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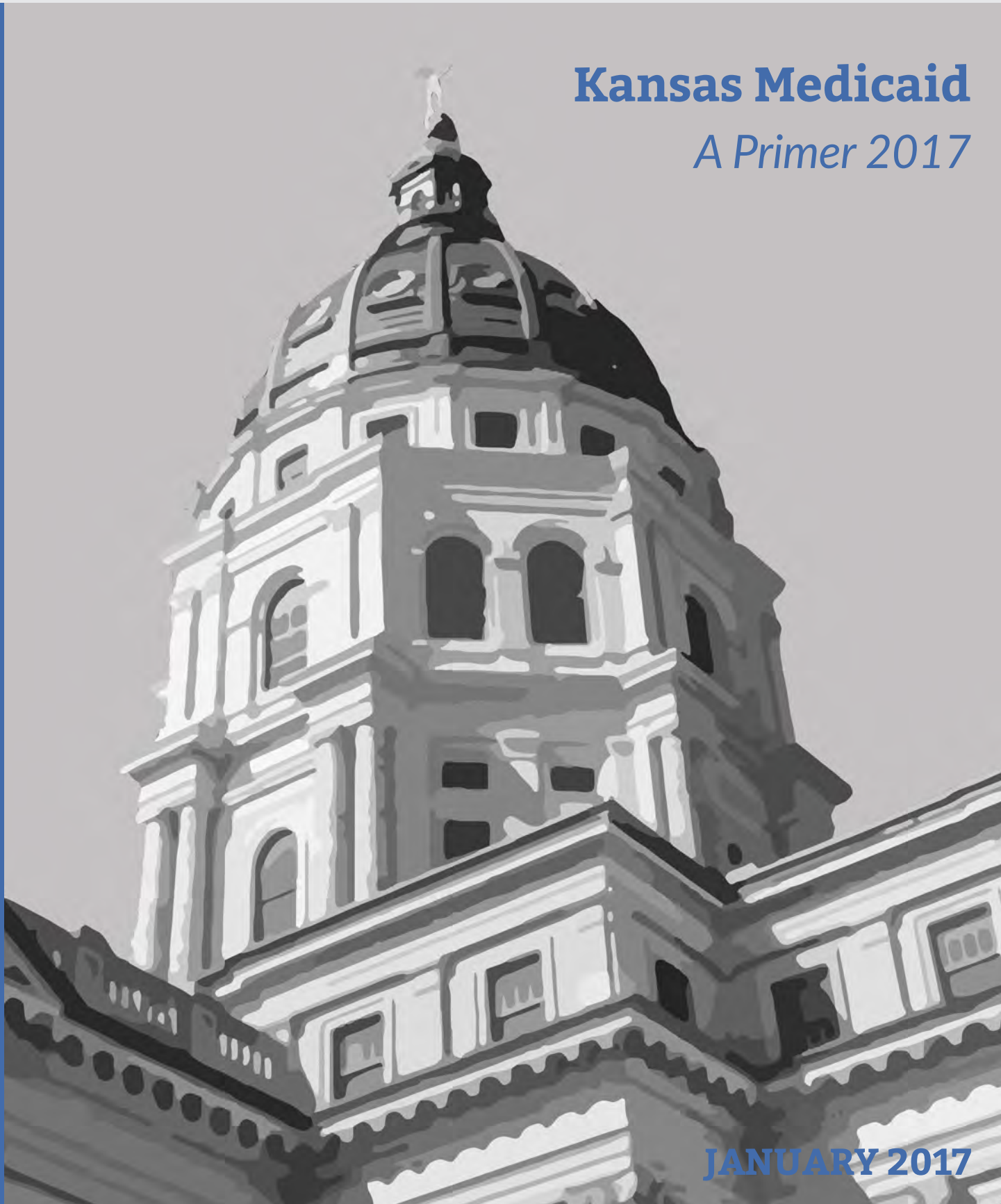
Kansas Medicaid

A Primer 2017



JANUARY 2017

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KANSAS MEDICAID
A Primer 2017

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Acknowledgments

This report, *Kansas Medicaid: A Primer 2017*, was produced through a partnership of the Kansas Health Institute (KHI) and the Kansas Legislative Research Department (KLRD).

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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.

Since the last edition of this report in 2014, the system has continued to change as KanCare—the state's comprehensive managed care program—has matured and as new federal rules about the management of the program have been released.

Additionally, changes driven by the continued implementation of the Affordable Care Act (ACA) have had effects on enrollment and costs in Kansas, even though Kansas has not expanded its Medicaid program to include adults up to 138 percent of the federal poverty level (FPL), as permitted under the ACA.

With a national election now complete, more change may be on the horizon. Understanding the current system is a key component of anticipating and responding to possible changes ahead. KHI and KLRD are pleased to provide basic facts and information about Medicaid and CHIP in Kansas. This report, *Kansas Medicaid: A Primer 2017*, includes an overview of Medicaid and CHIP, analysis of recent trends in Kansas, and basic information about covered services and populations.

This report is the fourth edition of this information, following 2005, 2009 and 2014 versions. Unless otherwise noted, data used in this report originated with the Kansas Department of Health and Environment (KDHE) through the publicly available Medical Assistance Report (MAR).

Previous editions included fee-for-service and managed care expenditures. Since the adoption of KanCare, nearly all Medicaid and CHIP costs are incorporated into managed care. As a result, unlike earlier editions, some figures in this publication are based on encounter data, or data about individual claims related to services paid for by managed care organizations (MCOs). Those figures cite KDHE's Data Analytic Interface (DAI) as the data source.

Introduction to Medicaid and CHIP

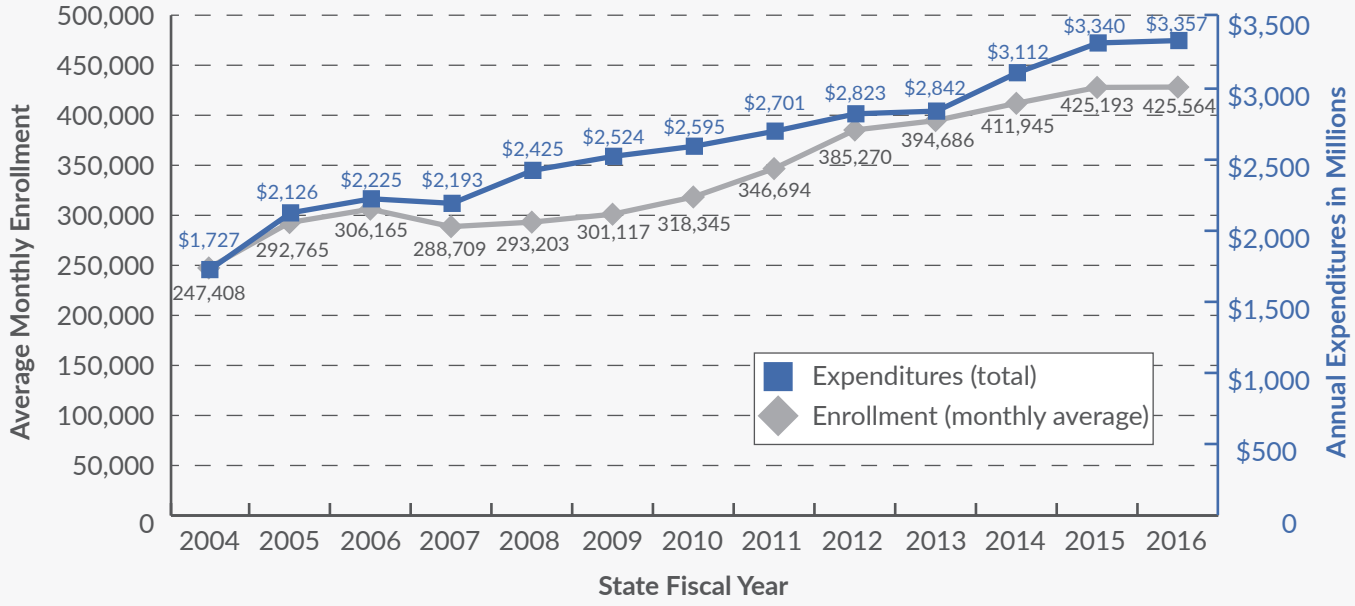
Medicaid is the second-largest source of health coverage in the nation, following employment-based coverage. It is a publicly financed source of health insurance and long-term care coverage for eligible population groups, jointly funded by the federal government and the states. Medicaid is the third-largest domestic program in the federal budget, behind only Medicare and Social Security.[1]

In state fiscal year (FY) 2016, Medicaid and the related Children's Health Insurance Program (CHIP) covered a monthly average of about 426,000 people in Kansas at an annual cost of almost $3.4 billion, as shown in *Figure 1*. Medicaid provides health care coverage to low-income dependent children, very low-income parents, certain pregnant women, some individuals 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 states and the federal government. In federal fiscal year (FFY) 2015, the federal government spent more than $554.3 billion dollars on the program nationally.[2] In Kansas, the federal government will contribute approximately $1.28 during FFY 2017 for every dollar of standard state Medicaid spending.[3] Stated another way, the federal government pays 56.21 percent of Medicaid expenses in Kansas. The rate of this match varies from state to state and changes from year to year as states' relative economic positions improve or worsen. In general, standard match rates are higher in poorer states. The match rate also varies by program; for example, the CHIP match rate is 92.35 percent in FFY 2017.

