Kansas
Department of Health and Environment
*Division of Health Care Finance*

| Policy Memo | |
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| **KDHE-DHCF POLICY NO:** 2018-12-03 | **From:** Jeanine Schieferecke |
| **Date:** December 31, 2018 | **KEESM Reference:** 8270 |
| **RE:** Implementation of KanCare 2.0, Fair Hearing, and HCBS Changes | **Program(s):** All Medical Assistance Programs |

This memo sets forth instructions for implementation of policy changes effective January 1, 2019. Specific dates associated to the implementation are noted in the applicable section. Revisions to the Medical KEESM and KFMAM manuals will coincide with the release of this memo. Additional information related to the implementation of these changes is available through training material released to eligibility staff.

Items 1 and 2 are applicable to all Medical Assistance programs, items 3-5 are applicable to Elderly and Disabled programs only.

## 1) Implementation of KanCare 2.0

Since 2013, Kansas Medicaid and CHIP have been delivered under the KanCare program brand, with 3 Managed Care Organizations (MCO) responsible for coordinating service delivery for the majority of program beneficiaries. Beginning on January 1, 2019 the program will upgrade to KanCare 2.0 with the implementation of benefit enhancements, new value-added services and new quality initiatives. For eligibility staff, the most impactful change will be the transition of MCO contractors – with Aetna replacing Amerigroup as a KanCare MCO effective January 1, 2019. This memo will only address changes and processes tied to the MCO change. More information regarding other changes with KanCare 2.0 can be obtained on the KanCare website.

### A. MCO Change

As indicated above, a new MCO choice will be offered to applicants beginning January 1, 2019 – Aetna Better Health of Kansas. Amerigroup will no longer be an active MCO provider after

12-31-18. Amerigroup has been accepting limited new enrollment since November 1, 2018. Amerigroup will continue to provide medical coverage and support for any services provided on or before December 31, 2018 for the next several months. This includes coverage of certain newborns, HCBS adjustments and other changes even though the individual may now be assigned to another plan.

As with all MCO assignments, the fiscal agent, DXC, is responsible for ensuring beneficiaries are reassigned to a new plan beginning January 1, 2019. This process began several months ago with notification to existing beneficiaries regarding new plan choices. Most people will also have a special open enrollment period that will allow an MCO change through 04-03-19. If a current Amerigroup beneficiary does not make a plan choice on their own, the individual will be automatically assigned to a plan. The assignment will be listed on the PMP window in the MMIS.

## B. MCO Assignment Process

In order to support federal requirements regarding consumer choice of MCO plans, an applicant is allowed the ability to choose an MCO as part of the application process. The choice is captured in KEES, but the information is transmitted to the MMIS where the official assignment occurs. The MMIS records and maintains all MCO assignment information and history. The KEES Individual Demographics page is used to capture the choice from the application.

### a. KEES Impact on the MCO Assignment

The KEES MCO choice is a key factor in the MCO assignment logic. However, it is not the only factor. Consider the following:

(1) The MCO choice on the Individual Demographics page is only relevant at certain points throughout medical case processing. For new applicants, this is generally only when the case is initially processed. Changes reported later are not picked up by the MMIS. The individual must call the DXC Managed Care enrollment center to make any plan enrollment change. The phone number of the enrollment center is 1-866-305-5147. The MCO Choice field on the Individual Demographics page in KEES is not updated when a new choice is made through DXC. Therefore, the choice listed here is usually outdated and inaccurate.

Outside of the initial application, there are a few instances when the MCO listed on the individual demographics page will update the MMIS. These are generally when the consumer has a change in coverage or when there has been a lapse in coverage. See examples below.

(2) In certain scenarios, the MCO Choice from KEES can unexpectedly cause a change in the MCO assignment. See examples below:

(i) An MCO choice was set as UHC 30 months ago when the child first applied. The child's MCO has since changed to Sunflower. When the worker completes a review, the coverage changes from Medicaid to CHIP. Because this is a KanCare assignment program change in the MMIS, the old MCO choice will look like a new choice to the MMIS and could cause an unwanted MCO change.

(ii) A former beneficiary lost eligibility in April and is now being reapproved in October. He chose Sunflower originally but later changed to UHC. When the new application is processed, the choice listed on the Individual Demographics page is still Sunflower. When this is picked up by the MMIS, the MCO assignment will be Sunflower.

However, if the MCO choice had been removed from the page, the MCO assignment process would apply and he would have been attached to his latest choice – United Health Care.

