

Testimony on:
Enrollment in the Kansas HealthWave and Medicaid Programs

presented to:
House Health Task Force

by:
Dr. Marcia Nielsen
Executive Director

Dr. Andrew Allison
Deputy Director and
Acting Medicaid Director

January 31, 2007

For additional information contact:

Luke Thompson
Kansas Health Policy Authority

Landon State Office Building
900 SW Jackson Street, Suite 900
Topeka, KS 66612
Phone: 785-296-3981
Fax: 785-296-4813

Agency Website: www.khpa.ks.gov
Address: Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220

Medicaid and HealthWave:
Phone: 785-296-3981
Fax: 785-296-4813

State Employee Health
Benefits and Plan Purchasing:
Phone: 785-296-6280
Fax: 785-368-7180

State Self Insurance Fund:
Phone: 785-296-2364
Fax: 785-296-6995

House Health Task Force
January 31, 2007

Enrollment in Kansas HealthWave and Medicaid Programs

Good afternoon. I am Marcia Nielsen, Executive Director of the Kansas Health Policy Authority (KHPA). Andy Allison, our Deputy Director and Acting Medicaid Director is with me today, as well. I appreciate the opportunity to talk to you today about changes we've seen in the number of Kansans enrolled in Medicaid, SCHIP, and HealthWave in recent years, and in the last few months. After sustained growth in enrollment since 1999, the state has seen a very rapid decline totaling over 20,000 Kansans – roughly the population of Derby or Hays. I'd like to provide some historical background on insurance coverage in this state before I address the long-run trends and more recent enrollment challenges in our programs, especially the impact of Federal requirements to verify citizenship and identity.

Health Insurance for Low-Income Kansans

Background. Health insurance plays an important role in the U.S. health care system, spreading costs to ensure access to care and prevent catastrophic financial loss. However, affordable private health insurance is not available to all Americans, especially the poor and those with predictable health costs, such as the elderly and disabled, for whom private insurance markets are both expensive and unstable. To address these chronic gaps in private insurance markets, states and the Federal government have invested in at least three major health insurance programs since the 1960s: Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Medicare provides traditional health insurance services for the nation's elderly and disabled. Medicaid supplements Medicare for low-income seniors and insures low-income women and children. SCHIP provides health insurance to an additional group of low-income children. Today Medicare covers about 13% of the Kansas population, while Medicaid and SCHIP cover about 10%. About 65% of Kansas' population is privately insured, and 11% remain uninsured. Most of the uninsured in Kansas live in households with at least one worker. As the cost of health insurance continues to rise, an increasing number of working Kansas families cannot afford health insurance. Those working in small businesses are less apt to be offered insurance, and those with low and modest incomes often have difficulty affording health insurance.

Federal Funding. Medicaid and the State Children's Health Insurance Program (SCHIP) are Federal programs that provide matching funds for state-run insurance programs. Both Medicaid and SCHIP are contained in the Social Security Act of 1965 (SSA): Medicaid was authorized as a part of the original SSA legislation and can be found in Title XIX of the Act; SCHIP was added as Title XXI of the SSA in 1997. The Federal match rate for SCHIP is slightly higher than Medicaid (72% v. 60% in Kansas), but unlike Medicaid, SCHIP matching funds are subject to a state-specific cap, or allotment. In Kansas, SCHIP is available state-wide to children who are Kansas residents from birth to age 19 who are not eligible for Medicaid and who live in families with incomes up to 200 percent of FPL (\$33,200 annually for a family of three). Medicaid covers children at lower levels of income.

State Programs. Medicaid and SCHIP are funding sources tied to specific Federally-determined populations. The state uses those funding sources to purchase health care through both managed care and fee-for-service programs. The managed care program is called "HealthWave," KHPA's best-known and most widely advertised product line. Both Medicaid- and SCHIP-eligible children and families have been enrolled in HealthWave since FY 2002. By state law, all 34,791 SCHIP children must be enrolled in managed care, which means all are enrolled in HealthWave. As of January 2007, about 145,000 Medicaid beneficiaries – mothers

Enrollment in the Kansas HealthWave and Medicaid Programs

Kansas Health Policy Authority ♦ Presented on: 1/31/07

and children – are also eligible to be enrolled in HealthWave. To distinguish the Medicaid and SCHIP populations within HealthWave, KHPA often refers to the HealthWave-XIX and HealthWave-XXI populations, a direct indication of the SSA funding rules and eligibility criteria that apply to the HealthWave program.

Background on Stairstep Income Thresholds Distinguish Medicaid and SCHIP Eligibility. Eligibility for public health insurance in Kansas can be based on family income, disability, or other specific health care needs, e.g., long-term care or community-based support. Most Medicaid - and all SCHIP - enrollees are eligible solely because of their family's low income. These populations also comprise the vast majority of our HealthWave program. Income-based eligibility in Medicaid and SCHIP is tied to Federal Poverty Levels (FPL). Medicaid covers the poorest Kansas children, while SCHIP covers children with incomes that exceed Medicaid limits but are less than 200% of the FPL. Because Medicaid income thresholds decline with age, the dividing line between Medicaid and SCHIP poverty-related eligibility is commonly referred to as a "stairstep."

- The highest Medicaid income threshold is 150% of the FPL and applies to infants less than one and their pre- and post-partum mothers.
- The next highest Medicaid income threshold is 133% of the FPL and applies to children ages 1 through five.
- The lowest eligibility ceiling for children is 100% of FPL and applies to children ages 6 through 18.
- SCHIP funding is used to provide health coverage for children in each age group above the Medicaid eligibility levels up to 200% of FPL.
- Non-disabled, non-elderly adults are generally not eligible for Medicaid unless pregnant (below 150% FPL) or eligible for cash benefits (parents only below 37% FPL).

Long-run and short-run trends in enrollment

- There has been steady growth in the cash assistance-related (TAF), poverty-related, and disabled populations in Medicaid and SCHIP since July 2003. Most of the increase is comprised of children in Medicaid and SCHIP. The attached charts illustrate the enrollment increases in these populations, and the corresponding cost increases, which have been concentrated in the disabled population.
- The drop in enrollment in Medicaid after July 2006 is due primarily to the new federal citizenship and identification requirements. New applications are not being processed as quickly as before, nor are reviews of existing beneficiaries being completed as quickly. A KHPA Fact Sheet is attached that describes the impact of the citizenship verification requirements on beneficiaries and KHPA operations in more detail.
- SCHIP has generally had smaller and steadier growth than Medicaid. Since the citizenship and identification requirements do not have to be applied to this program, there has been a smaller decline in enrollment since July 2006. Some decline did occur because of the volume of documents and phone calls the Clearinghouse began receiving in July.

Healthy Kansas First Five Proposal

Despite the availability of public programs, and years of outreach effort, there are still today about 48,000 Kansas children under the age of 18 without health insurance. Of those children, about 15,000 are under the age of five, the most formative years when access to prevention-oriented health care is most critical. These estimates pre-date the implementation of the citizenship verification requirements and do not reflect the decline in HealthWave enrollment, and likely increase in the number of uninsured children, associated with those requirements. KHPA is addressing the impact of the citizenship verification requirements in its budget proposal.

As the leading agency on health and health care services, the Kansas Health Policy Authority is committed to providing access to care, especially care that is cost effective for the state in the long term. To help give our children the critical healthy start in life, KHPA proposes expanding access to care for children through the creation of the Healthy Kansas First Five Program. This program would expand health care coverage to children age five and under from low and moderate income families who lack health care insurance by expanding affordable options through the HealthWave program.

This program was introduced last year by Governor Sebelius but not funded by the Legislature. The KHPA Board considers access to care for Kansans a critical component of a coordinated health agenda for Kansas, and this program in particular a high priority this upcoming legislative session.

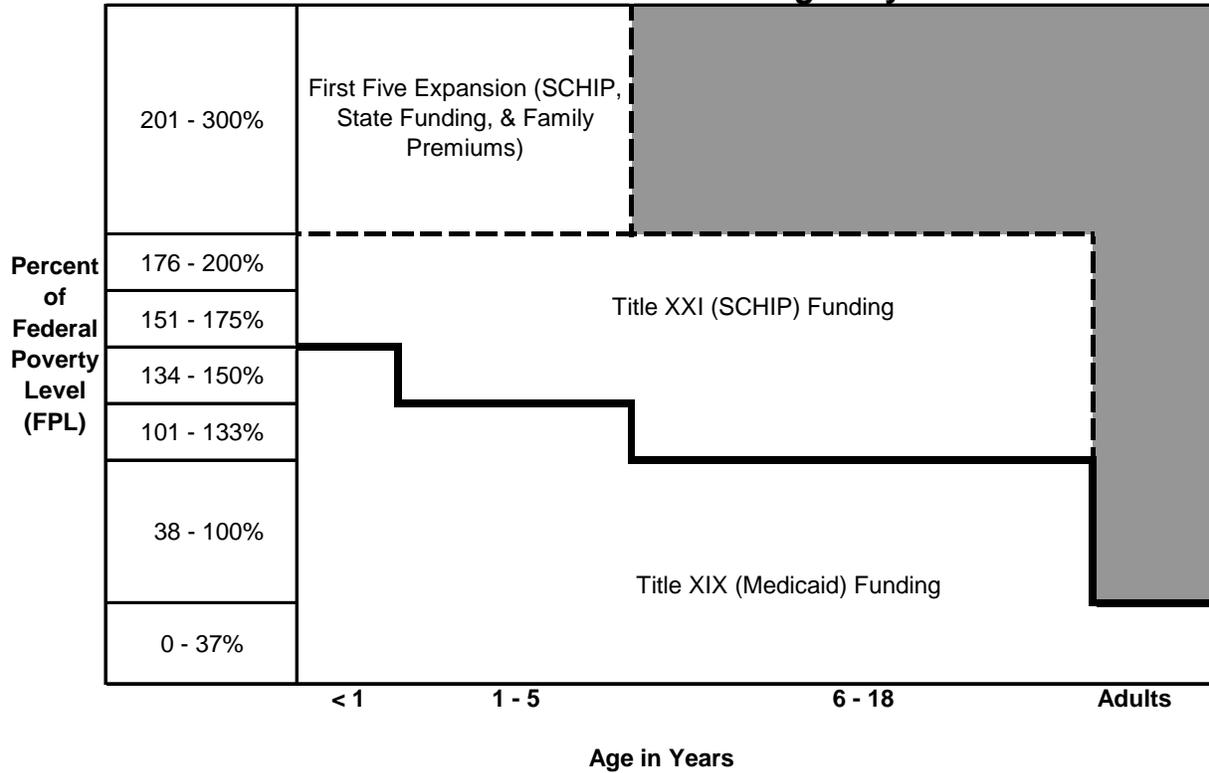
Healthy Kansas First Five is designed to significantly reduce the number of uninsured children below the age of five. It is estimated that 2,000 children would be served in the first year of operation (2008), with additional enrollment expected thereafter.

Healthy Kansas First Five Plan to Expand Thresholds. To provide coverage options for Kansas children under the age of five, KHPA proposes to expand the stairstep income eligibility thresholds in these age ranges.

The upper income limit for the HealthWave program would increase from the current level of 200% of the poverty level (yearly income of approximately \$33,200 for a family of three) to 235% of the poverty level, and to create a state-only funded HealthWave buy-in option for young children in families up to 300% of the poverty level. Both components require families to pay a premium related to their level of income. Above 300% of poverty, families would be allowed to enroll their children at the full actuarial cost of the HealthWave benefit. To remain within Federal spending limits for the HealthWave program, this proposal may require some families with incomes between 133% and 200% of poverty be transferred from HealthWave Title XXI to HealthWave Title XIX coverage. Medicaid eligibility for pregnant women would also be increased to approximately 185% of poverty, increasing expectant mothers' access to prenatal care.

