

Frail Elderly (FE) 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 FE Waiver Program?

The FE Waiver provides Kansas seniors an alternative to nursing home care. Services include personal care, household tasks, and health services. The program promotes independence within the community and helps to offer residency in the most integrated environment.

3. Program Eligibility:

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

- Must be 65 years old or older
- Meet the Medicaid nursing facility threshold score
- Be financially eligible for Medicaid

4. FE Waiver Services:

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

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- **Adult Day Care** - Adult Day Care provides activities meeting the needs and interests (for example, social, intellectual, cultural, economic, emotional, and physical) of the person to help them maintain physical and social function. This service includes basic nursing and daily supervision or physical assistance with eating, mobility, bathing, and dressing.
- **Assistive Technology** - Assistive Technology provides supports or items that address the person's needs as documented in their Person-Centered Service Plan. These services are designed to enhance an individual's independence or abilities through purchase of adaptive equipment, assistive technology, or home modification.
- **Personal Care Services** - Personal Care Services 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.
- **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.
- **Home Telehealth** - Home Telehealth is a remote monitoring system that includes education, counseling, and nursing supervision. It allows the person to manage their disease(s) and recognize issues before their health declines. This system is monitored by a nurse who is alerted if survey responses, and/or vital sign measurements shows a need for follow-up by a health care professional.
- **Medication Reminder** - Medication Reminder service provides a scheduled reminder to the person when it's time for him or her to take their medications. This service may also include a medication dispenser which stores and dispenses medications at the appropriate time.
- **Nursing Evaluation Visit** - Nursing Evaluation Visit is an evaluation completed by a nurse to see which personal care services worker may best meet the needs of the person and any special instructions or requests of the person regarding delivery of services.

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- **Oral Health Services** - Oral Health Services provide dental services based on a person's level of need. Oral Health Services include accepted dental procedures, which include diagnostic, prophylactic, and restorative care. These services allow for the purchase, adjustment, and repair of dentures, which are provided to adults on the FE Waiver.
- **Personal Emergency Response** - Personal Emergency Response provides electronic devices with portable buttons worn by the person to provide access to assistance or emergency help 24hours a day.
- **Wellness Monitoring** - Wellness Monitoring allows regularly scheduled nursing visits to check a person's health status and monitor for changes in health and wellbeing.
- **Comprehensive Support** - Comprehensive Support provides one-on-one support and observation to supervise and assist with incidental care as needed in order to meet the person's health and welfare needs. This does not include hands-on nursing, but is completed by a worker present to supervise the person and to assist with minor care as needed. There are additional criteria required in order to qualify for this service.
- **Enhanced Care Services** - 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. There are additional criteria required in order to qualify for this service.

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

Not all individuals who receive FE 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.

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 and assets of the person who will receive services. However, for married couples, the eligibility process will look at both persons income and assets and may do a division of assets. (see [Division of Assets Fact Sheet](#) on KanCare website)

- **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).
- **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 \$747 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 gross monthly income - \$747 = Monthly Client Obligation

- **Example 1:** Gross Monthly income of \$1250 - \$747 = \$503 Monthly Client Obligation
- **Example 2:** Gross Monthly income of \$900 - \$747 = \$153 Monthly Client Obligation

What if my gross income is \$2,313 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 \$2313, 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 examples below repeat the Client Obligation calculation from Question 7, 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 \$150/month**).

Take the KanCare Member's total gross monthly income - \$747 - Premium for other health insurance paid out-of-pocket = Monthly Client Obligation.

- **Example 1:** Gross Monthly income of \$1250 - \$747 - **\$150** = \$353 Monthly Client Obligation
- **Example 2:** Gross Monthly income of \$900 - \$747 - **\$150** = \$3.00 Monthly Client Obligation

9. How do I apply for FE Waiver services?

- 1) **Applying for Functional Eligibility-** Contact the local Aging and Disability Resource Center (ADRC) by calling 855-200-2372 to request a functional assessment for FE services. The functional assessment tool will determine if you meet functional eligibility criteria for the FE program.
 - If you ARE NOT functionally eligible: You may be referred to other resources that may be able to help. You will also be told about your rights and what to do if you disagree with the decision.

- 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.

- 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 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. You can 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

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responsible for finding, selecting, hiring, training and monitoring your own staff. A financial management service (FMS) provider will assist you with payroll services.

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

- a. Use services at least monthly.
- b. Participate in annual functional assessment.
- c. Participate in updating your Person-Centered Service Plan 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. Notify the KanCare Clearinghouse **and** your managed care organization (Aetna, Sunflower, or 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 FE waiver does not currently have a wait list.

13. Crisis and Exception:

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

14. Frequently Asked Questions

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 [2019 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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Will HCBS FE services pay for an individual who chooses to live in an Assisted Living Facility, Residential Health Care Facility, Home Plus or Boarding Care Home?

- The HCBS FE program will pay for some but not all services delivered to you in an Assisted Living Facility, Residential Health Care Facility, Home Plus or Boarding Care Home. You are responsible for paying for your room and raw food costs. HCBS/FE will pay for the direct services provided to the participant in accordance with the plan of care (Person-Centered Service Plan).

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 (Acting on Behalf, Activated Durable Power of Attorney, and Guardian/Conservator).

15. Who do I contact when I have questions?

- **Point of Entry (Functional Eligibility) – Aging and Disability Resource Center**
 - Contact your local ADRC 1-855-200-2372 to request a Functional Assessment.
- **FE Waiver Program Manager**
 - To receive additional information about the HCBS FE Program please contact:
 - **Phone:** (785) 296-4983
- **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
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- **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

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).