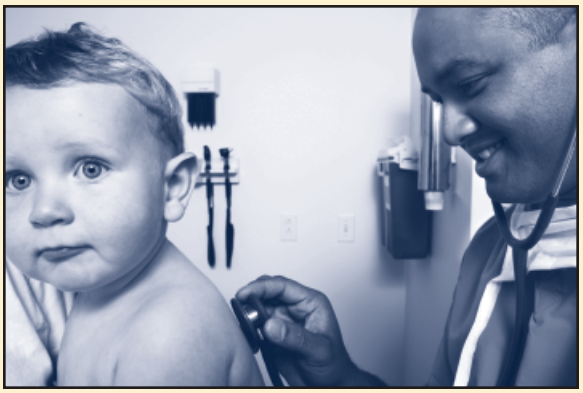
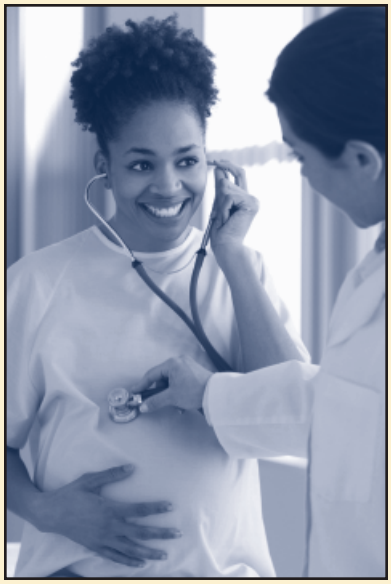
Kansas Medicaid





A Primer

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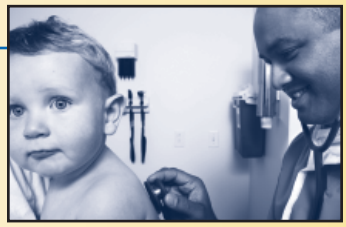

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ACKNOWLEDGMENTS

This primer was jointly produced by the Kansas Legislative Research Department and the Kansas Health Institute, with technical assistance from the Kansas Health Policy Authority.

The Kansas Legislative Research Department (KLRD) is a nonpartisan agency that provides support services to the Kansas Legislature. KLRD has provided nonpartisan, objective research and fiscal analysis since 1934.

The Kansas Health Institute (KHI) is an independent, nonprofit health policy and research organization based in Topeka, Kansas. Established in 1995 with a multi-year grant from the Kansas Health Foundation, KHI conducts research and policy analysis on issues that affect the health of Kansans.

The Kansas Health Policy Authority is the state agency responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. The Kansas Health Policy Authority administers the Medicaid and SCHIP programs.

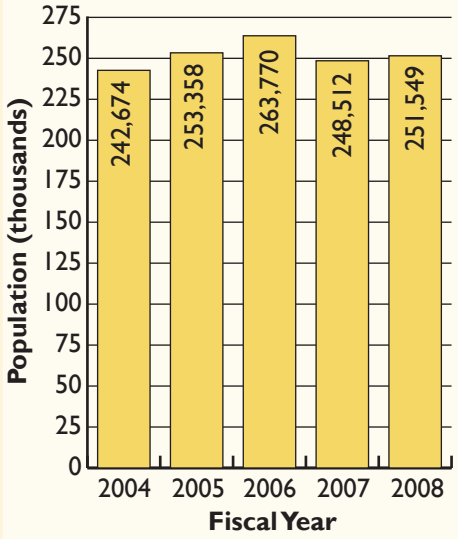
INTRODUCTION TO MEDICAID

Medicaid is a publicly financed source of health insurance and long-term care coverage for certain eligible population groups. It is the second largest source of health coverage in the nation, following employer-based coverage. In 2008, the Kansas Medicaid program was estimated to cover more than 250,000 people at a cost of over $2.4 billion. Medicaid provides health care coverage to low-income dependent children, very low-income parents, certain pregnant women, some disabled and elderly individuals, and some individuals with specific health conditions.

Medicaid is a partnership between the state and federal government that has a significant impact on the Kansas economy. In fiscal year (FY) 2006, the federal government spent nearly $304 billion dollars on the program nationally.[1] The federal government contributes approximately $1.50[2] for every dollar of state Medicaid spending in Kansas. The rate of this match varies from state to state — and is generally higher in poorer states. In Kansas, Medicaid accounts for 14.8 percent of the state budget (State General Fund only) and represents a significant portion of total spending on health care services. The only program for which the state spends more money is K–12 education.

