2019 Special Committee on Medicaid Expansion November 12 - November 13, 2019

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February 2019 | Issue Brief

Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers

Elizabeth Hinton, MaryBeth Musumeci, Robin Rudowitz, Larisa Antonisse, and Cornelia Hall

Section 1115 Medicaid demonstration waivers provide states an avenue to test new approaches in Medicaid that differ from what is required by federal statute. Waivers can provide states considerable flexibility in how they operate their programs, beyond what is available under current law. Waivers generally reflect priorities identified by states and the Centers for Medicare and Medicaid Services (CMS) and often reflect changing priorities from one administration to another. In November 2017, CMS, under the Trump administration, posted revised criteria for Section 1115 waivers that no longer include the goal of increasing coverage, as in prior administrations. In January 2018, CMS posted new guidance to allow state Section 1115 waiver proposals to condition Medicaid on meeting a work requirement and subsequently has approved the first waivers of that type in the history of the Medicaid program. Each administration has some discretion over which waivers to approve and encourage (see Appendix A) but that discretion is not unlimited. Litigation challenging waiver approvals in Kentucky and Arkansas is ongoing.[1]

Section 1115 waiver activity is expected to continue both through administrative actions and the courts. This brief provides basic information about the purpose and function of Section 1115 waivers, describes the current administration's waiver priorities, and discusses trends in recent state waiver requests and waiver decisions. The most current activity is contained in our Medicaid waiver tracker,[2] which shows approved and pending waivers.

What are Section 1115 Medicaid waivers?

Authority and Purpose. Under Section 1115 of the Social Security Act, the Secretary of HHS can waive specific provisions of major health and welfare programs, including certain requirements of Medicaid and CHIP. This authority permits the Secretary to allow states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under the federal rules, as long as the Secretary determines that the initiative is an "experimental, pilot, or demonstration project" that "is likely to assist in promoting the objectives of the program."[3] States can obtain "comprehensive" Section 1115 waivers that make broad changes in Medicaid eligibility, benefits and cost-sharing, and provider payments across their programs.[4,5] There also are narrower Section 1115 waivers that focus on specific services or populations. While the Secretary's waiver authority is broad, it is not unlimited. There are some elements of the program that the Secretary does not have authority to waive, such as the federal matching payment system for states, or requirements that are rooted in the Constitution such as the right to a fair hearing.[6] Waivers are typically approved for a five-year period and can be extended, typically for three years.

Financing. While not set in statute or regulation, a longstanding component of Section 1115 waiver policy is that waivers must be budget neutral for the federal government. This means that federal costs under a waiver must not exceed what federal costs would have been for that state without the waiver, as calculated by the administration. The federal government generally enforces budget neutrality by establishing a per member per month cap on federal funds under the waiver, putting the state at risk for increases in per member per month costs but not for increased costs due to enrollment growth.[7]

Transparency, Public Input, and Evaluation. The Affordable Care Act (ACA) made Section 1115 waivers subject to new rules about transparency, public input, and evaluation. In February 2012, HHS issued new regulations that require public notice and comment periods at the state and federal levels before new Section 1115 waivers and extensions of existing waivers are approved by CMS.[8,9] Although the final regulations involving public notice do not require a state-level public comment period for amendments to existing/ongoing demonstrations, CMS has historically applied these regulations to amendments. The ACA also implemented new evaluation requirements for these waivers, including that states must have a publicly available, approved evaluation strategy.[10] States have traditionally been required to submit quarterly reports and must submit an annual report to HHS that describes the changes occurring under the waiver and their impact on access, quality, and outcomes.[11,12]

What waiver priorities have been identified by the Trump administration?

New Waiver Approval Criteria. Marking a new direction for Medicaid waivers, on November 7, 2017, CMS posted revised criteria for evaluating whether Section 1115 waiver applications further Medicaid program objectives (see Appendix B).[13] The revised criteria no longer include expanding coverage among the stated objectives. Instead, the revised waiver criteria focus on positive health outcomes, efficiencies to ensure program sustainability, coordinated strategies to promote upward mobility and independence, incentives that promote responsible beneficiary decision-making, alignment with commercial health products, and innovative payment and delivery system reforms.

Work Requirements / Community Engagement. CMS also has issued new guidance identifying waiver policy priority areas and inviting applications from states. In January 2018, CMS issued new guidance for Section 1115 waiver proposals that impose work requirements (referred to as community engagement) in Medicaid as a condition of eligibility. This action reverses previous Democratic and Republican administrations, which had not approved such waiver requests on the basis that such provisions would not further the program's purposes of promoting health coverage and access. The guidance asserts that such provisions would promote program objectives by helping states "in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement." In June 2018, a federal district court invalidated CMS's initial approval of Kentucky's waiver, which included a work requirement and other eligibility restrictions, finding that the Secretary failed to consider the waiver's impact on Medicaid's primary objective of providing affordable health coverage. Litigation challenging CMS's re-approval of Kentucky's waiver as well as CMS's approval of a work requirement waiver in Arkansas is ongoing.

Opioids / Behavioral Health. CMS continues to use waivers to help states address the opioid epidemic as well as broader behavioral health initiatives. On November 1, 2017, CMS issued a state Medicaid director letter revising guidance issued by the Obama administration in July 2015. The revised guidance continues to allow states to use Section 1115 waivers to pay for substance use disorder (SUD) treatment services in "institutions for mental disease" (IMDs), and CMS continues to approve IMD SUD payment waivers.[14] On November 13, 2018, CMS also issued new guidance inviting states to apply for Section 1115 waivers of the federal IMD payment exclusion for services for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED). This guidance reverses prior CMS policy to not use Section 1115 waiver authority to allow Medicaid payments for non-elderly adults with a primary mental health diagnosis in IMDs[15] and could have implications for states' community integration obligations under the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision. As of early February 2019, CMS has not posted any state waiver applications under the new guidance. CMS notes that states may participate in the SUD demonstration opportunity and the SMI/SED demonstration at the same time.

Process and Evaluation. CMS released an Informational Bulletin in November 2017 indicating it will consider approving "routine, successful, non-complex" Section 1115 waiver extension requests for up to 10 years.[16] On December 28, 2017, CMS approved the Mississippi Family Planning Medicaid Waiver extension for a 10-year period. Mississippi is the first state to receive a 10-year Section 1115 waiver extension under the new policy. In the same November 2017 guidance, CMS also signaled an interest in moving toward reducing the frequency of reporting required for states from quarterly to semi-annually or annually for certain demonstrations. CMS's August 2017 renewal of Florida's Managed Medical Assistance Section 1115 waiver allows the state to submit annual reports (and semi-annual reports at CMS's request) instead of quarterly reports.

Endnotes

[1] In June 2018, the DC federal district court set aside the work requirement and other provisions that restrict eligibility and enrollment in the Kentucky HEALTH waiver approval and sent it back to HHS to reconsider. In November 2018, CMS re-approved the Kentucky waiver. In January 2019, the plaintiffs filed an amended complaint challenging CMS's re-approval of the waiver, and briefing is underway.

[2] Major areas of focus of current approved state Section 1115 waivers include: the implementation of alternative ACA Medicaid expansion models; eligibility and enrollment restrictions; work requirements; benefit restrictions, copays and healthy behaviors; delivery system reform initiatives; behavioral health; authorizing the delivery of Medicaid long-term services and supports (LTSS) through capitated managed care; and responding to public health emergencies and providing coverage for other targeted groups.

[3] 42 U.S.C. § 1315.

[4] Some states have multiple waivers, and many waivers are comprehensive and may fall into a few different areas.

[5] Increasingly, states are using Section 1115 waivers to combine programs under one single authority (e.g., including authorities otherwise available under Section 1915 (b) managed care waivers and/or Section 1915 (c) home and community based services waivers, along with Section 1115 authority for other eligibility, benefits, delivery system, and payment reforms).

[6] The Secretary's waiver authority is limited to the provisions of 42 U.S.C. § 1396a, provided that waivers are demonstration projects that further Medicaid program objectives. 42 U.S.C. § 1315.

[7] On August 22, 2018, CMS released a letter to state Medicaid directors describing current policies related to budget neutrality for Section 1115 Medicaid demonstration projects.

[8] Kaiser Commission on Medicaid and the Uninsured, *The New Review and Approval Process Rule for Section 1115 Medicaid and CHIP Demonstration Waivers,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2012), http://kff.org/health-reform/fact-sheet/the-new-review-and-approvalprocess-rule/.

[9] Indiana filed an amendment to its pending extension on May 25, 2017 and Kentucky filed an amendment to its pending application on July 3, 2017. Neither state held a state-level public comment period before submission to CMS. Although the final regulations involving public notice do not require a state-level public comment period for amendments to existing/ongoing demonstrations, CMS has historically applied these regulations to amendments. However, these amendments were not to ongoing demonstrations but to a new waiver request (KY) and extension request (IN).

[10] However, CMS relieved Montana from the requirement to evaluate its expansion waiver based on its participation in a cross-state federal evaluation.

[11] Robin Rudowitz, MaryBeth Musumeci, and Alexandra Gates, *Medicaid Expansion Waivers: What Will We Learn?* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2016), http://kff.org/medicaid/issue-brief/medicaid-expansion-waivers-what-will-we-learn/.

[12] The November 6, 2017 CMCS Information Bulletin (found at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617-2.pdf) on Section 1115 demonstration process improvements also signaled CMS's interest in moving toward reducing the frequency of reporting required for states to semi-annually or annually for certain demonstrations.

[13] "About Section 1115 Demonstrations," CMS, last accessed Jan. 29, 2019, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html.

[14] Federal law generally bars states from receiving "any such [federal Medicaid] payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an [IMD]." 42 U.S.C. § 1396d (a)(29)(B).

[15] One state, Vermont, currently has waiver authority for IMD mental health services, but those payments must be phased out between 2021 and 2025. Vermont had sought expanded waiver authority for IMD mental health services, and other states, including Illinois, Massachusetts, and North Carolina, had sought IMD mental health authority; all of these requests were denied by CMS. In the Vermont, Illinois, and North Carolina denials, CMS specifically cited its

policy to not allow Medicaid payments for individuals who receive only mental health treatment in IMDs. Maryland also indicated that CMS had denied its request for IMD mental health payment waiver authority.

[16] This CMCS Information Bulletin also outlines changes to the "fast track" federal review process for Section 1115 waiver extension requests, removing the requirement that states must have at least one full extension cycle without "substantial program changes" before they are eligible to be considered for the "fast track" review process. (The "fast track" process was designed to expedite the federal review of certain Section 1115 waiver extensions requests that meet specified criteria.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG 16 2019

The Honorable Gary R. Herbert
Governor of Utah
Salt Lake City, UT 84114

Dear Governor Herbert:

This letter pertains to your 1115 demonstration request entitled, "Per Capita Cap," submitted on August 1, 2019. Thank you for your submission. The Centers for Medicare & Medicaid Services (CMS) has long supported state flexibility to design innovative Medicaid demonstrations that improve outcomes and promote fiscal sustainability.

CMS is committed to working with Utah on achieving its goals for the Medicaid program. While the state's application remains under review, I wanted to inform you of CMS's policy related to two elements of the proposal. Utah, like some other states, has asked CMS to approve a demonstration under which the state would cover only a portion of the adult expansion group and still access the enhanced federal funding available under section 1905(y)(1) of the Social Security Act. While we have carefully considered these requests, CMS will continue the existing policy of only approving section 1115 demonstrations under which the section 1905(y)(1) match rate is provided if the demonstration covers the entire adult expansion group.[1]

Additionally, enrollment caps would also have the effect of limiting enrollment to less than the full group otherwise eligible for Medicaid, which would be tantamount to "partial expansion." Therefore, in light of our decision to retain our existing policy of only providing an enhanced match if the full group is covered, we will not authorize the enhanced match rate if enrollment caps are implemented through section 1115 demonstrations for the new adult group.

Although we will not be able to approve these components of Utah's request, the CMS team is working to analyze the other elements of the proposal and will continue to support state efforts to design reforms that promote the objectives of the Medicaid program while ensuring greater fiscal and programmatic sustainability.

CMS looks forward to continuing to assist you in this important work to increase coverage for low-income Utahans in a fiscally sustainable manner. We are committed to working with your team to provide feedback in as timely manner as possible. If you have any questions, please feel free to reach out to me or contact Calder Lynch, Acting Deputy Administrator and Director, Center for Medicaid and CHIP Services at 202-690-7428.

Sincerely,

[redacted]

Seema Verma

[1] See CMS Statement on Partial Medicaid Expansion Policy, *available at* https://www.cms.gov/newsroom/press-releases/cms-statement-partial-medicaid-expansion-policy.

2019 Federal Poverty Guidelines*

Federal Poverty Percentage	Household Size							
	1	2	3	4	5	6	7	8
24%	$ 2,998	$ 4,058	$ 5,119	$ 6,180	$ 7,241	$ 8,302	$ 9,362	$ 10,423
27%	3,372	4,566	5,759	6,953	8,146	9,339	10,533	11,726
29%	3,622	4,904	6,186	7,468	8,749	10,031	11,313	12,595
37%	4,621	6,257	7,892	9,528	11,163	12,798	14,434	16,069
50%	6,245	8,455	10,665	12,875	15,085	17,295	19,505	21,715
75%	9,368	12,683	15,998	19,313	22,628	25,943	29,258	32,573
100%	12,490	16,910	21,330	25,750	30,170	34,590	39,010	43,430
106%	13,239	17,925	22,610	27,295	31,980	36,665	41,351	46,036
125%	15,613	21,138	26,663	32,188	37,713	43,238	48,763	54,288
130%	16,237	21,983	27,729	33,475	39,221	44,967	50,713	56,459
133%	16,612	22,490	28,369	34,248	40,126	46,005	51,883	57,762
138%	17,236	23,336	29,435	35,535	41,635	47,734	53,834	59,933
150%	18,735	25,365	31,995	38,625	45,255	51,885	58,515	65,145
185%	23,107	31,284	39,461	47,638	55,815	63,992	72,169	80,346
200%	24,980	33,820	42,660	51,500	60,340	69,180	78,020	86,860
220%	27,478	37,202	46,926	56,650	66,374	76,098	85,822	95,546
221%	27,603	37,371	47,139	56,908	66,676	76,444	86,212	95,980
225%	28,103	38,048	47,993	57,938	67,883	77,828	87,773	97,718
238%	29,726	40,246	50,765	61,285	71,805	82,324	92,844	103,363
241%	30,101	40,753	51,405	62,058	72,710	83,362	94,014	104,666
243%	30,351	41,091	51,832	62,573	73,313	84,054	94,794	105,535
250%	31,225	42,275	53,325	64,375	75,425	86,475	97,525	108,575
300%	37,470	50,730	63,990	77,250	90,510	103,770	117,030	130,290
400%	49,960	67,640	85,320	103,000	120,680	138,360	156,040	173,720

For households with more than 8 persons, add $4,420 for each additional person in the household for 100% of FPL.

* From U.S. Department of Health and Human Services (www.aspe.hhs.gov). Figures are for the 48 contiguous states and the District of Columbia.

Note: The HHS poverty guidelines, or percentage multiples of them (such as 125 percent) are used as an eligibility criterion by a number of federal programs including Head Start, Supplemental Nutrition Assistance Program (formerly known as Food Stamps), National School Lunch Program, Low-Income Home Energy Assistance, Children's Health Insurance Program, and some parts of the Medicaid program. In general, cash public assistance programs do not use these poverty guidelines in determining eligibility. A more detailed list of programs that use and do not use these guidelines can be found at www.aspe.hhs.gov.

Appendix A. FMAP Rates for Medicaid, by State

Table A-1 shows regular FY2014-FY2019 FMAP rates calculated according to the formula described in the text of the report (see "How FMAP Rates Are Calculated"). In FY2019, FMAP rates range from 50% (14 states) to 76% (Mississippi). From FY2018 to FY2019, regular FMAP rates are to decrease for 13 states, increase for 23 states, and remain the same for 15 states (including the District of Columbia). Most of the states (14 states) for which the FMAP rates do not change have the statutory minimum FMAP rate of 50%, and the FMAP rate for the District of Columbia is statutorily set at 70%.

Table A-1. Regular FMAP Rates, by State, FY2014-FY2019

State	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	Change FY2018 to FY2019
Alabama	68.12	68.99	69.87	70.16	71.44	71.88	0.44
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Arizona	67.23	68.46	68.92	69.24	69.89	69.81	-0.08
Arkansas	70.10	70.88	70.00	69.69	70.87	70.51	-0.36
California	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Colorado	50.00	51.01	50.72	50.02	50.00	50.00	0.00
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Delaware	55.31	53.63	54.83	54.20	56.43	57.55	1.12
District of Columbia[a]	70.00	70.00	70.00	70.00	70.00	70.00	0.00
Florida	58.79	59.72	60.67	61.10	61.79	60.87	-0.92
Georgia	65.93	66.94	67.55	67.89	68.50	67.62	-0.88
Hawaii	51.85	52.23	53.98	54.93	54.78	53.92	-0.86
Idaho	71.64	71.75	71.24	71.51	71.17	71.13	-0.04
Illinois	50.00	50.76	50.89	51.30	50.74	50.31	-0.43
Indiana	66.92	66.52	66.60	66.74	65.59	65.96	0.37
Iowa	57.93	55.54	54.91	56.74	58.48	59.93	1.45
Kansas	56.91	56.63	55.96	56.21	54.74	57.10	2.36
Kentucky	69.83	69.94	70.32	70.46	71.17	71.67	0.50
Louisiana[b]	62.11	62.05	62.21	62.28	63.69	65.00	1.31
Maine	61.55	61.88	62.67	64.38	64.34	64.52	0.18
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Michigan	66.32	65.54	65.60	65.15	64.78	64.45	-0.33
Minnesota	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Mississippi	73.05	73.58	74.17	74.63	75.65	76.39	0.74
Missouri	62.03	63.45	63.28	63.21	64.61	65.40	0.79

State	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	Change FY2018 to FY2019
Montana	66.33	65.90	65.24	65.56	65.38	65.54	0.16
Nebraska	54.74	53.27	51.16	51.85	52.55	52.58	0.03
Nevada	63.10	64.36	64.93	64.67	65.75	64.87	-0.88
New Hampshire	50.00	50.00	50.00	50.00	50.00	50.00	0.00
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	0.00
New Mexico	69.20	69.65	70.37	71.13	72.16	72.26	0.10
New York	50.00	50.00	50.00	50.00	50.00	50.00	0.00
North Carolina	65.78	65.88	66.24	66.88	67.61	67.16	-0.45
North Dakota	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Ohio	63.02	62.64	62.47	62.32	62.78	63.09	0.31
Oklahoma	64.02	62.30	60.99	59.94	58.57	62.38	3.81
Oregon	63.14	64.06	64.38	64.47	63.62	62.56	-1.06
Pennsylvania	53.52	51.82	52.01	51.78	51.82	52.25	0.43
Rhode Island	50.11	50.00	50.42	51.02	51.45	52.57	1.12
South Carolina	70.57	70.64	71.08	71.30	71.58	71.22	-0.36
South Dakota	53.54	51.64	51.61	54.94	55.34	56.71	1.37
Tennessee	65.29	64.99	65.05	64.96	65.82	65.87	0.05
Texas	58.69	58.05	57.13	56.18	56.88	58.19	1.31
Utah	70.34	70.56	70.24	69.90	70.26	69.71	-0.55
Vermont	55.11	54.01	53.90	54.46	53.47	53.89	0.42
Virginia	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Washington	50.00	50.03	50.00	50.00	50.00	50.00	0.00
West Virginia	71.09	71.35	71.42	71.80	73.24	74.34	1.10
Wisconsin	59.06	58.27	58.23	58.51	58.77	59.37	0.60
Wyoming	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Number with increase from previous year	14	21	22	25	25	23	
Number stayed the same from previous year	14	12	12	13	13	14	
Number with decrease from previous year	22	17	16	12	12	13	

Source: Department of Health and Human Services, Annual *Federal Register* Notices.

Notes: Reflects FMAP rates calculated using the regular FMAP formula, with exceptions noted below.

a. Section 4725(b) of the Balanced Budget Act of 1997 amended Section 1905(b) to provide that the FMAP rate for the District of Columbia shall be set at 70% for purposes of titles XIX and XXI and for capitation payments and DSH allotments under those titles. For other purposes, the percentage for the District of Columbia is 50%, unless otherwise specified by law.

b. Louisiana's FMAP rate was higher than the regular FMAP rate from the fourth quarter of FY2011 through FY2014 due to the disaster-recovery FMAP adjustment. In FY2011, Louisiana's FMAP rate was its regular FMAP rate of 63.61% for the first three quarters of the year, and the disaster-recovery adjusted FMAP rate that took effect for the fourth quarter of the year was 68.04%. The table reflects the disaster-recovery adjusted FMAP rates for FY2012 through FY2014, but the regular FMAP rates for those years would have been 61.09% for FY2012, 61.24% for FY2013, and 60.98% for FY2014.

West's Kansas Statutes Annotated
Chapter 44. Labor and Industries
Article 12. Minimum Wage and Maximum Hours

K.S.A. 44-1203

44-1203. Same; minimum wage; computation; applicability of section

Currentness

(a) Except as otherwise provided in the minimum wage and maximum hours law, every employer shall pay to each employee wages at a rate as follows:

(1) Prior to January 1, 2010, employee wages shall be paid at a rate of not less than $2.65 an hour; and

(2) on and after January 1, 2010, employee wages shall be paid at a rate of not less than $7.25 an hour.

(b) In calculating such minimum wage rate, an employer may include tips and gratuities received by an employee if such tips and gratuities have customarily constituted part of the remuneration of the employee and if the employee concerned actually received and retained such tips and gratuities. For employees receiving tips and gratuities, the employer shall pay a minimum wage of at least $2.13 an hour. If when combined with the minimum wage rate prescribed in this subsection the amount of the employee's tips and gratuities are:

(1) At least equal to $7.25 an hour, no further payment is required by the employer; or

(2) less than $7.25 an hour, the employer must pay the employee the difference between $7.25 an hour and the actual hourly amount received by the employee determined by combining the amount of tips and gratuities received by the employee with the minimum wage prescribed by this subsection paid by the employer.

(c) The provisions of this section shall not apply to any employers and employees who are covered under the provisions of the federal fair labor standards act (29 U.S.C.A. § 201 et seq.), and any other acts amendatory thereof or supplemental thereto.

Credits
Laws 1977, ch. 179, § 5; Laws 1988, ch. 175, § 2; Laws 2009, ch. 115, § 1, eff. July 1, 2009.

Notes of Decisions (6)

K. S. A. 44-1203, KS ST 44-1203
Statutes are current through laws effective on or before July 1, 2019, enacted during the 2019 Regular Session of the Kansas Legislature.

Identifying Full-time Employees

Basic Information

Determining which employees are full-time employees is central to the employer shared responsibility provisions. An employer must identify its full-time employees as part of determining:

1. If it is an ALE and, therefore, subject to the employer shared responsibility provisions;
2. To whom it must offer minimum essential coverage to avoid an employer shared responsibility payment; and
3. The amount of any potential liability for an employer shared responsibility payment. Note that an employer is not obligated to calculate its liability, and should not make a payment without first being contacted by the IRS.

Definition of Full-Time Employee

For purposes of the employer shared responsibility provisions, a full-time employee is, for a calendar month, an employee employed on average at least 30 hours of service per week, or 130 hours of service per month.

There are two methods for determining full-time employee status:

- The monthly measurement method, and
- The look-back measurement method.

Under the monthly measurement method, the employer determines if an employee is a full-time employee on a month-by-month basis by looking at whether the employee has at least 130 hours of service for each month.

Under the look-back measurement method, an employer may determine the status of an employee as a full-time employee during what is referred to as the stability period, based upon the hours of service of the employee in the preceding period, which is referred to as the measurement period. The look-back measurement method may **not** be used to determine full-time employee status for purposes of ALE status determination.

For more information on each of these methods, see section 54.4980H-3 of the ESRP regulations.

Hour of Service

An hour of service is:

- Each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and
- Each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Exclusion from the definition of hour of service is provided for services performed in certain capacities, which are not counted as hours of service for purposes of the employer shared responsibility provisions:

- Volunteer employees – Hours of bona fide volunteer service for a government entity or tax-exempt organization do not count as hours of service.
- Students performing work-study – Hours of service do not include hours performed by students as part of the federal work study program or a substantially similar program of a state or political subdivision.
- Members of religious orders – Until further guidance is issued, under certain circumstances, a religious order is permitted to not count as an hour of service work performed by an individual who is

Employer Topics

- HealthCare.gov
- Small Business Health Care Tax Credit and the SHOP Marketplace
- Employer Shared Responsibility Provisions
- Information Reporting by Applicable Large Employers
- Information Reporting by Providers of Minimum Essential Coverage
- Affordable Care Act Information Returns (AIR)
- ACA Information Center for Tax Professionals

Related Links

- Small Business Administration
- Department of Labor
- BusinessUSA

subject to a vow of poverty. For this exclusion to apply, the employee must be a member of the religious order and must be performing tasks that are usually required of active members of that order.
- Compensation that is not U.S. source income – Hours of service do not include hours for which an employee receives compensation that is taxed as income from sources outside the United States (generally meaning certain work overseas).

For more information about these exclusions, see our Questions and Answers page and section 54.4980H-1(a)(24) of the ESRP regulations.

Application of Hours of Service to Certain Categories of Employees

Certain categories of employees have hours of service that are particularly challenging to identify or track. In other cases, general rules for determining hours of service in the employer shared responsibility regulations may present special difficulties. For these workers, employers are required to use a reasonable method of crediting hours of service that is consistent with the employer shared responsibility provisions. The preamble to the employer shared responsibility regulations provides guidance for the following categories on certain methods of determining hours of service that are reasonable and certain other methods that are unreasonable:

- Adjunct faculty
- Airline industry employees and others who work layover hours
- Employees who work on-call hours

For more information about determining hours of service for certain categories of employees, see Q&A #23 in our Questions and Answers page and section VI.C of the preamble to the ESRP regulations.

