

Kansas Medicaid: A Primer

2014

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&
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Department





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Medicaid in Kansas A Timeline

1965



Medicaid enacted
into law with Medicare.

AUTHORS

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This report, *Kansas Medicaid: A Primer 2014*, was produced through a partnership of the Kansas Health Institute (KHI) and the Kansas Legislative Research Department (KLRD).

KHI is a nonprofit, nonpartisan, independent health policy and research organization based in Topeka. Established in 1995 with a multiyear grant from the Kansas Health Foundation, KHI conducts research and policy analysis on issues that affect the health of Kansans.

KLRD is a nonpartisan government agency that provides support services to the Kansas Legislature. Since 1934, KLRD has provided nonpartisan, objective research and fiscal analysis.

ABOUT THIS REPORT

Medicaid and the Children's Health Insurance Program (CHIP) play a substantial role in the Kansas health care system by providing health and long-term care coverage to the state's most vulnerable populations. In 2013, the state significantly changed the way Medicaid and CHIP services are administered and delivered in Kansas through a new initiative called KanCare. In addition, federal health policy changes in the Affordable Care Act (ACA) affect Kansas Medicaid and CHIP. As part of the ACA changes, legislators and state officials must decide whether to expand the Kansas Medicaid program to include more adults.

At this critical time of new state and federal initiatives, KHI and KLRD are pleased to provide basic facts and objective information about Medicaid and CHIP in Kansas. This report, *Kansas Medicaid: A Primer 2014*, includes an overview of Medicaid and CHIP, an analysis of recent trends and basic information about the covered services and populations.

Kansas Medicaid: A Primer 2014 is the third edition of this information, following 2005 and 2009 versions. Unless otherwise noted, data in this report were provided by the Kansas Department of Health and Environment through its publicly available *Medical Assistance Report*. This report, *Kansas Medicaid: A Primer 2014*, includes information from state fiscal year 2012 (FY 2012) and earlier, prior to implementation of KanCare. The shift to KanCare changes the way the state collects and reports data. In addition to providing an updated look at Medicaid and CHIP in Kansas, this report establishes a baseline for the KanCare program.

We hope this information contributes to a better understanding of Medicaid and CHIP among Kansas policymakers, policy analysts and interested consumers, and also enhances dialogue and decision-making about the programs.

1967



Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements added for all Medicaid children.

1972



Federal law required states to cover elderly and people with disabilities receiving SSI.

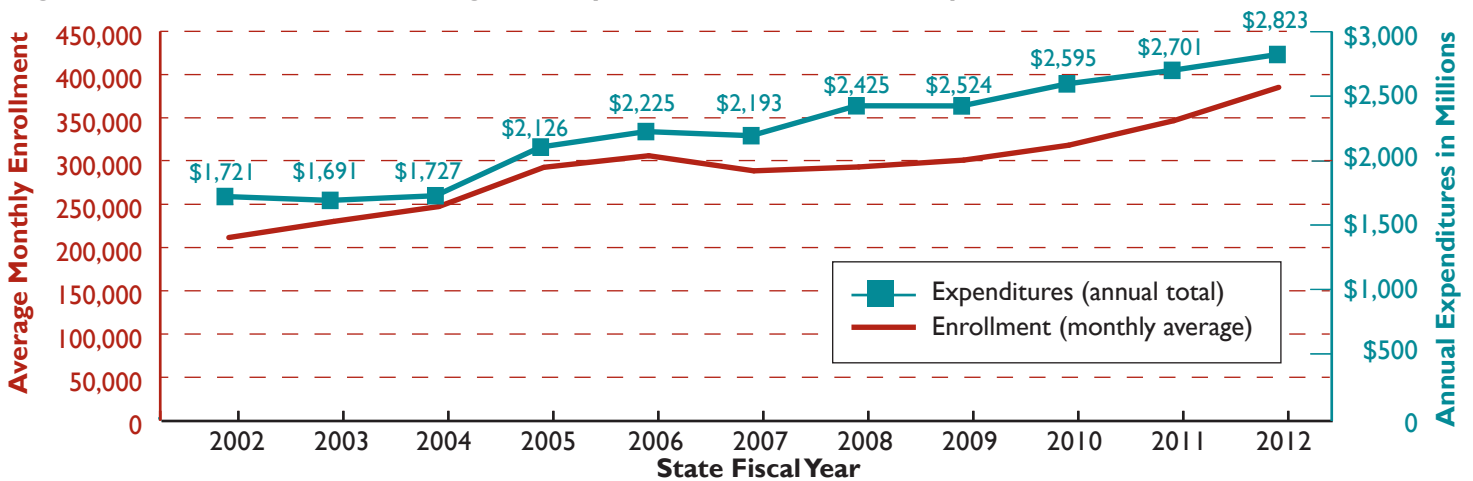
INTRODUCTION TO MEDICAID

Medicaid is a publicly financed source of health insurance and long-term care coverage for certain eligible population groups. It is the second-largest source of health coverage in the nation, following employment-based coverage. In state fiscal year 2012 (FY 2012), Medicaid in Kansas and the related Children’s Health Insurance Program

(CHIP) were estimated to cover more than 385,000 Kansans at a cost of almost \$3 billion, as shown in Figure I. Medicaid provides health care coverage to low-income dependent children, very low-income parents, certain pregnant women, some people with disabilities, low-income seniors and some individuals with specific health conditions. CHIP provides similar coverage to uninsured low-income children who are not eligible for Medicaid.

Medicaid is a partnership between the state and federal governments that has a significant impact on the Kansas economy. In federal fiscal year 2011 (FFY 2011), the federal government spent more than \$264 billion on the program nationally.¹ The federal government contributed approximately \$1.30 for every dollar of state Medicaid spending in Kansas during FY 2013.² The rate of this match varies year to year and from

Figure I. Medicaid and CHIP: Average Monthly Enrollment and Annual Expenditures



Notes: The number of beneficiaries is represented by the average monthly enrollment for the state fiscal year. All Medicaid and CHIP beneficiaries are included.

Expenditures include total state and federal spending for the state fiscal year.

Source: KHI Analysis of Kansas Medical Assistance Report, 2012, from the Division of Health Care Finance, Kansas Department of Health and Environment.

1972



All states except Arizona participated in Medicaid.

1981



Omnibus Budget Reconciliation Act of 1981 (OBRA-81) allowed states to make Disproportionate Share (DSH) payments to hospitals serving a large number of Medicaid or uninsured patients.

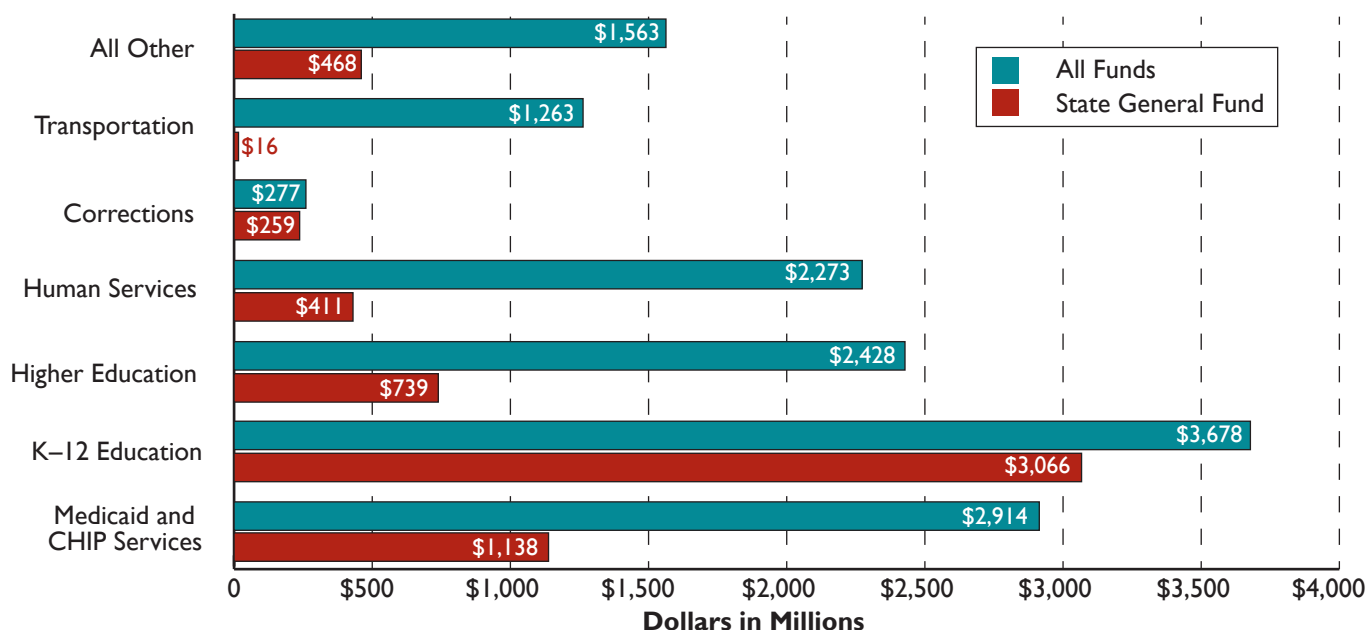
state to state, and generally is higher in poorer states. In Kansas, Medicaid and CHIP account for 18.7 percent of the state budget (State General Fund only) and represent a significant portion of total spending on health care services.³ In FY 2012, the state spent more money only on K–12 education, as shown in Figure 2.

