Kansas Health Policy Authority

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To: EES Program Administrators & Staff
HealthWave Clearinghouse Staff

Date: June 27, 2007

From: Jeanine Schieferecke

RE: Implementation Instructions – KEESM Revision 32 and Medical Changes Effective 07-01-2007

This memo sets forth implementation instructions for medical assistance changes effective July 1, 2007. Changes addressed in this memo related to Estate Recovery, WORK, Working Healthy and Psychiatric Residential Treatment Facilities are included in KEESM revision 32. Changes related to the implementation Mental Health and Substance Abuse managed care are also being addressed in this memo.

I. Estate Recovery

As mandated by the 2006 Kansas Legislature, KHPA has entered into a contract with Health Management Systems, Inc. (HMS) to support the Estate Recovery process. The Estate Recovery Unit will continue to provide some direct services related to the recovery process and will have oversight over the contractor.

Services HMS will provide include:

- Post-death recoveries involving probate, conservatorships, guardianships, family agreements in lieu of probate, nursing home funds, POD bank accounts, funeral plan excess and (d)(4) trusts (disability payback and charitable pooled trusts)
- Pre-death recoveries involving Medicaid liens
- Waiver requests involving recovery areas
- Negotiated settlements involving recovery areas
- Inquiries on claims amounts (for handling TOD deeds, resident trust funds, funeral plan excess and POD accounts)
- Inquiries on procedures used by HMS in recoveries

The Estate Recovery unit will continue to handle other functions, such as pre-payment and spousal elective share consultation. Eligibility workers do not need a release of information to discuss case issues related to the estate recovery process with HMS staff. Like other Medicaid contractors with limited job function, information beyond that necessary to perform the above estate recovery functions is prohibited.

HMS can be contacted through the following:

HMS Estate Recovery Program
2942 Wanamaker, Suite 1C
Topeka, KS 66614

Tel: 1-800- 817-8617
Fax: 1-646-465-6530 (goes to email)
Email: KSestaterecovery@hmsy.com

II. Transfer Of Property Penalty Divisor

Based on a change in the average state-wide nursing home facility private pay rate, the transfer of property daily penalty divisor for transfers occurring on or after 2-8-2006 is increasing from $131.80 to $136.60. The new rate is applicable to all transfer penalties with an effective date of 7-1-2007 or later. The monthly divisor for transfers occurring prior to 2-8-2006 has not changed. That amount remains $4,000.

The transfer of property calculator tool for transfers occurring on or after 2-8-2006 has been updated with the new daily divisor amount and is being re-issued to the field along with the accompanying worksheet guides as an e-mail attachment. The calculator should be saved as a desk top icon and the old version of the tool deleted.

See Attachments A1, A2 and A3.

III. Work Opportunities Reward Kansans (WORK)

WORK is a new program for employed persons with disabilities which provides personal assistance services to individuals enrolled in Working Healthy. Enrollment into WORK begins July 1, 2007.

A. WORK Services and Enrollment Process

The services WORK participants receive are similar to the services provided to HCBS participants. Participants in WORK must meet a level of care similar to that required under the various waivers. However, it is important to note that WORK is not a waiver program, and rules for participation are different from HCBS. The attached training guide provides additional information regarding WORK services and participation. All policies and procedures regarding functional eligibility and service delivery for WORK are found in the KHPA WORK Program Manual, which will be available on the KHPA website soon. All WORK services will be outlined in a Plan for Independence, which is similar to an HCBS Plan of Care.

B. Payment of WORK Services

WORK is provided under a 'cash and counseling' service delivery model, designed to enable individuals to direct and manage their personal assistance services according to their own specific needs. A flexible monthly allowance is provided to each participant to purchase these services according to their specific needs, often referred to as 'cashing out' the services. Under WORK, the monthly payment will be in the form of an allocation and is based on the service needs identified on the Plan for Independence.

By accepting an allocation payment, the beneficiary then becomes responsible for ensuring his unique service providers are paid. As part of WORK planning, the detailed planned expenditures are documented in an individualized budget. The WORK Program Manager has final authority to approve or deny and service on the individualized budget.

Although all WORK participants are enrolled in the cash and counseling model, the individual does have a choice in how the allocation payment is received and how distributions are made.

1. **Recipient Managed:** The beneficiary receives the allocation payment directly and is responsible for the distribution of all funds. This option is very hands-on and requires the individual to keep detailed records of each expenditure but also to ensure appropriate deductions and withholdings are made from the provider's payment. Persons who wish to manage their own funds must successfully complete a comprehensive training offered by WORK.

2. **Fiscal Agent Managed:** The beneficiary elects for the payments to go to an authorized agent where payments are made according to the participant's instructions as outlined in the individualized budget. The fiscal agent then becomes responsible for ensuring appropriate withholding and deductions are made from the account and for tracking payments to be sure the expenditures are allowable. WORK contracts with a single fiscal agent to provide this service, KATCO.