ATTACHMENT 1

HealthWave Income Eligibility



Federal Poverty Level (FPL) for a Household of Three (3)

Percent of Federal Poverty Level (FPL)	Income Thresholds
300%	\$49,800
235%	\$39,010
200%	\$33,200
175%	\$29,050
150%	\$24,900
133%	\$22,078
100%	\$16,600

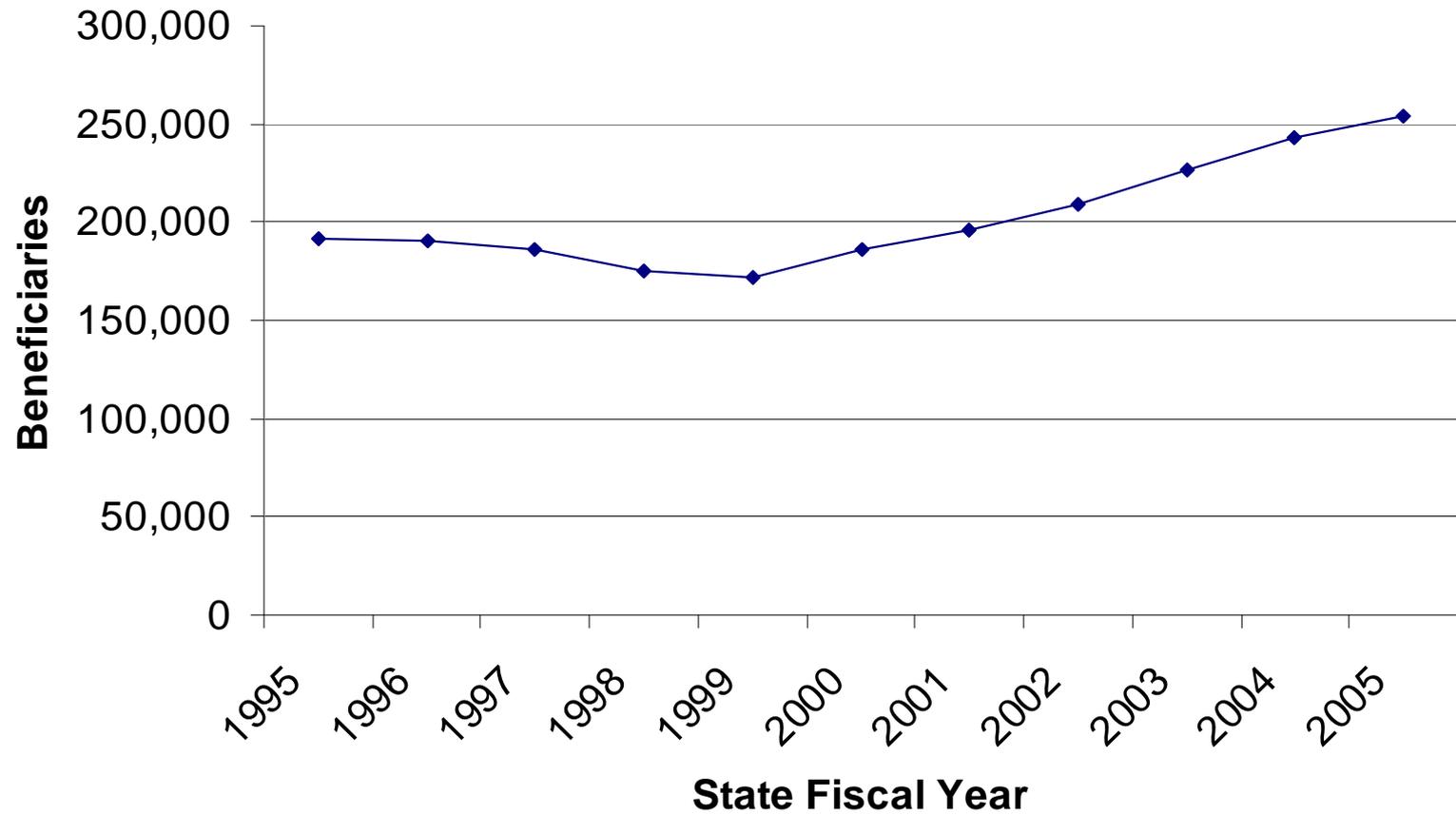


Medicaid and SCHIP Eligibility Historical Trends

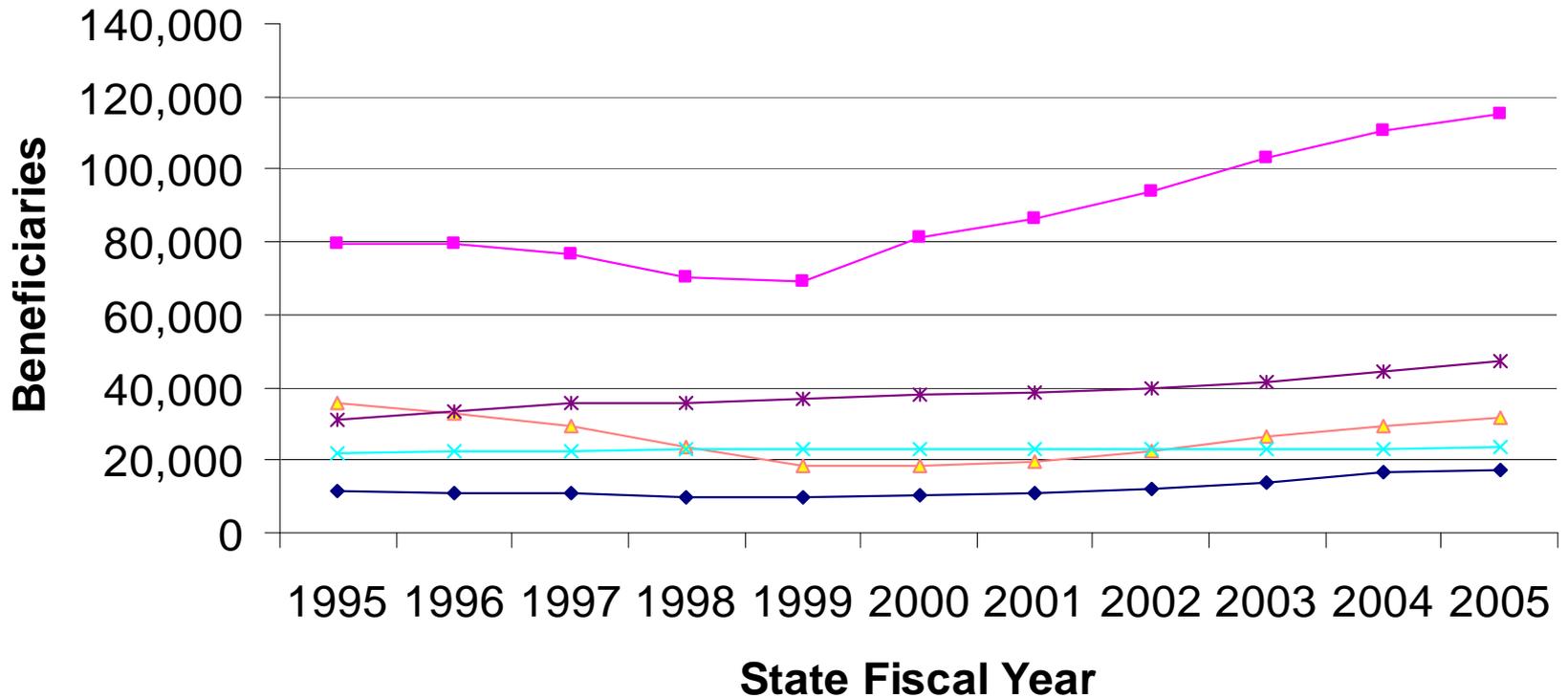
Marcia J. Nielsen, PhD, MPH

Andrew Allison, PhD

All Kansas Medicaid Beneficiaries

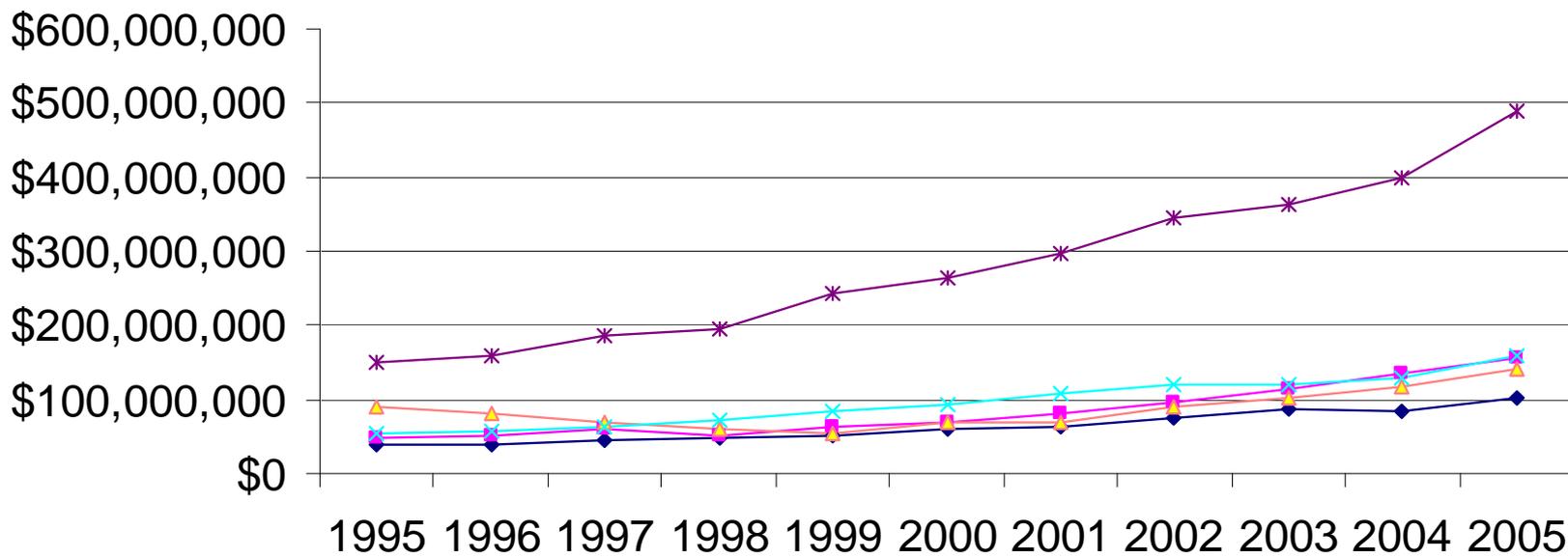


Kansas Medicaid Populations Groups



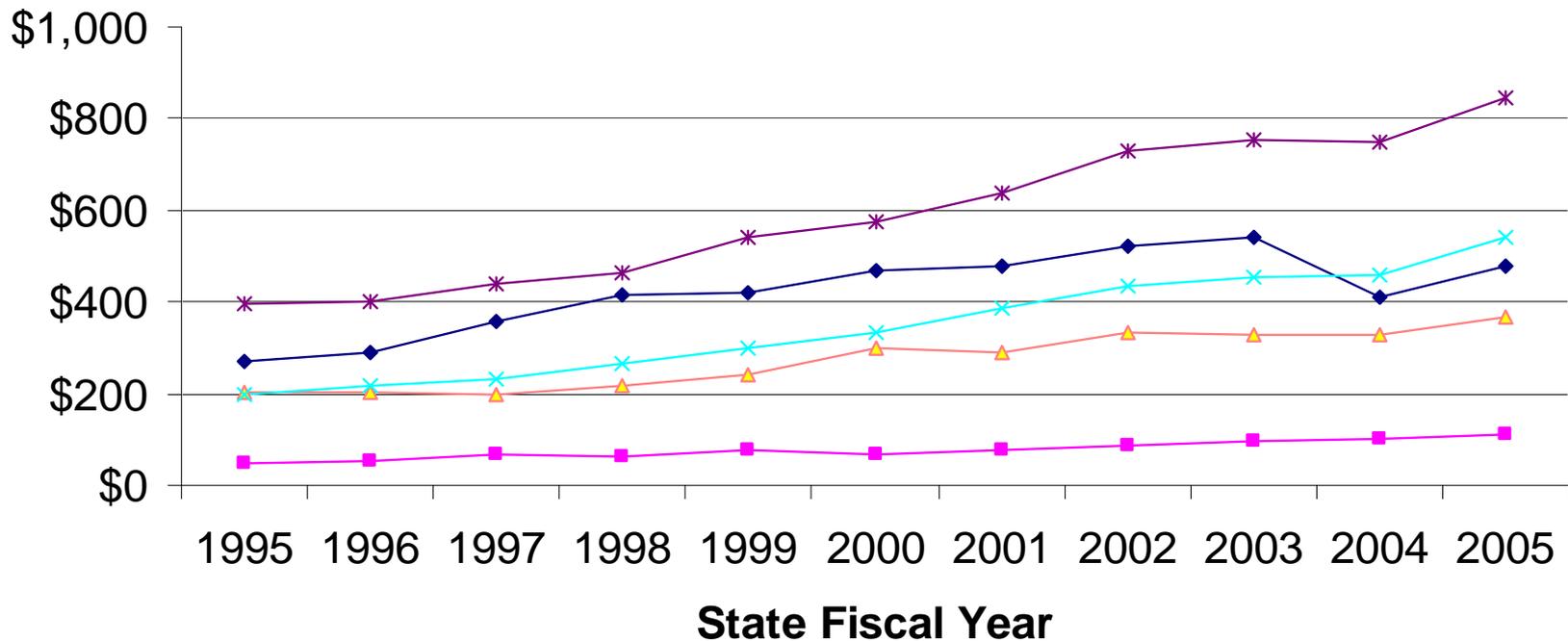
◆ Infants ■ Children ▲ Adults × Aged * Disabled