Medicaid History

Medicaid was enacted in 1965, at the same time as Medicare, with the passage of Title XIX of the Social Security Act under President Lyndon Johnson’s administration. But it was two decades earlier, in 1945, when President Harry S. Truman began to discuss the creation of the program

by requesting the establishment of a national health care system. What followed was 20 years of debate over the potential perils of socialized medicine. As part of the goals related to the creation of the “Great Society,” President Johnson signed Medicare and Medicaid into law on July 30, 1965.

Figure 2: Medicaid and CHIP Spending Compared With All Categories of State Spending, State FY 2012



Note: Total Medicaid and CHIP expenditures vary slightly from the expenditure reported in Figure 1. Figure 2 relies on actual expenditures reported in the FY 2014 Governor’s Budget Report instead of the total reported in the Medical Assistance Report.

Source: KHI analysis of FY 2014 Governor’s Budget Report.

1981



States permitted to request home and community-based services long-term care services waivers (OBRA 1981).

1982



States allowed to charge premiums and co-payments, in nominal amounts, in Medicaid (Tax Equity and Fiscal Responsibility Act [TEFRA]).

State participation in Medicaid is voluntary, but all 50 states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands currently participate in the program. The Medicaid program in Kansas was administered on a county level until 1974, when the Department of Social and Rehabilitation Services was created.

The federal Balanced Budget Act of 1997 created CHIP as part of Title XXI of the Social Security Act in order to cover uninsured low-income children who are not eligible for Medicaid. CHIP was authorized by the Kansas Legislature in 1998 and implemented in Kansas in 1999.

As shown in the timeline on page 20, the Medicaid program has shifted

between several state agencies since 2005. Currently the Division of Health Care Finance (DHCF) within the Kansas Department of Health and Environment (KDHE) administers Medicaid and CHIP. DHCF establishes eligibility criteria, benefit packages, payment rates and program administration. The Kansas Department for Aging and Disability Services (KDADS) is responsible for

Figure 3. Difference between Medicaid and Medicare

MEDICAID	MEDICARE
<ul style="list-style-type: none"> • Provides health insurance for low-income children and some parents, seniors and individuals with disabilities. • Provides medical care and long-term care coverage. • Has eligibility rules based on income. • Receives state and federal funding. • Administered on a state level, within federal guidelines. 	<ul style="list-style-type: none"> • Provides health insurance for seniors 65 and older, and for some adults with disabilities. • Provides medical care coverage but very limited long-term care coverage. • Has no income limit for eligibility. • Receives federal funding collected by payroll deduction. • Administered on a federal level.

1986



Kansas implemented its first home and community-based services waiver (traumatic brain injury).

1990



Federal Medicaid rules required coverage for children ages 6–18 in families under 100 percent of FPL and created special low-income Medicare beneficiaries. Created prescription drug rebate program.

Medicaid mental health services and for Medicaid services for people with disabilities and seniors.

The Affordable Care Act, signed into law in March 2010, originally expanded state Medicaid programs to include adults with income under 138 percent of the federal poverty level (FPL) as of January 2014. A July 2012 Supreme Court decision made the Medicaid expansion under the ACA essentially optional for states.

In November 2011, Kansas Governor Sam Brownback announced significant structural and operational changes in the Kansas Medicaid

program. These changes, called KanCare, were designed to slow the growth of Medicaid costs and improve health outcomes by requiring nearly all 385,000 Kansans in Medicaid and CHIP to enroll in managed care plans.

KanCare fundamentally changes the way Medicaid in Kansas operates for both consumers and health care providers. KanCare also changes how information about Medicaid services and expenditures will be reported.

This report, *Kansas Medicaid: A Primer 2014*, relies on data from state FY 2012 and earlier, prior to the implementation of KanCare.

Unless otherwise noted, data have been compiled using KDHE *Medical Assistance Reports*. Throughout the document, changes related to KanCare are addressed where applicable.

MEDICAID AND CHIP SPENDING

In Kansas, about 17 percent of all Medicaid and CHIP enrollees have a disability, but this population incurs nearly 50 percent of total state expenditures for the Medicaid and CHIP programs, as shown in Figure 4. Children and families, including

KanCare

Under KanCare, Medicaid and CHIP spending is directed into managed care for most eligible groups, including children, pregnant women, low-income adults, most people with disabilities and people eligible for both Medicare and Medicaid. In KanCare, Medicaid and CHIP enrollees are automatically assigned to one of three managed care organizations (MCOs). The KanCare contracts require that the MCOs provide all services previously available through Medicaid. This includes prenatal care, well-child visits, preventive services, hospital care, in-home care, community-based services and nursing facility care. The MCOs also must ensure services are available statewide and at Medicaid-required levels.

1991



DSH payments capped and provider taxes and donations restricted.

1993



OBRA 1993 established national standards for preferred drug lists.

children in CHIP, account for approximately 72 percent of Medicaid and CHIP enrollees but represent about 27 percent of the state expenditures for the programs.

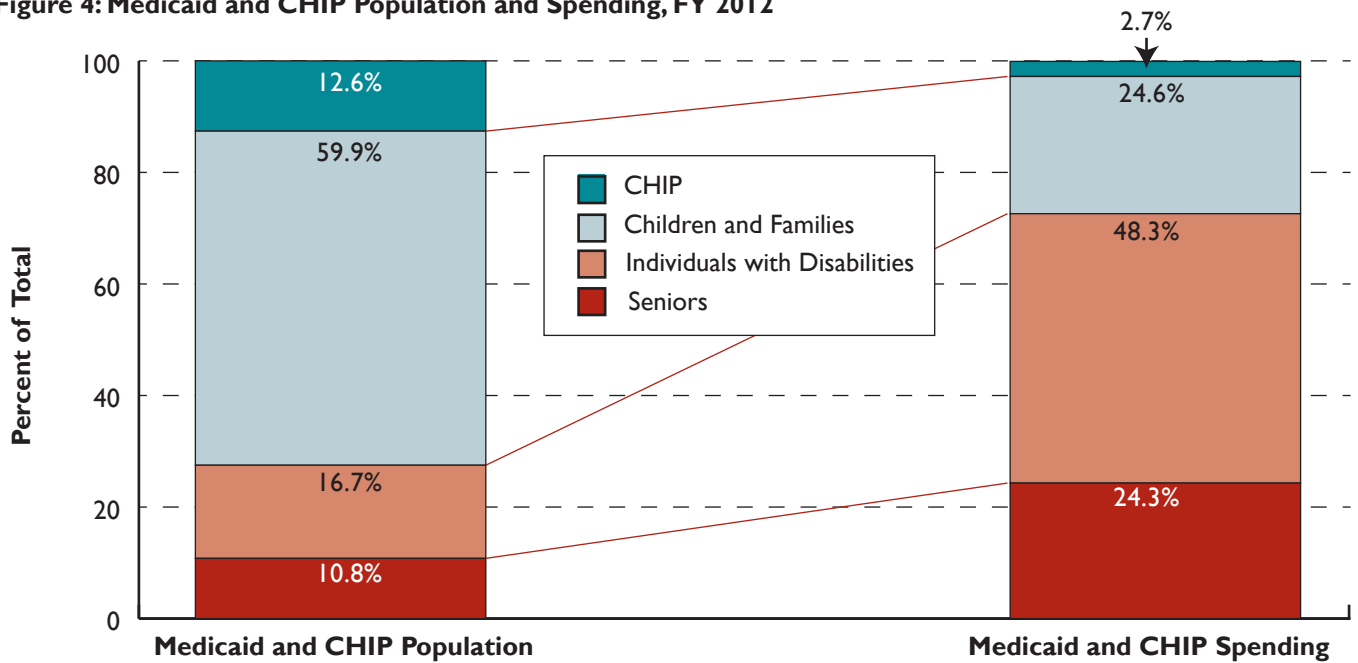
Annual Medicaid and CHIP spending in Kansas averaged about \$2,800 per pregnant woman, child or family member in FY 2012, compared to about \$19,500 per enrollee with a

disability and \$15,250 per senior enrollee. These differences reflect the higher utilization of medical care services and long-term care services by seniors and Kansans with disabilities. Services for these populations tend to be far more costly than routine health and preventive services that children and parents generally require. Medical

care for seniors and individuals with disabilities typically includes doctor visits, hospitalization, durable medical equipment, prescription drugs, home health services and nursing facility care. (Appendix B contains a list of mandatory and optional services covered by Medicaid in Kansas.)

In Kansas, the rate of growth in Medicaid spending has been slower

Figure 4: Medicaid and CHIP Population and Spending, FY 2012



Note: Numbers and expenditures do not include the following populations: foster care/adoption, refugees, special tuberculosis, breast and cervical cancer, the Sixth Budget Reconciliation Act (SOBRA) program and AIDS Drug Assistance Program.

Source: KHI analysis of Kansas Medical Assistance Report, 2012, from the Division of Health Care Finance, Kansas Department of Health and Environment.

1996



Personal Responsibility and Work Opportunity Act (PRWOA) separated cash assistance and Medicaid eligibility.

1997



State Children's Health Insurance Program (Title XXI) established in the Balanced Budget Act (BBA 1997).

than in most states, as shown in Figure 5. Kansas ranks near the bottom, 42nd, in the percent of the state population that is enrolled in Medicaid. Because very few non-disabled adults younger than 65 are eligible for Medicaid in Kansas, the state ranks near the bottom in Medicaid spending for this group.

