

**Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary**

Integrated Service Delivery - Candy Shively, Deputy Secretary (785) 296-3271

Economic and Employment Support - Bobbi Mariani, Director (785) 296-3349

MEMORANDUM

To: EES Chiefs and Staff
HealthWave Clearinghouse Staff

Date: October 7, 2003

From: Bobbi Mariani

RE: Implementation of Additional
Medical Assistance Changes for
10-2003

The purpose of this memo is to communicate implementation instructions and background information regarding medical assistance changes. Additional policy information is also contained in this material. These changes are associated with the implementation of the interChange MMIS. All changes also involve changes to the KAECSES system. Migration of these modifications are scheduled to take place over several days. This will require the mainframe systems to be brought down at 12:00 noon on 10/10/03. The systems will be unavailable until 1:00 on 10/13/03, at which time migration is expected to be completed. Please note that the changes to the KAECSES MEEEX and LOTC screens will also migrate according to this schedule. Changes associated with new race/ethnic coding and family medical related changes will also be migrated at this same time. Those changes will be addressed in a separate memorandum. All changes are effective 10-13-03.

- A. **AIDS Drug Assistance Program (ADAP)** - Based on an action taken during the 2002 Kansas Legislative Session, the ADAP program was transferred to SRS from KDHE. The ADAP program is designed to pay medication expenses of persons diagnosed with AIDS or who are HIV positive and have limited income.

Although the program was transferred to SRS, KDHE still maintains responsibility for eligibility determinations. This essentially means that SRS is responsible for those program aspects related to budget, caseload, provider payments and federal reporting. KDHE will continue to maintain the eligibility determination. The interChange MMIS will be used to meet many of the SRS requirements, including provider payment.

Most SRS eligibility workers are familiar with ADAP as a state-funded program which can sometimes help pay expenses which are then also used against spenddown (see KEESM Section 7532.3). In actuality, ADAP is composed of three separate programs. Each different program must be individually maintained and tracked. The programs are:

Ryan White - The majority of funding for the program comes from federal Ryan White funds. Persons in this group are not Medicaid eligible. Two separate funding sources make up this group, with each beneficiary assigned a single funding source. Most are

included in the general program, or Title II. However, some persons in the Kansas City metro area are included in a special population that receives funding through a different mechanism. These are identified as Title I funded individuals. It is important to note that benefits and coverage are not dependent upon the funding source. This is used as an internal mechanism for budgeting and payment only.

State-Only ADAP - Persons in this group are on the Medically Needy program with an unmet spenddown. Because state funds are used for these claims, the expense can be used to meet a spenddown even though the client is not obligated for the expense.

ADAP Tracking Only - Some persons associated with the Ryan White Title II CARE program are not eligible for payment of medication expenses, but may be eligible for other services. These include Ryan White Case Management and dental services. Because the federal agency monitoring the ADAP program requires information on all such individuals, we must maintain these individuals in any data base used to generate federal reports. However, no services will be paid for these persons, unless they are also eligible for some other type of medical coverage (such as Medicaid or MediKan). The ADAP-T designation is used for tracking only.

Eligibility - As indicated earlier, KDHE will continue to provide for eligibility determinations within the ADAP program. Kansas Ryan White Title II CARE program staff currently provide this service and will continue to do so. Regional case managers will accept and process applications, including making necessary collateral contacts.

As part of the ADAP application process, CARE case managers are required to determine if the individual is potentially eligible for Medicaid. Like many federal programs, all persons must be screened for Medicaid before ADAP enrollment is finalized. To accomplish this, a screening tool, Medicaid Eligibility Screening form, has been developed. This form shall be completed by ADAP case managers prior to finalizing enrollment into ADAP. If the screening indicates potential eligibility, the individual will be required to apply for Medicaid. The case manager may assist the client in this process and may contact the appropriate eligibility worker directly. To ensure medication access immediately, case managers may enroll the client in the ADAP program on an interim basis. Generally, the interim enrollment is for a period of about 30 days.