Kansas Regular Medical Medicaid Expenditures by Population Groups Excluding LTC

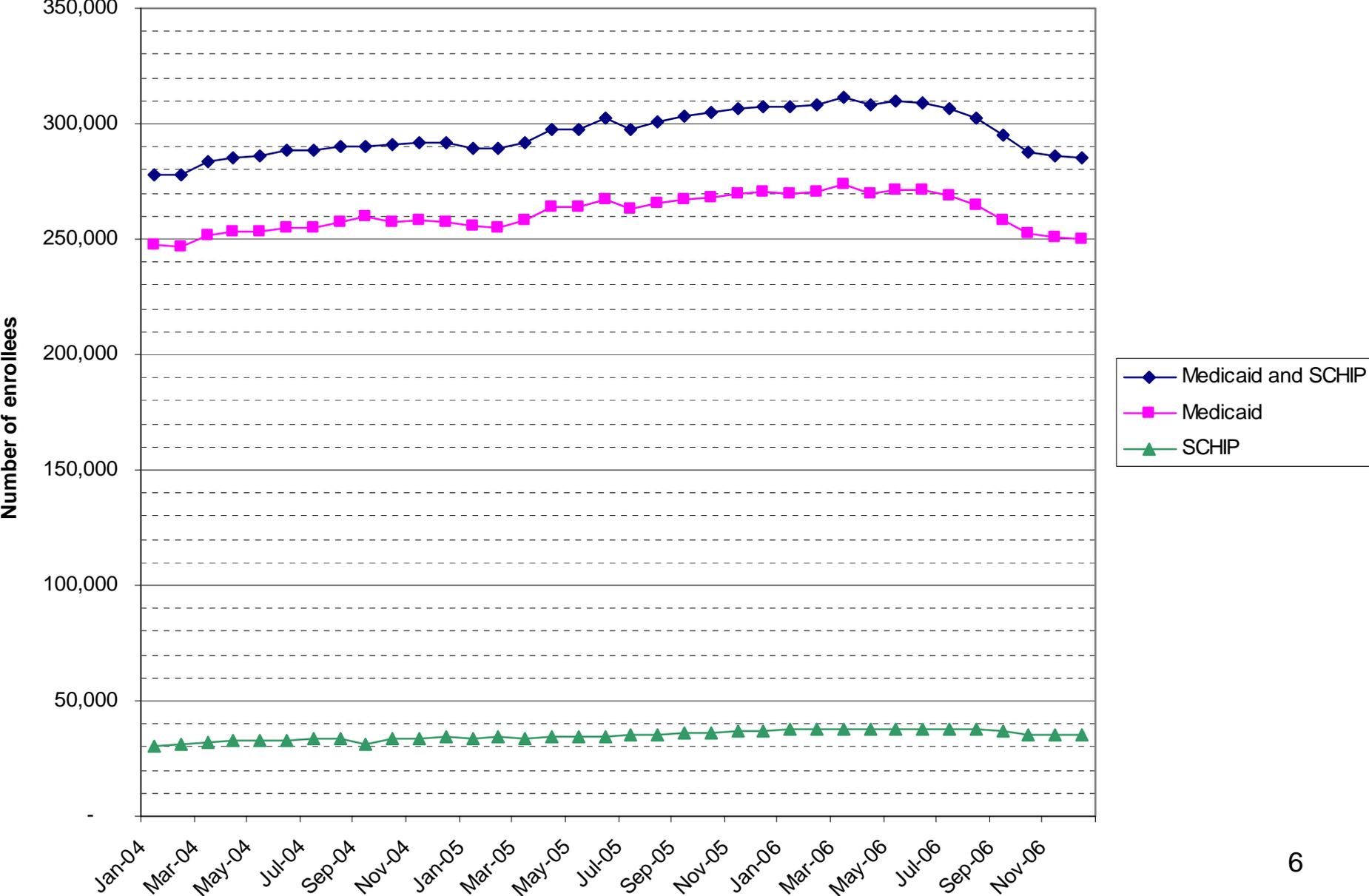


Infants
 Children
 Adults
 Aged
 Disabled

Regular Medical Medicaid Expenditures Per Person Per Month per Population Group

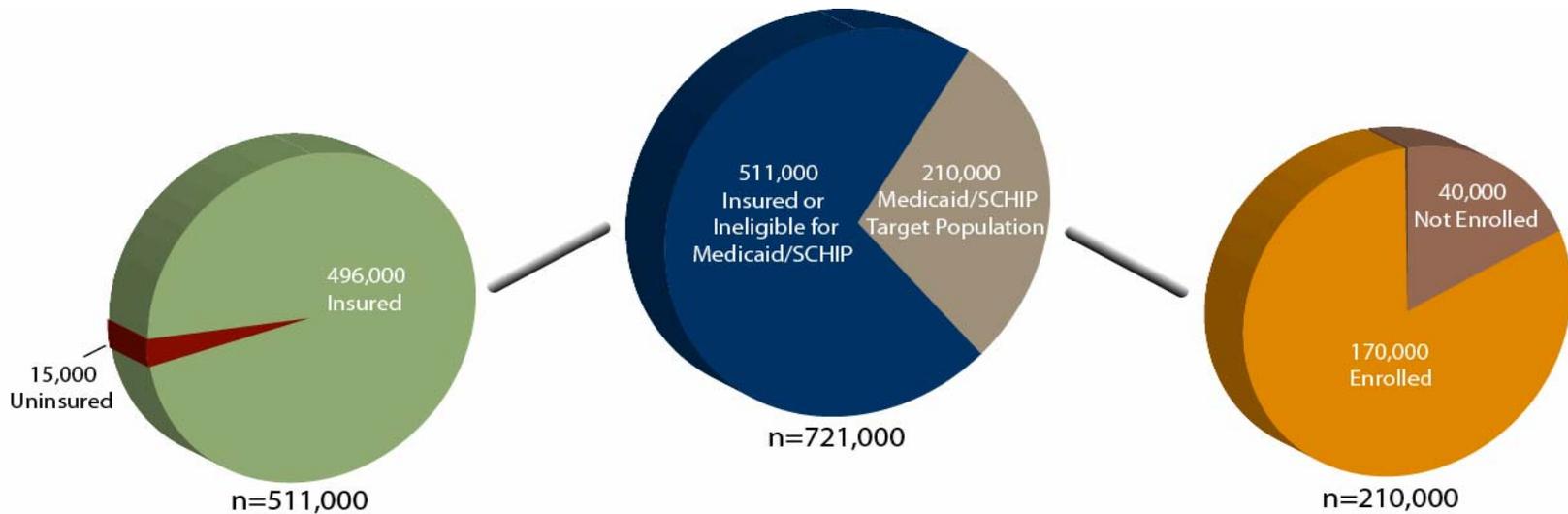


Enrollment in Medicaid and SCHIP: FY 2004-2007



Health Insurance Status of Kansas Children

Kansas Children Under the Age of 19



Insured or Ineligible for Medicaid/SCHIP

Medicaid/SCHIP Target Population

- Kansas Medicaid/SCHIP programs insure 81 percent of target population



House Health Task Force

January 31 2007

Marcia J Nielsen PhD MPH
Executive Director, Kansas Health Policy Authority

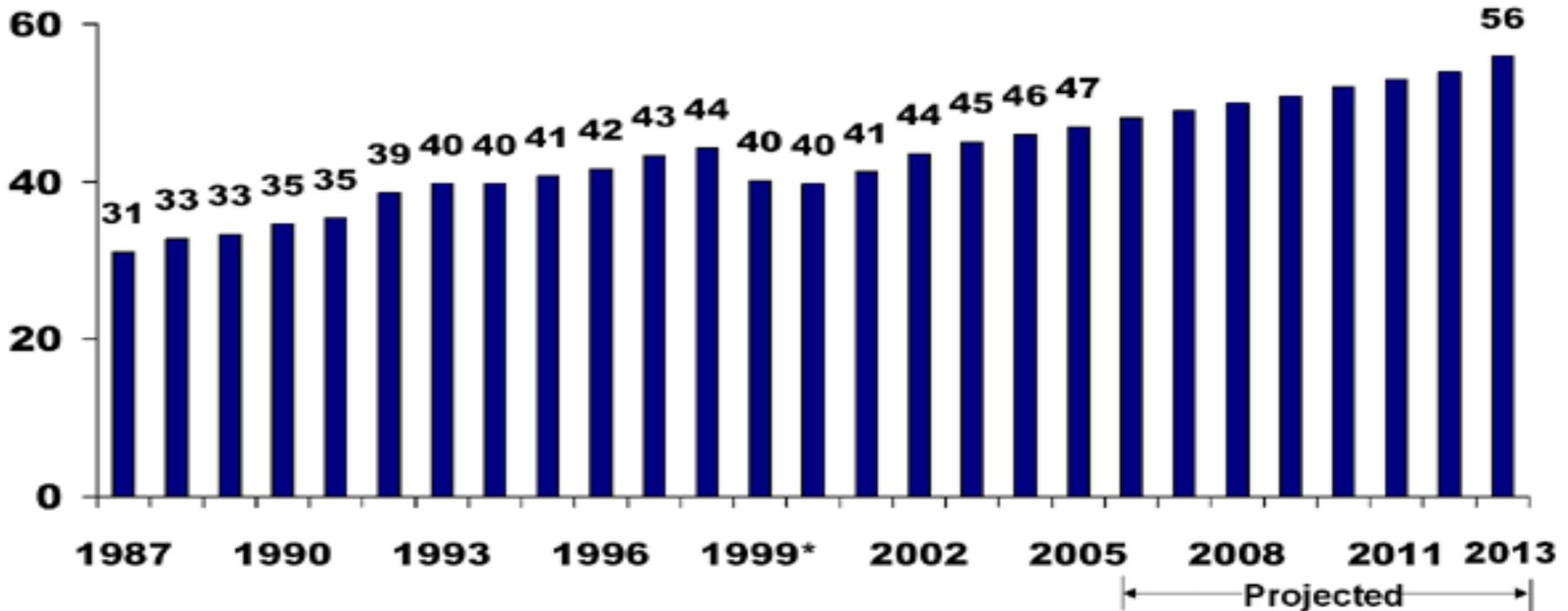
Challenges.....

A Failing National Health "System"

Rising Rates of Uninsured

**Figure 4. 47 Million Uninsured in 2005;
Increasing Steadily Since 2000**

Number of uninsured, in millions



*1999–2003 estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.

Note: Projected estimates for 2006–2013 are for nonelderly uninsured based on T. Gilmer and R. Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs* Web Exclusive, Apr. 5, 2005.

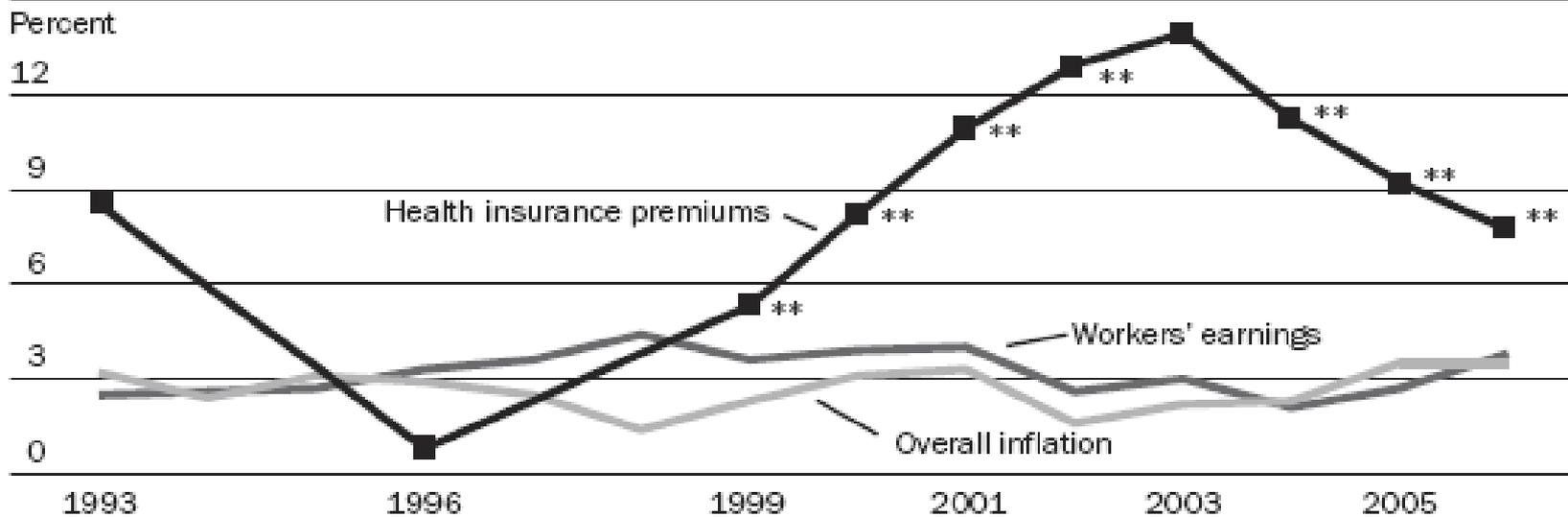
Source: U.S. Census Bureau, March CPS Surveys 1988 to 2005.



Insurance Affordability

EXHIBIT 1

Increases In Health Insurance Premiums Compared With Other Economic Indicators, 1993-2006



SOURCES: Premiums: Henry J. Kaiser Family Foundation/Health Research and Educational Trust Survey of Employersponsored Health Benefits, 1999-2006, and KPMG Survey of Employersponsored Health Benefits, 1993 and 1996. Inflation: Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation, April to April), 1993-2006. Earnings: Bureau of Labor Statistics, seasonally adjusted data from the Current Employment Statistics Survey (April to April), 1993-2006.

NOTES: Data on premium increases reflect the cost of health insurance premiums for a family of four. Data are weighted by covered workers. Statistical significance indicators denote that premium estimates are statistically different from the estimate for the previous year shown.

** $p < .05$

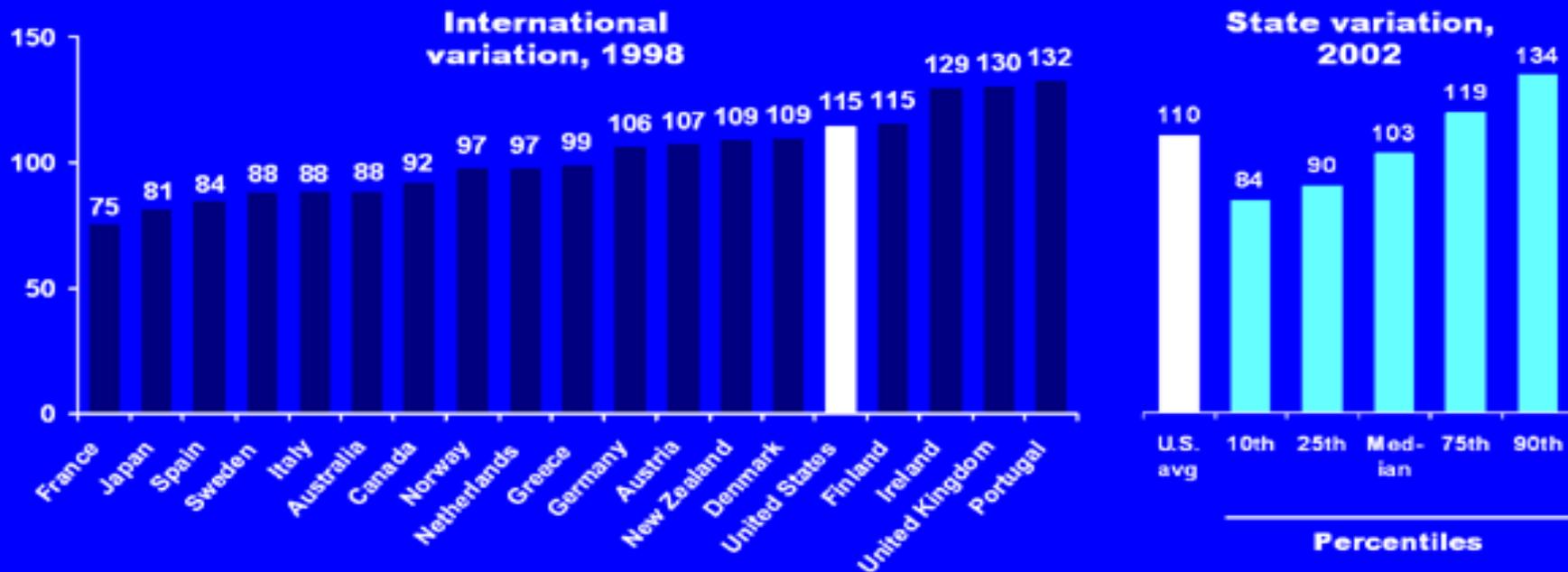
Getting what we pay for?

