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Kansas Medicaid

A PRIMER 2022



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KANSAS MEDICAID

A Primer 2022

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

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About this Report

Medicaid and the Children's Health Insurance Program (CHIP) play a substantial role in the Kansas health care system by providing coverage for health services and long-term care for low-income children and families, people with disabilities and older adults.

KHI and KLRD are pleased to provide basic facts and information about Medicaid and CHIP in Kansas. This report, *Kansas Medicaid: A Primer 2022*, includes an overview of Medicaid and CHIP, analysis of recent trends in Kansas, and general information about covered services and populations.

In the three years since the last edition of this report, federal policy has continued to evolve, and the COVID-19 pandemic has affected Medicaid

and CHIP. Some effects of the pandemic are reflected in key figures in this report, as well as in a new section starting on page 17.

KanCare, the state's comprehensive managed care program, has been in place for nine years, and this report captures data from that entire period as well as the pre-KanCare period.

This report is the sixth edition of this information, following 2005, 2009, 2014, 2017 and 2019 versions. Unless otherwise noted, data used in this report were derived from the publicly available Medical Assistance Report (MAR) published by the Kansas Department of Health and Environment (KDHE). Figures that depend upon encounter data, or data about individual claims related to services paid for by managed care organizations, were derived from the KDHE Enterprise Data Warehouse.

Introduction to Medicaid and CHIP

Medicaid provides health care coverage to low-income dependent children, parents, pregnant women, people with disabilities and older adults, 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.

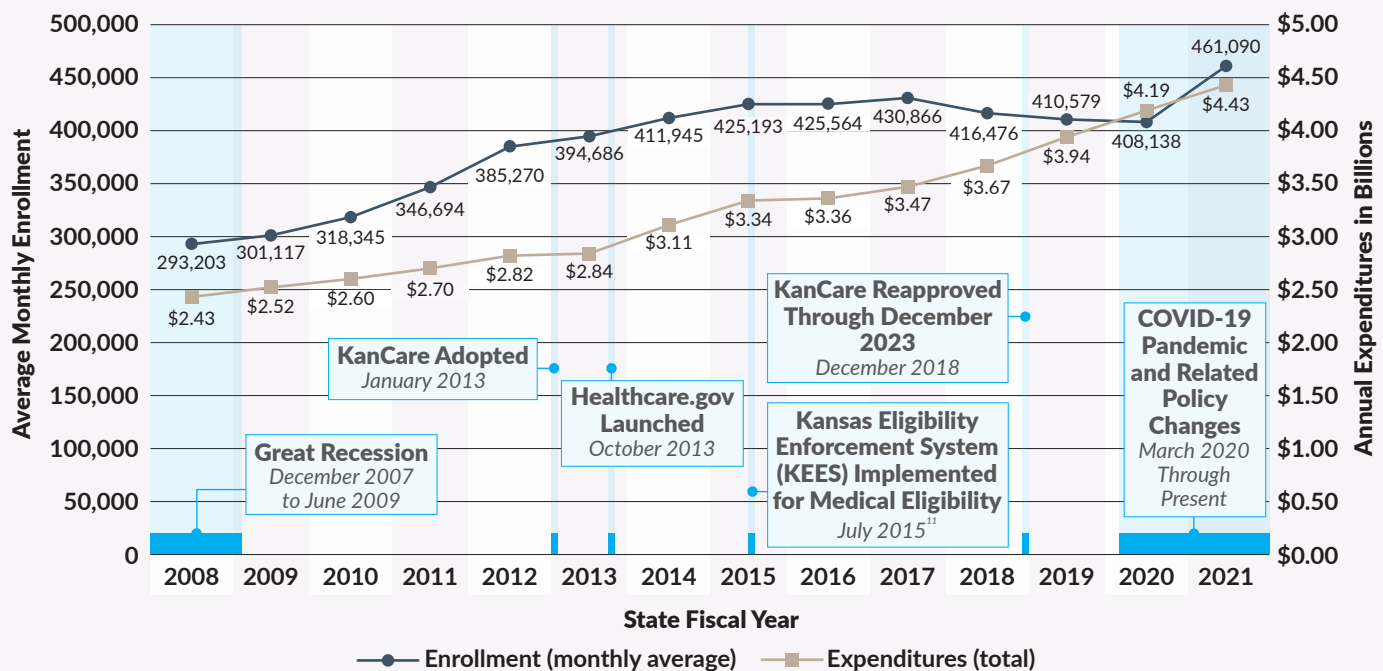
Medicaid is the second-largest source of health coverage in the nation, following employment-based coverage. It is a publicly financed source of health insurance and long-term care for eligible population groups. The Medicaid program is jointly funded by the federal government and the states. Medicaid is traditionally the third-largest domestic program in the federal budget, behind only Medicare and Social Security. However, during the COVID-19 pandemic the Medicaid program was temporarily eclipsed by the Paycheck Protection Program (PPP) and enhanced unemployment compensation, which were enacted to support the economy.^{1,2} CHIP is similarly jointly funded by the

federal government and the states but has fewer enrollees and less total spending than Medicaid.

In state fiscal year (FY) 2021, Medicaid and CHIP covered an average of 461,090 people in Kansas per month at a cost of \$4.4 billion for the year, as shown in *Figure 1*. Expenditures for Medicaid and CHIP have increased steadily since 2008. While average monthly enrollment in Medicaid and CHIP increased each fiscal year between 2008 and 2017, enrollment decreased from FY 2018 through FY 2020 before increasing sharply in FY 2021 due to the COVID-19 pandemic. Medicaid enrollment rose across the country towards the end of FY 2020 and throughout FY 2021 in response to worsening economic conditions and incentives enacted by the federal government to support continued health insurance coverage for under-resourced populations during the pandemic.³

In federal fiscal year (FFY) 2019, total Medicaid spending nationally was \$626.9 billion, while total CHIP spending nationally was \$18.8 billion.^{4,5} In Kansas, the federal government will contribute a base rate of approximately \$1.50 during FFY 2022 for every \$1 of

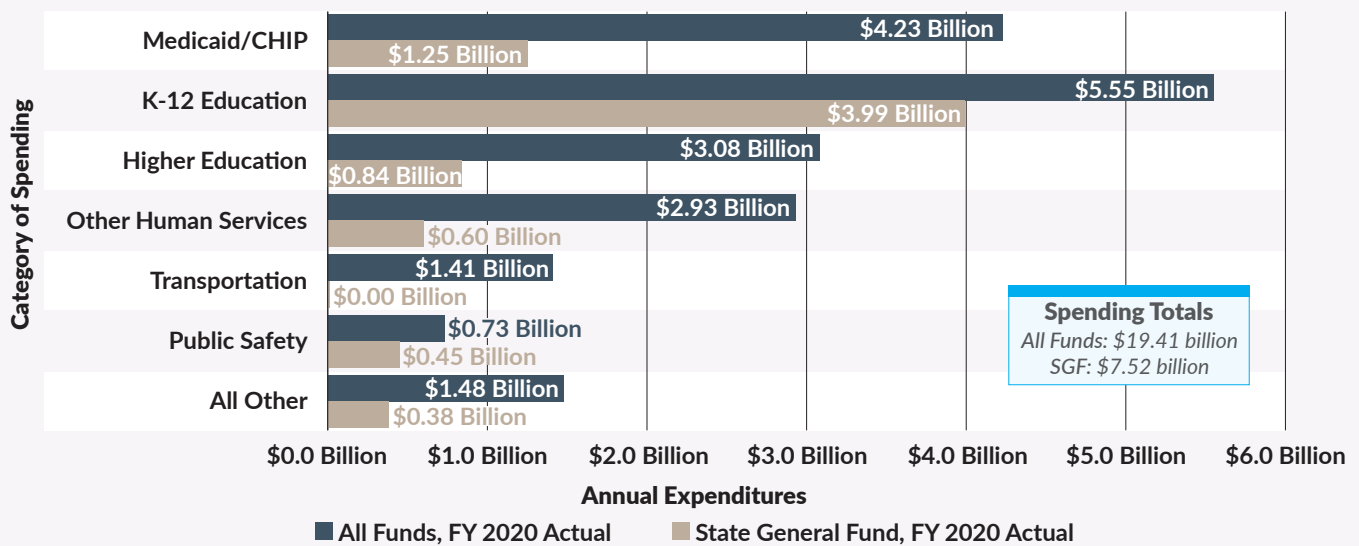
Figure 1. Medicaid and CHIP Average Monthly Enrollment and Annual Expenditures in Kansas, Fiscal Years 2008–2021