(iii) Consumer applied three years ago and indicated she wanted UHC. However, she was approved for QMB only and was never assigned to an MCO. That choice is still listed on the individual demographics page when a request for nursing home coverage is approved. Because this is seen as new coverage by DXC, she will be assigned to UHC if nothing is done to remove the record. If the consumer still wanted that MCO, this is not a problem. However, if she wanted a different plan, the choice coming from KEES would take priority and she would be assigned to UHC.

## b. KEES MCO CHOICE – BEST PRACTICES

Eligibility staff are not required to know all detailed MCO assignment rules. However, staff should be aware of how the information coming from KEES is used by DXC when making the assignment. Staff should use the following guidelines when working with the MCO choice field in KEES.

(1) Only record an entry on the Individual Demographics page if the consumer has specifically listed the choice on their application or communicated it to staff directly.

(2) When processing a change only update the Individual Demographics page if the consumer has selected an MCO on the application or if the choice has been communicated to the agency directly within the last 3 months (e.g. a recent application or phone call recorded in the journal). This is true when adding a new person to a case.

(3) If a current choice has not been communicated, remove any previous selection from the Individual Demographics page – leaving it blank. Even though the change may not be used by the MMIS, removing the choice from the system will reduce the chance of unintended MCO changes.

(4) Any changes or questions consumers have regarding the MCO assignment shall always be directed to the MCO Enrollment Center. The phone number is 1-866-305-5147.

## c. MCO Process – HCBS Cases

HCBS cases require special processing and it is necessary to identify the MCO when HCBS is initially authorized. This is because both the ES-3160- Notification of KanCare/HCBS Services form and the electronic record must be sent to the appropriate MCO to begin developing the Person Centered Service Plan and services. The following steps apply whenever a beneficiary is newly approved for HCBS:

(1) Check MMIS to determine if the individual is a current beneficiary and view the PMP Managed Care assignment page.

(2) If the beneficiary has active coverage and is currently assigned to an MCO, enter this choice on the LTC data details page. Also, remove any MCO choice entry from the Individual Demographics page, as it could negatively impact assignment changes in the future. The ES-3160 will be sent to the current MCO.

(3) If the individual is not an active beneficiary or is eligible only for coverage that is not part of KanCare (e.g. QMB only, resident of a State Hospital) AND there was an active assignment within the past 90 days reflected in the MMIS, the MCO reflected in MMIS will be assigned. The MMIS will re-attach the beneficiary to the previous plan regardless of what is entered on the Individual Demographics page. Staff should use enter the previous MCO from the MMIS on the LTC data details page. Also, remove the choice entry from the Individual Demographics page as this could negatively impact assignment in the future. The ES-3160 will be sent to this MCO.

(4) If neither condition (2) nor (3) is true, use the MCO choice selected by the consumer on the application. This is entered on both the Individual Demographics and the LTC Data Details page. If one was not selected, you must contact with the consumer to determine the appropriate MCO. At least two contacts must be attempted to obtain the individuals choice.

(5) If you are unable to reach the individual to obtain the choice directly, contact the entity originating the ES-3160 (e.g. the ADRC) to determine if they have information regarding the choice.

(6) As a last resort, follow the LTC data clean-up process by allowing the MMIS to generate an assignment. To do this, process the case without completing the LTC data details page, therefore generating an eligibility record to the MMIS. The next day, obtain the MCO from the PMP window in the MMIS and use this MCO on the LTC data details page. The ES-3160 will be sent to this MCO. Run EDBC to generate appropriate eligibility records and notices to the beneficiary. This process should only be used in rare instances and must be documented,

## C. Application Changes

All medical assistance applications include the ability for an applicant to choose an MCO in the event they are approved for coverage. All paper applications, as well as the Medical SSP are being updated to reflect the new MCO choice.

New paper applications will be printed and distributed when available. A supply of applications will be sent to Outstationed workers and other community contacts according to historic distribution volumes. Upon receipt of the new applications, all previous versions must be destroyed.

**Note**: Previous versions of the application will be accepted and treated as a valid application. However, if a choice of Amerigroup is indicated on the application leave the MCO choice field 'blank' in KEES.

For SSP applications, a message has been displayed on the medical CSSP notifying applicants that Amerigroup will no longer be a valid choice after December 31, 2018. On December 16, 2018 the option to select Amerigroup from the SSP was removed and applicants have two choices until Aetna is added as a third option on January 1, 2019.