Kansas spends a higher percentage of its Medicaid dollars on payments for individuals with disabilities and seniors.⁴

MEDICAID AND CHIP TRENDS

Enrollment growth for children and families, individuals with disabilities

and seniors in Kansas has steadily increased from state FY 2008 through FY 2012, as shown in Figure 6.

Children and families make up the largest share of enrollees in Kansas Medicaid, and their enrollment grew about 44 percent from FY 2008 to FY 2012. The ongoing economic recession resulted in an increased

Figure 5. Medicaid in Kansas Compared with Other States, Selected Spending and Enrollment Indicators

INDICATOR	KANSAS	UNITED STATES	KANSAS RANK COMPARED TO OTHER STATES ^A
Total Medicaid Spending, ^B FFY 2011 ^C	\$2,692,883,785	\$413,855,637,091 ^D	35th
Average Annual Growth in Medicaid Spending, FFY 2007–2010	4.5%	6.8%	47th
Medicaid Enrollment as a Percent of Total Population, FFY 2010	14%	21%	42nd
Distribution ^E of Medicaid Payments for Children, FFY 2010	21%	21%	30th
Distribution of Medicaid Payments for Non-Disabled Adults Age 19–64, FFY 2010	9%	15%	42nd
Distribution of Medicaid Payments for Individuals with Disabilities, FFY 2010	49%	42%	7th
Distribution of Medicaid Payments for Seniors, FFY 2010	22%	22%	22nd

- Notes: A. Rankings reflect Kansas' position compared with all 50 states and Washington, D.C. In each case, the state ranked as first has the highest value (i.e., highest spending, growth or distribution) and the state ranked as 51st has the lowest value.
 B. Medicaid spending differs significantly by state because the state populations and demographics differ significantly, as do state policies for Medicaid eligibility and services provided under Medicaid.
 C. The federal fiscal year (FFY) runs from Oct. 1 to Sept. 30. For example, FFY 2011 refers to the period from Oct. 1, 2010, to Sept. 30, 2011.
 D. Includes spending for all 50 states and Washington, D.C. It does not include the U.S. Territories. It also does not include administrative costs or accounting adjustments.
 E. Due to rounding, distribution of Medicaid payments does not add up to 100 percent.

Source: Kaiser State Health Facts, 2013.

1999



Kansas implemented SCHIP based on state law.

Kansas disbanded original managed care plan for SCHIP and awarded contract to FirstGuard.

share of Kansas children eligible for Medicaid — those living in families with incomes near the federal poverty level. The rate of children in poverty jumped from 15 percent in 2008 to a sustained rate of 18 percent in 2009 and 2010 before ticking up to 19 percent the next year.⁵ Beginning in 2009, the state was not able to process Medicaid

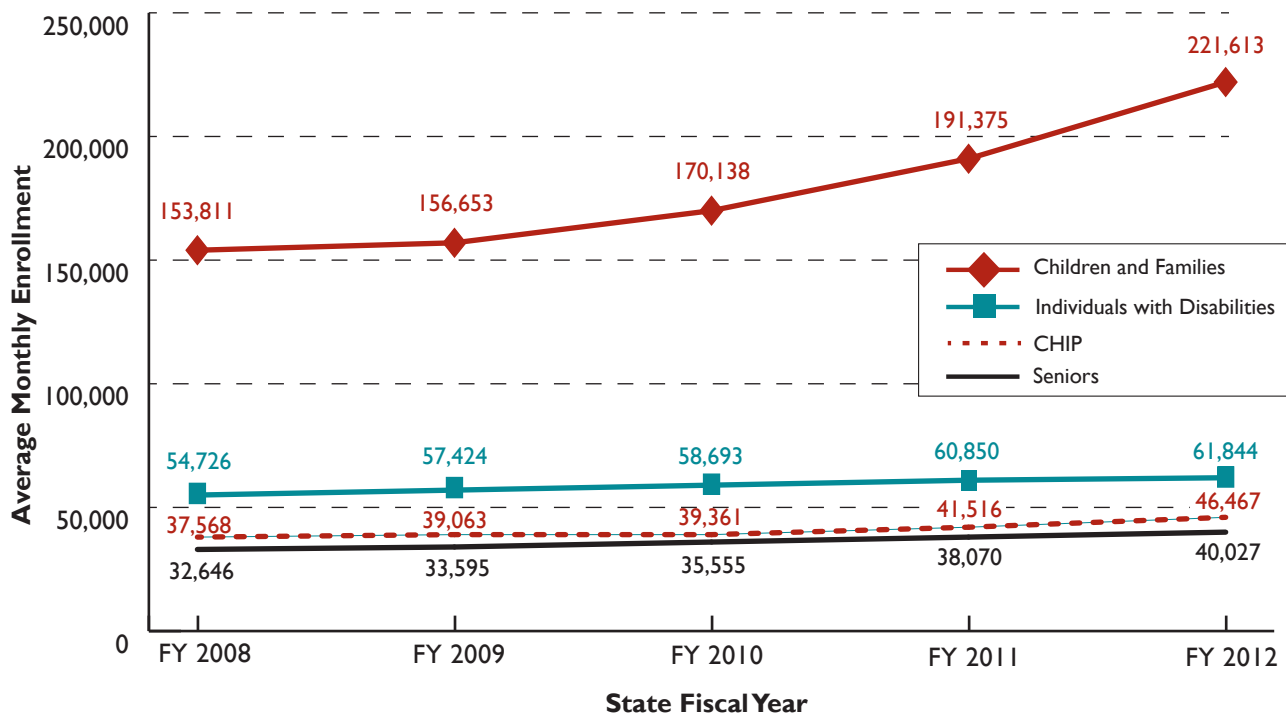
applications as quickly as it received them. This created a backlog of applications beginning with 2,000 applications pending longer than 30 days in April 2009,⁶ and rising to 14,000 unprocessed applications by June 2009.⁷ The state implemented a number of modifications in late 2010 to ease the backlog and simplify enrollment and renewals. The buildup

was cleared by March 2011, and an enrollment increase of children and families followed.

MEDICAID AND CHIP SERVICES

Kansas Medicaid and CHIP expenditures for services can be divided into two broad categories: medical care (about \$1.7 billion in FY

Figure 6. Enrollment Growth for Children and Families, Seniors, Individuals with Disabilities and CHIP, FY 2008–FY 2012



Note: Numbers and expenditures do not include the following populations: foster care/adoption, refugees, special tuberculosis, breast and cervical cancer, Sixth Omnibus Budget Reconciliation Act program (SOBRA) and AIDS Drug Assistance Program.

Source: KHI analysis of Kansas Medical Assistance Reports, 2008–2012, from the Division of Health Care Finance, Kansas Department of Health and Environment.

1999



U.S. Supreme Court ruled in *Olmstead v. L.C.* that states are required to provide community-based services when institutional care is appropriate.

Ticket to Work and Work Incentives Improvement Act allowed states to cover working people with disabilities up to 250 percent of FPL and charge income-based premiums.

2012) and long-term care (nearly \$1.1 billion in FY 2012), as shown in Figure 7.

Medical Care

In Kansas, spending on medical care includes a variety of physical health services as well as payments to managed care companies to coordinate medical care services. Overall, medical care services

represent about 62 percent of Medicaid and CHIP spending in FY 2012. Although many cost control measures have been implemented over the years, the cost of medical care services continues to rise — from about \$1.3 billion in FY 2008 to about \$1.7 billion in FY 2012, an increase of about 30 percent.

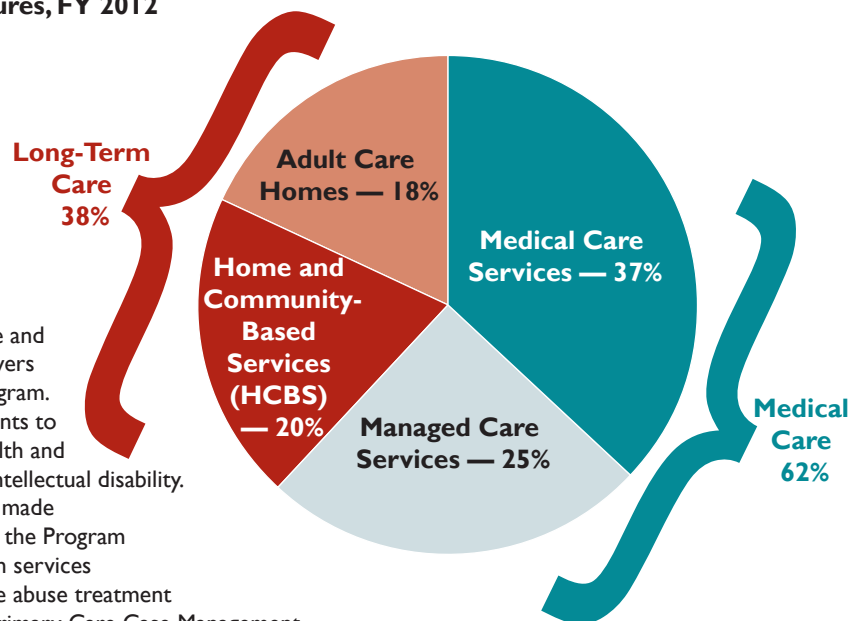
Medical Care Services: Medical care services under Medicaid and

CHIP include physician and hospital services, dental services, pharmacy and rehabilitation. The most costly of these services are inpatient and outpatient hospital care, followed by pharmacy expenditures, as shown in Figure 8.