More Information

More information about the employer shared responsibility provisions is available in our Questions and Answers. The Department of the Treasury and the IRS have also issued the following legal guidance related to the employer shared responsibility provisions:

- Regulations on the employer shared responsibility provisions
- Notice 2013-45 (PDF), announcing transition relief for 2014.
- Notice 2014-49 (PDF), regarding a proposed approach to the application of the look-back measurement method in situations in which the measurement period applicable to an employee changes.

More information is also available in this fact sheet (PDF) issued by the U.S. Department of the Treasury.

Page Last Reviewed or Updated: 30-May-2019

Determining if an Employer is an Applicable Large Employer

Basic Information

- Two provisions of the Affordable Care Act apply only to applicable large employers (ALEs):
  - The employer shared responsibility provisions; and
  - The employer information reporting provisions for offers of minimum essential coverage
- Whether an employer is an ALE is determined each calendar year, and generally depends on the average size of an employer's workforce during the prior year.
- If an employer **has fewer than 50** full-time employees, including full-time equivalent employees, on average during the prior year, the employer is not an ALE for the current calendar year. Therefore, the employer is not subject to the employer shared responsibility provisions or the employer information reporting provisions for the current year. Employers who are not ALEs may be eligible for the Small Business Health Care Tax Credit and can find more information about how the Affordable Care Act affects them on the ACA Tax Provisions for Small Employers page.
- If an employer **has at least 50** full-time employees, including full-time equivalent employees, on average during the prior year, the employer is an ALE for the current calendar year, and is therefore subject to the employer shared responsibility provisions and the employer information reporting provisions.
- To determine its workforce size for a year an employer adds its total number of full-time employees for each month of the prior calendar year to the total number of full-time equivalent employees for each calendar month of the prior calendar year and divides that total number by 12.
- The Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 provides that an employee will not be counted toward the 50-employee threshold for a month in which the employee has medical care through the military, including Tricare or Veterans' coverage. This is solely for the purpose of determining whether an employer is an "applicable large employer" subject to the employer shared responsibility rules of § 4980H. For more information, see IRC § 4980H(c)(2) subparagraph (F) "Exemption for Health Coverage Under Tricare or the Veterans Administration."

Full-time Employees and Full-Time Equivalent Employees

A full-time employee for any calendar month is an employee who has on average at least 30 hours of service per week during the calendar month, or at least 130 hours of service during the calendar month.

A full-time equivalent employee is a combination of employees, each of whom individually is not a full-time employee, but who, in combination, are equivalent to a full-time employee. An employer determines its number of full-time-equivalent employees for a month in the two steps that follow:

1. Combine the number of hours of service of all non-full-time employees for the month but do not include more than 120 hours of service per employee, and
2. Divide the total by 120.

An employer's number of full-time equivalent employees (or part-time employees) is only relevant to determining whether an employer is an ALE. An ALE need not offer minimum essential coverage to its part-time employees to avoid an employer shared responsibility payment. A part-time employee's receipt of the premium tax credit for purchasing coverage through the Marketplace cannot trigger an employer shared responsibility payment.

The Employer Shared Responsibility Provision Estimator helps employers understand how the provision works and learn how the provision may apply to them. Employers can use the estimator to determine:

- The number of full-time employees, including full-time equivalent employees,
- Whether an employer might be an applicable large employer, and

Employers Topics

- HealthCare.gov
- Small Business Health Care Tax Credit and the SHOP Marketplace
- Employer Shared Responsibility Provisions
- Information Reporting by Applicable Large Employers
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- ACA Information Center for Tax Professionals

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- BusinessUSA

- For employers that are an applicable large employer, an estimate of the maximum amount of the potential liability for the employer shared responsibility payment that could apply, based on the number of full-time employees reported if an employer fails to offer coverage to its full-time employees.

Basic ALE Determination Examples

Example 1 – Employer is Not an ALE

- Company X has 40 full-time employees for each calendar month during 2018.
- Company X also has 15 part-time employees for each calendar month during 2018 each of whom have 60 hours of service per month.
- When combined, the hours of service of the part-time employees for a month totals 900 [15 x 60 = 900].
- Dividing the combined hours of service of the part-time employees by 120 equals 7.5 [900 / 120 = 7.5]. This number, 7.5, represents the number of Company X's full-time equivalent employees for each month during 2018.
- Employer X adds up the total number of full-time employees for each calendar month of 2018, which is 480 [40 x 12 = 480].
- Employer X adds up the total number of full-time equivalent employees for each calendar month of 2018, which is 90 [7.5 x 12 = 90].
- Employer X adds those two numbers together and divides the total by 12, which equals 47.5 [(480 + 90 = 570)/12 = 47.5].
- Because the result is not a whole number, it is rounded to the next lowest whole number, so 47 is the result.
- So, although Company X has 55 employees in total [40 full-time and 15 part-time] for each month of 2018, it has 47 full-time employees (including full-time equivalent employees) for purposes of ALE determination.
- Because 47 is less than 50, Company X is not an ALE for 2019.

Example 2 – Employer is an ALE

- Company Y has 40 full-time employees for each calendar month during 2018.
- Company Y also has 20 part-time employees for each calendar month during 2018, each of whom has 60 hours of service per month.
- When combined, the hours of service of the part-time employees for a month totals 1,200 [20 x 60 = 1,200].
- Dividing the combined hours of service of the part-time employees by 120 equals 10 [1,200 / 120 = 10]. This number, 10, represents the number of Company Y's full-time equivalent employees for each month during 2018.
- Employer Y adds up the total number of full-time employees for each calendar month of 2018, which is 480 [40 x 12 = 480].
- Employer Y adds up the total number of full-time equivalent employees for each calendar month of 2018, which is 120 [10 x 12 = 120].
- Employer Y adds those two numbers together and divides the total by 12, which equals 50 [(480 + 120 = 600)/12 = 50].
- So, although Company Y only has 40 full-time employees, it is an ALE for 2019 due to the hours of service of its full-time equivalent employees.

Additional examples can be found in section 54-4980H-2 of the ESRP regulations.

Employer Aggregation Rules

Companies with a common owner or that are otherwise related under certain rules of section 414 of the Internal Revenue Code are generally combined and treated as a single employer for determining ALE status. If the combined number of full-time employees and full-time equivalent employees for the group is large enough to meet the definition of an ALE, then each employer in the group (called an ALE member) is part of an ALE and is subject to the employer shared responsibility provisions, even if separately the employer would not be an ALE.

Example 3 – Employers are Aggregated to Determine ALE Status:

- Corporation X owns 100 percent of all classes of stock of Corporation Y and Corporation Z.
- Corporation X has no employees at any time in 2018.
- For every calendar month in 2018, Corporation Y has 40 full-time employees and Corporation Z has 60 full-time employees. Neither Corporation Y nor Corporation Z has any full-time equivalent employees.
- Corporations X, Y, and Z are considered a controlled group of corporations.
- Because Corporations X, Y and Z have a combined total of 100 full-time employees for each month during 2018, Corporations X, Y, and Z together are an ALE for 2019.
- Corporation Y and Z are each an ALE member for 2018.
- Corporation X is not an ALE member for 2019 because it does not have any employees during 2018.

There is an important distinction for employers to keep in mind regarding these aggregation rules. Although employers with a common owner or that are otherwise related generally are combined and treated as a single employer for determining whether an employer is an ALE, potential liability under the employer shared responsibility provisions is determined separately for each ALE member.

Also, a special standard applies to government entity employers in the application of the aggregation rules under section 414. Because section 414 relates to common ownership and ownership isn't a typical arrangement for government entities, and because specific rules under section 414 of the Code for government entities haven't yet been developed, government entities may apply a good faith reasonable interpretation of section 414 to determine if they should be aggregated with any other government entities.

See Q&A #s11 and 44 on our employer shared responsibility provisions questions and answers page for more information.

Seasonal Workers

When determining if an employer is an ALE, the employer must measure its workforce by counting all its employees. However, there is an exception for seasonal workers.

An employer is not considered to have more than 50 full-time employees (including full-time equivalent employees) if both of the following apply:

1. The employer's workforce exceeds 50 full-time employees (including full-time equivalent employees) for 120 days or fewer during the calendar year, and
2. The employees in excess of 50 employed during such 120-day period are seasonal workers.

A *seasonal worker* is generally defined for this purpose as an employee who performs labor or services on a seasonal basis. For example, retail workers employed exclusively during holiday seasons are seasonal workers. For more information about how seasonal workers affect ALE determinations, see our Questions and Answers page. For information on the difference between a seasonal worker and a seasonal employee under the employer shared responsibility provisions see Q&A #26. And for the full definition of seasonal worker, see section 54.4980H-1(a)(39) of the ESRP regulations.

Application to New Employers

A new employer (that is, an employer that was not in existence on any business day in the prior calendar year) is an ALE for the current calendar year if it reasonably expects to employ, and actually does employ, an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the current calendar year. See Q&A #7 on our employer shared responsibility questions and answers page for more information.

More Information

More information about determining ALE status can be found in our Questions and Answers and Publication 5208, Affordable Care Act – Are you an applicable large employer? The Department of the Treasury and the IRS have also issued the following legal guidance related to the employer shared responsibility provisions:

- Regulations on the employer shared responsibility for employers. In particular, section 54.4980H-2 of the regulations addresses rules for determining ALE status.
- Notice 2013-45, announcing transition relief for 2014.

More information is also available in this fact sheet issued by the U.S. Department of the Treasury.

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KANSAS MEDICAID

A Primer 2019

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This report, *Kansas Medicaid: A Primer 2019*, was produced through a partnership of the Kansas Health Institute (KHI) and the Kansas Legislative Research Department (KLRD). KHI authored the report, and KLRD analysts provided content review and analysis.

KHI is a nonprofit, nonpartisan, educational organization based in Topeka. It was established in 1995 with a multiyear grant from the Kansas Health Foundation. KHI provides education based on research and policy analysis of 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.

KHI/19-01

Table of Contents

About this Report

Medicaid and the Children's Health Insurance Program (CHIP) play a substantial role in the Kansas health care system by providing coverage for health services and long-term care to the state's most vulnerable populations.

KHI and KLRD are pleased to provide basic facts and information about Medicaid and CHIP in Kansas. This report, *Kansas Medicaid: A Primer 2019*, includes an overview of Medicaid and CHIP, analysis of recent trends in Kansas, and basic information about covered services and populations.

In the two years since the last edition of this report, federal policy has continued to evolve, and more change is likely to be on the horizon. KanCare, the state's comprehensive managed care program, has been in place for six years, and this report captures data from across that period, as well as data from the pre-KanCare period.

This report is the fifth edition of this information, following 2005, 2009, 2014 and 2017 versions. Unless otherwise noted, data used in this report come from the Kansas Department of Health and Environment (KDHE) through the publicly available Medical Assistance Report (MAR). Figures that depend upon encounter data, or data about individual claims related to services paid for by managed care organizations, come from KDHE's Data Analytic Interface (DAI).

Introduction to Medicaid and CHIP

Medicaid provides health care coverage to low-income dependent children, parents, pregnant women, people with disabilities and seniors, as well as some individuals with specific health conditions. The related Children's Health Insurance Program (CHIP) provides similar coverage to uninsured low-income children who are not eligible for Medicaid.

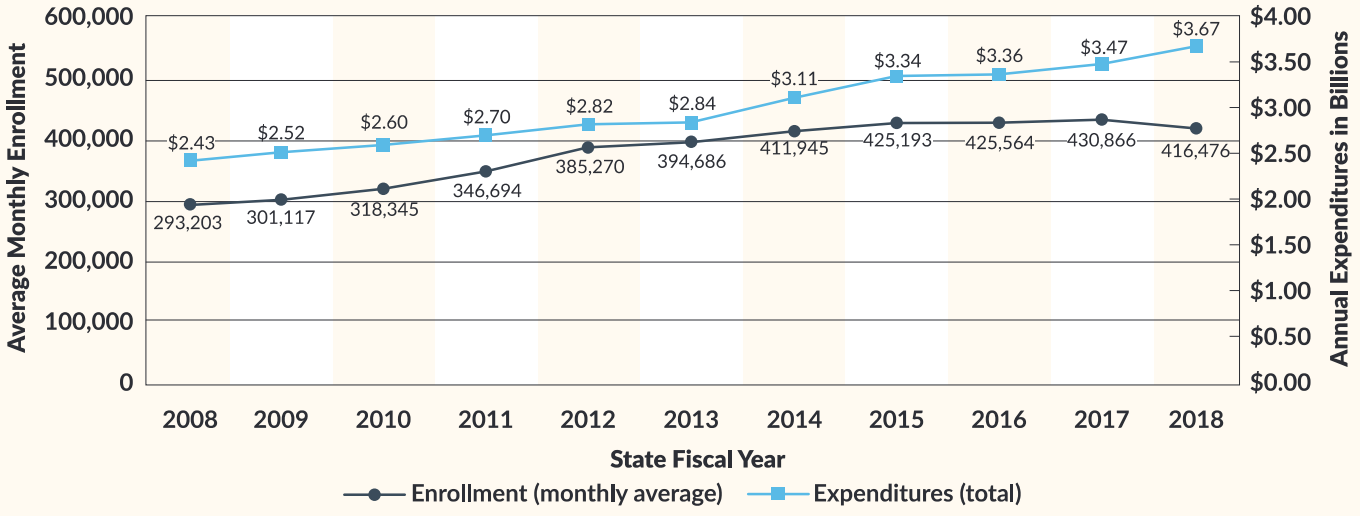
Medicaid is the second-largest source of health coverage in the nation, following employment-based coverage. It is a publicly financed source of health insurance and long-term care coverage for eligible population groups, jointly funded by the federal government and the states. Medicaid is the third-largest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

In state fiscal year (FY) 2018, Medicaid and CHIP covered an average of 416,476 people in Kansas per month at a cost of almost $3.7 billion for the year, as shown in *Figure 1*. Expenditures for Medicaid and CHIP have increased steadily since 2008. While enrollment in Medicaid and CHIP increased each fiscal year between 2008 and 2017, enrollment decreased in FY 2018. Medicaid enrollment also has declined in other states, with some attributing the change to a stable economy and reductions in Affordable Care Act-related enrollment.[2]

In federal fiscal year (FFY) 2016, national Medicaid spending was estimated at $575.9 billion, while national CHIP spending was estimated at $15.6 billion.[3,4] In Kansas, the federal government will contribute approximately $1.33 during FFY 2019 for every $1 of regular state Medicaid spending, although the match rate can vary for certain expenses.[5] (For example, most administrative costs are split equally between the federal and state government.) Stated another way, the federal government pays 57.1 percent of Medicaid expenses in Kansas. The rate of this match varies from state to state and can change from year to year as the relative economic position of the state improves or worsens. In general, federal match rates are higher in poorer states. The match rate also varies by program; for example, the CHIP match rate in Kansas is 92.97 percent in FFY 2019.[6]

In FY 2017, Medicaid and CHIP accounted for 20 percent of actual expenditures in the Kansas State General Fund 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).[7]

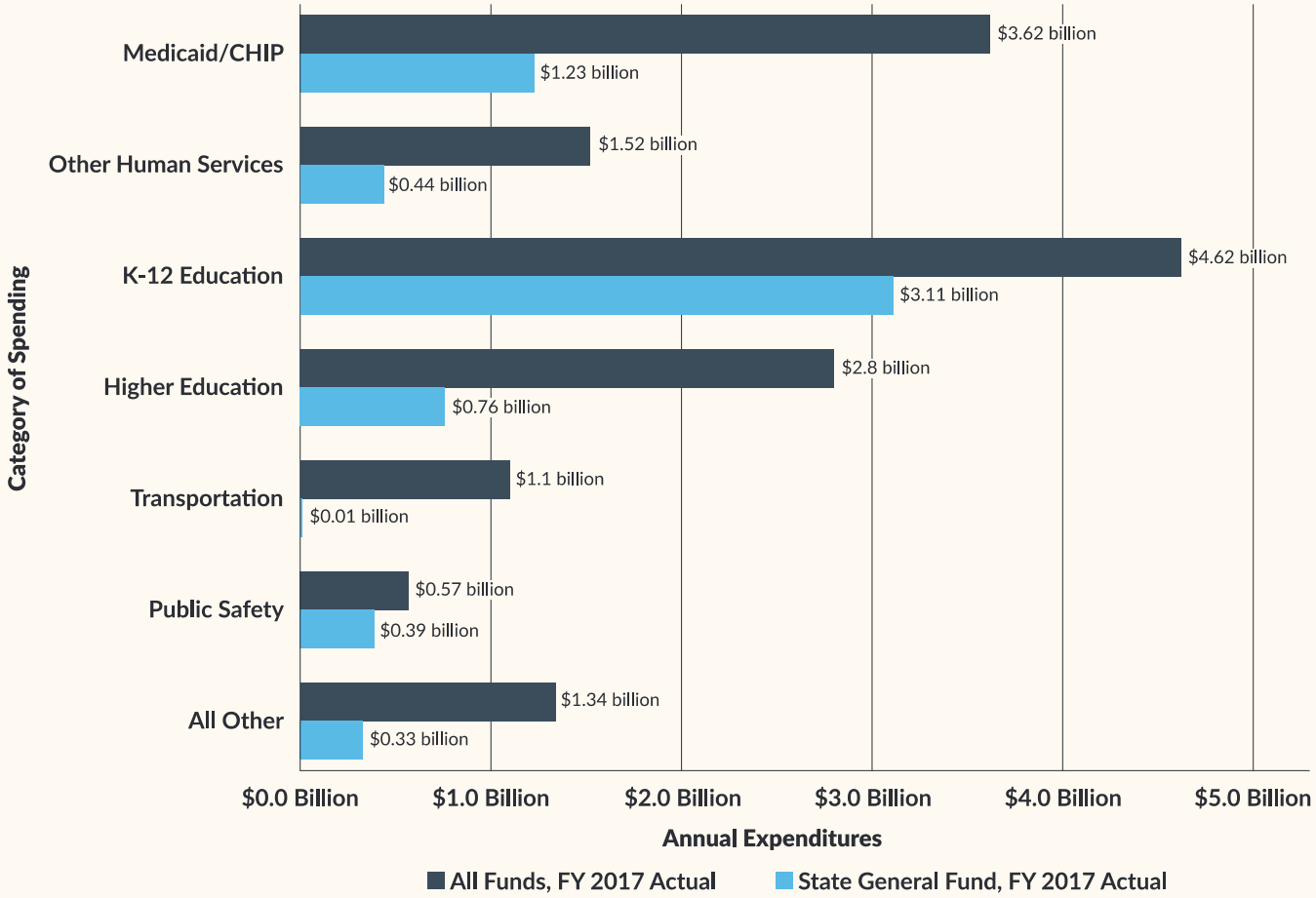
Figure 1. **Medicaid and CHIP Average Monthly Enrollment and Annual Expenditures in Kansas, Fiscal Years 2008–2018**



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 fiscal year.

Source: KHI Analysis of Kansas Medical Assistance Report (MAR), 2008–2018, Division of Health Care Finance, Kansas Department of Health and Environment.

Figure 2. **Medicaid and CHIP Spending Compared to all Categories of Spending, Kansas Fiscal Year 2017**



Note: Medicaid/CHIP total differs from *Figure 1* because certain expenses (such as state hospitals) are included in the Medicaid total in the Governor's Budget Report but not in the Medical Assistance Report.

Source: KHI analysis of FY 2019 Governor's Budget Report, Schedules 2.1, 2.2, 5.1 and 5.2, FY 2017 Actual.

What is Managed Care?

Under KanCare, Medicaid and CHIP spending 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 capitated payments place the MCOs at risk for the cost of care for their members, and they are incentivized to ensure enrollees receive services that help reduce costs over time by improving their health and quality of life.

Contracts the state has 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.

CHIP was authorized by the Kansas Legislature in 1998 and implemented in 1999. CHIP was designed to be an extension of the public health programs to serve children at higher income ranges than traditionally served by Medicaid. Federal funding for CHIP expired in September 2017, but in January 2018 the U.S. Congress passed a six-year extension for the program. The extension provides CHIP with federal funding through 2023.[8]

The Medicaid program in Kansas was administered on 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 in 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.

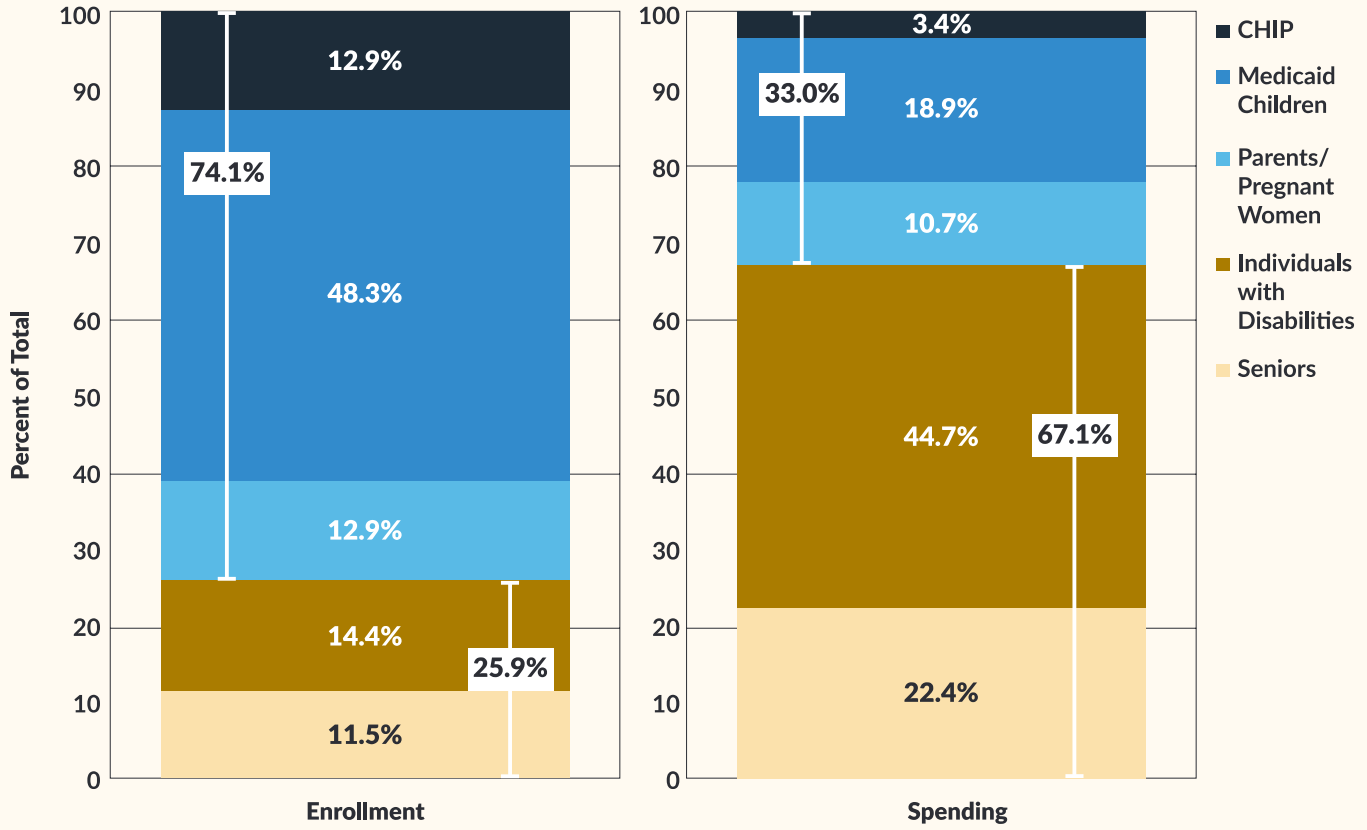
Managed care had been provided for children and families in Kansas Medicaid and CHIP since the 1990s, but now most services for most members are provided through managed care. KanCare was approved as a five-year demonstration from January 1, 2013, to December 31, 2017, and the Centers for Medicare and Medicaid Services (CMS) approved a one-year extension to continue the demonstration through the end of 2018. In December 2017, the state submitted a renewal application for KanCare to CMS, which may be approved 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

Note: Individuals can be eligible for both Medicare and Medicaid, and those who qualify for both are referred to as dual eligible beneficiaries. In FY 2018, an average of 63,424 Medicaid beneficiaries each month were also eligible for Medicare.

Figure 4. Medicaid and CHIP Population Groups and Spending, Kansas Fiscal Year 2018



Note: Enrollment and spending do not include the following populations: foster care/adoption, the Sixth Omnibus Budget Reconciliation Act (SOBRA) program, tuberculosis, breast and cervical cancer, and the AIDS Drug Assistance Program (ADAP). Figures may not sum to 100 percent because of rounding. Additional information on populations begins on Page 12.

Source: KHI analysis of Kansas Medical Assistance Report (MAR), 2018, and additional data from the Division of Health Care Finance, Kansas Department of Health and Environment.

Medicaid and CHIP Spending in Kansas

In Kansas, about one-quarter (25.9 percent) of all Medicaid and CHIP enrollees are seniors or people with disabilities, but this combined population incurs two-thirds (67.1 percent) of total state expenditures for the Medicaid and CHIP programs, as shown in *Figure 4*. Children and families, including children in CHIP, account for nearly three-quarters (74.1 percent) of total enrollees and incur about a third (32.9 percent) of the state expenditures in these programs.

In FY 2018, annual Medicaid and CHIP spending averaged $3,701 per pregnant woman, child or family member, compared to $25,814 per enrollee with a disability and $16,202 per senior enrollee (*Figure 5*, Page 6). These differences reflect the greater use of services, including long-term services and supports, by seniors and people with disabilities. (Appendix B, Page 18, contains a complete list of both mandatory and optional services covered by Medicaid in Kansas.)

In Kansas, the rate of growth for both costs and total enrollees in Medicaid has been slower than nationally, as shown in *Figure 6*, Page 7.