## D. ES- 3160 Update

The ES-3160 Notification of KanCare HCBS Services form has been updated to reflect the new MCO choice. The new version is to be used for all communication on or after January 1, 2019. If a 3160 is received with a choice of Amerigroup, the worker must contact the individual to obtain the correct MCO (see item (B)(4) above.

Additional changes were also made to the ES-3160: Updates were made to support changes described in item 4 regarding Institutional Transition, SSN is now a required field, TBIRF has been added as an option for both Sections 1 and 2. Finally, the form has now been converted to an enterable PDF.

## E. KEES CHANGES

To support the transition to the MCO, changes are made to the KEES system.

### a. CHANGE IN MCO CHOICE

Changes are being made to the MCO carriers listed on the Individual Demographics page in KEES. Beginning December 31, 2018, Amerigroup will no longer be a valid option on this page. Beginning 01-01-19, Aetna will be listed on the page as a valid option.

Staff will encounter cases impacted by these updates. For example, an application processed on January 5, 2019 for an applicant who filed an SSP application on 12-01-18 and selected Amerigroup as their choice, or an applicant who submits an old application and selects Amerigroup in 2019. The KEES options on the Individual Demographics page will not support these selections. When these situations are encountered the following rules apply:

(1) Do not select an MCO choice for the consumer. If the individual hasn't indicated an option do not pick one randomly.

**(2)** When the consumers choice cannot be accommodated, such as the situations above, do not select any value and leave the field 'blank'.

**(3)** Staff using the Worker Portal shall follow the same rule and leave the field 'blank' if Amerigroup or Aetna were listed on the application and these selections are not available.

**(4)** HCBS cases require special processing, as indicated in item ( c)(3) above.

### b. REMOVING AMERIGROUP RECORDS IN KEES

To avoid incorrect assignment information being sent to the MMIS, a KEES update will occur the evening of 12-31-18 to eliminate all Amerigroup choices in the KEES system. This update will literally remove all pending, current and historic choice selections of Amerigroup from KEES for both active and inactive persons. Historic information regarding MCO assignment or selection should be obtained through the MMIS or by reviewing selections made on the application.

For processing purposes, the next time the Individual Demographics page is accessed, staff may be prompted to make an MCO selection on this page. Do not select a new

assignment. Following the rules above, staff should only select a new entry if they have a specific choice from the consumer made within the past three months, as indicated on an application or other communication coming directly from the individual. Otherwise, leave the selection with choice of 'blank'. DXC will ensure the appropriate assignment is made.

If staff encounter an Amerigroup record inadvertently missed by the KEES update, manually remove the selection by selecting the blank option. Effective January 1, 2019 if Amerigroup is selected as the MCO of choice on the individual demographics detail page, and staff try to save and continue off this page, an error will display. This is your prompt to make a valid MCO selection. Unless the consumer has specifically chosen an MCO in the last three months, this field should be left 'blank'. A recent MCO choice would be indicated in a recent application or other communication coming directly from the individual.

### C. RESOURCE DATA BANK/LTC DATA DETAILS

The change in MCO will also require changes to options available on the LTC Data Details page for HCBS cases. A new resource has been loaded into the RDB for Aetna consumers. The resource will not be available to select until January 1, 2019. This is to be used for persons receiving HCBS.

Resource ID: 1912024
**Aetna Better Health**
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210
1-855-221-5656

The Amerigroup Resource ID, 1066422, shall be end dated effective December 31, 2018. This ID is not to be selected after this date.

## F. MCO COMMUNICATION PROCESS

The MCO Communication process is being updated with this implementation. The MCO will continue to send potential changes and other concerns on special spreadsheets. The report, '*MCO Clearinghouse Report of Changes*' is submitted by each MCO to a special FTP site managed by KDHE. Reports are submitted weekly. The MCO is now asked to provide additional details regarding the source of the information.

The MCO is required to file a report by close of business each Monday (Tuesday if Monday is a Holiday). The report should display all activity through the previous Friday. In the future, the report may be enhanced to include additional detail.

The MCO is to report general beneficiary changes or concerns. Eligibility staff are required to review each report and determine appropriate action. The action depends upon the type of report as well as the source of the information from the MCO.

(1) Address Change: The address change provided by the MCO is accepted if the MCO indicates the beneficiary reported the new address directly to the MCO. If the MCO indicated it came from another source (such as a provider) the address must be confirmed. In addition, staff must pay special attention to the persons in the household impacted by the change. If some are not listed do not make the address change until you confirm the new address applies to everyone in the household, as this could result in violation of confidentiality.