All allocation payments must be deposited into a designated, special account, referred to as the WORK account. This account is only used for WORK program purposes. Co-mingling of WORK funds with non-WORK funds is not allowable and no other deposits can be made into the WORK fund. However, the individual may be allowed to move funds from the daily WORK account (a checking account) into a WORK account designed for savings, as determined by the individual budget.

WORK payments are exempt as income in the month received for all programs and as a resource in the subsequent months if funds are being maintained appropriately. It is the responsibility of the WORK program manager to make this determination. Any WORK funds withdrawn from the WORK account and used for non-approved purposes are countable or subject to recovery, depending upon the availability of the funds.

WORK participants must agree to abide by strict rules regarding use of the allocation payment. However, if misuse of the funds is suspected, notify the WORK program manager immediately for investigation. Individuals who are confirmed to have misused WORK funds are subject to termination and recovery is initiated on misspent funds.

Note: Because there is flexibility for the WORK participant to hire family members to provide personal care services, an individual choosing to pay a member of the assistance plan may impact Working Healthy eligibility. For example, a husband hires his wife to provide services in the evenings will actually increase countable income of the assistance plan.

C. Working Healthy Participation

In order to receive WORK services, the individual must be eligible for and receiving Medicaid through Working Healthy. Persons enrolled in other Medicaid coverage groups cannot receive WORK services. Some individuals who are currently receiving Medicaid under other coverage groups may wish to move to Working Healthy in order to receive WORK. However, this option is not available to all Medicaid eligible individuals. Specifically, persons who are eligible under a mandatory categorically needy group (see KEESM 2611) are not allowed to enroll in Working Healthy and must stay in the mandatory coverage category. Examples of mandatory categorically needy individuals include SI recipients (including those 1619B) and MP eligibles. Persons, who are not eligible for WORK because of program eligibility, but report a need for personal care services, are referred to the Benefits Specialist to discuss other options for obtaining these services.

D. Enrollment Dates

Enrollment into WORK is always prospective and will always begin on the first day of a month. The ES-3160 will be sent from the WORK Program Manager advising of a start day for WORK services. For enrollment of a current Medicaid recipient, the ES-3160 is to be sent no later than the 18th of the month for enrollment to begin the first of the following month. This general rule shall be used for new applicants as well, but enrollment may not be possible until the second month following receipt of the ES-3160, or later.

Because WORK begins July 1, 2007 the effective date of WORK eligibility can never be earlier than 07-01-07.

E. Premiums vs. Client Obligation

Because all individuals receiving WORK must also be enrolled in Working Healthy, all individuals are subject to Working Healthy premium requirements. The premiums must continue to be paid. However, there is NO CLIENT OBLIGATION for WORK participants.

F. LOTC Coding

WORK eligibility is recorded on the KAECSES LOTC screen. It is then communicated to the MMIS where special payment features have been implemented. A new Living Arrangement/Level of Care code combination on the KAECSES LOTC screen has been created and must be used for all WORK approvals.

All WORK cases must have the following LOTC information:

Living Arrangement: WK
Level of Care: NA
LA/LOC Payment Effective Date: The first day of the appropriate month
Patient Liability: $00.00
Date Screen Completed: Date WORK Request known to Eligibility Worker

G. Notices

Because WORK eligibility does not carry special eligibility rules, special WORK notices are not necessary. Working Healthy notices are sent as appropriate. Notification to the beneficiary is the responsibility of the WORK Program Manager and may be designated to contractors.

H. Communication

The ES-3160 and ES-3161 will be used to communicate WORK participation information to and from eligibility staff. These forms have been modified to include WORK information commonly referenced. The Benefits Specialist will receive all information going to and from the WORK program manager and the eligibility worker, as well as act as a liaison where needed.

The Benefits Specialist will continue to serve as the primary contact for the beneficiary for all Working Healthy cases. The Benefits Specialist will be especially valuable when an individual is uncertain about moving from an HCBS waiver to WORK. The eligibility worker shall refer all individuals inquiring about WORK services to the local Benefits Specialist.

I. Examples

Example 1: Wally is currently on Working Healthy and has a $55.00/month premium. He is eager to participate in WORK and contacts his eligibility worker on July 3 about the services. Wally is referred to the Benefits Specialist where a referral is then made to the WORK program manager. An assessment is completed and Plan for Independence is developed immediately. An ES-3160 is received on July 16 stating that WORK begins on 08-01-07 for Wally.

Since Wally already receives Working Healthy, the only action required is to approve WORK payments. The eligibility worker completes LOTC with the special WORK coding:

Living Arrangement -WK
Change Level of Care – NA
LA/LOC Eff Date – 080107
Patient Liability - 00
Patient Liability eff date – 080107

A notice is not required because no changes in eligibility are being made, but the ES-3160 is completed and sent to the Benefits Specialist.