Enrollment Process - Upon completion of the eligibility determination, case managers will forward information to staff in KDHE's central office in Topeka. Central office staff will then enter eligibility information into the KAECSES system. This is done for the sole purpose of assigning a client ID number and passing eligibility information to the MMIS. ADAP eligibility information will be sent from KAECSES to the MMIS on the daily MMIS eligibility file. Once the MMIS has this information an ADAP benefit plan will be assigned. Payment of drug benefits is dependent upon the presence of the ADAP benefit plan.

LIME Screen/KAECSES Coding - A new KAECSES screen has been created to capture ADAP eligibility records. The new screen is called the Limited Medical Eligibility (LIME). In general, KDHE staff assigned to ADAP data entry are the only users of this screen. Unlike other medical eligibility records, LIME will not send monthly records to the MMIS. Instead, an eligibility range is entered on the LIME screen at

approval. When the MMIS receives this information, eligibility will be set for each month within the range. If the eligibility range is not reset on the screen, eligibility will terminate.

Although a case number is needed to initially establish a LIME record, the case does not have to be maintained in 'open' status to authorize coverage. LIME records are considered authorized when the user authorizes coverage to be sent to the MMIS.

When an ADAP record is ready to be entered, a client search will be completed on KAECSES. Depending on the client's status in KAECSES, the following action will be taken:

1. For individuals unknown in the client master file, the individual will be created and an MS program will be registered with a new case number. This number will carry the ADAP record. KDHE staff will then enter demographic information on all appropriate screens (SSDO, ETRC, etc.) as well as the address information. The MS program will be immediately denied and no open program will exist.

A new section has been created in the KAECSES Section Code Table for KDHE/ADAP staff. Section 821 carries the KDHE caseload.

2. If the client is known to KAECSES, the existing client ID number will be used. Subsequent action is dependent upon the current case status of other programs. If there is an open, active case number for the client under any program type, the case number will be selected for authorization of ADAP coverage. The case will not need to be CARC'd, as KDHE staff will be able to create a LIME record on the case as is. The current eligibility worker will be notified when this occurs.
3. If the client is known to KAECSES but an active number is not available under any program type, the most recent number will generally be selected and the LIME record will be added. The closed case number holding that record will be CARC'd to the ADAP worker by KDHE staff. Demographic information will be updated as necessary. No formal notification to the former eligibility worker will be made when this occurs.

When a current ADAP recipient who is not receiving other benefits or coverage applies for Medicaid or other programs, it is not necessary to create a new case number. Because the existing program will be in a closed status, the case will be registered per normal case registration procedures using the new caseworker's section/unit/caseload number. However, it is important that the new eligibility worker notify the KDHE Central Office contact of the application and the change in caseload.

When other SRS programs close and a current ADAP benefit is in place or when the SRS case is closed and ADAP is added, the case will be CARC'd to KDHE for ongoing maintenance. SRS and Clearinghouse staff are advised to hold onto the case for 30 days to

allow for possible reopening. However, this time frame may be adjusted on a case-by-case basis.

Identifying ADAP Clients - Because neither MEBH nor ACHI capture LIME activity, staff cannot rely on these processes to determine if a client is currently receiving ADAP. A new program/person alert has been created to help identify ADAP recipients. The new PRAP alert of AD (ADAP client) will be noted on all ADAP clients. KDHE staff will input this code upon approval of ADAP coverage. However, because full eligibility information will only be available through the MMIS, staff should routinely access the MMIS to determine if the individual's coverage is current. In the MMIS, ADAP recipients are noted by the presence of one of the following benefit plans:

ADAP-D: ADAP-Drug (receives drug coverage)

ADAP-T: ADAP-Tracking (does not receive any benefits, only used for tracking)

Other Information - Listed below are several important facts regarding ADAP implementation