Also included under the category of medical care services are payments to safety net providers. Current federal law requires that states make

Figure 7. Kansas Medicaid and CHIP Expenditures, FY 2012

Spending in Dollars (All Funds, FY 2012)	
Medical Care Services	— \$1,039,055,990
Managed Care	— \$ 700,328,376
Adult Care Homes	— \$ 514,990,019
HCBS	— \$ 568,778,401
Total	— \$2,823,152,786



Notes: **HCBS expenditures** include payments for home and community-based services (HCBS) through waivers and through the Money Follows the Person program.

Adult care home expenditures include payments to nursing facilities, nursing facilities for mental health and intermediate care facilities for individuals with intellectual disability.

Managed care expenditures include payments made to managed care organizations and payments for the Program of All-Inclusive Care for the Elderly, mental health services through Prepaid Inpatient Health Plans, substance abuse treatment through Prepaid Ambulatory Health Plans and Primary Care Case Management.

Medical care services expenditures include all other expenditures not accounted for in the HCBS, adult care home and managed care categories (such as physician and hospital services, dental, pharmacy, rehabilitation, etc.).

Source: KHI analysis of Kansas Medical Assistance Report, 2012, from the Division of Health Care Finance, Kansas Department of Health and Environment.

2003



Jobs and Growth Tax Relief Reconciliation Act raised all Medicaid matching rates by 2.95 percentage points from April 2003 through June 2004 as temporary fiscal relief to the states.

Medicare Prescription Drug, Improvement, and Modernization Act established a new prescription drug benefit for people over 65.

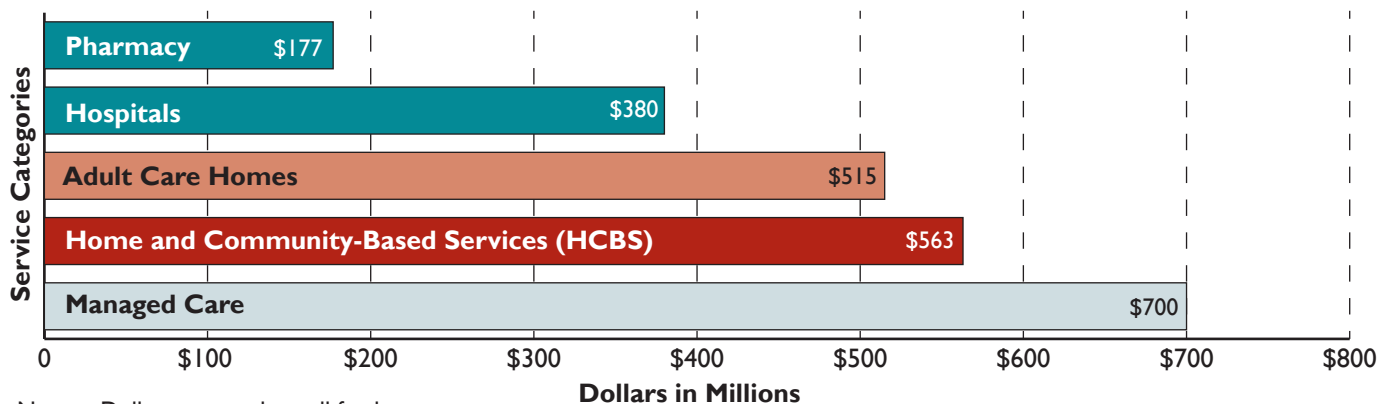
disproportionate-share payments to hospitals that serve large numbers of low-income and uninsured patients. This provision helps to support hospitals that provide substantial uncompensated care in addition to essential community services. Federal law also allows for enhanced provider reimbursements for services provided at safety net health clinics and rural health clinics.

Managed Care Services: In a managed care model, the state negotiates a capitated rate with managed care organizations (MCOs), and MCOs pay providers directly for covered services. Prior to the implementation of KanCare in 2013, nearly all managed care payments were for medical services. KanCare shifts nearly all populations and all services, including most long-term

care services, into managed care. KanCare excludes a small number of services and populations, such as the MediKan program, the AIDS Drug Assistance Program (ADAP) and several others. For a full list of the populations excluded from KanCare, see Appendix C.

For the most part, long-term care services were not covered through

Figure 8. Top Five Medicaid and CHIP Service Categories and Expenditures in Kansas, FY 2012



Notes: Dollars reported are all funds.

Hospital expenditures include both inpatient and outpatient hospital payments for direct care services but do not include disproportionate-share hospital payments.

Home and community-based services (HCBS) expenditures include payments for HCBS through waivers and through the Money Follows the Person program.

Adult care home expenditures include payments to nursing facilities, nursing facilities for mental health and intermediate care facilities for individuals with intellectual disability.

Managed care expenditures include payments made to managed care organizations and payments for the Program of All-Inclusive Care for the Elderly, mental health services through Prepaid Inpatient Health Plans, substance abuse treatment through Prepaid Ambulatory Health Plans and Primary Care Case Management.

Source: KHI analysis of Kansas Medical Assistance Report, 2012, from the Division of Health Care Finance, Kansas Department of Health and Environment.

2004



The Kansas Legislature passed the Hospital Provider Assessment Program.

2005



Kansas Health Policy Authority was created to run the Medicaid and State Employee Health Insurance Program.

managed care before 2013, and long-term care services for individuals with intellectual or developmental disabilities were not included in KanCare's first year. But in August 2013, the state requested the federal government's approval to provide long-term care services for individuals with intellectual or developmental disabilities in KanCare beginning on January 1, 2014.

Prior to KanCare, children and families received services through managed care. For seniors and individuals with disabilities, managed care preceding KanCare covered a limited number of services, such as the Program of All-Inclusive Care for the Elderly (PACE), mental health services through Prepaid Inpatient Health Plans, substance abuse treatment through Prepaid Ambulatory Health Plans and Primary Care Case Management.

Long-Term Care

Long-term care services include adult care home services and home and community-based services. They accounted for about 38 percent of total Medicaid and CHIP expenditures in FY 2012.

Adult Care Home Services:

Adult care home services include general nursing facilities, nursing facilities for mental health and intermediate care facilities for the mentally disabled. Adult care home expenditures increased from \$424.9 million in FY 2008 to \$515 million in FY 2012, which is an increase of about 21 percent. Nursing facility expenditures also increased significantly between FY 2010 and FY 2011, when the Kansas Legislature enacted a new nursing home provider tax. The tax generates about \$16.7 million annually, which includes \$9.2 million in federal Medicaid matching funds based on the FFY 2012 Medicaid match rate. The state has used the revenue to increase reimbursements to Medicaid nursing home providers.

Home and Community-Based Services: Medicaid provides a variety of long-term care services to support individuals in their home and community. For example, individuals who qualify may receive specialized medical care, case management or personal care services to assist them with daily activities such as bathing or taking medications. Medicaid beneficiaries who are

medically eligible for placement in an institutional setting may receive home and community-based services (HCBS), with the goal being for them to remain in a community setting. Nationally, the average cost for a Medicaid beneficiary with a disability to receive community-based care is less than half (about 45 percent) of the cost to receive institutional care.⁸

The state provides most HCBS through waivers. The federal government requires states to manage their Medicaid program within federal regulations, but waivers allow states to forgo certain Medicaid rules. For example, waivers allow states to institute waiting lists, something that is not allowed for the non-waiver Medicaid populations. In Kansas, the populations eligible for HCBS through waivers include:

- Individuals with physical disabilities;
- Individuals with developmental disabilities;
- Children with serious emotional disturbance;
- Individuals with traumatic brain injury;

2006



Deficit Reduction Act required verification of citizenship and identity for people applying for Medicaid.

Kansas converted dental services for CHIP from managed care to fee-for-service.

- Individuals eligible for frail-elderly services;
- Children who require technology-based assistance; and
- Children who have an early autism diagnosis.

In the private sector, administrative costs are about 12.4 percent of the premiums that consumers pay.¹⁰ Using the 2012 national average cost of \$15,745 for employment-based family coverage as estimated by the Kaiser Family Foundation,¹¹ administrative costs for a family health plan are about \$1,952 annually — more than twice the administrative cost of the Kansas Medicaid program.

Medicaid programs are required to provide coverage to all eligible individuals in certain population categories.

Medicaid eligibility is always based on income but also may depend on age, availability of financial resources and, in some cases, health care needs. For most Medicaid enrollees, income eligibility criteria are based on FPL guidelines, as shown in Figure 9 (page 12).

There are five main criteria of Medicaid eligibility: categorical,

Administrative Spending

Total Medicaid and CHIP administrative costs were \$154 million in FFY 2011, representing about 5 percent of all state Medicaid and CHIP expenditures and approximately \$408 per enrollee.⁹

MEDICAID POPULATIONS

As a federally designated “entitlement” program, state

Waivers and State Plan Amendments

Medicaid is administered on a state level, but must meet certain federal guidelines. For each state, the federal Centers for Medicare and Medicaid Services (CMS) approves a State Plan, which is a contract between the state and the federal government describing how that state administers its Medicaid program, what services it will cover, to what groups it will extend eligibility, and how much it will reimburse providers. There are two ways to make changes to the Medicaid state plan — by submitting a State Plan Amendment (SPA) or a waiver.