In state FY 2015, Medicaid and CHIP accounted for 21 percent of the Kansas state general fund's actual expenditures and represented a significant portion of total spending on health care services. The only program for which the state spends more money is K-12 education (*Figure 2*, page 3).[4]

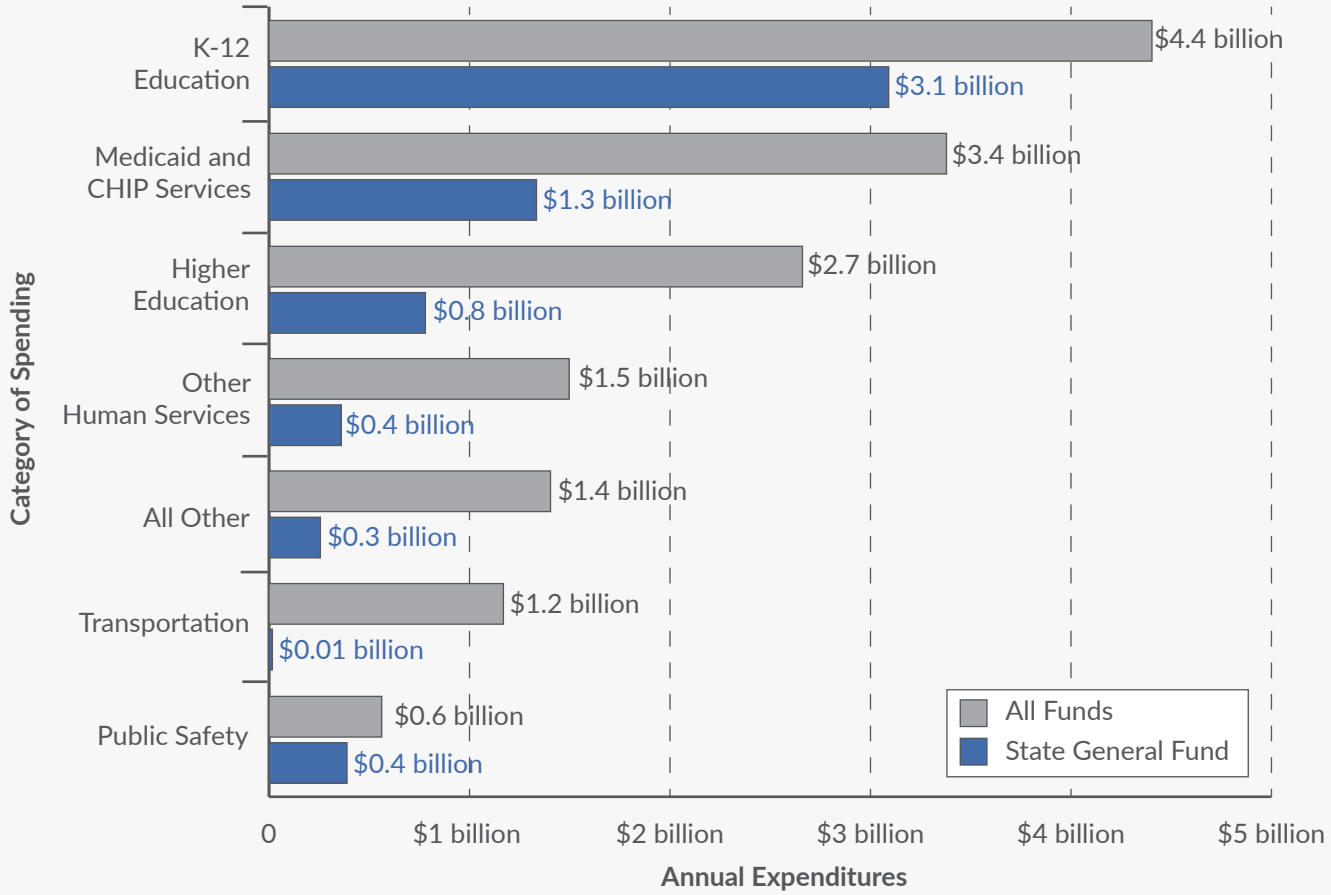
Figure 1. **Medicaid and Children's Health Insurance Program (CHIP) Average Monthly Enrollment and Annual Expenditures in Kansas, Fiscal Years 2004–2016**



Note: Enrollment represents 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, 2004–2016, Division of Health Care Finance, Kansas Department of Health and Environment.

Figure 2. **Medicaid and Children's Health Insurance Program (CHIP) Spending Compared to all Categories of Spending, Kansas Fiscal Year 2015**



Source: KHI analysis of FY 2017 Governor's Budget Report, FY 2015 actuals.

What is Managed Care?

Under KanCare, spending for Medicaid and the Children's Health Insurance Program (CHIP) is directed into managed care for most eligible groups, including children, pregnant women, low-income adults, people with disabilities and people with both Medicare and Medicaid (dual eligibility). In KanCare, enrollees choose or are assigned to one of three managed care organizations (MCOs).

The MCOs receive monthly payments from the state based upon their total number of enrollees and historical costs associated with the various population groups. The payments place the MCOs at risk for the cost of care for their members, and MCOs are incentivized to ensure enrollees receive services that help reduce costs over time by improving their health and quality of life.

The state's contracts with the MCOs require them to provide services previously available through Medicaid, including prenatal care, well-child visits, preventive services, hospital care, medication, in-home care, community-based services and nursing facility care. The MCOs also must ensure services are available statewide and at Medicaid-required levels. They may provide additional services not traditionally covered by Medicaid to help prevent hospital admissions or institutionalization.

Medicaid and CHIP History

Medicaid and Medicare (*Figure 3*) were enacted in 1965 as components of President Lyndon Johnson's "Great Society" domestic program agenda. Medicaid was authorized under Title XIX of the Social Security Act. 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 Children's Health Insurance Program (CHIP) was authorized by the Kansas Legislature in 1998 and implemented in the state in 1999. CHIP was designed to be an extension of public coverage in order to serve children at higher income ranges than those traditionally served by Medicaid.

The Medicaid program in Kansas was administered at a county level until 1974, when the Kansas Department of Social and Rehabilitation Services (SRS) was created. SRS acted as the single state Medicaid agency until 2005, when the Kansas Health Policy Authority (KHPA) was created. KHPA administered Medicaid and CHIP until Executive Reorganization Order No. 38 in 2011 transferred the program to the Kansas Department of Health and Environment (KDHE).

Within KDHE, the Division of Health Care Finance (DHCF) administers Medicaid under federal guidelines and rules that ensure a minimum level of coverage for certain population groups. DHCF is responsible for establishing eligibility criteria, benefit packages, payment rates and program administration. The Kansas Department for Aging and Disability Services (KDADS) is responsible for management of Medicaid program services related to mental health, people with disabilities and seniors.

In November 2011, Kansas Governor Sam Brownback announced significant structural and operational changes to the Kansas Medicaid program. These changes created KanCare, and were designed to slow the growth of Medicaid costs and improve health outcomes by requiring nearly all Kansans in Medicaid and CHIP to enroll in private managed care plans.