- The worker number for ADAP cases with no active KAECSES program will begin with the new 821 KDHE section number. The worker number for ADAP cases where other KAECSES programs are open will remain with the eligibility worker number responsible for the other program. For example, an open FS and MS case with a current, valid LIME record will belong to the EES Specialist.
- Notices of action will NOT be sent from KAECSES for ADAP eligibility records.
- Eligibility staff will not have access to LIME through normal user profiles. This is to prevent accidental updates to the LIME screen. If staff have a need to view information on the LIME screen, access should be gained through the use of the COREVIEW profile. LIME must be accessed through the "NEXT" field on a KAECSES screen.
- Action taken on the LIME screen will not be reflected on the ACHI screen.
- Medical history for benefits authorized through LIME will not be reflected on MEBH

- Persons on ADAP only will receive a medical card. The color designation 'tan' will appear in the lower right hand corner of the card if the beneficiary is not eligible for any other benefit plans.
- For common cases, it is important that staff work together when changes occur. If one entity becomes aware of a change that impacts information on the system, such as an address or name change, the other party should be notified of the change.
- Burial assistance is available to persons covered under either benefit plan, ADAP-T or ADAP-D, on the date of death.
- It is also necessary to stress the need to protect the privacy of individual beneficiaries by prudently following HIPAA, Medicaid and other State confidentiality guidelines. It will rarely be necessary to disclose to anyone the nature of the medical assistance coverage the individual is receiving. Providers inquiring should be routed to appropriate provider verification processes, where carefully scripted messages regarding coverage information are communicated.

Benefits - For those eligible under ADAP only, coverage is limited to certain prescription drugs, as provided on a formulary developed by Health Care Policy-Medical Programs and ADAP program staff. Persons also eligible for other benefit plan coverage, such as regular Medicaid, QMB or Medikan will have covered services under the particular benefit plan.

Special processing has been added to the interChange MMIS for persons eligible for both ADAP and Medically Needy benefit plans to automate the special rule for allowing ADAP-paid expenses against the spenddown. When state ADAP funds are used to pay the prescription claim, the bill is to be allowed against the spenddown even though the client is not directly responsible for the expense. When a claim for a covered drug is received for an ADAP-Medically Needy eligible person with an unmet spenddown, the claim will be paid under the state-funded ADAP group mentioned above. The amount paid will then be automatically applied to the spenddown. Expenses paid through ADAP funding are not to be allowed as a medical expense on a Food Stamp case. No additional steps will be necessary by the client, eligibility worker or provider. When the spenddown is met, covered services will be paid under the Medicaid program.

For persons eligible only for ADAP, there will be no copay requirements. However, for persons also eligible for other benefit

plans, copay will apply. TPL editing will apply for persons with other insurance coverage.

Conversion - KDHE staff will input information on all ADAP eligibles into KAECSES . This process is already underway and should be completed in the month of October.

Communication - A Case Manager Contact Sheet is included with this material. Questions should be directed to the individual case manager or to David Tritle in Topeka through phone 785-296-8701 or through email, dtritle@kdhe.state.ks.us. David, as well as KDHE staff person Lois Seipel, lseipel@kdhe.state.ks.us, will soon be added to the GroupWise directory.

- B. **MEIN and Buy-In** - Although no significant buy-in related policy changes are being implemented, modifications to KAECSES have been made to better support identification of Medicare entitlement and buy-in processing in the interChange MMIS, primarily involving the MEIN screen.

Currently, the MEIN screen is primarily populated with information coming directly from Social Security through the TPQY or BENDEX. This process will not change significantly with these changes. In addition, automated requests through EATSS when new applications or reviews are received and prior to a 65th birthday will also continue to be generated.



A copy of the updated MEIN screen is pictured above. The changes to this screen are highlighted on the screen and noted below.