Note: Enrollment represents the average monthly enrollment for the state fiscal year. All Medicaid and CHIP beneficiaries are included. Expenditures include total state and federal spending for the state fiscal year.

Source: KHI analysis of Kansas Medical Assistance Report (MAR), 2008–2021, 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 2020



Note: Medicaid/CHIP total differs from Figure 1 because certain expenses are included in the Medicaid total in the Governor's Budget Report but not in the Medical Assistance Report.

Source: KHI analysis of FY 2022 Governor's Budget Report, Schedules 2.1, 2.2, 5.1 and 5.2, FY 2020 Actual.

regular state Medicaid spending, although the match rate can vary for certain expenses.⁶ (For example, most administrative costs are split equally between the federal and state government.) Stated another way, the federal government will pay 60.16 percent of most Medicaid expenses in Kansas.⁷ 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 72.11 percent in FFY 2022.⁸ During the

COVID-19 public health emergency, an additional 6.20 percentage points were applied to the Medicaid FMAP in each state, and 4.34 percentage points to the CHIP enhanced match rate, effective through the quarter in which the emergency was to end.

In FY 2020, Medicaid and CHIP accounted for 16.7 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*.⁹

What is Managed Care and Why Does it Matter?

In 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 most 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.

The state has contracts with the MCOs that 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 and the territories of Guam, Puerto Rico, the Northern Mariana Islands, American Samoa and the Virgin Islands currently participate in the program.¹⁰

CHIP was authorized by the Kansas Legislature in 1998 and implemented in 1999. CHIP was designed to serve children at higher income ranges than traditionally served by Medicaid. Federal

funding for CHIP is periodically renewed and was most recently extended in January 2018 through September 2027.¹¹

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

Figure 3. Differences Between Medicaid and Medicare in Kansas

Medicaid:

- Provides benefits for low-income children and pregnant women, and some low-income parents, adults age 65 and older and individuals with disabilities.
- Provides medical care and long-term care coverage.
- Eligibility rules based on income.
- Receives state and federal funding.
- Administered at a state level, within federal guidelines.

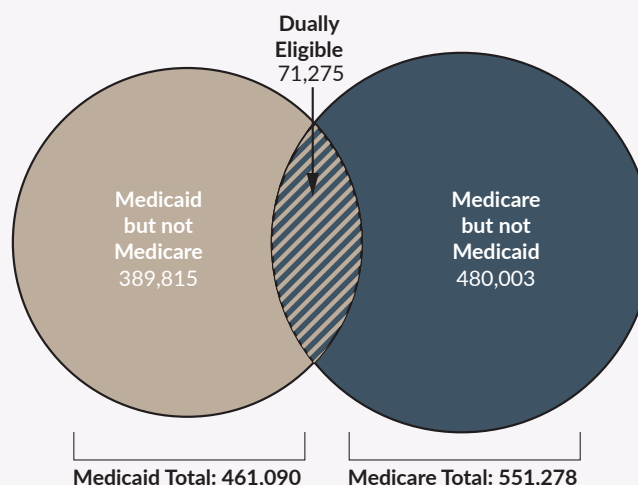
Dually Eligible:

- Medicare provides medical care coverage for low-income adults age 65 and older and low-income individuals with disabilities who qualify for social security disability benefits.
- Medicaid pays for Medicare premiums, out-of-pocket expenses and additional services not provided through Medicare, like long-term services and supports.
- Together, the programs provide medical care coverage and long-term care coverage.
- Have eligibility rules based on income, assets and entitlement.
- Receive state and federal funding.
- Administered at the state and federal levels.

Medicare:

- Provides benefits for adults age 65 and older, some people with disabilities who qualify for social security benefits or who are receiving treatment for end-stage renal disease.
- Provides medical care coverage, but very limited long-term care coverage.
- Has no income limit.
- Receives federal funding collected by payroll deduction.
- Administered at the federal level.