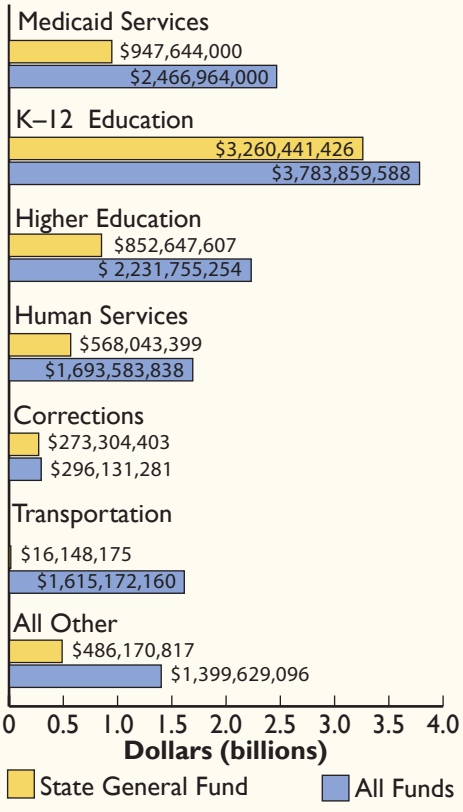
Medicaid was enacted in 1965, at the same time as Medicare, with the passage of Title XIX of the Social Security Act. In 1945, President Truman began to discuss the creation of the program by requesting the establishment of a national health care system. What followed was 20 years of debate over the potential perils of socialized medicine. As part of the goals related to the creation of the "Great Society,"

Figure 1. **Total Medicaid Population, FY 2004 – FY 2008**

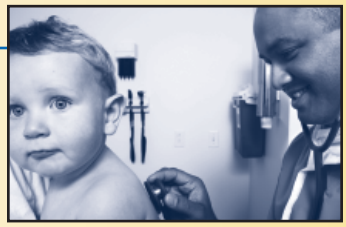


Sources: See endnote 19.

Figure 2. **Medicaid in Comparison to All Categories of State Spending, FY 2008 Approved**



Source: See endnote 20.



Medicaid is a partnership between the state and federal government that has a significant impact on the Kansas economy.

In Kansas, 21 percent of all Medicaid enrollees are disabled, but this population incurs 51 percent of total state expenditures for the program.

Lyndon Johnson signed Medicare and Medicaid into law on July 30, 1965.

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

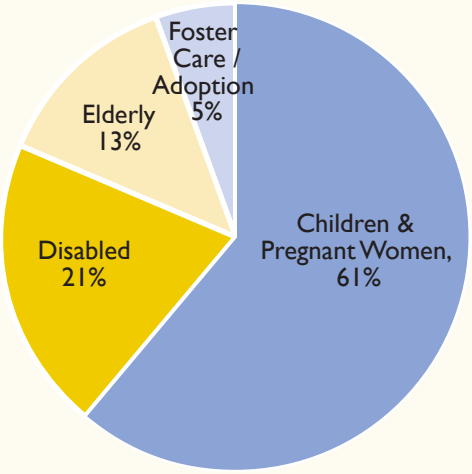
In 2005, the Kansas Health Policy Authority (KHPA) was created and became the single state agency responsible for Medicaid. KHPA administers Medicaid under broad federal guidelines and rules that ensure a minimum level of coverage for certain population groups (see inset for more information about KHPA). The agency is responsible for establishing eligibility criteria, benefits packages, payment rates and program administration. The Kansas Department of Social and Rehabilitation Services is generally responsible for Medicaid services that relate to mental health and the disabled, and the Kansas Department on Aging is responsible for Medicaid services for the elderly.

MEDICAID SPENDING IN KANSAS

In Kansas, 21 percent of all Medicaid enrollees are disabled, but this population incurs 51 percent of total state expenditures for the program. While pregnant women and children comprise two-thirds of Medicaid enrollees, they incur less than one-quarter of the expenditures.

Medicaid spending (excluding long-term care) was projected to average $2,215 per pregnant woman, child or family member in FY 2008, compared to $20,009 per disabled enrollee and $15,953 per elderly enrollee. These differences reflect the higher utilization

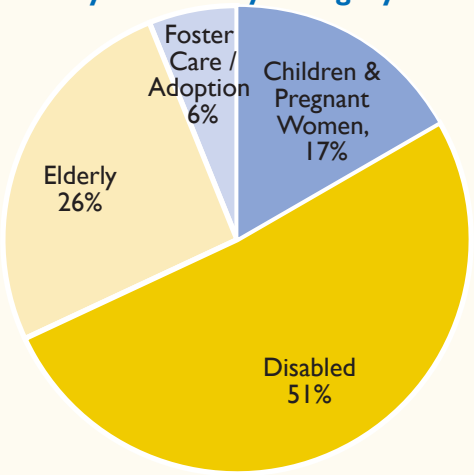
Figure 3. **Distribution of Medicaid Beneficiaries**



Number of Enrollees (FY 2008):
Children & Pregnant Women — 153,736;
Disabled — 51,580;
Elderly — 32,646;
Foster Care / Adoption — 13,587;
Total — 251,549.

Source: See endnote 21.

Figure 4. **Medicaid Spending by Beneficiary Category**



Spending in Dollars (FY 2008):
Children & Pregnant Women — $340,477,570;
Disabled — $1,032,049,581;
Elderly — $520,803,628;
Foster Care / Adoption — $119,768,346;
Total — $2,013,099,125 (excludes general assistance, refugee, special tuberculosis, ADAP & SCHIP populations).

Source: See endnote 21.

