

Brain Injury Professional Conference

# Evolving Landscape of Brain Injury Services and State-funded Initiatives

April 17, 2026



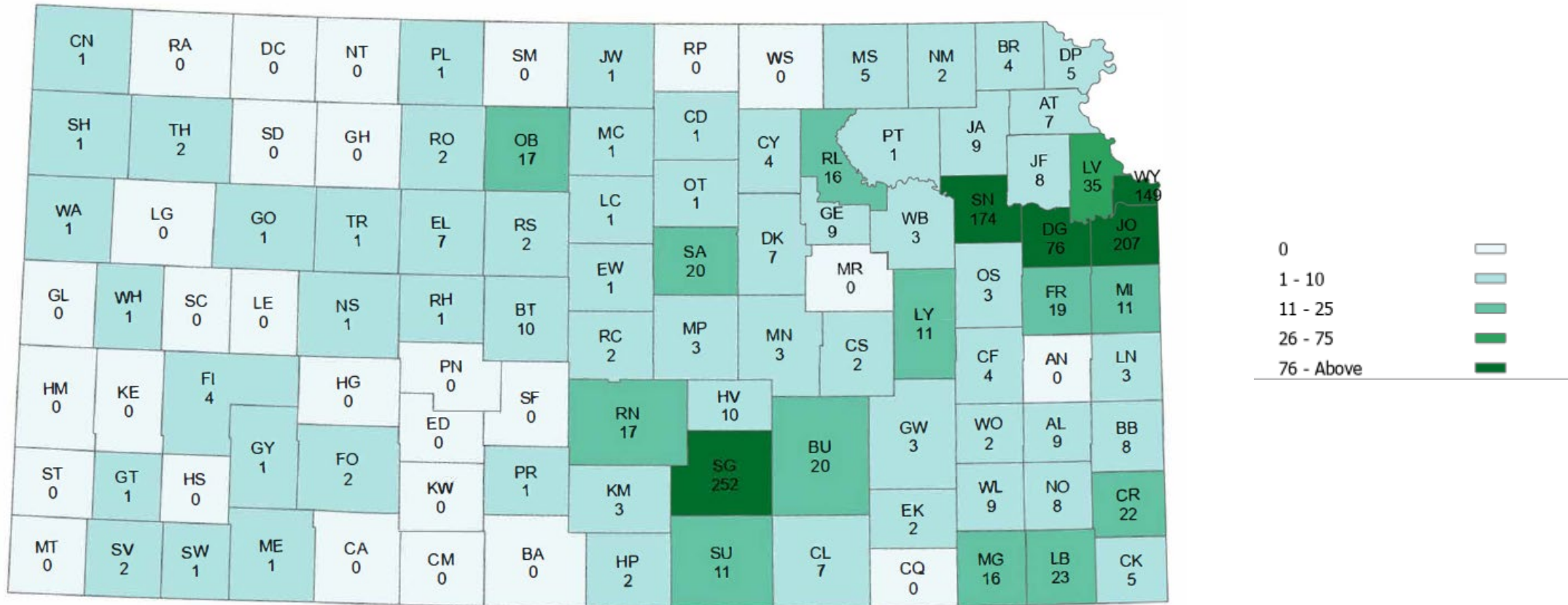
# KANSAS

# What We Will Cover Today

- Home and Community-Based Services (HCBS)
  - HCBS and the Brain Injury (BI) Waiver
- BI Waiver Eligibility/Pathway to the Waiver
  - MCO and Care Coordination
    - Person Centeredness
- BI Waiver Services and Transition Planning
  - Growth of the BI Waiver
- ACL Traumatic Brain Injury State Partnership
  - Kansas BI Strategic Plan
    - Closing and Q&A

