KanCare General Information Fact Sheet

Technology Assisted (TA) HCBS Waiver

1. What are Home and Community Based Services (HCBS)?

Home and Community Based Service (HCBS) waivers are KanCare (Kansas Medicaid) programs that provide services to a person in their community instead of an institution, such as a nursing home or state hospital. In Kansas, the Kansas Department for Aging and Disability Services (KDADS) oversees the HCBS waivers. There are currently seven HCBS waivers in the state of Kansas. The services you receive will vary depending on the waiver you qualify for and your individual needs. **HCBS services do not pay for living expenses, or room and board.**

2. What is the TA Waiver Program?

The TA waiver provides services to individuals ages 0 through 21 years who are chronically ill or medically fragile and dependent upon a ventilator or medical device to compensate for the loss of vital bodily function. Eligible individuals require substantial and ongoing daily care by a nurse comparable to the level of care provided in a hospital setting to avert death or further disability.

3. Program Eligibility:

To be eligible for the TA Waiver, an individual must meet the following criteria:

- Be between 0 and 21 years of age
- Meet the HCBS Technology Assisted Program definition
- Require one or more of the identified primary medical technology(ies) and meet the minimum technology score for the specified age group
- Meet the minimum nursing acuity level of care threshold for the specified age group
- Be financially eligible for Medicaid

4. TA Waiver Services:

Below are the services you may qualify for on the TA waiver. Your final services will be determined by you and your Managed Care Organization (MCO) and will be based on your assessed needs.

1. **Health Maintenance Monitoring -** Health Maintenance Monitoring allows for regularly scheduled nursing visits to check a person's health status and monitor for changes in health and wellbeing.

2. **Home Modification -** Home Modification provides modifications or adaptations to a person's home through tangible equipment or hardware, such as adaptive equipment or environmental modifications.

3. **Financial Management Services -** Financial Management Service (FMS) provides administrative and payroll services for people who choose to self-direct some or all of their services. FMS provides payroll, payment, reporting services, employer orientation, skills training, and other fiscal-related/administrative services to participant-employers.

4. **Intermittent Intensive Medical Care -** Intermittent Intensive Medical Care provides people using personal care services with nursing services to meet specific skilled nursing care needs.

5. **Personal Care Services -** Personal Care Services (PCS) provides supervision and/or physical assistance with instrumental activities of daily living (IADLs) and activities of daily living (ADLs), health maintenance activities, and in some cases socialization/recreation. *This is the only TA Waiver service that can be self-directed. All other services on this waiver must be agency-directed (see page 6 of this packet for explanation of self-directed vs agency-directed services).

6. **Medical Respite -** Medical Respite is a temporary service provided on an intermittent basis to provide the beneficiary's family short, specified periods of relief.

7. **Specialized Medical Care -** Specialized Medical Care (SMC) provides long-term Registered Nurse or Licensed Practical Nurse support for people who are medically fragile and technology-dependent. (Only if parent is a Registered Nurse and meets specific criteria can they be the SMC provider. If this applies to your situation, talk to your MCO about the specific criteria that must be met.)

5. How many hours of service can I have once I am approved for TA Waiver services?

Not all individuals who receive TA Waiver services will receive the same services or the same amount of services. Service hours are based on the assessed needs of the individual. This is done through the MATLOC assessment administered by a State Assessor. The Assessor helps establish what is recommended to the Managed Care Organization to assist in creating an individualized, Person-Centered Service Plan based on your assessed needs. See more info under question #9

6. What are the income and asset guidelines for HCBS Waiver programs?

Once you have been approved for functional eligibility for an HCBS waiver, KanCare will look only at the income of the person who will receive services, even for children (no asset test on this program because it covers children only).

- **Assets:** For any HCBS program for children, there will be no assets test.
- **Income:** You may have to help pay for part of your services if you (the person who receives the services) have income of more than $2543 per month in the form of a monthly premium called a "Client Obligation."

7. How do you calculate the monthly premium (Client Obligation)?

Take the KanCare Member's total monthly income - $2543 = Monthly Client Obligation

- **Example 1:** Monthly income of $2700 - $2543 = $157 Monthly Client Obligation
- **Example 2:** Monthly income of $900 - $2543 = $0 Monthly Client Obligation

What if my gross income is $3220 or higher (300% or more above the federal poverty level)?

- **Cost of Care Determination:** The expected monthly cost of your care (determined by the Person-Centered Service Plan, set by the MCO) must be higher than your Client Obligation, or you may be ineligible for this program.

- If your gross monthly income is less than $2543, the cost of care determination does **not** apply to you.

8. Can I reduce my monthly premiums?

Participants may be able to reduce the amount they owe on their Client Obligation by submitting receipts for medical costs not covered by insurance for member (out-of-pocket medically necessary expenses). These receipts must be submitted to the KanCare Clearinghouse.