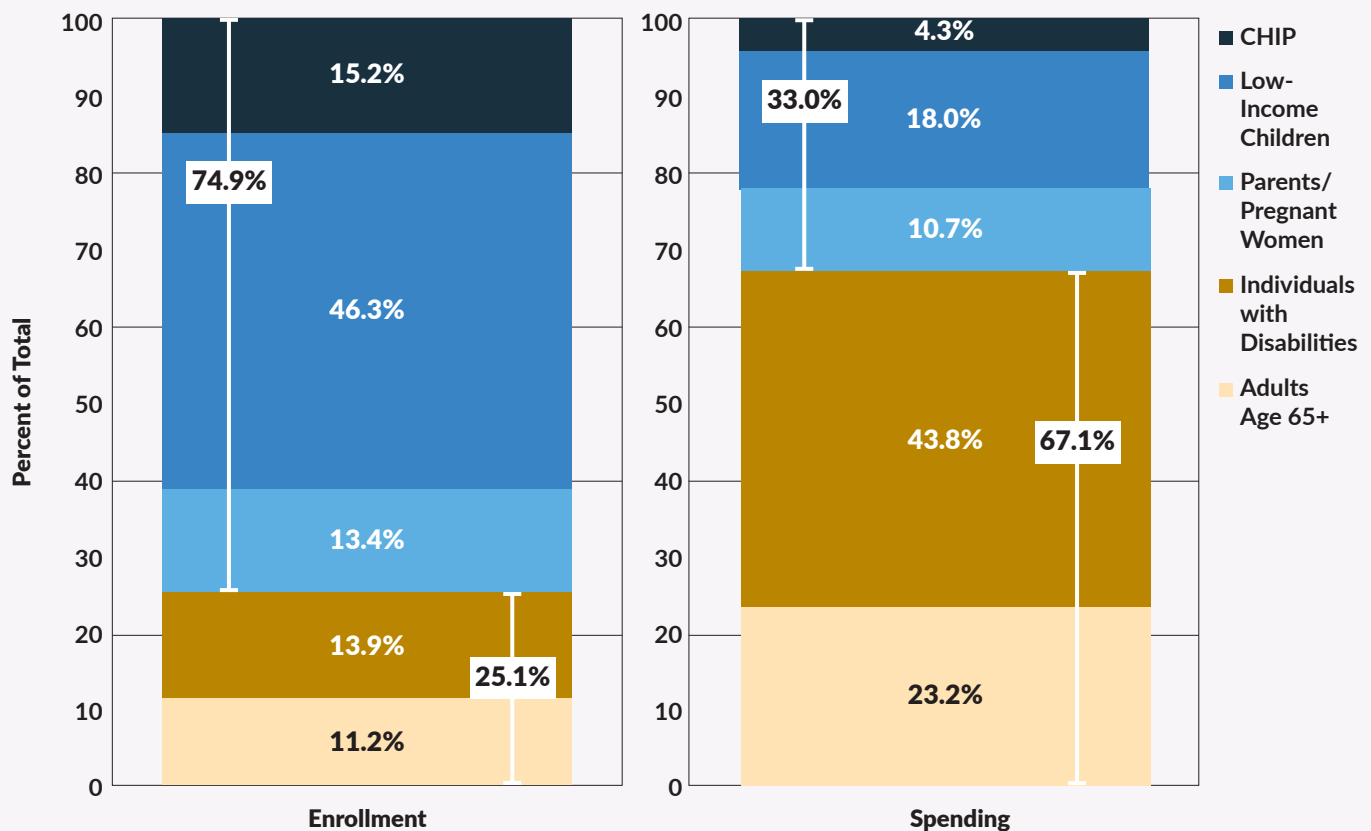
Number of Enrollees, Fiscal Year 2021



Note: Additional information on Medicaid enrollees who are also eligible for Medicare is available from the Centers for Medicare and Medicaid Services (CMS): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf

Source: KHI analysis of data from the KDHE Enterprise Data Warehouse and CMS Program Statistics.

Figure 4. Medicaid and CHIP Population Groups and Spending, Fiscal Year 2021



Note: Low-income children include those enrolled in Medicaid based on household income. 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), FY 2021, and additional data from the Division of Health Care Finance, Kansas Department of Health and Environment.

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 behavioral health, people with disabilities and adults age 65 and older.

In November 2011, Kansas announced significant structural and operational changes in the 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. After a one-year extension of the initial demonstration, the Centers for Medicare and Medicaid Services (CMS) approved a second KanCare demonstration in December 2018 that is authorized through December 31, 2023. The procedures set by the federal government to submit and approve changes to the KanCare program are described on page 10.

Medicaid and CHIP Spending in Kansas

In Kansas, about one-quarter (25.1 percent) of all Medicaid and CHIP enrollees are adults age 65 and older or people with disabilities, but this combined population incurs two-thirds (67.0 percent) of total state expenditures for the Medicaid and CHIP programs, as shown in *Figure 4* (page 5). Children and families, including children in CHIP, account for nearly three-quarters (74.9 percent) of total enrollees and incur about a third (33.0 percent) of the state expenditures in these programs.

In FY 2021, annual Medicaid and CHIP spending averaged \$3,908 per pregnant woman, child or family member, compared to \$27,898 per enrollee with a disability and \$18,387 per enrollee age 65 and older (*Figure 5*). These differences reflect the greater use of services, including long-term services and supports, by

adults age 65 and older and people with disabilities. *Appendix B* (page 21), contains a complete list of both mandatory and optional services covered by Medicaid in Kansas.)

In Kansas, the percentage of the population enrolled in the Medicaid program decreased between FFY 2014 and FFY 2019, while it increased across the United States as many states expanded their programs. The decrease in the percentage of Kansans enrolled in the program was greater than in the group of other states that had not expanded Medicaid. However, while enrollment as a percent of the population declined during this period, the cost of benefits per enrollee in Kansas increased by more than the national average and by more than the average for states that had expanded Medicaid as well as those that had not (*Figure 6*, page 7). Analyses that use other data sources or base years could produce different results.



Figure 5. Per Capita Annual Cost by KanCare Population, Kansas Fiscal Year 2021

Annual Medicaid Spending by Population Group	FY2021
Individuals with Disabilities	\$27,898
Adults Age 65 and Older	\$18,387
Parents/Pregnant Women	\$7,070
Medicaid Children	\$3,450
CHIP	\$2,523
CHIP/Medicaid Children and Families Combined	\$3,908
All Enrollees	\$8,866

Note: Costs as incurred by the program. 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 11.

Source: KHI analysis of Kansas Medical Assistance Report (MAR), 2021, and additional data from the Division of Health Care Finance, Kansas Department of Health and Environment.

Medicaid and CHIP Enrollment Trends

Enrollment increased 47.0 percent from FY 2008 through FY 2017 as Kansans recovered from the great recession and as state agencies worked through challenges modernizing eligibility and enrollment systems required by the Affordable Care Act. Enrollment decreased for three years starting in FY 2018, but rose sharply in FY 2021, surpassing previous enrollment totals, as the state and federal governments implemented new policies to maintain health insurance coverage during the COVID-19 pandemic (Figure 1, page 2).

Children and families (Figure 7, page 8) make up the largest share of enrollees in Medicaid. Enrollment for this group increased the most (17.3 percent) between FY 2020 and FY 2021.¹²

Enrollment for adults age 65 and older and people with disabilities also increased. Enrollment for older adults has increased steadily since 2011 —

2.5 percent per year on average — as the “baby boomer” generation ages, but it increased by more (4.8 percent) between FY 2020 and FY 2021. The total enrollment for people with disabilities declined overall from FY 2011 through FY 2019 before increasing 1.4 percent in FY 2020 and another 5.6 percent in FY 2021. 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 income over \$495 a month to “spend down” or pay a portion of their health care costs, has steadily declined since FY 2012. While the protected income limit (PIL) for individuals receiving home and community-based services and those enrolled in the Program of All-Inclusive Care for the Elderly was raised to 300 percent of the monthly SSI payment (\$2,523 a month in 2022) for Fiscal Year 2022, the PIL for Medically Needy (\$495 a month in 2022), 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 Enrollment and Costs Compared with Other States, Selected Indicators, 2014-2019