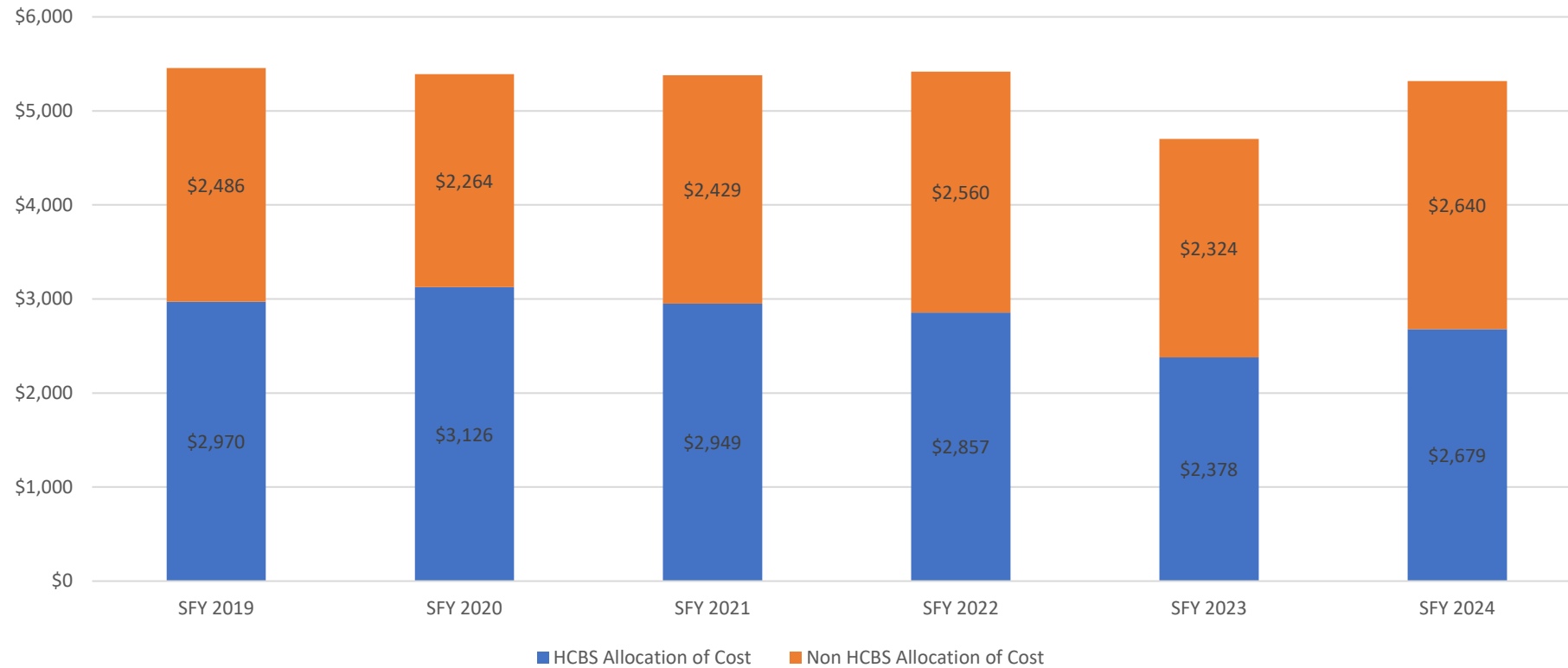
# Brain Injury in Kansas

## Brain Injury Waiver Participants by County



# Brain Injury in Kansas

## Average Monthly Cost Per Participant





# HCBS in Kansas

## Purpose

*“HCBS ensures that people who receive services and supports through Medicaid’s HCBS programs have full access to the benefits of community living and can receive services in the most integrated setting.” ~ CMS*



Originally established in 1986, Kansas was the first state in the nation to offer a brain injury-specific waiver program. The BI waiver provides clinically prescribed habilitation/rehabilitation therapy services on a short-term/transitional basis to eligible Kansans following the occurrence of, and treatment for their brain injury. The program offers an alternative to seeking services from more expensive, non-inclusive, institutional settings when negative symptoms of a brain injury rise to the level that the social determinants of health are negatively impacted. Typically, they reach their transition goals between years 2 and 4.

# HCBS in Kansas

## Purpose

Kansans, both in the community and in institutional settings, who have a brain injury are given the option to receive the HCBS BI Waiver services in their private home and community in a cost-efficient manner.