Example 2: Jim is on the HCBS/PD Waiver. He has Social Security Disability income of $820 per month and he earns $8.00 per hour working 20 hours per week at the Generic City Library. Jim drives to and from work in his modified vehicle, qualifying him for an Impairment Related Work Expense (IRWE). He drives 20 miles per week to and from work ($.43 per mile, this is $34.40 every four weeks) and is qualified for the standard IRWE deduction of $100. His countable monthly income is $1061.50,

including the deduction for the IRWE, leaving him with a Client obligation of $345.50.

On 07-20-07, Jim contacts his EES worker and asks about WORK. The EES worker refers Jim to the Benefits Specialist. The Benefits Specialist discusses the differences between HCBS and WORK with Jim and makes an informal determination of Jim's eligibility for Working Healthy. Jim decides to try WORK and a 3160 is sent to the WORK Program Manager for an assessment.

The assessment process results in Jim being approved for WORK services. The WORK Program Manager notifies, via the 3160, the EES worker, Benefits Specialist, HCBS provider, and HCBS Program Manager of WORK approval effective 09-01-2007. The ES-3160 is received 08-13-07. Since this is before the 18th of the month, WORK services begin the first day of the following month. (Note - if the 3160 is sent to the EES worker after the 18th, WORK services begin the first day of the second month following notification).

The eligibility worker must now convert Jim's case from HCBS to Working Healthy and approve WORK payments. The following changes are necessary:

a) **SEPA:** Change MS/HC to MS/WH

b) **PICK**: Use WQ, WL or WH as appropriate. Jim's code is WH.

c) **LOTC**: Change Living Arrangement from HC to WK
Change Level of Care to NA
Change LA/LOC Eff Date to 090107 (Jim's eff date)
Patient Liability changed from $345.50 to $00
Patient Liability eff date to 090107

d) **MSID**: Add Working Healthy premium

e) **SPEN:** Remove 'Y' from Cost of Care > Remaining Spenddown
Authorize benefits

f) **WOAL**: Set alert for 6 month desk review

g) **ADAD:** Add Benefits Specialist information to this screen

h) **NOHS:** Send appropriate notices to end HCBS and begin Working Healthy

Example #3: Barley Corn receives HCBS/PD services and his community spouse, Sweet, is allocated a portion of his income. Barley is employed and he heard about this new program called WORK and he called his EES worker and asked to know more. The EES worker referred Mr. Corn to the Benefits Specialist.

Barley receives $825 per month in SSDI and his gross earnings are $750 per month.

Sweet works and earns $1200 gross per month. Rent for their apartment is $700 per month.

Based on the above amounts, Barley is allocating $980 of his income to Sweet, leaving him with $595. Since his remaining income is below the HCBS PIL, he has no HCBS patient liability.

The Benefits Specialist discusses HCBS vs. WORK. In order to participate in WORK, Barley would have to move to Working Healthy. Sweet's income would be countable and he would no longer be able to allocate income to her. The Working Healthy premium is estimated to be approximately $112.00 per month. The Benefits Specialist confirms these estimates with the eligibility worker and presents them to Mr. Corn. He decides that WORK is not a good option and withdraws his request for WORK.

IV. Working Healthy

Changes to the Working Healthy determination are applicable to all Working Healthy cases, regardless of the individual's participation or request for WORK. These changes are applicable to new determinations made on or after July 1, 2007. All current cases must be reviewed no later than the next review or desk review for ongoing eligibility under these new provisions.

Loss of Working Healthy eligibility due to either of the new minimal earning requirements may initiate a Temporary Unemployment Period. Cases where Working Healthy eligibility is denied or terminated due to these new requirements are referred to the Benefits Specialist for possible establishment of a Temporary Unemployment Plan

A. Earned Income Threshold

To receive Working Healthy, countable monthly earned income must exceed the standard earned income disregard of $65.00. Persons with income below the disregard are not eligible for Working Healthy.

Countable income is determined after considering all income-producing costs, IRWE and BWE allowances. For self-employment, all applicable expenses including the 25% deduction are considered prior to making the determination.

Note that income is also considered using the appropriate budgeting method for the month. Fluctuations in income must also be considered when determining if this test is met. These must be considered on a case by case basis.

B. Minimum Wage Requirement

To receive Working Healthy, the individual must be earning at least the federal minimum wage, currently $5.15/hour. Persons earning wages below this level are not considered fully employed for Working Healthy purposes.

The minimum wage requirement is not applicable to the self-employed.