An SPA is used when the proposed change is in accordance with federal requirements, such as changing provider rates or eliminating or adding optional services. A waiver is used when a state wishes to make an exception to existing federal requirements.

Waivers for Home and Community-Based Services (HCBS) are the most common type of waiver in Medicaid. These waivers give states flexibility to provide additional services, like HCBS, that are not typically covered by Medicaid. States can provide these services to specific targeted groups only, and can limit the number of individuals the waiver will serve. An SPA differs from these waivers because an SPA does not allow targeting to specific populations or waiting lists.



Implementation of Medicare Part D shifted costs of prescription drugs for elderly Medicaid patients to the federal government.

Kansas moved mental health services for CHIP (HealthWave) to managed care.

income, resource, immigration status and residency. In order to qualify for Medicaid, an individual must qualify under *all five criteria*.

- **Categorical eligibility.** Four main categories of individuals are eligible for Medicaid or CHIP: children, parents and caregivers with children, people with disabilities and seniors.
- **Income eligibility.** Income thresholds pertain to each category of eligibility. For most Medicaid enrollees, income eligibility criteria are based on FPL guidelines.

- **Resource eligibility.** For seniors and individuals with disabilities, Medicaid places limits on resources such as income, cars, houses or savings accounts. An individual may be income or resource eligible by “spending down” funds on health care each month. Those eligible under these criteria are also known as “medically needy.”
- **Immigration status.** An individual must be a U.S. citizen or legal immigrant to receive Medicaid. Many legal immigrants must wait five years to be eligible for Medicaid benefits.

- **Residency.** An individual must establish residency in the state where they are requesting Medicaid. A person who lives in a state and intends to remain indefinitely is considered a resident, according to Medicaid rules.

Medicaid-eligible populations can be divided into two broad categories: **low-income children and families** and **low-income seniors and individuals with disabilities**. Because states have the flexibility to expand eligibility, the population covered varies greatly among the states. For more information about

Figure 9. HHS Poverty Guidelines (FPL) 48 Contiguous States and D.C. for 2013

PEOPLE IN FAMILY OR HOUSEHOLD	ANNUAL INCOME (100% OF FPL)
1	\$11,490
2	\$15,510
3	\$19,530
4	\$23,550
5	\$27,570
6	\$31,590
7	\$35,610
8	\$39,630
For each additional person per household, add:	\$4,020

Source: U.S. Department of Health and Human Services.

2007



Kansas implemented a limited dental benefit for Medicaid beneficiaries with disabilities based on new funding.

Kansas implemented the Working Healthy program, allowing people with disabilities to keep Medicaid support services while working.

populations that must be covered as required by federal law and the optional populations to whom Kansas has expanded coverage, see page 17.

Low-Income Children and Families

More than half of Medicaid enrollees are children and families (such as pregnant women or parents and caretakers). Children and families are relatively healthy and typically use

lower-cost medical services, such as checkups, vaccinations and treatment for minor illnesses and injuries.

Children: More children than adults are enrolled in Medicaid because they are eligible at a higher income level than adults, as shown in Figure 10 (page 14). In 2013, children under age 1 were eligible if their annual family income was less than 150 percent of FPL (\$35,325 for a family of four in 2013). Children age

1–5 were eligible for Medicaid if their annual family income was less than 133 percent of FPL (\$32,322 for a family of four in 2013). Children age 6–18 were eligible if their annual family income was less than 100 percent of FPL (\$23,550 for a family of four in 2013). CHIP extends coverage to children in families with higher income levels. (See page 19 for more information on CHIP.)

Medically Needy

The medically needy segment is comprised of people who meet the non-financial criteria of one of the categorically needy programs such as age or disability but do not qualify because of excess income or resources or, in the case of pregnant women and children, have income that exceeds the FPL guidelines of Medicaid or CHIP. Most people in the medically needy group are obligated to pay a share of their medical costs through the “spend down” process. Coverage of this group is optional under federal law. If a state chooses this option, it must cover pregnant women (including coverage of the 60-day postpartum period) and children. Kansas provides coverage for the following groups:

1. Pregnant women.
2. Children up to age 18 or age 18 and working toward attainment of a high school diploma or its equivalent.
3. People age 65 or older.
4. People who are disabled or blind under federal standards.

Medically needy coverage also may be provided to caretaker relatives of dependent children, but Kansas does not currently provide for this.

2007



Kansas implemented managed care for mental health and substance abuse services.

Kansas awarded HealthWave physical health contracts to Unicare and Children’s Mercy Family Health Partners.

Parents and Pregnant Women:

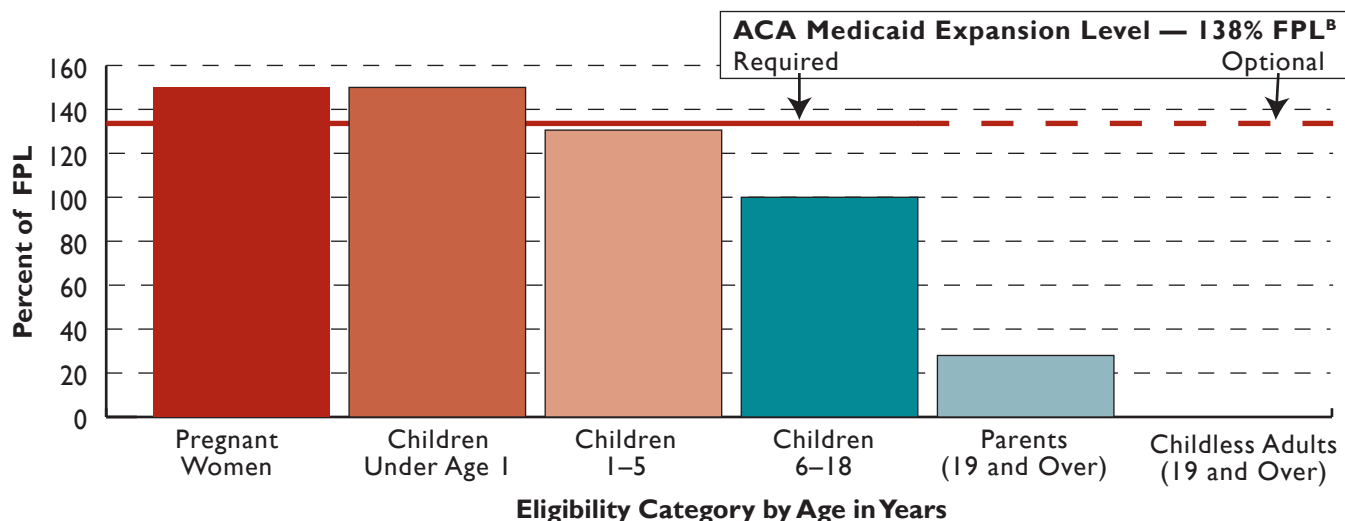
In 2013, parents with annual income of no more than \$7,000 for a family of four also were eligible for Medicaid. Parents above this annual income level were not eligible for Medicaid even though their children might have been covered. Adults who were not parents, pregnant, disabled or elderly were not eligible for Medicaid. Pregnant women and new mothers (up to 60 days postpartum) with incomes below 150 percent of FPL were eligible.

In 2014, all children in families with annual income under 138 percent of FPL, or about \$32,500 for a family of four, will be eligible for Medicaid through the ACA. States have the option to expand Medicaid to include low-income parents and adults without children, up to 138 percent of FPL, under the ACA. As of November 2013, Kansas officials had not yet decided whether to expand the program to cover these adults.

Low-Income Seniors and Individuals with Disabilities

Seniors and individuals with disabilities frequently have complex health needs that require costly services such as surgery, physical therapy, home and community-based care, nursing home care or end-of-life care. Generally, individuals must meet medical criteria to receive these services and cannot have resources or assets above a certain level in order to qualify for Medicaid. In

Figure 10: Income Eligibility Levels for Medicaid Children and Adults, 2013^A



- Notes: A. Income levels shown are only applicable to children and non-elderly adults without disabilities or other health needs that would make them eligible at a different income level.
- B. In 2014, all children in families with income under 138 percent of federal poverty level (FPL) will be eligible for Medicaid through the Affordable Care Act (ACA). States have the option to expand Medicaid to low-income parents and adults without children, up to 138 percent of FPL, under the ACA. Children in Kansas were eligible for CHIP up to 225 percent of FPL in 2013, above the ACA required expansion level for Medicaid.

Source: Eligibility information from the Division of Health Care Finance, Kansas Department of Health and Environment.

2008



Kansas implemented the Money Follows the Person demonstration project.

2009



Children's Health Insurance Program Reauthorization Act mandated states apply Medicaid managed care rules to the operation of CHIP managed care plans.

FY 2012, nearly 102,000 individuals with disabilities and seniors enrolled in Kansas Medicaid by meeting the criteria highlighted in this section and in Figure 11.