Examples of Allowable Expenses:

- Health Insurance Premiums (Medicare, Medicare Supplemental, Private Insurance)
- Medically necessary expenses that Medicaid, Medicare and other health insurance does not cover

The example below repeats the Client Obligation calculation from Question 7 (Example 1), but reduces that monthly premium by the amount the individual is paying out-of-pocket from a separate health insurance premium (for example, **an out-of-pocket Blue Cross Blue Shield (BCBS) insurance premium of $200/month**).

Take the KanCare Member's total monthly income - $2543 - Premium for other health insurance paid out-of-pocket = Monthly Client Obligation.

- **Example:** Monthly income of $2850 - $2543 - **$200** = $107 Monthly Client Obligation

9. How do I apply for TA Waiver services?

1) **Applying for Functional Eligibility** - To apply for the TA Waiver contact *Children's Resource Connection* by phone: (316) 721-1945 or email: crctaks@gmail.com . A MATLOC Eligibility Specialist (MES) will complete the MATLOC assessment to determine your medical technology dependency and the level of needs by specific age group. MATLOC assessments are required every 6 months for TA waiver participants. All MATLOCK assessors are Registered Nurses (RNs) and are trained to administer the State assessment tool.

2) **Apply for Financial Eligibility** (through the KanCare Clearinghouse). Do not wait for Functional Eligibility approval before you start the application for **Financial Eligibility**. You want to apply as early in the process as possible. Be sure to ask for HCBS services. If using a paper KanCare application, check the "HCBS" box on page 3. The KDHE Eligibility team at the KanCare Clearinghouse determines if a person is financially eligible for HCBS Waiver programs. Your MES can assist you in completing your Medicaid application.

3) **Choose the managed care organization (MCO)** that fits your needs best. You can select an MCO at the time of application or within 90 days from your initial enrollment date. (This is true for new applicants only. For ongoing beneficiaries, switching program types or adding on HCBS waiver services doesn't allow you to choose a new MCO; you will need to wait until your annual open enrollment period.) See the Selecting and Changing an MCO Fact Sheet on the KanCare Ombudsman webpage.

10. What happens once I'm approved for HCBS Services (Starting HCBS Services)?

a. Once approved for the HCBS waiver (functionally and financially) you'll be informed of your monthly Client Obligation (by KDHE and the KanCare Clearinghouse.)

b. An MCO Care/Service Coordinator will also be assigned to you. This MCOs Managed Care Coordinator will meet with you (and your family if appropriate) to talk about your needs, service options, and how much help you can expect to get. They will create an

individualized, Person-Centered Service Plan based on your assessed needs.

c. For the TA Waiver, all services must be agency-directed, with one exception. Personal Care Services (see definition on page 1 of this packet) can be self-directed in some cases. Your MCO Care Coordinator can help explain these options.

- **Agency Directed Care:** Agency directed services typically have an agency hiring, firing and scheduling staff to come to a person's home to assist them with activities of daily life.
- **Self-Direction:** Self direction for personal care services is based on the belief that people receiving services should be able to make decisions about their services if they want to, including who provides them. When you choose self-direction, you are responsible for finding, selecting, hiring, training and monitoring your own staff. A financial management service (FMS) provider will assist you with payroll services. Self-Direction can only apply to Personal Care Services, not Specialized Medical Care (SMC). Unless otherwise approved by KDADS, all services must be provided through the agency directed service model.

11. How to avoid losing services (Maintaining Services)?

a. Use services at least monthly.

b. MATLOC assessments are required every 6 months for TA waiver participants.

c. Participate in updating your Person-Centered Service Plan at least annually with your MCO.

d. Quarterly contact with your MCO Care Coordinator (face-to-face).

e. Turn in your KanCare renewal (plus any requested documents) annually and **on time**.

f. Notify the KanCare Clearinghouse **and** your managed care organization (Aetna, Sunflower, UnitedHealthcare) if you move or information changes (including income changes).

g. Read any notices from KanCare carefully and right away. Respond to all requests for information in a timely manner.

12. Wait List information:

The TA wavier does not currently have a wait list.

13. Crisis and Exception:

There is no crisis and exception for the TA waiver because there currently is no wait list.

14. Frequently Asked Questions

What happens when I turn 22?

When you are approaching your 22nd birthday you will have the option to transition to either the HCBS Physically Disabled (PD), Intellectual/ Developmental Disability (I/DD) or Brain Injury (BI) waiver provided you meet the established eligibility criteria. For more information on each of the waivers click the below links.

- Physically Disabled (PD) Program
- Brain Injury (BI) Program
- Intellectual/Developmental Disability (I/DD) Program

Note: Start this process ahead of time to allow you time to work with your Care Coordinator to complete all requirements for this transition (for example: new assessments, etc.).

If the participant is assessed for a new waiver and is found ineligible by the contracted independent assessor. The MCO care/ service coordinator is required to transition to consumer off the waiver to other community program and resources within 30 days after receiving the notice of action from KDADS.