(2) PII Change: When the MCO has different identifying information for the beneficiary – such as SSN, Date of Birth, Date of Death, or name, the information is investigated. If confirmed by an approved source (e.g. EATSS record) the information is updated. Do not update KEES with the reported information until the change is confirmed.

(3) Household Info Change: When the MCO becomes aware of changes in the household, they are encouraged to report it. For example, they report persons entering or leaving the home. These reports need to be individually researched and the information confirmed before acting on the report. Once confirmed, appropriate action is taken.

(4) LOC Issue: The MCO is encouraged to report Level of Care issues for research and resolution. There are a wide range of issues that may be reported, including persons newly admitted into an NF, changes in HCBS or other recent changes that has not yet been acted upon. If the information is new, staff shall research, contacting any NF or other facility necessary, to obtain accurate information. If the beneficiary has recently entered a facility, staff shall request the MS-2126 and proceed as normal. If the MCO is reporting a change or inconsistent information with KEES, the MCO should research before submitting.

(5) Other Issues: If the MCO is reporting other issues or concerns, it is almost always necessary to research and determine if there has been any change that requires action. As this will usually require direct consumer contact, you must follow the general verification/change protocol to react to the change.

## 2) Fair Hearing Changes

The following changes have been made to the fair hearing process.

### A. DDS Disability Determinations

The fair hearing process is being modified to allow for instances when the individual has not cooperated with the reconsideration process. When a fair hearing is requested regarding a DDS disability determination, the following actions are required.

## a. Reconsideration

Every request for fair hearing based upon a claim regarding the disability finding initiates with a reconsideration. The agency shall initiate a reconsideration of the disability determination by sending the appellant a special Medical Assistance Reconsideration Disability Report and two new DD-1103 release forms. The appellant shall be instructed to complete the Disability Report form, sign two DD-1103 forms and return to the agency within 12 days. If timely returned, the forms, along with a new DD-1104 completed by the agency with the reconsideration box clearly marked shall be forwarded to DDS for review. The original disability determination packet compiled by DDS shall also be included. If the appellant fails to timely return the requested forms, no further action on reconsideration is required.

## b. Appeal Summary

The agency shall complete an Appeal Summary and forward to the Office of Administrative Hearings. The Appeal Summary shall be clearly identified as a DDS disability determination appeal. A copy of the original DDS disability determination file shall be included. In most instances, the reconsideration process will not be completed by DDS at this point. The Appeal Summary should reflect that a disability reconsideration by DDS is in progress.

## c. Fair Hearing

If the reconsideration is completed by DDS before the scheduled hearing date, the agency shall take appropriate action based on the new determination. If the DDS decision is favorable, eligibility shall be redetermined and approved for coverage if otherwise eligible. The agency shall submit a motion to dismiss the appeal to the Office of Administrative Hearings because the issue is now moot. If the decision is unfavorable, the agency shall submit the reconsideration packet received from DDS as newly received evidence to support the agency decision.

If the reconsideration is not completed by DDS before the scheduled hearing date, the agency shall request a continuation of the hearing clearly stating the reason for the request. If the request is denied, the agency shall proceed to hearing without the reconsideration decision or documentation. However, the reconsideration process at DDS shall continue.

## d. Hearing Record

The agency may request that the hearing record remain open after the scheduled hearing to submit the DDS reconsideration decision and documentation once completed. If the

request is granted, the agency shall submit the documentation once received. If the request is denied, the reconsideration process will continue, but the ultimate decision and documentation will not be included in the hearing decision.

### e. Agency Action

The agency shall still act upon the reconsideration decision, even when reported after the hearing decision is issued. If the DDS decision is unfavorable, no further action is required. If the decision is favorable, the individual meets disability criteria and eligibility shall be redetermined and approved for coverage if otherwise eligible – even if contrary to the fair hearing decision.

## B. Expedited Fair Hearings

Federal rules state all applicants and recipients have the right to request an expedited fair hearing. An expedited fair hearing is basically the same as a regular fair hearing, except scheduling is accelerated if the appellant demonstrates an urgent medical need. The request may be made either at the time the fair hearing is filed or any time thereafter up to the actual date of the scheduled hearing. If the request is granted, the hearing will be scheduled as soon as possible. If the request is denied, the hearing process will proceed on a normal schedule.