C. Premium Operations

Beginning July 1, 2007, KHPA has contracted with KATCO to provide Working Healthy premium management functions. KATCO will collect and track all Working Healthy premiums. They will be responsible for sending out statement and answering questions from beneficiaries. Eligibility workers are to contact KATCO regarding payment status of premiums.

Because KATCO is a Medicaid contractor, the eligibility worker does not need a release of information to discuss issues related to Working Healthy premium collection and maintenance with KATCO. However, other information related to the beneficiary's case cannot be shared with KATCO.

A memo with contact information is included with this material (Attachment B).

V. Mental Health and Substance Abuse Managed Care

Effective July 1, 2007 Mental Health (MH) and Substance Abuse (SA) services for most medical assistance beneficiaries will be provided by separate Managed Care Organizations (MCO). The MCO contracts are similar to the medical managed care contracts in place with Children's Mercy Family Health Partners and Unicare which cover most children and non-disabled adults. But the contracts are also different in that the MH and SA MCOs will also cover the elderly and persons with disabilities. The Centers for Medicare and Medicaid Services (CMS) authorized two special types of managed care contracts to provide services in this manner:

> **Mental Health MCO**: Mental health services will be provided under a Prepaid Ambulatory Health Plan (also called a PAHP). This essentially means that inpatient services are excluded from the list of services the MCO is responsible for covering. The MH MCO is Kansas Health Solutions.
>
> **Substance Abuse MCO:** Substance abuse services will be provided under a Prepaid Inpatient Health Plan (also called a PIHP). This essentially means that inpatient services, not already covered by a medical MCO, related to substance abuse (e.g. acute detoxification, residential substance abuse treatment) are included in the list of services the MCO is responsible for covering, which include outpatient services. The Substance Abuse MCO is ValueOptions.

Persons do not have a choice of participating in either managed care plan. Except for populations specifically excluded by the assignment process, all individuals will receive MH and SA services through these managed care organizations.

Both Kansas Health Solutions and ValueOptions will offer expanded services to their members as well as an expanded provider network. For the KMAP beneficiary, this should result in easier access and a system designed to better meet their needs.

A. Payment and Assignment Background

The MH and SA contracts will operate much like traditional MCOs, with KMAP paying a specified amount periodically to the MCO to ensure delivery of the specified health services. The MCO is then responsible for contracting with medical providers to deliver the service. The provider receives payment for all services through the MCO, not directly through KMAP. The periodic payment made by KMAP is generally meant to cover all services.

The KMAP beneficiaries who are served by the MH and SA plans is based upon their assignment to the MCO. The Medicaid fiscal agent, EDS, will establish individual member assignments to the MCOs through automated processes in the MMIS. Individuals who are not assigned to the MCO will receive MH and SA services outside of the managed care networks. The provider will receive payment from the MCO for applicable services if the individual is assigned. The provider will receive payment from KMAP if the individual is not assigned.

B. Assignment Populations

Because the MH and SA plans include non-traditional managed care participants (e.g. Medically Needy, HCBS and Medicare beneficiaries), different assignment types have been created to support the new Managed Care plans. Assignments into the MH and SA plans are based on two factors in the MMIS: The type of medical program and the type of any long term care living arrangement and level of care that exists. For persons residing in an institution, the facility is responsible for Mental Health and Substance Abuse Services. Other issues, such as the timing of the assignment, also plays into the logic.

Focus Group 1 (PMP Loc = A): Assigned to the MCO as a full participant with the MCO. A payment is made on behalf of the beneficiary and the MCO will ensure service delivery. Most KMAP beneficiaries fall into Focus Group 1 and include:

- MA/CM, TransMed, Extended Medical Families
- Poverty Level Eligible (MP)
- SSI Medical
- Medically Needy - spenddown met, no spenddown
- Working Healthy and Medically Improved
- Breast/Cervical Cancer
- Adoption Support
- Foster Care
- Presumptive 19
- MediKan – Mental Health only; MediKan does not provide substance abuse services

Also includes those individuals with LOTC:

- HCBS Living Arrangement (HC – TA, HI, DD, FE, PD, SE)
- WORK Living Arrangement (WK)
- Temporary Care –SED Waiver (TC-SE)

Focus Group 2 (PMP Loc = B): Assigned to the MCO for administrative purposes only and no capitation payments are made by EDS. The purpose of a Focus Group 2 assignment is to connect the MCO and the beneficiary in preparation for a likely future Focus Group 1 assignment.

- Child Institution
- Medically Needy – unmet spenddown
- TC Living Arrangement Code on LOTC, except for TC-SE

Focus Group 3 (No PMP Loc): No assignment. The individual received services outside of the MCO.