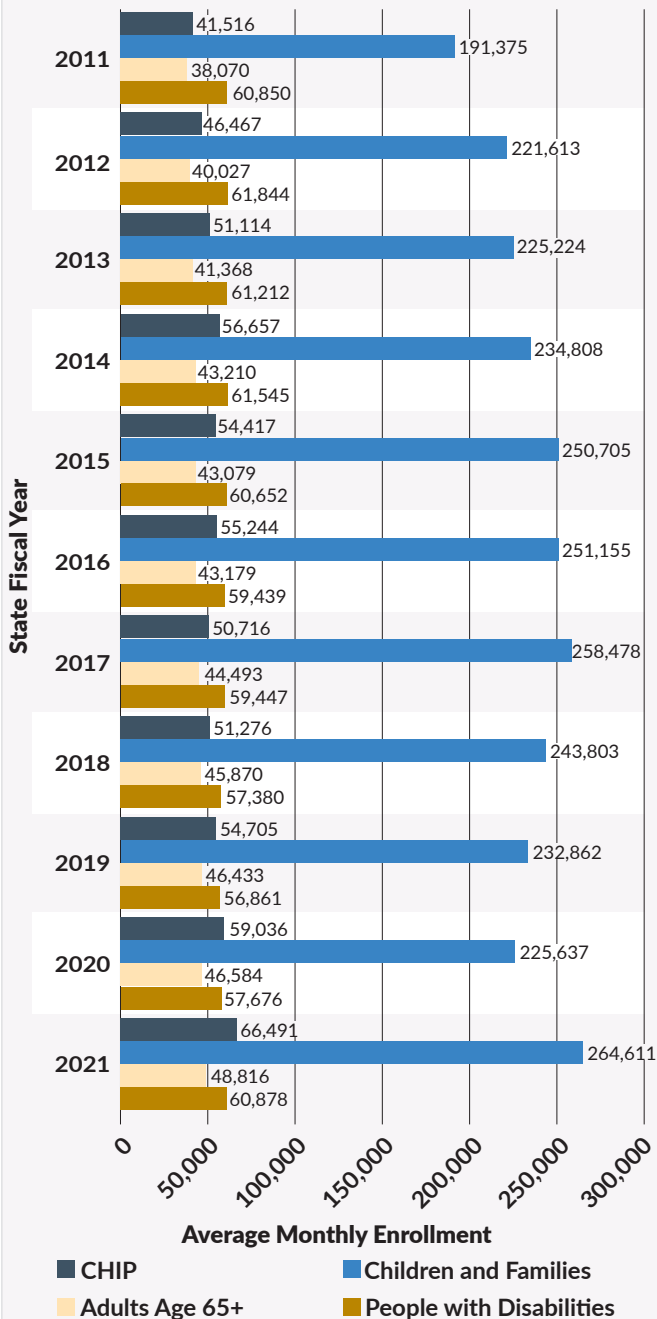
	Federal Fiscal Year 2019					Percent Change in Percent of Population Enrolled in Medicaid, FFY 2014-FFY 2019	Percent Change in Spending on Benefits per Enrollee, FFY 2014-FFY 2019
	Average Monthly Medicaid Enrollment	Percent of Population Enrolled in Medicaid	Total Spending on Benefits (billions)	Spending on Benefits per Enrollee	Administrative Cost as Percent of Total Spending		
Colorado*	1,249,083	21.7%	\$9.20	\$7,367	3.3%	14.4%	26.3%
Iowa*	604,562	19.2%	\$5.20	\$8,601	2.8%	11.7%	17.0%
Kansas	361,503	12.4%	\$3.60	\$9,964	5.2%	-1.5%	33.5%
Missouri	873,180	14.2%	\$10.53	\$12,065	3.4%	9.6%	7.4%
Nebraska	243,705	12.6%	\$2.14	\$8,788	5.5%	0.9%	16.4%
Oklahoma	643,919	16.3%	\$4.76	\$7,393	4.1%	-16.1%	19.1%
United States	73,741,365	22.5%	\$594.57	\$8,063	4.7%	4.4%	18.6%
Medicaid Expansion States*	53,051,871	25.3%	\$441.41	\$8,320	4.9%	7.0%	20.0%
Non-Medicaid Expansion States	20,689,495	17.4%	\$153.16	\$7,403	4.2%	-0.9%	14.6%

Note: The federal fiscal year (FFY) runs from October 1 through September 30. For example, FFY 2019 refers to the period from October 1, 2018, through September 30, 2019. It overlaps with the state fiscal year in Kansas, which runs from July through June. Average monthly enrollment in FY 2014, the baseline year for comparison, was calculated using January-September enrollment reports. Analysis excludes CHIP enrollment and spending and enrollment and spending in U.S. territories.

*Indicates states that had adopted Medicaid expansion as of September 2019. Missouri, Nebraska and Oklahoma adopted Medicaid Expansion after September 2019.

Source: KHI analysis of U.S. Census Bureau state population estimates; Centers for Medicare and Medicaid Services (CMS) Quarterly Medicaid Enrollment Data from the Medicaid Budget and Expenditure System (MBES); and CMS-64 reports.

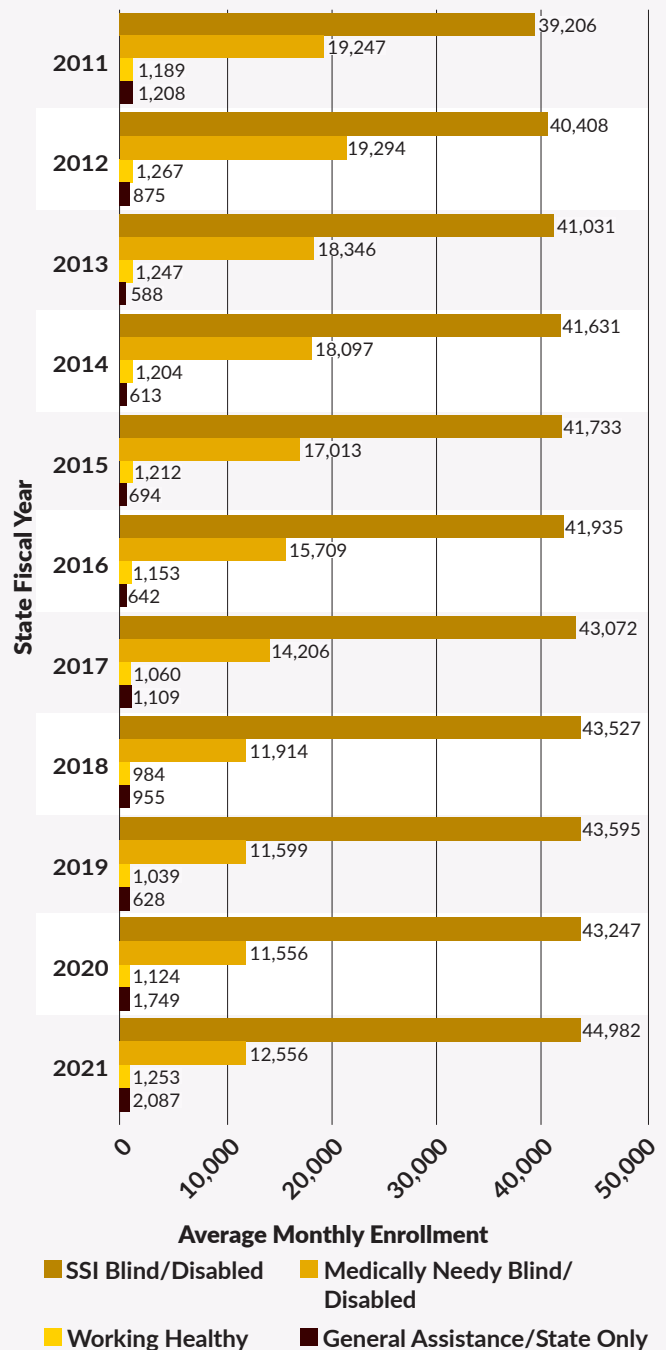
Figure 7. Average Monthly Medicaid Enrollment for Children and Families, CHIP, Adults Age 65 and Older and People with Disabilities in Kansas, Fiscal Years 2011-2021



Note: Does 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 not Medicaid-eligible after the Affordable Care Act (ACA) was enacted; 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), 2011-2021, from the Division of Health Care Finance, Kansas Department of Health and Environment

Figure 8. Average Monthly Medicaid Enrollment for People with Disabilities by Eligibility Group in Kansas, Fiscal Years 2011-2021



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), 2011-2021, from the Division of Health Care Finance, Kansas Department of Health and Environment..

Medicaid and CHIP Services

Since 2013, payments for health care services provided to Kansas Medicaid and CHIP enrollees have primarily been 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 2021, 89.5 percent of state payments were for managed care (*Figure 9*).

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 D*, page 24, such as members for whom the state only pays Medicare cost-sharing.