Figure 5. Per Capita Annual Cost by KanCare Population, Kansas Fiscal Year 2018

Population Enrolled in Medicaid or CHIP	Per Capita Cost
Individuals with Disabilities	$25,814
Seniors	$16,202
Parents/Pregnant Women	$6,901
Medicaid Children	$3,247
CHIP	$2,206
CHIP/Medicaid Children and Families Combined	*$3,701*
All Enrollees	**$8,326**

Note: Costs as incurred by the state. Enrollment and costs do not include the following populations: foster care/adoption, the Sixth Omnibus Budget Reconciliation Act (SOBRA) program, tuberculosis, breast and cervical cancer, and the AIDS Drug Assistance Program (ADAP). Additional information on populations begins on Page 12.

Source: KHI analysis of Kansas Medical Assistance Report (MAR), 2018, and additional data from the Division of Health Care Finance, Kansas Department of Health and Environment.

Federal Influence in the Medicaid Program

Medicaid is a partnership between states and the federal government. While states are responsible for running their individual Medicaid programs, changes at the federal level — through waiver approval, agency policy and legislation — can influence Medicaid across the country.

One example of this influence has been the approval of work requirements in select states through the waiver process. Medicaid beneficiaries subject to work requirements in such states must report a minimum number of work hours to remain eligible for Medicaid. At the beginning of 2018 CMS signaled its willingness to approve work requirements, which had never previously been approved by the federal government. Following the announcement, multiple states submitted applications to add work requirements to their Medicaid programs, and a few have already begun implementation.

Another change to Medicaid that has been discussed at the federal level is the use of block grants. Under the current system, the amount of federal funding a state receives is dependent on how much a state spends on eligible services to eligible populations. The federal government matches state spending at established rates, which vary year to year based on the economic position of a state. Block grants, or the related concept of per-capita caps on expenditures, could preserve the concept of a match rate, but at a funding level established either globally or at the per-person level. States could spend funds at their discretion, subject to federal approval. The use of block grants would require a change in legislation from the U.S. Congress and would impact all state Medicaid programs.

Medicaid and CHIP Enrollment Trends

Enrollment increased from FY 2008 through FY 2017, but decreased in FY 2018, as shown in *Figure 1*, Page 2.

Children and families (*Figure 7*, Page 8) make up the largest share of enrollees in Medicaid, and enrollment for that group increased 35.1 percent between FY 2011 and 2017, before declining about 6 percent from 2017 to 2018. Recent improvement in the economy has led to fewer children and adults being eligible at current income criteria, which might have contributed to the decrease in enrollment. Enrollment also was affected by a "backlog" in processing Medicaid and CHIP applications. Starting in late 2015, 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.[9] The total backlog has been reduced, however, with the state reporting in July 2018 that about 1,500 new applications had not been processed within 45 days.[10]

Enrollment for seniors increased over the FY 2011–2018 period, while total enrollment for people with disabilities declined. In that group, enrollment for people with disabilities eligible for Supplemental Security Income (SSI) increased, as shown in *Figure 8*, Page 8. Medically Needy enrollment for people with disabilities, which requires those with incomes over $495 a month to "spend down" or pay a portion of their health care costs, has steadily declined since FY 2012. The protected income limit (PIL) for the program has not changed substantively since 1994. A more detailed discussion of the Medically Needy program and spend down is on Page 16.

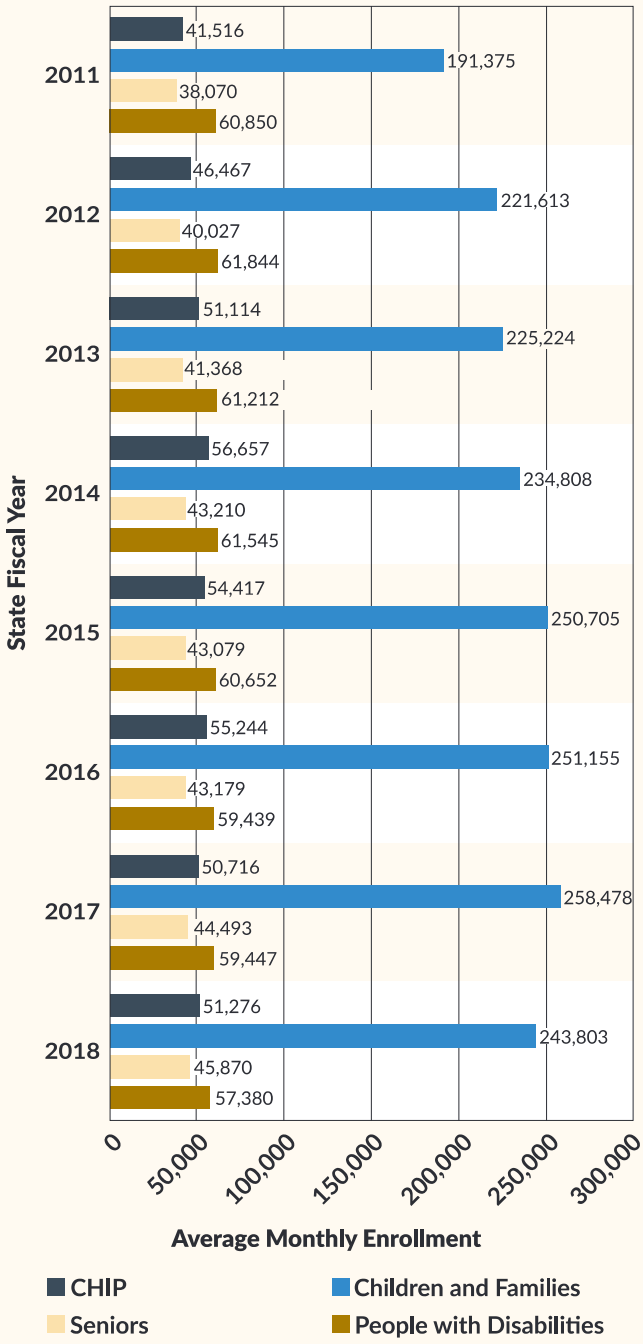
Figure 6. **Kansas Medicaid Compared with Other States, Selected Indicators**

	Total Medicaid Spending, FFY 2016, in Billions	Average Annual Growth in Medicaid Spending, FFY 2010-2014	Total Medicaid and CHIP Enrollment, July 2018	Medicaid and CHIP Enrollment Growth Post-ACA (January 2014-July 2018)
United States	$553	5.2%	73,189,584 individuals	28%
Colorado	$7.93	10.1%	1,337,830	71%
Iowa	$4.80	6.7%	678,106	37%
Kansas	$3.27	3.2%	386,547	2%
Missouri	$9.90	2.4%	933,441	10%
Nebraska	$2.01	1.2%	243,308	-1%
Oklahoma	$4.81	4.8%	788,159	0%

Note: Column 1 excludes CHIP spending. The federal fiscal year (FFY) runs from October 1 through September 30. For example, FFY 2016 refers to the period from October 1, 2015, through September 30, 2016. It overlaps with Kansas' state fiscal year, which runs July through June, by three months. FY 2016 ran from July 1, 2015, to June 30, 2016. Iowa and Colorado are Medicaid expansion states.

Source: Kaiser State Health Facts, 2018 http://kff.org/state-category/medicaid-chip/

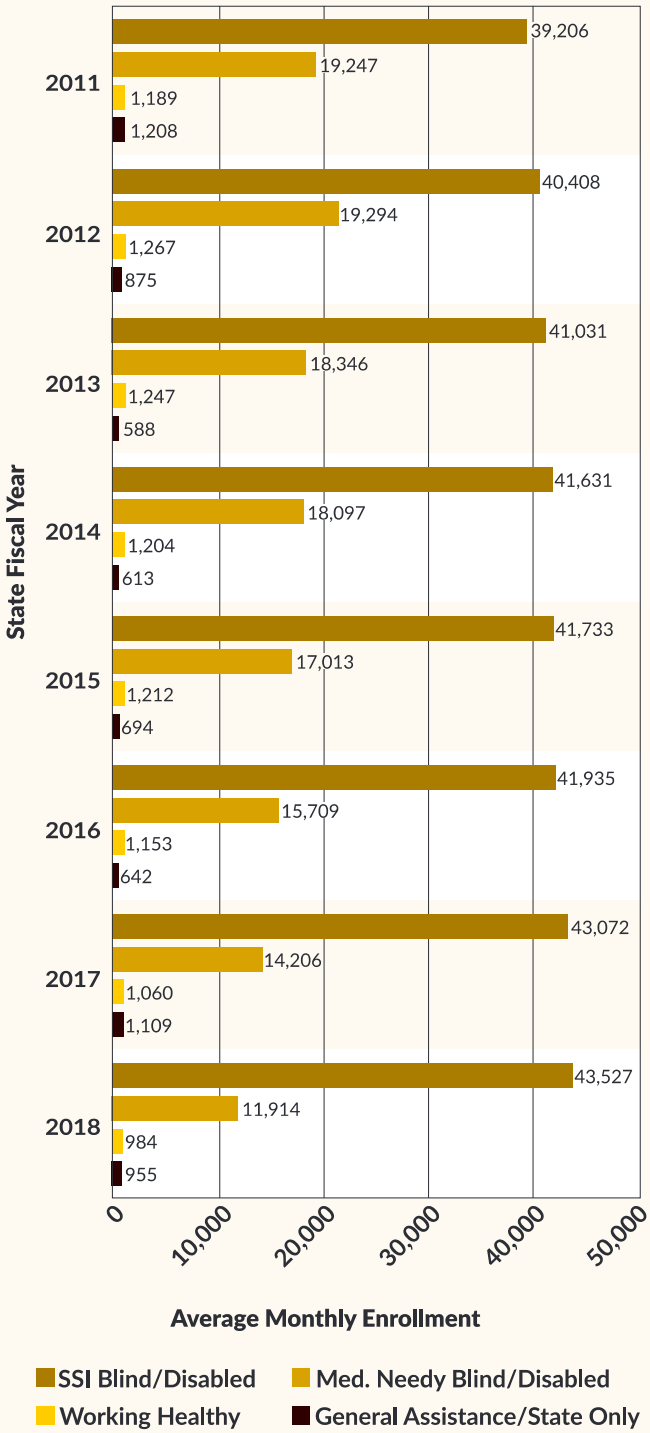
Figure 7. **Average Monthly Enrollment for Children and Families, CHIP, Seniors and People with Disabilities in Kansas, Fiscal Years 2011–2018**



Note: Numbers do not include the following populations: foster care/adoption, refugees, SOBRA, tuberculosis, breast and cervical cancer, and the AIDS Drug Assistance Program (ADAP). M-CHIP includes previously CHIP-eligible children now Medicaid-eligible after the ACA; the state receives CHIP match rates for this group. Beginning in October 2016, children in long-term care were moved from the Medically Needy Blind/Disabled group to a single population code categorized with Children and Families. Additional information on populations begins on Page 12.

Source: KHI analysis of Kansas Medical Assistance Report (MAR), 2011–2018, Division of Health Care Finance, Kansas Department of Health and Environment.

Figure 8. **Average Monthly Enrollment for People with Disabilities by Eligibility Group in Kansas, Fiscal Years 2011–2018**



Note: Beginning in October 2016, children in long-term care were moved from the Medically Needy Blind/Disabled group to a single population code categorized with Children and Families. Additional information on populations begins on Page 12.

Source: KHI analysis of Kansas Medical Assistance Report (MAR), 2011–2018, Division of Health Care Finance, Kansas Department of Health and Environment.

Medicaid and CHIP Services

Kansas Medicaid payments for services are now primarily made to managed care organizations (MCOs), which are responsible for paying providers for services used by their members. The year before KanCare was launched, 25 percent of total Medicaid expenses paid by the state were made through managed care. In FY 2018, 88.3 percent of state payments were for managed care, as *Figure 9* illustrates.

Payments by the state are made monthly 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 rarely are paid directly by the state. Exceptions generally are related to excluded populations as outlined in Appendix C, Page 19, such as members for whom the state only pays Medicare cost-sharing.

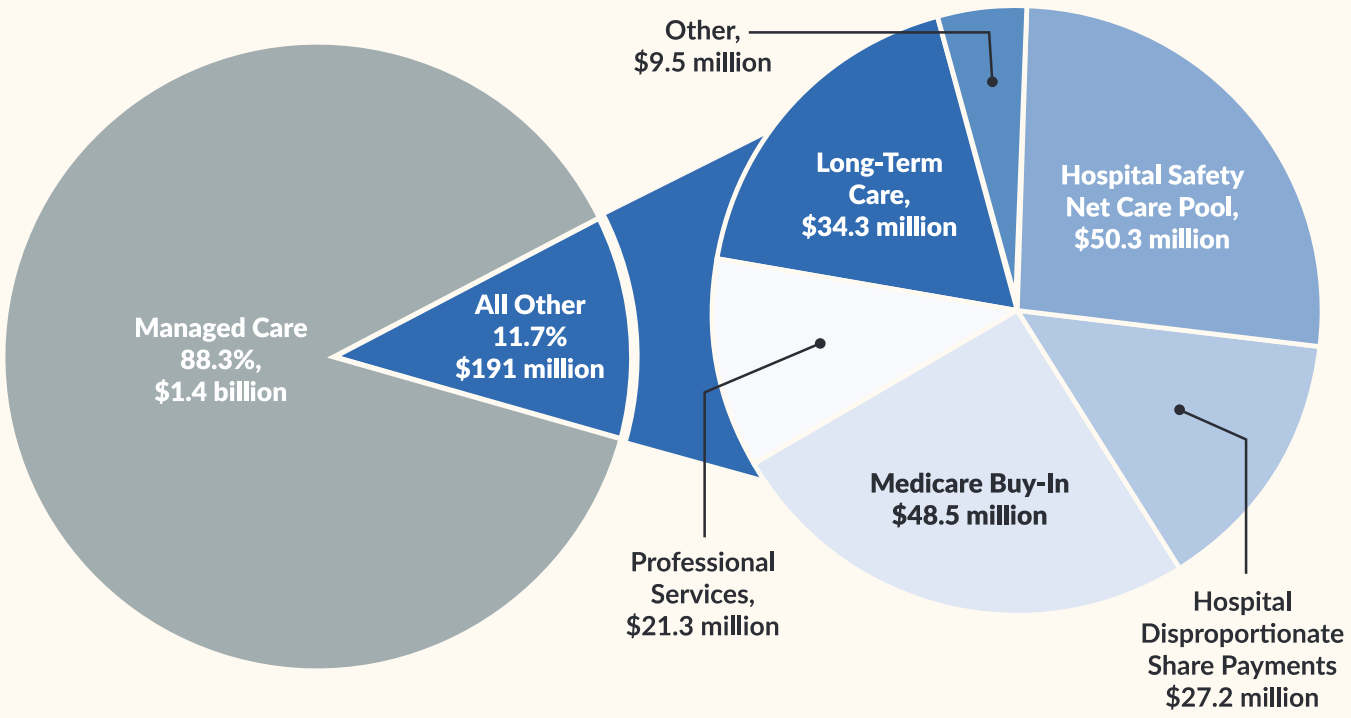
As a result, *Figure 10*, Page 10, which represents how members use services, comes from claims the MCOs have paid to providers. It may total more or less than the state paid the MCOs in capitation rates.

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 58 percent of spending by MCOs in FY 2018.

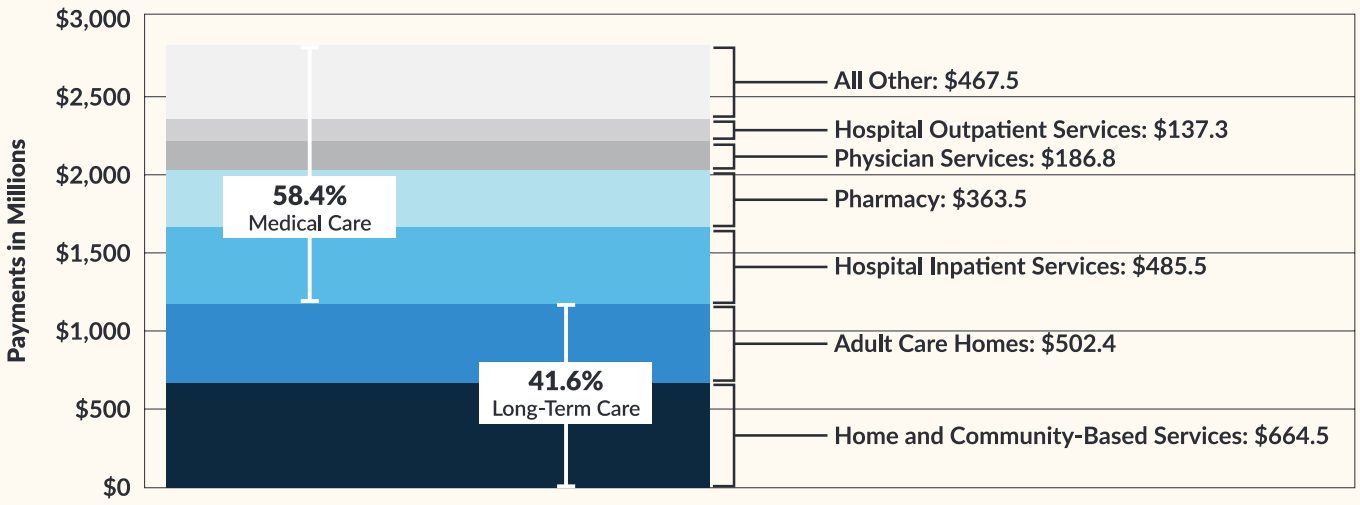
The costliest of these services are inpatient and outpatient hospital care, physician services, and pharmacy, as shown in *Figure 10*, Page 10. Other payments to medical care providers made directly by the state are not included in the payments MCOs make. For example, the Disproportionate Share Hospital (DSH) program helps reimburse hospitals that serve a large number of low-income and uninsured patients.

Figure 9. **Managed Care as a Portion of Total Medicaid and CHIP Expenditures in Kansas, State Funds Only, Fiscal Year 2018**



Note: Long-Term Care includes payments to nursing facilities for mental health. School-based services are included in Professional Services.
Source: KHI analysis of Medical Assistance Report (MAR), FY 2018, Kansas Department of Health and Environment.

Figure 10. KanCare Managed Care Organization (MCO) Payments to Providers by Category of Service, Fiscal Year 2018, in millions



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, FY 2018.

State Plan Amendments and Waivers

The federal Centers for Medicare and Medicaid Services (CMS) approves a State Plan for the Medicaid and CHIP programs in each state. A State Plan is a contract between the state and the federal government describing how the state administers 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.

SPAs are used when a proposed change is in accordance with federal requirements, such as changing provider rates or eliminating or adding optional services. States can file SPAs at any time, and they 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 by CMS 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 target groups only and can limit the number of individuals the waiver will serve. SPAs differ from these waivers because SPAs do 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 allows, among other things, the mandatory enrollment of nearly all covered populations in managed care for most services. The KanCare demonstration was approved through the end of calendar year 2017, with CMS approving a one-year extension to continue the demonstration through the end of calendar year 2018. The state also has submitted a waiver application to renew KanCare through 2023, which at the time of publication remains under review.

Long-Term Care

Long-term care services include all services provided by adult care homes and home and community-based services; they account for about 42 percent of total payments MCOs made on behalf of their members in FY 2018.

Adult Care Home Services: Adult care home services include nursing facilities, nursing facilities for mental health and intermediate care facilities for individuals with intellectual disabilities, but do not include state hospitals. Some of the costs of these services are offset by a provider tax on nursing homes.

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 that they remain 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 eligible for HCBS through waivers and their institutional equivalents in Kansas are shown in *Figure 11*.

Administrative Spending

The state also spends significant funds operating the Medicaid and CHIP programs. 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 design of new computer systems. Total administrative costs were $168.5 million in FFY 2016, accounting for approximately 5 percent of all Medicaid expenditures in Kansas.[11]

Figure 11. **Kansas Populations Eligible for Home and Community-Based Services (HCBS) Through Waivers and Their Institutional Equivalents**

KANSAS HCBS WAIVER PROGRAMS	INSTITUTIONAL EQUIVALENTS
Autism (children; AU)	Inpatient Psychiatric Facility for Age 21 and Under
Frail Elderly (FE)	Nursing Facility
Intellectual/Developmental Disability (I/DD)	Intermediate Care Facility for Individuals with Intellectual Disabilities
Physical Disability (PD)	Nursing Facility
Serious Emotional Disturbance (children; SED)	Inpatient Psychiatric Facility for Age 21 and Under
Technology Assisted (children; TA)	Hospital
Traumatic Brain Injury (TBI)	TBI 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 always is 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 12*.

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.

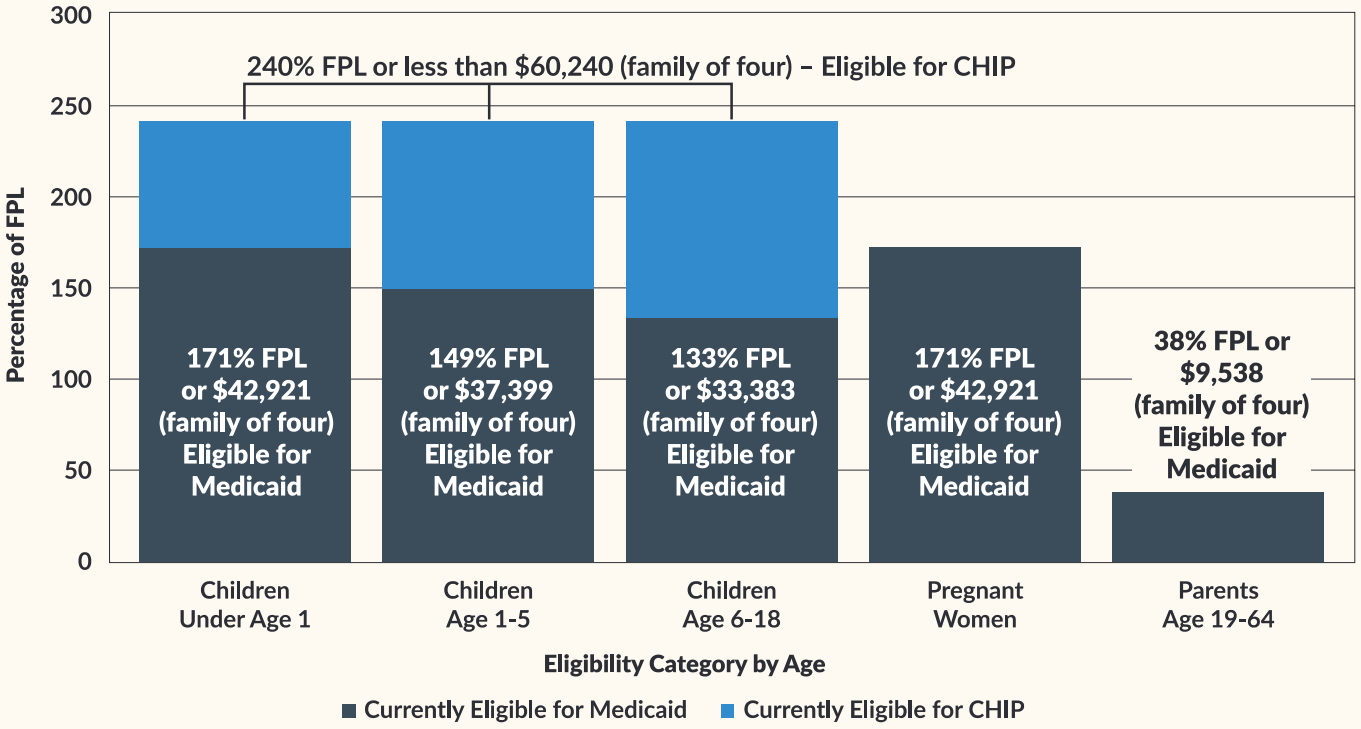
- **Categorical Eligibility:** There are four main categories of individuals who are eligible for Medicaid — children, parents or caregivers with children, people with disabilities, and seniors.
- **Income Eligibility:** Different income thresholds pertain to each category of eligibility. For most enrollees, income eligibility criteria are based on federal poverty level (FPL) guidelines, as shown in *Figure 13*, Page 13.
- **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 the spend down process also are 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 under Medicaid rules. There is no waiting period.

Figure 12. **Federal Poverty Guidelines for the Contiguous 48 States and the District of Columbia, 2018**

Persons in Family/Household	Annual Income (100 percent of FPL)
1	$12,140
2	$16,460
3	$20,780
4	$25,100
5	$29,420
6	$33,740
7	$38,060
8	$42,380
For families/households with more than eight persons, add $4,320 for each additional person.	

Source: U.S. Department of Health and Human Services, 2018.

Figure 13. **Income Eligibility Levels for Children and Families in Kansas Medicaid and CHIP, 2018**



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, 2018.

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 14*, Page 15.

Under the ACA, states have the option to expand Medicaid to include low-income adults up to 138 percent of FPL. Kansas has not expanded Medicaid to this population.

Low-Income Children and Families

Nearly three-quarters 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 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 13*. The CHIP program extends income levels even higher for children. In 2018, children and infants under age 1 were eligible for Medicaid if their annual family income was less than 171 percent of FPL ($42,921 for a family of four). Children age 1–5 were eligible if their annual family income was less than 149 percent of FPL ($37,399 for a family of four). Children age 6–18 were eligible if their annual family income was less than 133 percent of FPL ($33,383 for a family of four). All other children up to 240 percent of FPL ($60,240 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 2018, parents or caretakers of children with an annual household income up to 38 percent of FPL ($9,538 for a family of four) also are eligible for coverage under

Medicaid. Parents who are above this annual income are 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 ($42,921 for a family of four) were eligible in 2018.

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 FY 2018, total enrollment for individuals with disabilities and seniors was approximately 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 age 65 and older 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 cost the state about $6.2 million in FY 2018 to cover an average of 955 people per month. This program is not eligible for federal matching dollars and has not been included in managed care.

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) model provides long-term care services to qualifying individuals in their communities, as opposed to in a nursing home.

