

G-1
Foster Care

G-2
Medicaid Waivers

G-3
**Recent Changes to
Health Professions'
Scope of Practice**

G-4
State Hospitals

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Health and Social Services

G-2 Medicaid Waivers

This article provides information related to the history of Medicaid waivers in the United States, Medicaid waivers specific to Kansas, and the history of waiver integration proposals.

The History of Medicaid

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, the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, 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 (referred to throughout this article as the ACA) expanded Medicaid to all Americans under age 65 whose family income is at or below 138 percent of the federal poverty level (FPL) by January 1, 2014. (*Note:* This amount has been cited as 133 percent FPL. However, because of modified adjusted gross income calculations, this threshold is effectively 138 percent FPL). Under the provisions of the ACA, if a state did not expand Medicaid, the state risked losing its entire federal Medicaid allotment.

The Medicaid expansion provision led to challenges in the U.S. Supreme Court. On June 28, 2012, the Supreme Court ruled in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012), that Congress may not make a state's entire existing Medicaid funding contingent upon

the state's compliance with the ACA provision regarding Medicaid expansion. Consequently, Medicaid expansion is voluntary and has become a highly discussed topic in state legislatures across the country.

As of September 10, 2019, 36 states and the District of Columbia have expanded Medicaid, and 14 states, including Kansas, have not participated in expansion.

KanCare: Medicaid in Kansas

Kansas participates in Medicaid, but it has not expanded the program under the ACA. In 2017, legislative action was taken to expand Medicaid through HB 2044. The bill passed the Legislature, but was vetoed by the Governor. The House of Representatives sustained the Governor's veto. In 2019, a Medicaid expansion bill (HB 2066) passed the House. The bill remains in the Senate Committee on Public Health and Welfare.

Kansas administers Medicaid through the program known as KanCare, which 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. In June 2018, KDHE awarded contracts to Sunflower State Health Plan, UnitedHealthcare Community

Plan of Kansas, and Aetna Better Health of Kansas, Inc., to serve as the State's MCOs. These new contracts began January 1, 2019, and end December 31, 2023.

Each Medicaid consumer 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.

KDHE submitted a request to extend the KanCare program under a Section 1115 waiver to the Centers for Medicare and Medicaid Services (CMS). CMS approved a one-year extension of the current KanCare demonstration, which was set to expire December 31, 2018. The State submitted an application to renew KanCare through 2023. The application was approved by CMS December 18, 2018.

Types of Medicaid Waivers Approved by CMS

Sections 1115 and 1915(b) and (c) 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 CMS in order to operate a waiver.

Section 1115 Research and Demonstration Projects

Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects. These demonstrations can give states additional flexibility to design and improve their Medicaid programs. The purpose of these demonstrations is to demonstrate and evaluate state-specific policy approaches to better serve Medicaid populations. See the CMS website for more information: <https://www.medicare.gov/medicaid/section-1115-demo/about-1115/index.html>.

CMS performs a case-by-case review of each state's Medicaid proposal. CMS has invited states to propose reforms that promote Medicaid's objectives, such as reforms that would:

- Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;
- Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term;
- Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
- Strengthen beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision making;
- Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and
- Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

In general, Section 1115 waivers are approved for an initial five-year period and can be extended for an additional three to five 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 32 states that have approved Section 1115 waivers with CMS. Those states are Alabama, Alaska, Arkansas, California, Colorado, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Vermont, Washington, and Wisconsin. Additionally, several states had Section 1115 waivers listed as "pending" approval with CMS. According to

a search of the CMS website on September 10, 2019, KanCare was listed by CMS as pending approval, although the KanCare demonstration was extended until December 31, 2023. See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html> to search for the current status of states' waiver authority.

In January 2018, CMS posted new guidance for state Section 1115 waiver proposals to condition Medicaid on meeting work requirements. According to the Kaiser Family Foundation, Arizona, Indiana, Michigan, Ohio, Utah, and Wisconsin have approved Section 1115 Medicaid waivers containing work requirements, but, with the exception of Indiana, these waivers are not yet implemented. Section 1115 waivers with work requirements are pending in Alabama, Mississippi, Oklahoma, South Carolina, South Dakota, Tennessee, and Virginia. Waivers in Arkansas, Kentucky, and New Hampshire have been set aside by courts.

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): restricts Medicaid enrollees from receiving services within the managed care network (freedom of choice);
- 1915(b)(2): utilizes a "central broker" (enrollment broker);
- 1915(b)(3): uses cost savings to provide additional services to beneficiaries (non-Medicaid services waiver); and
- 1915(b)(4): restricts the provider from whom the Medicaid eligible may obtain services (selective contracting waiver).