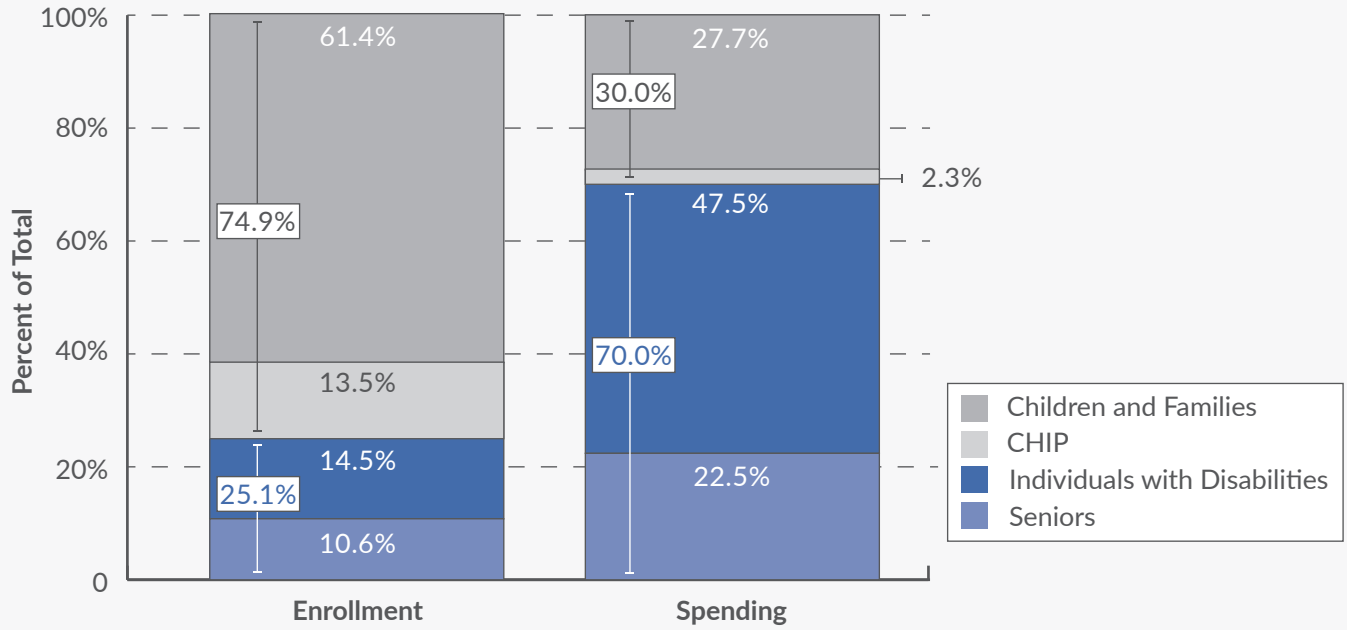
KanCare fundamentally changed the way Medicaid in Kansas operates for both consumers and health care providers. KanCare also changed some of the ways in which Medicaid service and expenditure information is reported.

Managed care had been provided for children and families in Kansas Medicaid and CHIP since the 1990s, but now nearly all services are provided through managed care for the majority of members. KanCare was approved as a five-year demonstration from January 1, 2013, to December 31, 2017. The program may be extended or amended under procedures set by the federal government, as described on page 10.

Figure 3. **Differences Between the Medicaid and Medicare Programs**

MEDICAID	MEDICARE
• Provides health insurance for low-income children and some parents, seniors and individuals with disabilities	• Provides health insurance for seniors age 65 and older, and for some adults with disabilities
• Provides medical care and long-term care coverage	• Provides medical care coverage, but very limited long-term care coverage
• Has eligibility rules based on income	• Has no income limit
• Receives state and federal funding	• Receives federal funding collected by payroll deduction
• Administered on a state level, within federal guidelines	• Administered on a federal level

Figure 4. **Medicaid and Children's Health Insurance Program (CHIP) Population Groups and Spending, Kansas Fiscal Year 2016**



Note: Enrollment and spending do not include the following populations: foster care/adoption, refugees, the Sixth Omnibus Budget Reconciliation Act (SOBRA) program, tuberculosis, the AIDS Drug Assistance Program (ADAP) and breast and cervical cancer.
Source: KHI analysis of Kansas Medical Assistance Report, 2016, Division of Health Care Finance, Kansas Department of Health and Environment.

Medicaid and CHIP Spending in Kansas

In Kansas, about one-quarter (25.1 percent) of all Medicaid and Children's Health Insurance Program (CHIP) enrollees are seniors or people with disabilities, but this combined population incurs 70.0 percent of total state spending for the Medicaid and CHIP programs, as shown in *Figure 4*. Children and families, including children in CHIP, account for 74.9 percent of Medicaid and CHIP enrollees and incur 30.0 percent of the state expenditures in these programs.

In FY 2016, annual Medicaid and CHIP spending averaged $2,925 per pregnant woman, child or family member, compared to $23,863 per enrollee with a disability and $15,540 per senior enrollee.

These differences reflect the greater use of medical care and long-term care services by seniors and those with disabilities. Services for these populations tend to be far costlier than routine health and preventive services that are generally required for children and parents. Traditionally, medical care for seniors and individuals with disabilities includes services that range from doctor visits and hospitalization to durable medical equipment, prescription drugs, home health services and nursing facility care. (*Appendix B* on page 18 contains a complete list of both mandatory and optional services covered by Medicaid in Kansas.)

In Kansas, the rate of growth in Medicaid spending has been slower than in most states, as shown in *Figure 5* (page 6), both in terms of costs and total enrollees.

Figure 5. **Kansas Medicaid Compared with Other States, Selected Indicators**

INDICATOR	KANSAS	U.S.	KANSAS COMPARED TO OTHER STATES
Total Medicaid Spending, FFY 2015	$3.04 billion	$532 billion (all states)	36th
Average Annual Growth in Medicaid Spending, FFY 2010–2014	3.2%	5.2%	36th
Medicaid Enrollment Growth Post-Affordable Care Act Implementation (February 2014–July 2016)	12%	27%	34th

Note: The federal fiscal year (FFY) runs from October 1 through September 30. FFY 2015 refers to the period from October 1, 2014, through September 30, 2015. It overlaps by three months with Kansas' state fiscal year (FY), which runs July through June. State FY 2016 refers to the period from July 1, 2015, through June 30, 2016.

Source: Kaiser State Health Facts, 2016.

426,000 Kansans, on average, were covered by Medicaid and the Children's Health Insurance Program (CHIP) each month during state fiscal year 2016.

Medicaid and CHIP Trends

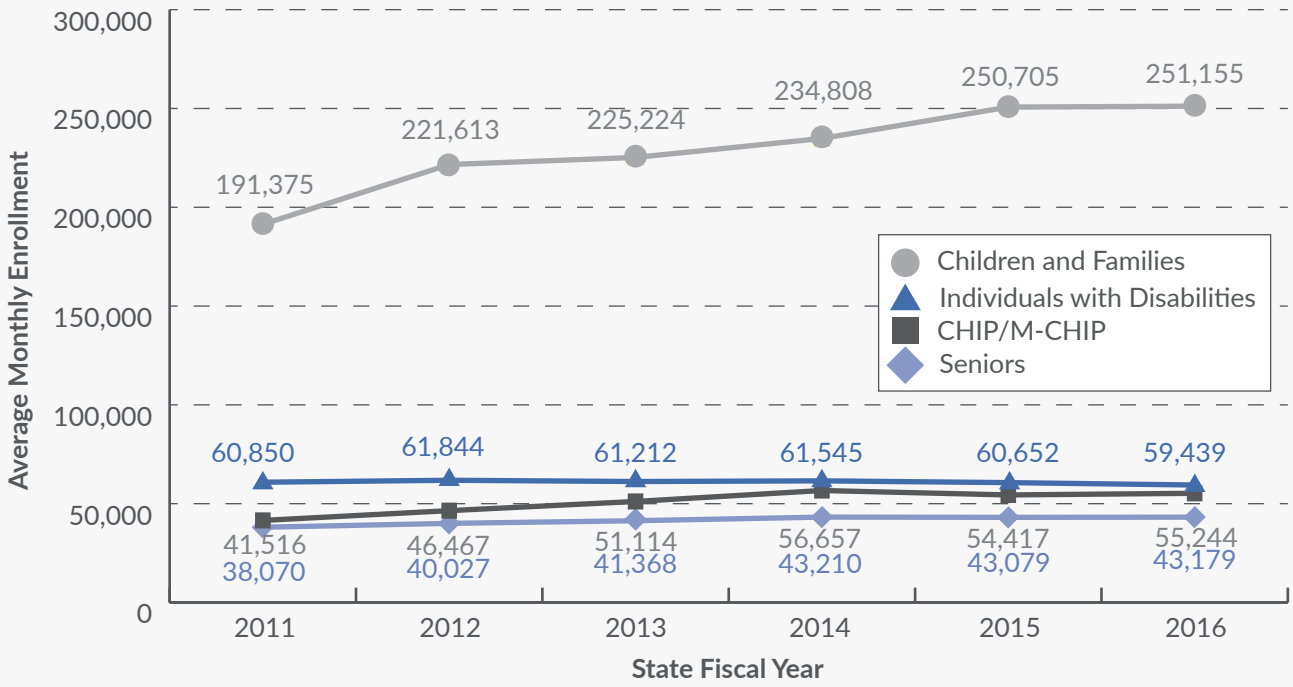
Enrollment has steadily increased from state fiscal year (FY) 2011 through FY 2016, as shown in *Figure 6*, driven primarily by increased enrollment for children and families in Medicaid, as well as growth in Children's Health Insurance Plan (CHIP) enrollment.