'Medicare HMO' - This new field has been added for informational purposes only to identify those covered through non-traditional Medicare plans offered through HMO's. The information contained in this field is not currently sent to the MMIS. This indicator will default to a blank. A traditional Medicare coverage record will continue to be sent to the MMIS. An additional segment reflecting the Medicare HMO coverage must also be loaded reflecting the replacement plan.

'Travelers Medicare' to 'Railroad Medicare' - The title of this field has been changed, as Travelers is no longer the Medicare Part B carrier for Railroad annuitants. The functionality of this field has not changed however. A 'Y' entered in this field will establish an MMIS record of Medicare Part B coverage through the current Railroad carrier.

Entitlement 'Start Dt (Date)' and 'End Dt (Date)' - These new fields have been added to capture terminated Medicare coverage segments. The start date field replaced the previous 'Entitlement' field. The 'End Dt' field has been added. These fields will display Medicare entitlement periods of coverage. Multiple coverage periods may be present under either Part A or Part B.

Prior to this change, negative information placed on MEIN, such as a change in the 'Coverage in Effect' indicator, did not transfer to the MMIS. When coverage terminated all information in the MMIS had to be manually updated. With this change, these changes will be sent to MMIS. The rules listed under the heading 'CIE Processing' explain this process. Please note that once a termination date is input on MEIN, staff will not be able to update the effective dates. Contact HelpDesk if updates are needed to this information.

Terminated Medicare Segments - Information available through the current MMIS will be used to initially populate the new 'End Dt' field on MEIN. A file of all terminated Medicare segments on the current MMIS has been produced. This information will be used to populate the current system the weekend starting 10-10-03. Alerts notifying staff of the change in MEIN information will be generated as a result of the update. New termination alerts have been created as indicated below. Although in some cases, staff will be aware of the previous Medicare coverage, this may be new information in some instances. Therefore, QMB, LMB or MEEX allowances may need to be updated as a result. Keep in mind that the information coming from the conversion report is coming from the existing MMIS and not directly from CMS. Before taking any action to terminate or reduce benefits, Medicare entitlement should be verified. If it is discovered that Medicare coverage was terminated in error, a TPQY should be requested. If existing Medicare entitlement is present, it will overlay the existing terminated segment.

CIE Update - Once each month, a special cycle will be ran which will compare the Part A and/or B effective dates to the current coverage in effect indicator. The indicator will be updated for those gaining or losing coverage in the current month. This is referred to as the Coverage In Effect (CIE) update. This update will occur on the third day of each month. The information will be transmitted to the MMIS following this update.

For example, MEIN is updated on 02-15 with a termination date of 02-28. The CIE update is ran on 03-03, changing the CIE indicator from Y to N. This information is then sent to MMIS. If MEIN was populated with a new start date of 03-01 on 02-15, the CIE indicator would be switched from N to Y on 03-03.

Note: Direct update capability of these fields is not available. Staff becoming aware of coverage terminations that are not included in an automated update should contact HelpDesk to request updates. Additional automated updates of this information are planned for the future.

*****IMPORTANT*** Special processing for new Medicare Beneficiaries** - A special process is being implemented to allow for authorization of QMB coverage for current Medicaid clients newly approved for Medicare. It is important to note that this is not expected to impact a large number of clients

Authorizing QMB eligibility through the SIAU or MSID screens is dependent upon the Medicare Part A indicator on the MERE screen being set to 'Y'. Direct update of MERE is not allowed, as this field is populated through information on MEIN. Generally, the information on MERE mirrors MEIN information. For most situations, if the Part A CIE indicator on MEIN is set to a Y, the MERE indicator will also be a Y, and vice versa.