LONG, HEALTHY & PRODUCTIVE LIVES

Mortality Amenable to Health Care

Mortality from causes considered amenable to health care is deaths before age 75 that are potentially preventable with timely and appropriate medical care

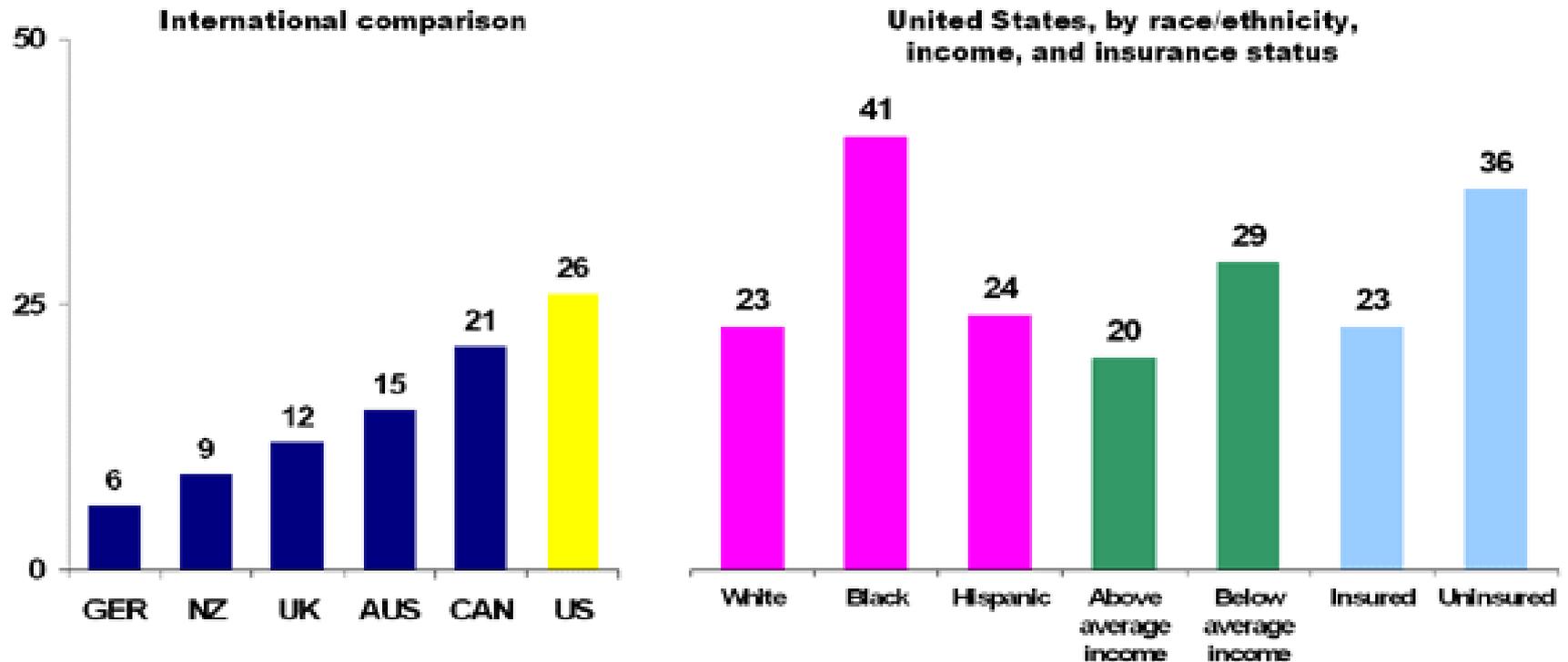
Deaths per 100,000 population*



* Countries' age-standardized death rates, ages 0–74; includes ischemic heart disease. See Technical Appendix for list of conditions considered amenable to health care in the analysis. Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003); State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.

Went to ER for Condition That Could Have Been Treated by Regular Doctor, Among Sicker Adults, 2005

Percent of adults who went to ER in past two years for condition that could have been treated by regular doctor if available



GER=Germany; NZ=New Zealand; UK=United Kingdom; AUS=Australia; CAN=Canada; US=United States.
 Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults;
 Schoen et al. 2005a.



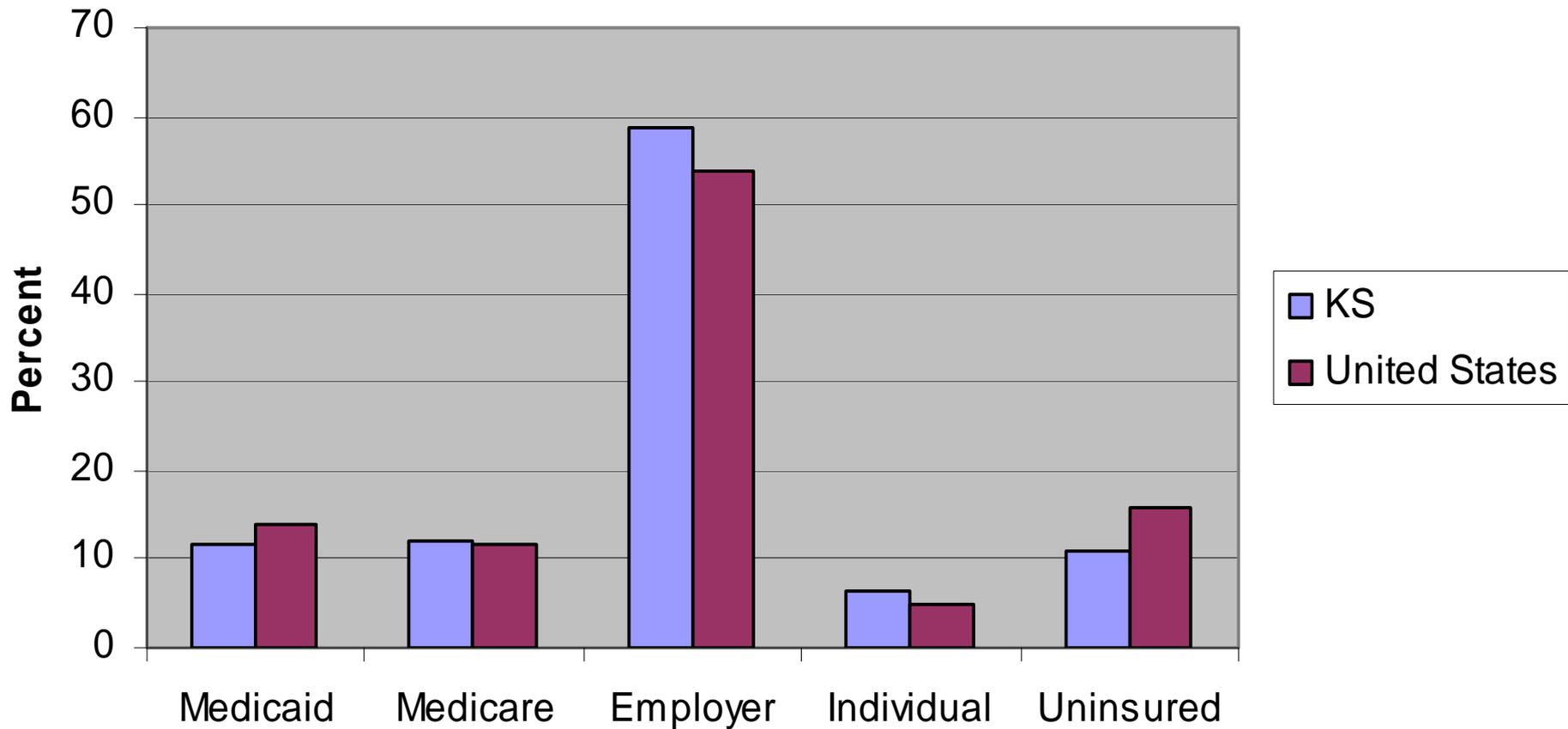
What are states trying?

- ***Moving toward Universal Coverage:***
 - Massachusetts, California, Iowa, Minnesota, Kansas?
- ***Premium assistance programs:***
 - States subsidies to low-income uninsured individuals to purchase private insurance;
- ***New insurance products:***
 - High Deductible/Consumer Driven Plans: Extends more affordable coverage to small businesses, self-employed individuals;
- ***Tax credits:***
 - For small businesses who offer health care and contribute toward employees' health insurance expenses;
- ***Children's health coverage:***
 - Expansion through both SCHIP program and innovative 1115 waivers;
- ***Access to community health centers:***
 - As an alternative, non-emergent care option for uninsured populations seeking primary care services.

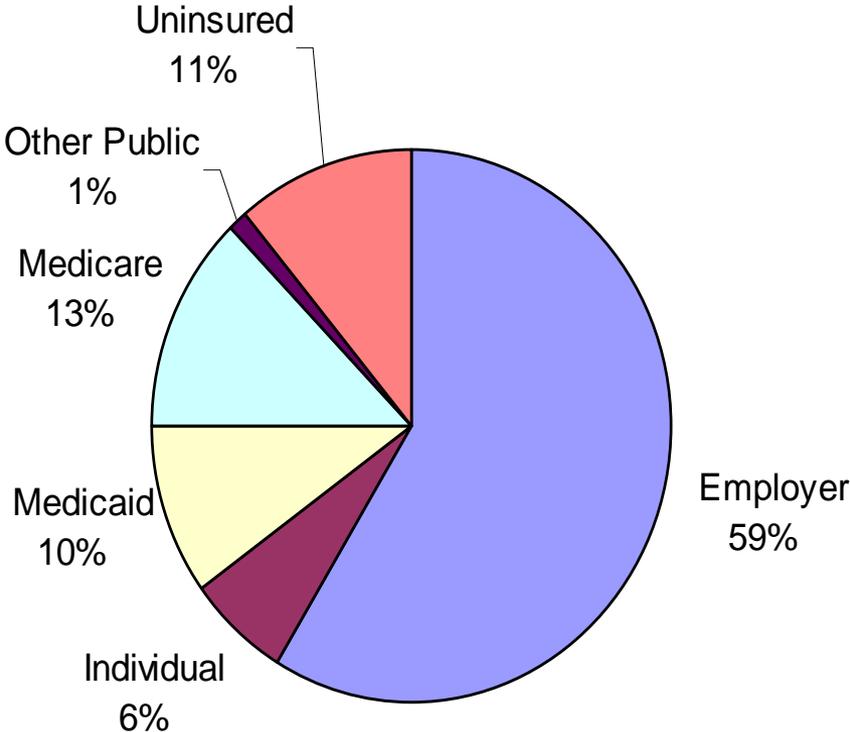
State leadership, but...