Do I have to apply for Medicaid?

Yes, Medicaid pays for services provided under the TA Program. Your MES and/ or Children's Resource Connection can assist you in answering questions to help you complete your Medicaid application.

Who will help me get my services started?

Your chosen MCO Care Coordinator will assist you with getting services started. If you are already on Medicaid and have not heard from your MCO Care Coordinator, you will need to contact your health plan (MCOs: Aetna, Sunflower, United Healthcare).

Is it easy to find qualified staff to provide services in my home?

There is currently a nursing and health care worker shortage (throughout Kansas). Finding qualified staff can take some time.

What is an MCO?

Kansas contracts with three health plans or Managed Care Organizations (MCOs) which are: Aetna, Sunflower, and United Healthcare. These are the 3 health plans you can choose from under KanCare.

When do I select a Managed Care Organization (MCO)?

You can select an MCO at the time of application or within 90 days from your initial enrollment date. (This is true for new applicants only. For ongoing beneficiaries, switching program types or adding on HCBS waiver services doesn't allow you to choose a new MCO; you will need to wait until your annual open enrollment period.)

How to make sure I'm choosing the Managed Care Organization (MCO) that's best for me?

- Make sure your critical or favorite providers are in the MCO's provider network. Check to make sure the providers you use for all services are listed with the MCO you choose.
- Look at the **Health Plan Highlights** (MCO Differences Chart) to view the extra services provided by each MCO.
- Review the **Selecting or Changing an MCO Fact Sheet**.

What can I do if I receive a letter from the MCO saying the waiver services are being changed and I don't agree with the changes?

- You have the option of filing an appeal with the MCO. For more information on filing an appeal, go to the KanCare Ombudsman webpages for Appeals and Fair Hearings and scroll to the Managed Care Organization section.
- If the appeal is denied, you have the option of filing a fair hearing. For more information on filing a fair hearing, go to the KanCare Ombudsman webpages for Appeals and Fair Hearings and scroll to the Managed Care Organization section.

Can my family be paid for helping me?

- You can choose a family member to provide Personal Care Services. The family member cannot be a spouse or a person who has been appointed by you or the court to represent you (For example: Guardian/Conservator Activated Durable Power of Attorney, Acting on Behalf, etc.).
- Parents or legal guardians can only provide services by applying for an exception through the MCO (and based on final approval by KDADS, TA Program Manager).

How many hours of Specialized Medical Care (SMC) can I get?

MCOs may authorize Persons delivering services under the provision of "extraordinary care" are providing Specialized Medical Care service under the direction of a Physician and are an employee of a Home Health Agency, enrolled as a Medicaid provider of HCBS-TA Waiver services The services under the Technology Assistance Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Specialized medical care services are limited to a maximum of an average of 12 hours per day or 372 hours (1488 units) per month. One unit is equal to 15 minutes.

You will need to provide documentation from health care professionals that show why more than 12 hours is necessary to meet the needs of the member. If the parent or legal guardian is interested in being the SMC, they will need to show proof that they are a Registered Nurse (RN), and/or Licensed Practice Nurse (LPN), and meets specific criteria. Talk to your MCO Care Coordinator about the specific criteria that must be met.

16. Who do I contact when I have questions?

- **Point of Entry (Functional Eligibility) – Children's Resource Connection**
  - To get more information about this waiver or to make a self-referral to the program, contact *Children's Resource Connection* by phone: (316) 721-1945 or email: crctaks@gmail.com

- **TA Waiver Program Manager**
  - To receive additional information about the HCBS TA Program please contact:
    - **Email:** angela.hellerworkman@ks.gov
    - **Phone:** (785) 296-4983 (general number, messages will be forwarded)

- **KanCare Clearinghouse**
  - For questions about initial eligibility or status of application, annual renewals, and calculating or lowering client obligations.
    - **Customer Service:** 1-800-792-4884
    - **Mailing Address:** P.O. Box 3599, Topeka, KS 66601-9738
    - **Fax #s:** 1-800-498-1255 or 1-844-264-6285
    - **Apply online:** www.kancare.ks.gov/consumers/apply-for-kancare

- **Managed Care Organization –** For questions about specific benefits and services, and who can provide those services in your home, contact the MCO Care Coordinator.
  - **Aetna:** (1-855-221-5656) (TTY:711)
  - **Sunflower:** (1-877-644-4623) (TTY: 1-888-282-6428)
  - **United Healthcare:** (1-877-542-9238) (TTY: 711)

- **KanCare Ombudsman's office –** When other assistance is not working out, the KanCare Ombudsman's office helps in resolving problems regarding services, coverage, access and rights.
  - **Phone:** 1-855-643-8180
  - **Email:** **KanCare.Ombudsman@ks.gov**

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This fact sheet was created in cooperation with the Kansas Department for Aging and Disability Services (KDADS) and the Kansas Department for Health and Environment/Health Care Finance (KDHE/HCF).