Medical Care

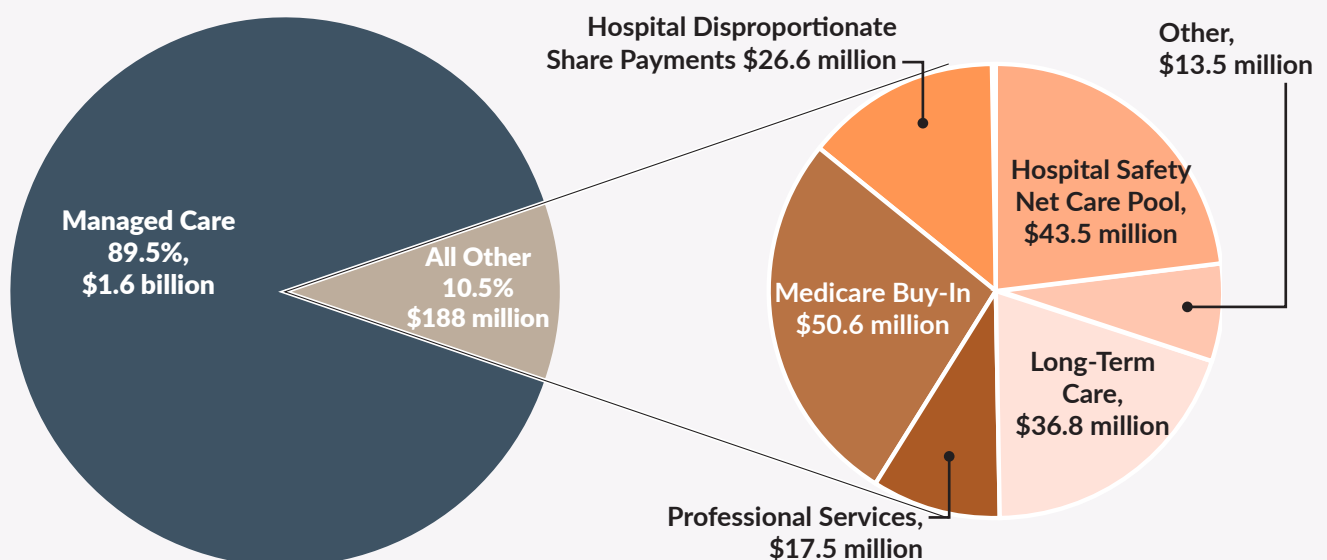
Medical care services under Medicaid include physician and hospital services, dental services, pharmacy, rehabilitation and a host of other services. Medical care services represented 58.2 percent of

spending by MCOs in FY 2021 (*Figure 10*), which is consistent with spending on medical care services in prior years.

MCOs spend the most on inpatient hospital services followed by pharmacy, physician services, behavioral health services, outpatient hospital care, other professional services and dental care. 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 many low-income and uninsured patients. Additionally, a provider assessment paid by hospitals offsets some medical care costs.

In addition to paying for medical services, MCOs also pay providers for other activities to support the health care needs of KanCare members. For example, in the OneCare Kansas program — which launched in April 2020 for KanCare members with serious and persistent mental illness or those with asthma who are at risk for developing another chronic condition — services include comprehensive care management, care coordination, comprehensive transitional care, patient and family support (including authorized representative), referral to community and social support services, and health promotion.

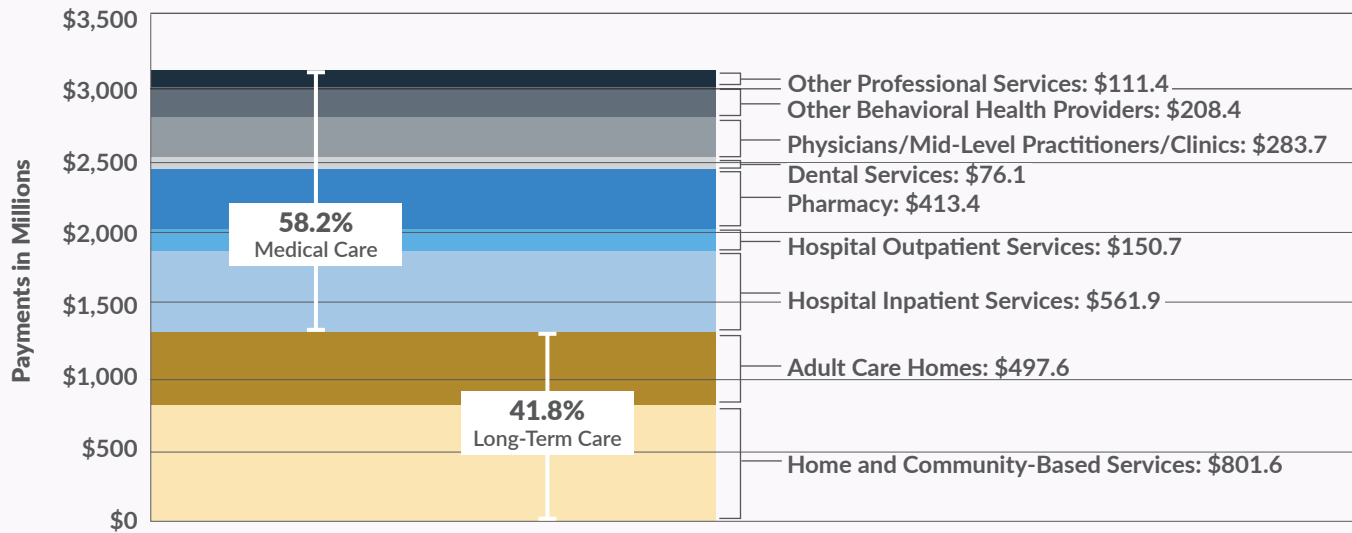
Figure 9. Managed Care as a Portion of Total Medicaid and CHIP Expenditures in Kansas, State Funds Only, Fiscal Year 2021



Note: Long-Term Care in this chart includes fee-for-service payments to nursing facilities for mental health. School-based services are included in Professional Services.

Source: KHI analysis of Kansas Medical Assistance Report (MAR), 2021, from the Division of Health Care Finance, Kansas Department of Health and Environment.

Figure 10. KanCare Managed Care Organization (MCO) Payments to Providers by Category of Service, Fiscal Year 2021, in Millions



Note: KanCare MCO payments to providers totaled \$3.1 billion in FY 2021. Home and community-based services (HCBS) includes services provided through waivers and by providers of other HCBS. Categories of service are determined based on a hierarchy, so that no category contains reimbursements represented in another category. Other behavioral health providers, for example, includes payments to behavioral health providers not captured in categories presented below it.

Source: KHI analysis of data from the Kansas Department of Health and Environment, FY 2021.

State Plans, 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 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.

Waivers also must meet tests designed to ensure cost-effectiveness. Waivers for HCBS must demonstrate they are cost-neutral in the aggregate, comparing the costs for service recipients to those receiving institutional services. Section 1115 demonstrations, which can include waivers and expenditure authorities, must be budget neutral (costing no more than the federal government would pay without the demonstration) over the life of the demonstration.

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 first implemented in January 2013. The program was renewed in December 2018 through the end of calendar year 2023.

Long-Term Care

Long-term care services include all services provided by adult care homes and home and community-based services. These services account for 41.8 percent of total payments made by MCOs on behalf of their members in FY 2021 (Figure 10).