The Balanced Budget Act of 1997 established the PACE model as a provider for both Medicare and Medicaid, and the first Kansas PACE provider began offering services in 2002. In FY 2018 an average of 550 individuals utilized PACE services per month, at an annual cost of $19 million.

To qualify for PACE, an individual must be age 55 or older, live in an area served by a PACE provider, and require nursing home care. If an individual meets those requirements, and their care needs could safely be met in their community with the help of PACE services, they qualify. Kansans currently can receive PACE services in 23 counties, and the state is expanding the number of counties in which PACE services are provided.

Each PACE participant is served by an interdisciplinary provider team, and a variety of services are covered under the model including (but not limited to) primary care services, social services, transportation, physical therapy, nutritional counseling and adult day care.

Figure 14. **Mandatory and Optional Populations**

MANDATORY POPULATIONS, REQUIRED BY FEDERAL LAW

- Infants and children whose families earn less than 138 percent of FPL
- Infants born to a Medicaid mother
- Parents or caretakers whose income is 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 but 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 wages
- Children in foster care (IV-E)
- Young adults under age 26 who have aged out of foster care
- 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 240 percent of FPL
- Adults in MediKan (state-funded)
- Individuals with disabilities age 16–64 in the Working Healthy program
- Individuals screened and diagnosed with breast or cervical cancer through the Early Detection Works program
- Individuals eligible for the AIDS Drug Assistance Program (ADAP)
- Individuals receiving inpatient treatment for tuberculosis
- Non-IV-E foster care and adopted children with special needs
- Individuals in long-term institutional care, subject to income and resource limits
- Individuals receiving home and community-based services
- Older adults in the Program of All-Inclusive Care for the Elderly (PACE)

Kansas also extends Medicaid coverage to:

- Medically Needy: Aged, disabled, pregnant women and children
- Children: Kansas extends coverage to children under 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 federal maintenance of effort requirements, all children's eligibility levels must be preserved though FFY 2023.

Source: KanCare Special Terms and Conditions, Centers for Medicare & Medicaid Services, January 2014; CMS "List of Medicaid Eligibility Groups," accessed August 2018; Medical Assistance Standards, Kansas Department of Health and Environment, April 2018.

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. People in this program must pay a premium for medical services, depending on their income. The Working Healthy program cost the state almost $6 million in FY 2018 to cover about 1,000 people on average per month. Total costs, including the federal share, were nearly $13 million.

Medicaid-Medicare Dual Eligibility: Medicaid provides assistance with co-pays, 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 23 counties, adults age 55 and older have the option to enroll in PACE. PACE 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 PACE when they join. It includes both Medicare and Medicaid services for dually eligible individuals.

Other Medicaid Populations

About 5 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 covers limited life-threatening emergency care costs and childbirth costs for some non-citizens. (Temporary coverage for refugees as defined by federal law was discontinued in Kansas Medicaid in 2016.)

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.

Medically Needy and "Spend Down"

The medically needy segment 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 under the age of 19;*
- *People age 65 or older; or*
- *Persons who are blind or disabled under federal standards.*

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 (CHIP) 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 Health Care Access Improvement Program to implement a hospital provider assessment.
2005	Kansas Health Policy Authority was created to run Medicaid and State Employee Health Plan.
2006	Kansas converted dental services for 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 that was to be effective in 2014 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 (KDHE).
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.
2015	Kansas implemented a new computerized system, the Kansas Eligibility Enforcement System (KEES), through which Kansans apply for Medicaid and other services.
2017	Kansas published a request for proposals (RFP) for new KanCare managed care contracts in October 2017.
2018	The U.S. Congress reauthorized CHIP through 2023.

Source: Kansas Health Institute.

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

THE FOLLOWING SERVICES ARE CONSIDERED MANDATORY[12,13]	OPTIONAL SERVICES PROVIDED IN KANSAS[14]
• 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 ACA, Medicaid MCOs must comply with the federal parity law for mental health and substance use disorder services)
• 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
• Tobacco cessation counseling and pharmacotherapy for pregnant women	• Intermediate care facility services for individuals with intellectual disabilities
• 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

OTHER SERVICES	
• Managed care organizations (MCOs) provide value-added services, which can vary by plan and year. Examples include preventive dental benefits for adults, or incentive programs for healthy behaviors.	• MCOs can provide "in lieu of" services, which are defined as medically appropriate, cost-effective alternatives to state plan or managed care contracted services. An MCO can provide an "in lieu of" service if it could help prevent a higher-cost service, such as an inpatient hospitalization.

Appendix C. **Medicaid Populations Excluded from KanCare**

POPULATION	DESCRIPTION
Qualified Medicare Beneficiary (QMB), not otherwise Medicaid eligible	This program covers the Medicare out-of-pocket expenses of low-income Medicare recipients, including premiums and copayments.
Low-Income Medicare Beneficiary (LMB), not otherwise Medicaid eligible	This program only pays the Medicare Part B premium for low-income Medicare recipients.
Expanded Low-Income Medicare Beneficiary (E-LMB)	This program also pays the Medicare Part B premium for low-income Medicare recipients. However, all individuals eligible for this program cannot 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 with income under $250 a month. 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 (for example, documented immigrants must wait five years to be eligible) 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 240 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 eligibility due solely to a Social Security cost of living increase.
Adult Disabled Child	This eligibility 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 eligibility 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 the seven Kansas 1915(c) waivers: Autism, Intellectual/Developmental Disability, Frail Elderly, Physical Disability, Serious Emotional Disturbance, Technology Assisted and Traumatic Brain Injury.

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

Appendix E: Helpful Links

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 Kansas Medicaid and CHIP programs, 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 & Medicaid Services: www.medicaid.gov
Kaiser Program on Medicaid and the Uninsured: www.kff.org/about/kcmu.cfm
National Conference of State Legislators: www.ncsl.org
National Academy of State Health Policy: www.nashp.org

For more population data about health insurance, see:
United States Census Bureau:
https://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 package from 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 U.S. 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 2018, the FPL for a family of four was an annual income of $25,100. 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)

An 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 23 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 2018, parents or caretakers of children with an annual household income up to 38 percent of FPL ($9,538 for a family of four) also are eligible for coverage under Medicaid.

Appendix G. **Acronyms and Meanings**

Acronym	Meaning
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AU	Autism
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
FE	Frail Elderly
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
I/DD	Intellectual/Developmental Disability
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
OBRA-81	Omnibus Budget Reconciliation Act of 1981
PACE	Program of All-Inclusive Care for the Elderly
PD	Physical Disability
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)
SED	Serious Emotional Disturbance
SLMB	Special Low-Income Medicare Beneficiaries
SOBRA	Sixth Omnibus Budget Reconciliation Act
SPA	State Plan Amendment
SSI	Supplemental Security Income
TA	Technology Assisted
TBI	Traumatic Brain Injury

Endnotes

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3. CMS Office of the Actuary. (2016). *2016 Actuarial Report on the Financial Outlook for Medicaid*.

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5. Kaiser State Health Facts. (2018). *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*. Retrieved from http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

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KANSAS HEALTH INSTITUTE

The Kansas Health Institute supports effective policymaking through nonpartisan research, education and engagement. KHI believes evidence-based information, objective analysis and civil dialogue enable policy leaders to be champions for a healthier Kansas. Established in 1995 with a multiyear grant from the Kansas Health Foundation, KHI is a nonprofit, nonpartisan educational organization based in Topeka.

KANSAS LEGISLATIVE RESEARCH DEPARTMENT

The Kansas Legislative Research Department provides nonpartisan, objective research and fiscal analysis for the Kansas Legislature. The Department is one of four nonpartisan agencies that provide support services for the Kansas Legislature.

KLRD

Providing objective research and fiscal analysis for the Kansas Legislature

KANSAS HEALTH INSTITUTE

Informing Policy. Improving Health.

Presented by Senator Denning at the Senate Select Committee on Healthcare Access on October 23, 2019

Senate Position: State Innovative Solutions for Affordable Health Care

10/18/2019

A. The Senate position is a comprehensive approach to providing improved access to:

1. Health care. Catalyst to improving the health of Kansans in the short and long-term
2. Health insurance. Which is sustainable for patients, healthcare providers, and payers

B. The objectives are:

i. To enable the uninsured to become and stay insured
   - ✓ Both Medicaid and Non-Medicaid market

ii. Sustainable for patients, healthcare providers, and payers
iii. Ensure the private Individual market is affordable
iv. Make the health care insurance market more seamless and useful for Kansans
v. Benchmark and track improved health matrixes for Kansas
vi. Measure improved health care access and quality for rural Kansas

1. Waivers will be Required

a. **Medicaid Expansion**
   i. File a CMS 1115 waiver for Medicaid expansion
   ii. Kansas expands Medicaid with the 90% / 10% funding match
   iii. Expansion population to be covered under the same KanCare MCO model as currently provided

b. **Uninsured / Unaffordable Private Individual Market**.
   i. File a CMS 1332 State Innovation Waiver
   ii. Provide re-insurance to health plans sold on the ACA exchange
   iii. Making insurance more attractive to the young and health
      1. More balanced risk pool
      2. Consumer friendly plan design. I.e. insurance before high deductible

2. Action Items:

a. 1115 Waiver. Expanding Medicaid to 19-64 year old's with the federal 90/10 match
b. 1332 Waiver. Provide a state/federal funded re-insurance. Private Individual market
   i. Stabilize the exchange market
   ii. Re-creation of KS High Risk Pool
   iii. Lower premiums in the private individual market, benefiting <u>unsubsidized</u> consumers who are being priced out of affording health insurance
   iv. Reduce market volatility
   v. Promote competition. Greater stability makes participating in the individual market more attractive for carriers
   vi. Leverage new funding opportunities. The premium reduction caused by reinsurance reduces federal spending. Federal Advance Payment of Premium Tax Credits (APTC) saving given back to the State
      1. States can access these savings to help pay for the program

c. Work with the various stakeholders to include federal, state, local gov't, not-for-profits and for-profits to develop and implement new care models to include addressing social determinants to health care, SDoH

3. Super/Combo Waiver Concept Approach

a. Can submit the 1332 Innovation Waiver together with a Medicaid expansion 1115 waiver, but each waiver is evaluated separately

b. Ask CMS to expand Medicaid to 100% FPL while we wait on decision of 1332 State Innovation Waiver
   i. Request for 100-138% of FPL to stay on the Exchange if budget neutral
   ii. 45 days preliminary review
   iii. 180 days final decision made

*c. Would be structured with **"if, then"** logic to keep waiver processing moving to cover up to 138% of FPL.*
   i. Expand to 100% of FPL with 90/10 match, and allow 100-138% to stay on exchange. If no, then proceed to ii.
   ii. Expand to 100% of FPL with 90/10 match, and allow 100-138% the option to stay on exchange and continue to receive the subsidy. If no, then proceed to iii.
   iii. Expand to 138% in standard fashion

d. This would provide a solution to consumers who receive no subsidies being priced out of the expensive and high deductible plans being sold on the ACA Exchange

e. Budget neutral to CMS to go to 100% of FPL with integrated 1332, i.e. Not increase the federal deficit

f. Under a 1332 Innovation Waiver, savings from less Federal Advance Payment of Premium Tax Credits (APTC), due to reduced premiums, can be a pass-through to the state to help fund the reinsurance in the ACA market

4. Provide Pathway to Employment

a. Able bodied adults

b. Integrate work assessment questionnaire with Medicaid application/eligibility process
   i. Do you work?
   ii. Part time, <20 hours, >20 hours, Full time, Not working, etc.
   iii. What is keeping you from working?
      1. No high school diploma
      2. No jobs
      3. No transportation
      4. Caretaker
      5. Raising small children
      6. No child care
      7. Full time student
      8. Health reason

9. Behavioral health
10. Other

iv. Integrate with the Kansasworks - Work Force Development Program
1. Administered by the Department of Commerce
2. Create a separate database for Medicaid applicants to track progress and outcomes
3. Register and follow up with work development programs
4. Connect to employers etc.
5. Outcomes
6. Annual reports on results of pathway to employment

v. Approach to integrate with social determinants of health care

5. State Medicaid Expansion PayFors

State Share	– 10%	$121M
Federal Share	– 90%	$975M
	Total	$1.1B

a. MCO (HMO) tax 5.77% $63M
b. Current to Expanded $23M
c. Drug Rebates – SB231 $4M
d. Hospital Provider Surcharge $31M
$121M

i. Design with 90/10 match.
ii. Federal/Hospital $27M/$3M

6. State Innovation Waiver – Reinsurance PayFors

a. Tobacco/E-Cig/VAPE tax to pay for 1332 only. $50M

7. Premium Payments Vs Co-Pays

i. Max amount of premium payments allowed
1. <100% of FPL. $0.00
2. 100% -138% of FPL 5% of household income
3. Premium favorable to CMS approving Super Waiver? 90% Feds
    i. Credit collections of premiums to SGF
4. Collectable thru tax return garnishments, gambling winnings, etc.
5. Co-Pays appear to be problematic, too costly to collect. Possible exception of unnecessary ER visit Co-Pay
6. Ask CMS if a non-emergency ER visit co-payment would be allowed in addition to the 5% premium payment

8. Lock out period

a. For >100% FPL, patient cannot be eligible for Medicaid until 1st payment is made
b. After 60 days of no payment, then locked out for 6 months
c. State will garnish tax refunds, lottery winnings, etc. for any balance due

9. **Dept of Corrections (DOC)**
    a. Medicaid funding is used for inpatient services when the stay is longer than 24 hours
        i. Inmate must meet all required eligibility criteria and have a qualifying event
        ii. Requires an application and supporting documents to be submitted
        iii. Local jails can participate as well
        iv. <5% eligible now. Post expansion >80% will be eligible
        v. Could save ~$2M annually

    b. KDOC facilitates the process for those transitioning out of a restricted setting and onto Medicaid, if they are eligible
        i. Restricted settings include prisons, jails, mental institutions, and state hospitals
        ii. KDOC has automated interfaces to receive release information which triggers reinstatement of eligibility
        iii. Local jails can participate as well

10. **Tiering the Medicaid plan**
    a. Reward patients who have annual wellness exams, medication compliance, etc.
    b. Basic plan, Basic plus plan, Premium plan. Based on patient behavior
        i. Vision, enhanced
        ii. Ride to work
        iii. Gift card
        iv. Dental
        v. Child care gift card
        vi. OTC drugs covered
        vii. Other

11. **Require Managed Care Delivery System**
    a. KanCare MCO bidders cannot be discriminated based on tax status. I.e. Profit Vs Not for Profit
    b. Required to sell insurance product on exchange as well.
        i. Or at least given a large positive weight in contract award process
    c. Patients then can easily move back and forth between Medicaid and private Exchange plans

12. **Support Legislation 1115/1332 Super/Combo Waiver Submission**
    a. The agency (s) who submit the waivers will support the legislative intent and fight for everything contained in the bill. No wink/nod maneuver.

    b. Submission of CMS Waiver application(s) to health and budget standing committees of each chamber and members of LCC 10 days before submission to CMS

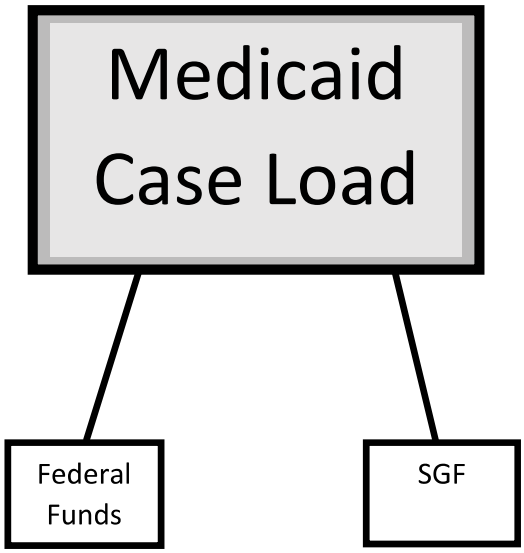
13. **Measure economic impact**
    a. LPA produce an annual report for first 2 years on direct economic activity that can be measured in the SGF

14. **Plan terminates if Federal Match/FMAP is modified below the 90% level**
    a. Non-Severable

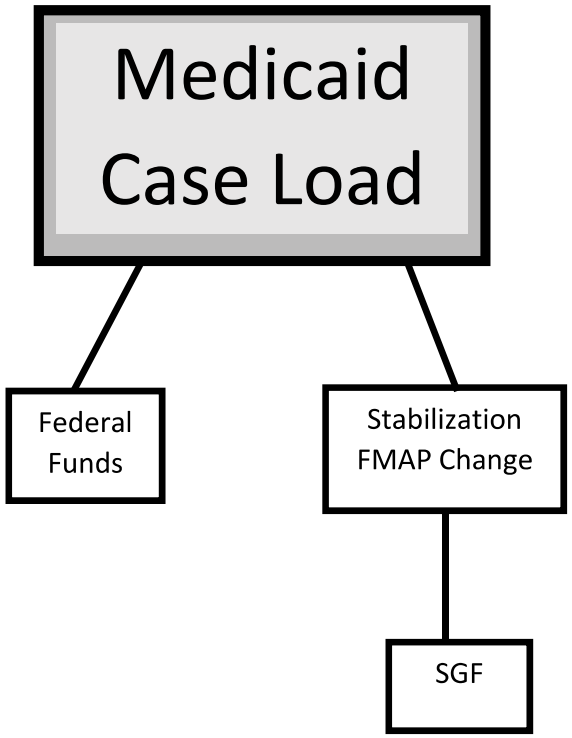
15. FMAP Stabilization fund on existing Medicaid funding

a. SB2
b. Any funds recovered from the federal government as a result of the pending lawsuit Texas v. United States, no. 7:15-cv00151-O be deposited into the stabilization fund.
c. In years when the Federal Medical Assistance Percentage (FMAP) increases resulting in lower state expense for Title XIX programs, the bill would require a transfer of the amount of those savings from the State General Fund to the new stabilization fund
d. In years when the FMAP decreases, the corresponding dollar amount of increased state share responsibility would be transferred from the stabilization fund to the State General Fund

Without Stabilization Fund



With Stabilization Fund



OTHER POLICY RECOMMENDATIONS

1. Rural Hospitals

a. Rural Hospital structure.
    i. Federal modified model.
    ii. Develop innovation waiver different physical structure and Medicare payments structure
b. Provider tax unique from/to critical access hospitals.
    i. Re allocated to keep them whole under a value-based method
c. Recommend BCBS-KS and MCO's develop capitated models of payment to those hospitals who think they can benefit from known cash flow

d. Demonstration project?
e. Access to Capital.
    i. Could Reach Health Foundation provide loan?
e. USDA grants

2. IMD exclusion waiver

a. The Medicaid Institutions for Mental Diseases (IMD) exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21, and has long been a barrier to efforts to use Medicaid to provide nonhospital inpatient behavioral health services.
b. Substance use Disorder SUD modification?

3. **Initiatives focusing on the Social Determinants of Health**.

a. Have MCO's identify?
    i. Such as housing insecurity, lack of transportation and poor nutrition.
b. Should MCO's manage or a separate agency/group
c. Follow up programs based on data collected

4. Improve "access to care" "usual place of care"

a. MCO's contract with: Walk in clinics, retail clinics, sites where Medicaid patients can get care without an appointment
b. Some hospitals advertise "short wait ER times, 5 min wait etc." Will be recruiting this new population with that call to action?

Presented by Senator Denning at the Senate Select Committee on Healthcare Access on October 23, 2019

SENATE PROPOSAL ON

State Innovative Solutions for Affordable Health Care

Health – *Improve*
Health Insurance – *Affordable*

October 23, 2019

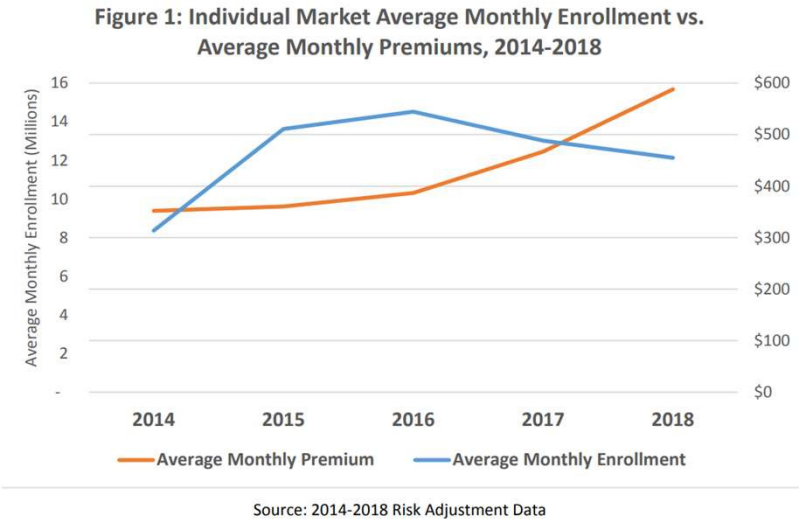
Senate Select Committee on Healthcare Access

1

OBJECTIVES

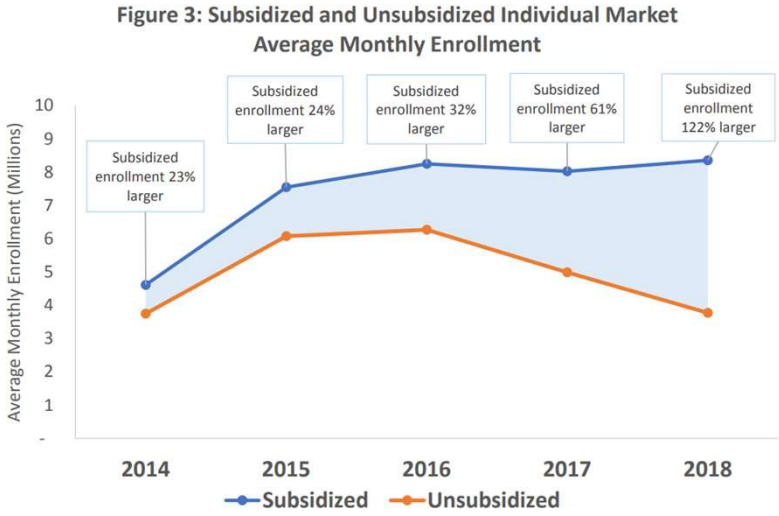
- The Senate position is a comprehensive approach to providing improved access to health care and health insurance
  - Establish means for the uninsured to become and stay insured
    - Both Medicaid and Non-Medicaid market
  - Sustainable for patients, health care providers, and payers
  - Ensure the private individual market is affordable
  - Create a seamless and more useful health care insurance market
  - Identify and track improved health matrixes for Kansas
  - Measure improved health care access and quality for rural Kansas

2



Source: CMS/CCIIO. Trends in Subsidized and Unsubsidized Enrollment. August 2019. https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf

3



Source: CMS/CCIIO. Trends in Subsidized and Unsubsidized Enrollment. August 2019. https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY17-18.pdf

4

Required Federal Waivers

1115 Waiver

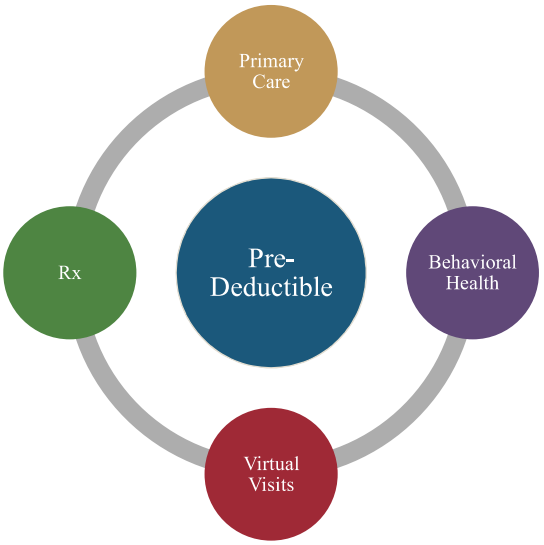
- *Medicaid Expansion*
  - File CMS 1115 waiver for Medicaid Expansion
  - Kansas expands with 90/10 funding match
  - Expansion population to be covered under the same KanCare model as currently provided

1332 Innovation Waiver

- *Uninsured/Unaffordable Individual Market*
  - File CMS 1332 State Innovation Waiver
  - Provides reinsurance to plans sold on ACA Exchange
  - Makes insurance more attractive to the young/healthy
  - Has a more balanced risk pool
  - Consumer friendly plan design
    - Insurance before high deductible

5

High Deductible Health Plan Ideas



Source: United Healthcare

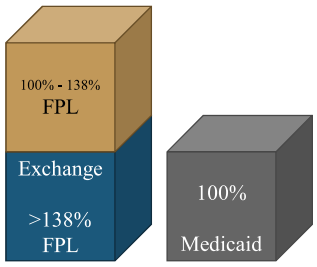
6

Action Items

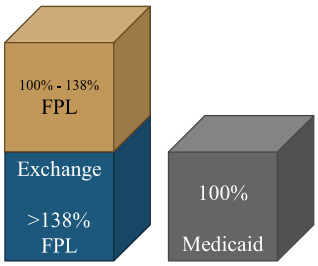
- Super Waiver approach
  - Submission of the 1332 Innovation Waiver *together* with the 1115 Medicaid Expansion Waiver
  - Objective is to allow 100% - 138% of FPL to stay on private insurance rather than being forced onto Medicaid
  - Ask CMS to expand Medicaid to 100% FPL while we wait on decision of 1332 State Innovation Waiver
- The 1115 Waiver
  - Expanding Medicaid to those age 19-64 with the Federal 90/10 match
- The 1332 or 'Innovation' Waiver
  - Provide a state/federal funded reinsurance fund
  - Stabilize the Exchange private market
  - Re-creation of the Kansas High Risk Pool
  - Lower premiums in the individual market, benefiting unsubsidized consumers who are being priced out of affording health insurance
  - Promote competition in that greater stability makes participating in the individual market more attractive for carriers

7

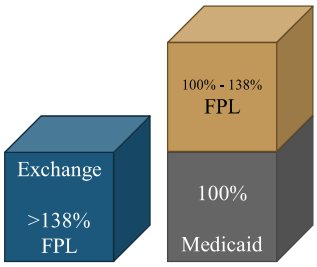
Super Waiver structured with "if, then" logic



1. Expand to 100% of FPL with 90/10 match and allow 100% - 138% to stay on the exchange.



2. Expand to 100% of FPL with 90/10 match and allow 100% - 138% *the option* to stay on the exchange.



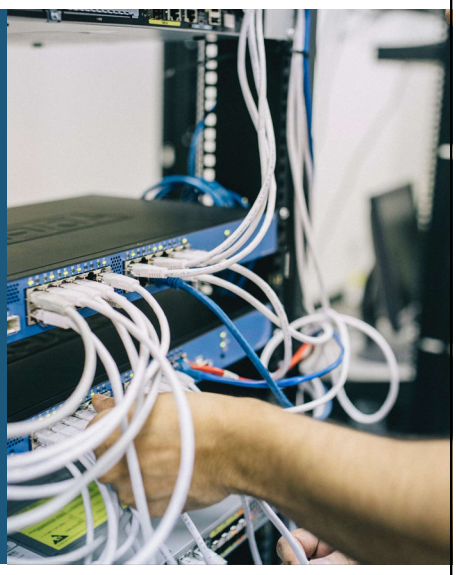
3. Expand in standard fashion.

