

## ***Introduction***

### **A-1 Description and Use of the Manual**

The Home and Community Based Services (HCBS) Physically Disabled Waiver (HCBS/PD) Policy and Procedure manual contains the official policies and procedures to be used when providing services under the HCBS waiver for persons with physical disabilities. The information in this manual was developed through a policy and procedure review process conducted by Community Supports and Services (CSS), a unit of the Kansas Department of Social and Rehabilitation Services/Division of Health Care Policy. It is consistent with the Medicaid waiver criteria set forth by the federal Centers for Medicare and Medicaid Services (CMS). Providers are encouraged to become familiar with the contents of the manual and refer to it as the first course of action when questions arise.

### **A-2 Maintenance of the Manual**

The manual will be revised and updated as policies change. The holder of the manual is responsible for adding updates to the manual as they become available. Updates can only be made by CSS. When revisions are made to the manual, instructions for filing the revised material will be distributed to all service providers.

### **A-3 History of HCBS and the PD waiver in Kansas**

Title XIX (Medicaid) of the federal Social Security Act is a public assistance medical care program administered by states and financed jointly through federal and state funds. The purpose of the program is to help states meet the costs of necessary health care for low-income and medically needy populations. States qualify to receive federal matching funds to help finance these costs by filing a state Medicaid plan document with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. States have substantial flexibility in designing their own programs as long as they stay within the parameters of federal requirements related to eligibility, services, program administration, and provider compensation.

The federal Medicaid statute requires states to specify the amount, duration, and scope of each service they provide, which must be sufficient to reasonably achieve its purposes. States may not place limits on services or arbitrarily deny or reduce coverage of required services solely because of diagnosis, type of illness, or condition. Also, in general, a state plan must be in effect throughout an entire state (i.e., the amount, duration, and scope of coverage must be the same statewide). In 1981, Congress authorized the waiver of certain

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Title XIX requirements to enable states to provide home and community based services to individuals who would otherwise require institutional care. The waiver programs are called 1915(c) waivers after the section of the Social Security Act that authorized them.

In 1984, the Kansas Department of Social and Rehabilitation Services (SRS) established the first HCBS waiver program which was called HCBS/Nursing Facility (HCBS/NF). Consumers were eligible for the program if they had a level of functional impairment equivalent to that which was necessary to enter a nursing facility. The services offered under the HCBS/NF program were much like the services provided in a nursing facility. Persons with physical disabilities found that they had special needs which were different from elders and that the HCBS/NF waiver services did not meet these needs. By working together, advocates, consumers, and SRS and the Kansas Department on Aging (KDOA) staff designed a new and separate HCBS program for persons with physical disabilities. The outcome was two new waivers: the HCBS/Physically Disabled waiver and a separate waiver for elders called HCBS/Frail Elderly (HCBS/FE). They became effective on January 1, 1997, replacing the HCBS/NF program.

The HCBS/PD program covers persons who are 16 - 64 years of age<sup>1</sup>, are determined to be physically disabled according to Social Security disability standards, are financially eligible for Medicaid, and who are in need of long term care services to accomplish the normal rhythms of the day. Some of the rules for determining financial eligibility are different. For example, the amount of money a consumer can receive each month and not have to contribute to the cost of HCBS services is greater for the HCBS/PD program than for other Medicaid programs. Since consumers who are eligible for HCBS are also eligible for Medicaid State Plan Services and because of the different eligibility rules for HCBS, some consumers would not be eligible for Medicaid if they were not also eligible for HCBS services.

CMS does not specifically define special populations that may be served by a waiver, but allows states latitude in identifying groups of individuals with similar health care needs. Once a special population has been identified, the state must be able to demonstrate an institutional model eligible for reimbursement from Title XIX from which cost-effectiveness can be determined. For the HCBS/PD program, the institutional comparison model is the nursing facility. Therefore, the total cost to serve persons receiving HCBS/PD services must

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<sup>1</sup> Consumers turning age 65 on July 1, 2002 or after this date may remain on the HCBS/PD waiver if they so choose as long as they continue to meet the eligibility criteria.

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be equal to or less than the total cost in a nursing facility. If HCBS/PD waiver program costs are greater, on average, than the cost to serve all persons in a nursing facility, Kansas loses the authority to provide services under the HCBS/PD program.

In addition to determining cost-effectiveness, the institutional comparison model is also the basis for many HCBS rules and regulations. CMS will not allow states to develop policies or procedures for HCBS programs that would not be allowed in the institutional model. For example, CMS prohibits families from financially supplementing needed services on the HCBS Plan of Care because families are also prohibited from financially supplementing costs in a nursing facility. While families cannot financially supplement HCBS care plans, families are encouraged, when appropriate, to remain a part of the informal support system. Families who remain actively involved in providing care tend to help ensure quality services and cost-efficiency in HCBS.

#### **A-4 HCBS/PD Program Administration and Operation**

The Kansas HCBS/PD waiver program is administered by Community Supports and Services (CSS), which is a department of Social and Rehabilitation Services/Division of Health Care Policy. CSS is responsible for formulating HCBS/PD policies and procedures within the framework of state and federal laws and regulations. CSS is also responsible for overseeing the waiver program to ensure that it is effectively and efficiently implemented throughout the state.

Centers for Independent Living (CILs) and Home Health Agencies (HHAs) who are enrolled to provide Independent Living Counseling assess the level of functional impairment of potential consumers. Financial eligibility is determined by Economic Employment Support (EES) Specialists in local SRS offices. Because a portion of eligibility determination is completed by different agencies, communication among these agencies is crucial.