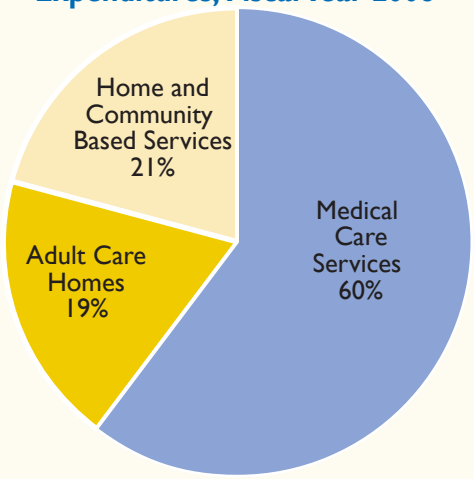
of medical care services by elderly enrollees and those with disabilities. Services for these populations tend to be far more costly than routine health and preventive services that are generally required for children and their parents. Traditionally, medical care for the aged and disabled includes services that range from doctor visits and hospitalization to durable medical equipment, prescription drugs and home health services. See Appendix B for a list of both mandatory and optional services covered by Medicaid in Kansas.

WHAT SERVICES DOES MEDICAID PAY FOR?

Kansas Medicaid expenditures for services can be divided into three broad categories — Medicaid payments for medical care services ($1.3 billion in FY 2008), adult care homes ($416.4 million in FY 2008) and home and community based services ($460.3 million in FY 2008).

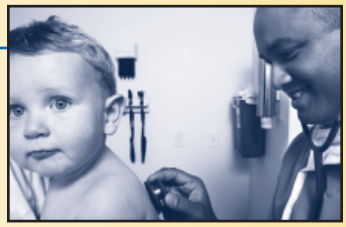
Total administrative costs were just under $148 million in FY 2008, accounting for six percent of all state Medicaid expenditures and approximately $585 per enrollee.[3] In the private sector, administrative costs are about 12.4 percent of the premiums that are paid by consumers.[4] Using the average cost of employer-sponsored family coverage as estimated by the Kaiser Family Foundation of $12,680 annually,[5] administrative costs for a family health plan are about $1,572 an-

Figure 5. **Kansas Medicaid Expenditures, Fiscal Year 2008**



Spending in Dollars (FY 2008):
Medical Care Services — $1,344,128,991;
Adult Care Homes — $416,369,145;
Home and Community Based Services — $460,262,064;
Total — $2,220,760,201 (excludes non-population expenditures).

Source: See endnote 21.



THE KANSAS HEALTH POLICY AUTHORITY (KHPA)

The KHPA is a state agency created by the Legislature in 2005. It is governed by a nine-member board that includes health care, business and community leaders as well as eight ex-officio members that include state cabinet secretaries and the director of KHPA. The board is appointed by the Governor and the Legislature.

The KHPA is responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies. All health insurance purchasing by the state is now combined under the authority, including publicly funded programs (Medicaid, State Children's Health Insurance Program and MediKan) and the State Employee Health Benefits Plan (SEHBP). The authority is responsible for compiling and distributing uniform health care data to provide health care consumers, payers, providers and policymakers with information regarding trends in the use and cost of health care for improved decision making.

nually — more than twice the administrative costs of the Medicaid program.

The state pays for Medicaid services either directly through fee-for-service or through a managed care organization (MCO). The state negotiates a capitated rate with the MCO. Medicaid beneficiaries who participate in a managed care program select or are placed in a MCO plan. The MCOs pay providers directly for covered services.

Medical Care Services

Medical care services under the Kansas Medicaid plan include physician and hospital services, dental services, pharmacy, rehabilitation, targeted case management and behavior management and a host of other services.

Adult Care Home Services

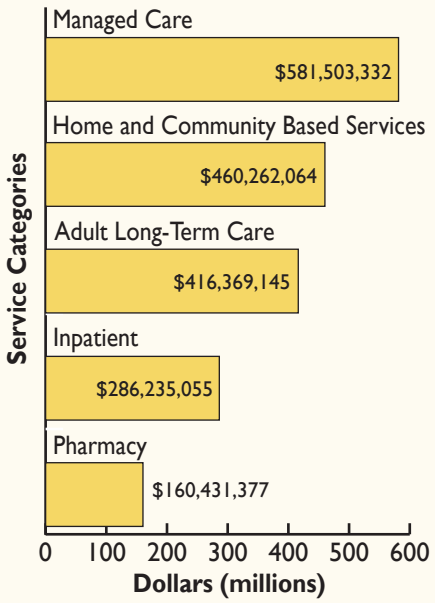
Adult care home services include nursing facilities, nursing facilities for mental health and intermediate care facilities for the developmentally disabled.

Home and Community Based Services

A variety of services are provided to support individuals in their home or community. The average cost of these services is 15 percent to 50 percent less than in a nursing facility.

The state receives money from the federal government to provide home and community based services (HCBS) through waivers. The federal government requires states to manage their Medicaid program within federal regulations. Waivers allow states to develop programs outside of these regulations with the permission of the federal government. Waivers for HCBS are the most common waiver in Medicaid. HCBS waivers allow Medicaid beneficiaries that are medically eligible for placement in an institutional setting to remain in a community setting and receive services.