8

Animations on slide 8 cannot be depicted on handout

Provide a Pathway to Employment

- Integrate work assessment questionnaire as part of Medicaid application and eligibility process
  - Do you work?
  - If no, what is keeping you from working?
- Integrate with KansasWorks
  - Administered by the Department of Commerce
  - Connections with employers
  - Provide annual outcomes



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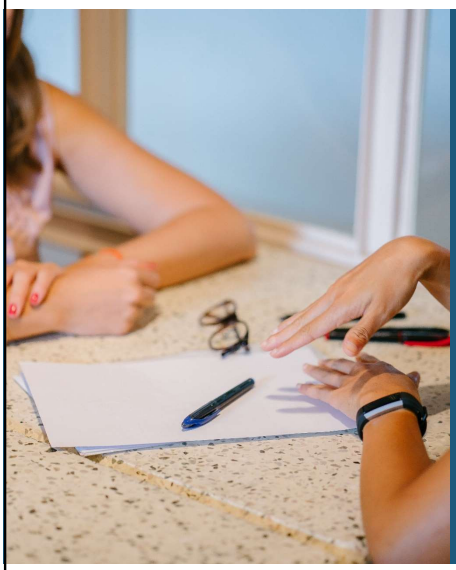


Workforce Development Assessment

- What is keeping you from working?
  - Does not have a high school diploma
  - Cannot find a job
  - Does not have transportation
  - Acts as a caretaker
  - Currently raising small children
  - Unable to find or afford childcare
  - Currently a full-time student
  - Physical, mental, or behavioral health problems
  - Other

10

State Medicaid Expansion Pay-fors

State Share -10%	***$121 M***
Federal Share – 90%	***$975 M***
	$1.1 B

› MCO (HMO) 5.77% Tax	$63 M
› Current to Expanded	$23 M
› Drug Rebates *SB 231*	$4 M
› Hospital Tax *Surcharge approach*	$31 M
	$121 M

State Innovation Waiver Pay-for

› Tobacco/E-Cig/Vape Tax increase	$50 M

11

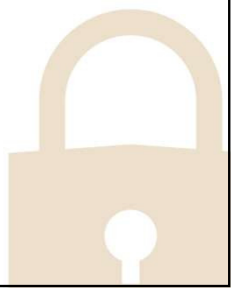
Premium Payments vs Co-Pays

- Maximum amount of premium payments allowed
  - **<100% FPL** **0%**
  - **100% - 138% FPL** **5% of household income**
- Co-pays appear problematic and too costly to collect
  - Possible exception for unnecessary ER visit co-pays
- Collectable from tax return garnishments, gambling winnings, etc.
- Ask CMS if a non-emergency ER visit co-payment would be allowed in addition to the 5% premium
- Lock-out period

12

Lock-out Period

- For >100% FPL, patient cannot be eligible for Medicaid until first payment is made
- After 60 days of non-payment, patient is locked out for six months
- State will garnish tax refunds, gambling winnings, etc. for any balance due

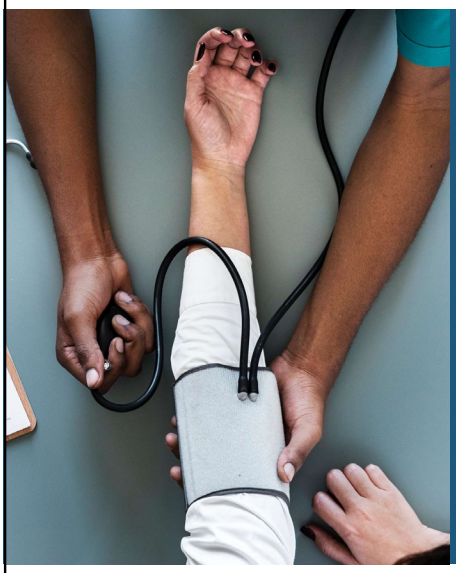


13

Department of Corrections

- Medicaid funding is used for inpatient services when the stay is longer than 24 hours
  - Inmate must meet all required eligibility criteria and have a qualifying event
  - Requires an application and supporting documents to be submitted
  - <5% eligible now. Post expansion >80% will be eligible
  - Could save DOC ~$2M annually
  - Local jails can participate as well
- KDOC facilitates the process for those transitioning out of a restricted setting and onto Medicaid, if they are eligible
  - Restricted settings include prisons, jails, mental institutions, and state hospitals
  - KDOC has automated interfaces to receive release information which triggers reinstatement of eligibility
  - Local jails can participate as well

14



Tiering the Medicaid Plan

- Reward patients who have annual wellness exams, annual diabetic eye exams, medication compliance, etc.
- Based on patient behavior, MCOs to offer options such as Basic, Basic Plus, and Premium plans

15

Require Managed Care Delivery System

- KanCare bidders cannot be discriminated against based on tax status
  - *Example:* For-profit vs. Not-for-profit
- Required, *or to be given a large positive weighting in contract award process,* if bidders sell product on the Exchange as well
  - Patients could easily move back and forth between Medicaid and Exchange plans

16

Waiver Submission and Support

- Agencies submitting the waivers will support the legislative intent and fight for everything contained in the bill
  - No "wink/nod" maneuver with CMS
- CMS Waiver application(s) will be submitted to the health and budget standing committees of each chamber and to the LCC at least 10 days prior to submission

17

Data Measurements

- *Economic Impact*
  - LPA to produce an annual report for the first two years on direct economic activity that can be measured in the SGF
- *Social Determinants of Health*
  - Follow up on program initiatives based on the data received

18

THE GUARDRAIL

- The entire program terminates if Federal Match/FMAP is modified below the 90% level
- Non-Severable

19

FMAP STABILIZATION FUND ON EXISTING MEDICAID FUNDING *SB2*

- Any funds recovered from the federal government as a result of the pending lawsuit Texas v. United States, no. 7:15-cv00151-O will be deposited into the stabilization fund
  - Roughly ~ $30M
- In years when FMAP increases and results in lower state expenses for Title XIX programs, the bill would require a transfer of the amount of those savings **to** the new stabilization fund
- In years when the FMAP decreases and results in higher state expense, the corresponding dollar amount of increased state responsibility would be transferred **from** the stabilization fund to the State General Fund

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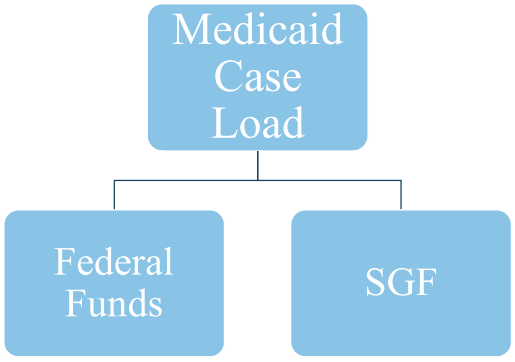
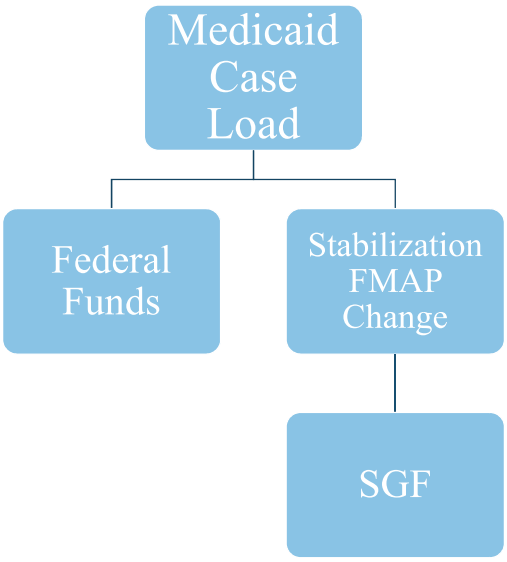
Without Stabilization Fund



With Stabilization Fund



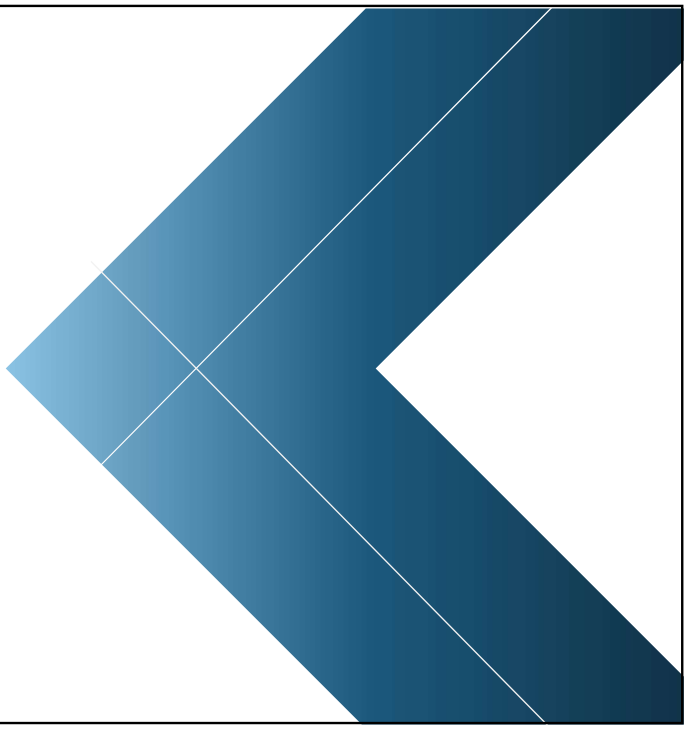
21

Rural Healthcare

- Rural Hospital Structure
  - Federal modified model
  - Develop innovation waiver with different physical structure and Medicare payments structure
- Provider tax unique to and from critical access hospitals
  - Re-allocated to keep them whole under a value-based method
- Demonstration Project

22

QUESTIONS?



October 23, 2019

Senate Select Committee on Healthcare Access

23

the parent is required to pay for family cov- erage under section 1902(cc)(2)(A)(i) of the Act, and other cost sharing charges may not exceed:

i. 5 percent of the family's income if the family's income is no more than 200 percent of the FPL.

ii. 7.5 percent of the family's income if the family's income exceeds 200 percent of the FPL but does not exceed 300 percent of the FPL.

4. Qualified disabled and working individ- uals described in section 1905(s) of the Act, whose income exceeds 150 percent of the FPL, may be charged premiums on a sliding scale based on income, expressed as a per- centage of Medicare cost sharing described at section 1905(p)(3)(A)(i) of the Act.

5. Medically needy individuals, as defined in §§ 435.4 and 436.3 of this chapter, may be charged on a sliding scale. The agency must impose an appropriately higher charge for each higher level of family income, not to exceed $20 per month for the highest level of family income.

(b) *Consequences for non-payment.* (1) For premiums imposed under paragraphs (a)(1), (a)(2), (a)(3) and (a)(4) of this section, the agency may not require a group or groups of individuals to prepay.

2. Except for premiums imposed under paragraph (a)(5) of this section, the agency may terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

3. For premiums imposed under paragraph (a)(2) of this section—

i. For individuals with annual income ex- ceeding 250 percent of the FPL, the agency may require payment of 100 percent of the premiums imposed under this paragraph for a year, such that payment is only required up to 7.5 percent of annual income for indi- viduals whose annual income does not exceed 450 percent of the FPL.

ii. For individuals whose annual adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) exceeds

$75,000, increased by inflation each calendar year after 2000, the agency must require pay- ment of 100 percent of the premiums for a year, except that the agency may choose to subsidize the premiums using state funds which may not be federally matched by Med- icaid.

4. For any premiums imposed under this section, the agency may waive payment of a premium in any case where the agency deter- mines that requiring the payment will create an undue hardship for the individual or fam- ily.

5. The agency may not apply further con- sequences or penalties for non-payment other than those listed in this section.

(c) *State plan specifications.* For each pre- mium, enrollment fee, or similar charge im- posed under paragraph (a) of this section,

subject to the requirements of paragraph (b) of this section, the plan must specify—

1. The group or groups of individuals that may be subject to the charge;

2. The amount and frequency of the charge;

3. The process used by the state to iden- tify which beneficiaries are subject to pre- miums and to ensure individuals exempt from premiums are not charged; and
4. The consequences for an individual or family who does not pay.

§ 447.56 Income-related charges.

Subject to the maximum allowable charges specified in § 447.54 (a) and (b), the plan may provide for income-re- lated deductible, coinsurance or co- payment charges. For example, an agency may impose a higher charge on medically needy beneficiaries than it imposes upon categorically needy bene- ficiaries.

EFFECTIVE DATE NOTE: At 78 FR 42307, July 15, 2013, § 447.56 was revised, effective Jan. 1, 2014. For the convenience of the user, the re- vised text is set forth as follows:

§ 447.56 Limitations on premiums and cost sharing.

1. *Exemptions.* (1) The agency may not im- pose premiums or cost sharing upon the fol- lowing groups of individuals:

i. Individuals ages 1 and older and under age 18 eligible under § 435.118 of this chapter.

ii. Infants under age 1 eligible under § 435.118 of this chapter whose income does not exceed the higher of—

1. 150 percent FPL (for premiums) or 133 percent FPL (for cost sharing); and
2. If applicable, the percent FPL de- scribed in section 1902(l)(2)(A)(iv) of the Act up to 185 percent FPL.

iii. Individuals under age 18 eligible under § 435.120–§ 435.122 or § 435.130 of this chapter.

iii. Children for whom child welfare serv- ices are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

iv. At state option, individuals under age 19, 20 or age 21, eligible under § 435.222 of this chapter.

v. Disabled children, except as provided at § 447.55(a)(4) (premiums), who are receiving medical assistance by virtue of the applica- tion of the Family Opportunity Act in ac- cordance with sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

vi. Pregnant women, except for premiums allowed under § 447.55(a)(1) and cost sharing for services specified in the state plan as not pregnancy-related, during the pregnancy and through the postpartum period which begins

on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of preg- nancy ends.

viii. Any individual whose medical assist- ance for services furnished in an institution, or at state option in a home and community- based setting, is reduced by amounts reflect- ing available income other than required for personal needs.

ix. An individual receiving hospice care, as defined in section 1905(o) of the Act.

x. An Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through re- ferral under contract health services is ex- empt from premiums. Indians who are cur- rently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under con- tract health services are exempt from all cost sharing.

xi. Individuals who are receiving Medicaid because of the state's election to extend cov- erage as authorized by § 435.213 of this chap- ter (Breast and Cervical Cancer).

2. The agency may not impose cost shar- ing for the following services:

i. Emergency services as defined at sec- tion 1932(b)(2) of the Act and § 438.114(a) of this chapter;

ii. Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharma- ceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies;

iii. Preventive services, at a minimum the services specified at § 457.520 of chapter D, provided to children under 18 years of age re- gardless of family income, which reflect the well-baby and well child care and immuniza- tions in the Bright Futures guidelines issued by the American Academy of Pediatrics; and

iv. Pregnancy-related services, including those defined at §§ 440.210(a)(2) and 440.250(p) of this chapter, and counseling and drugs for cessation of tobacco use All services pro- vided to pregnant women will be considered as pregnancy-related, except those services specifically identified in the state plan as not being related to the pregnancy.

v. Provider-preventable services as de- fined in § 447.26(b).

2. *Applicability.* Except as permitted under § 447.52(d) (targeted cost sharing), the agency may not exempt additional individuals from cost sharing obligations that apply generally to the population at issue.

2. *Payments to providers.* (1) Except as pro- vided under paragraphs (c)(2) and (c)(3) of this section, the agency must reduce the payment it makes to a provider by the amount of a beneficiary's cost sharing obli- gation, regardless of whether the provider

has collected the payment or waived the cost sharing.

2. For items and services provided to Indi- ans who are exempt from cost sharing under paragraph (a)(1)(x) of this section, the agen- cy may not reduce the

payment it makes to a provider, including an Indian health care provider, by the amount of cost sharing that will otherwise be due from the Indian.

3. For those providers that the agency re- imburses under Medicare reasonable cost re- imbursement principles, in accordance with subpart B of this part, an agency may in- crease its payment to offset uncollected cost sharing charges that are bad debts of pro- viders.
4. *Payments to managed care organizations.* If the agency contracts with a managed care organization, the agency must calculate its payments to the organization to include cost sharing established under the state plan, for beneficiaries not exempt from cost sharing under paragraph (a) of this section, regard- less of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.
5. *Payments to states.* No FFP in the state's expenditures for services is available for—
    1. Any premiums or cost sharing amounts that recipients should have paid under

§§ 447.52 through 447.55 (except for amounts that the agency pays as bad debts of pro- viders under paragraph (c)(3) of this section; and

    2. Any amounts paid by the agency on be- half of ineligible individuals, whether or not the individual had paid any required pre- mium, except for amounts for premium as- sistance to obtain coverage for eligible individuals through family coverage that may include ineligible individuals when author- ized in the approved state plan.

(f) *Aggregate limits.* (1) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of the family's income applied on either a quarterly or monthly basis, as specified by the agency.

2. If the state adopts premiums or cost sharing rules that could place beneficiaries at risk of reaching the aggregate family limit, the state plan must indicate a process to track each family's incurred premiums and cost sharing through an effective mecha- nism that does not rely on beneficiary documentation.
3. The agency must inform beneficiaries and providers of the beneficiaries aggregate limit and notify beneficiaries and providers when a beneficiary has incurred out-of-pock- et expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

4. The agency must have a process in place for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a pre- mium.

5. Nothing in paragraph (f) shall preclude the agency from establishing additional ag- gregate limits, including but not limited to a monthly limit on cost sharing charges for a particular service.

§ 447.57 Restrictions on payments to providers.

1. *The plan must provide that the agency does not increase the payment it makes to any provider to offset un- collected amounts for deductibles, co- insurance, copayments or similar charges that the provider has waived or are uncollectible, except as permitted under paragraph (b) of this section.*
2. For those providers that the agen- cy reimburses under Medicare reason- able cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to offset uncollected deductible, coinsur- ance, copayment, or similar charges that are bad debts of providers.
3. Payment under Medicaid due to an Indian health care provider or a health care provider through referral under contract health services for di- rectly furnishing an item or service to an Indian may not be reduced by the amount of any enrollment fee, pre- mium, or similar charge, or any de- ductible, copayment, cost sharing, or similar charge that otherwise would be due from the Indian.

[43 FR 45253, Sept. 29, 1978, as amended at 75
FR 30262, May 28, 2010]

EFFECTIVE DATE NOTE: At 78 FR 42307, July 15, 2013, § 447.57 was revised, effective Jan. 1, 2014. For the convenience of the user, the re- vised text is set forth as follows:

§ 447.57 Beneficiary and public notice re- quirements.

1. The agency must make available a pub- lic schedule describing current premiums and cost sharing requirements containing the following information:
    1. The group or groups of individuals who are subject to premiums and/or cost sharing and the current amounts;
    2. Mechanisms for making payments for required premiums and cost sharing charges;
    3. The consequences for an applicant or re- cipient who does not pay a premium or cost sharing charge;

4. A list of hospitals charging cost sharing for non-emergency use of the emergency de- partment; and
5. A list of preferred drugs or a mechanism to access such a list, including the agency Web site.

2. The agency must make the public schedule available to the following in a man- ner that ensures that affected applicants, beneficiaries, and providers are likely to have access to the notice:
    1. Beneficiaries, at the time of their en- rollment and reenrollment after a redeter- mination of eligibility, and when premiums, cost sharing

charges, or aggregate limits are revised, notice to beneficiaries must be in accordance with § 435.905(b) of this chapter;

2. Applicants, at the time of application;
3. All participating providers; and
4. The general public.

(c) Prior to submitting to the Centers for Medicare & Medicaid Services for approval a state plan amendment (SPA) to establish or substantially modify existing premiums or cost sharing, or change the consequences for non-payment, the agency must provide the public with advance notice of the SPA, speci- fying the amount of premiums or cost shar- ing and who is subject to the charges. The agency must provide a reasonable oppor- tunity to comment on such SPAs. The agen- cy must submit documentation with the SPA to demonstrate that these requirements were met. If premiums or cost sharing is sub- stantially modified during the SPA approval process, the agency must provide additional public notice.

§ 447.58 Payments to prepaid capita- tion organizations.

If the agency contracts with a pre- paid capitation organization that does not impose the agency's deductibles, coinsurance, co-payments or similar charges on its beneficiary members, the plan must provide that the agency calculates its payments to the organi- zation as if those cost sharing charges were collected.

[48 FR 5736, Jan. 8, 1983, as amended at 67 FR 41116, June 14, 2002]

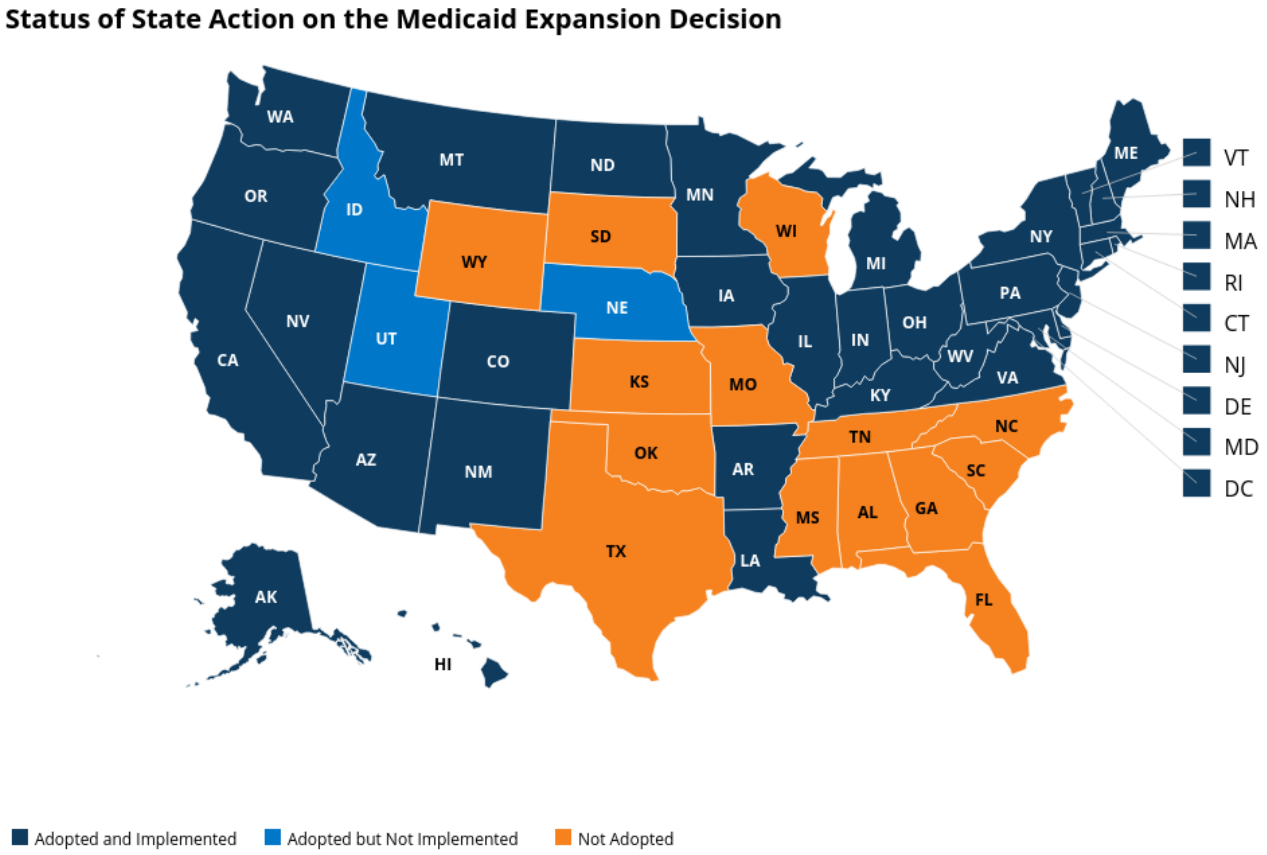
FEDERAL FINANCIAL PARTICIPATION

§ 447.59 FFP: Conditions relating to cost sharing.

No FFP in the State's expenditures for services is available for—

(a) Any cost sharing amounts that beneficiaries should have paid as en- rollment fees, premiums, deductibles, coinsurance, copayments, or similar charges under §§ 447.50 through 447.58

Visual of U.S. states and their Medicaid expansion status as of November 6, 2019



SOURCE: Kaiser Family Foundation, kff.org

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

Filling the need for trusted information on national health issues...