- Refugee
- Expanded Low Income Medicare Beneficiary
- Low Income Medicare Beneficiary
- Qualified Medicare Beneficiary/Qualified Working Disabled
- Title XXI (**Cenpatico for HealthWave XXI)**
- Presumptive XXI
- SOBRA
- Tuberculosis
- AIDS Drug Assistance Program
- Any institutional LOTC code combination: BF-MH, NF-SN, NF-MH, NF-HI, NF-SB, PACE, SH-DD, SH-MH as well as NS-NA

Note: Persons eligible for ELMB, LMB, QMB, QWD or ADAP in addition to a plan in Focus Group 1 or Focus Group 2 are included in Focus Group 1 or Focus Group 2. For example, an individual receiving both HCBS and QMB is in Focus Group 1.

C. Timing of Enrollment/Assignment

EDS has built the assignment logic into the MMIS to determine when a mental health or substance abuse assignment is appropriate and the effective date of the assignment. Assignments may be prospective or retroactive:

Prospective Assignment: An assignment for a future month. Prospective assignments are effective the month following the month eligibility is received on a monthly file (medical card cutoff). Daily files received prior to medical card cutoff are also enrolled effective the next month. Daily files received after medical card cutoff are effective the second month following the month the record is received.

Retroactive Assignment: An assignment for a past month. Retroactive assignments are effective the first day of eligibility, but not prior to 07-01-2007.

The following rules are used to determine if the assignment will be prospecitive or retroactive and the effective date of the assignment:

1) Assignments are prospective (begin the month following the month received by the MMIS or the second month following the month the record is received) unless one of the following is true:

   - Eligibility does not exist in the MMIS for that time period (e.g. a brand new approval). Eligibility is retroactive to the first day of eligibility that carries a MH/SA assignment, but never prior to 07-01-07; or

   - Existing eligibility exists for the month and a LOC with HCBS-SED waiver eligibility is received (HC SE or TC SE). These assignments are always retroactive up to 9 months in the past.

2) An assignment begins on the first day of the month and ends on the last day of the month, except for death.

3) Medically Needy beneficiaries who meet spenddown are moved from Focus Group 2 to Focus Group 1 the month following the month in which the spenddown is met. However, because the beneficiary is linked to the MCO through the Group 2 assignment, a special off-system payment process has been established for the provider to be paid for MA or SA services during the period between the spenddown met date and the first of the following month, when the individual is assigned to Group 1.

4) An LOTC change occurs. Persons residing in an institution are not assigned to the MCOs, but to access the full array of MH and SA services upon reentry into the community the individual must be assigned to the MCO. Because there is already eligibility in the MMIS when a Medicaid beneficiary discharges from a facility, the assignment will be prospective- earlier the month following the month of action or the second month following the month. It is important for facilities to inform eligibility workers of a discharge quickly and for the eligibility worker to process LOTC changes quickly, to minimize the impact on the system.

   Eligibility staff are strongly advised to check the LOTC screen when authorizing benefits for a case that was previously opened. If incorrect codes are on LOTC, incorrect eligibility and assignment information will be sent to the MMIS.

   If the eligibility worker discovers active information on the LOTC screen which is no longer valid, update LOTC with accurate information regarding the closure of the prior long term care arrangement. If that information is no longer valid, update LOTC with the following:

   Living Arrangement - NO
   Level of Care - NA
   LA/LOC Eff Date - One day prior to the effective date of current eligibility

Consider these examples:

Example 1: Bill last received Medicaid in 2003. He is approved for full Medicaid (SI Program) on 10-14-07, effective 09-01-07. As there is no eligibility for the prior

months, his assignment is retroactive and is effective 09-01-2007.

Example 2: Nancy is an ongoing QMB eligible who is approved for HCBS – FE waiver in 10-2007 effective 09-20-07. The eligibility worker takes the action on 11-04-07. Nancy is now eligible for full Medicaid beginning 09-01-2007, but because she already has existing QMB eligibility in September, October and November, her SA and MH managed care assignments will be prospective – and will not begin until 12-01-2007. Nancy's MH and SA services will be paid fee-for-service during these three months if needed.

Example 3: Eddie has an open NF/SN case and is not assigned to the MH/SA MCOs. He leaves the facility on Aug. 4 and begins HCBS/FE. The EES worker updates the LOTC coding to HC/FE on Sept. 15. The assignment to the MCOs begins effective 10/1.

If Eddie tries to access any MH/SA services after Aug. 4 - before the LOTC coding is updated - the MMIS will show Eddie is a resident of the facility. To the MMIS, the facility is responsible to provide those services. However, the facility will not pay for any of Eddie's services as he is no longer a resident. Eddie might have a problem getting services.

The EES worker may be contacted by the facility, Eddie or the MH/SA provider to get the coding updated. After September 15, when the coding is updated, the MMIS will begin paying Eddie's MH/SA services he received between Aug. 5 and Sept. 30. But, he will not be assigned to KHS and ValueOptions until 10/01.