- “Laboratories of Democracy” for innovative reform, but...
- Must have for federal assistance with
 - Health insurance reform (ERISA pre-emption)
 - Cost containment strategies
 - Growing cost of Medicaid (Long Term Care) as population ages
 - Standards for HIT/HIE interoperability
 - Resolving “Border Issues”

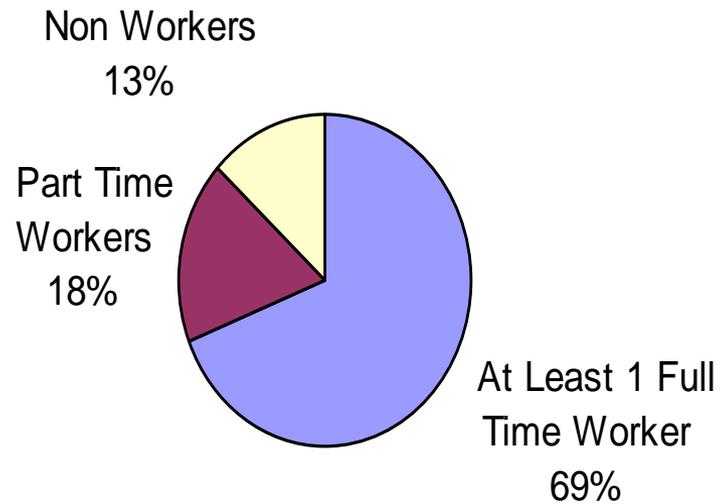
Where Kansans gets health care coverage



Health Insurance Status in Kansas

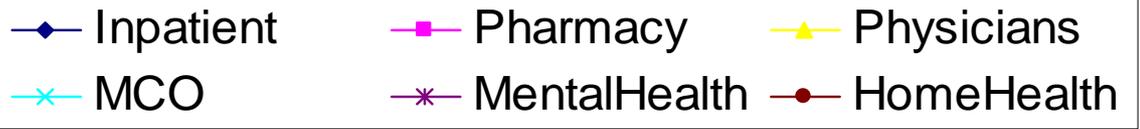
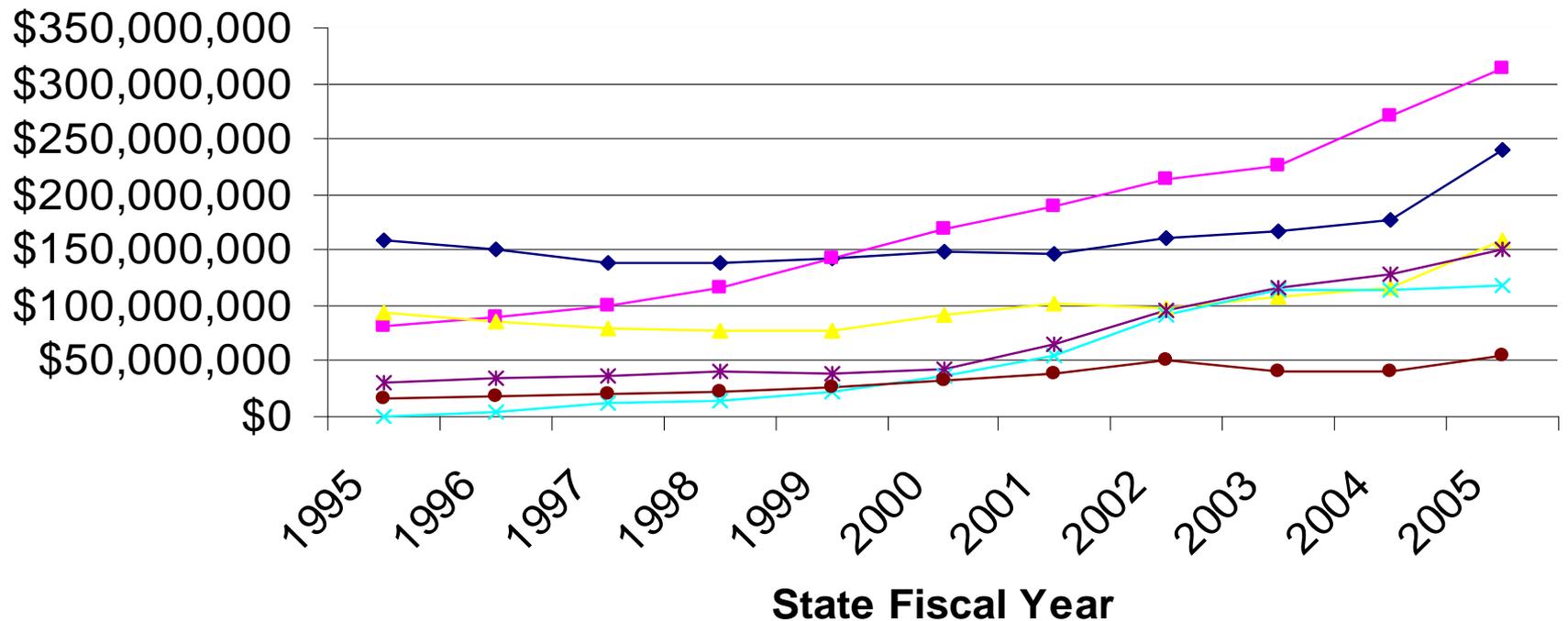


Uninsured in Kansas by Insurance Status

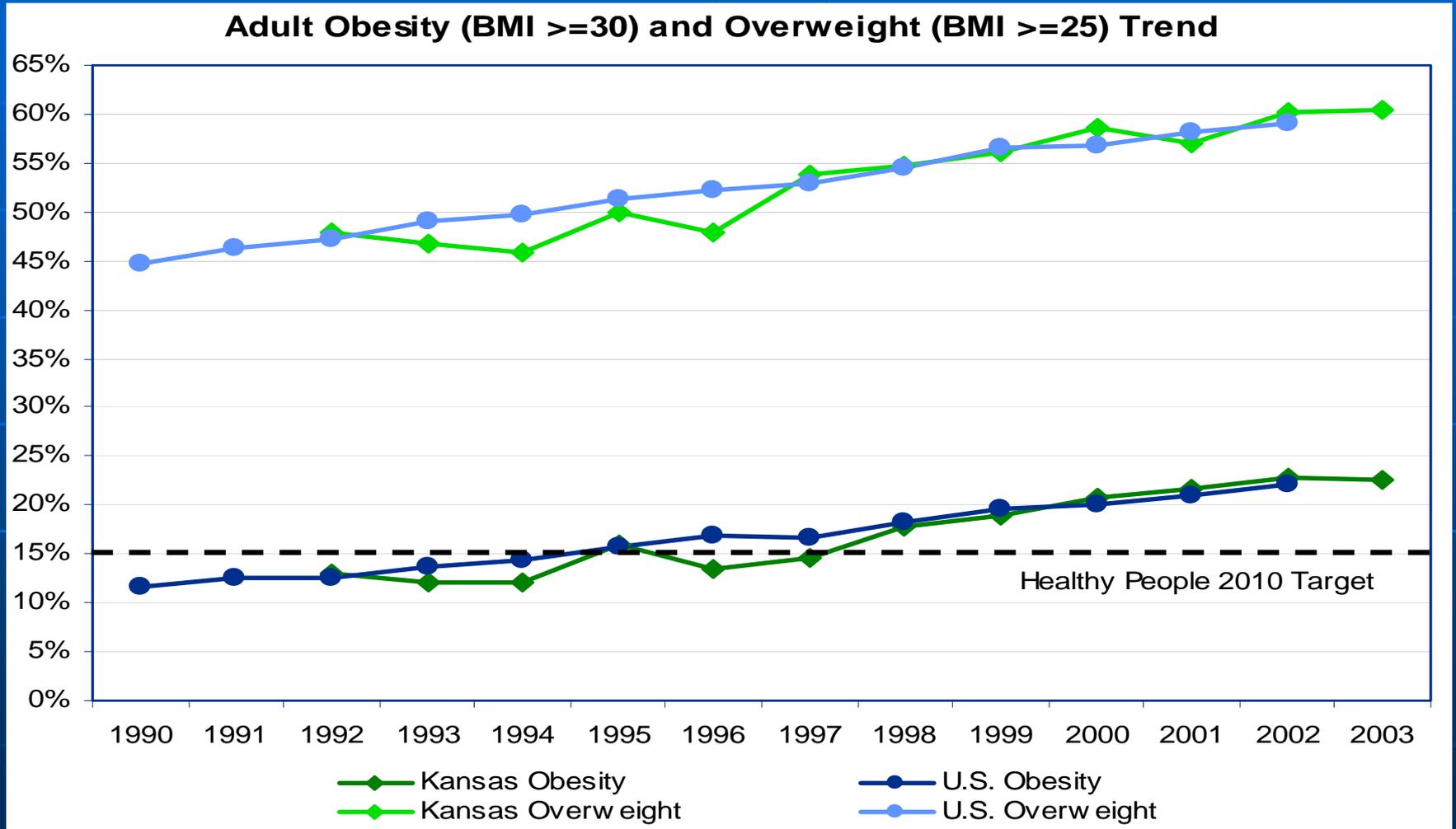


Expenditures by Service

Six Largest Regular Medical Expenditures including Certified Match

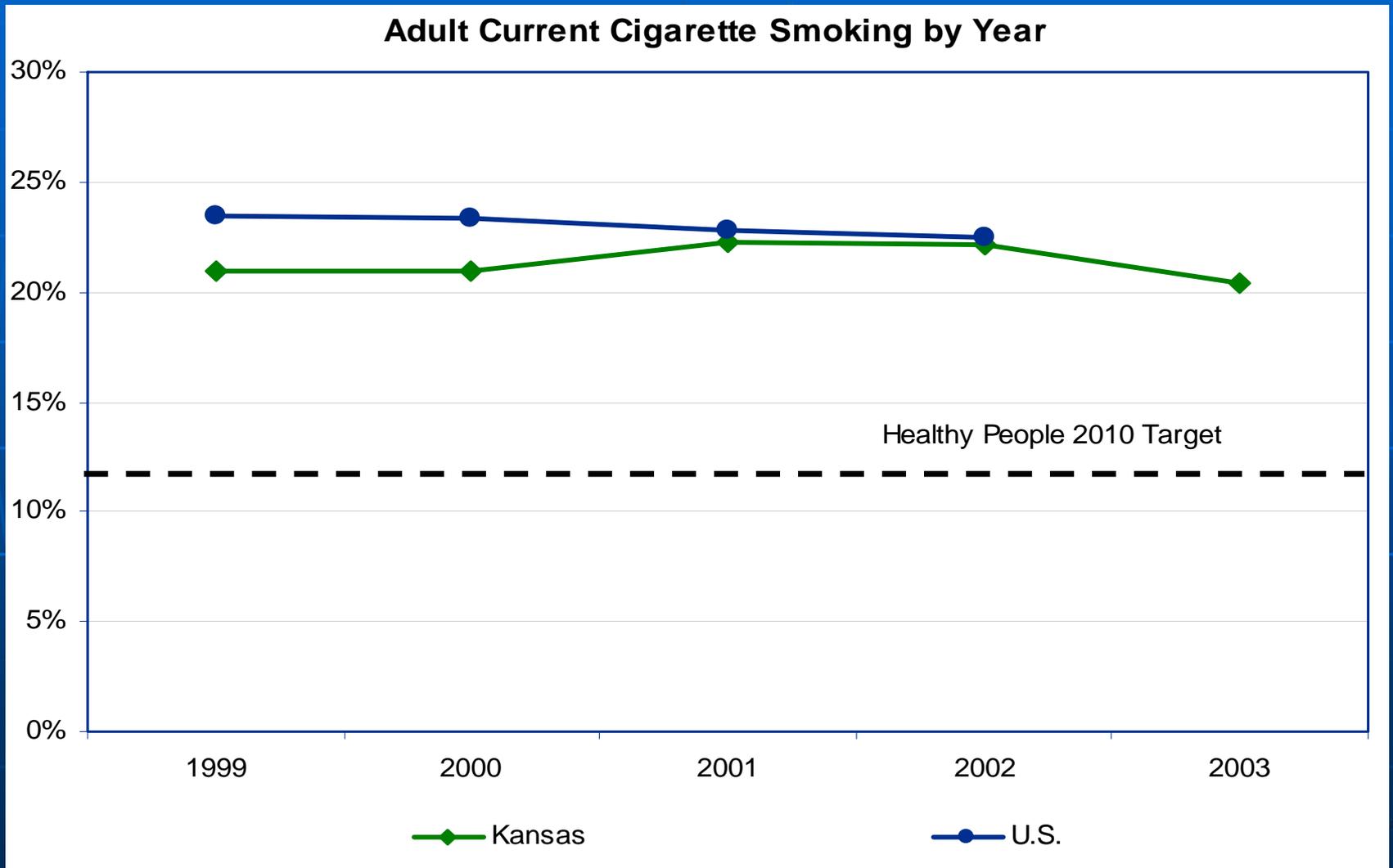


Overweight & Obesity, Selected Trend Data



Source: Leading Health Indicators, Health Kansas 2010, May 12, 2005

Tobacco Use, Selected Data



Source: Leading Health Indicators, Health Kansas 2010, May 12, 2005

Where is KHPA going in the future?





Vision Principles

- Adopted by the KHPA Board
- Will provide direction to the Board as they and this agency develops and maintains a coordinated health policy agenda
- Guiding framework of the Board and the work the Agency intends to accomplish

Access to Care

Kansans should have access to patient-centered health care and public health services which ensure the right care, at the right time, and the right place.

- Indicators:
 - (1) Health insurance status;
 - (2) Health professions workforce;
 - (3) Safety net stability;
 - (4) Medicaid eligibility;
 - (5) Health disparities.

Quality and Efficiency

The delivery of care in Kansas should emphasize positive outcomes, safety and efficiency and be based on best practices and evidence-based medicine.

- Indicators:
- (1) Use of Health Information Technology/Health Information Exchange;
- (2) Patient Safety;
- (3) Evidence based care;
- (4) Quality of care;
- (5) Transparency (of cost and quality of health information).

Affordable & Sustainable Health Care

The financing of health care and health promotion in Kansas should be equitable, seamless, and sustainable for consumers, providers, purchasers, and government.

- Indicators:
- (1) Health insurance premiums;
- (2) Cost sharing by consumers;
- (3) Uncompensated care;
- (4) Medicaid and SCHIP enrollment;
- (5) Health and health care spending.

Health and Wellness

Kansans should pursue healthy lifestyles with a focus on wellness as well as a focus on the informed use of health services over their life course.

- Indicators:
- (1) Physical fitness;
- (2) Nutrition;
- (3) Age appropriate screening;
- (4) Tobacco control;
- (5) Injury control.

Responsible Stewardship

The KHPA will administer the resources entrusted to us by the citizens and the State with the highest level of integrity, responsibility and transparency.

- Indicators:
- (1) Open decision making;
- (2) Responsible spending;
- (3) Financial reporting;
- (4) Accessibility of information;
- (5) Cooperation with the Centers for Medicare and Medicaid Services – our federal partners for the Medicaid and S-CHIP programs

Education & Engagement of the Public

Kansans should be educated about health and health care delivery to encourage public engagement in developing an improved health system for all.

- Indicators:
- (1) Advisory Council Participation;
- (2) Data Consortium Participation;
- (3) Public communication;
- (4) Community/Stakeholder/Advocacy Partnership;
- (5) Foundation Engagement.