Updated January 2016 | Fact Sheet

Medicaid Expansion in Michigan

Michigan obtained approval from the Centers for Medicare and Medicaid Services (CMS) to implement the Affordable Care Act's (ACA) Medicaid expansion through a Section 1115 demonstration waiver, called the "Healthy Michigan Plan." The waiver initially was approved on December 30, 2013, and was implemented beginning April 1, 2014. On December 17, 2015, CMS approved Michigan's waiver amendment, with new authorities to take effect in April 2018, after the expansion has been in effect for 48 months.[1]

Under the current Healthy Michigan Plan, the state provides Medicaid coverage to all newly eligible adults with income up to and including 138% of the federal poverty level (FPL, $16,243 per year for an individual in 2015).[2] An estimated 605,000 adults are enrolled in coverage through the waiver as of September, 2015.[3] The waiver requires all beneficiaries to make monthly payments into a health savings account based on their average co-payments for services used in the previous six months (at state plan amounts). The waiver also requires beneficiaries from 100-138% FPL to make income-based monthly premium contributions to health savings accounts (2% of income). Health savings account payments can be reduced through compliance with specified healthy behaviors, and failure to pay copayments or premiums does not result in a loss of Medicaid eligibility. The waiver uses Michigan's pre-existing Medicaid Managed Care Organizations (MCOs), and Pre-paid Inpatient Health Plans (PIHPs) for mental health and substance abuse services, to serve the newly eligible population.

Under the approved waiver amendment, beneficiaries between 100% and 138% FPL who are not medically frail will choose between two coverage options as of April 2018:[4]

- Continued coverage through Medicaid managed care (the Healthy Michigan Plan), or
- Medicaid premium assistance for Marketplace coverage through a Qualified Health Plan (QHP) (the Marketplace Option).

If beneficiaries choose Medicaid managed care, they will be required to complete a healthy behavior, or they are subject to transition to a QHP. Beneficiaries above 100% FPL will face monthly premiums of up to 2% of income in both Medicaid managed care and QHPs, but failure to pay would not result in termination of eligibility.

As of December 2015, 31 states (including DC) have adopted the ACA's Medicaid expansion. Michigan is one of six states (along with Arkansas, Indiana, Iowa, Montana, and New Hampshire) that are implementing the Medicaid expansion using a Section 1115 demonstration waiver as of 2016. Pennsylvania had initially implemented the Medicaid expansion using a Section 1115 demonstration but later transitioned to a traditional Medicaid expansion using state plan authority.

Table 1 highlights the components in Michigan's original waiver and is updated to reflect approved changes in the waiver amendment effective in April 2018.

Table 1: Healthy Michigan Plan as Amended on December 17, 2015	
Element	**Healthy Michigan Plan**
Overview:	Covers childless adults ages 19 to 64 from 0 to 138% FPL statewide through Medicaid managed care. Requires copayments at state plan amounts for all beneficiaries, which may be reduced by participating in specified healthy behavior activities. Copayments are paid into health savings accounts monthly based on the average copayments for services used in the previous six months. Also requires beneficiaries 100-138% FPL to pay monthly premiums (2% of income) into health savings accounts. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services, for failure to pay copays or premiums. Beginning April 2018, beneficiaries with incomes above 100% FPL who are not medically frail will choose between 2 options: continued coverage through Medicaid managed care or Marketplace QHP coverage with Medicaid premium assistance and cost-sharing subsidies. Those choosing Medicaid managed care must meet a healthy behavior requirement after a one year grace period.
Duration:	12/30/13 to 12/31/18. Enrollment began 4/1/14.
Coverage Groups:	Adults ages 19-64 up to 138% FPL (childless adults 0-138% FPL, non-working parents from 37-138% FPL, and working parents from 64-138% FPL).[5]
Exempt Populations:	Noncitizens eligible only for emergency services, Program for All-Inclusive Care for the Elderly (PACE) participants, and individuals residing in intermediate care facilities for individuals with intellectual and developmental disabilities (ICFs/IDD). As of April 2018, newly eligible adults above 100% FPL who are medically frail will remain in Medicaid managed care and are not subject to being transferred to a Marketplace QHP with Medicaid premium assistance if they do not complete a healthy behavior (described below).
Premiums:	Beneficiaries above 100% FPL pay monthly premiums in the amount of 2% of income. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay premiums. This applies to both those in Medicaid managed care and in QHP coverage, when that option becomes available in April 2018. Cost-sharing and premiums cannot exceed 5% of household income.
Co-Payments:	All demonstration beneficiaries have cost-sharing obligations based on their average prior 6 months of copays, billed at the end of each quarter. Cost-sharing is paid into health savings accounts and can be reduced through compliance with healthy behaviors. Amount of cost-sharing is based on state plan amounts and not changed from what would have been collected without the waiver.[6] Cost-sharing for beneficiaries receiving coverage through Marketplace QHPs, when that option becomes available in April 2018, also will be limited to Medicaid state plan amounts. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copays. Copays in excess of 2% of income may be reduced through compliance with healthy behaviors. Cost-sharing and premiums cannot exceed 5% of household income. These provisions apply to beneficiaries in Medicaid managed care and those in QHP coverage
Health Savings Account and Healthy Behavior Protocols:	Health savings account and healthy behavior protocols were developed by the state and approved by CMS. The health savings account protocol describes the online accounts used by beneficiaries enrolled in MCOs and the healthy behavior protocol describes the services beneficiaries can engage in to decrease cost-sharing requirements and how engaging in these activities decreases their required cost-sharing. Changes to the protocols are also subject to CMS approval.[7] The state must submit a revised healthy behavior protocol to CMS by July 1, 2017 to

Table 1: Healthy Michigan Plan as Amended on December 17, 2015	
Element	**Healthy Michigan Plan**
	implement the new healthy behavior requirements for non-medically frail beneficiaries with incomes above 100% FPL as of April 2018; these requirements cannot be more restrictive than those approved in August 2014. These beneficiaries will have a one year grace period to complete a healthy behavior before they are subject to being moved from Medicaid managed care to Marketplace premium assistance. Enrollees who move from Medicaid managed care to Marketplace premium assistance (for failure to complete a healthy behavior) will be automatically transitioned without additional eligibility determinations. Those who are newly enrolled or whose income increases above 100% FPL in or after April 2018, will have one year of Medicaid managed care coverage to complete a healthy behavior before they are subject to QHP enrollment. By April 1, 2017, the state must submit a transition plan for how the new waiver provisions will be implemented for beneficiaries above 100% FPL in April 2018.
Delivery Systems and Benefits:	No Medicaid benefits are waived. Medicaid MCOs and PIHPs (for mental health and substance abuse services) are used to serve the newly eligible population. Beneficiaries in Medicaid managed care receive an Alternative Benefits Plan (ABP) that contains the same benefits as the state plan benefit package. Beneficiaries receiving Medicaid premium assistance for Marketplace coverage (beginning in April 2018) will receive an ABP that may be specific to the QHP in which they are enrolled. Michigan will provide wrap-around coverage on a fee-for-service basis for non-emergency medical transportation, EPSDT and family planning services and supplies including access to out-of-network family planning providers for beneficiaries in QHPs. These beneficiaries will also have access to at least one QHP in each service area that contracts with an FQHC/RHC. QHP enrollees may have prescription drug prior authorization requests decided within 72 hours instead of 24 hours, with a 72 hour supply dispensed in an emergency. Those newly determined eligible for waiver coverage will initially be placed in fee-for-service until an MCO is selected or auto-assignment occurs.
Plan Choice and Auto-Assignment:	Enrollment broker assists beneficiaries with MCO selection before relying on auto-assignment. According to the waiver, MCO auto-assignment first takes into account beneficiary's prior or current MCO history and then MCO affiliation of beneficiary's historic providers. In rural counties,[8] there will only be one MCO. In all other areas, beneficiaries will have a choice of MCOs. There will be one PIHP per region. MCO lock-in for 12 months after initial 90 days to switch plans. The state will develop an auto-assignment methodology for QHP enrollment when that option becomes available in April 2018,
Financing:	The budget neutrality limit calculations for the waiver are estimated to be the PMPM for each year increased by 5.1% multiplied by the number of eligible member months and adding the products across years and applying the federal share.
Cost-effectiveness:	Michigan may apply state-developed measures in evaluating the cost-effectiveness of Marketplace premium assistance.
Evaluation:	An evaluation design was developed by the state and approved by CMS to examine the following topics: uncompensated care costs, reduction in number of uninsured, impact on healthy behaviors and health outcomes, beneficiary views on impact of demonstration, impact of contribution requirements, and impact of health accounts.[9] The state must submit a draft evaluation design update reflecting the waiver amendment provisions by April 2016.

Endnotes

[1] The state legislation authorizing Medicaid expansion called for the termination of the Healthy Michigan Plan on April 30, 2016 if the state failed to obtain approval of the waiver amendment by December 31, 2015. Mich. Comp. Laws § 400.105d, http://www.legislature.mi.gov/(S(w0bdpchgm10lcvuemkvl5bic))/mileg.aspx?page=getObject&objectName=mcl-400-105d.

[2] Marilyn Tavenner, Administrator of the Centers for Medicare and Medicaid Services, Waiver Approval Letter, December 30, 2013, accessed on January 3, 2014, http://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf.

[3] Healthy Michigan Section 1115 Demonstration, Centers for Medicare and Medicaid Services, Special Terms and Conditions Approved December 17, 2015. https://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf

[4] Healthy Michigan Section 1115 Demonstration, Centers for Medicare and Medicaid Services, Special Terms and Conditions Approved December 17, 2015. https://www.michigan.gov/documents/snyder/Healthy_Michigan_1115_Demonstration_Approval_12302013_443466_7.pdf

[5] Childless adults ages 19-64 from 0 to 35% FPL eligible for Michigan's limited benefit package covered by the Adult Benefits Waiver that existed prior to initial implementation of the Healthy Michigan Plan transitioned to full Medicaid coverage as part of the new expansion group.

[6] Beneficiaries are subject to co-pays according to the current state plan (inpatient hospital admission (except emergent admission), $50; non-emergency use of the ER, brand-name drugs, dental visit, or hearing aid, $3; physician, podiatry, or vision office visits, $2; outpatient hospital or chiropractic visit or generic drugs, $1).

[7] Health savings account protocol is Attachment E, and the healthy behaviors protocol is Attachment F of the waiver's Special Terms and Conditions.

[8] Counties considered rural are Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft.

[9] Evaluation plan is Attachment B of the waiver's Special Terms and Conditions.

HEALTHY MICHIGAN SECTION 1115 DEMONSTRATION
FACT SHEET

Name of Section 1115 Demonstration:	Healthy Michigan
Waiver Number:	11-W-00245/5
Date Proposal Received:	September 27, 2009
Date Proposal Approved:	December 22, 2009
Date Implemented:	January 1, 2010
Date Expires:	December 31, 2018

SUMMARY

The Healthy Michigan demonstration will enable Michigan to test innovative approaches to beneficiary cost sharing and financial responsibility for care for the new adult eligibility group, described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act). The new adult population with incomes above 100 percent of the Federal poverty level (FPL) will be required to make contributions equal to two percent of their family income toward the cost of their health care. In addition, all newly eligible adults from 0 to 133 percent of the FPL, regardless of their income, will pay required Medicaid copayments through a credit facility operated in coordination with the Medicaid Health plan. An MI Health Account will be established for each enrolled individual to track beneficiaries' contributions and how they were expended. Beneficiaries will receive quarterly statements that summarize the MI Health Account funds balance and flows of funds into and out of the account, and the use of funds for health care service copayments. Beneficiaries will have opportunities to reduce their regular or average utilization based contribution by demonstrating achievement of recommended Healthy Behaviors.

Prior to its amendment to authorize Healthy Michigan, the demonstration provided federal financial participation for the Adult Benefit Waiver (ABW) program, ABW provides a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the FPL who are not eligible for Medicaid. The ABW program was first approved in January 2004 as a title XXI funded Health Insurance Flexibility and Accountability (HIFA) section 1115 demonstration. In December 2009, ABW was reauthorized as a new Medicaid section 1115 demonstration, under provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Section 112 of CHIPRA prohibited the use of title XXI funds for childless adults' coverage after December 31, 2009, but allowed states to continue existing programs as new Medicaid demonstrations under special budget formula. Michigan will continue to provide ABW program coverage through April 1, 2014, at which time program beneficiaries will transition to the expanded Medicaid program and Healthy Michigan.

AMENDMENTS

Amendment #1: An amendment was approved to authorize the Healthy Michigan program, and to phase-out ABW as of April 2014. The name of the demonstration was changed from

"Michigan Medicaid Non-pregnant Childless Adults Waiver (Adult Benefits Waiver)" to "Healthy Michigan." The amendment was approved through December 31, 2018, to allow sufficient time to test the unique features of Healthy Michigan.

Date Amendment #1 Submitted: November 8, 2013
Date Amendment #1 Approved: December 30, 2013

ELIGIBILITY

Medicaid beneficiaries eligible for the new adults groups under section 1902(a)(10)(A)(i)(VIII) of the Act must participate in Healthy Michigan, unless specifically exempted.

Eligibility for ABW is offered to uninsured, non-pregnant childless adults ages 19 through 64 years with incomes at or below 35 percent of the FPL who are not otherwise eligible for Medicaid.

ENROLLMENT

Standard Medicaid eligibility and enrollment processes will be used to enroll adults who qualify for the new adults group, who will participate in Healthy Michigan. Michigan estimates that between 300,000 and 500,000 individuals will enroll.

Applicants for enrollment in the ABW program use the same application and enrollment procedures required of other individuals applying for other Medicaid programs. Congress established a methodology for the budget neutrality limit for the childless adult demonstrations such as ABW. Based on this methodology, Michigan is able to sustain coverage for approximately 62,000 childless adults. The State may impose an enrollment cap, as necessary, in order to operate within the budget neutrality limit.

BENEFIT PACKAGE

Healthy Michigan beneficiaries will receive the benefits in the approved Alternative Benefit Plan (ABP) state plan amendment.

ABW beneficiaries receive a limited benefit package that consists of outpatient hospital, physician, diagnostic, pharmacy, and mental health and substance abuse services. Enrollees may be required to receive prior authorization from their assigned county health plans or the State before accessing certain ambulatory services.

DELIVERY SYSTEM

Healthy Michigan beneficiaries will receive coverage through the same Medicaid managed care plans that serve other Medicaid populations in the state.

ABW beneficiaries receive their coverage through a managed healthcare delivery system utilizing a network of county health plans and the Public Mental Health and Substance Abuse

provider network. In counties where a county health plan does not exist, the delivery system is Medicaid fee for service.

COST SHARING AND PREMIUMS

Healthy Michigan beneficiaries will face the nominal copayment requirements as specified in the Medicaid state plan. Beneficiaries will be responsible for copayment liability based upon the prior 6 months of copayment, but will billed for such copayments only at the end of each quarter. Beneficiaries may achieve reduction in their copayment liability if certain healthy behaviors are maintained or attained. Beneficiaries with income above 100 percent of the FPL will in addition be responsible for a monthly premium that shall not exceed 2 percent of income. Premium amounts paid by beneficiaries will be used to defray the cost of items or services they receive that otherwise would be covered under their Medicaid benefit. Premium contributions that are unused at time of the beneficiary's disenrollment from Healthy Michigan may be returned to the beneficiary. MI Health Accounts will be established to track and record beneficiary payments and liabilities. The state must receive CMS approval for protocols that describe the operational details of the premiums, cost sharing provisions, MI Health Accounts, and healthy behavior incentives prior to their implementation.

ABW beneficiaries are required to pay copayments in order to access certain services. The co-payment amounts are nominal.

Last updated: January 3, 2014

Healthy Michigan

State:

Michigan

Waiver Authority:

1115

Status:

Approved

Waiver Dates

Approval:

12/22/2009

Effective:

01/01/2010

Expiration:

12/31/2023

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February 2018 | Issue Brief

Approved Changes in Indiana's Section 1115 Medicaid Waiver Extension

MaryBeth Musumeci, Robin Rudowitz, and Elizabeth Hinton

On February 1, 2018, the Centers for Medicare and Medicaid Services (CMS) approved an amended extension of Indiana's Healthy Indiana Program 2.0 (HIP 2.0) Section 1115 demonstration waiver. Indiana's waiver initially implemented the ACA's Medicaid expansion from February, 2015 through January, 2018 by modifying Indiana's pre-ACA limited coverage expansion waiver (HIP 1.0). Unlike other states that implemented the ACA's Medicaid expansion through a waiver, Indiana's demonstration also changes the terms of coverage for non-expansion adults (low-income parents and those eligible for Transitional Medical Assistance, TMA). The February, 2018 extension continues most components of HIP 2.0 and adds some new provisions.

Key provisions of HIP 2.0 that continue under the waiver extension include:

- Charging monthly premiums, paid into a health account, for expansion adults and low-income parents;
- Disenrolling and imposing a 6-month coverage lock-out on those with incomes from 101-138% FPL who fail to pay premiums after a 60-day grace period;
- Delaying coverage until the 1st premium payment, or for those from 0-100% FPL, after the expiration of the 60-day payment period; and
- Enrolling adults who pay premiums in HIP Plus, an expanded benefit package with co-payments only for non-emergency use of the ER. Beneficiaries at or below 100% FPL who fail to pay premiums receive HIP Basic, a more limited benefit package with state plan level co-payments for most services.

Key changes to HIP 2.0 approved on February 1, 2018 include:

- Increasing premiums by 50% for all tobacco users beginning in their second year of enrollment;
- Conditioning Medicaid eligibility for most adults on meeting a work requirement beginning in 2019;
- Disenrolling most adults who do not timely complete the eligibility renewal process; in addition, expansion adults are locked out of coverage for 3 months;
- Changing premiums to a tiered structure instead of a flat 2% of income; and
- Restricting TMA eligibility to 139-185% FPL; those who otherwise would have qualified for TMA up to 138% FPL instead will be treated like expansion adults under the waiver for premiums and benefits.

The February, 2018 waiver extension also waives the "institution for mental disease" (IMD) payment exclusion for short-term SUD treatment services for all Medicaid adults ages 21-64.

The waiver extension does not continue the demonstration authority to test graduated copayments up to $25 for non-emergency use of the ER (instead, non-emergent use of the ER is subject to an $8 copay, which is within statutory limits with no waiver required). The waiver extension also does not continue the previous authority to use Medicaid as premium assistance for those with employer-sponsored insurance.

Indiana is the first state to receive approval to impose a premium surcharge for tobacco users. Indiana is the second state to receive authority to impose a work requirement as a condition of Medicaid eligibility following CMS's guidance released on January 11, 2018, and approval of the Kentucky waiver on January 12, 2018. Similar to Kentucky, Indiana requires payment of the initial premium (or expiration of the 60-day payment period for those at or below 100% FPL) prior to starting coverage and imposes a lock-out for failure to pay premiums as well as a lock-out for failure to timely renew coverage.

As with Kentucky's waiver, no operational protocols are required for Indiana to implement the new work requirement, a provision that is likely to have significant implications for beneficiaries' ability to retain coverage for which they are eligible. While Indiana's waiver includes numerous exemptions for certain individuals and good cause exceptions, as well as "state assurances" about implementation, these provisions are complex and will require administrative staff time and resources and sophisticated systems to implement. In addition, Indiana had requested changes to its healthy behavior incentive program that would include "completion of specified outcome milestones and targets"; however, these provisions are not discussed in the waiver renewal so it is unclear if these state is planning to move ahead with these changes. Implementation of new waiver provisions and understanding the impact of the waiver on enrollment, program costs and administrative costs will be important areas to watch. This fact sheet summarizes key provisions of Indiana's approved waiver. Specific details are included in Table 1.

Table 1: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved and amended, 2/1/18**
Overview:	Indiana's waiver initially implemented the ACA's Medicaid expansion from February, 2015 through January, 2018, by requiring most expansion adults with incomes from 101-138% FPL to pay monthly premiums by contributing to a Personal Wellness and Responsibility (POWER) health account. Coverage does not start until the 1st premium payment, or, for those from 0-100% FPL, after the expiration of the 60-day payment period. All expansion adults who pay premiums are eligible for HIP Plus, an expanded benefit package with co-payments only for non-emergency use of the ER. Those with incomes from 101-138% FPL who fail to pay premiums after a 60-day grace period are disenrolled from coverage and barred from re-enrolling for 6 months. Beneficiaries with incomes at or below 100% FPL who fail to pay premiums after a 60-day period receive HIP Basic, a more limited benefit package with state plan level co-payments. The waiver also allowed non-expansion parent/caretakers to pay premiums in lieu of co-payments for state plan. Indiana's waiver was extended and amended for February, 2018 through December, 2020. Key changes to the main demonstration program, HIP 2.0, for expansion adults and low-income parent/caretakers include conditioning Medicaid eligibility on meeting a work requirement, imposing a 3-month coverage lockout on beneficiaries who do not timely complete the eligibility renewal process, increasing premiums by 50% for tobacco users beginning in their second year of enrollment, changing premiums to a tiered structure instead of a flat 2% of income, requiring parents who would have qualified for Transitional Medical Assistance up to 138% FPL to pay premiums like expansion adults, and eliminating demonstration authority to test graduated copays up to $25 for non-emergency use of the ER. (Instead, non-emergent use of the ER is subject to an $8 copay which is within statutory limits with no waiver required). The waiver extension also waives the IMD payment exclusion for short-term SUD treatment services for all Medicaid adults ages 21-64.
Duration:	2/1/18 to 12/31/2020
Coverage Groups:	Covers adults ages 19-64 with incomes from 0-138% FPL, including non-expansion (§ 1931) parent/caretakers, those eligible for Transitional Medical Assistance (TMA, formerly eligible as § 1931parent/caretakers), pregnant women, and adults newly eligible through the ACA's Medicaid expansion (nearly 397,000 beneficiaries statewide as of Dec. 17, 2017). Under the waiver extension, the TMA group now includes former parent/caretakers with incomes from 138-185% FPL (instead of all those above the § 1931parent/caretaker income limit up to 185% FPL). Former parent/caretakers up to 138% FPL who otherwise would have qualified for TMA will instead enroll in HIP Basic or HIP Plus like expansion adults. The extension also adds pregnant women up to 138% FPL to HIP 2.0. Excludes children, seniors, and dual eligible beneficiaries. American Indian/Alaska Natives may opt out of the demonstration 30 days after enrollment. Newly eligible AI/ANs who remain in the demonstration have the more generous (HIP Plus) benefit package, with coverage effective on the date of application, and no premiums or co-payments.
Coverage Effective Date:	Waives reasonable promptness so that HIP Plus coverage begins on the first day of the month in which a beneficiary makes an initial premium payment instead of the date on which beneficiary is determined eligible for Medicaid (retroactive to the application date). Beneficiaries have 60 days from the date of their eligibility determination to make this payment. However, different provisions apply to individuals determined presumptively eligible (described below). For those at or below 100% FPL who do not pay premiums, HIP Basic coverage begins on the first day of the month in which the 60-day premium payment period expires. Once in HIP Basic, beneficiaries cannot move to HIP Plus until eligibility renewal, receipt of rollover funds (described below) or at other times designated by the state. Under the waiver extension, those who move from another Medicaid coverage group (not subject to the waiver) into HIP 2.0, will immediately be enrolled in HIP Basic and then have 60 days to choose to pay a premium and enroll in HIP Plus.
Fast Track Payments:	Effective April 1, 2015, state allows for an optional $10.00 fast track initial POWER account pre-payment that makes enrollment effective the first day of the month in which payment is received, once a beneficiary is determined eligible. However, the beneficiary cannot change MCOs for a year after making a fast track payment. The fast track payment is refundable if the applicant is determined ineligible. If the beneficiary's regular monthly premium is less than $10.00, the MCO shall credit the remaining portion of the fast track payment to subsequent premium payments. If the

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Element	**Indiana Waiver Provision, as approved and amended, 2/1/18**
	beneficiary's regular monthly premium is more than $10.00, the beneficiary will be billed the difference on the next POWER account invoice.
Presumptive Eligibility:	State shall include FQHCs, RHCs, CMHCs, and health department sites in an expanded presumptive eligibility program. Presumptive eligibility enables applicants to receive Medicaid-covered services as of the date that a qualified provider entity preliminarily determines that the applicant is financially and categorically eligible for Medicaid, while the final eligibility determination is pending with the state Medicaid agency. Under the waiver extension, individuals determined presumptively eligible will maintain Medicaid coverage until the last day of the month following the presumptive eligibility determination, unless they submit an application for a full Medicaid eligibility determination. Those who receive a full Medicaid eligibility determination after having been determined presumptively eligible will move to HIP Basic on the first of the month following their application approval, with no gap in coverage, and will have 60 days from the date that they were eligible to make a Fast Track payment (following application filing) to pay a premium. The state has the option to reclassify presumptively eligible individuals as eligible in the expansion group for up to 3 months prior to their effective coverage date (date of first premium payment or for those at or below 100% FPL, the expiration of 60-day payment period), and terminate eligibility for premium non-payment within 60 days for those above 100% FPL.
Retroactive Coverage Transition Program:	Waives retroactive coverage of services incurred during the 90 days prior to Medicaid eligibility except for pregnant women. The waiver extension eliminates the prior claims payment program that previously covered retroactive bills for non-expansion parent/caretakers.
Lock-Out for Noncompliance with Renewals*:*	Under the waiver extension, all beneficiaries (except those who are pregnant or 60 days post-partum) who do not provide necessary information or documentation to complete the eligibility renewal process are disenrolled from coverage but can re-enroll without a new application if they provide verification within 90 days of disenrollment. After 90 days of disenrollment, expansion adults are locked out of coverage for another 3 months and cannot re-enroll unless they are exempt or provide verification of good cause. People who are medically frail, those who become pregnant, and non-expansion low-income parents are disenrolled for failure to comply with redeterminations but not subject to the 3-month lockout. Qualifying good cause events include: obtained and subsequently lost private coverage; lost income after disqualification due to increased income; moved to another state and then returned; domestic violence; residing in disaster area in 60 days prior to disenrollment; hospitalized, otherwise incapacitated, or has a disability and as a result was unable to comply during the entire 90-day period, or did not receive needed reasonable modifications, or there were no reasonable modifications that would have enabled compliance; an immediate family member in the home was institutionalized or died during the reporting period, or caretaking or other disability-related responsibilities for an immediate family member living in the home prevented compliance; and additional circumstances deemed necessary by the state.
Delivery System and Health Savings Accounts:	Services provided by MCOs. MCOs also must bill and collect premiums from beneficiaries. Each demonstration enrollee has a health account called a POWER account. POWER accounts are jointly funded by beneficiary premiums and the state. POWER account funds are used to fund the first $2,500 of covered claims, except for preventive services required by 42 USC § 300gg-13,[i] the cost of which are not charged against POWER account funds. Other preventive services are covered, subject to a $500 annual cap, and are charged against POWER account funds. Enrollees have a Jan.-Dec. calendar year benefit period. MCO selection and the POWER account remain active for the entire calendar year, even if individuals experience a gap in coverage. State pays capitated rate to MCOs for services after the $2,500 POWER account funds are exhausted. The process for collecting POWER account contributions is governed by an operational protocol.
Beneficiary Premiums:	Monthly premiums apply to all beneficiaries from 0-138% FPL based on income and are at least $1.00. Premiums are a condition of eligibility only for non-medically frail, non-pregnant beneficiaries from 101-138% FPL. Under the waiver extension, tobacco users will have a premium surcharge equal to a 50% increase in their monthly contribution amount after the 1st year of enrollment. Health plans shall conduct active outreach and member education related to tobacco-cessation benefits. The tobacco surcharge will