Thus, the 1915(b) waivers allow a state to provide Medicaid services through managed care delivery systems, effectively limiting the consumer's choice of providers. CMS has started the process of "modularizing" its current 1915(b)

waiver application to separate the various statutory authorities. See <https://www.medicaid.gov/medicaid/managed-care/authorities/index.html> for more information.

Currently, there are 38 states 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, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, 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 services include, but are not limited to, case management (supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), 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, including Kansas, 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.

Section 1332 State Innovation Waivers

Section 1332 of the ACA permits a state to apply for a State Innovation Waiver (Section 1332

waiver, now also referred to as a State Relief and Empowerment Waiver). Guidance was issued in 2015 related to these new waivers, and waivers were available beginning January 1, 2017. According to the National Conference of State Legislatures, at least 35 states have considered legislation to begin the Section 1332 waiver application process as of late October 2018. However, on October 22, 2018, CMS, HHS, and the Department of the Treasury published new guidance intended to “expand state flexibility, empowering states to address problems with their individual insurance markets and increase coverage options for their residents, while at the same time encouraging states to adopt innovative strategies to reduce future overall health care spending.” The comment period for the rule ended December 24, 2018. On May 3, 2019, CMS, HHS, and the Department of the Treasury published a request for information regarding State Relief and Empowerment Waivers. The comment period closed July 2, 2019. For more information, see:

- <http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx>;
- <https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers>; and
- <https://www.federalregister.gov/documents/2019/05/03/2019-09121/request-for-information-regarding-state-relief-and-empowerment-waivers>.

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 Section 1115 waiver. The seven 1915(c) waivers are Autism (AU), Frail Elderly (FE), Intellectual and Developmental Disability (I/DD), Physical Disability (PD), Serious Emotional Disturbance (SED), Technology Assisted (TA), and Brain Injury (BI).

To participate in a 1915(c) waiver, the individual requiring services must be financially and functionally eligible for Medicaid. Individuals with income above \$1,177 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 (AU) Waiver provides services to children from the time of diagnosis of Autism Spectrum Disorder, Asperger 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 MCO must demonstrate a need for continued AU Waiver services.

To apply for the AU Waiver, a parent or guardian must complete an application. The application requests basic information about the child and the child’s family. Also, the application requires the parent or guardian to indicate the screening tool used in the child’s diagnosis and documentation of an autism diagnosis or a signature of a licensed medical doctor or psychologist.

The program manager pre-screens for the autism diagnosis and places the child on the proposed recipient list. As of July 31, 2019, there were 304 children on the proposed recipient list. Once a position becomes available, the program manager contacts the family to offer them the potential position. As of August 13, 2019, there were 49 children eligible to receive services under this waiver.

Kansas received direction from CMS to move consultative clinical and therapeutic services, intensive individual supports, and interpersonal communication therapy from the AU Waiver to the Medicaid State Plan Amendment. 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 amendments were approved by CMS in June 2017.

Frail Elderly

The Frail Elderly (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 meet the Medicaid nursing facility threshold score and are financially eligible for Medicaid. If applying for the FE Waiver, the individual should contact their local Aging and Disability Resource Center (ADRC). There are 11 ADRCs in the state. Services and supports included under the FE Waiver are adult day care, assistive technology, personal care services, comprehensive support, financial management services, home telehealth, medication reminder, nursing evaluation visit, oral health services, personal emergency response, enhanced care services (previously referred to as sleep cycle support), and wellness monitoring.

As of August 13, 2019, there were 4,571 individuals eligible to receive services under this waiver.

Intellectual and Developmental Disability

The Intellectual and Development Disability (I/DD) Waiver provides services to individuals five years of age and older who meet the definition of intellectual disability, have a developmental disability, or are eligible for care in an intermediate care facility for individuals with intellectual disabilities. Those with a developmental disability may be eligible if their disability was present before age 22 and they have a substantial limitation in three areas of life functioning.

The point of entry into the I/DD Waiver is an individual’s local community developmental disability organization. The program manager provides final approval of program eligibility. As of August 13, 2019, there were 4,035 individuals on the I/DD waiting list.

Services and supports under the I/DD Waiver may include assistive services, adult day supports, financial management services, medical alert rental, overnight respite, personal care services, residential supports, enhanced care services, specialized medical care, supported employment, supportive home care, and wellness monitoring. As of August 13, 2019, there were 8,975 individuals eligible to receive services under this waiver.