As noted above, for those clients newly approved for Medicare, this flag won't be turned on until after the beginning of the month, therefore setting a MERE indicator of N for Part A and Part B. If the Part A indicator is not Y, it is not possible to authorize QMB coverage for Medicare start dates in the future. Thus, making it impossible to authorize QMB earlier than the month in which Medicare is effective. Policy requires that QMB coverage be authorized in advance of the start date. This will not be possible to do through the indicators on SIAU or MSID. As a temporary workaround, staff must utilize an appropriate PICK code (QO, QS, QM or WQ) to provide QMB coverage for the initial month of eligibility UNTIL the CIE indicator switch is fixed. When the CIE indicator is switched and MERE updated, the PICK code is to be removed and QMB authorized on SIAU or MSID. An alert will be generated when the change occurs.

Please note on variance to the above process. Cases with a future Z99 date will have a MEIN Part A CIE of 'N'. However, in this instance only the Part A indicator on MERE is set to a Y. This is to allow for authorization of QMB for a pending Part A segment. Since Medicare Part A enrollment cannot be finalized until QMB is determined, it is possible to utilize SIAU or MSID to authorize QMB for these situations prior to the first month of Medicare Part A.

New Alerts and Updates:

MMIS Part A End (Name) (MMCCYY) and MMIS Part B End (Name)(MMCCYY) -

Through the buy-in process, CMS tells us when Medicare entitlement has terminated. The buy-in transaction code of 15 (or 16 in case of death) is used for this purpose. When a code 15 is received through the buy-in file, EDS will create an alert to KAECSES. This will tell the eligibility worker that coverage has terminated. Information on the MEIN screen is updated through this alert, cancelling any present Medicare indicators. This process occurs in the current MMIS and will continue with the interChange system. However, it will be enhanced by the addition of the termination date to the current alert message. When received by KAECSES, the termination date will also be passed onto MEIN and loaded on the screen.

MMIS Part A Z99 Accrete (name) - Persons who are not entitled to free Medicare Part A may conditionally enroll in Medicare through Social Security. This is conditional because the individual won't actually be enrolled until a QMB determination is completed and he is formally accreted to buy-in. This alert will be generated when an ongoing Part A buy-in transaction code is received from CMS for a person with a Z99 date on file. This will tell the worker Medicare Part A is now in place.

HIC # chg (name)(New HIC) - Through buy-in, CMS tells us when an individual's Health Insurance Claim number (HIC) changes. This number is also called the Medicare ID number and is the number which carries the individual's Medicare coverage. The buy-in transaction code of 2361 carries claim number change transactions. When a code 2361 is received, an alert to KAECSES is produced. This is expected to occur on the first Friday of the first full week of the month. When the alert is received, MEIN will be populated with this new claim number. It will then be transmitted to the MMIS, triggering a claim number change on the Medicare file. A TPQY will also be requested at the time the new HIC # alert is received. This will enable the worker to view any payment changes that sometimes accompany a claim number change.

Part A Ended for (client first name)

Part B Ended for (client first name) - When coverage is terminated on MEIN, the alert will be generated when the CIE indicator is actually switched from Y to N.

Claim Number Issues - Two additional items to note regarding Medicare claim numbers:

RRB Number Issue - One item to note is the temporary update of certain claim numbers which appear to be invalid numbers. During buy-in processing CMS converts all Railroad Retirement Board numbers to a format necessary for system processing. This converted 'number' will frequently contain letters and other unusual symbols that are not typically found in claim numbers. This is called a pseudo number. When this occurs, a code 2361 is then transmitted through the buy-in process for each client informing us of the claim number change. However, programming to discern the 'real' claim number changes from the pseudo number changes is not yet completed in the interChange system. Until it is, KAECSES alerts will be received for all converted RRB claim numbers. In some instances, this number will also be placed on the MEIN screen. It is important that any automated updates with the pseudo the number be promptly corrected by staff. When an alert is received with a pseudo number, staff should access the MEIN screen and correct the number. The programming to screen these alerts is expected to be completed within 4 -6 months.