Those actively engaged in the BI Waiver therapies can also use a comprehensive package of other waiver services, as well as medical services offered by the KanCare health plans through the Managed Care Organizations (MCO). This provides individuals the opportunity to live outside the “crisis” lane and to reintegrate into their families, friends, and communities, thereby improving health outcomes and reducing frequent ER visits, hospitalizations, and placement in long-term care facilities.

# BI Waiver Eligibility

## Pathway to the Waiver

There are 3 reasonable indicators that the BI Waiver is the best match for the applicant:

1. Has the person been diagnosed with a BI that is not diagnosed as chromosomal, congenital, or degenerative? Can they provide the diagnostic documentation from a qualified medical provider?
2. Is the person wanting to engage in therapies, a requirement of this waiver? Do they have desired outcome goals, even if they are not sure they can meet them?
3. Does the person live in a waiver-approved setting? The BI waiver participant's residential setting is within their family residence, or their privately leased or owned residence, not agency-owned.

## Pathway to the Waiver

If the answer is **YES**  
the BI waiver is the correct eligibility path

# BI Waiver Eligibility

## Pathway to the Waiver

### Entry Point – ADRC (Liberty Healthcare)

- Individuals contact the Aging and Disability Resource Center (ADRC)
- Receive **Options Counseling** on available community services
- If appropriate, referred for BI Waiver assessment



## Pathway to the Waiver

### Assessment – Statewide Assessing Entity (Maximus)

- Conducts HCBS assessments for BI Waiver eligibility
- Reviews functional needs and eligibility criteria

**maximus**

# BI Waiver Eligibility

## Pathway to the Waiver

### Eligibility Review – KDADS

- Individual completes MFEI and submits medical documentation
- KDADS reviews and determines program eligibility



# BI Waiver Eligibility

## Eligibility Criteria

1. Meet the criteria for placement in a Brain Injury Rehabilitation Facility (BIRF) or hospital, which is determined by completing the BI Medicaid Functional Eligibility Instrument (MFEI) and meeting the level of care criteria for those aged 4 through 64;
2. Be 0 through 64 years old at the time they complete the eligibility process;
3. Be a resident of the state of Kansas;
4. Be financially eligible for Medicaid;
5. Have an active BI habilitation /rehabilitation needs and want to actively engage in the therapies offered to improve their cognitive, behavioral, communication, physical, vocational, and independent living skills lost because of their brain injury.
6. Have a documented medical diagnosis of a Traumatic Brain Injury or Acquired Brain Injury (TBI or ABI) that has not also been diagnosed as chromosomal, congenital, or degenerative.

*Note: Eligibility for ages 0 through 3 is too young to assess. KDADS will determine eligibility by reviewing the documentation from their medical provider. Paperwork must be provided to the assessing entity or KDADS to determine program eligibility.*

## Pathway to the Waiver

### Final Determination – KDHE (KanCare)

- Reviews for Medicaid/Disability eligibility
- If approved, assigns waiver start date



## Pathway to the Waiver

### Enrollment & Notification

- Decision shared with participant
- Managed Care Organization (MCO) is notified



## Then & Now

### At Inception:

- Served individuals with Traumatic Brain Injury (TBI)
- Eligibility limited to ages 16–64