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 nonwaiver Medicaid populations. The populations eligible for HCBS through waivers and their institutional equivalents in Kansas are shown in Figure 11.

Administrative Spending

The program 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 \$196.9 million in FFY 2019, accounting for 5.2 percent of Medicaid expenditures in Kansas.¹³

Figure 11. Kansas Home and Community-Based Services (HCBS) Waivers, Enrollment, Waiting Lists and Institutional Equivalents, July 2021

Waiver Program	Enrollees	Individuals on Waiting List/ Proposed Recipients	Institutional Equivalent
Autism (age 0-5 for initial eligibility; AU)	44	350	Inpatient psychiatric facility for age 21 and under
Brain Injury (age 0-64; BI)	764	0	Traumatic Brain Injury rehabilitation facility and hospital
Frail Elderly (age 65+; FE)	5,820	0	Nursing facility
Intellectual/Developmental Disability (age 5+; I/DD)	9,116	4,523	Intermediate care facility for individuals with intellectual disabilities
Physical Disability (age 16-64; PD)	6,041	2,191	Nursing facility
Serious Emotional Disturbance (age 4-18; SED)	3,416	0	Inpatient psychiatric facility for age 21 and under
Technology Assisted (age 0-21; TA)	623	0	Hospital

Note: The waiver for children with autism has a list of proposed recipients, while the waivers for individuals with intellectual or developmental disabilities and for individuals with physical disabilities have waiting lists.

Source: Kansas 1915(c) waivers and July 2021 HCBS Monthly Summary, Kansas Department for Aging and Disability Services.

Medicaid and CHIP Eligibility Groups

As a federally designated entitlement program, Medicaid requires states to provide coverage to all eligible individuals in certain population categories. Medicaid eligibility is always based on income, but may also depend on age, availability of financial resources and, in some cases, health care needs depending on the population group. 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 applicable 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 adults age 65 and older.



- **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 adults age 65 and older 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.

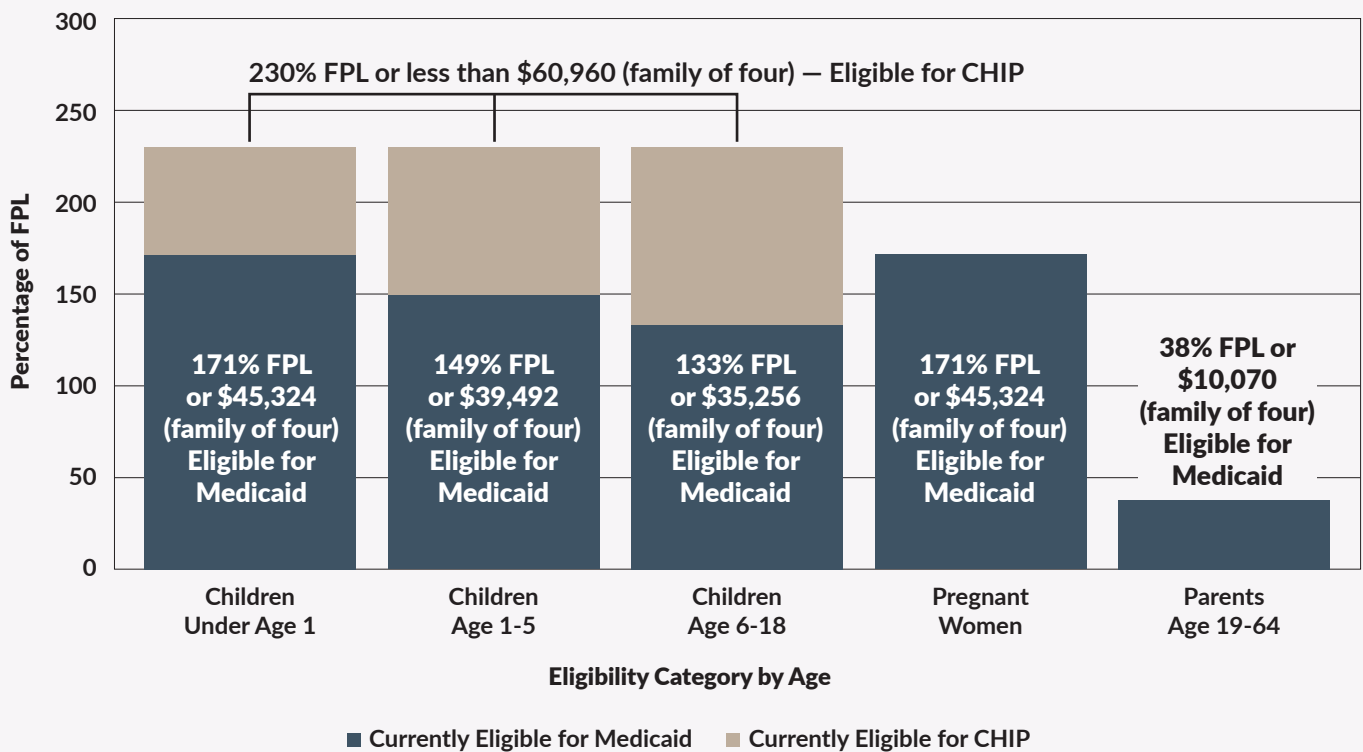
Figure 12. Federal Poverty Guidelines for the Contiguous 48 States and the District of Columbia, 2021

Persons in Family/Household	Annual Income (100 percent of FPL)
1	\$12,880
2	\$17,420
3	\$21,960
4	\$26,500
5	\$31,040
6	\$35,580
7	\$40,120
8	\$44,660

For families/households with more than eight persons, add \$4,320 for each additional person.

Source: U.S. Department of Health and Human Services, 2021.

Figure 13. Income Eligibility Levels for Children and Families in Kansas Medicaid and CHIP, 2021



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. Annual income levels are calculated using monthly limits multiplied by 12.

Source: Eligibility information from the Division of Health Care Finance, Kansas Department of Health and Environment, 2021.

Medicaid eligibility can be divided into two broad categories: low-income children and families, and low-income older adults 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 Affordable Care Act (ACA), states have the option to expand Medicaid to include low-income adults up to 138 percent 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*. CHIP extends income levels even higher for children. In 2021, children and infants under age 1 were eligible for Medicaid if their annual family income was less than 171 percent FPL (\$45,324 for a family of four). Children age 1–5 were eligible if their annual family income was less than 149 percent FPL (\$39,492 for a family of four). Children age 6–18 were eligible if their annual family income was less than 133 percent FPL (\$35,256 for a family of four). All other children up to 230 percent FPL (\$60,960 for a family of four) were eligible for CHIP. Families pay premiums up to \$50 a month for CHIP children, depending on household income.¹⁴

Parents and Pregnant Women: In 2021, parents or caretakers of children with an annual household income up to 38 percent FPL (\$10,070 for a family of four) also were eligible for coverage under Medicaid. Parents who were above this annual income were

not eligible for Medicaid even if their children were covered. Pregnant women and new mothers with income below 171 percent FPL (\$45,324 for a family of four) were eligible in 2021. Adults who are not parents, pregnant, disabled or medically needy are not eligible for Medicaid in Kansas.

Low-Income Older Adults and Individuals with Disabilities

Adults age 65 and older and individuals with disabilities frequently have complex health needs, often requiring many services like office visits and physical therapy, or costly services such as surgery, home and community-based care, nursing home care or end-of-life care. In FY 2021, total enrollment for individuals with disabilities and adults age 65 and older was approximately 110,000. There are various criteria by which older adults 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, blind 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 \$7.7 million in FY 2021 to cover an average of 2,087 people per month. This program is not eligible for federal matching dollars and has not been included in managed care.