Table 1: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved and amended, 2/1/18**
	be removed from the following benefit year's contribution amount if a beneficiary informs the state that they have stopped using tobacco. Under the waiver extension, premiums change to the following tiered structure (instead of flat 2% of income): 0-22% FPL (0-$223/month for an individual in 2018) = $1.00/individual, $1.00/spouse 23-50% FPL ($233-$506/month) = $5.00/individual, $2.50/spouse 51-75% FPL ($516-$759/month) = $10.00/individual, $5.00/spouse 76-100% FPL ($769-$1,012/month) = $15/individual, $7.50/spouse 101-138% FPL ($1,022-$1,397/month) = $20/individual, $10.00/spouse Cost-sharing (both premiums and co-payments) limited to 5% of quarterly household income. Beneficiary premium amounts are adjusted at annual renewal and anytime the state is made aware of an income change during the current coverage period. Beneficiary premiums shall be reduced by any POWER account contributions made by third parties, such as employers or non-profit organizations.
State Contributions:	The state funds the difference between the beneficiary's monthly premiums and the full $2,500 POWER account value. The state will make an initial $1,300 account contribution upon the beneficiary's MCO enrollment, and any additional amount owed by the state to the MCO for services provided to the beneficiary shall be reconciled after 12 months.
Consequences of Premium Non-Payment:	Expansion adults from 101-138% FPL who do not make a premium payment within a 60-day grace period are disenrolled from coverage and locked out for six months. Prior to disenrollment, the state shall review all other bases of Medicaid eligibility and notify the beneficiary about the option to request a medical frailty determination, and the MCO must provide 2 written notices about the delinquent payment. Beneficiaries who are disenrolled for non-payment of premiums are not subject to the lock-out if they re-apply with verification of non-payment due to a "qualifying event," such as obtaining and subsequently losing private coverage, losing income after disqualification due to increased income, moving to another state and then returning, experiencing domestic violence, residing in a county subject to a disaster declaration in the 60 days prior to termination for non-payment, medical frailty, or other circumstances deemed necessary by the state. Individuals who never make their initial premium payment are not subject to the 6 month lock-out. Expansion adults from 101-138% FPL who are medically frail who do not pay premiums are not terminated from coverage. Instead, these beneficiaries must continue to have access to the state plan benefit package,[ii] are subject to state plan co-payments for services, and continue to be billed for premiums. Expansion adults at or below 100% FPL who do not make an initial premium payment within 60 days of their eligibility determination or who do not make a subsequent premium payment within the 60-day grace period are automatically enrolled in the HIP Basic plan. These beneficiaries will be subject to state plan co-payments for services, which may exceed the cost of monthly premiums applicable under HIP Plus. Non-expansion parent/caretakers and newly eligible adults at or below 100% FPL who are medically frail who do not pay premiums retain their existing benefit package (described below) and are subject to state plan co-payments. Pregnant women who do not pay premiums retain access to the state plan benefit package and do not have copays. Under the wavier extension, low-income parent/caretakers who previously would have qualified for TMA (based on income above the parent/caretaker limit) up to 138% FPL instead must pay premiums to access HIP Plus. TMA is restricted to enrollees from 139-185% FPL; this group qualifies for HIP coverage for up to 12 months. If their income remains between 139-185% FPL after the first 6 months of TMA eligibility, they can continue to receive HIP for another 6 months as long as they pay premiums.
Debts/Refunds Upon Disenrollment:	Payment of unpaid premiums is not a condition of Medicaid re-enrollment but may be owed as a debt.[iii] MCOs may attempt to collect unpaid premiums from beneficiaries but may not report debt to collection agencies, place a lien on beneficiary's home, refer cases to debt collectors, file a lawsuit, seek a court order to garnish wages, or sell the debt to a third party for collection.

Table 1: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved and amended, 2/1/18**
	If beneficiaries have paid excess premiums,[iv] they are owed a refund, subject to a 25% penalty if the beneficiary is terminated for non-payment of premiums.
Healthy Behavior Incentives:	HIP Plus beneficiaries who make timely premium payments will be eligible to rollover their share of the unused POWER account balance at the end of 12 months. If the beneficiary completes age and gender appropriate preventive services, the rollover balance for HIP Plus beneficiaries will be doubled by the state, not to exceed the beneficiary's total premium payments for the year. HIP Basic beneficiaries can rollover unused POWER account funds, up to 50% of the amount of premiums required for HIP Plus, if they obtained unspecified age and gender appropriate preventive services. Rollover funds can be used to reduce the required beneficiary premiums in the subsequent year. Debts may be collected from rollover account balances.
Co-Payments for Non-Emergency Use of the ER:	Enrollees who pay premiums are not subject to copayments except for non-emergency use of the ER at the state plan amount ($8). The waiver extension eliminates the Section 1916 (f) authority to test graduated copays up to $25 for non-emergency use of the ER.
Work Requirement:	Under the waiver extension, meeting a work requirement in 8 out of 12 months is a condition of eligibility as of 2019 for most HIP adults. Those eligible for Medicaid for less than a full year will still have 4 months of the year in which they do not have to comply. Required participation hours are as follows: 1-6 months – no weekly hour requirement 7-9 months – 5 hours/week 10-12 months – 10 hours/week 13-18 months – 15 hours/week 18+ months – 20 hours/week If enrollees exceed their hourly requirement in a week, they can apply extra hours to other weeks in the same month. Non-exempt beneficiaries must document their participation online, by phone, by mail, in person or by other commonly available electronic means and can use self-attestation at state option. Work activities include but are not limited to: -Subsidized or unsubsidized employment -Job search -General education (high school, GED, community college, college, graduate education) -Accredited ESL education -Accredited homeschooling -MCO employment initiatives -Job skills training -Education related to employment (e.g., employer subsidized classes) -Vocational training/education -Community work experience -Participation in Gateway to Work (referral to available employment, work search, and job training programs) -Community/public service -Volunteer work (e.g., classroom volunteer, faith-based internship work or mission trips sponsored by recognized religious institution) -Caregiving for nondependent relative or other person with chronic disabling health condition, including those receiving FMLA -Meeting or exempt from SNAP work requirements -Members of the Pokagon Band of Potawatomi and participating in the tribe's Pathways program -Any other beneficiary participating in a workforce participation program that the state has determined will promote full employment and meet the goals of Indiana's community engagement initiative Enrollees are exempt from the work requirement for a given month if they are: -Full or part-time students -Pregnant -Primary caregiver of dependent child below mandatory education age or dependent with a disability -Medically frail (serious & complex medical condition, chronic SUD, disability determination)

Table 1: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved and amended, 2/1/18**
	-Have a temporary illness or incapacity documented by a third party -In active substance use disorder treatment -Over age 59 -Homeless -Incarcerated in the last 6 months -Eligible for Medicaid in a coverage group other than parent/caretakers, expansion adults, TMA, or pregnant women -Meet or exempt from TANF work requirements -Receiving Medicaid premium assistance for ESI -Determined eligible for a good cause exemption Good cause exemptions will include at least the following verified circumstances: -People with disabilities defined by the ADA/504/1557 who were unable to comply for a reason related to the disability -People with an immediate family member in the home with a disability who were unable to comply for a reason related to the family member's disability -Beneficiary or immediate family member in the home has a hospitalization or serious illness -Victim of domestic violence -Additional circumstances as the state deems necessary. Work requirement hours for the prior year will be reviewed for all enrollees each December. Medicaid coverage for non-exempt beneficiaries who do not comply with work requirements will be suspended effective the 1st day of the new calendar year and remain suspended until the beneficiary's renewal date at which point they will be disenrolled if they are not meeting the requirement or exempt. Those with suspended eligibility can reactivate eligibility by becoming eligible in a Medicaid coverage group that is exempt from the work requirement; meeting an exemption or good cause; or by completing 1 month of required hours. Those who complete 1 month of required hours have eligibility re-established in the month following notice to the state of their compliance. The state must provide reasonable accommodations for people with disabilities under the ADA, Section 504 and Section 1557 to enable them to have an equal opportunity to participate in the work requirement. The state also must provide reasonable modifications to program procedures, such as assistance with demonstrating good cause, appealing suspensions, providing documentation, understanding notices and rules. Reasonable modifications must include exemptions for people unable to participate due to disability-related reasons, modifications to the number of hours required, and the provision of support services necessary to participate. The state should evaluate individuals' ability to participate and the types of reasonable modifications and supports needed. The state must make good faith efforts to connect enrollees with existing community supports that are available to assist in meeting the work requirement, including available non-Medicaid assistance with transportation, child care, language access services and other supports, and make good faith efforts to connect people with disabilities with services and supports necessary to enable them to comply. According to CMS guidance, Medicaid funds cannot be spent on employment support services. The state must assess areas that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions and/or additional mitigation strategies so that the work requirement will not be impossible or unreasonably burdensome for beneficiaries to meet. The state must assess whether people with disabilities have limited job or other opportunities for reasons related to a disability and address those barriers. The state shall provide timely written notice about when the work requirement begins; whether an enrollee is exempt, how to indicate to the state that they are exempt, and under what conditions the exemption would end; the specific number of hours per week required and how and when the beneficiary must report participation; specific information about how participation will be assessed at the end of the calendar year; the specific activities to satisfy the work requirement; resources that help connect beneficiaries to opportunities for activities that would meet the work requirement and community supports available to assist beneficiaries in meeting the requirement; how hours will be counted and documented; what gives rise to a suspension and how it could affect renewal, how to apply for good cause; how eligibility will be denied and terminated at renewal if in suspension status; how to appeal disenrollment; whether a beneficiary is out of compliance and the

Table 1: Indiana's Section 1115 Medicaid Expansion Demonstration Waiver Provisions	
Element	**Indiana Waiver Provision, as approved and amended, 2/1/18**
	consequences; how to appeal a suspension and have a suspension lifted; any differences between TANF and SNAP requirements and the Medicaid work requirement; whether a good cause exemption has been approved or denied, the explanation for good cause decisions, and how to appeal.
Benefit Packages:	Expansion adults 0-138% FPL who pay premiums receive HIP Plus, an ABP that includes the ACA's essential health benefits and covers more services (including vision, dental, and chiropractic coverage, and more generous prescription drug coverage) than HIP Basic. Expansion adults at or below 100% FPL who do not pay premiums (other than American Indian/Alaska Natives) receive HIP Basic, an ABP that includes the ACA's essential health benefits but with fewer covered services (no vision or dental and less generous prescription drug coverage) compared to HIP Plus. HIP Basic includes all EPSDT services for 19 and 20 year olds, consistent with federal law. Expansion adults who are medically frail receive an ABP that is equivalent to the state plan benefit package.[v] Non-expansion parent/caretaker relatives and those receiving Transitional Medical Assistance (139-185% FPL in their 1st 6 months of TMA) receive the Medicaid state plan benefit package. Those receiving TMA (139-185% FPL in their 2nd 6 months of TMA) must pay premiums and receive HIP Plus. Pregnant women receive state plan benefits during their pregnancy and 60 days post-partum and then transition back to HIP Plus (if they pay premiums) or HIP Basic. (Benefit package contents are specified in state plan amendments, not the waiver terms and conditions.)
SUD Services in IMDs:	The waiver extension includes an SUD program that applies to all Indiana Medicaid enrollees. Specifically, the IMD payment exclusion is waived for "short-term residents" who are primarily receiving SUD treatment and withdrawal management services provided in IMDs to adults ages 21-64 (no explicit day limit). These provisions are effective upon CMS approval of the SUD implementation protocol (approved 2/1/18). IMD services will include residential treatment, withdrawal management, and contingent on SPA approval, opioid treatment program services and addiction recovery management services.
Non-Emergency Medical Transportation:	Waives non-emergency medical transportation (NEMT) for expansion adults, except 19 and 20 year olds subject to EPSDT, pregnant women and those who are medically frail.
Process for Waiver Amendments:	Waiver amendments are subject to guidance published in a 1994 Federal Register public notice, instead of the ACA public notice and comment process. The 1994 public notice requires the state to do one of the following: (1) hold at least one public hearing with time for comment on the "most recent working proposal"; (2) use a commission or similar process with an open public meeting in proposal development; (3) submit results from enactment of a proposal by the state legislature that includes an "outline" of the proposal; (4) provide for formal notice and comment of at least 30 days under the state administrative procedures act; (5) post a notice of intent to submit a proposal in newspapers of general circulation and provide a mechanism for receiving a copy of the proposal and at least 30 days to comment; or (6) any other similar process for public input that would allow an interested party to learn about and comment on the proposal contents.
Next Steps:	SUD provisions: SUD monitoring protocol due by 7/1/18. SUD evaluation design due by 7/31/18. SUD mid-point assessment to be performed between DY 5 and 6. For the overall demonstration, a draft evaluation design is due by 7/31/18. The draft interim evaluation report is due at waiver renewal or 1 year prior to the demonstration's end. The summative evaluation report is due by 7/1/22 (18 months from STC end). The state also must submit 3 quarterly reports (due 60 days after the quarter ends) and 1 annual report (due 90 days after the DY ends) each year. The state must hold an annual public forum for comment on the demonstration's progress. There are no operational protocol requirements for implementation of the work requirement.
SOURCE: Healthy Indiana Plan, Special Terms and Conditions, #11-W-00296/5, effective Feb. 1, 2018-Dec. 31, 2020.	

NOTES: i- These include all services rated "A" or "B" by the U.S. Preventive Services Task Force, immunizations recommended by the CDC Advisory Committee on Immunization Practices, and services for infants, children, adolescents, and women supported by HRSA guidelines.

ii- Technically, these beneficiaries receive an ABP that is equivalent to the state plan benefit package.
iii- The debt is limited to the amount of the beneficiary's pro rata share of claims paid during the coverage period or amounts permissible under Medicaid cost-sharing rules for deductibles, whichever is less.
iv- Refunds are based on premium payments in excess of the beneficiary's pro rata share of claims at disenrollment.
v- Technically, these beneficiaries receive an ABP that is equivalent to the state plan benefit package.

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FACT SHEET

OCTOBER 2019

UNINSURED RATE AMONG NONELDERLY ADULTS VARIES BY REGION IN KANSAS

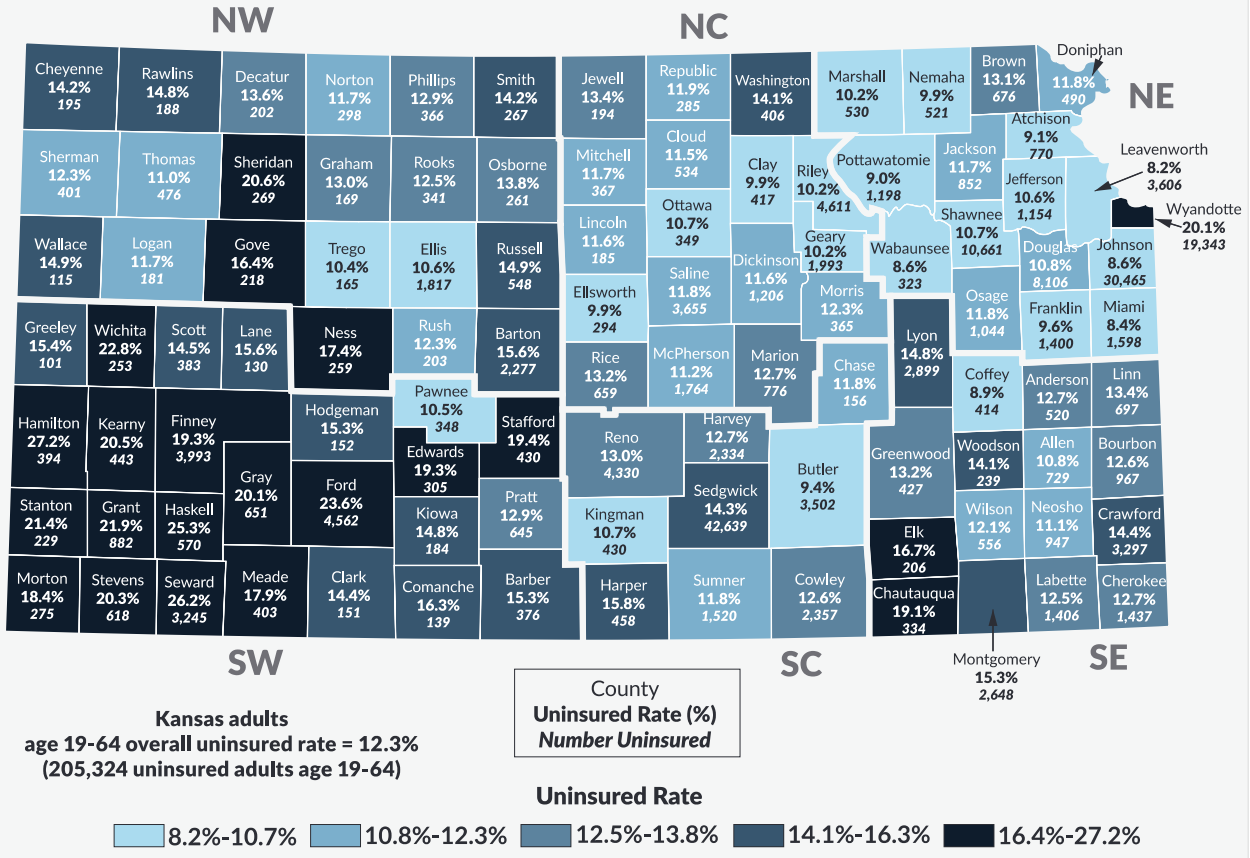
This fact sheet is the first of a three-part series examining the geographic variation in health insurance coverage for Kansans.

While Kansas has made strides in reducing the uninsured rate among nonelderly adults age 19-64, gains in health insurance coverage have stalled in recent years. In 2017, the overall uninsured rate among Kansas nonelderly adults remained unchanged from the previous year at 12.3 percent (205,324 Kansans). This fact sheet examines the county-specific uninsured rate among Kansas nonelderly adults in 2017 (*Figure 1*) — the most recent year for which county-level data are available — and regional changes in the uninsured rate from 2009 to 2017 (*Figure 2*, page 2). It uses data from the U.S. Census Bureau 2017 Small Area Health Insurance Estimates.

Uninsured Rate Varies by County

- There was more than a three-fold difference between Kansas counties with the highest and lowest uninsured rate among nonelderly adults in 2017: 27.2 percent in Hamilton County and 8.2 percent in Leavenworth County.
- While most counties with the highest uninsured rates were in the southwest

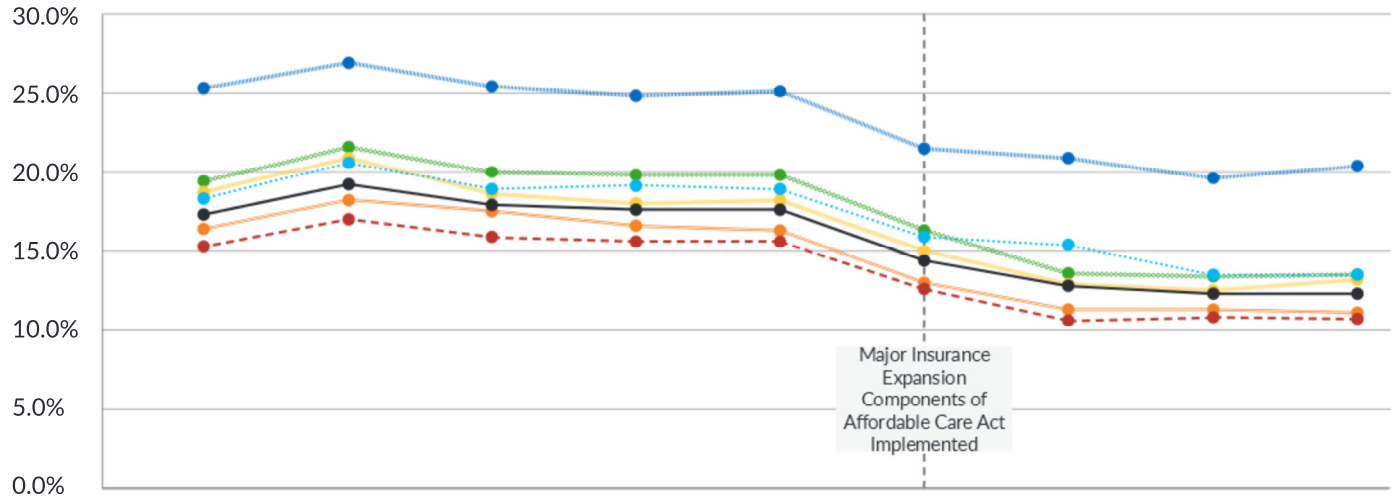
Figure 1. **Kansas Adults Age 19-64: Uninsured Rate and Number by County, 2017**



Note: Uninsured Kansas adults age 19-64 (not in institutions) = 205,324. County-level data in Excel format are available at bit.ly/2OC2dTr. Regions are designated using the Kansas Department of Health and Environment District Office Boundaries map.

Source: KHI analysis of data from the U.S. Census Bureau 2017 Small Area Health Insurance Estimates.

Figure 2. **Kansas Adults Age 19-64: Uninsured Rate by Regions, 2009-2017**



	2009	2010	2011	2012	2013	2014	2015	2016	2017
SW	25.3%	26.9%	25.4%	24.8%	25.1%	21.5%	20.9%	19.6%	20.4%
SE	19.4%	21.6%	20.0%	19.8%	19.8%	16.3%	13.6%	13.4%	13.5%
NW	18.7%	20.9%	18.6%	18.0%	18.2%	15.0%	12.9%	12.5%	13.2%
SC	18.3%	20.6%	18.9%	19.1%	18.9%	15.9%	15.4%	13.5%	13.5%
NC	16.4%	18.2%	17.5%	16.6%	16.3%	13.0%	11.3%	11.3%	11.1%
NE	15.3%	17.0%	15.9%	15.6%	15.6%	12.6%	10.6%	10.8%	10.7%
KS	*17.3%*	*19.2%*	*17.9%*	*17.6%*	*17.6%*	*14.4%*	*12.8%*	*12.3%*	*12.3%*

Note: Regions are designated using the Kansas Department of Health and Environment District Office Boundaries map.

Source: KHI analysis of data from the U.S. Census Bureau 2009-2017 Small Area Health Insurance Estimates.

region of the state, Wyandotte County in northeast Kansas also had one of the highest rates (20.1 percent).

Uninsured Rate Has Flattened

- The southwest region of Kansas had a consistently higher uninsured rate than other regions in Kansas from 2009 to 2017.
- Between 2013 and 2016, there was a significant decrease in the uninsured rate among nonelderly adults in each region. However, the uninsured rate in all regions has flattened out since 2016.

Discussion

Regardless of where Kansas adults age 19-64 live, insurance coverage has improved since 2009, and the improvement has followed a similar trend across all regions. However, the gap between the southwest and other regions in the state persists. Further analysis of the underlying contributors to the high uninsured rate in the southwest could help communities implement targeted approaches.

Technical Note

The U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) data is the only data source for single-year county-specific estimates for health insurance coverage (http://www.census.gov/programs-surveys/sahie/about.html). SAHIE estimates for health insurance coverage at the state level could differ slightly from those derived from other data sources because of differences in methodology.

ABOUT THE FACT SHEET

This fact sheet is based on work done by Hina B. Shah, M.P.H.; Cheng-Chung Huang, M.P.H.; and Wen-Chieh Lin, Ph.D. It is available online at khi.org/policy/article/19-38.