Children and families make up the largest share of enrollees in Medicaid, and enrollment for that group grew about 31 percent from state FY 2011 to FY 2016. Fewer children and adults are eligible at current income criteria, but enrollment has increased nonetheless, possibly attributable to enrollment outreach efforts related to the Affordable Care Act.

The upward trend has continued even through issues during a "backlog" in processing Medicaid and CHIP applications. From late 2015 to late 2016, the state was not able to process eligibility applications as quickly as it received them. The result was a backlog of applications that in May 2016 had reached more than 15,000, including approximately 11,000 new applications that had not been processed within the 45 days allowed under federal rules for most applications.[5]

Enrollment for seniors also increased over the state FY 2011–2016 period, while total enrollment for people with disabilities declined slightly. In that group, enrollment for people with disabilities eligible for Supplemental Security Income (SSI) increased, as shown in *Figure 7*, page 8. Enrollment in the Medically Needy category for people with disabilities—which requires those with incomes over $475 a month to "spend down" or pay a portion of their health care costs—has steadily declined since state FY 2012. A more detailed discussion of the Medically Needy program is on page 15.

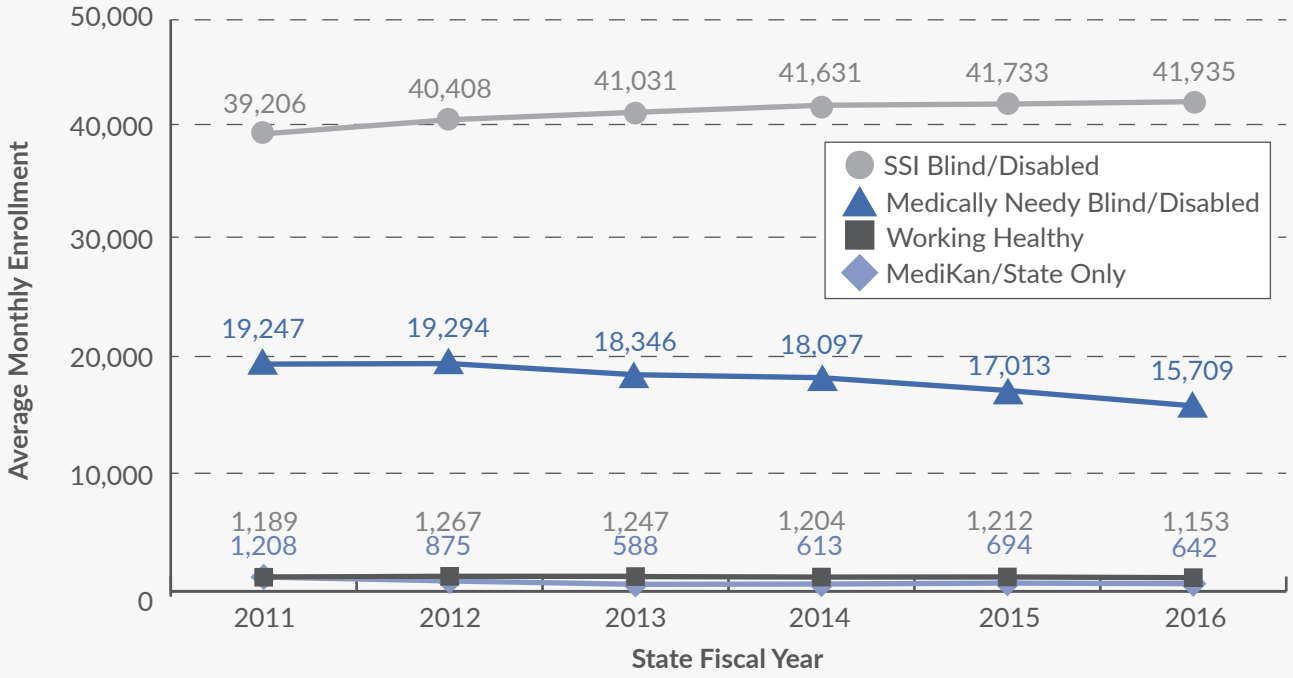
Figure 6. **Average Monthly Enrollment in Kansas by Category in Medicaid and the Children's Health Insurance Program (CHIP), Fiscal Years 2011–2016**



Note: Numbers do not include the following populations: foster care/adoption, refugees, the Sixth Omnibus Budget Reconciliation Act (SOBRA) program, tuberculosis, the AIDS Drug Assistance Program (ADAP) and breast and cervical cancer. M-CHIP includes previously CHIP-eligible children now Medicaid-eligible after the ACA; the state receives CHIP match rates for this group.

Source: KHI analysis of Kansas Medical Assistance Report, 2011–2016, Division of Health Care Finance, Kansas Department of Health and Environment.

Figure 7. **Medicaid Enrollment for People with Disabilities by Eligibility Group in Kansas, Fiscal Years 2011–2016**



Source: KHI analysis of Kansas Medical Assistance Report, 2011–2016, Division of Health Care Finance, Kansas Department of Health and Environment. Categories are defined on pages 15–16.

Approximately $1.4 billion in state funds were needed to insure eligible Kansans through Medicaid and the Children's Health Insurance Program (CHIP) in state fiscal year 2016.

Medicaid and CHIP Services

Kansas Medicaid expenditures for services are now primarily made to managed care organizations (MCOs), which are responsible for paying providers for their members' use of services. The year before KanCare was launched, about 25 percent of total Medicaid and Children's Health Insurance Program (CHIP) expenses paid by the state were made through managed care. In state FY 2016, more than 90 percent of state payments were through managed care, as *Figure 8* illustrates.

The state's payments are made on a monthly basis to the MCOs based upon capitated "per member per month" (PMPM) rates set according to the eligibility group to which each member belongs. Costs associated with individual use of services are rarely paid directly by the state, which is a change from how costs were described in pre-KanCare editions of the *Medicaid Primer*. Exceptions are generally related to excluded populations as outlined in *Appendix C* (page 19), such as members for whom the state only pays Medicare cost-sharing.

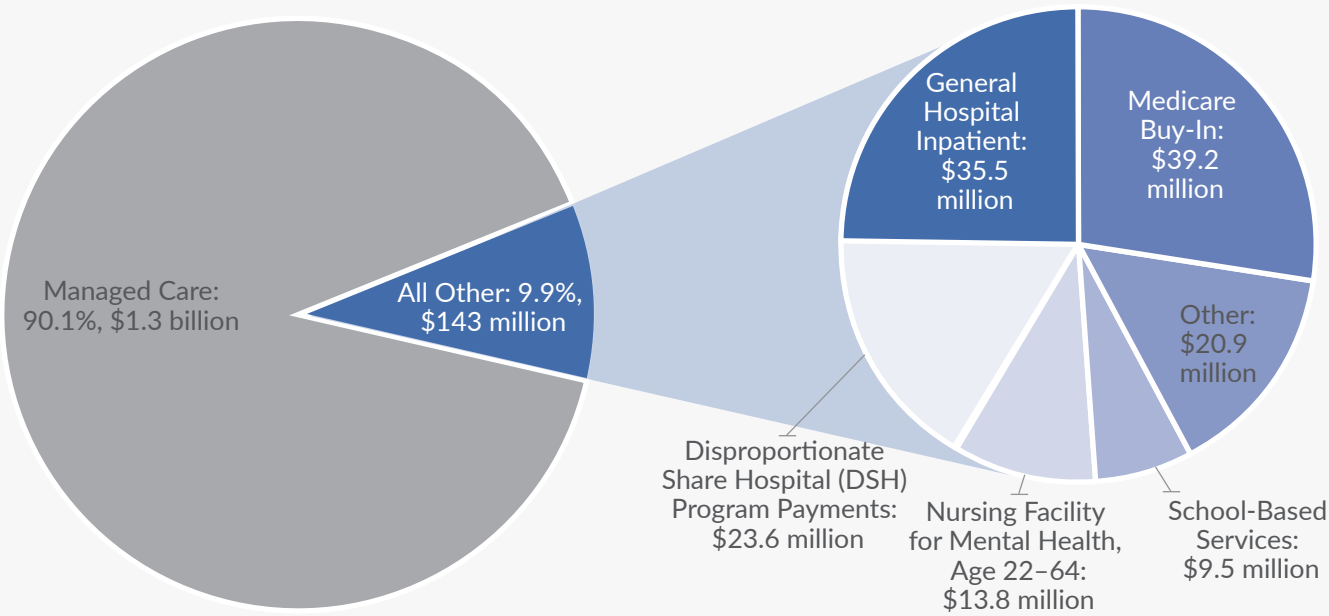
As a result, *Figure 9* (page 10), which represents how members use services, comes from claims the MCOs have paid to providers. It may total more or less than the amount the state paid to the MCOs.