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 \$5.6 million in FY 2021 to cover about 1,253 people on average per month. Total costs, including the federal share, were nearly \$14 million.¹⁵

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, some individuals with disabilities also are eligible for both Medicare and Medicaid.

Program of All-Inclusive Care for the Elderly^{16,17}

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 2021 approximately 725 individuals utilized PACE services per month, at an annual cost to the state of nearly \$14 million for FY 2021.

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. As of August 2021, three PACE organizations offer services to Kansans in 20 counties. The state is preparing to expand 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	OPTIONAL POPULATIONS, KANSAS-SPECIFIC COVERAGE
• Infants and children whose families earn less than 138 percent FPL • Infants born to a Medicaid mother • Parents or caretakers whose income is less than 38 percent FPL • Pregnant women up to 171 percent FPL • Adults age 65 and older 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	• Children's Health Insurance Program (CHIP) up to 230 percent 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 (HCBS) • Older adults in the Program of All-Inclusive Care for the Elderly (PACE) Kansas also extends Medicaid coverage to: • Medically Needy: Older adults, people with disabilities, pregnant women and children • Children: Kansas extends coverage to children under 1 whose families earn less than 171 percent FPL; and children 1-5 whose families earn less than 149 percent 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 FPL, but a 5 percent income disregard would apply if a state did not have a CHIP program.

Source: *KanCare Special Terms and Conditions, Centers for Medicare and Medicaid Services, January 2019; Medical Assistance Standards, Kansas Department of Health and Environment, April 2021.*

Program of All-Inclusive Care for the Elderly (PACE): In 20 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 can live safely in the community with the support of a PACE center. The PACE program covers both Medicare and Medicaid services for dually eligible individuals.

Other Medicaid Populations

Between 4 and 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 Acquired Immunodeficiency Syndrome (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.)

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; and
- Persons determined to have disabilities by Social Security.

Some of these populations are included in managed care, but others are excluded. For more information on populations not included in KanCare, see Appendix D, page 24.

Helpful Links

For more from the sponsors of this report, see:

- Kansas Legislative Research Department: www.kslegislature.org/kldr
- 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 and Medicaid Services: www.medicare.gov
- Kaiser Program on Medicaid and the Uninsured: www.kff.org/about/kcmu.cfm
- National Conference of State Legislatures: www.ncsl.org
- National Academy for State Health Policy: www.nashp.org

For more population data about health insurance, see:

- United States Census Bureau: <https://www.census.gov/topics/health/health-insurance.html>

COVID-19 and KanCare

The COVID-19 pandemic has had a significant effect on all of society, with both early and enduring consequences for the Medicaid and CHIP programs. The effects can be observed in many of the figures and tables in this edition of the Primer and in more detail in this section.

How Did Enrollment Change?

In anticipation of the health and economic effects of COVID-19, including unemployment, Congress enacted enhanced federal matching rates as incentives for states to maintain enrollment in Medicaid and CHIP.

Among other actions, Kansas implemented a continuing coverage policy that triggered the enhanced match rate, significantly reducing disenrollment and “churn” (disruption in coverage) during the federally declared public health emergency. The policy meant that all enrollees eligible on March 18, 2020, or thereafter would remain eligible throughout the public health emergency, unless they requested disenrollment, moved out of state, died, or were determined not to be validly enrolled. While

not required, Kansas (and 27 other states) also extended enrollment for children in CHIP.

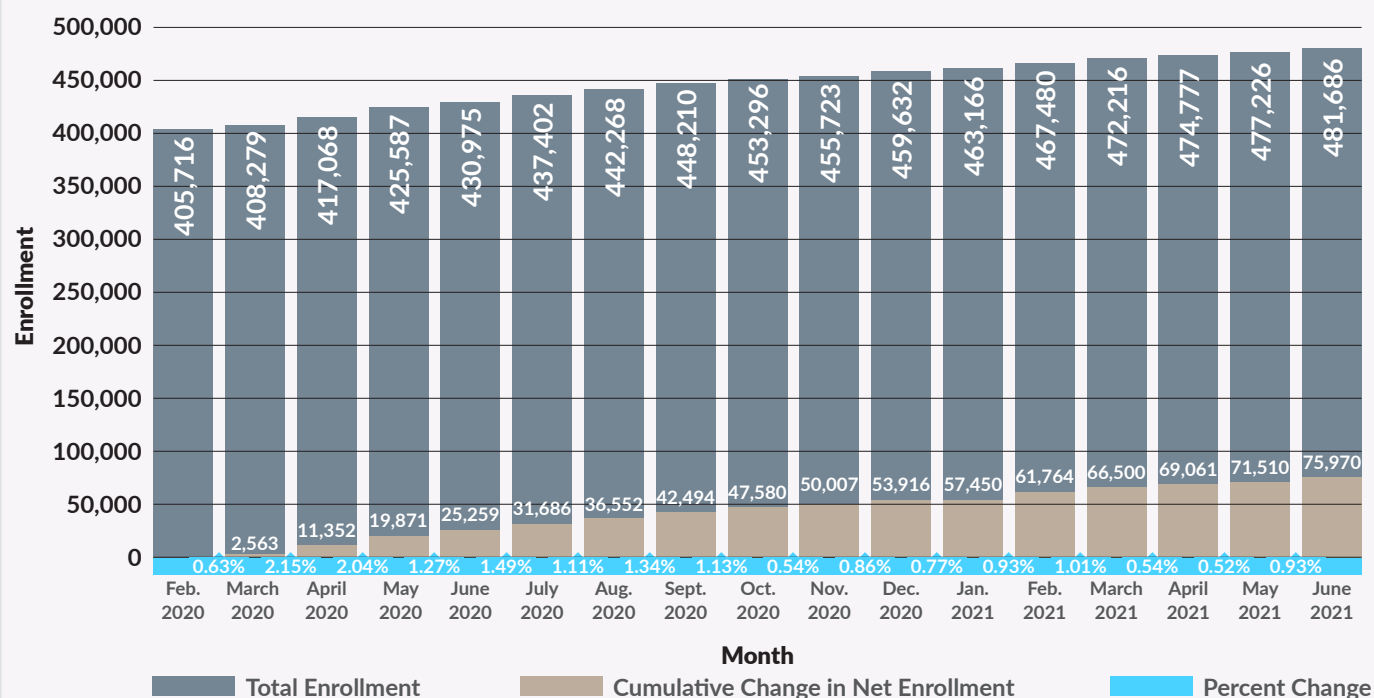
Kansas Medicaid and CHIP enrollment increased 18.7 percent (from 405,716 to 481,686) between February 2020 and June 2021 (Figure 15). Much of the increase in enrollment was driven by the policy decision to delay action on annual reviews until after the public health emergency, ensuring continuous coverage during the pandemic.

Kansas made other temporary adjustments that affected enrollment during the pandemic, including expanding the use of presumptive eligibility (which provides temporary coverage while full eligibility is being determined) by increasing the number of presumptive eligibility periods allowed in a 12-month period, and adding more entities that could determine presumptive eligibility.

How Did Spending Change?