A request for expedited fair hearing may be made at any time prior to the scheduled fair hearing date. Documentation supporting the request for an expedited hearing is required. The fair hearings section on the back of notices and forms will be updated to reflect this change by including information regarding the right to request an expedited hearing. The new section will be implemented on all notices produced from KEES with the release scheduled on or about 01-27-19. The Standard Cut and Paste will also be updated. In addition, reviews and application forms will be updated as those documents are updated. A special message will be available on the Medical SSP directing those who seek more information on the process to access the KanCare website. Additional information regarding the process for an expedited fair hearing can be found in Job Aid 7.35, Fair Hearings Process.

## C. Federally Facilitated Exchange (FFE)

The third fair hearings change involves requests initiated with the Federally Facilitated Marketplace (FFM). An applicant may appeal a decision made by the Federally Facilitated Marketplace (FFM)) concerning his/her application for coverage and/or eligibility for the subsidy through the Health Insurance Marketplace. That appeal request will be sent to the Marketplace Appeals Center for processing and hearing. If, during the appeal process, the

Marketplace Appeals Center determines the appellant is potentially eligible for Medicaid or CHIP coverage, the fair hearing is passed onto the state to review the case. The state is then responsible to review the material and process any potential change.

Cases are identified to come to the state after the FFM has evaluated the information claimed by the appellant and has determined at least one individual may be potentially eligible for Medicaid or CHIP based upon the new information. The Marketplace Appeals Center will submit an electronic appeal package to the agency containing consumer account information. The package of information will include not only information provided directly by the applicant when he/she completed the Health Insurance Marketplace application, but also data obtained from the result of any verifications performed by the FFE. Also included in the package is the appeal request submitted by the appellant. This information shall be used by the agency to review the individual's eligibility for medical assistance.

**Note**: The agency should only receive an appeal package for individuals who have already been denied Medicaid and/or CHIP coverage by the agency.

Upon receipt of the appeal package, the agency shall conduct an administrative review of the case based on the information provided and redetermine eligibility for Medicaid and/or CHIP coverage if necessary. If the applicant is determined eligible based on the review, coverage shall be promptly approved with notification provided to the applicant. If the agency determines that the applicant is not eligible, the application shall remain denied. The applicant shall be notified of the decision with the right to appeal. The agency shall notify the FFE of the outcome of the redetermination through the automated referral process, special communication is not required. If there is no need for a redetermination (example – the consumer in question, has actually received Medicaid or CHIP) no additional action is taken.

KDHE Central Office will receive all appeal packages and will be responsible for conducting the review of the case and any adjustments that are necessary.

# 3) Money Follows the Person (MFP) Program Ending

## A. Background

Money Follows the Person (MFP) is a demonstration grant program which implemented July 1, 2008. The intent of this program is to help shift Medicaid's traditional emphasis on institutional care to a system offering greater choices that include home and community based services (HCBS) allowing what would otherwise be nursing home funding to "follow the person" to a community assisted living setting. MFP serves individuals transitioning from a nursing facility or Institutional Care Facility for Individuals with Intellectual Disabilities (ICF-IID) to community based services.

Coverage under MFP is limited to a total of 365 days. Those days need not be consecutive but must begin prior to the end of the demonstration grant period. The MFP Program Manager is responsible for tracking the 365 days.

### B. End Date of Money Follows the Person

Effective December 31, 2018, funding for the MFP program will end. This means individuals currently receiving coverage under the MFP program must be transitioned to an existing HCBS waiver beginning with the January 2019 benefit month. For example, an individual receiving MFP/FE coverage must be transferred to the HCBS/FE waiver effective January 1, 2019. This will involve terminating the LTC Data Detail record for MFP and adding a new LTC Data Detail record to establish coverage under the appropriate HCBS waiver. An ES-3160 must be sent to the MCO and screening entity (e.g. ADRC, CDDO) to notify them of this change. For waivers with a wait list, the ES-3160 must also be sent to the HCBS Waiver Manager. A report of individuals currently receiving MFP coverage will be provided.

MFP will remain an option for LTC Type on the LTC Data Details page even though funding for this program is no longer available. When taking action to authorize LTC eligibility after January 1, 2019, eligibility staff must pay careful attention to the type of LTC Data Details record they are adding, as use of the MFP LTC Type is no longer permitted.

## 4) Institutional Transition Program

Information contained within this section establishes the policy and process for requesting, managing, and determining eligibility for individuals in Medicaid approved institutional settings to transition into the community and onto HCBS waiver services.