Individuals who receive Supplemental Security Income: Individuals who receive Supplemental Security Income (SSI) cash assistance are automatically eligible for Medicaid. Seniors must be at least age 65, meet citizenship requirements and

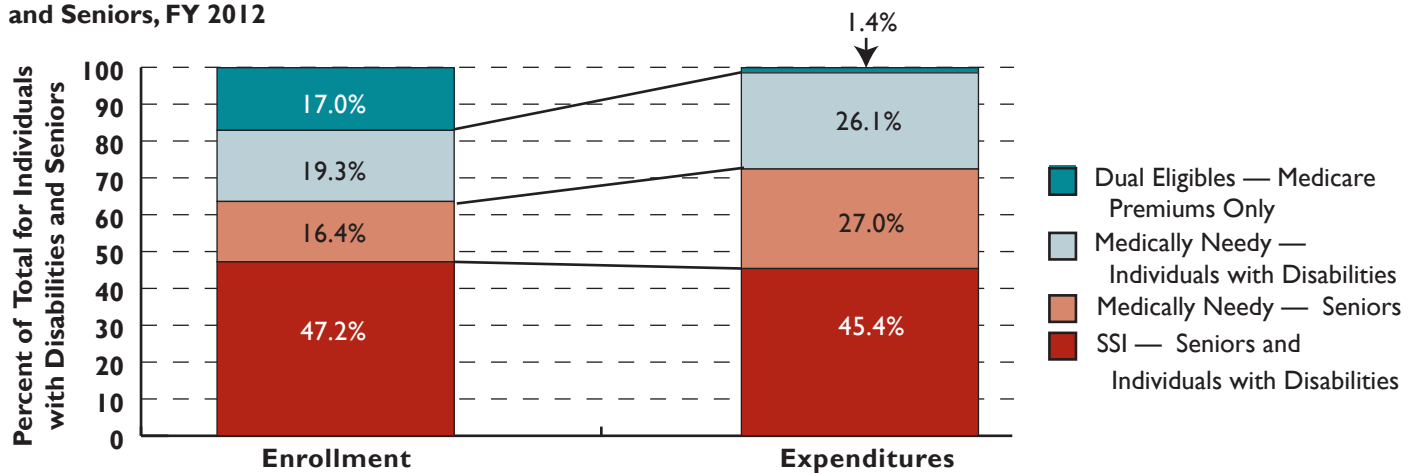
have limited income and resources to qualify for SSI. They also must be declared “disabled,” which means they have a medical condition that prevents them from working and is expected to last at least 12 months or result in death. Children who have a severe functional limitation also may qualify.

Medically Needy: Kansans who earn too much money to qualify for SSI may be eligible to “spend down”

some of their income on health care each month before they become eligible for Medicaid benefits through the medically needy program.

MediKan: It can take up to three years for the federal government to declare an individual “disabled” and begin to send payments to that individual. During the waiting period, a state program called MediKan covers their health expenses. In FY 2012, Kansas spent about \$6.5 million

Figure 11: Medicaid Average Monthly Enrollment and Total Expenditures for Individuals with Disabilities and Seniors, FY 2012



Notes: The percentages for enrollment and expenditures reflect the percentage of the total for these four categories of individuals with disabilities and seniors.

Not represented are individuals with disabilities who are enrolled in Medicaid through the MediKan or Working Healthy programs; these individuals account for about 2 percent of the total enrollment and less than 1 percent of the total expenditures for individuals with disabilities and seniors in Medicaid.

Supplemental Security Income (SSI) includes both individuals with disabilities and seniors. Because these individuals qualify for the SSI program, they are automatically eligible for Medicaid.

The percentages for “Dual Eligibles — Medicare Premiums Only” reflect dual eligibles who only receive assistance with Medicare premiums and cost sharing, and do not receive full Medicaid benefits. Dual eligibles who qualify for full Medicaid benefits, including long-term care and prescription drugs, are not included in this category.

Source: KHI analysis of Kansas Medical Assistance Report, 2012, Division of Health Care Finance, Kansas Department of Health and Environment.

2009



Kansas expanded CHIP to children up to 250 percent of the 2008 Federal Poverty Level.

American Recovery and Reinvestment Act (ARRA) increased the Medicaid federal matching percentage by 6.2 percent between October 2008 through December 2010.

to cover about 900 people on average per month in the MediKan program. This program is not eligible for federal matching dollars.

Working Healthy: The Working Healthy program offers Medicaid coverage to people age 16–64 with disabilities who are working. Income and resource limits apply but are higher than other Medicaid programs. Some people in this program must pay a premium for medical services, depending on their income. The Working Healthy program cost the state about \$7 million in FY 2012 to cover about 1,300 people on average per month.

Medicaid-Medicare Dual

Eligibility: About 17 percent of Kansas Medicaid beneficiaries have “dual eligibility” for both Medicare and Medicaid.¹² Medicaid provides assistance with copays, deductibles and long-term care services for low-income Medicare beneficiaries age 65 and older. In addition, individuals with disabilities who receive SSI automatically qualify for both Medicare and Medicaid.

Program of All-Inclusive Care for the Elderly (PACE): In eight counties, Kansans age 55 and older have the option to enroll in PACE, which provides long-term care through a managed care network for

eligible seniors. The program may be expanded in the future.

Other Medicaid Populations

About 3.5 percent of Medicaid beneficiaries and roughly 4 percent of total Medicaid spending are in other categories. For example, Medicaid pays for limited services for eligible individuals with breast cancer, cervical cancer, tuberculosis or AIDS. Medicaid also provides temporary coverage for those in the refugee assistance program and covers limited life-threatening emergency care costs and childbirth costs for some non-citizens. Some of these “other” populations are excluded

“Dual Eligibility”

Nearly all (92 percent) senior Medicaid beneficiaries also are enrolled in Medicare. Medicaid covers most health care costs for low-income seniors because Medicare does not cover long-term care services, such as nursing facility care.

In 2009, about 17 percent of Medicaid beneficiaries also were eligible for Medicare, and these “dual eligible” individuals accounted for 42 percent of state Medicaid spending. Kansas ranked 16th highest among all other states for spending on dual eligibles. For dual eligibles, 78 percent of the costs were for long-term care services.

Source: Kaiser State Health Facts. (2013). Dual Eligibles.

2010



Affordable Care Act was signed into law, including an expansion of Medicaid to all adults under 138 percent of the federal poverty level.

Kansas discontinued adult preventative dental services due to budget cuts.

from KanCare. For more information about the populations excluded from KanCare, see Appendix C.

In 2013, children who were in state-sponsored adoption assistance programs or foster care also were automatically eligible for Medicaid coverage until age 21. In 2014, the ACA will require that former foster care children remain eligible for Medicaid until age 26, provided they turned 18 while in foster care and

were enrolled in Medicaid at that time.

Mandatory and Optional Medicaid Populations

Until 1980, states did not have much latitude to provide Medicaid coverage to people beyond very low-income populations. Since then, states have been given more flexibility to expand coverage to “optional populations.” Figure 12 (page 18) shows populations that must be

covered as required by federal law and the optional populations to whom Kansas has expanded coverage.

A provision of the ACA requires states to maintain Medicaid and CHIP eligibility levels that were in place on March 23, 2010. The state cannot lower the eligibility level until 2014 for adults and until 2019 for children. States that violate these provisions risk losing federal Medicaid funding.

Medicaid was enacted in 1965, at the same time as Medicare, with the passage of Title XIX of the Social Security Act under President Lyndon Johnson’s administration.



President Lyndon B. Johnson flips pages of the bill as President Harry S. Truman holds up signing pens. Lady Bird Johnson, Vice President Hubert Humphrey, and Bess Truman are behind them. (LBJ Library photo).

2010



Governor Parkinson reduced Medicaid provider rates by 10 percent to meet budget allotments.

2011



Kansas shifted Medicaid Program administration to Kansas Department of Health and Environment.

Figure 12: Mandatory and Optional Medicaid Populations, 2013

MANDATORY POPULATIONS, REQUIRED MEDICAID COVERAGE BY FEDERAL LAW	OPTIONAL POPULATIONS, KANSAS-SPECIFIC MEDICAID COVERAGE (NOT REQUIRED BY FEDERAL LAW)
<ul style="list-style-type: none"> • Infants and children up to age 6 whose families earn less than 133 percent of FPL.^A • Children, age 6 and older, whose families earn less than 100 percent of FPL.^A • Parents whose income is below the state’s threshold to receive Temporary Assistance to Families (TAF), roughly 30 percent of FPL.^A • Pregnant women up to 133 percent of FPL. • Seniors and individuals with disabilities who receive Supplemental Security Income (SSI) with incomes at or below 74 percent of FPL. • Certain working individuals with disabilities. • Medicare buy-in groups: Qualified Medicare Beneficiaries (QMB), Special Low-Income Medicare Beneficiaries (SLMB) and Qualifying Individuals (QI). 	<p>Populations eligible through the following programs:</p> <ul style="list-style-type: none"> • MediKan • Working Healthy • Breast and Cervical Cancer Screening • AIDS Drug Assistance Program (ADAP) • Tuberculosis • Foster Care Aging Out^B <p>Kansas also extends Medicaid coverage to the following populations:</p> <ul style="list-style-type: none"> • Medically needy seniors, individuals with disabilities and pregnant women. • Pregnant women: Kansas extends coverage up to 150 percent of FPL. • Children: Kansas extends coverage to children under age 1 whose families earn less than 150 percent of FPL.

Note: The Children’s Health Insurance Program (CHIP) is not included in this chart; only Medicaid is included. There is no federal requirement to participate in CHIP. Kansas offered CHIP coverage for children in families with annual incomes up to 225 percent of federal poverty level (FPL) in 2013.