Figure 6. **Top Five Service Categories and Expenditures, FY 2008**



Source: See endnote 21.

WAIVERS AND STATE PLAN AMENDMENTS

There are two ways to make changes to the Medicaid state plan — by submitting a State Plan Amendment (SPA) or a waiver. A SPA is used when the proposed change is in accordance with federal requirements. A waiver is used when a state wishes to make an exception to existing federal requirements. Many changes can now be made by filing a SPA — rather than going through the waiver process. Critics say that the SPA process, while less cumbersome, cuts out the opportunity for public comment, provider input and other important steps that should be a part of the process when making changes to state health policy that have a significant effect on vulnerable populations.

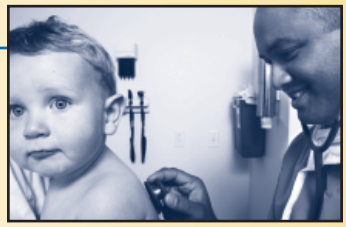
Each HCBS waiver is limited to one specific population; therefore, Kansas currently has multiple HCBS waivers. In Kansas, seven populations may be eligible for waiver services:

- Individuals with developmental disabilities;
- Persons with a traumatic brain injury;
- Individuals with physical disabilities;
- Individuals determined as frail elderly;
- Children who have a severe emotional disturbance;
- Children who require technology-based assistance; and
- Children who have an early autism diagnosis.

WHOM DOES MEDICAID COVER?

As a federally designated "entitlement" program, states are required to provide coverage to all eligible individuals in certain population categories. Medicaid eligibility is always based on income, but may also depend on age, availability of financial resources and, in some cases, health care needs. For most Medicaid enrollees, income eligibility criteria are based on federal poverty guidelines. Because states have flexibility to expand eligibility, specific eligibility varies greatly among the states. There are five main criteria for Medicaid eligibility: categorical eligibility, income eligibility, resource eligibility, immigration and citizenship status, and Kansas residency. In order to qualify for Medicaid, an individual must qualify under all five criteria.

- *Categorical Eligibility*
  There are four categories of individuals who are eligible for Medicaid — low-income families with children, the disabled, the aged, and individuals diagnosed with breast or cervical cancer.
- *Income Eligibility*
  There are income thresholds that pertain to each category of eligibility. Usually these thresholds are expressed in terms of the federal poverty level, or FPL. This measure is updated annually and made available by the U.S. Department of Health and Human Services. See Appendix A for information about the 2008 and 2009 FPL guidelines.
- *Resource Eligibility*
  The process of determining Medicaid eligibility takes into account the resources available to a potential beneficiary. Resources such as income, cars, houses or savings accounts are defined as assets. There are limits placed on the assets that an individual can have and still qualify for participation under some Medicaid categories.
- *Citizenship and Immigration Status*
  An individual must be a U.S. citizen or legal immigrant to receive Medicaid. See Appendix E for more information about citizenship requirements and the Medicaid program. Legal immigrants are eligible for the Medicaid program — although the law is somewhat complicated. Immigrants residing in the U.S. prior to August 22, 1996, are eligible for Medicaid if they meet all other requirements. Most immigrants who moved to the U.S. on or after



As a federally designated "entitlement" program, states are required to provide coverage to all eligible individuals in certain population categories.

Income eligibility differs depending on the age of the beneficiary.

that date must wait five years to be eligible for Medicaid benefits. There is also a provision that allows any immigrant to receive emergency medical care under Medicaid, but they must meet all other requirements — and even then, the coverage is on an emergency basis and is determined after the service is provided.

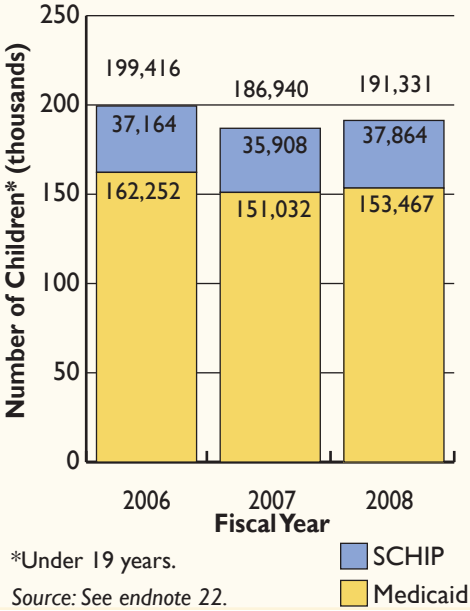
- *Kansas Residency*
  Individuals must establish residency in Kansas if they are requesting Medicaid. This is important because states receive matching funds for the beneficiaries residing in that state. Even if a beneficiary were to receive treatment in a state other than the one in which they reside, their state of residence pays for that treatment and the federal matching dollars go to that state. This was a considerable problem in the wake of Hurricane Katrina when 76,000 Gulf Coast residents were displaced, many of whom were Medicaid beneficiaries.[6] For purposes of Medicaid eligibility, a person who lives in a state and intends to remain indefinitely is considered a resident. Residency requirements for Medicaid are different than, and separate from, college residency requirements or any other residency requirements.