Medical Care

Medical care services under Medicaid include physician and hospital services, dental services, pharmacy, rehabilitation and a host of other services. Overall, medical care services represented about 61 percent of spending by managed care organizations (MCOs) in state FY 2016, as shown in *Figure 9*, page 10.

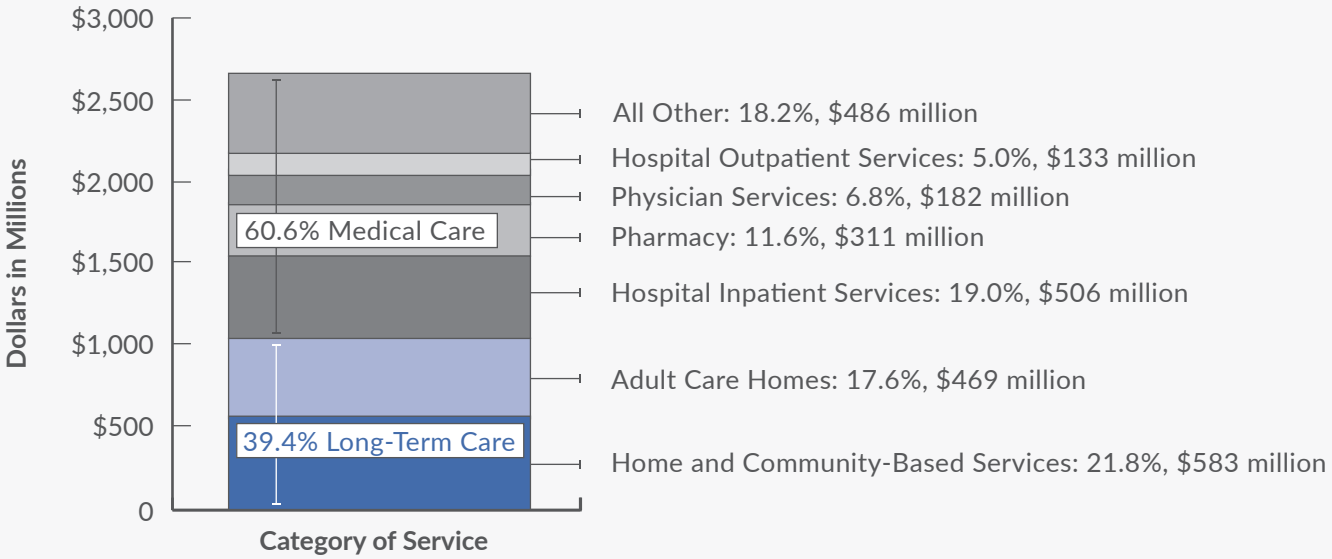
The costliest of these services are inpatient and outpatient hospital care, physician services and pharmacy. Other payments to medical care providers made directly by the state are not included in the payments MCOs make. For example, the Disproportionate Share Hospital (DSH) program helps reimburse hospitals that serve a large number of low-income and uninsured patients.

Figure 8. **Managed Care as a Portion of Total Medicaid and Children's Health Insurance Program (CHIP) Expenditures in Kansas, State Funds Only, Fiscal Year 2016**



Note: General Hospital Inpatient includes hospital safety net care pool payments.
Source: KHI analysis of Kansas Medical Assistance Report, 2016, Division of Health Care Finance, Kansas Department of Health and Environment.

Figure 9. **KanCare Managed Care Organization (MCO) Payments to Providers by Category of Service, Fiscal Year 2016**



Note: Includes home and community-based services provided through waivers and the Money Follows the Person program, and independent targeted case management.
Source: Data Analytic Interface, Kansas Department of Health and Environment, 2016.

State Plan Amendments and Waivers

The federal Centers for Medicare and Medicaid Services (CMS) approves a State Plan for each state's Medicaid program and Children's Health Insurance Program (CHIP). A State Plan is a contract between the state and the federal government describing how the state will administer its program, what services it will cover, what groups it will extend eligibility to and how much it will reimburse providers. There are two ways to make changes to a State Plan—by submitting a State Plan Amendment (SPA) or a waiver.

A 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 state can file a SPA at any time, and it can have retroactive application. A waiver is used when a state wants an exception from existing federal requirements. While SPAs are permanent changes, waivers are generally approved for three to five years, and can be renewed or amended.

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 that are not typically covered by Medicaid. States can provide these services to specific groups only, and can limit the number of individuals the waiver will serve. A SPA differs from these waivers because a SPA does not allow targeting to specific populations or waiting lists.

KanCare operates under concurrent waivers—a set of Section 1915(c) waivers for HCBS and a Section 1115 demonstration that created KanCare and allows—among other things—the mandatory enrollment of nearly all covered populations in managed care for most services. The current KanCare demonstration is approved through the end of calendar year 2017, and the state may request it be extended. Renewals require specific actions to ensure transparency, including public meetings.

Long-Term Care

Long-term care services include all services provided by adult care homes and home and community-based services (HCBS); they accounted for about 39 percent of total payments MCOs made on behalf of their members in state fiscal year (FY) 2016.

Adult Care Home Services: Adult care home services include nursing facilities, nursing facilities for mental health and intermediate care facilities (but not state hospitals) for individuals with intellectual disabilities. Some of the costs of these services are offset by a provider tax on nursing homes. In 2016, the Legislature increased the tax, providing about $70 million in funding to increase rates for Medicaid nursing home providers.

Home and Community-Based Services (HCBS): Medicaid provides a variety of long-term care services to support individuals in their homes and communities. For example, individuals who qualify may receive specialized medical care 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 ("institutional equivalents") may receive HCBS waiver services, with the goal of remaining in a community setting.

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 for select services, something that is not allowed for the non-waiver Medicaid populations. The populations in Kansas that are eligible for HCBS through waivers, and their institutional equivalents, are shown in *Figure 10*.

Administrative Spending

The state also spends significant funds operating the Medicaid program and Children's Health Insurance Program (CHIP). Some of the costs are for program oversight—including state employees managing the program—and other costs are for contractual services such as eligibility processing and the development and maintenance of computer systems. Total administrative costs were $214.7 million in federal fiscal year (FFY) 2014, accounting for approximately 6 percent of all state Medicaid expenditures.[6]

Figure 10. **Kansas Populations Eligible for Home and Community-Based Services (HCBS) through Waivers and their Institutional Equivalents**

KANSAS HCBS WAIVER PROGRAMS	INSTITUTIONAL EQUIVALENTS
Autism (children)	Inpatient psychiatric facility for age 21 and under
Frail Elderly	Nursing facility
Intellectual/Developmental Disability	Intermediate Care Facility for Individuals with Intellectual Disabilities
Physical Disability	Nursing facility
Serious Emotional Disturbance (children)	Inpatient psychiatric facility for age 21 and under
Technology Assisted (children)	Hospital
Traumatic Brain Injury	Traumatic brain injury rehabilitation facility

Source: Kansas 1915(c) waivers.

Medicaid and CHIP Populations

As a federally designated entitlement program, Medicaid requires states to provide coverage to all eligible individuals in certain population categories.

Medicaid eligibility is always based on income but may also depend on age, availability of financial resources and, in some cases, health care needs. For many enrollees, income eligibility criteria are based on federal poverty guidelines, as shown in *Figure 11*.

There are five main criteria for Medicaid eligibility: categorical eligibility, income eligibility, resource eligibility, immigration status and residency. To qualify for Medicaid, an individual must qualify under all five criteria:

- **Categorical Eligibility:** There are four main categories of individuals who are eligible for Medicaid—children, parents or caregivers with children, people with disabilities and seniors.
- **Income Eligibility:** Different income thresholds pertain to each category of eligibility. For most enrollees, income eligibility criteria are based on federal poverty level (FPL) guidelines.
- **Resource Eligibility:** For seniors and people with disabilities, Medicaid places limits on resources including income and certain assets. An individual may become income- or resource-eligible by "spending down" funds on health care services over a defined period. Those eligible through spend down 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. There are limited exceptions, including for refugees and those granted asylum.
- **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 under Medicaid rules. There is no waiting period.