### 2020 Update:

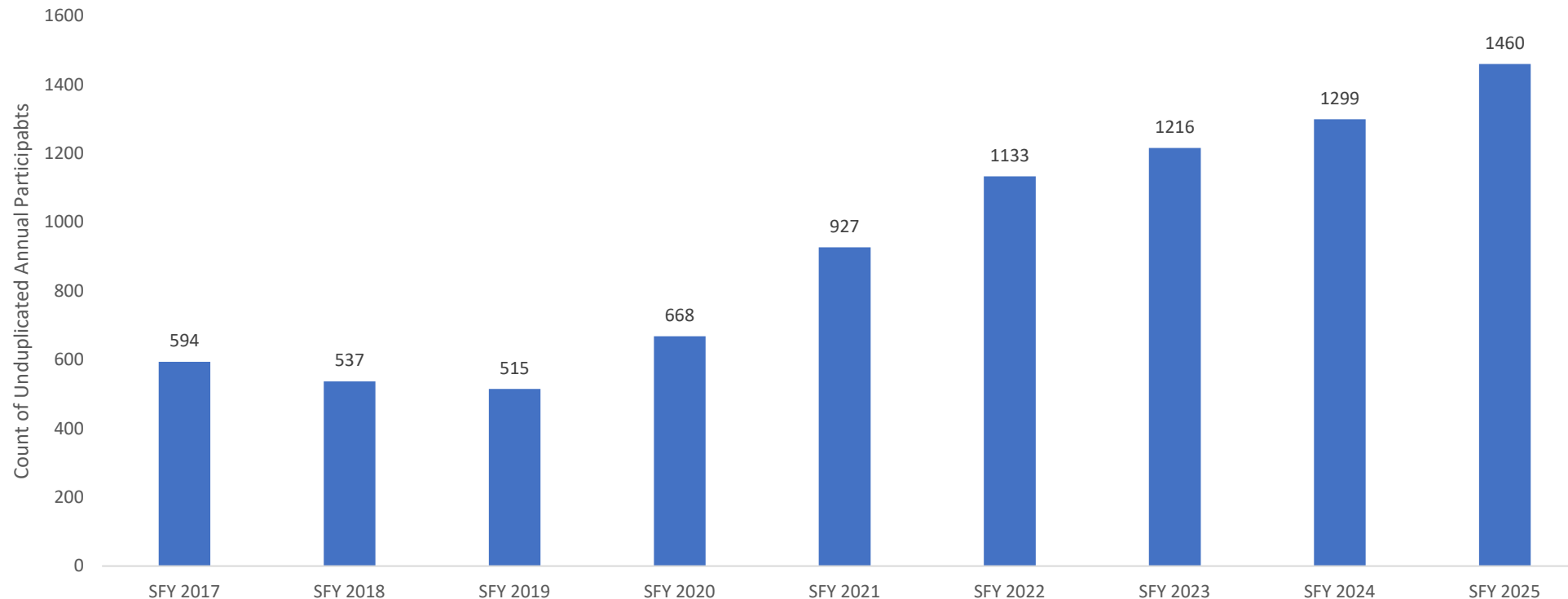
- **Expanded** to include Acquired Brain Injury (ABI)
- Eligibility updated to **ages 0–64**
- Renamed the **Brain Injury (BI) Waiver**
- Expanded number of participants with **access** to rehabilitation and independent living supports
- Resulted in **increased** enrollment and service utilization



# Waiver Growth

## Annual Unduplicated Count by Waiver Year

An **unduplicated count** in the context of waivers (specifically Medicaid 1915(c) Home and Community-Based Services) refers to the total number of unique individuals served within a single waiver year.



## Waiver Professionals

The State of Kansas contracts with three Managed Care Organizations (MCOs) to coordinate HCBS services through the KanCare program. These organizations support participants in achieving health, wellness, and independence through integrated, whole-person care.



# Care Coordination

## MCOs

- The Care Coordinator will meet with the new enrollee in person and complete the service needs assessment and Personal Interest Inventory with them. These are the first steps to creating the Person-Centered Service Plan (PCSP).
- Choices: The new enrollee is given a list of BI waiver service providers to reach out to and determine who is the best fit.