### A. Overview of Institutional Transition Program

The intent of the Institutional Transition program is to transition eligible individuals from institutional care settings onto the Frail and Elderly (FE), Intellectual and Developmental Disability (I/DD), Physical Disability (PD), and Traumatic Brain Injury (TBI) waiver programs.

### B. Eligibility Requirements

To be eligible for an institutional transition, an individual must meet the criteria outlined below and be approved for transition by the KDADS HCBS Transition Specialist. This approval will be documented on the ES-3160.

1. A resident of Kansas.

2. Reside in an institutional setting. The following are examples of institutional settings: Nursing Facility, State Hospital (Kansas Neurological Institute, Larned, Osawatomie,

and Parsons), Institutional Care Facility for Individuals with Intellectual Disabilities (ICF-IID), Traumatic Brain Injury Rehabilitation Facility (TBIRF), and Psychiatric Residential Treatment Facility (PRTF).

a. For waivers with waiting lists, the individual must be a current resident in an institutional setting with a minimum of ninety (90) consecutive days before being considered eligible to apply for an institutional transition.

b. In the event an individual is in a nursing facility for a temporary stay which then becomes long term with no disruption of services, the temporary stay days shall count toward the consecutive ninety (90) days stay requirement.

3. Meet the HCBS waiver program eligibility criteria of the waiver they are transitioning to.

4. Have the applicable functional eligibility assessment and be found functionally eligible for waiver services.

5. Meet financial eligibility criteria outlined in Medical KEESM 8270.

## C. Referral and Transition Process

### a. Referral and Assessment

Most individuals residing in an institutional care facility who currently receive Medicaid are assigned to an MCO. The MCO is responsible for initiating the referral process and sends a request for institutional transition to the HCBS Transition Specialist. The HCBS Transition Specialist will ensure individuals referred for institutional transition have a current assessment on file and meet functional eligibility criteria for the requested HCBS waiver.

### b. Transition

If an individual meets transition criteria, the HCBS Transition Specialist will complete an ES-3160 indicating approval and send it to the KanCare Clearinghouse **prior to** discharge from the institutional care facility. Upon discharge from the institution into the community, the institutional care facility will send an MS-2126 Notification of Facility Admission/Discharge form to the KanCare Clearinghouse verifying the date of discharge. Action must be taken to process the institutional transition after the individual has left the institutional care facility, not before. If the date of discharge on the MS-2126 differs from

the date of discharge on the ES-3160, the date of discharge on the MS-2126 is entered into KEES as that is the actual date the beneficiary left the facility.

### C. EXAMPLES

Consider the following examples:

**(1)** Margaret is 71 years old and is covered under the Medically Needy spenddown program with a base period of November – April. In January, Margaret fell and broke her hip and was admitted to the nursing facility for a short term stay. When Margaret is ready to discharge and return home, the MCO makes a referral for Institutional Transition so Margaret can receive HCBS under the FE. The HCBS Transition Specialist approves Margaret for Institutional Transition and sends an ES-3160 to the KanCare Clearinghouse authorizing FE waiver services to begin on the date she discharges from the nursing facility. The nursing facility sends an MS-2126 to the KanCare Clearinghouse indicating Margaret was discharged on April 28th. The LTC Data Details record for Institutional Care is edited to include the date Margaret discharged from the nursing facility. A new LTC Data Details record is added for HCBS to begin effective April 28th, the date of discharge.

**(2)** Samuel is 57 years old and is covered under the Medicare Savings Program QMB. In January, Samuel was in a car accident and sustained a traumatic brain injury (TBI) and was admitted to the Traumatic Brain Injury Rehabilitation Facility (TBIRF) for rehabilitative care. After several months, Samuel is ready to discharge and return home. The MCO makes a referral for Institutional Transition so Samuel can receive HCBS at home under the TBI waiver. The HCBS Transition Specialist approves Samuel for Institutional Transition and sends an ES-3160 to the KanCare Clearinghouse authorizing TBI waiver services to begin on the date he discharges the TBIRF. The TBIRF sends an MS-2126 to the KanCare Clearinghouse indicating Samuel was discharged on May 9th. The LTC Data Details record for Institutional Care is edited to include the date Samuel discharged from the TBIRF. A new LTC Data Details record is added for HCBS to begin effective May 9th, the date of discharge.

## D. REFERRAL AND TRANSITION FROM THE STATE HOSPITAL OR MENTAL HEALTH NURSING FACILITY

Because there is no MCO assignment in place, special consideration and processing instruction is necessary when an individual is discharging from a State Hospital or Mental Health Nursing Facility (NF/MH).