In addition to determining functional eligibility, IL Counseling agencies are responsible for developing individual Plans of Care. The HCBS waiver requires that each individual receiving HCBS services has a plan of care that identifies, at a minimum: 1) medical and other services (regardless of funding sources) to be furnished; 2) the frequency, scope, and duration of the services; and 3) the provider who will furnish each service. The Plan of Care must be entered into the Medicaid Management Information System (MMIS) so that claims for authorized services will be reimbursed to the providers who delivered the authorized service.

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Area Medicaid Management (AMM) staff approve Plans of Care. In addition, AMM's provide technical assistance to Independent Living Counselors (ILCs) and conduct annual reviews of each HCBS/PD consumer of services. Cases are reviewed for accuracy in assessment, appropriateness of the Plan of Care, technical accuracy of forms completion and case file documentation, and claims payment review.

### **A-5 Independent Living Philosophy**

The history of independent living stems from the philosophy that people with all types of disabilities should have the same civil rights, options, and control over choices in their own lives as do people without disabilities. The philosophy of independent living involves shifting attitudes away from dependency, pity, and charity to advocacy, integration, and removal of architectural and other barriers.

The first Center for Independent Living (CIL) was organized in Berkeley, California by a group of students with disabilities. Ed Roberts, who is considered the "father" of independent living was one of those individuals. A person with quadriplegia, Roberts had to fight the California Department of Rehabilitation for his right to attend college. Due to a lack of accessibility and structural issues (the weight of his iron lung), Roberts lived in the campus hospital when he first arrived at Berkeley. Because of his tenacity, by 1967 there were 12 individuals with severe disabilities following his example and attending Berkeley. All of the individuals were forced to live on the same wing of the hospital, and eventually formed a group focusing on the civil rights of people with disabilities, calling themselves "The Rolling Quads." This vehicle of empowerment led to the formation of the Physically Disabled Students' Program, which branched into the service of non-students and the creation of the first CIL.

Another independent living policy framer was Judy Heumann who served both on the Board of Directors and as Chief Deputy Director of the CIL in Berkeley. She later served as Assistant Secretary of the Office of Special Education and Rehabilitative Services, a division of the U.S. Department of Education, during the Clinton Administration.

Based largely on Ed Robert's testimony, the U.S. Congress gave the Commissioner of the Rehabilitation Services Administration the power to fund states to operate CILs in 1978.

### **A-6 Laws and case law**

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Listed below are important federal and state laws and recent case law that has affected people with disabilities and has also had a direct impact on the development of the HCBS/PD waiver.

1953 - Kansas Act Against Discrimination	This state law addresses the illegal discrimination of people with disabilities and other protected classes in the areas of employment, housing, and public accommodations. Amended several times over the years, it is currently considered to be substantially equivalent to several federal laws including the Fair Housing Act, Title VII of the Civil Rights Act, and the Americans with Disabilities Act.
1964 - Civil Rights Act	Signed into law by President Lyndon Johnson, the Civil Rights Act (amended 1991) prohibits discrimination in employment and public accommodations on the basis of race, color, national origin, religion, sex, age, disability.
1968 - Architectural Barriers Act	This act prohibits architectural barriers in all federally-owned or leased buildings.
1970 - Urban Mass Transit Act	This act requires that all new mass transit vehicles be equipped with wheelchair lifts.
1973 - Rehabilitation Act	A landmark law, the Rehabilitation Act bars discrimination against persons with disabilities by programs receiving federal funds—particularly Title V, Sections 501, 503, and 504.
1975 - Developmental Disabilities Bill of Rights Act	This act establishes, among other things, Protection and Advocacy services (P & A).

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1975 - Education of All Handicapped Children (PL 94-142)	This law requires free, appropriate public education in the least restrictive environment for children with disabilities. This law was amended in 1997 and is now called the Individuals with Disabilities Education Act (IDEA).
1978 - Amendments to the Rehabilitation Act	These amendments provide for consumer-controlled Centers for Independent Living.
1983 - Amendments to the Rehabilitation Act	Provides for the Client Assistance Program and advocacy programs for consumers of rehabilitation and independent living services.
1985 - Mental Illness Bill of Rights Act	Requires protection and advocacy services (P & A) for people with mental illness.
1988 - Civil Rights Restoration Act	Congress overrode President Reagan's veto and reversed the impact of unfavorable case law (the 1984 United States Supreme Court [USSC] ruling in Grove City College v. Bell) by clarifying Congress' original intention under the Rehabilitation Act. The Act restores the reach of Title IX and other laws that prohibit discrimination by entire programs that receive federal funding (not just the part of the program which directly receives the funding).
1988 - Fair Housing Amendments Act	Originally passed in 1968, this act was amended and now prohibits discrimination in housing and related transactions on the basis of race, color, national origin, sex, religion, disability and familial status. It also provides for architectural accessibility of certain new

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housing units, renovation of existing units, and accessibility modifications at the renters expense. The Act covers all kinds of housing-related transactions, including rentals, home sales, mortgage lending, homeowners' insurance, home improvement and zoning.

1990 - Americans with Disabilities Act

A landmark comprehensive civil rights law, the ADA bans job discrimination on the basis of disability and requires businesses, public transportation, and other public facilities to be made accessible to persons with disabilities.

1991 - Civil Rights Act (as amended)

This act legislatively reversed the USSC's 1989 decision that narrowly interpreted job discrimination laws and provides money damages for victims of intentional job discrimination to compensate them for their injuries and to deter future employer wrong doing.

1998 - Bragdon v. Abbott

This was the first ADA case to make its way to the USSC, which holds, among other things, that HIV+ individuals are protected under the ADA.

1999 - Olmstead v. L.C.

This case reaffirms that Title II of the ADA bars the unnecessary segregation of people with disabilities in state institutions. As the USSC noted, such segregation is often motivated by irrational fears, stereotypes, and patronizing attitudes, and unfairly relegates individuals with disabilities to second-class

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