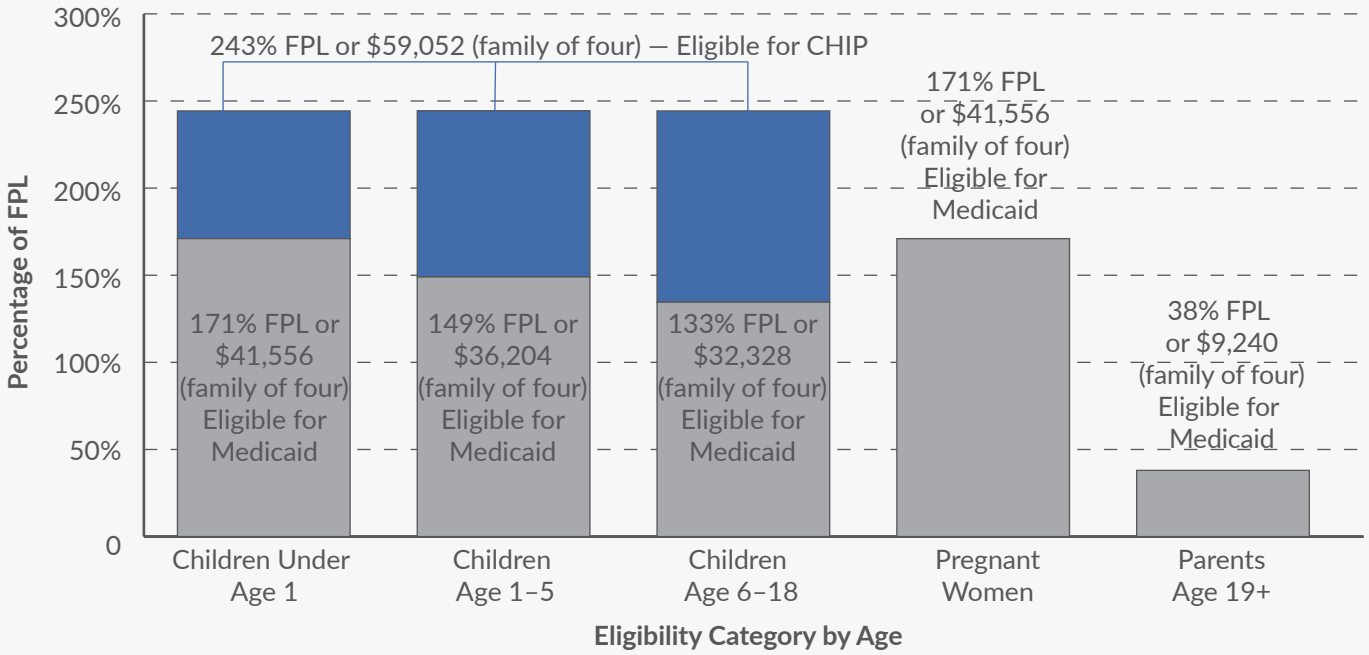
Figure 11. **Federal Poverty Guidelines for the Contiguous 48 States and the District of Columbia, 2016**

PERSONS IN FAMILY/HOUSEHOLD	ANNUAL INCOME
1	$11,880
2	$16,020
3	$20,160
4	$24,300
5	$28,440
6	$32,580
7	$36,730
8	$40,890

For families/households with more than eight persons, add $4,160 for each additional person.

Source: U.S. Department of Health and Human Services, 2016.

Figure 12. **Income Eligibility Levels for Kansas Medicaid and the Children's Health Insurance Program (CHIP), 2016**



Note: Income levels shown are applicable to children and non-elderly adults without disabilities or other health needs that could make them eligible at a different income level. Eligibility levels reflect Modified Adjusted Gross Income (MAGI) rules, including a 5 percent income disregard that may be applied on an individual basis.

Source: Eligibility information from the Division of Health Care Finance, Kansas Department of Health and Environment, 2016.

Medicaid eligibility can be divided into two broad categories: low-income children and families, and low-income seniors and people with disabilities. For more information about populations that must be covered as required by federal law and the optional populations for whom Kansas has extended coverage, see *Figure 13*, page 14.

States have the option to expand Medicaid to include low-income adults up to 138 percent of FPL under the Affordable Care Act (ACA). Kansas has not expanded Medicaid to this population.

Low-Income Children and Families

More than half of Medicaid enrollees are children and families (including pregnant women and low-income parents or caretakers). Children and families tend to use lower-cost services, such as check-ups, vaccinations and treatment for minor illnesses and injuries. All Children's Health Insurance Program (CHIP) enrollees are children up to age 19.

Children: More children than adults are enrolled in Medicaid because they are eligible at a higher income level than adults, as shown in *Figure 12*. The CHIP program extends income levels even higher for children. In 2016, children and infants under age 1 were eligible for Medicaid if their family income was less than 171 percent of FPL ($41,556 for a family of four). Children age 1–5 were eligible if their annual family income was less than 149 percent of FPL ($36,204 for a family of four). Children age 6–18 were eligible if their annual family income was less than 133 percent of FPL ($32,328 for a family of four). All other children up to 243 percent of FPL ($59,052 for a family of four) were eligible for CHIP. Families pay premiums up to $50 a month for CHIP children, depending on household income.

Parents and Pregnant Women: In 2016, parents or caretakers of children with an annual household income up to 38 percent of FPL ($9,240 for a family of four) also were eligible for coverage

Figure 13. **Mandatory and Optional Populations for Medicaid Coverage**

MANDATORY POPULATIONS, REQUIRED BY FEDERAL LAW

- Infants and children whose families earn less than 138 percent of federal poverty level (FPL)
- Infants born to a Medicaid mother
- Parents or caretakers whose incomes are less than 38 percent of FPL
- Pregnant women up to 171 percent of FPL
- Seniors and individuals with disabilities who receive Supplemental Security Income (SSI)
- Individuals who would be eligible for SSI if it were not for Social Security cost-of-living adjustments
- Certain working individuals with disabilities
- Medicare Buy-In Groups: Qualified Medicare Beneficiaries (QMB), Special Low-Income Medicare Beneficiaries (SLMB) and Qualifying Individuals (QI)
- Extended transitional coverage for low-income families who have recently lost eligibility due to higher income or child/spousal support
- Children in foster care (IV-E: Eligible for federal matching funds for foster care services)
- Adopted children with special needs (IV-E)
- Early or disabled widows and widowers
- Children living in a long-term care institution
- Certain adults who qualify for Social Security Disability Insurance based upon a disability occurring in childhood and parental work history

OPTIONAL POPULATIONS, KANSAS-SPECIFIC COVERAGE

- Children's Health Insurance Program (CHIP), up to 243 percent of FPL
- MediKan
- Working Healthy
- Breast and Cervical Cancer
- AIDS Drug Assistance Program (ADAP)
- Tuberculosis
- Non-IV-E foster care and adopted children with special needs
- People in long-term institutional care, subject to income and resource limits
- People receiving home and community-based services
- Program of All-Inclusive Care for the Elderly (PACE)

Kansas also extends Medicaid coverage to the following populations:

- Medically Needy: Aged, disabled and families
- Children: Kansas extends coverage to children under age 1 whose families earn less than 171 percent of FPL; and children ages 1–5 whose families earn less than 149 percent of FPL

Note: The Affordable Care Act extended eligibility for former foster care children up to age 26 as long as they were in foster care and enrolled in Medicaid at age 18. CHIP is a separate program in Kansas, but enrollees have benefits identical to Medicaid-enrolled children. Children's Medicaid coverage is mandatory up to 133 percent of FPL, but a 5 percent income disregard would apply if a state did not have a CHIP program. Under Affordable Care Act maintenance of effort requirements, all children's eligibility levels must be preserved through September 30, 2019.

Source: KanCare Special Terms and Conditions, Centers for Medicare and Medicaid Services (CMS), January 2014; CMS "List of Medicaid Eligibility Groups," accessed October 2016; Medical Assistance Standards, Kansas Department of Health and Environment, 2016.

Adults who are not parents, pregnant, disabled or medically needy are not eligible for Medicaid in Kansas.

under Medicaid. Parents who are above this annual income level were not eligible for Medicaid even though their children might be covered. Adults who are not parents, pregnant, disabled or medically needy are not eligible for Medicaid. Pregnant women and new mothers with incomes below 171 percent of FPL ($41,556 for a family of four) were eligible in 2016.

Low-Income Seniors and Individuals with Disabilities

Seniors and individuals with disabilities frequently have complex health needs, often requiring 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 to qualify for Medicaid. In state fiscal year (FY) 2016, total enrollment for individuals with disabilities and seniors was nearly 103,000. There are various criteria by which seniors and individuals with disabilities are eligible for Medicaid, as highlighted below.

Individuals who Receive Supplemental Security Income (SSI): Individuals who receive federal SSI are automatically eligible for Medicaid. The group includes low-income people who are over age 65 or disabled. 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 services before becoming eligible for Medicaid benefits.

MediKan: People in this program are waiting for the federal government to declare them disabled. The MediKan program assists these people for up to 12 months by providing a limited set of benefits. The MediKan program covered an average of 642 people per month in FY 2016 and cost the state about $3.5 million. This program is not eligible for federal matching dollars and is not included in managed care.