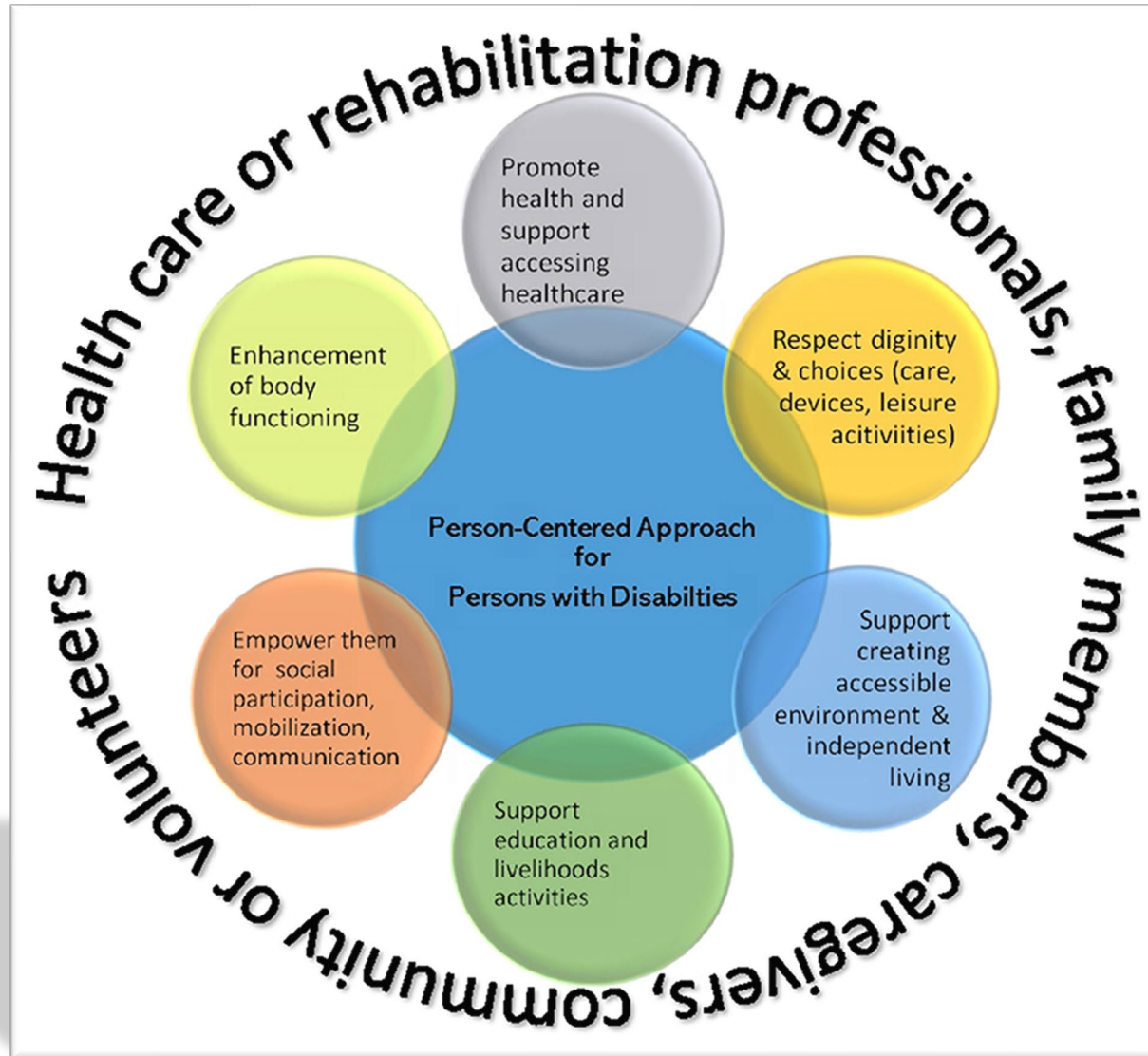
Care Coordinators are responsible for assisting the participant in developing, monitoring, and following up on the outcomes of the PCSP, as well as the person's satisfaction with services.

# Person-Centered Care

As professionals, in all waiver service areas, we often learn what works well for those utilizing our services. The word “EXPERT” identifies us as someone with the background and knowledge to help those with a brain injury within the scope of their credentialing.

Participants are the experts in their own lives. Along with their natural supports, they define their goals and direct their care. Our role is to support their choices, respect their autonomy, and provide guidance when needed.

# Person-Centered Care



# Partnership Opportunities

## Charting the LifeCourse



- KDADS continues its partnership with The LifeCourse Nexus, Charting the LifeCourse.
- The framework is human-centric, meaning the principles are designed to reflect the needs of people.
- The key principles were initially developed to drive person-centered change for people with developmental disabilities. This has now been expanded to other populations.
- The LifeCourse framework and tools can be applied to everyone and can be used to drive transformational change in practices, organizations, policies, and communities.