## a. Referral and Assessment

### (1) State Hospital

Individuals residing in a State Hospital between the ages of 21 – 64 are not eligible for Medicaid coverage. There are currently two state hospitals meeting these criteria: Larned State Hospital and Osawatomie State Hospital. They must also apply for Medicaid prior to discharge from the state hospital before eligibility may be determined under this program. The State Hospital Discharge Planner is responsible for assisting the individual with the Medicaid application process.

Once the individual has chosen an MCO, the State Hospital Discharge Planner will contact the HCBS Transition Specialist to refer the individual for Institutional Transition. For individuals requesting I/DD waiver services, the HCBS Transition Specialist will notify the assessing entity of the individual's choice to transition out of the institution after the individual is determined to be program eligible. The assessing entity will then complete an assessment to determine functional eligibility for the waiver.

### (2) Mental Health Nursing Facility

Persons between the ages of 21 - 64 who are residents of a Mental Health Nursing Facility (NF/MH) remain eligible for Medicaid but lose their MCO assignment effective the first day of the month they are admitted. Once the individual has chosen an MCO, the Facility Administrator will contact the HCBS Transition Specialist to refer the individual for Institutional Transition. The HCBS Transition Specialist will ensure individuals referred for institutional transition have a current assessment on file and meet functional eligibility criteria for the requested HCBS waiver.

## b. Transition

Once functional eligibility is determined, if the individual meets transition criteria, the HCBS Transition Specialist will complete an ES-3160 indicating approval for transition and send it to the KanCare Clearinghouse. On the day of transition, the discharging institution shall send an MS-2126 to the KanCare Clearinghouse indicating the individual has been discharged. Again, action must be taken to process the institutional transition after the individual has left the state hospital or NF/MH, not before. If the date of discharge on the MS-2126 differs from the date of discharge on the ES-3160, the date of discharge on the MS-2126 is entered into KEES.

### c. EXAMPLES

Consider the following examples.

**(3)** Dennis (51 years old) was admitted to Osawatomie State Hospital for a long term stay on January 3rd. An MS-2126 was received, eligibility is discontinued effective 1/31/2019, and MCO assignment is removed 1/1/2019. After several months, Dennis is ready to discharge and return home. The State Hospital Discharge Planner helps Dennis complete an application for Medicaid and an MCO is chosen. The State Hospital Discharge Planner contacts the HCBS Transition Specialist to make a referral for Institutional Transition. Dennis is assessed by the CDDO and determined functionally eligible for the I/DD waiver and a person-centered service plan is developed by the MCO. The HCBS Transition Specialist approves Dennis for Institutional Transition and sends an ES-3160 to the KanCare Clearinghouse authorizing I/DD waiver services to begin on the date he discharges the State Hospital. The State Hospital Discharge Planner sends an MS-2126 to the KanCare Clearinghouse verifying Dennis was discharged on April 25th. Eligibility is determined for April with HCBS beginning effective April 25th.

**(4)** Charles (43 years old) was admitted to the NF/MH for a long term stay on December 18th. His Medicaid eligibility continues but his MCO assignment is terminated effective 12/1/2018. After several months, Charles is ready to discharge and return home. The Facility Administrator contacts the HCBS Transition Specialist to make a referral for Institutional Transition. Charles is assessed by the CDDO and determined functionally eligible for the I/DD waiver. Charles chooses an MCO and a person-centered service plan is developed. The HCBS Transition Specialist approves Charles for Institutional Transition and sends an ES-3160 to the KanCare Clearinghouse authorizing I/DD waiver services to begin on the date of discharge. The Facility Administrator sends an MS-2126 to the KanCare Clearinghouse verifying Charles was discharged on June 10th. The Institutional Care LTC Data Details record is updated to reflect the date Charles discharged and a new LTC Data Details record is added to authorize HCBS with an effective date of June 10th.

## E. KEES DATA ENTRY

When completing the eligibility determination in KEES for Institutional Transition, staff must be diligent in correctly completing the Individual Demographics page (when necessary) and LTC Data Details page to accurately reflect the MCO the individual has chosen. Failure to update these pages appropriately may cause an incorrect MCO assignment. See Section 1 (B)(c) for more information.