A. In 2014, states are required to cover all children under 138 percent of FPL as part of the Affordable Care Act (ACA). States may choose to expand coverage to adults (both parents and childless adults) up to 138 percent of FPL through the ACA. As of November 2013, Kansas had not yet decided if it would expand the Medicaid program to include adults up to 138 percent of FPL.

B. In 2014, the ACA requires Medicaid to cover former foster care children until they reach the age of 26, provided that they turned 18 while in foster care, and were enrolled in Medicaid at that time.

Source: Kansas Health Policy Authority. (April 26, 2010). *Medicaid Savings Options Presented to the Kansas Legislature: Revised and Updated.*

2012



Supreme Court ruled that the Medicaid expansion to low-income adults in the Affordable Care Act is constitutional but optional for states.

CHILDREN'S HEALTH INSURANCE PROGRAM

In Kansas, CHIP is available to children under age 19 in families with incomes below 225 percent of 2013 FPL (\$52,987 for a family of four). CHIP is designed to bridge

the gap between Medicaid and private insurance. In FY 2012, CHIP served a monthly average of nearly 49,000 Kansas children at an annual cost of about \$20.4 million to the state and \$48 million to the federal government. Medicaid for children

and CHIP are operated under KanCare, essentially giving two levels of coverage. Children who do not qualify for Medicaid, which has lower qualifying income levels, are screened for CHIP.

Federal CHIP Legislation

The Balanced Budget Act of 1997 created the CHIP program as part of Title XXI of the Social Security Act in order to cover uninsured low-income children who are not eligible for Medicaid. In February 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). As with Medicaid, the state receives matching funds from the federal government for the program. However, this matching arrangement differs from Medicaid in that it is a block grant and the federal match is greater than Medicaid.

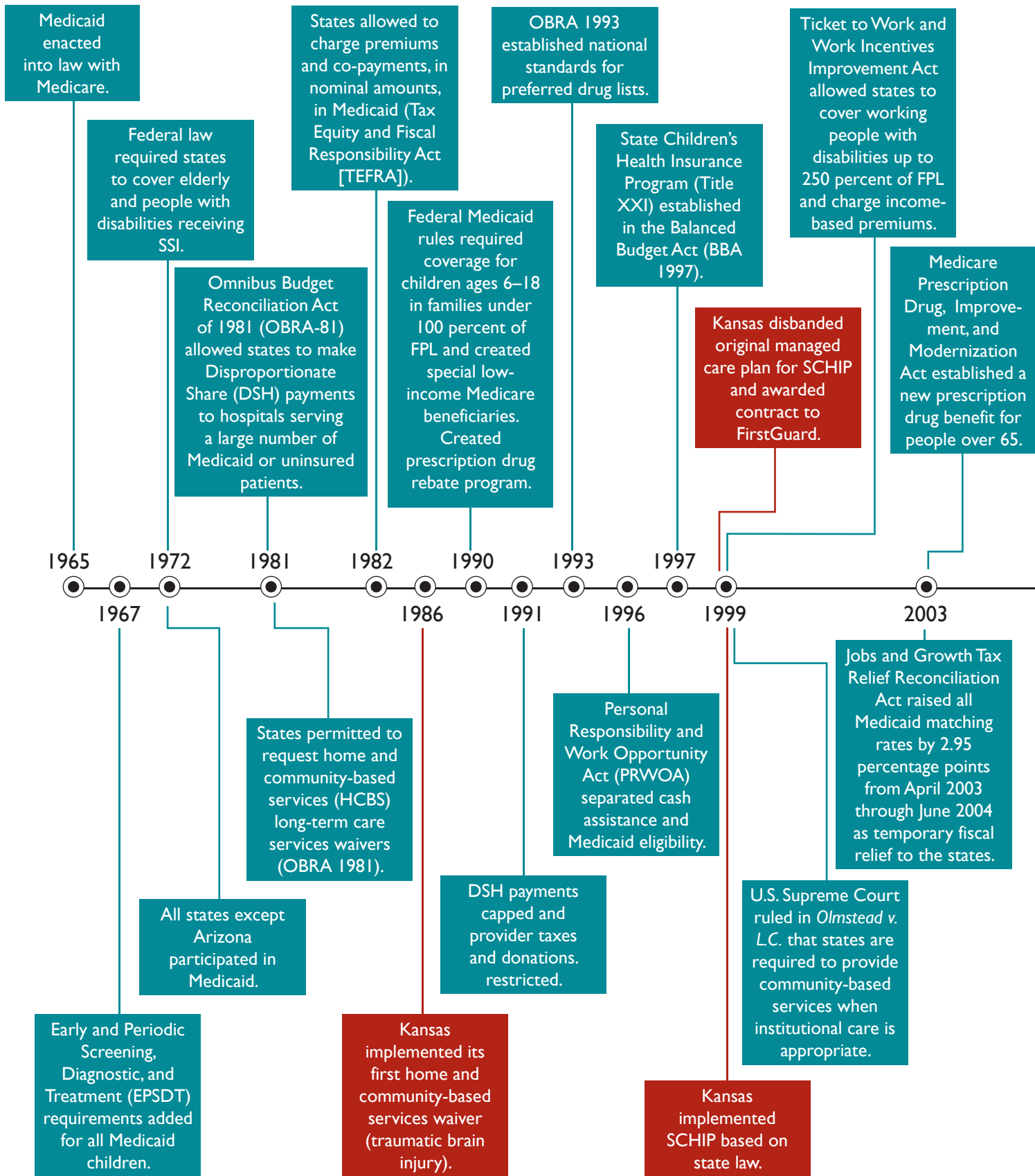
With CHIPRA, Congress also approved performance bonuses intended to help states offset the added costs of insuring low-income children and encouraged states to adopt strategies to identify, enroll and retain health coverage for uninsured children. In 2011, Kansas received about \$6 million in bonus payments for simplifying the enrollment process and about \$12.2 million in 2012 for adopting more than five of the required program features to enhance access for eligible children and streamline administrative functions.¹³

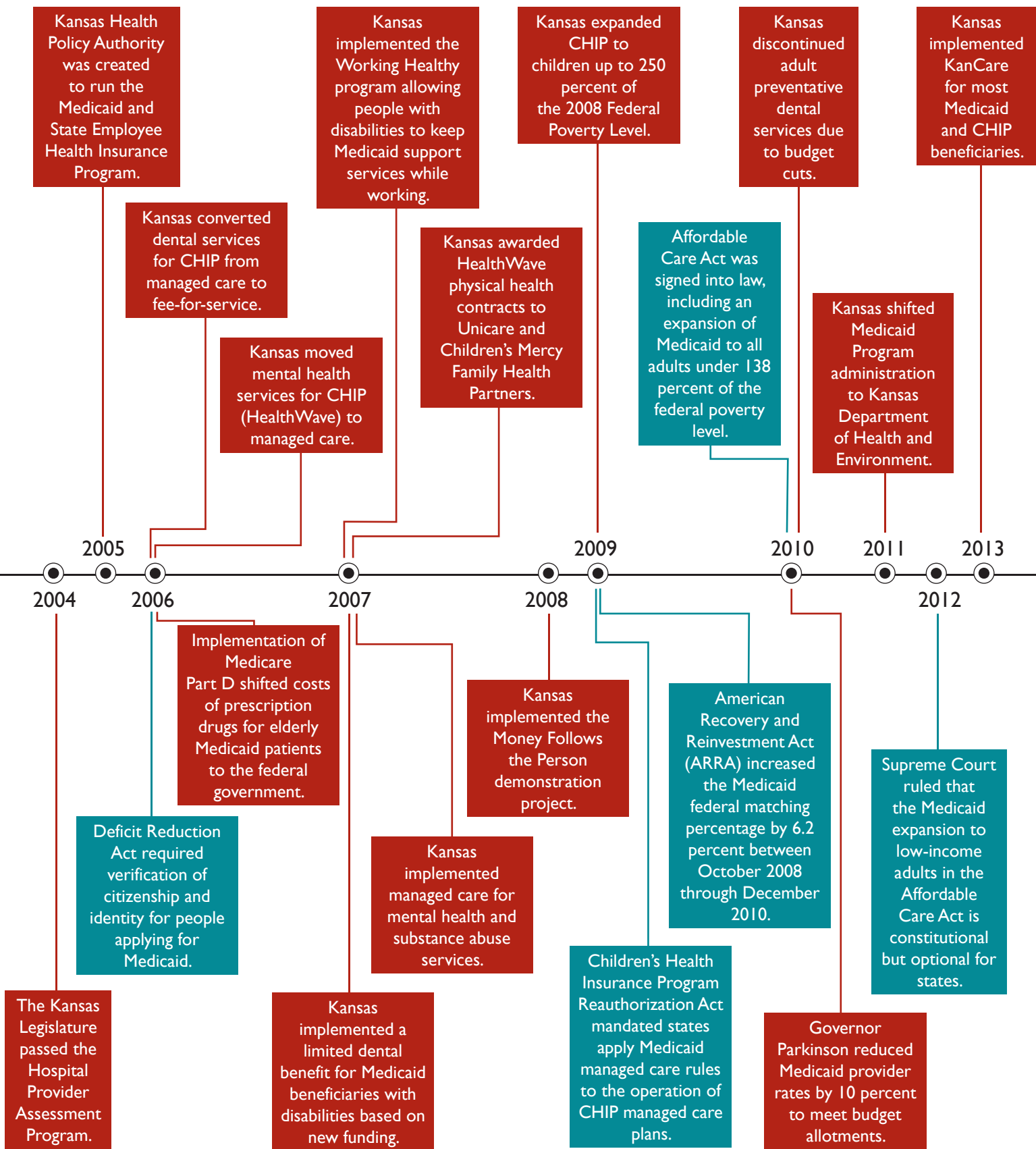
2013



Kansas implemented KanCare for most Medicaid and CHIP beneficiaries.