Invalid Claim Numbers - Unlike the previous MMIS, the interChange system will edit all incoming Medicare claim numbers for validity. Although the validity check is not full proof, it does provide a minimal screening for bad numbers. All invalid claim numbers coming from MEIN will error off and will not post to interChange. The check compares the suffix of the claim number with a list of valid suffixes from CMS and there are no spaces, symbols or other funky characters included in the number. Those which fail will be placed on the error report.

While converting information from the current MMIS to interChange, a number of invalid Medicare claim numbers were discovered. A list of these numbers is enclosed with this material. Although a number of these were transmitted through MERE in pre-MEIN days and can essentially be ignored, some are numbers currently on MEIN and are preventing successful buy-in and could potentially cause Medicare billing errors as well. The report shall be carefully reviewed and any updates to MEIN applied accordingly.

MMIS Health Insur Terminated - This alert will be generated when health insurance coverage is terminated in the MMIS for persons currently receiving benefits through the MS or CI programs only.

- C. **Swing Bed Facilities** - Long term care processing will begin functioning for swing bed hospital facilities. For eligible beneficiaries, payment to these facilities will be dependent upon appropriate LOTC coding. Previous information indicated similar rules would also be implemented for Head Injury/Rehabilitation and Level VI facilities. However, interChange system programming has not been completed for these facility types and will be delayed until 2004.

LOTSC Screen - Effective for billing dates after interChange implementation (10-20-03), swing bed hospital claims will be denied unless the appropriate level of care information is present for the beneficiary. A living arrangement code of NF and a level of care code of SB are entered on LOTC beginning with the date payment is approved. No CARE assessment or LOC score is required for persons in these living arrangements.

Patient liability must be computed and entered on LOTC. Patient liability editing in the MMIS will apply to swing bed hospital claims. For new cases, the same policies used for regular nursing facility situations regarding establishing and changing the patient liability are followed for both swing bed hospitals too. Independent living budgeting is applicable for the month of LTC entrance (except for spousal impoverishment and certain child cases) with LTC budgeting applicable thereafter.

Living Arrangement/Level of Care Changes - For persons moving to or from a regular NF or other institutional living arrangement to a swing bed facility, the liability will be assigned to the first living arrangement of the month. If the individual is moving to another swing bed facility, the liability is assigned to the first paid claim(s) for the month.

Coding must also be adjusted for current HCBS waiver participants who temporarily enter a swing bed hospital arrangement as well. A living arrangement code of TC, in combination with the appropriate waiver code (e.g. PD, FE) will also permit payment of swing bed hospital payments. Patient liability rules in place for HCBS-TC situations are also applicable to swing bed facilities, where the obligation will continue to be assigned to HCBS services only.

Conversion - For existing residents of these facilities, LOTC must be completed before any payment to the hospital will be made. If the patient liability has not yet been determined, it must be computed prior to completing LOTC. Timely and adequate notice is required for cases initially receiving a liability. A facility notice must also be issued. No additional notification is needed if the resident and facility have previously been notified of the liability. Facilities will be informed of the new billing process through provider notification.

A list of beneficiaries with recent swing bed hospital claims in the MMIS has been attached. Staff should review this list and, if the individual is still residing in the facility, update LOTC accordingly. Coding for other residents not previously identified may be input when staff become aware of them.

The new coding will be available for use beginning 10-13-03. Cases should be converted as quickly as possible. However, because most facilities will not be billing the MMIS immediately, coding can be delayed for a brief period. Please attempt to have all coding completed by first medical card cutoff, 10-23-03.

New Alert - Because the duration of many of these stays may be relatively short, staff may not always be notified timely of the placement. A new alert has been created to assist staff in identifying these beneficiaries:

'Swing Bed Claim (10 digit provider number)' - This alert is generated by the MMIS and sent to KAECSES when a swing bed hospital claim is received for an eligible beneficiary without corresponding long term care coding in the MMIS.

