



Brain Injury (BI) 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 BI Waiver Program?

The BI (Brain Injury) waiver program serves Kansas residents between the ages of birth-64 who have a documented medical diagnosis of an acquired or traumatic brain injury that has caused injuries that would continue to improve with the intensive brain injury therapies and would otherwise require institutionalization in a TBI Rehabilitation Facility. It's a habilitative/rehabilitative and independent living program with an emphasis on the development of new independent living skills and/or re-learning of lost independent living skills due to an acquired or traumatic brain injury. Participants who have a medically diagnosed brain injury receive intensive therapies and services based on the goals of the participant, their providers and their Managed Care Organization (MCO).

How long can I stay on the BI waiver? The participant's goals and progress will be evaluated every 6 months until they are no longer in need of these services or they reach a plateau in their progress and may be eligible to transition to another long-term waiver.

What types of brain injuries don't qualify? Brain injuries due to chromosomal or congenital diagnosis such as Down Syndrome, Spina Bifida, Cerebral Palsy, etc. do not qualify for the BI waiver.

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3. Program Eligibility:

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

- Be 0 - 64 years of age (individuals ages 65 and older are eligible to apply for the Frail Elderly Waiver).
- Be a resident of the state of Kansas
- Be determined disabled by Social Security standards
- Be financially eligible for Medicaid
- Meet the criteria for placement in a Traumatic Brain Injury Rehabilitation Facility (TBIRF). This is determined by completing the Brain Injury Medicaid Functional Eligibility Instrument Assessment (MFEI) through the local Aging and Disability Resource Center (ADRC).
- Have a documented medical diagnosis of a traumatic brain injury or acquired brain injury, signed off by an acceptable medical provider. (**Note:** Brain injuries due to chromosomal or congenital diagnosis do not qualify for the BI waiver.)
- For ages 0-3 years, the participant must submit diagnostic documentation from a physician showing they have a qualifying brain injury, but they will not be required to complete the Medicaid Functional Eligibility Instrument Assessment.
- For ages 4 years and older, the participant must submit diagnostic documentation from a physician showing they have a qualifying brain injury and must complete the Medicaid Functional Eligibility Instrument (MFEI) assessment and meet the established level of criteria.
- Have active habilitation/rehabilitation need for BI therapies. (Program eligibility is based on the need and ability to engage in the habilitation/rehabilitation brain injury therapy services.)

4. Age Clarification:

Are you over 65?

Members will not be removed (age out) from the program just because they turn 65; members can continue receiving services as long as they are making progress with their rehabilitation

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therapies and transitional living skills. If you are age 65 or older and have not yet applied, you may be eligible for the FE Waiver.

Are you under 21?

If the brain injury occurred prior to the age of 21 years, during the person's developmental years, the individual may also be referred to the Community Developmental Disability Organizations (CDDOs) for program and functional eligibility determination. The CDDOs complete the assessment required to determine functional eligibility for the HCBS Intellectual/Developmental Disability (IDD) Waiver program. Note: this is not the only step needed to be found eligible for the HCBS IDD Waiver program.

5. BI Waiver Services:

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

- **Assistive Services:** Services designed to enhance an individual's independence or abilities through purchase of adaptive equipment, home modification and assistive technology.
- **Financial Management Services (FMS):** Provides administrative and payroll services for people who choose to self-direct some or all their services. FMS provides payroll, payment, reporting services, employer orientation, skills training, and other fiscal-related/administrative services to participant-employers.
- **Home Delivered Meals Service:** One or two prepared meals can be delivered to a person to ensure individuals are receiving adequate nutrition and regular meals
- **Medication Reminder Services:** Ensures that an individual has assistance through a medication reminder device or individual to take required medications on time and consistently
- **Personal Emergency Response System (PERS) and Installation:** Allows an individual to live safely at home while having a mobile personal emergency response device on them at all times to allow them to call for help if needed.
- **Personal Care Services (PCS):** Provides supervision and/or physical assistance with instrumental activities of daily living (IADLs) and activities of daily living (ADLs),

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health maintenance activities, and in some cases socialization/recreation.