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Kansas Adults Age 19-64: Uninsured Rate and Number by County, 2017

Prepared by Kansas Health Institute, October 2019

County	Region	Number of Uninsured Adults Age 19-64	Total Number of Adults Age 19-64	Uninsured Rate of Adults Age 19-64
Kansas	--	205,324	1,663,977	12.3%
Allen County, KS	Southeast	729	6,758	10.8%
Anderson County, KS	Southeast	520	4,079	12.7%
Atchison County, KS	Northeast	770	8,500	9.1%
Barber County, KS	Southwest	376	2,456	15.3%
Barton County, KS	Northwest	2,277	14,561	15.6%
Bourbon County, KS	Southeast	967	7,702	12.6%
Brown County, KS	Northeast	676	5,168	13.1%
Butler County, KS	South central	3,502	37,231	9.4%
Chase County, KS	South central	156	1,323	11.8%
Chautauqua County, KS	Southeast	334	1,746	19.1%
Cherokee County, KS	Southeast	1,437	11,332	12.7%
Cheyenne County, KS	Northwest	195	1,376	14.2%
Clark County, KS	Southwest	151	1,051	14.4%
Clay County, KS	North central	417	4,200	9.9%
Cloud County, KS	North central	534	4,652	11.5%
Coffey County, KS	Southeast	414	4,627	8.9%
Comanche County, KS	Southwest	139	852	16.3%
Cowley County, KS	South central	2,357	18,747	12.6%
Crawford County, KS	Southeast	3,297	22,861	14.4%
Decatur County, KS	Northwest	202	1,490	13.6%
Dickinson County, KS	North central	1,206	10,413	11.6%
Doniphan County, KS	Northeast	490	4,170	11.8%
Douglas County, KS	Northeast	8,106	75,201	10.8%
Edwards County, KS	Southwest	305	1,580	19.3%
Elk County, KS	Southeast	206	1,236	16.7%
Ellis County, KS	Northwest	1,817	17,206	10.6%
Ellsworth County, KS	North central	294	2,973	9.9%
Finney County, KS	Southwest	3,993	20,680	19.3%
Ford County, KS	Southwest	4,562	19,355	23.6%
Franklin County, KS	Northeast	1,400	14,547	9.6%
Geary County, KS	North central	1,993	19,500	10.2%
Gove County, KS	Northwest	218	1,329	16.4%
Graham County, KS	Northwest	169	1,303	13.0%
Grant County, KS	Southwest	882	4,020	21.9%

Source: U.S. Census Bureau 2017 Small Area Health Insurance Estimates.

Note: Regions are designated using the Kansas Department of Health and Environment District Office Boundaries map.

The Small Area Health Insurance Estimates (SAHIE) program was created to develop model-based estimates of health insurance coverage for counties and states. SAHIE is the only source of single-year estimates of health insurance coverage for all counties in the US. SAHIE uses information from the American Community Survey (ACS), demographic population estimates, aggregated federal tax returns, records for the Supplemental Nutrition Assistance Program (SNAP), County Business Patterns, Medicaid, Children's Health Insurance Program (CHIP) records, and decennial Census to calculate

County	Region	Number of Uninsured Adults Age 19-64	Total Number of Adults Age 19-64	Uninsured Rate of Adults Age 19-64
Gray County, KS	Southwest	651	3,246	20.1%
Greeley County, KS	Southwest	101	657	15.4%
Greenwood County, KS	Southeast	427	3,236	13.2%
Hamilton County, KS	Southwest	394	1,447	27.2%
Harper County, KS	South central	458	2,897	15.8%
Harvey County, KS	South central	2,334	18,373	12.7%
Haskell County, KS	Southwest	570	2,254	25.3%
Hodgeman County, KS	Southwest	152	995	15.3%
Jackson County, KS	Northeast	852	7,280	11.7%
Jefferson County, KS	Northeast	1,154	10,897	10.6%
Jewell County, KS	North central	194	1,445	13.4%
Johnson County, KS	Northeast	30,465	354,783	8.6%
Kearny County, KS	Southwest	443	2,161	20.5%
Kingman County, KS	South central	430	4,007	10.7%
Kiowa County, KS	Southwest	184	1,242	14.8%
Labette County, KS	Southeast	1,406	11,267	12.5%
Lane County, KS	Southwest	130	834	15.6%
Leavenworth County, KS	Northeast	3,606	43,728	8.2%
Lincoln County, KS	North central	185	1,588	11.6%
Linn County, KS	Southeast	697	5,202	13.4%
Logan County, KS	Northwest	181	1,545	11.7%
Lyon County, KS	Southeast	2,899	19,557	14.8%
McPherson County, KS	North central	1,764	15,818	11.2%
Marion County, KS	North central	776	6,131	12.7%
Marshall County, KS	Northeast	530	5,217	10.2%
Meade County, KS	Southwest	403	2,250	17.9%
Miami County, KS	Northeast	1,598	18,991	8.4%
Mitchell County, KS	North central	367	3,127	11.7%
Montgomery County, KS	Southeast	2,648	17,278	15.3%
Morris County, KS	North central	365	2,956	12.3%
Morton County, KS	Southwest	275	1,492	18.4%
Nemaha County, KS	Northeast	521	5,286	9.9%
Neosho County, KS	Southeast	947	8,515	11.1%
Ness County, KS	Northwest	259	1,488	17.4%
Norton County, KS	Northwest	298	2,537	11.7%
Osage County, KS	Northeast	1,044	8,825	11.8%
Osborne County, KS	Northwest	261	1,895	13.8%
Ottawa County, KS	North central	349	3,258	10.7%

County	Region	Number of Uninsured Adults Age 19-64	Total Number of Adults Age 19-64	Uninsured Rate of Adults Age 19-64
Pawnee County, KS	Southwest	348	3,306	10.5%
Phillips County, KS	Northwest	366	2,835	12.9%
Pottawatomie County, KS	Northeast	1,198	13,330	9.0%
Pratt County, KS	Southwest	645	5,010	12.9%
Rawlins County, KS	Northwest	188	1,272	14.8%
Reno County, KS	South central	4,330	33,210	13.0%
Republic County, KS	North central	285	2,385	11.9%
Rice County, KS	North central	659	4,990	13.2%
Riley County, KS	North central	4,611	45,127	10.2%
Rooks County, KS	Northwest	341	2,731	12.5%
Rush County, KS	Northwest	203	1,644	12.3%
Russell County, KS	Northwest	548	3,672	14.9%
Saline County, KS	North central	3,655	30,957	11.8%
Scott County, KS	Southwest	383	2,637	14.5%
Sedgwick County, KS	South central	42,639	298,188	14.3%
Seward County, KS	Southwest	3,245	12,362	26.2%
Shawnee County, KS	Northeast	10,661	99,895	10.7%
Sheridan County, KS	Northwest	269	1,309	20.6%
Sherman County, KS	Northwest	401	3,265	12.3%
Smith County, KS	Northwest	267	1,886	14.2%
Stafford County, KS	Southwest	430	2,220	19.4%
Stanton County, KS	Southwest	229	1,070	21.4%
Stevens County, KS	Southwest	618	3,043	20.3%
Sumner County, KS	South central	1,520	12,882	11.8%
Thomas County, KS	Northwest	476	4,347	11.0%
Trego County, KS	Northwest	165	1,580	10.4%
Wabaunsee County, KS	Northeast	323	3,762	8.6%
Wallace County, KS	Northwest	115	773	14.9%
Washington County, KS	North central	406	2,883	14.1%
Wichita County, KS	Southwest	253	1,111	22.8%
Wilson County, KS	Southeast	556	4,606	12.1%
Woodson County, KS	Southeast	239	1,691	14.1%
Wyandotte County, KS	Northeast	19,343	96,068	20.1%

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FACT SHEET

OCTOBER 2019

WESTERN COUNTIES HAVE HIGHEST UNINSURED RATE FOR KIDS

This fact sheet is the second of a three-part series examining the geographic variation in health insurance coverage for Kansans.

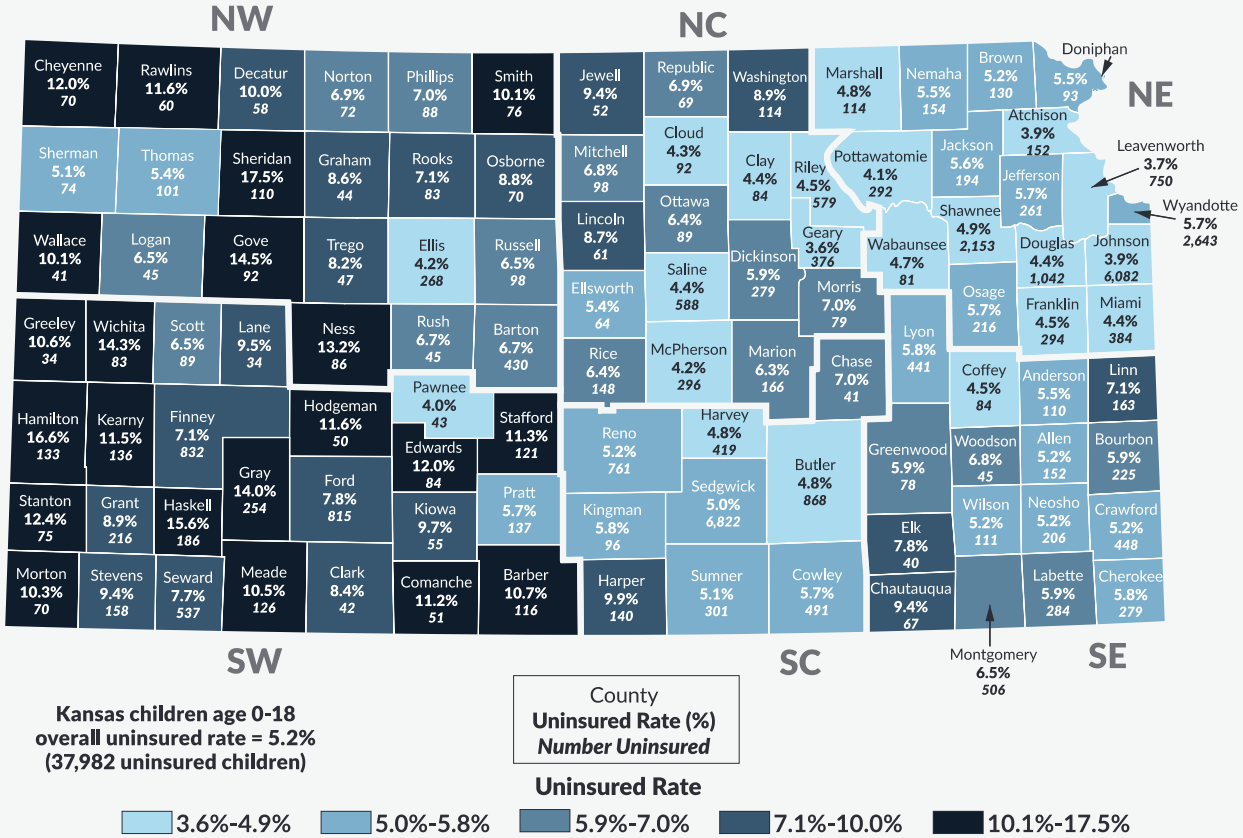
Gains in health insurance coverage have stalled in recent years for Kansas children age 0-18. In 2017, the overall uninsured rate among Kansas children was 5.2 percent (37,982 uninsured children).

This fact sheet examines the county-specific uninsured rate among Kansas children in 2017 (*Figure 1*) — the most recent year for which county-level data are available — and regional changes in the uninsured rate for children from 2009 to 2017 (*Figure 2*, page 2). It uses data from the U.S. Census Bureau 2017 Small Area Health Insurance Estimates.

Uninsured Rate Varies by County

- There was a nearly five-fold difference between the counties with the highest and lowest uninsured rate among children in 2017: 17.5 percent in Sheridan County and 3.6 percent in Geary County.
- The 21 counties with the highest uninsured rate (10.1 percent to 17.5 percent) among children in 2017 were all located in the western half of the state.
- However, nearly half (49.3 percent, or 18,742) of uninsured children lived in one of the five most populous counties (Douglas, Johnson, Sedgwick, Shawnee and Wyandotte) in 2017.

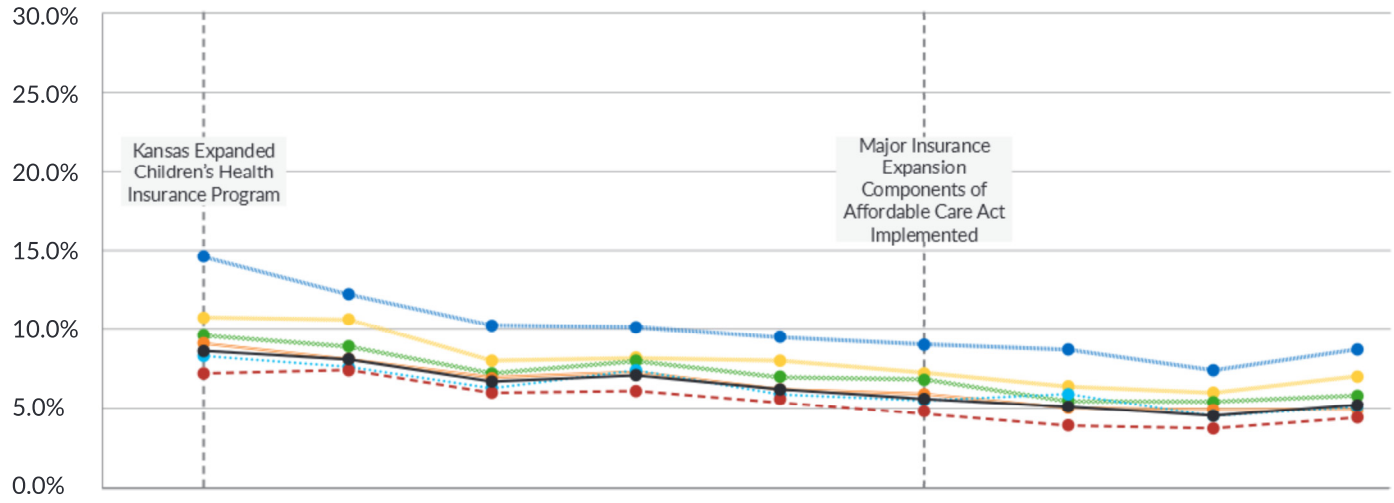
Figure 1. **Kansas Children Age 0-18: Uninsured Rate and Number by County, 2017**



Note: Uninsured Kansas children age 0-18 (not in institutions) = 37,982. County-level data in Excel format are available at bit.ly/2LZwVnD. Regions are designated using the Kansas Department of Health and Environment District Office Boundaries map.

Source: KHI analysis of data from the U.S. Census Bureau 2017 Small Area Health Insurance Estimates.

Figure 2. **Kansas Children Age 0-18: Uninsured Rate by Region, 2009-2017**



	2009	2010	2011	2012	2013	2014	2015	2016	2017
SW	14.6%	12.2%	10.2%	10.1%	9.5%	9.0%	8.7%	7.4%	8.7%
NW	10.7%	10.6%	8.0%	8.2%	8.0%	7.2%	6.4%	6.0%	7.0%
SE	9.6%	8.9%	7.2%	8.0%	7.0%	6.8%	5.5%	5.4%	5.8%
NC	9.1%	8.1%	6.9%	7.3%	6.2%	5.9%	5.0%	4.9%	4.9%
SC	8.3%	7.6%	6.3%	7.4%	5.9%	5.5%	5.9%	4.5%	5.1%
NE	7.2%	7.4%	6.0%	6.1%	5.6%	4.8%	3.9%	3.7%	4.4%
KS	*8.6%*	*8.1%*	*6.7%*	*7.1%*	*6.2%*	*5.6%*	*5.1%*	*4.5%*	*5.2%*

Note: Regions are designated using the Kansas Department of Health and Environment District Office Boundaries map. Kansas expanded Children's Health Insurance Program (CHIP) to children up to 250 percent of the 2008 federal poverty level.

Source: KHI analysis of data from the U.S. Census Bureau 2009-2017 Small Area Health Insurance Estimates.

The Trend in Uninsured Rate is Similar Among Regions

- The southwest region of Kansas had a higher uninsured rate for children than other regions in the state over the period 2009 to 2017.
- Trends in the uninsured rate for children were similar across regions from 2009 to 2017.
- While the uninsured rate for children increased in 2017 for all regions except north central Kansas, the change in each region was not statistically significant.

Discussion

Eligibility for the Children's Health Insurance Program (CHIP) was expanded by the Kansas Legislature in 2009. Expanded Medicaid eligibility for adults as allowed under the Affordable Care Act has not occurred in Kansas. Research shows that expanding eligibility for Medicaid among parents is associated with increased coverage among children. This suggests that Medicaid expansion for adults in Kansas could further reduce the uninsured rate among children as well.

Technical Note

The U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) data is the only data source for single-year county-specific estimates for health insurance coverage (http://www.census.gov/programs-surveys/sahie/about.html). SAHIE estimates for health insurance coverage at the state level could differ slightly from those derived from other data sources because of differences in methodology.

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FACT SHEET

OCTOBER 2019

25,000 UNINSURED, KANCARE-ELIGIBLE CHILDREN: WHERE ARE THEY?

This fact sheet is the third of a three-part series examining the geographic variation in health insurance coverage for Kansans.

Public health insurance through Medicaid and the Children's Health Insurance Program (CHIP) is a key source of coverage for children age 0-18 in Kansas. These programs are administered at the state level through KanCare. In 2017, Medicaid or CHIP was available for children living in low-income families that earned less than 241 percent of the federal poverty level (FPL; $59,286 for a family of four in 2017). This fact sheet provides data on where Kansas children enrolled in KanCare in 2017 lived (*Figure 1*), and examines where uninsured children likely eligible for KanCare but not enrolled lived (*Figure 2*, page 2).

Medicaid/CHIP Enrollment by County in 2017

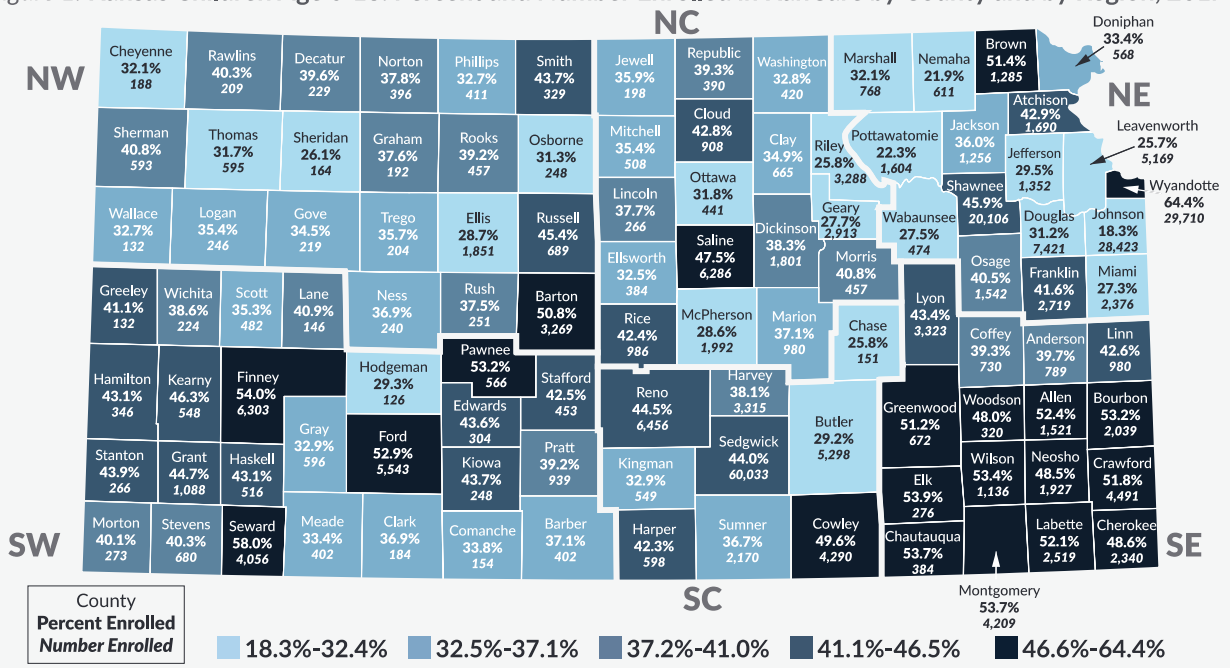
Using data from the Kansas Department of Health and Environment, there were 276,562 (37.5 percent) Kansas children enrolled in KanCare in 2017 (*Figure 1*).

Half (52.7 percent) of Kansas children enrolled in KanCare lived in one of the five most populous counties (Douglas, Johnson, Sedgwick, Shawnee and Wyandotte). However, the percentage of children enrolled in KanCare also was high in the southeast and southwest regions.

Likely Eligible, but Uninsured

An estimated 37,982 children in Kansas were uninsured in 2017, and 25,436 (67.0 percent) of

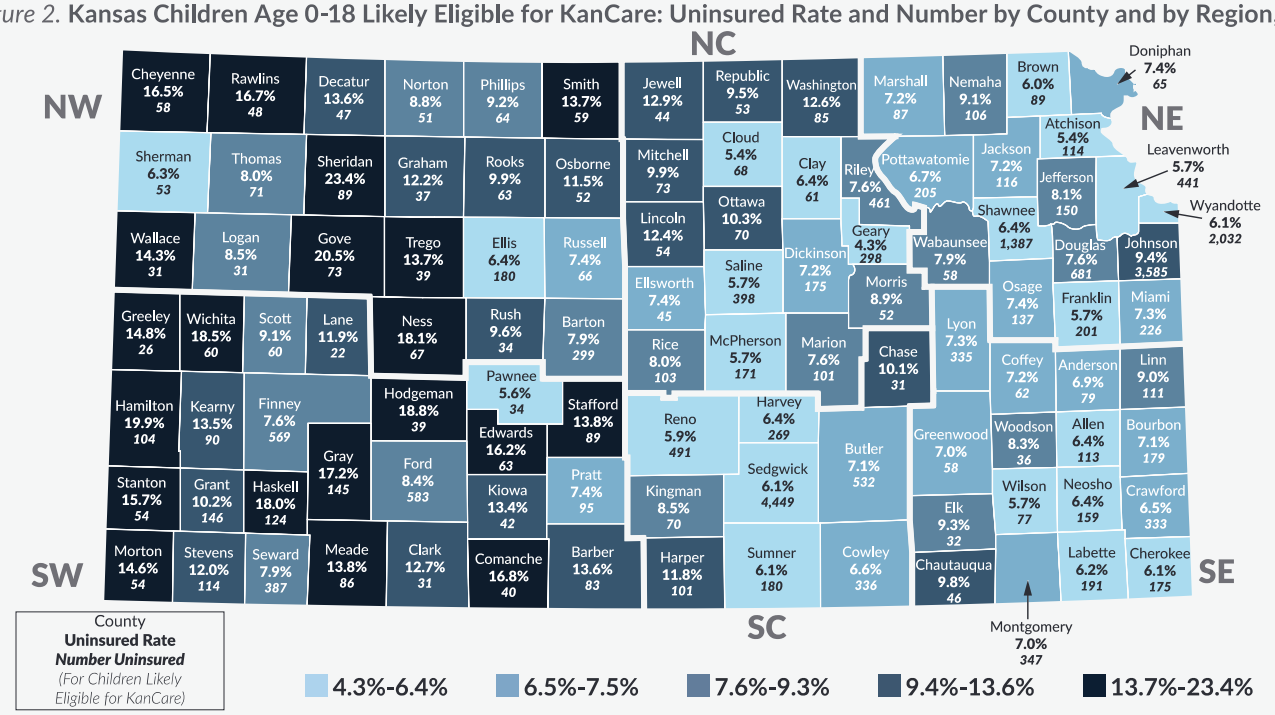
Figure 1. **Kansas Children Age 0-18: Percent and Number Enrolled in KanCare by County and by Region, 2017**



Region	North Central	Northeast	Northwest	South Central	Southeast	Southwest	Kansas
Percent Enrolled	34.8%	31.6%	38.1%	42.3%	49.4%	48.4%	37.5%
Number Enrolled	22,883	107,074	11,112	82,860	27,656	24,977	276,562

Note: KanCare enrollees age 0-18 = 276,562. Regions are designated using the Kansas Department of Health and Environment District Office Boundaries map. The percent of children age 0-18 enrolled in KanCare (Medicaid/CHIP) is calculated using average monthly enrollment of children and dividing by the total number of children. County-level data in Excel format are available at bit.ly/35g4MjL.
Source: KHI analysis of data from the Kansas Department of Health and Environment Data Analytic Interface and U.S. Census Bureau 2017 Small Area Health Insurance Estimates (SAHIE).

Figure 2. **Kansas Children Age 0-18 Likely Eligible for KanCare: Uninsured Rate and Number by County and by Region, 2017**



Region	North Central	Northeast	Northwest	South Central	Southeast	Southwest	Kansas
Uninsured Rate (For Children Likely Eligible for KanCare)	6.6%	7.3%	9.7%	6.3%	6.9%	9.9%	7.2%
Number Uninsured (For Children Likely Eligible for KanCare)	2,312	9,680	1,512	6,459	2,333	3,140	25,436

Note: Uninsured Kansas children age 0-18 likely eligible for Medicaid/CHIP (based on income alone) = 25,436. Children living in families with incomes less than or equal to 250 percent of the federal poverty level (FPL; $61,500 for a family of four in 2017) were used as a proxy for those eligible for Medicaid/CHIP, which is 241 percent of FPL ($59,286 for a family of four in 2017) because all income categories are not available in the data. Regions are designated using the Kansas Department of Health and Environment District Office Boundaries map. The uninsured rate is calculated by dividing the number of uninsured children likely eligible for KanCare by the total number of children likely eligible for KanCare. County-level data in Excel format are available at bit.ly/2MnXPV5.

Source: KHI analysis of data from the U.S. Census Bureau 2017 Small Area Health Insurance Estimates (SAHIE).

them might have been eligible for KanCare but were not enrolled (*Figure 2*).

Many counties in western Kansas had a significantly higher uninsured rate among children likely eligible for KanCare than the statewide rate (7.2 percent). The highest uninsured rate (23.4 percent) was in Sheridan County, representing 89 children. The northwest region of Kansas as a whole had a rate of 9.7 percent, representing 1,512 children. The southwest region had a rate of 9.9 percent, representing 3,140 children.

The uninsured rate for KanCare-eligible children generally was not as high in more populous areas of the state. However, nearly half (47.7 percent) of uninsured children likely eligible for KanCare lived in one of the five most populous counties — Douglas, Johnson, Sedgwick, Shawnee and Wyandotte — representing 12,134 children.

Conclusion

Reaching children and families who are eligible for KanCare could be particularly challenging in rural areas of the state. Partnering with local organizations is an important strategy to facilitate enrollment.

Technical Note

The U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) data is the only data source for single-year county-specific estimates for health insurance coverage (http://www.census.gov/programs-surveys/sahie/about.html). SAHIE estimates for health insurance coverage at the state level could differ slightly from those derived from other data sources because of differences in methodology.

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