Physically Disability

The Physically Disability (PD) Waiver provides services to individuals 16 to 64 years of age who meet the criteria for nursing facility placement due to their physical disability. The individual must be determined disabled by the Social Security Administration, need assistance to perform activities of daily living, and meet the Medicaid nursing facility threshold score.

The point of entry for the PD Waiver is an individual's local ADRC. The program manager provides final approval of program eligibility. As of August 13, 2019, there were 1,805 individuals on the PD waiting list. Services and supports under the PD Waiver may include assistive services, financial management services, home-delivered meals, medication reminder services, personal emergency response systems and installation, personal care services, and enhanced care services. As of August 13, 2019, there were 5,660 individuals eligible to receive services under this waiver.

Serious Emotional Disturbance

The Serious Emotional Disturbance (SED) Waiver provides services to individuals ages 4 to 18 who have been diagnosed with a mental health condition that substantially disrupts the individual's ability to function socially, academically, emotionally, or all. The waiver is designed to divert the individual from psychiatric hospitalization to intensive home and community based supportive services.

Services and supports under the SED Waiver may 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 August 13, 2019, there were 3,327 individuals eligible to receive services under this waiver.

Technology Assisted

The Technology Assisted (TA) Waiver provides services to people through the age of 21 who require substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital.

The individual is determined TA program-eligible if he or she is 0 through 21 years of age, is chronically ill or medically fragile, requires one or more of the identified primary medical technologies and meets the minimum technology score for the specified age group, and meets the minimum nursing acuity level of care threshold for the specified age group. The point of contact for the program is the Children's Resource Connection.

Services and supports under this waiver may include financial management services, health maintenance monitoring, intermittent intensive medical care, specialized medical care, medical respite, personal care services, and home modification. As of August 13, 2019, there were 565 individuals eligible to receive services under this waiver.

Brain Injury

The Brain Injury (BI) Waiver is a habilitative/rehabilitation and independent living program with an emphasis on the development of new independent living skills and/or relearning of lost independent living skills due to an acquired or traumatic brain injury.

A legislative proviso in the 2018 Omnibus Appropriations Bill, House Sub. for SB 109, required KDADS to implement a change to the Traumatic Brain Injury (TBI) Waiver to allow coverage for individuals with documented acquired brain injuries from a cause not already covered under the waiver and eliminate the requirement that individuals on the waiver must be at least

16 years old. On August 5, 2019, the TBI Waiver transitioned to a BI Waiver upon approval by CMS of a request for a waiver amendment to add acquired brain injuries for the adult population. However, a new functional assessment tool for BI youth under the age of 16 had to be developed and be ready for implementation before KDADS could submit a waiver amendment to CMS to include the new youth population. KDADS indicated a target date of October 28, 2019, to submit the waiver amendment to add the youth population to the BI Waiver.

As of August 5, 2019, to be eligible for the BI Waiver, the individual must be 16 to 65 years of age, be determined disabled or have a pending determination by the Social Security Administration, have active habilitation or rehabilitation needs for BI therapies, and have a documented medical diagnosis of a traumatic or acquired brain injury. Brain injuries due to a chromosomal or congenital diagnosis do not qualify for the BI Waiver.

The point of entry for an individual is the local ADRC. Services and supports under this waiver may include assistive services; financial management services; home-delivered meals; medication reminder services; personal emergency response system and installation; personal care services; rehabilitation therapies, including behavior therapy, cognitive rehabilitation, physical therapy, speech-language therapy, and occupational therapy; enhanced care services; and transitional living skills. As of August 13, 2019, there were 400 individuals eligible to receive services under this waiver.

Waiver Integration

In Summer 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 work groups 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 (2016) was introduced by 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 fiscal year (FY) 2016 and FY 2017 to proceed with waiver integration if the proposed integration was planned to occur prior to FY 2019.

In 2017, a HCBS integration proviso was added to the Omnibus Appropriations Bill, Senate Sub. for HB 2002. The proviso would have prohibited the integration, consolidation, or otherwise altering the structure of HCBS waivers, or submitting a proposal to combine, reassign, or otherwise alter the designated responsibilities to provide intake, assessment, or referral services for medical services, behavioral health services, transportation, nursing facilities, other long-term care, or HCBS waivers prior to FY 2020. This proviso was line-item vetoed by the Governor. In his veto message, Governor Brownback stated concern over the broad nature of the proviso language and its potential to limit changes to non-HCBS programs within KDADS. The veto message also stated the Brownback administration would not integrate or consolidate HCBS waivers, nor make any substantive changes to the intake, assessment, and referral system for the I/DD Waiver without meaningful engagement with stakeholders and approval of the Legislature.

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