- **Rehabilitation Therapies:** Assist with the restoration of physical and mental functioning and include behavior therapy, occupational therapy, physical therapy, speech-language therapy, and cognitive rehabilitation.
- **Enhanced Care Services (ECS):** Provides immediate supervision or physical assistance with tasks such as toileting, transferring, mobility, and medication reminders as needed, or to contact a doctor, hospital, or medical professional in the event of an emergency while the participant is sleeping.
- **Transitional Living Skills (TLS):** Are skills training exercises in which people with BI practice skills in real-life situations in their homes and communities. These trainings are designed to prevent or minimize chronic disabilities while restoring the person to an optimal level of physical, cognitive, and behavioral functioning within the context of the person, family, and community.

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

Not all individuals who receive BI Waiver services will receive the same services or the same amount of services. Service hours are based on the assessed needs of the individual. The Managed Care Organization will meet with you and create an individualized, Person-Centered Service Plan based on your assessed needs.

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

Once you have been approved for functional and program eligibility for an HCBS waiver, you must meet financial eligibility through KanCare. The Brain Injury Program manager will submit those who are found to be program eligible to the KanCare Clearinghouse for Financial Eligibility Review. They will look at the income and assets of the person who will receive services (and their spouse), including children.

- **Assets:** The resource limit for the HCBS program is \$2,000 for single persons and there are special resource provisions for those individuals who have a spouse (see [Division of Assets Fact Sheet](#) on KanCare website).

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- **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 \$2,543 per month in the form of a monthly premium called a “Client Obligation.”

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

Take the KanCare Member’s total monthly income - \$2,543 = Monthly Client Obligation

- **Example 1:** Monthly income of \$2,700 - \$2,543 = \$157 Monthly Client Obligation
- **Example 2:** Monthly income of \$900 - \$2,543 = \$0 Monthly Client Obligation

What if my gross income is \$3,220 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 \$2,543, the cost of care determination does **not** apply to you.

9. Can I reduce my monthly premiums?

Participants may be able to reduce the amount they owe on their Client Obligation by submitting receipts for private health insurance premiums or 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 8 (Example 1), but reduces that monthly premium by the amount the individual is paying out-of-pocket for a separate health insurance premium (for example, **an out-of-pocket Blue Cross Blue Shield (BCBS) insurance premium of \$200/month**).

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Take the KanCare Member's total monthly income - \$2,543 - Premium for other health insurance paid out-of-pocket = Monthly Client Obligation.

- **Example:** Monthly income of \$2,850 - \$2,543 - **\$200** = \$107 Monthly Client Obligation

10. How do I apply for BI Waiver services?

- 1) **Applying for Functional Eligibility-** Contact the local Aging and Disability Resource Center (ADRC) by calling 855-200-2372 to request a BI Medicaid Functional Eligibility Instrument assessment. The functional assessment tool will determine if you meet functional eligibility criteria for the BI program.
 - If you are NOT functionally eligible: You may be referred to other resources that may be able to help, including your local Center for Independent Living, www.kcdinfo.ks.gov/resources/service-maps. You will also be told about your rights and what to do if you disagree with the decision.
 - If you are functionally eligible: The KDHE Eligibility team at the KanCare Clearinghouse will determine if the participant meets the financial eligibility guidelines.

Clarification on Age:

- For ages 0-3 years, the participant must submit diagnostic documentation from a physician showing they have a qualifying brain injury to the local ADRC, but they will not be required to complete the Medicaid Functional Eligibility Instrument Assessment.
 - For ages 4 years and older, the participant must submit diagnostic documentation from a physical showing they have a qualifying brain injury to the local ADRC, and, complete and meet the established level of criteria for the Youth Medicaid Functional Eligibility Instrument (MFEI) assessment.
- 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.

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The KDHE Eligibility team at the KanCare Clearinghouse determines if a person is financially eligible for HCBS Waiver programs. You will want to use the Application for Medical Assistance for the Elderly & Persons with Disabilities to apply for this.

- 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.

11. 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 the KanCare Clearinghouse.) They will forward your eligibility information to the chosen MCO.
- b. An MCO Care Coordinator will also be assigned to you. This MCO's Managed Care Coordinator will meet with you (and your family if appropriate) to complete your needs assessment, 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. You decide from self-directed care, agency-directed care or a combination of the two. 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 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.