Additional Information

- Dr. Andrew Allison
 - Kansas Medicaid and SCHIP Program Program
 - Kansas Medicaid Waivers
 - Resources in packet
- Website: www.khpa.ks.gov
- Question and Answer Session



VISIT US ON THE WEB

<http://www.khpa.ks.gov/>

Fact sheet on Deficit Reduction Act requirements for citizenship and identity

Kansans of all ages need health coverage. Unfortunately, in the past six months, between 18,000 and 20,000 Kansans have lost their Medicaid benefits due to the state's compliance with a new federal law, which became effective July 1, 2006, that requires many Medicaid applicants to provide documentation verifying their citizenship and identity. These new requirements, additional work now required for both applicants and state eligibility workers, and the abbreviated implementation timeframe dictated by the Federal government have created a barrier to coverage for both Medicaid and State Children's Health Insurance Program (SCHIP) eligible individuals. KHPA staff have re-engineered enrollment and utilized electronic verification where appropriate, but will not be able to address the new workload without additional resources. Even after resources are made available, the new requirements may have a negative impact on coverage for eligible Kansans. KHPA is recommending that Congress revisit the legislation to consider the impact on states and beneficiaries.

Impact on beneficiaries

How have beneficiaries been affected?

- Significantly increased time and other costs of applying for Medicaid benefits have affected beneficiaries. Although KHPA has made arrangements to electronically "match" with Kansas state birth certificate records, many applicants who were born out of state report the need to purchase and wait for their birth records to be sent by mail.
- Those denied coverage or who are waiting for their applications to be reviewed may experience increased out-of-pocket health costs and reduced access to service.
 - Research clearly indicates that the uninsured have a harder time accessing health care services than those with Medicaid coverage.
 - Those who are uninsured as a result of the new laws may be required to purchase medical services using grocery money or other scarce resources, or to incur medical debt that could otherwise have been avoided.
 - Applicants in Kansas have shared numerous personal stories with the Clearinghouse over the last six months that validate these concerns:
 - A woman who applied for benefits for her and her child two months ago, has still not heard back on whether they are insured. Now, her child is sick.
 - After applying for Medicaid several months ago, a pregnant mother has not yet received her Medicaid card. The baby is due soon and her doctor is now billing her.
 - One family moved from Iowa and is struggling to get their son medication for his extreme case of ADHD. An Iowa doctor sent the prescription twice and asked a pharmacy to pay, but he will no longer fill the prescription and the family cannot get the son into a doctor without HealthWave coverage. The school reports that the son is spending more time in the principal's office than in the classroom because he is not getting his medication.

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How has caseload been affected?

- The number of individuals enrolled in Kansas Medicaid or SCHIP has fallen significantly since the requirements went into effect. Caseload in the two programs combined was 308,994 in June 2006 and 285,134 in January 2006. We estimate that 18,000-20,000 of this decline is a direct result of the new verification requirements.
- Of this drop, 2,381 individuals are those whose applications or renewal cases have been closed because they could not provide the newly required documents in a timely fashion.
- Another 16,000 or more are waiting to enroll in the program, or have fallen off the program while waiting to be re-enrolled, as a result of the large backlog of cases the new requirements have created.
- Many of those waiting to be enrolled are eligible citizens. Recent experience indicates that the majority of children and families with pending applications will qualify for coverage under the new requirements when we are able to complete processing.

How have other states been affected by these new requirements?

- Since Kansas first reported on the impact of the new requirements in November, other States across the country have reported similar difficulties.
- Virginia has seen about 12,000 children who have been dropped from the state's Medicaid caseload since July 1, 2006. Iowa, Louisiana, New Hampshire and Wisconsin have experienced similar decreases.
- Like Kansas, Iowa reports the impact of the requirements on eligible citizens who need Medicaid benefits and are not able to obtain coverage.

Caused by new documentation requirements and overworked enrollment process

What are the new documentation requirements?

- The new Federal laws, effective July 1st, do not change eligibility rules but instead require applicants to provide certain documents verifying that they comply with rules governing citizenship and identity. States were notified of this new requirement on June 9, 2006 and the interim final rule was published in the federal register on July 12, 2006.
 - Citizenship: Medicaid eligibility has long been restricted to American citizens and certain legal immigrants such as refugee.
 - Identity: identity isn't an eligibility requirement, per se, but individuals and parents are required to apply on behalf of themselves and their children. In addition, applicants already must provide social security numbers and documentation of family income.
- The new laws require applicants, including those renewing their eligibility, to document citizenship and identity through one of the following criteria:
 - A *primary* document that verifies both citizenship and identity, such as a passport or certificate of naturalization; or
 - Separate *secondary* documents, one verifying citizenship, such as a birth certificate, and another verifying identity, such as a driver's license or school picture ID.

How have the new federal requirements impacted the enrollment process in Kansas?

- The Kansas Family Medical Clearinghouse, which handles about 85% of applications from children and families, receives about 9,500 applications or renewals each month representing about 35,000 individuals, each required to provide at least one new document.
- The number of customer service calls to the Clearinghouse has more than doubled from 23,000 to 49,000 per month.
- The number of voicemails received has increased tenfold from 1,200 to 11,000 per month.
- The number of faxes received has doubled to 6,000.
- Collecting, matching, and verifying these documents have increased the average amount of time required to

complete an application.

Who is being affected by these new rules?

- The new rules apply to all Medicaid applicants and beneficiaries EXCEPT Medicare beneficiaries and those individuals receiving Supplemental Security Income (SSI). Recent federal law changes have also provided additional exemptions to those receiving Social Security Disability benefits and most youth in foster care or receiving adoption support.
- The primary impact of the new requirements is on children and families.
- To one extent or another, all Medicaid applicants may be affected.
 - Applicants who are unable to provide the required documentation in a timely manner are denied coverage.
 - Many applicants – especially children and families -- end up in the backlog that has developed since the new requirements were introduced. These applicants may or may not meet the documentation requirements, but in the meantime experience delays in the application process.
 - Disabled applicants who are not qualified for Medicare or SSI must comply with the new requirements, including children receiving home and community-based services, children needing institutional care, and adults applying for medical assistance through the Presumptive Medical Disability process, many of whom have a mental illness.
 - Because the vast majority of seniors age 65 and over receive Medicare, very few elderly are affected.

We anticipate hospital emergency rooms and other health care providers will bear some of the costs associated with uninsured applicants – especially for pregnant women who have been unable to enroll in Medicaid.

Steps being taken to mitigate the problem

What are the budgetary costs of the new requirements for the state of Kansas?

- In order to meet the new administrative burdens and mitigate the resulting impact on applicants, the KHPA is requesting an additional \$1 million in funding for FY 2007 and FY 2008 for the operation of its enrollment clearinghouse.
- These funds will be used by the enrollment contractor to hire 17 new contract staff to work through the backlog of pending applications, reduce waiting times and return eligible applicants to the program.
- KHPA is also requesting to hire an additional 4 state staff in FY 2007 and FY 2008 to address additional volume-related issues at the Clearinghouse, not related to the new citizenship requirements.

What measures are being taken to reduce the impact on beneficiaries?

- Resources at the Clearinghouse have been reallocated and enrollment processing has been adjusted to accommodate the new documentation requirements.
- KHPA is utilizing approved and reliable electronic sources of documentation, including the state's birth and immunization registries.
- KHPA will also be calling on our Congressional delegation to provide an update on the impact of these new laws, to suggest policy alternatives, and to recommend a Congressional review of the legislation.

(Rev 1-19-07)

Services for People with Developmental Disabilities

Persons with a developmental disability (DD) can access services through a locally managed system of community service providers. The Community Developmental Disability Organization (CDDO) serves as the local system manager and gate keeper.

Developmental Disabilities Waiver

Kansans of all ages who have a Developmental Disability and are Medicaid eligible can receive community-based day and residential services through the DD waiver program. The DD waiver makes medicaid funded services available for individuals in their home communities who otherwise would be eligible for placement in an intermediate care facility. CDDOs (see provider list, page 63) work with community service providers (CSPs) to deliver these services.

Developmental Disabilities Waiver

Average Monthly Persons	6,262
Actual Expenditures---SFY 2006*	\$224,500,734
State General Funds	\$88,557,196

*FY 06 expenditures includes FY 06 expenses paid in FY 07

Community and Family Services and Supports

Persons with developmental disabilities not eligible for the DD waiver may still receive some services. These services include day activities such as employment or general living assistance in the person's home and community. The state provides funds to CDDOs to assist them in covering the cost of services provided to individuals with DD in their geographical area. Families may also receive limited direct financial support through a family subsidy to defray costs associated with a child with special needs.

Community and Family Services Supports

Total Persons Served---SFY 2006	2,563
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DD Grants

Actual Expenditures---SFY 2006	\$19,022,447
State General Funds	\$12,779,599

Targeted Case Management--Medicaid

Average Monthly Persons	8,099
Actual Expenditures---SFY 2006*	\$26,228,535
State General Funds	\$1,214,234

*FY 06 expenditures includes FY 06 expenses paid in FY 07

Positive Behavior Supports---Medicaid

Average Monthly Persons	22
Actual Expenditures--SFY 2006*	\$189,425
State General Funds	69,673

*FY 06 expenditures includes FY 06 expenses paid in FY 07

Private Intermediate Care Facilities ICF/MR

These residential facilities are designed for Kansans with DD who need continuous, intensive services. These privately operated programs are funded by Medicaid. They are categorized as small (eight or fewer individuals), medium (nine to 15 individuals) or large (16 or more individuals). These facilities work closely with the CDDOs to arrange supports and services in the community when the person is ready to live more independently.

Private Intermediate Care Facilities ICF/MR

Average Monthly Persons	263
Actual Expenditures---SFY 2006*	\$17,610,104
State General Funds	\$6,933,408

*FY 06 expenditures includes FY 06 expenses paid in FY 07

State Mental Retardation Hospitals

Kansas currently has two state operated hospital based residential facilities for persons with MR or DD requiring specialized treatment. The individuals who reside at the Kansas Neurological Institute (KNI) and Parsons State Hospital and Training Center (PSH) receive training, as well as daily living assistance. These facilities work closely with the CDDOs to arrange supports and services in the community when the person is ready to live more independently.

Kansas Neurological Institute

Average Daily Census---SFY 2006	166
Actual Expenditures---SFY 2006	\$27,109,432

Parsons State Hospital

Average Daily Census---SFY 2006	198
Actual Expenditures---SFY 2006	\$23,038,105

Frequently Asked Questions

“How does a person with a developmental disability or a family with a child that has a developmental disability get services?”

The first step is to go to the CDDO responsible for the area in which the person lives. There are 27 CDDOs covering all 105 Kansas counties (see provider list, page 63). Kansas law makes CDDOs the single point of entry into the DD service system. They determine who is eligible for DD services within available resources. If funds are available, the CDDO is responsible to serve or arrange to serve eligible persons needing services in their area. If funding is not available, the individual is placed on a waiting list managed through the local CDDO. Individuals and families may choose their actual community service provider.

“What services are available under the DD waiver?”

Services provided include: residential services, day services, medical alert, wellness monitoring, family and individual supports, and environmental and adaptive equipment.

“I’m concerned about the quality of service provided. Who can I contact?”

All CDDOs are required to make sure the services provided by community service providers (CSPs) are of good quality, meet individual needs, and are responsive to the choices of the person with DD. The CDDO must provide on-site monitoring of these requirements by a local Quality Assurance (QA) committee made up of persons served, their families, guardians, interested citizens, and providers.

“In general, how are services paid for?”

Services are paid for from many different sources. Reimbursement for services is generally based on a predetermined tiered rate which is derived from the average level of severity of disability. Some services are paid for with state dollars, while others are paid for with a combination of state and federal dollars. Some may be funded by local county dollars, while others are paid for by the individual being served.

Services for People with Physical Disabilities

A number of support programs funded with state and federal Medicaid funds are available in the community to provide assistance to persons with physical disabilities.

Grants to Centers for Independent Living

The Centers for Independent Living (CILs) (see provider list, page 56) use grant funds to provide the following core services: information and referral, independent living skills training, peer counseling, and individual and systems advocacy. The CILs added a fifth core service, deinstitutionalization, that assists persons transitioning from nursing facilities to community-based services.

Grants to Centers for Independent Living

Average Monthly Persons	1,000
Actual Expenditures---SFY 2006	\$1,294,799
State General Funds	\$121,875
Fee Funds	\$839,227

Physically Disabled Waiver

The Home and Community-Based Service waiver for persons with a physical disability (HCBS/PD waiver) serves Kansans aged 16 to 64 years who have a physical disability (as determined by Social Security standards) and who are Medicaid eligible. The waiver redirects Medicaid funding, which would have provided nursing facility assistance, to community-based services. Services to persons on the PD waiver are provided through Centers for Independent Living (CILS) and licensed home health agencies. A current HCBS/PD waiver consumer may, before their 65th birthday, choose to remain on the HCBS/PD waiver, or they may choose to transition to the HCBS/Frail Elderly (HCBS/FE) waiver. Services to persons aged 65 years and older are provided through the HCBS/FE waiver administered by the Kansas Department on Aging.

Physically Disabled Waiver (age 16-64)

Average Monthly Persons	5,533
Actual Expenditures---SFY 2006*	\$83,243,298
State General Funds	\$32,704,513
Fee Funds	\$130,028

*FY 06 expenditure includes FY 06 expenses paid in FY 07

Traumatic Brain Injury Waiver

The Traumatic Brain Injury (TBI) waiver serves Kansans age 16-65 who have an injury to the brain caused by an external physical force, such as blunt or penetrating trauma, and who are Medicaid eligible. The waiver redirects Medicaid funding that would have been used for an individual's care in a brain injury rehabilitation facility to support community based services. People who receive services on this waiver may continue coverage until it is determined that they are no longer making progress in attaining independent living skills.