D. Medically Needy

As previously indicated, Medically Needy participants are included in the MH and SA MCO plans. Medically needy with an unmet spenddown will be associated to the MCO with a Focus Group 2 assignment, which does not require payment of any KMAP service. The assignment will change to a capitated Focus Group 1 assignment the month following the month in which the individual meets the spenddown.

> **Example**: Joy has a base period of 07/2007 – 01/2008. She is assigned to Focus Group 2 beginning 07/01/2007. She meets her spenddown on 9/15/07, so her assignment moves to Focus Group 1 effective the following month, 10/2007.

Consider the following regarding the Medically Needy:

- When a beneficiary's base period ends and a new base period begins, the beneficiary will be assigned to FocusGroup 2 until the spenddown is met.
- When a Medically Needy beneficiary with an unmet spenddown is assigned, the MCO will receive a claim from a service provider and pass that claim through to the MMIS.
- The claims received through the MCO will then be applied to the

beneficiary's spenddown by the MMIS, using all existing logic. This includes Medicare and TPL requirements.

- These claims will be processed by the MCOs daily, to avoid delays in applying toward spenddown, if possible.

- The MCOs will receive a weekly report from the MMIS that provides updated spenddown amounts. The MCOs will also be expected to check the MMIS for the most current spenddown amount prior to processing the claim.

- Beneficiary Billed claims are not used for MH or SA services just to avoid involving the established process with the MCOs. When a beneficiary presents a MH or SA bill to allow against a spenddown, the beneficiary is instructed to present the bill to the appropriate MCO to submit for spenddown purposes. However, if a beneficiary receives a service provided out-of-network, the MCO cannot bill it to the MMIS. In these cases, a Bene Billed claim is appropriate. The eligibility worker shall obtain a confirmation from the MCO the provider is not included in the provider network.

- Medical necessity for Substance Abuse services is determined, in part, by prior authorization. The medical necessity determination for substance abuse services occurs as part of the KCPC. If a substance abuse service is denied by the MCO due to no prior authorization then medical necessity has not been established for the service and these should not be applied to spend down.

- Eligibility workers shall take care not to establish unnecessary Medically Needy spenddowns. Individuals who do not meet one spenddown base period and do not indicate a subsequent base can be met, may be terminated from Medically Needy coverage.

E. MMIS Updates

These program changes require extensive modifications to the MMIS which will not be completed by 7/1/07. Interim processes have been developed for the months of July and August until the MMIS modifications are completed for 9/1/07.

1) MMIS Interim Process

a. An edit will be created in the MMIS that will deny all mental health and substance abuse services provided by the MCOs on or after July 1.

b. To provide KHS and ValueOptions a roster of eligible individuals, EDS will produce and send the MCOs two extracts of assigned beneficiaries, one listing Focus Group 1 beneficiaries, and one listing Focus Group 2 beneficiaries. The Focus Group 2 extract will allow the MCOs to identify the beneficiaries with an unmet spenddown.

c. Service providers have been instructed to bill the MCOs directly.

d. The MCOs will hold all claims until the MMIS programming is completed and then will submit them to the MMIS. However, payment to the service providers will not be delayed during this process. They will be paid directly by the MCOs.

e. Claims for Medically Needy cases with an unmet spenddown will be submitted by the MCOs to the MMIS daily so these claims can be applied against the spenddown.

f. A weekly report will be generated to capture all claims for beneficiaries in Focus Group 2 that were applied to spenddown. This report is sent to the MCOs.

g. After MMIS modifications are completed, a one time retroactive assignment will be processed for all beneficiaries who were eligible in July or August.

2) Special Retro Assignment Process

A one time retroactive mass assignment process to make the assignments for July and August on the MMIS is planned following completion of the necessary system modifications. The assignments for these two months will be based on the eligibility information present in the MMIS on the date the assignment process is ran, currently scheduled for August 25, 2007. Because the actual assignment information sent to the MCOs was based on eligibility information present at the time the list was produced, it is possible eligibility has since been adjusted and different eligibility exists at the time of the retroactive run. This could result in different assignment information on the MMIS.

Example: A beneficiary was receiving HCBS services in July. They were assigned to KHS and VO for July. On July 20, the bene entered a Nursing Facility. The EES worker received the MS-2126 and updated LOTC (NF/SN) in KAECSES on Aug. 14. The bene was still assigned to KHS and VO for Aug. as the system wasn't updated until Aug. 14. When the ONE TIME retro assignment is run on 8/25, current eligibility in the MMIS indicates a LA/LOC of NF SN for July and Aug. The system will NOT create an MH/SA assignment for those months even though the MCOs indicated they were assigned for those months.

After this retroactive process is completed, the July and Aug. assignment information will be available on the MMIS.