APPENDIX A: MEDICAID IN KANSAS: A TIMELINE





APPENDIX B: SERVICES COVERED BY MEDICAID IN KANSAS

The following services are mandatory for the categorically needy eligibility group:¹⁴

- Hospital care (inpatient and outpatient);
- Nursing facility services;
- Physician services;
- Certified pediatric and family nurse practitioner services (when licensed to practice under state law);
- Laboratory and X-ray services;
- Immunizations and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children;¹⁵
- Family planning services and supplies;
- Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services;
- Nurse-midwife services;
- Medical and surgical services of a dentist;
- Home health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan;
- Pregnancy-related services and service for other conditions that might complicate pregnancy; and
- Postpartum pregnancy-related services (60 days).

The following services are mandatory for the medically needy eligibility group:

- Prenatal and delivery services;
- Postpartum pregnancy-related services for beneficiaries under age 18 who are entitled to institutional and ambulatory services defined in a state's plan; and
- Home health services to beneficiaries who are entitled to receive nursing facility services under the state's Medicaid plan.

Optional services provided in Kansas include:¹⁶

- Alcohol and drug abuse treatment;
- Audiological services;
- Behavior management;
- Community Mental Health Center and psychological services;
- Dental services (limited to children);
- Durable medical equipment;
- Medical supplies, orthotics and prosthetics;
- Early childhood intervention;
- Health clinics;
- Home and community-based services;
- Hospice services;

- Inpatient psychiatric services;
- Intermediate care facility services;
- Local education agencies;
- Local health department services;
- Nursing services;
- Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders;
- Prescribed drugs;
- Podiatric services covered for EPSDT beneficiaries only;
- Respiratory care for ventilator-dependent individuals;
- Services for special disorders;
- Targeted case management for assistive technology; and
- Vision services.

APPENDIX C: MEDICAID POPULATIONS EXCLUDED FROM KANCARE

While most populations are included in KanCare, some Medicaid beneficiaries are excluded from the program. Populations excluded from KanCare will continue in the Medicaid fee-for-service program.

FIGURE C-1: MEDICAID POPULATIONS EXCLUDED FROM KANCARE

POPULATION	DESCRIPTION
Qualified Medicare Beneficiary (QMB)	This program covers the Medicare out-of-pocket expenses of low-income Medicare recipients, including premiums and co-payments. However, eligible individuals may not be otherwise Medicaid eligible or seeking Medicaid eligibility.
Low-Income Medicare Beneficiary (LMB)	This program only pays the Medicare Part B premium for low-income Medicare recipients. However, eligible individuals may not be otherwise Medicaid eligible or seeking Medicaid eligibility.
Expanded Low-Income Medicare Beneficiary (E-LMB)	This program also only pays the Medicare Part B premium for low-income Medicare recipients. However, eligible individuals may not be otherwise Medicaid eligible or seeking Medicaid eligibility.
Program of All-Inclusive Care for the Elderly (PACE)	This program is for disabled individuals age 55 years or older residing in selected counties. Eligible individuals receive long-term care coverage through a managed care network. HCBS guidelines apply to individuals living in the community and institutional guidelines apply to those living in a facility.
AIDS Drug Assistance Program (ADAP)	This program is for individuals diagnosed with AIDS. Coverage for eligible individuals is limited to payment of prescription drugs related to treatment of AIDS.
MediKan	This program is for individuals who qualify for a cash payment under the General Assistance (GA) program. Eligible individuals must meet program disability guidelines and must not be eligible for Medicaid.
Sixth Omnibus Budget Reconciliation Act (SOBRA)	This program is for non-citizens who are undocumented or who do not meet other non-citizen qualifying criteria and would otherwise qualify for Medicaid if not for their alien status. Eligible individuals may only receive coverage for approved emergency medical conditions.
Tuberculosis	This program is for individuals diagnosed with tuberculosis and in need of care for this condition. Coverage for eligible individuals is limited to inpatient hospital care or alternative community-based services related to the condition.
Long-Term Institutional Care	This program is for individuals residing in a public Intermediate Care Facility for the Mentally Retarded (ICF/MR). Individuals residing in a private ICF/MR are included in KanCare.
Residents of Mental Health Nursing Facilities and State Mental Health Hospitals (ages 22–64)	This program is for individuals residing in a mental health nursing facility (NFMH) or state mental health hospital for a long-term stay and who are between the ages of 22 and 64 years old. Individuals residing in an NFMH or state mental health hospital who are under the age of 22 or over the age of 64 are included in KanCare.
Individuals with Intellectual or Developmental Disabilities — Long-Term Services and Supports (LTSS)	LTSS for individuals with intellectual or developmental disabilities are delayed entry into KanCare until January 1, 2014, pending approval from the federal government. These waiver consumers are included in KanCare for all non-waiver services.

APPENDIX D: GLOSSARY

Affordable Care Act

The Affordable Care Act (ACA) is the federal statute signed into law in March 2010 as a part of the health care reform agenda of the Obama administration. First, the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. A few days later, the Health Care and Education Reconciliation Act, which modified several provisions of the PPACA, was signed into law. The two, collectively known as the ACA, included multiple provisions that would take effect over several years, including the expansion of Medicaid eligibility on January 1, 2014. A July 2012 Supreme Court ruling made the Medicaid expansion essentially optional for states.

Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) was established by Title XXI of the Social Security Act (as of its reauthorization in 2009, the program is referred to as the Children's Health Insurance Program or CHIP). CHIP is jointly financed by the federal and state governments and administered by the states within broad federal guidelines. Each state determines the design

of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. CHIP provides matching funds that are capped to a certain amount. Formerly operated under HealthWave in Kansas, the CHIP program was folded into KanCare in January 2013.

Federal Poverty Level

The Federal Poverty Level (FPL) is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. The number is adjusted for inflation and reported annually in the form of poverty guidelines. These poverty guidelines, or the FPL, are the same for the 48 contiguous states and the District of Columbia, but they vary according to family size. For example, in 2013, the FPL for a family of four is an annual income of \$23,550.

KanCare

As of January 1, 2013, Kansas administers Medicaid and CHIP through three private managed care organizations (MCOs) under the umbrella of KanCare. These MCOs coordinate the physical and

behavioral health care, community-based services and long-term care services for most of the 385,000 Kansans in Medicaid and CHIP. The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer KanCare within the state. KDHE manages finances and oversees contracts, while KDADS administers mental health and substance abuse services, state hospitals and institutions, and Medicaid waiver programs for disability services. A KanCare waiver amendment to include the non-medical services for individuals with developmental disabilities was submitted for federal approval in August 2013.

Medically Needy

The medically needy segment is comprised of people who meet the non-financial criteria of one of the categorically needy programs — such as age or disability —but do not qualify because of excess income or resources or, in the case of pregnant women and children, have income that exceeds Medicaid or CHIP poverty guidelines. Most people in the medically needy group must pay a share of their medical costs through the “spend down” process.

MediKan

MediKan is a program, established in 1973, funded by the state and intended to bridge the gap between the time that an adult becomes disabled and the time that they begin receiving federal disability payments. It can often take two to three years for these payments to begin, although support from the program is limited to 12 months.

State Plan Amendment

A state submits a state plan amendment (SPA) in order to make a change to its Medicaid state plan that is in accordance with the federal requirements. Since the Federal Deficit Reduction Act of 2005 was passed, many changes can now be made by filing an SPA rather than going through the waiver process. Waivers and state plan amendments are the only ways that a state can administratively change the structure of its Medicaid program.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal program that provides cash assistance to seniors, individuals with disabilities, and those who are blind who are not eligible for Social Security Disability Income (SSDI).

Eligibility determinations for SSI are performed by the Social Security Administration. If an individual receives SSI benefits, they are automatically eligible for Medicaid. Seniors must make less than 74 percent of FPL and have limited assets to qualify. For individuals with disabilities to qualify, they must have a medical condition that prevents them from working and is expected to last at least 12 months or result in death.

Waiver

A state must submit a waiver to make an exception to federal requirements of the Medicaid program. There are waivers in place

in Kansas for home and community-based services. Waivers and state plan amendments are the only ways that a state can administratively change the structure of the state Medicaid program. In order to implement KanCare, the state submitted and received federal approval through a 1115 demonstration waiver.

HELPFUL LINKS

Centers for Medicare and Medicaid Services: www.cms.hhs.gov

Kaiser Commission on Medicaid and the Uninsured: www.kff.org/about/kcmu.cfm

KanCare: www.kancare.ks.gov

Kansas Department for Aging and Disability Services: www.kdads.ks.gov

Kansas Department of Health and Environment, Division of Healthcare Finance: www.kdheks.gov/hcf

Kansas Health Institute: www.khi.org

Kansas Legislative Research Department: www.kslegislature.org/klrd

National Academy for State Health Policy: www.nashp.org

National Conference of State Legislators: www.ncsl.org

U.S. Census Bureau: www.census.gov/hhes/www/hlthins/

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