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

- a. Use services at least monthly, working towards accomplishing your therapy goals.
- b. Participate in annual functional assessment.
- c. Participate in updating your Person-Centered Service Plan, based on your goals of what you hope to achieve from participating in the brain injury waiver therapies at least annually.
- 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. You **must** notify the KanCare Clearinghouse of any changes in information provided in the application process; this includes changes to: name, address, phone number, income, resources, other medical insurance, people in your household, and work status. It is also important to notify your MCO Care Coordinator of changes to name, address, phone number, people in your household, and work status.
- g. Read any notices from KanCare carefully and right away. Respond to all requests for information in a timely manner.

13. Wait List information:

The BI waiver does not currently have a wait list.

14. Crisis and Exception:

There are **no crisis and exception** criteria for the BI waiver because there is currently no wait list.

15. Frequently Asked Questions

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What is the difference between an acquired and traumatic brain injury?

- A traumatic brain injury (TBI) is an injury to the brain caused by an external force after birth. Common causes of a traumatic brain injury include gunshot wounds, motor vehicle crashes, assaults, or falling and striking your head.
- An acquired brain injury (ABI) includes brain injuries caused after birth by cerebral vascular accidents (commonly known as stroke), and loss of oxygen to the brain (hypoxic brain injury).

Note: Both types of brain injuries are now covered by the BI waiver.

What does Supporting BI Documentation mean?

- Supporting BI documentation provided to the ADRC needs to be a medical documentation of brain injury completed by a qualified medical professional. If a medical documentation of brain injury is not available, the individual applying for waiver services must submit a Brain Injury Program Eligibility Attestation Form completed by a qualified medical professional. A Brain Injury Program Eligibility Attestation Form can be found at: [https://kdads.ks.gov/commissions/home-community-based-services-\(hcbs\)/programs/tramatic-brain-injury](https://kdads.ks.gov/commissions/home-community-based-services-(hcbs)/programs/tramatic-brain-injury), in the “Enrollment Section”. It may also be requested from ADRCs, MCOs or KDADS-HCBS Brain Injury Program Manager (see last page of this fact sheet for contact information to each of these organizations).

Is there a time limit on the HCBS BI Program?

- The BI program is a short-term rehabilitative program. You may participate in the program as you continue to make progress in your rehabilitation and transitional living skills, at least until you no longer show habilitative/rehabilitative needs or progress.
- The participant will establish goals with their provider and the MCO that will be used to track habilitative and rehabilitative progress of their independent living skills. When the participant achieves their goals and services are no longer needed or reaches a plateau in their progress, they will have the opportunity to discontinue the BI waiver or transition to another long-term HCBS waiver program for ongoing supports.

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Can my family be paid for helping me?

- You may choose a family member to provide Personal Care Services (PCS). The family member cannot be a parent (for minors), spouse or a person who has been appointed by you or the court to represent you (Acting on Behalf, Activated Durable Power of Attorney, and Guardian/Conservator). They must meet the qualification requirements for these positions, so would be subject to approval.

What is an MCO?

Kansas contracts with 3 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 [2021 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.

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16. Who do I contact when I have questions?

- **Point of Entry (Functional Eligibility) – Aging and Disability Resource Center**

- The first step for anyone/any age in need of more information or to complete intake for the HCBS Brain Injury Waiver is to contact the Statewide ADRC Help line, 1-855-200-2372. They will connect you with the ADRC for your county who will determine your functional eligibility and will send the outcome of your Brain Injury MFEI (or diagnostic information for ages 0-3) to KDADS Brain Injury Program Manager.

- **BI Waiver Program Manager**

The Brain Injury Waiver Program Manager will review your assessment outcome and diagnostic documentation for program eligibility. If both meet the criteria for Program Eligibility the Program Manager will forward the determination to the KanCare Clearinghouse.

- To receive additional information about the HCBS BI Program please contact:
 - **Phone:** (785) 296-4983; General HCBS number, will forward messages to Waiver Manager

- **KanCare Clearinghouse**

The KanCare Clearinghouse will determine your financial eligibility, and if eligible will forward your information to your chosen MCO.

- 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:** 1-844-264-6285
 - **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)

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- **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

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