3) MMIS Modifications

To accommodate the new MCO assignment process, several MMIS system modifications will be implemented. Two new windows are being created in the MMIS to display the PIHP/PAHP assignment information: The PIHP/PAHP Assignment History window and The PIHP/PAHP Assignment Maintenance window.

The PIHP/PAHP Assignment History window will display the current and historical assignments to KHS and VO. The information in this window can be utilized to answer assignment questions that a beneficiary may ask, such as:

Why am I receiving notices from KHS/VO?
What provider may I use for my MH/SA services?
Why isn't this MH/SA claim being applied to my spenddown?
Who is responsible to pay for my MH/SA claims?

The PIHP/PAHP Assignment Maintenance window was created to make adjustments to assignments as the beneficiary's eligibility is adjusted. The window will be utilized to make these adjustments. SRS and KHPA staff can view this window but will not have update capability. These adjustments and updates will be made by EDS staff.

The Medicaid Liaisons will provide additional training in the SRS regions when these windows are available and functioning in the MMIS.

Copies of the proposed new windows are included with this information. (Attachment C)

4) Medical Card Changes

July and August medical cards will not show the MH/SA assignment information. No assignment information will be available to view on the MMIS. The MCOs will have the assignment information so if a beneficiary needs to know if they are assigned, they need to contact KHS/VO directly.

September medical cards will display the MH/SA assignment information. The assignment information for September will also be in the MMIS and can be viewed using the new PIHP/PAHP Assignment History windows.

A sample copy of a medical card is included with this material (Attachment D)

F. Beneficiary Information

Both EDS and the new MCOs have generated information to KMAP beneficiaries regarding these changes.

EDS included a special stuffer in the June medical cards announcing the upcoming changes. This same stuffer was included with the July medical cards too.

KHS and ValueOptions have provided information to all eligible beneficiaries listed on the preliminary rosters sent from EDS in early June, and will do a follow up mailing to target new beneficiaries. The member handbook is available in both English and Spanish, and has been mailed to all current Medicaid members, with a welcoming cover letter, a forecast about provider directories to be done in early July, and a self identification tip sheet for people who may be in need of services.

SRS and KHPA staff who receive questions about assignment to either plan should direct the caller to contact the appropriate MCO. The attached flyer providers contact

information for the MCO as well as a link to a special website dedicated to providing information regarding the new service model. (See Attachment E)

VI. Psychiatric Residential Treatment Facilities (PRTF)

A PRTF is a new institutional classification which provides comprehensive behavioral health care in an institutional environment to children and adolescents who, due to mental illness, substance abuse or severe emotional disturbance, are in need of treatment. The PRTF was created in response to concerns raised by the Centers for Medicare and Medicaid Service regarding the existing institutional structure used to treat youth with these diagnoses, where services were delivered in Level V and Level VI facilities. The existing classification system ends June 30, 2007. At this time, all existing Level V and Level VI facilities must transition to PRTF status in order to receive Medicaid funding. Those facilities who choose not to transition to PRTF status may elect to be licensed as Youth Residential Center (YRC).

A complete list of facilities currently licensed as PRTF is attached. A list of YRCs is not available at this time.

A. Responsibilities of the PRTF

Eligibility rules for the PRTF mirror those previously used for a Level VI placement. Like other facility types, a pre-admission screening and an MS-2126 are necessary before Medicaid payment can be authorized. Kansas Health Solutions (KHS) provides oversight of the PRTF preadmission screening process, according to instructions issued by SRS-Mental Health. All PRTF preadmission screening are recorded in the MMIS as a Prior Authorization (PA) by the Mental Health Consortium, a contractor of KHS. If a PA is not present on the MMIS when the facility bills, the claim will be denied. All admissions into a PRTF must go through this process (except for special emergency requests). Therefore, prescreening information is not obtained by the eligibility worker.

Upon admission into the PRTF, the facility administrator (or designee) must prepare the MS-2126 and submit the completed, signed form to the SRS contact. The facility should strive to submit the form within 5 days of admission. Payment is not available to the PRTF unless these processes are completed.

B. Medicaid Eligibility

As Medicaid is an important funding source for the PRTF, the facility will assist in the Medicaid application process. Upon entry into the facility, staff will begin working with the family to determine funding possibilities. If Medicaid is a likely source, the facility will help secure a completed application from the family, if necessary. The facilities are encouraged to contact the appropriate SRS eligibility contact if technical assistance regarding the application is needed.

As with any institutional living arrangement, the resident's eligibility is partially determined by the length of the stay in the facility. A patient liability must also be

determined for each stay. Detailed processing instructions were previously released in KEESM-related implementation memos dated 03-14-2005 and 09-16-2005. These instructions are available on the KEESM website for review.

The general rules are as follows:

1) If the stay is expected to be less than 30 days, the stay is considered temporary and the child would continue to be considered a member of the assistance plan at the time of entrance.