# Partnership Opportunities

## ACL Traumatic BI State Partnership Program

The Traumatic Brain Injury (TBI) State Partnership Program is a federal grant initiative administered by the Administration for Community Living (ACL). Its primary mission is to help states create and strengthen person-centered, culturally competent systems of services and supports for individuals with TBI, their families, and their support networks throughout their lives.



Kansas started this partnership in 2018 at the request of stakeholders to expand opportunities for those in our community living with brain injuries.

# Partnership Opportunities

## ACL Traumatic BI State Partnership Program Goals

**Partnership Activities** - identifying and reaching out to new partners, coordinating and aligning activities, information exchange, collaboration on grant activities, and collaboration on activities related to the grant

**Planning and Infrastructure** – state planning, policy and procedures development, state councils, needs assessment, surveillance, registry, IT systems

**Information and Referral and Assistance (I&R/A)** – bringing people and services together, answering questions from individuals and families about human service resources, helping people get connected to public benefits, and sharing information about available services like home care and adaptive equipment.

# Partnership Opportunities

## ACL Traumatic BI State Partnership Program Goals

**Screenings** - using a standardized procedure, structured interview, or tool to elicit the lifetime history of TBI for an individual. Screening can be used for clinical, research, programmatic, eligibility determination, service delivery, or treatment purposes.

**Resource Facilitation** – this category of activity could include developing resources such as databases, resource directories, and communication tools to improve service delivery. It could also mean helping through an accessible, holistic, and person-centered process that engages individuals in decision-making about their options, preferences, values, and financial resources and helps connect them with programming, services, and supports they choose.

**Trainings, Outreach and Awareness** – continuing education for professionals who may work with or provide services for people who have experienced a TBI, training for individuals who have experienced a TBI, public education and awareness, training for caregivers, on-the-job training for agency staff, and cross-training with partnering agencies.

# Partnership Opportunities

## ACL Grant Outcomes

- Development, education, and execution of the professional conference you are attending today.
- Continued growth of border state relationships with providers such as Madonna Rehabilitation Hospital and QLI in Nebraska, and Craig Hospital in Colorado, to build upon their evidence-based practices and resources for survivors in Kansas.
- Improvements to the BIAKS website to improve accessibility and inclusion of a resource directory.

# Partnership Opportunities

## ACL Grant Outcomes

- Planning for a new series of survivor events, “Survivor and Family Gatherings.” The goal of these is to create four events across the state annually, so we can expand our physical reach by connecting survivors and families in person.
- This partnership has allowed Kansas access to technical support from NASHIA and ACL for continued opportunities, goals, and growth in our state.

## KDADS/BIAKS Goal Categories

### *Advocacy and Protection*

- Goal 1: To enhance the self-advocacy skills of persons with BI.
- Goal 2: Pursue funding opportunities for awareness education.
- Goal 3: Advocate in Legislative and State Agency Systems
- Goal 4: Increase prevention strategies and public education awareness

### *Social and Recreational Support*

- Goal 1: Identify accessible facilities and activities in our communities
- Goal 2: Promote support groups that are inclusive and available statewide

## KDADS/BIAKS Goal Categories

### *Independent Living Services*

- Goal 1: Promote person-centered, trauma-informed practices to support workforces, communities, and all types of caregivers.
- Goal 2: Enhance caregiver awareness, workforce development, and all aspects of independent living

### *Employment/Vocational Services*

- Goal 1: Working with Vocational Rehabilitation (VR) and educating VR about BI
- Goal 2: Educating the public about the benefits and working with BI
- Goal 3: Self-employment and volunteer opportunities

## KDADS/BIAKS Goal Categories

### *Training and Education*

- Goal 1: Expand learning opportunities for students, workforces, caregivers, and communities.
- Goal 2: Create alliances with organizations to support community education on BI prevention

For more information and to participate in the BI Advisory Board or in the implementation of the Kansas Brain Injury Strategic Plan, contact:

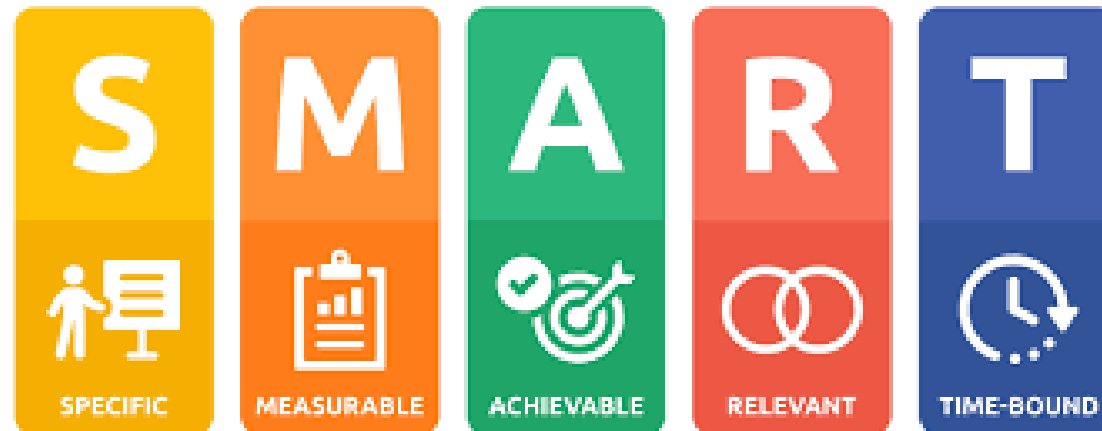
~Brain Injury Association of Kansas & Greater KC (800) 444-6443 [admin@biaks.org](mailto:admin@biaks.org) OR

~Brain Injury Waiver Program Manager, Kansas Department for Aging and Disability Services,  
(785) 368-6302 [susan.segelquist2@ks.gov](mailto:susan.segelquist2@ks.gov)

# Services & SMART Goals

## SMART

The BI waiver supports individuals with functional limitations from their BI and provides community-based services that address SMART goals. This approach transforms vague intentions into actionable plans with clear metrics and deadlines. SMART goals are a structured framework for goal-setting designed to increase the likelihood of success by making objectives:



## Services

Goals and functional limitations may be supported by the following services offered on the waiver. Rehabilitative therapies are a required component of the BI waiver.

- Rehabilitation Therapies: Behavior Therapy, Cognitive Rehabilitation, Physical Therapy, Speech-Language Therapy, and Occupational Therapy
- Specialized Medical Equipment and Supplies, Home and Environmental Modification Services, Vehicle Modification Services

# Services & SMART Goals

## Services (continued)

- Financial Management Services
- Home-Delivered Meals
- Medication Reminder Services
- Personal Emergency Response System and Installation (PERS)
- Personal Care Services (PCS)
- Enhanced Care Services (ECS)
- Transitional Living Skills (TLS): In-person services to support goals of increasing independence in the home and community



## Transitioning from the BI Waiver

- Each person's goals and timelines are unique. On average, we see people reaching the therapy milestones within 2-4 years.
- During that time, it is important to identify what happens at the end of the waiver. The participant may seek to close their services, contact an independent living center, or transition to WORKS/Working Healthy, PACE, or another HCBS Waiver for which they meet the criteria.
- A minimum of 6 months active participation in therapies is required to be able to determine inability to make progress on the established therapy goals to qualify for a waiver-to-waiver transition and bypass the wait list for that waiver.

# Next Steps, Closing and Q&A

## Looking Ahead

- Building a stronger service network
- Enhancing long-term supports
- Increasing awareness and early intervention
- Supporting families and caregivers
- Expand provider training
- Increase provider network and telehealth opportunities in rural areas
- Strengthen community partnerships
- Improve data collection

## Closing Remarks

- Commitment to Partnerships
- Eliminate Barriers
- We Want to Hear From You

**Contact:**

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Brain Injury Program Manager  
[Susan.Segelquist2@ks.gov](mailto:Susan.Segelquist2@ks.gov)  
785.368.6302

# Next Steps, Closing and Q&A

**Q&A**

# THANK YOU

Thank you for your commitment to improving the lives of Kansans  
with brain injuries.