Services for People with Physical Disabilities Continued

Traumatic Brain Injury Waiver (age 16-65)

Average Monthly Persons	168
Actual Expenditures---SFY 2006*	\$5,753,437
State General Funds	\$2,269,156

*FY 06 expenditure includes FY 06 expenses paid in FY 07

Traumatic Brain Injury Rehabilitation Hospital--Medicaid

Average Monthly Persons	24
Actual Expenditures -- FY 2006*	\$6,499,347
State General Funds	\$2,565,219

*FY 06 expenditure includes FY 06 expenses paid in FY 07

Technology-Assisted Children Waiver

The Technology-Assisted (TA) Children waiver serves Kansas children with disabilities from birth to age 18 who are Medicaid eligible, and who need technological devices to sustain life. The waiver redirects Medicaid funding that would have been used to serve these children in acute care hospitals to home and community-based services.

Technology-Assisted Children Waiver (birth to age 18)

Average Monthly Persons	44
Actual Expenditures---SFY 2006*	\$185,143
State General Funds	\$41,652
Fee Funds	\$31,376

*FY 06 expenditure includes FY 06 expenses paid in FY 07

Attendent Care for Independent Living -- Medicaid

Average Monthly Persons	242
Actual Expenditures--FY 2006*	\$17,956,002
State General Funds	\$7,031,396

*FY 06 expenditure includes FY 06 expenses paid in FY 07

Frequently Asked Questions

“What services are available through the PD waiver?”

Services available include: Personal Services which provide assistance with daily living tasks which might include dressing, shopping, cooking, and bathing, Assistive Services which provide

A success Story



A family needed assistance with their 5 yr old girl who had chronic lung disease and multiple secondary diseases. The girl entered the ACIL program in December 2001, technologically dependent upon a ventilator, trach, G-tube, oxygen and frequent mucosal suctioning. She was on multiple meds and required around the clock care. With the services provided by ACIL, this young girl has improved remarkably to the point that her health has stabilized allowing her to attend public schools. By September 2006, she no longer required any of her life sustaining technologies. The program has empowered her parents to become independent of the program by providing necessary medical supports and services, allowing her time to adjust and care for their child.

medical equipment, home modifications, and technology assistive devices which improve the person's quality of life and level of independence, and Independent Living Counseling which provides assistance in linking the individual to support agencies and programs allowing the individual to become fully integrated and active in the community. Additional services include Sleep Cycle Support and a Personal Emergency System.

“Who monitors services under these programs?”

All Physical Disability waiver service providers are required to ensure the services they provide are of good quality, meet individual needs, and are responsive to the choices of the person with the disability. Regional SRS staff review provider files regularly and conduct consumer interviews. Under the TBI waiver, each person who receives services is visited annually to discuss their satisfaction with services.

“How can an individual with a physical disability apply for the PD waiver?”

To apply for the PD waiver, contact your local SRS office (see regional offices listing, page 52), CIL (see provider list, page 56), or designated home health agency (see provider list, page 58) and ask for help in applying for PD waiver services.

“What services are available through the TBI waiver?”

Services available include: Personal Services which provide assistance with daily living tasks such as dressing, shopping, cooking, and bathing; assistive services which provide medical equipment, home modifications, and technology assistive devices; transitional living services which teach individuals independent living skills; and rehabilitation therapies such as physical, occupational, speech, behavioral, cognitive, and drug and alcohol counseling. Additional services include Sleep Cycle Support through which assistance is available during sleeping hours and Personal Emergency Response Systems through which individuals can access help in an emergency.

“How do I apply for the TBI waiver?”

To apply for the TBI waiver, contact your local SRS office (see regional offices listing, page 52), CIL (see provider list, page 56), or designated home health agency (see provider list, page 58) and ask for help in applying for TBI waiver services.

“What if I don't qualify for Medicaid? Can I still get help to live independently?”

CILs provide assistance in communities to help persons with disabilities live independently. Contact your local CIL (see provider list, page 56) or Home Health Agency (see provider list, page 58) to talk to a case manager for information about community resources.



KANSAS DEPARTMENT ON AGING
Improving Security, Dignity, and Independence

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Home and Community Based Services for the Frail Elderly

Revised March 2005

- [Medicaid HCBS/FE Eligibility](#)
- [HCBS/FE Benefits](#)
- [Your rights and responsibilities](#)
- [Glossary of Terms](#)
- [Contact information](#)

Introduction

Kansas has a variety of programs promoting independent living in safe, healthy environments. Individuals age 65 or older who qualify for Medicaid benefits may be eligible to receive services through the Home and Community Based Services Frail Elderly program (HCBS/FE). The goal of HCBS/FE is to provide long term care services in the least intensive care setting of your choice.

The HCBS/FE program has been administered by the Kansas Department on Aging since July 1, 1997. The purpose of this booklet is to assist Kansans who need help as they grow older. The HCBS/FE program may enable them to stay in their homes or make other successful living arrangements in the community.

Program Definition -

HCBS/FE helps Kansans age 65 or older who are in frail health. Services include:

- Personal care such as feeding, bathing, and dressing;
- Household tasks, such as shopping, meal preparation, house cleaning, and laundry;
- Health services, such as health monitoring, 24-hour support for medical emergencies.

Am I eligible for Medicaid HCBS/FE Benefits?

- You must be age 65 or older and in frail health
- You must be assessed by a qualified case manager and determined to need long-term care services
- Your countable assets cannot exceed \$2,000 (a home and vehicle are not included in the total).
- You will be asked to help pay for services if your countable income is greater than the allowable income per month (your local SRS office will help you determine your current allowable income).

[See Estate Recovery information](#)

How do I apply for Medicaid Benefits?

To see if you qualify for Medicaid benefits, contact your local Kansas Department of Social and Rehabilitation services (SRS) office and tell them you would like to apply for Medicaid and the HCBS/FE program. [You can find contact information at the end of this online publication](#).

You will need to fill out an application for Medicaid assistance. Information and verification of your income and assets will be required. An Economic and Employment Support Specialist at the SRS office will help you with this process. If you now receive Medicaid assistance and think you are eligible for the HCBS/FE program, you may [contact your local Area Agency on Aging \(AAA\)](#) directly.

What Else can I Expect?

In order to obtain home and community based services, your health care needs will be assessed to determine the services necessary to maintain your highest level of independence.

This screening will be done by the AAA or by an assessor approved by the Kansas Department on Aging (KDOA). [Contact your local AAA](#) to obtain an assessment. This process is very detailed and will take approximately two hours to complete.

What will Happen If I Am Eligible for HCBS?

A plan of care will be developed before you can begin to receive services. This plan of care is based on information gathered during the assessment process. You will be actively involved in creating this plan with help from a case manager from the AAA. You will have final approval of the plan. This process is meant to ensure your health and well-being are protected. You will have the opportunity to choose your provider(s) and direct your attendant care, if desired.

Your plan of care will include:

- The type, amount, frequency, and length of time each individual service is to be provided.
- The providers who you decide are best able to furnish each of the services you need.

What Happens If I Am Not Eligible for HCBS?

If you do not meet the eligibility criteria for the HCBS/FE program, there may be other services that can help you. Your case manager from the Area Agency on Aging can help you review your needs and connect you with the appropriate services. The case manager will then check back with you to see how things are working and to review any changes to your situation.

What Benefits Can I Receive Through The HCBS/FE Program?

The HCBS/FE Program has many services available to you including:

- Adult Day Care
- Assistive technology
- Attendant care services
- Medication Reminder
- Nursing evaluation visit
- Personal emergency response
- Sleep cycle support
- Wellness monitoring

Case management is also available to individuals who qualify for this program. The following definitions give a better understanding of the services available.

Adult Day Care -

Adult day care is a service to maintain a person's optimal social functioning. Depending on your personal plan of care and your chosen provider, this service may include:

- Daily supervision
- No more than two meals a day
- Assistance with eating, toileting, or mobility.

Assistive Technology -

Assistive technology provides equipment or modifications in your home to increase, maintain or improve your ability to perform daily activities.

Attendant Care Services-

An attendant is trained to assist you with activities you cannot perform or for which you may need some assistance. There are two levels of care.

Level one services may include...

- Shopping, house cleaning, meal preparation, laundry, grooming, toileting, or feeding
- Supervision of mobility, such as getting in and out of bed, the bath, a wheelchair, or vehicle
- Accompanying to medical appointments
- Assisting in completion of paperwork; for example, filling out forms or paying bills
- Supervision of medication

Level two services may include...

- Physical assistance with bathing, dressing, walking, or transfers
- Routine monitoring of vital signs, such as blood pressure
- Care of ostomies, wounds, or catheters
- Feeding which requires tubes and/or special nutrients
- Assistance with medications (nurse delegation may be required)
- Assistance with range-of-motion activities

You may choose to direct either level of service yourself by hiring, training, and supervising your caregivers. Self-direction of some Level Two activities requires your physician's or nurse's written approval.

Medication Reminder-

A medication reminder system provides a scheduled reminder when it is time for you to take medications.

Nursing Evaluation Visit-

Nursing evaluation visit is completed by a Registered Nurse to evaluate your health care needs and determine the appropriate assistance to be provided by the attendant(s).

Personal Emergency Response-

Personal Emergency response provides consumers, whose health status may require immediate attention, with 24-hour on-call support. Persons with heart conditions, diabetes, epilepsy, breathing difficulties, or those prone to falls and injuries may be candidates for this service. Emergency response systems are usually electronic and involve the rental of specialized equipment which can alert family or medical personnel that assistance is required.

Sleep Cycle Support-

Sleep cycle support provides assistance in your home, during your sleeping hours. This service may include help with toileting, transferring in and out of bed, getting around, or reminding you to take medications.

Wellness Monitoring-

If your care plan includes wellness monitoring, a Licensed Nurse will visit you in your home to provide health assessment, education, counseling, and monitoring of any treatment program prescribed by health care professionals.

Case Management-

A case manager will help you to assess, coordinate, and obtain the services that you need. Your case manager will ensure that services are appropriate, adequate, and are of high quality. This program is committed to the efficient use of all available resources. It will assure that the services being rendered are sufficient in quantity and quality to meet the needs and preferences of those involved in the program. A case manager may advocate on your behalf with health care providers and other agencies.

What Are My Rights And Responsibilities?

Consumers who are eligible for the HCBS/FE program have the following rights and responsibilities:

I understand I have the right to...

- Have my financial eligibility for the HCBS/FE program determined within 45 days by the SRS Economic and Employment Support Specialist.
- Have services provided in accordance with the state Medicaid plan, dependent upon availability of services and financial eligibility.
- A fair hearing if I am dissatisfied with the decision made on my application or I feel there has been undue delay in acting on my application.
- Equal treatment as other applicants or recipients who are in similar situations.
- Confidentiality
- Freedom of choice regarding services for which I am eligible including:
 - Being informed about all feasible alternatives;
 - Whether to receive HCBS;
 - Refusing recommended services;
 - Choosing which qualified providers perform each service in my written plan of care;
 - Choosing to direct my own attendant care services;
 - Entering a nursing home.
- A review of my HCBS eligibility and plan of care at least every 12 months or any time my circumstances change.

To Appeal a Decision-

If you have any questions about an action taken or if you want more information considered before a planned action is taken, discuss these matters with you case manager. If you remain dissatisfied, you have the right to a hearing before the State Hearings Officer. Your request must be received in writing within 30 days of the date on the notice which provided you the information you are appealing. The Fair Hearings Staff at KDOA can answer any questions regarding the hearing procedure. They can be reached at 800.432.3535.

You may have legal counsel or other representation at the hearing. If a request for a fair hearing is received prior to the effective date of the transaction, assistance may continue at the current level pending the decision. However, any overpayment from a continuation may have to be repaid if the decision is not in your favor. If you are dissatisfied with a fair hearing decision, you may request a review by the State Appeals Committee.

Your Civil Rights-

No person shall be denied benefits on the grounds of race, color, national origin, age, disability, religion, or sex. No person may be excluded from participation in, of, or be subject to discrimination under any program or activity of KDOA, SRS or Medicaid.

If you feel you have been discriminated against on the above grounds, you may make a complaint in writing to KDOA's Diversity Manager at:

Kansas Department on Aging
503 S. Kansas Ave.
Topeka, Kansas
66603-3404
785-296-4986 and 1-800-432-3535

I understand that I have the responsibility to...

- Supply information essential to establishing my eligibility and to report fully all circumstances affecting my application.
- Allow a full investigation of my eligibility, including inquiries of employers, bankers, doctors, other business or professional persons as well as review of any state agency records. I further understand that if SRS needs additional information of my employers, I will be asked to sign a release. If SRS is given consent for release of any information from Supplemental Security Income and Social Security records, I understand that my Social Security Number will only be used in the administration of SRS or Medicaid programs.
- Report any changes in my circumstances which affect my eligibility.
- Cooperate in current and subsequent agency efforts to establish my eligibility.
- Pay my share of service costs, if applicable, in accordance with any fee schedule.
- Report if I plan to move or be away so that my Economic and Employment Support Specialist, Case Manager, and I can appropriately plan services.

Reporting to local Area Agency on Aging...

If you plan to move or be away temporarily, your Case Manager and Economic and Employment Support Specialist should be informed so that arrangements regarding your service needs can be planned with you. You are also required to report any change in income, family size, temporary assistance to needy families (TAF), or Supplemental Security Income status.

Estate Recovery-

This is a program which allows SRS and Medicaid to recover medical care costs from the estates of recipients who, prior to their death:

- Were 55 years of age or older;
 - Resided in a nursing facility or received HCBS services; and/or
 - Did not have a spouse, children under 21, or disabled dependents.
-
- A person's estate includes the home, savings, or other assets remaining upon death.
 - No lien will be placed upon property while the recipient or spouse is living, but a claim may be filed on the estate upon the death of both the recipient and spouse.
 - The claim will be in the amount of any medical expenses paid by Medicaid after June 30, 1992.
 - All medical expenses paid by SRS may be included in the claim, including Medicare premiums paid by SRS, Medicare cost sharing paid by the QMB program, and any other regular Medicaid expenditures.
 - Questions regarding the Estate Recovery Program can be directed to the Estate Recovery Unit at 785.296.6707.

