibility assessment is conducted by the local Aging and Disability Resource Center (ADRC). There are 11 ADRCs in the state. Program eligibility is determined by the Vineland functional assessment, and the individual must meet the Level of Care criteria.

Services and supports included under the HCBS/FE Waiver are: adult day care, assistive technology, attendant care services, nursing evaluation visit, personal emergency response, sleep cycle support, medication reminder, oral health services, and comprehensive support and wellness monitoring. Assistive technology, comprehensive support, oral health, and sleep cycle support are only available if a crisis exception is met. These services are based upon a consumer's need, which is determined by the consumer and a care coordinator.

As of September 13, 2016, there were 5,142 individuals eligible to receive services without the Money Follows the Person (MFP) program and 64 individuals eligible under the MFP program.

The MFP program is a federal demonstration grant given to help individuals currently living in institutional 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 five 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.

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. The Program Manager provides final approval of program eligibility. As of September 13, 2016, there were 3,488 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 care service, supported employment, assistive services, medical alert, sleep cycle support, specialized medical care, and supportive home care. As of September 13, 2016, there were 8,979 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, need assistance to perform normal rhythm of the day, and meet the Medicaid nursing facility threshold.

The point of entry for the HCBS/PD Waiver is an individual's local ADRC. The Program Manager provides final approval of program eligibility. As of September 13, 2016, there were 177 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 and installation. As of September 13, 2016, 6,101 individuals were eligible to receive services without the MFP program and 155 individuals were eligible under the MFP program.

Serious Emotional Disturbance

This Serious Emotional Disturbance (SED) Waiver provides services to individuals ages 4-18 who are experiencing a serious emotional disturbance. An age exception for clinical eligibility may be requested for participants under the age of 4 and over the age of 18 through the age of 21. The waiver is designed to divert the individual from psychiatric hospitalization to intensive home and community-based supportive services.

The local Community Mental Health Center serves as the functional assessor for the SED Waiver. A small portion of the costs for services may be billed to parents and guardians by the State of Kansas, based upon available resources. A child cannot be denied services or be removed from the SED Waiver because of nonpayment of the Partial Parent Fee. 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 13, 2016, there were 3,522 individuals eligible to receive services under this waiver.

Technology Assisted

The Technology Assisted (TA) Waiver provides services for children through 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.* 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.

The Children's Resource Connection conducts the functional eligibility assessment. Program eligibility is determined utilizing the Medical Assistive Technology Level of Care instrument. 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 13, 2016, there were 463 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 brain injury. The TBI Waiver is a short-term rehabilitative program. A consumer may receive services for up to four years, as long as the consumer continues to make progress in his or her rehabilitation and transitional living skills.

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. If a traumatic brain injury is obtained prior to the age of 21, the individual may be considered developmentally disabled and will be referred to the CDDO prior to a TBI screening.

The individual's local ADRC completes the functional eligibility assessment. The Program Manager provides final approval of program eligibility. Services and supports under this waiver may include personal services, assistive services, rehabilitation therapies, home delivered meals, medication reminder, and transitional living skills. As of September 13, 2016, there were 461 individuals eligible to receive services without the MFP program and 8 individuals eligible under the MFP program.

Waiver Integration

In the summer of 2015, KDHE and KDADS announced a plan to fully integrate the seven 1915(c) waivers into the 1115 waiver. Under this waiver integration plan, entrance to HCBS would remain the same, but services would fall into two broader categories: Children's Services and Adults' Services. The new integrated waiver would be called KanCare Community Care. KDHE and KDADS planned for this waiver integration to begin on January 1, 2017, if approved by CMS.

KDHE and KDADS held public information sessions and stakeholder workgroups regarding the planned integration and continued forward with the proposal. However, the House Committee on Health and Human Services (House Committee) appointed a subcommittee to study the issue during the 2016 Legislative Session. The subcommittee issued a report, proposing a bill to be considered by the House Committee requiring legislative approval of waiver integration and prohibiting implementation of waiver integration prior to January 1, 2018. The subcommittee also recommended KDHE report on the status of waiver integration planning to the Legislature in January 2017 and March 2017.

HB 2682 was introduced in the House Committee. The bill would have prohibited any state agency from making any changes to waiver services without express legislative authorization. The bill was heard by the House Committee, but died in that Committee. However, in the 2016 omnibus appropriations bill, House Sub. for SB 249, language was added directing no expenditures could be made during FY 2016 and FY 2017 to proceed with waiver integration if the proposed

integration was planned to occur prior to FY 2019. Additionally, the proviso required status reports on integration to the Legislature during FY 2017. Due to this legislative directive, KDHE and KDADS have suspended work on the waiver integration proposal for now.

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