Low-Income Children and Families

Income eligibility differs depending on the age of the beneficiary. For infants (less than one year), the income threshold is 150 percent of the federal poverty level (FPL); for children who are older than one but younger than six, the income threshold is 133 percent FPL; and for children ages six through 18 (up to age 19), the income threshold is 100 percent FPL. It is important to note that children above these income levels can be eligible for Kansas' State Children's Health Insurance Program (SCHIP), which is combined with the Medicaid program in Kansas and collectively referred to as HealthWave. Parents with an annual income of no more than $5,632 for a family of four in 2008 were also eligible for coverage under Medicaid. Parents that were above this annual income were not eligible for Medicaid even though their children might have been covered. Adults that are not parents, pregnant, disabled, or elderly are not eligible for Medicaid in Kansas.

Some individuals are eligible for Medicaid due to specific conditions or circumstances. For example, children who are in state-sponsored adoption assistance programs or foster care are automatically eligible for Medicaid coverage. Pregnant women and new mothers (60 days postpartum) with in-

Figure 7. **Average Monthly Enrollment of Children in Medicaid and SCHIP**



*Under 19 years.

Source: See endnote 22.

comes below 150 percent FPL are also automatically eligible.

Low-Income Seniors and Individuals with Disabilities

Individuals who receive Supplemental Security Income (SSI) cash assistance payments are automatically eligible for Medicaid. Seniors must be at least 65 years of age, declared disabled, meet citizenship requirements, and have limited income and resources to qualify for SSI. In order to be declared "disabled," an adult individual must have a medical condition that prevents them from working and is expected to last at least 12 months or result in death. Children who have a severe functional limitation also may qualify.

Persons with disabilities who are working and have incomes up to 300 percent FPL can also receive Medicaid with a premium through the Working Healthy program.

It may take two to three years for the federal government to declare an individual as "disabled" and begin to send payments to that individual. In the meantime, a state program called MediKan covers expenses on behalf of these individuals. The MediKan program cost the state $29 million in FY 2008 and covered approximately 4,000 people. This program is not eligible for federal matching dollars.[7]

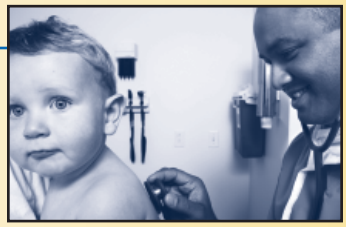
Those who make too much money to qualify for SSI (about $7,100 annually) may still qualify for Medicaid coverage through the Medically Needy program, depending on their situation.

Individuals with Breast or Cervical Cancer

Uninsured persons or those with very limited health care coverage who have been diagnosed with breast or cervical cancer through the Early Detection Works program are catagorically eligible for Medicaid coverage.

MANDATORY AND OPTIONAL ELIGIBILITY CATEGORIES

Until 1980, the states did not have much latitude to cover populations beyond very low-income populations. Since then, states have been given more flexibility to expand coverage to "optional populations." Over the years, Kansas has expanded coverage to the following optional populations who meet income eligibility:



MEDICAID IN AN ECONOMIC DOWNTURN

The Medicaid program faces a "double whammy" in an economic downturn. Often, Medicaid funding gets cut as state budgets tighten — which can generally be attributed to the fact that the Medicaid program is a large portion of most state budgets. At the same time, in an economic downturn, employers are often forced to lay off employees or stop offering health coverage — making more families eligible for Medicaid benefits. A survey by the Kaiser Family Foundation released in September 2008 found that, nationally, Medicaid enrollment in 2008 grew by 2.1 percent. States expect enrollment to go up another 3.5 percent and spending to go up 5.8 percent in 2009.

Source: See endnote 23.

- Individuals who are working but disabled;
- Pregnant women;
- Nursing home residents who fall above the threshold for SSI (74 percent FPL);
- The medically needy (see inset); and
- Children up to age 21 who have aged out of the foster care system at age 18.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM — SCHIP

The Balanced Budget Act of 1997 created the SCHIP program as part of Title XXI of the Social Security Act in order to cover uninsured low-income children who are not eligible for Medicaid. Like Medicaid, the state receives matching funds from the federal government for this program — however, this matching arrangement differs from Medicaid in that it is a block grant with a cap for spending each year and the percent of federal match is greater than Medicaid.

SCHIP gives states the option to expand their Medicaid program to include additional children or to create a separate program. Originally, Kansas marketed the SCHIP and Medicaid programs separately. In October 2001, the Medicaid and SCHIP programs were marketed as one program called HealthWave. In Kansas, SCHIP is available to children under the age of 19 who are in families that make less than 200 percent FPL, essentially picking up where Medicaid leaves off. In June 2007, the SCHIP program served 35,374 Kansas children at a cost of nearly $17.4 million to the state and $45 million to the federal government.[8,9]

MEDICALLY NEEDY

The medically needy segment is comprised of those persons, who while meeting the non-financial criteria of one of the categorically needy programs such as age or disability, do not qualify because of excess income or resources or, in the case of pregnant women and children, have income which exceeds the poverty level guidelines of either Medicaid or HealthWave. Most persons in the medically needy group are obligated for a share of their medical costs through the "spenddown" process. Coverage of this group is optional under federal law. If a state chooses this option, it must cover pregnant women (including coverage of the 60 day postpartum period) and children. Kansas provides coverage for the following groups:

1) Pregnant women
2) Children up to age 18 or age 18 and working toward the attainment of a high school diploma or its equivalent
3) Persons 65 years of age and older
4) Persons who are disabled or blind under SSA standards. Medically needy coverage can also be provided to caretaker relatives of dependent children but Kansas does not currently provide for this.