Glossary

AAA - Area Agency on Aging

Case Manager - An individual authorized by KDOA and SRS to provide assessments, service coordination, and cost containment for Medicaid long term care programs.

Economic and Employment Support Specialist - An SRS employee who determines financial eligibility for medical assistance.

Frail Elderly - Persons who are 65 years of age or older and in frail health.

HCBS/FE - Home and Community Based Services for the Frail Elderly.

KDOA - Kansas Department on Aging.

Medicaid - The state health care program that helps eligible people pay for medical services. An Economic and Employment Support Specialist at SRS determines financial eligibility for this program.

Medical Assistance - Another name for the Kansas Medicaid program

Primary Caregivers - Individuals or professionals providing care and support to a frail elder.

SRS - Kansas Department of Social and Rehabilitation Services

SS - Social Security

SSI - Supplemental Security Income

Contact information...

You can [locate your local SRS office by visiting the office locator](#) on the SRS web site.

To find out more about the Area Agency on Aging that serves you, [visit the Area Agencies on Aging section of Agingkansas.org](#).

You can find out more about this and other programs by [contacting the Kansas Department on Aging](#).

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Page Last Updated: September 5, 2006

Kansas & United States



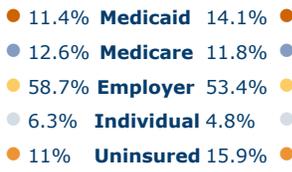
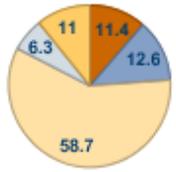
State Medicaid Fact Sheet The Kaiser Commission on Medicaid and the Uninsured

Total Residents, 2004-2005

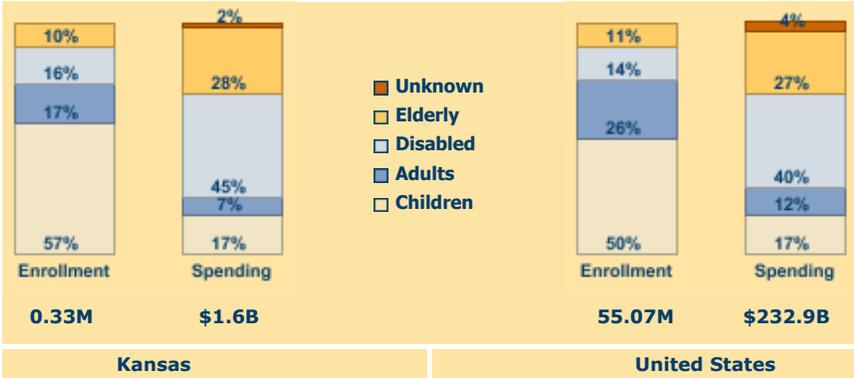
KS: 2,671,740 **US:** 292,947,440

Distribution By Insurance Status, 2004-2005

Kansas **United States**



Medicaid Enrollment and Spending by Group, FY2003



	Number		Percent		Notes
	KS	US	KS	US	

Demographic Profile, 2004-2005					
Total Residents	2,671,740	292,947,440	-	-	-
Income					
Poor: Below Federal Poverty Level (FPL)	403,530	50,658,400	15	17	% of total residents
Near-Poor: 100-199% of the FPL	497,530	55,241,860	19	19	% of total residents
Non-Poor: 200% of the FPL and above	1,770,690	187,047,180	66	64	% of total residents
Median Annual Income, 2003-2005	\$43,802	\$46,037	-	-	-
Age					
Children (0-18)	722,090	77,908,220	27	27	% of total residents
Poor Children	146,450	17,721,680	20	23	% of total children
Adults (19-64)	1,608,740	179,534,430	60	61	% of total residents
Poor Adults	224,760	28,177,220	14	16	% of total adults
Elderly (65+)	340,910	35,504,790	13	12	% of total residents
Poor Elderly	32,330	4,759,500	9	13	% of total elderly
Race/Ethnicity					
White	2,220,250	195,289,750	83	67	% of total residents
Black	145,600	35,539,910	5	12	% of total residents
Hispanic	162,600	43,077,110	6	15	% of total residents
Other	143,300	19,040,670	5	6	% of total residents
Non-Citizen	100,080	21,757,770	4	7	% of total residents
Population Living in Non-Metropolitan Areas	957,800	48,327,760	36	16	% of total residents

Health Insurance Coverage of the Nonelderly, 2004-2005					
Medicaid	247,970	34,802,750	11	14	% of Nonelderly
Children	162,900	20,354,580	66	58	% of Medicaid
Adults	85,070	14,448,170	34	42	% of Medicaid
Uninsured	289,330	46,118,230	12	18	% of Nonelderly
Children	50,050	9,035,420	17	20	% of uninsured
Adults	239,280	37,082,810	83	80	% of uninsured
Poor: Below Federal Poverty Level (FPL)	111,540	16,749,520	39	36	% of uninsured
Near-Poor: 100-199% of the FPL	91,860	13,345,370	32	29	% of uninsured
Employer Sponsored Insurance	1,572,020	156,430,100	67	61	% of Nonelderly
Individual Insurance	166,100	13,928,090	7	5	% of Nonelderly
Other Public	55,410	6,163,480	2	2	% of Nonelderly

	Number		Percent		Notes
	KS	US	KS	US	
Percentage Point Change Among Nonelderly 0-64 by Coverage Type, 2004-2005					
Uninsured	-	-	-0.2	0.3	% point change
Medicaid	-	-	0.0	-0.1	% point change
Employer-Sponsored	-	-	0.7	-0.3	% point change
Individually Purchased	-	-	0.1	-0.1	% point change
Medicaid Enrollment					
Total Enrollment, FY2003	325,100	55,071,200	12	19	% of total residents
Children	184,400	27,263,000	56.7	49.6	% of Medicaid enrollees
Adults	55,200	14,257,300	17	25.6	% of Medicaid enrollees
Blind and Disabled	-	-	-	-	% of Medicaid enrollees
Elderly	32,700	5,871,700	10.1	10.5	% of Medicaid enrollees
% Enrolled in Managed Care, 2004	-	-	56	62.9	% in managed care
Medicaid Expenditures					
Total Medicaid Spending in Millions, FY2005	\$1,981	\$305,337	-	-	Including DSH
Disproportionate Share Hospital Payments (DSH)	\$64	\$17,089	3.2	5.6	% of total spending
Acute Care	\$1,080	\$182,604	54.5	59.8	% of total spending
Rx Drugs	\$203	\$30,658	18.8	16.8	% of acute care spending
Long Term Care (LTC)	\$838	\$105,644	42.3	34.6	% of total spending
Nursing Home	\$340	\$46,949	40.5	44.4	% of LTC spending
Home/Personal Care	\$420	\$41,277	50.2	39.1	% of LTC spending
Per Enrollee Medicaid Spending, FY2003					
Total	\$4,856	\$4,072	-	-	-
Children	\$1,499	\$1,467	17.1	17.2	% of total spending
Adults	\$2,058	\$1,872	7.0	11.5	% of total spending
Blind and Disabled	\$4,856	\$4,072	-	-	% of total spending
Elderly	\$14,027	\$10,799	28.4	27.2	% of total spending
Unknown	-	-	-	-	% of total spending
Other Medicaid Spending Measures					
Federal Contribution per State Dollar, FY2006	-	-	-	≥50	federal matching rate
General Fund Spending on Medicaid, SFY2004	-	-	12.7	16.9	% of general fund spending
Medicaid Eligibility Levels by Annual Income and FPL, 2006					
Working Parents	\$5,916	\$10,849	36	65	% of federal poverty level
Pregnant Women	\$24,135	\$21,400	150	133	% of federal poverty level
Infants	\$24,900	\$22,078	150	133	% of federal poverty level
Children 1-5	\$22,078	\$22,078	133	133	% of federal poverty level
Children 6-19	\$16,600	\$16,600	100	100	% of federal poverty level
Medicaid and Medicare Dual Eligibles					
Total Dual Eligible Enrollment, 2003	-	-	15	14	% Medicaid enrollees
Total Dual Eligible Spending in Millions, 2003	-	-	50	40	% of all Medicaid spending
Total Medicare Enrollment, 2005	396,527	42,394,926	14	14	% of total residents
Estimated Annual "Clawback" Payment, 2006	\$44,048,082	\$6,605,675,559	-	-	-
SCHIP					
Eligibility Income Level for Family of 3, 2006	\$33,200	-	200	-	% of federal poverty level
Current SCHIP Enrollment, December 2004	-	-	-	-	% growth, 2003-2004
Total SCHIP Spending, FY2004	-	-	-	-	% of health spending

This fact sheet was printed on January 21, 2007. Additional Medicaid Fact Sheets available at <http://www.kff.org/MFS/>.

All data are drawn directly from statehealthfacts.org, Kaiser's continuously updated database for state-level health data. More detailed notes and sources are available by following the online links from each topic on the fact sheet.

Demographic Profile

Total Residents, Income, Age, Race/Ethnicity, Citizenship, Population Living in Non-Metropolitan Areas

Source: KCMU and Urban Institute analysis of the Current Population Surveys, March 2005 and 2006.

Notes: These demographic data may differ from Census Bureau figures due to grouping by health insurance unit (HIU) rather than household. A Metropolitan Statistical area must have at least one urban cluster of at least 10,000 but less than 50,000 population. A Non-Metropolitan Statistical Area lacks at least one urbanized area of 50,000 or more inhabitants.

Median Annual Income

Source: U.S. Census Bureau, Current Population Survey, 2004, 2005, and 2006 Annual Social and Economic Supplements. Three-Year-Average Median Household Income by State: 2003-2005

Health Insurance Coverage

Medicaid, Uninsured, Medicaid, Employer-Sponsored Insurance, Individual Insurance, Other Public, Percentage Point Change in the Rate of Coverage of the Nonelderly Population (0-64 years old)

Source: KCMU and Urban Institute analysis of the Current Population Survey, March 2005 and 2006.

Notes: State figures are based on pooled 2004 and 2005 data; U.S. figures are based on 2005 data.

Medicaid

Total Enrollment

Source: The Urban Institute and KCMU estimates based on data from MSIS reports from CMS for FY2003.

% Enrolled in Managed Care

Source: Medicaid Managed Care Penetration Rates by State as of December 31, 2004, CMS, DHHS.

Total Medicaid Spending in Millions

Source: Urban Institute estimates for KCMU based on CMS Form 64 for FY2005.

Notes: All spending includes state and federal expenditures. Expenditures include benefit payments and disproportionate share hospital payments; do not include administrative costs, accounting adjustments, or the U.S. Territories. Total spending including these additional items was about \$316.5 billion in FY2005.

Per Enrollee Medicaid Spending and Distribution by Group

Source: The Urban Institute and KCMU estimates based on data from MSIS reports from CMS for FY2003.

Multiplier and Federal Matching Rate

Source: KCMU calculations based on the FMAPs as published in the Federal Register.

Notes: The multiplier is based on the FMAP and represents the amount of federal funds a state receives for every dollar it spends on Medicaid. The rate varies year to year and is based on each state's relative per capita income. It ranges from a low of 50% to 76%, averaging roughly 60% nationally. For FY2006, the rate for Alabama was 1:2.30 (69.51%).

State Medicaid Spending as % of State General Fund

Source: 2004 State Expenditure Report, National Association of State Budget Officers

Notes: A state's general fund is the predominant fund for financing a state's operations.

Medicaid Eligibility Levels

Source: *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families*, The Center on Budget and Policy Priorities for KCMU, October 2005; and *Medicaid Eligibility*, DHHS, CMS.

Notes: All dollar figures represent the annual income for a family of three. For Working Parents, the U.S. figures represent the median annual income in dollars and as a percent of the FPL. For other groups, the U.S. figures represent the federal minimum annual income in dollars and as a percent of the FPL.

Medicaid and Medicare Dual Eligibles

Sources: *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, Urban Institute for KCMU, July 2005.

CMS Statistics: *Medicare State Enrollment*, CMS. *An Update on the Clawback: Revised Health Spending Data Change State Financial Obligations for the New Medicare Drug Benefit*, KCMU, March 2006.

SCHIP

Eligibility Income Level for a Family of Three

Source: *In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families*, The Center on Budget and Policy Priorities for KCMU, October 2005; and *Medicaid Eligibility*, DHHS, CMS.

Notes: The levels are for separate SCHIP programs only. The following states do not have a separate SCHIP program: AK, AR, DC, HI, LA, MN, MO, NE, NM, OH, OK, RI, SC, TN, WI.

Current SCHIP Enrollment

Source: Collected by Health Management Associates for KCMU. Data as of December 2004.

Notes: Figures represent the current monthly enrollment. AR and TN phased out their Medicaid expansion programs in September 2002.

Total SCHIP Spending

Source: FY2004 SCHIP Expenditures (state and federal), CMS, Special Data Request.

Abbreviations

CMS: Centers for Medicare and Medicaid Services

DHHS: U.S. Department of Health and Human Services

FMAP: Federal Medical Assistance Percentage

FPL: Federal Poverty Level (The FPL for 48 states was \$16,090 for a family of 3 in 2005; Alaska \$20,110 and Hawaii \$18,510.)

KCMU: The Kaiser Commission on Medicaid and the Uninsured

MSIS: Medicaid Statistical Information System

SCHIP: State Children's Health Insurance Program