   If the child is a Medicaid recipient at the time of admission, Medicaid payment to the facility is approved for the temporary stay. The eligibility worker completes the LOTC screen authorizing payment to the facility under the same case number as the existing plan.

   Example: Bobby enters the PRTF on 08-15-07 and is not expected to stay 30 days. He and his brothers, Greg and Peter, have an MP case with their father, Mike. Because Bobby's stay is less than 30 days, he remains open under the MP plan.

   If the child is a HealthWave XXI recipient at the time of admission, there is no HealthWave funding available for these services. If the family requests Medicaid coverage, a Medically Needy spenddown may be determined.

2) If the stay is expected to be 30 days or longer, institutional budgeting rules are applicable. The youth is considered a household of one and eligibility is determined using only the needs, income and assets of the child. (KEESM 8142(2) and 8143(3)).

   For current Medicaid recipients, a separate case must be established for the youth. The Child in an Institution (CI) program is generally used for this purpose. However, if the youth is open under a program where only his or her needs, income and resources are considered in the determination, the existing case may be retained. However, adjustments may be necessary to support an accurate determination of the patient liability. Cases which may be retained by the eligibility worker include:

   Foster Care and Adoption Support (patient liability is NA to FC)
   SI related Medical
   MS if the youth is the only individual on the case (eg MS HC)

   For HealthWave XXI eligibles, a new determination under Medicaid rules (CI program) is required.

3) A new application is generally necessary for all admissions. This is true of existing recipients, as necessary resource information may not be available to determine eligibility. However, if a current application which contains the necessary information to determine eligibility is available, a new application is not necessary.

4) The KAECSES LOTC screen is used to authorize payment for PRTF

placements. The following combination is appropriate for all PRTF approvals:

Living Arrangement:	BF
Level of Care:	MH

C. Implementation Issues

As indicated earlier, a number of Level V facilities will convert to PRTFs effective July 1, 2007. Eligibility for these residents will now be determined using institutional rules. Because Level V determinations were previously based on independent living rules, most residents of these facilities will not have an appropriate eligibility determination. In order for the facility to be paid for services provided on or after July 1, 2007, a LTC – based determination must be completed for the resident, and if eligible, LOTC must be completed and a patient liability computed.

The designated contact at each of the new PRTFs have been instructed of the new rules. Eligibility workers should expect to receive an MS-2126 for all current residents in the coming weeks. The facility may not secure an application for each individual, and it is the responsibility of the SRS contact to inform the facility when a new application is needed. A CI determination will be competed, if necessary, for each new application.

Institutional budgeting for the new PRTF residents is effective July 1, 2007 and eligibility for dates prior to 07-01 is determined using independent living methodologies. If the youth is eligible after July 1, the LOTC screen must be completed and a patient liability computed. The BF MH Living Arrangment/Level of Care combination is effective 07-01-07.

Example: Paul is a resident of Doughnut Village, a Level V facility which is moving to PRTF effective 07-01-07. Paul is in foster care, so he has a medical card. The eligibility worker receives an MS-2126 from Doughnut Village on 07-03-07 stating that Paul entered the village in May, 2007. As Paul is a foster care youth, payment to the village is approved. Since Doughnut Village is a new PRTF, LOTC isn't necessary until 07-01-07. The worker completes LOTC with BF/MH coding and a $0 patient liability effective 07-01-07

D. Discharge/SED Waiver Coordination

When a youth leaves a PRTF, it is critical that LOTC updates be completed as quickly as possible following discharge. This will facilitate a quicker attachment to the MH and SA Managed Care networks so appropriate services can be provided. PRTF designees have been notified of the importance of sending the MS-2126 to notify the eligibility worker of the discharge within 10 days of release.

SRS Mental Health will be working with the PRTFs and CMHCs to ensure an SED waiver assessment is completed on every youth leaving a PRTF. If the youth meets SED waiver functional eligibility requirements, he or she will be immediately targeted for SED waiver enrollment. Although the process is still in development, the goal is to have an ES-3160 available for all eligible youth immediately after discharge. Facilities will be asked to inform the eligibility worker on the MS-2126 of a possible SED waiver approval.

E. PRTF Contact Information

As the list of PRTF facilities and designated SRS contacts is not available at this printing, this information is not included with this memo. An updated list of facilities and contacts will be available in the near future.

If you have any questions about the material included in this memo, please contact the appropriate program manager. Questions regarding MMIS updates may be directed to the EDS Medicaid Liaison in the SRS regional office and questions regarding any KAECSES issues are directed to the SRS Business Help Desk at helpdeskbusiness@srs.ks.gov . Your dedication to ensuring these new programs and policies are implemented successfully continues to be much appreciated by everyone in KHPA and SRS Central Office.