Source: See endnote 24.

THE FEDERAL DEFICIT REDUCTION ACT OF 2005

The Federal Deficit Reduction Act of 2005 (DRA) was signed into law on February 8, 2006. The stated intent of the DRA is to provide the states more flexibility to change their Medicaid programs in an attempt to limit federal Medicaid spending — changes that the Congressional Budget Office estimates will reduce federal Medicaid spending by $11.5 billion through the year 2010 and $43.2 billion through the year 2015.[10]

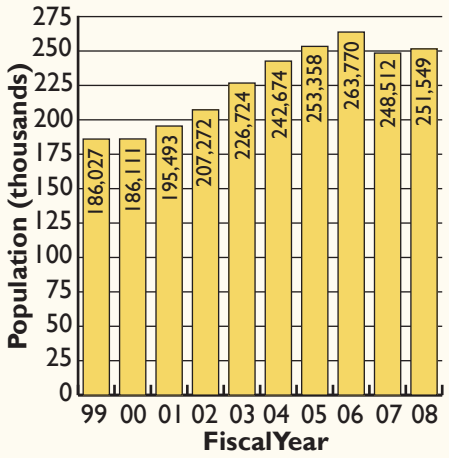
One of the most controversial regulations in the DRA requires states to verify the citizenship of the individual applying for Medicaid. According to some reports, eight percent of U.S. born adults over age 18 with annual incomes less than $25,000 do not have a birth certificate or passport with which to verify their citizenship.[11] This created backlogs in almost every state that heeded the regulation. Although the KHPA reports that the backlog has now been resolved in Kansas, as many as 20,000 Kansans were unable to receive Medicaid benefits due to citizenship documentation requirements.[12] This is a significant factor in the first decline in Medicaid enrollment in a decade.

ENROLLMENT TRENDS

During the past five years, the total number of Medicaid enrollees increased steadily until FY 2007. KHPA reports that the drop during FY 2007 in both enrollment and spending is attributed to the new DRA citizenship requirements.

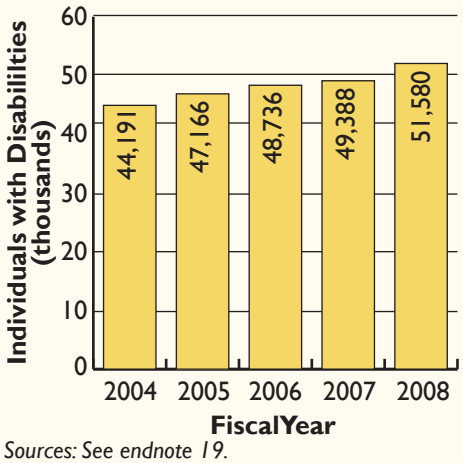
Enrollment for individuals with disabilities and older Medicaid recipients has steadily increased.

Figure 8. **Total Medicaid Population, FY 1999 – FY 2008**



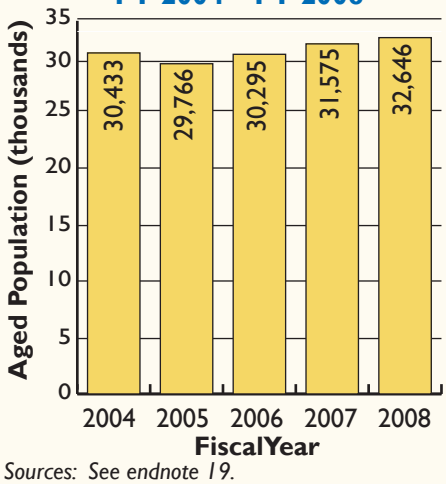
Sources: See endnote 25.

Figure 9. **Enrollment Growth for Individuals with Disabilities on Medicaid, FY 2004 – FY 2008**

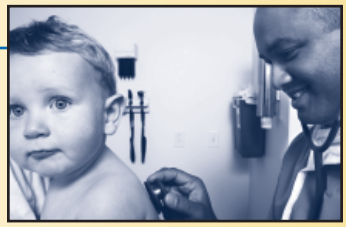


Sources: See endnote 19.

Figure 10. **Enrollment Growth for the Aged Population, FY 2004 – FY 2008**



Sources: See endnote 19.



Enrollment for individuals with disabilities and older Medicaid recipients has steadily increased.

To have been eligible for Medicaid as a parent in 2008, a family of four must have made less than $5,632 annually.