Medically Needy

The medically needy segment of the population is comprised of people who meet the criteria of a categorically eligible group but do not qualify because of excess income or resources. Most people in the medically needy group must pay for 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 and children. Kansas provides coverage for the following groups:

- *Pregnant women;*
- *Children up to age 18, or age 18 and working toward attainment of a high school diploma or its equivalent;*
- *People age 65 or older; and*
- *Persons who are blind or disabled under federal standards.*

Working Healthy: The Working Healthy program offers Medicaid coverage to people age 16 to 64 with disabilities who are working. Income and resource limits apply, but are higher than other Medicaid programs. People in this program must pay a premium for medical services, depending on their income. The Working Healthy program covered approximately 1,200 people on average per month in state FY 2016 and cost the state about $6 million. Total costs, including the federal share, were nearly $15 million.

Medicaid-Medicare Dual Eligibility: 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 21 Kansas counties, adults age 55 and older have the option to enroll in the PACE program. The PACE program provides long-term care services for people who would otherwise be eligible for nursing home care. It is an alternative to KanCare for people who are able to live safely in the community with the support of the PACE program when they join. PACE includes both Medicare and Medicaid services for dually eligible individuals.

Other Medicaid Populations

About 4 percent of Medicaid beneficiaries are in other categories. For example, Medicaid provides coverage for children in the state's foster care and juvenile justice systems, as well as for some children who have been adopted. Medicaid also pays for limited services for eligible individuals with breast and cervical cancer, tuberculosis or AIDS. Medicaid 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 populations are included in managed care, but others are excluded. For more information on populations not included in KanCare, see *Appendix C*, page 19.

Federal Children's Health Insurance Program (CHIP) Legislation

The Balanced Budget Act of 1997 created the Children's Health Insurance Program (CHIP) as part of Title XXI of the Social Security Act to cover uninsured low-income children who are not eligible for Medicaid. All states have expanded children's coverage through the program.

In April 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) became law. As in Medicaid, the state receives matching funds from the federal government for the program, but this matching arrangement differs from Medicaid in that it is a block grant, and the federal match is greater than the match for Medicaid.

Because MACRA extended CHIP for only two years—through September 30, 2017—Congress likely will soon consider reauthorization again. States such as Kansas that operate CHIP programs that are legally distinct from Medicaid would face a difficult decision if Congress were not to reauthorize the program and its federal matching funds that currently pay the majority of CHIP costs.

Appendix A. **Timeline of Important Events: Medicaid and the Children's Health Insurance Program in Kansas**

YEAR	ACTION
1965	Medicaid enacted into law with Medicare.
1967	Early and periodic screening, diagnostic and treatment (EPSDT) requirements added for all Medicaid children.
1972	Federal law required states to cover the elderly and people with disabilities receiving Supplemental Security Income (SSI).
1974	Administration of Kansas Medicaid program transferred from counties to the newly created Department of Social and Rehabilitation Services (SRS).
1981	Omnibus Budget Reconciliation Act of 1981 (OBRA-81) allowed states to make Disproportionate Share Hospital (DSH) Program payments to hospitals serving a large number of Medicaid or uninsured patients.
1981	States permitted to request home and community-based services (HCBS) long-term care services waivers (OBRA 1981).
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.
1996	Personal Responsibility & 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).
1999	Kansas implemented the State Children's Health Insurance Program (SCHIP) based on state law.
1999	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.
1999	U.S. Supreme Court rules in Olmstead v. L.C. that states are required to provide community-based services when institutional care is appropriate.
2004	The Kansas Legislature passed the Hospital Provider Assessment Program.
2005	Kansas Health Policy Authority created to run Medicaid and State Employee Health Insurance Program.
2006	Kansas converted dental services for the Children's Health Insurance Program (CHIP) from managed care to fee-for-service.
2006	Kansas moved mental health services for CHIP (HealthWave) to managed care.
2006	Deficit Reduction Act required verification of citizenship and identity for people applying for Medicaid.
2006	Implementation of Medicare Part D shifted costs of prescription drugs for elderly Medicaid patients to the federal government.
2007	Kansas implemented the Working Healthy program allowing people with disabilities to keep Medicaid support services while working.
2007	Kansas implemented a limited dental benefit for Medicaid beneficiaries with disabilities based on new funding.
2007	Kansas implemented managed care for mental health and substance abuse services.
2008	Kansas implemented the Money Follows the Person demonstration project.
2009	Kansas expanded CHIP to children up to 250 percent of the 2008 federal poverty level.
2009	CHIP Reauthorization Act mandated states to apply Medicaid managed care rules to the operation of CHIP managed care plans.
2010	Affordable Care Act passed, including an expansion of Medicaid to all adults under 138 percent of the federal poverty level.
2010	Kansas discontinued adult preventive dental services.
2011	Kansas shifted Medicaid program administration to the Kansas Department of Health and Environment.
2012	Supreme Court ruled that the Affordable Care Act is constitutional, but Medicaid expansion to low-income adults is optional for states.
2013	Kansas implemented KanCare comprehensive managed care for most Medicaid and CHIP beneficiaries. Adult preventive dental services are provided by MCOs.
2014	Long-term services and supports for members with developmental or intellectual disabilities were added to KanCare.

Source: Kansas Health Institute.

Appendix B. **Services Covered by Medicaid in Kansas**

THE FOLLOWING SERVICES ARE CONSIDERED MANDATORY[7,8]	OPTIONAL SERVICES PROVIDED IN KANSAS[8]
• Inpatient and outpatient hospital services	• Prescription drugs
• Nursing facility services for age 21 and older	• Clinic services
• Physician, midwife and nurse practitioner services	• Physical and occupational therapy
• Immunizations and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children	• Services for people with speech, hearing and language disorders
• Laboratory and x-ray services	• Substance abuse treatment and mental health services (under the Affordable Care Act, Medicaid managed care organizations must comply with the federal parity law for mental health and substance use disorder services)[9]
• Family planning services and supplies	• Medical supplies, orthotics and prosthetics
• Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	• Rehabilitation services
• Pregnancy care and freestanding birth center services	• Hospice services
• Home health services for beneficiaries who are entitled to nursing facility care	• Home and community-based services (HCBS)
• Tobacco cessation counseling and pharmacotherapy for pregnant women	• Intermediate care facility services for individuals with intellectual disabilities (ICF/IID)
• Dental services for children	• Targeted case management
• Non-emergency medical transportation	• Podiatry
	• Chiropractic care
	• Respiratory care for ventilator-dependent individuals
	• Vision services, including optometry and glasses

Sources: Kaiser Family Foundation, Kansas Department of Health and Environment and the Centers for Medicare and Medicaid Services. For more information, see endnotes 7, 8 and 9 on page 24.

Appendix C. **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 copayments. 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.
Public Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	This program is for individuals residing in public ICFs/IID who are not included in KanCare. Individuals residing in a private ICF/IID are included in KanCare.
Residents of Mental Health Nursing Facilities and State Mental Health Hospitals (age 22–64)	This program is for individuals residing in a nursing facility for mental health (NFMH) or a state mental health hospital for a long-term stay and who are between the ages of 22 and 64 years old. Individuals residing in a NFMH or state mental health hospital who are under the age of 22 or over the age of 64 are included in KanCare.

Source: Kansas Health Institute analysis of KanCare Special Terms and Conditions.

Appendix D. **Medicaid Populations Included in KanCare**

POPULATION	DESCRIPTION
Poverty Level-Related Pregnant Women	This eligibility group includes pregnant women eligible based upon poverty guidelines.
Poverty Level-Related Children	This group includes children from birth through age 18 based upon poverty guidelines. Newborns can be deemed eligible for Medicaid if their mother is enrolled in Medicaid.
Children's Health Insurance Program (CHIP)	CHIP is a separate program for children in households with incomes higher than the Medicaid guidelines, up to 243 percent of the federal poverty level. KanCare benefits are identical for children regardless of whether they are CHIP- or Medicaid-eligible.
Low-Income Families with Children	This eligibility group is for families, including parents or caretakers, based upon poverty guidelines.
Transmed—Work Transition	This program allows coverage for up to 12 months for families who had been eligible as *Low-Income Families with Children* and have lost financial eligibility due to increased earnings.
Extended Medical	This program allows coverage for up to four months for families who had been eligible as *Low-Income Families with Children* and have lost financial eligibility due to increased child or spousal support.
Foster Care Medical	This program is for children who have been taken into state custody and placed with an individual, family or institution.
Foster Care (Aged Out)	This program is for children transitioning to adult independent living who are being removed from the *Foster Care Medical* program because they are turning age 18. Coverage may continue up to age 26.
Adoption Support Medical	This program is for adopted children with special needs who were in state custody and were eligible for Medicaid at the time of adoption.
Supplemental Security Income (SSI) Recipients	Most recipients of SSI are automatically eligible for Medicaid. SSI is a federal program that makes monthly payments to people who have low income and few resources, and who are blind, disabled or age 65 and older.
Pickle Amendment	This eligibility group includes people who lose SSI eligiblity due solely to a Social Security cost of living increase.
Adult Disabled Child	This eligiblity group includes adults whose blindness or disability began before age 22 and who lose SSI eligibility because they receive Social Security Disability Insurance under the *Adult Disabled Child* program.
Early or Disabled Widows and Widowers	This eligiblity group includes people who lose SSI eligibility because they begin receiving Social Security early, or disabled widow or widower's benefits, and who meet certain other criteria.
Child in an Institution	This program is for children through age 21 residing in an institution for a long-term stay.
Medically Needy	This program is for people who meet categorical eligibility criteria but have excess income or resources, so they are required to "spend down" by paying a share of their costs.
Breast and Cervical Cancer	This program provides treatment for breast and cervical cancer for low-income women who were screened and diagnosed through the *Early Detection Works* program.