Total Medicaid and CHIP spending in Kansas increased 5.6 percent between FY 2020 and 2021 as enrollment climbed and some provider payments were temporarily enhanced to ensure access to care.

Figure 15. Monthly Medicaid and CHIP Enrollment from the Beginning of the COVID-19 Pandemic



Source: KHI analysis of Kansas Medical Assistance Report (MAR), 2020–2021, Division of Health Care Finance, Kansas Department of Health and Environment.

However, states were largely shielded from the cost of expanded enrollment and other temporary policy changes related to COVID-19. The federal incentive for states during the pandemic was a temporary 6.20 percentage point increase in the Federal Medical Assistance Percentage (FMAP), which also resulted in a 4.34 percentage point increase in the enhanced FMAP for CHIP. The adjustment was retroactive to January 1, 2020, and was to continue through the end of the federally declared public health emergency. As a result, the state share of program expenditures in Kansas was eased by \$125.7 million in FY 2020 and \$255.5 million in FY 2021.

Once the Secretary of the Department of Health and Human Services allows the public health emergency to expire, annual reviews will resume for KanCare enrollees as the temporary additional federal financial support for maintaining their enrollment expires.

What Other Policy Changes Were Made?

In addition to implementing continuing coverage, states that wanted to receive higher match rates also were required to maintain eligibility standards, methodologies and procedures that were no

more restrictive than those in effect on January 1, 2020; to not increase Medicaid premiums; and to cover COVID-19 tests and treatments, including vaccinations, without cost sharing.

The pandemic also prompted temporary changes in other policies, including those designed to make telehealth more accessible for KanCare

enrollees. Prior to the pandemic, KanCare covered the use of telemedicine technology for primary care, individual psychotherapy, pharmacological management, speech-language pathology and audiology services, and home telehealth for individuals on the frail elderly (FE) waiver, via live video or remote patient monitoring.

Examples of changes during the pandemic

included instituting payment parity for telehealth services in KanCare; expanding services allowed under telehealth (including dental services); allowing services by telephone instead of live video only; and allowing a patient's home or a nursing facility to be an originating site for telehealth services. Unlike some pandemic-related policy changes that are tied to the public health emergency declaration, state policy documents described the telehealth changes as being in place until rescinded.



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 age 6–18 in families under 100 percent FPL and created special low-income Medicare beneficiaries. Prescription drug rebate program created.
1996	Personal Responsibility and Work Opportunity Act (PRWOA) separated cash assistance and Medicaid eligibility.
1997	State Children's Health Insurance Program (Title XXI) established in the Balanced Budget Act (BBA 1997).
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 FPL and charge income-based premiums.
1999	U.S. Supreme Court rules in <i>Olmstead v. L.C.</i> 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.

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

YEAR	ACTION
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 FPL.
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 2027.
2018	In December 2018, federal government approves extension of KanCare demonstration from January 1, 2019, through December 31, 2023.
2020	State and federal policymakers implemented policy changes to maintain Medicaid and CHIP coverage and make it easier to access care during the COVID-19 pandemic.
2021	Kansas implemented the Supports and Training for Employing People Successfully (STEPS) pilot in July 2021.

Appendix B. Services Covered by Medicaid in Kansas

THE FOLLOWING SERVICES ARE CONSIDERED MANDATORY ¹⁸	OPTIONAL SERVICES PROVIDED IN KANSAS
• Inpatient and outpatient hospital services • Nursing facility services for age 21 and older • Physician, midwife and nurse practitioner services • Immunizations and early and periodic screening, diagnostic, and treatment (EPSDT) services for children • Laboratory and x-ray services • Family planning services and supplies • Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services • Pregnancy care and freestanding birth center services • Home health services for beneficiaries who are entitled to nursing facility care • Tobacco cessation counseling for pregnant women • Dental services for children • Emergency ambulance and non-emergency medical transportation	• Prescription drugs • Clinic services • Physical and occupational therapy • Services for people with speech, hearing, and language disorders • Substance use disorder 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) • Medical supplies, orthotics and prosthetics • Rehabilitation services • Home and community-based services (HCBS) • Intermediate care facility services for individuals with intellectual disabilities • Targeted case management • Hospice care • Institutional transitions
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.

Source: Centers for Medicare and Medicaid Services, and Attachment C – Services, Kansas Department of Health and Environment, October 2017.

Appendix C. 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 income higher than the Medicaid guidelines, up to 230 percent FPL in FY 2021. 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.

Appendix C (continued). Medicaid Populations Included in KanCare

POPULATION	DESCRIPTION
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.
Working Healthy	This program provides coverage to people age 16–64 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 Services Waiver Groups	These individuals are eligible for one of the seven Kansas 1915(c) waivers: Autism, Brain Injury, Intellectual/Developmental Disability, Frail Elderly, Physical Disability, Serious Emotional Disturbance, and Technology Assisted.
Supports and Training for Employing People Successfully (STEPS) pilot participants	Individuals age 16–65 who are enrolled in this pilot, designed to help members obtain and maintain employment through supportive services, are included in KanCare.

Source: KHI analysis of KanCare Special Terms and Conditions, Centers for Medicare and Medicaid Services, January 2019; Kansas Medical Assistance Standards, Kansas Department of Health and Environment, April 2021; and Kansas Medical Assistance Program (KMAP) General Bulletin 21908.

Appendix D. 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 co-payments.
Low-Income Medicare Beneficiary (LMB), not otherwise Medicaid eligible	This program pays only 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, or under \$325 a month for married couples. 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 noncitizen 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 a public ICF/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 age 22–64. 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.
Individuals on Home and Community Based Services Waiver waiting lists, not otherwise Medicaid eligible	Individuals on Section 1915(c) waiver waiting lists who are not otherwise eligible for Medicaid through the state plan are excluded from KanCare, except for those enrolled in the Supports and Training for Employing People Successfully (STEPS) pilot program.

Source: KHI analysis of KanCare Special Terms and Conditions, Centers for Medicare and Medicaid Services, January 2019, and Kansas Medical Assistance Standards, Kansas Department of Health and Environment, April 2021.

Appendix E: 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 low-income adults age 65 and older 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 2021, the FPL for a family of four was an annual income of \$26,500. 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 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 use disorder 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 (also known as “capitation”) 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 93 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.

Appendix E (continued). Glossary

MediKan

MediKan was established in Kansas in 1973 to bridge the gap between the time that adults become 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 also can 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 20 counties (as of August 2021) with an approved provider.

Psychiatric Residential Treatment Facility (PRTF)

PRTFs provide out-of-home residential psychiatric treatment to children and adolescents whose mental health needs cannot be effectively and safely met in a community setting. These programs are intended to provide active treatment in a structured therapeutic environment. The residential treatment facility is expected to work actively with the family and other agencies to offer strengths-based, culturally competent, trauma-informed, medically appropriate treatment designed to meet the individual needs of the residents.¹⁹

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 an 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 now can be made by filing an 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.

Appendix F. Acronyms and Meanings

Acronym	Meaning
ACA	Affordable Care Act
ADAP	AIDS Drug Assistance Program
AU	Autism
BBA	Balanced Budget Act
BI	Brain Injury
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
COVID-19	SARS-CoV-2
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 / Development 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
KPHA	Kansas Public Health 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

Acronym	Meaning
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
PRTF	Psychiatric Residential Treatment Facility
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
STEPS	Supports and Training for Employing People Successfully
TA	Technology Assisted
TBI	Traumatic Brain Injury

Endnotes

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