The largest change can be found in the number of children enrolled in Medicaid. In 1999, the SCHIP program was implemented with an aggressive outreach campaign. Outreach not only identified children who were eligible for SCHIP, but also children eligible for Medicaid, thus increasing enrollment. Another significant factor in the rising number of children on Medicaid has been the 1999 provision that the Kansas Medicaid program provide 12 months of continuous coverage to children enrolled in the program.

APPENDIX A — FEDERAL POVERTY GUIDELINES

Poverty Level Eligibility for Kansas Medicaid

To have been eligible for Medicaid as a parent in 2008, a family of four must have made less than $5,632 annually. Newborn children (under age one) are eligible if their family makes less than 150 percent FPL. Children who are older than one but younger than six are eligible for Medicaid if their family makes less than 133 percent FPL. Children who are six through 18 are eligible if their family makes less than 100 percent FPL.

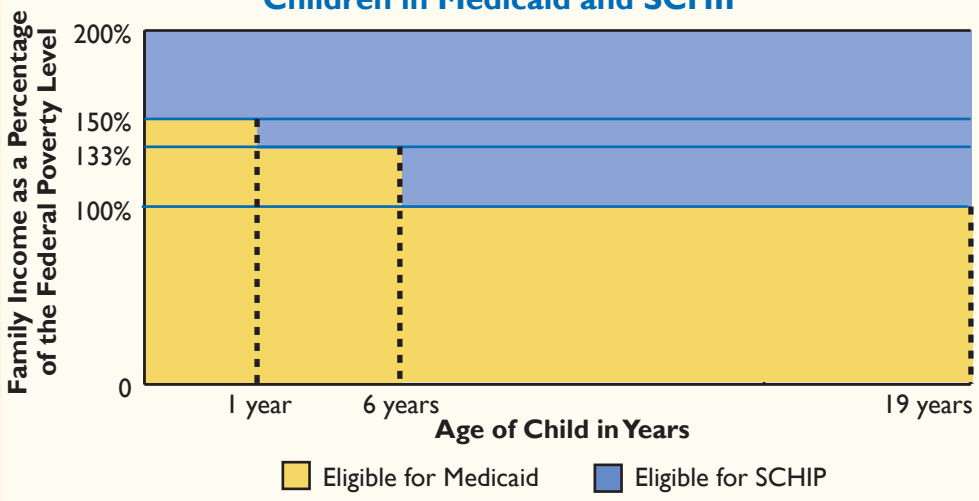
Figure A-2. **Health and Human Services Poverty Guidelines, 2008 and 2009, for 48 Contiguous States and District of Columbia***

Persons in Family or Household	2008 Annual Income Guidelines	2009 Annual Income Guidelines
1	$10,400	$10,830
2	$14,000	$14,570
3	$17,600	$18, 310
4	$21,200	$22,050
5	$24,800	$25,790
6	$28,400	$29,530
7	$32,000	$33,270
8	$35,600	$37,010
For each additional person per household add:	$3,600	$3,740

*There are different FPL Levels for Alaska and Hawaii due to significant differences in cost of living.

Source: See endnote 26.

Figure A-1. **Income Eligibility Thresholds for Children in Medicaid and SCHIP**



Note: In 2008, 100 percent of federal poverty level for a family of four was $21,200 per year.

APPENDIX B — SERVICES COVERED BY MEDICAID IN KANSAS

The following services are mandatory for the categorically needy eligibility group:[13]

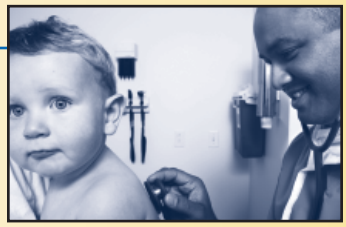
- Hospital care (inpatient and outpatient);
- Nursing facility services;
- Physician services;
- Certified pediatric and family nurse practitioner services (when licensed to practice under state law);
- Laboratory and x-ray services;
- Early and periodic screening, diagnostic and treatment (EPSDT) services and immunizations for children;[14]
- Family planning services and supplies;
- Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services;
- Nurse midwife services;
- Medical and surgical services of a dentist;
- Home health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan;
- Pregnancy-related services and service for other conditions that might complicate pregnancy; and
- 60 days postpartum pregnancy-related services.

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

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

Optional services provided in Kansas include:[15]

- Alcohol and drug abuse treatment;
- Audiological services;
- Behavior management;
- Community mental health center and psychological services;
- Dental services (limited to certain consumers);
- Durable medical equipment;
- Medical supplies, orthotics and prosthetics;
- Early childhood intervention;
- Health clinics;
- Home and community based services;
- Hospice services;
- Inpatient psychiatric services;
- Intermediate care facility services;
- Local education agencies;
- Local health department services;
- Nursing services;
- Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders;
- Prescribed drugs;
- Podiatric services covered for EPSDT beneficiaries only;
- Respiratory care for ventilator-dependent individuals;
- Services for special disorders;
- Targeted case management for assistive technology; and
- Vision services.