Appendix D continued. **Medicaid Populations Included in KanCare**

POPULATION	DESCRIPTION
Working Healthy	This program provides coverage to people age 16 to 64 with disabilities who are working; income and resource limits are higher for this group than for others, but participants may be required to pay a premium.
Working Healthy Medically Improved	This program provides extended coverage to *Working Healthy* participants who have been determined to no longer meet Social Security disability criteria because of a medical improvement.
Long-Term Institutional Care	The group includes individuals who meet income and resource standards and reside in institutions, except for those residing in a public intermediate care facility for individuals with intellectual disabilities (ICF/IID).
Residents of Nursing Facilities for Mental Health (NFMH) and State Mental Health Hospitals (under age 22, over age 64)	Individuals residing in an NFMH or state mental health hospital who are under the age of 22 or over the age of 64 may be eligible for KanCare.
Home and Community-Based Service Waiver Groups	These individuals are eligible for one of Kansas' seven 1915(c) waivers: Autism, Intellectual/Developmental Disabilities, Frail Elderly, Physical Disabilities, Serious Emotional Disturbance, Technology Assisted and Traumatic Brain Injury.

Source: Kansas Health Institute analysis of KanCare Special Terms and Conditions.

Appendix E: Helpful Links

Find this report online at www.khi.org/policy/article/MedicaidPrimer2017

For more from the sponsors of this report, see:
- Kansas Legislative Research Department: www.kslegislature.org/klrd
- Kansas Health Institute: www.khi.org

For more data and reports about the administration of the Kansas Medicaid program and the Children's Health Insurance Program (CHIP), see:
- Kansas Department of Health and Environment, Division of Health Care Finance: www.kdheks.gov/hcf
- KanCare: www.kancare.ks.gov
- Kansas Department for Aging and Disability Services: www.kdads.ks.gov

For more information about Medicaid and CHIP nationwide, see:
- Centers for Medicare and Medicaid Services: www.medicaid.gov
- Kaiser Commission on Medicaid and the Uninsured: www.kff.org/about/kcmu.cfm
- National Conference of State Legislatures: www.ncsl.org
- National Academy for State Health Policy: www.nashp.org

For more population data about health insurance, see:
- United States Census Bureau: http://www.census.gov/topics/health/health-insurance.html

Appendix F: Glossary

Affordable Care Act (ACA)

The ACA is the federal statute signed into law in March 2010 as a part of the health care reform agenda of the Obama administration. Two laws collectively are known as the ACA: the Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010; just days later, the Health Care and Education Reconciliation Act, which modified provisions of the PPACA, was signed. 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 Medicaid expansion optional for states.

Children's Health Insurance Program (CHIP)

CHIP was established by Title XXI of the Social Security Act. Originally known by the acronym SCHIP—the "S" stood for "State"—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 federal matching funds that are capped. Formerly operated under HealthWave in Kansas, the CHIP program was folded into KanCare in January 2013.

Dual Eligibility

Dual eligibility refers to people who are eligible for both Medicare and Medicaid. Medicare covers only very limited long-term care services. Medicaid covers most nursing facility and home and community-based service costs for seniors and people with disabilities who are eligible for Medicare.

Federal Poverty Level (FPL)

The FPL is defined as the minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, the level is determined by the U.S. 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. In 2016, the FPL for a family of four was an annual income of $24,300. Income eligibility limits for Medicaid, CHIP and other income-based programs are typically set as a percentage of FPL.

KanCare

Since January 1, 2013, Kansas has administered Medicaid and the Children's Health Insurance Program (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 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.

Managed Care Organization (MCO)

A MCO is an organization that receives a defined, "per member per month" fee to coordinate care and pay for services provided to members enrolled in its plan. In KanCare, the state has contracted with three MCOs to provide services for 96 percent of Medicaid and CHIP members. Federal law generally requires that members have a choice of at least two different plans. In addition, MCOs must have adequate networks of providers to ensure members have access to covered services.

Medically Needy

The medically needy segment of the population is comprised of people who meet the criteria of a categorically needy program such as age or disability but do not qualify because of excess income or resources. Most people in the medically needy group must pay a share of their medical costs through the "spend-down" process.

MediKan

MediKan was established in Kansas in 1973 to bridge the gap between the time that an adult becomes disabled and the time they begin receiving federal disability payments. The program is funded by the state and does not receive federal matching payments. MediKan provides a limited benefit package for up to a total of 12 months. It is not included in KanCare.

Program of All-Inclusive Care for the Elderly (PACE)

PACE is a program for people age 55 and older who would qualify to reside in a nursing facility but who can live independently with the support of an interdisciplinary team. It covers all medically necessary care and services. PACE consumers can be enrolled in either Medicare or Medicaid, or both. They can also pay for PACE privately if they are not eligible for either program. PACE is provided as an alternative to KanCare for eligible adults who live in one of the 21 counties with an approved provider.

Spend Down

A spend down for people in the medically needy group works like an insurance deductible. Eligible members pay a predetermined amount of their health care bills before Medicaid coverage takes over. The amount differs for every medically needy person and family and is determined by how much countable income they may have above the protected income limit. Deductions from countable income are given for earned income. The spend-down period is usually six months.

State Plan Amendment (SPA)

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

Supplemental Security Income (SSI)

SSI is a federal program that makes monthly payments to people who have low income and few resources, and who are blind, disabled or age 65 and older. SSI eligibility determinations are made by the Social Security Administration. Most people eligible for SSI are automatically eligible for Medicaid.

Waiver

A state must submit a waiver to make an exception to federal requirements of the Medicaid program. Kansas has 1915(c) waivers for home and community-based services (HCBS), and a Section 1115 demonstration waiver for KanCare. Waivers are for set periods of time—generally three to five years—and may be renewed through a public process. Waivers and state plan amendments (SPAs) are the only ways that a state can administratively change the structure of its Medicaid program.

In 2017, the federal government will pay approximately 56 percent of Kansas Medicaid costs and about 92 percent of Kansas CHIP costs.

Endnotes

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6. Centers for Medicare and Medicaid Services. *Financial Management Report for Federal Fiscal Year (FFY) 2014*. Based on state fiscal year (FY) 2014 expenditure data.
7. Paradise, Julia. *Medicaid Moving Forward*. Kaiser Family Foundation. March 9, 2015.
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ACRONYM	MEANING
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
BBA	Balanced Budget Act
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
DAI	Data Analytic Interface
DCF	Kansas Department for Children and Families
DHCF	Division of Health Care Finance
DSH	Disproportionate Share Hospital Program
E-LMB	Expanded Low-Income Medicare Beneficiary
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FY	State Fiscal Year
HCBS	Home and Community-Based Services
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
IV-E	Title IV-E of the Social Security Act
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KHI	Kansas Health Institute
KHPA	Kansas Health Policy Authority
KLRD	Kansas Legislative Research Department
LMB	Low-Income Medicare Beneficiary
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAGI	Modified Adjusted Gross Income
MAR	Medical Assistance Report
MCO	Managed Care Organization
NFMH	Nursing Facility for Mental Health
OMBRA-81	Omnibus Budget Reconciliation Act of 1981
PACE	Program of All-Inclusive Care for the Elderly
PMPM	Per Member Per Month
PPACA	Patient Protection and Affordable Care Act
PRWOA	Personal Responsibility & Work Opportunity Act
QI	Qualifying Individuals
QMB	Qualified Medicare Beneficiary
RHC	Rural Health Clinic
SCHIP	State Children's Health Insurance Program (now called CHIP)
SLMB	Special Low-Income Medicare Beneficiaries
SOBRA	Sixth Omnibus Budget Reconciliation Act
SPA	State Plan Amendment
SSI	Supplemental Security Income

KANSAS HEALTH INSTITUTE

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