- D. **SOBRA Spenddown** - As indicated in the previous implementation memo, the new spenddown process is not applicable to persons on spenddown and eligible only for SOBRA. This is because the interChange MMIS is not designed to process a spenddown for benefit plans other than medically needy. SOBRA is recognized as a specific benefit plan in the MMIS.

A manual process will be utilized to accomplish the actual count down of medical expenses for SOBRA spenddown cases. When an application is received and it appears a spenddown may apply, the current procedure for obtaining medical documentation of an emergency service are followed. Except for labor and delivery services, the MS-2156 must be sent to the provider for completion. The provider is then to return to the form to the fiscal agent where a medical determination will be made. If the determination indicates there is no emergency, the application is denied. However, if there is an approved emergency, the following procedure shall be followed:

1. Using an MS or MA program, process the case, ensuring an ES code is entered on ETRC and that MSID or MAID are passed through.
2. At the SPEN screen, enter the appropriate base period. The spenddown amount will display. Do NOT authorize the case at this point.
3. The case must remain deauthorized until sufficient bills to meet the spenddown have been obtained. The client must be instructed to provide bills directly to the eligibility worker that will be used against the spenddown. Because the same rules apply as with standard Medically Needy cases, bills other than those for the client may be used to meet the spenddown. This includes those for non-participating spouses, parents (MA only) and other assistance plan members as well as due and owing medical bills.
4. If the approved emergency service is not used toward the spenddown, all bills may be entered on the MEEEX screen to reduce the total spenddown. Once the spenddown is reduced to 0, the case is to be authorized ONLY for the month(s) in which approved emergency occurred. An SU code on MAID or MSID may be utilized to avoid providing benefits for other months of the base period. The interChange MMIS will only permit payment of the approved emergency, so additional notification to the fiscal agent is not necessary.
5. If the approved emergency service is used toward the spenddown, special steps must be taken to reduce the total payment amount to the provider. First, reduce the remaining spenddown by any other expenses on MEEEX as described in item 4 above. Then, make note of the remaining spenddown amount following these allowances. This amount will be deducted from the emergency service providers claim, when the claim is processed. To accomplish this, the case must be

approved, following the procedures list in item 4 above. Once completed, the total amount of the remaining spenddown must be immediately submitted to EES Central Office. This information will then be forwarded to the fiscal agent. At that point, a claims specialist with the fiscal agent will flag the file so the claim will be reduced by the total amount of spenddown.

6. Appropriate notification must be sent at various stages throughout the process.

Other SOBRA cases shall continue to be processed according to previous instructions.

E. **Enclosures** - Included with this material are several desk aids as well as specific printouts associated with implementation.

1. **MMIS implementation time line** - For informational purposes, a summary of key implementation dates is attached.
2. **October Medical Changes Training** - Questions and Answers
3. **Long Term Care LOTC/MMIS Codes** - A conversion guide to old and new MMIS LAC codes based on LOTC coding
4. **Swing Bed Hospital Facilities** - A listing of all current Medicaid swing bed hospitals
5. **Invalid Medicare ID Numbers** - A list from the MMIS of invalid Medicare claim numbers
6. **Cases with Swing Bed Hospital Claims** - For conversion, a list of cases with recent swing bed hospital claims

Your time and effort involved in completing the tasks identified in both this memo and all previous correspondence related to the interChange MMIS are very much appreciated, especially the spenddown related changes. The important role eligibility staff serve in the successful implementation and operation of this new system cannot be stressed enough. Thank you.

For system-related problems and questions, contact SRS TSC (HelpDesk). Please direct other questions to Jeanine Schieferecke, (785) 296-8866.

BM:JS:jmm

Attachments: Case Manager Listing 9-03

MMIS Timeline 10-03

LONG TERM CARE Code Table

MEDICAID SWING BED HOSPITALS

OCTOBER MEDICAL CHANGES TRAINING QUESTIONS &
ANSWERS

cc: Spenddown Implementation Team
HCP-MP Directors and Senior Managers
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SRS TSC
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