APPENDIX C — CONTACT INFORMATION AND HELPFUL LINKS

- Kansas Legislative Research Department: www.kslegislature.org/klrd
- Kansas Health Institute: www.khi.org
- Kansas Health Policy Authority: www.khpa.ks.gov
- Kansas Department on Aging: www.agingkansas.org
- Kansas Department of Social and Rehabilitation Services: www.srskansas.org
- Centers for Medicare and Medicaid Services: www.cms.hhs.gov
- American Legislative Exchange Council: www.alec.org
- Kaiser Commission 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

APPENDIX D – GLOSSARY

HealthWave: In January 1999, the Title XXI SCHIP program began, and was marketed in Kansas as HealthWave. In 2001, the Medicaid managed care program was blended with SCHIP into the HealthWave program to help ensure a seamless product. HealthWave enables families with children who are eligible for SCHIP and Medicaid to have the same health plan and health provider for all family members. The HealthWave program also serves Medicaid-eligible adults and children in the Temporary Assistance to Families (TAF) and Poverty Level Eligible (PLE) programs.[15]

MediKan: MediKan is a program, established in 1973, that is funded by the state of Kansas and intended to bridge the gap between the time that an adult becomes disabled and the time that they begin receiving federal disability payments. It often can take two to three years for the federal payments to begin. The state expenditure for this program in FY 2007 was $29 million and the program covered about 4,000 people.

State Children's Health Insurance Program (SCHIP): SCHIP is Title XXI of the Social Security Act. 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. Since 1998, SCHIP provides matching funds that are capped at a certain amount. To encourage states to cover children from higher income families, state dollars are matched at a higher precentage than Medicaid by the federal government. Federal payments to states under Title XXI are based on state expenditures under approved plans effective on or after October 1, 1997.[16] The Children's Health Insurance Program Reauthorization Act of 2009 expanded SCHIP and reauthorized it through 2013.

State Plan Amendment: A State Plan Amendment (SPA) is an administrative means for a state to change the structure of the state Medicaid program. A State Plan Amendment is used when the proposed change to the State Plan is in accordance with the federal requirements. Since the Federal Deficit Reduction Act of 2005 was passed,

many changes can now be made by filing a SPA — rather than going through the waiver process. Critics say that the SPA process, while less cumbersome, cuts out the opportunity for public comment, provider input and other important steps that should be a part of the process when making changes to state health policy that have a significant effect on vulnerable populations. Waivers and State Plan Amendments are the only ways that a state can administratively change the structure of the state Medicaid program.

Supplemental Security Income (SSI): SSI is a federal program that provides cash assistance to the disabled, elderly and blind. If an individual receives SSI benefits, then they are automatically eligible for Medicaid. A person must make less than 74 percent of the federal poverty level and have limited assets to qualify. If disabled, a person must have a medical condition that prevents them from working and is expected to last at least 12 months or result in death.

Waiver: A waiver is an exception to federal requirements of the Medicaid or SCHIP programs made by the state. There are waivers in place in Kansas for home and community based services. The waiver process can be complex and can take multiple years to gain approval from the federal government. Waivers and State Plan Amendments are the only ways that a state can administratively change the structure of the state Medicaid or SCHIP programs.

APPENDIX E – CITIZENSHIP DOCUMENTATION REQUIREMENTS IN KANSAS[17,18]

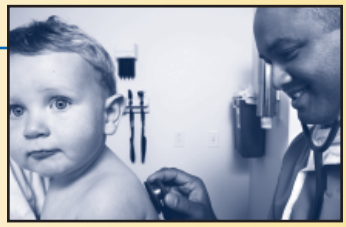
To apply successfully to the Medicaid program in Kansas, the applicant must provide primary documentation. Primary documentation must establish an individual's identity as well as citizenship. If primary documentation is not available, then the applicant must provide two separate documents — one that proves the individual's identity and one that proves the individual's citizenship. The state of Kansas does allow copies if they are clearly marked as such and appear to be authentic. In the case of children under age 16, school records (including records from day care or nursery school) are acceptable to establish identity, and citizenship must be established through other documentation. Newborn children born to mothers who are beneficiaries are exempt from proving citizenship until the next time that their eligibility is reviewed. Individuals who are or have been beneficiaries of Medicare or SSI are exempt from citizenship verification as are foster children.

Primary documentation includes:

- U.S. passport;
- Certificate of U.S. Naturalization;
- Certificate of U.S. Citizenship; or a
- State-issued driver's license.

Secondary documentation includes:

- Birth certificate;
- Other birth record issued by the state department;
- Military records; or an
- Adoption decree.



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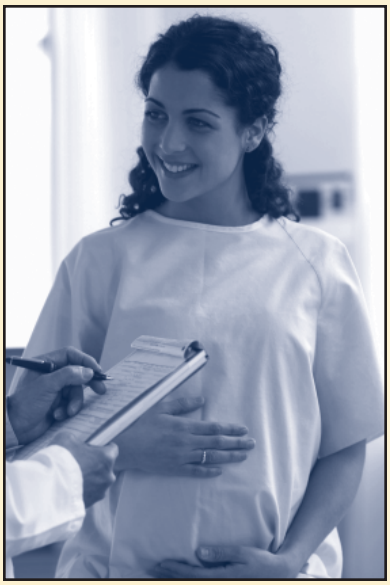

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