When processing an institutional transition, the LTC Data Details record for Institutional Care must be updated to reflect the individual's date of discharge from the long term care facility. Then, a new LTC Data Details record must be added to authorize HCBS as part of the

institutional transition. There is no specific data in KEES to differentiate individuals eligible for an institutional transition from those who are eligible to receive HCBS under an existing waiver. Eligibility staff must clearly indicate in the Journal that the individual has been approved for HCBS as an institutional transition and document the applicable waiver.

## 5) ANTICIPATED MONTHLY CLIENT OBLIGATION FOR HCBS

Upon completion of the eligibility determination for HCBS, the beneficiary is notified of their responsibility to pay a monthly client obligation and the amount of the client obligation. This is often problematic as the beneficiary may not have known or understood they would have a share of cost. In some situations, the individual may have requested termination of their HCBS services because they were unwilling or unable to pay their monthly client obligation.

In an effort to educate individuals requesting HCBS of their anticipated monthly share of cost, eligibility staff shall make contact with those who are anticipated to have a monthly client obligation by telephone or through use of the new ES-3159, HCBS Client Obligation Informational Agreement. It is not necessary to contact individuals who are not anticipated to have a monthly client obligation (e.g. SSI recipients, PMG eligible individuals, or individuals with income below the protected income limit).

The HCBS Client Obligation Informational Agreement was developed as a mechanism to provide specific information related to the individual's estimated monthly client obligation prior to completion of the eligibility determination. This allows the individual to make an informed decision regarding the type of medical assistance they wish to pursue, with the understanding of their responsibility to pay a monthly client obligation.

An HCBS brochure has also been developed as part of this implementation and will be distributed to screening entities. Like the HCBS Client Obligation Informational Agreement, the intent of the brochure is to provide the individual requesting HCBS with information related to their monthly client obligation at the time they are assessed.

### A. CONTACTING THE CONSUMER

The method in which the consumer is contacted is dependent on whether information must be requested from the consumer, in order, to complete the eligibility determination.

#### a. NO INFORMATION IS NEEDED

In situations where an individual requests HCBS and no additional information is needed to complete the determination, eligibility staff shall initiate contact with the consumer by telephone to explain the estimated monthly client obligation. If he or she cannot be reached, HCBS eligibility is determined without delay. There is no negative impact to the individual if contact by telephone is not successful.

### b. Additional Information is Needed

When processing an HCBS request for an individual who is anticipated to have a monthly client obligation, eligibility staff shall send the HCBS Client Obligation Informational Agreement to the consumer at the same time additional information (e.g. income, resources) is requested. If the individual returns the requested information but does not return the HCBS Client Obligation Informational Agreement, eligibility staff will initiate contact with the individual by telephone. If the individual cannot be reached by telephone, HCBS eligibility is determined without delay. Again, there is no negative impact to the consumer if the HCBS Client Obligation Informational Agreement is not returned and contact by telephone is unsuccessful.

## 6) Conclusion

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff listed below.

Jerri Camargo , Family Medical Program Manager - Jerri Camargo@ks.gov
Erin Kelley, Elderly and Disabled Program Manager – Erin.Kelley@ks.gov
Jeanine Schieferecke, Senior Manager – Jeanine.Schieferecke@ks.gov

Questions regarding any KEES issues are directed to the KEES Help Desk at KEES.HelpDesk@ks.gov

Kansas
Department of Health and Environment
Division of Health Care Finance

# HCBS CLIENT OBLIGATION INFORMATIONAL AGREEMENT

Name of Applicant or Beneficiary: _____

Social Security Number: _____ Case Number: _____

_____ request for Medical Assistance for Home and Community Based Services (HCBS) was received on _____. We need more information about your requested coverage options. Please review carefully. Once you have reviewed and made a decision, please mark your choice, sign and date, then return the form to the KanCare Clearinghouse by _____.

Home and Community Based Services (HCBS) offers services in the community instead of in the nursing home. Persons must have a medical need for this care and there must be an available slot on the requested HCBS waiver. The asset limit is $2,000 for single persons.

Persons receiving HCBS may also have a monthly share of cost. This is called a client obligation. The client obligation is determined by the agency and is based on the gross monthly income of the individual requesting HCBS. Some eligible medical expenses, such as private health insurance, may be deducted as well.

Based on the information you provided on your application, we have calculated your ***estimated*** monthly client obligation to be $_____.

In anticipation of qualifying for HCBS, I agree to the following (choose one):

_____ I agree to pay the monthly client obligation and wish to proceed with the HCBS application process.

_____ I do not want to pay the client obligation and wish to withdraw my request for HCBS. Please review my application for coverage under other medical assistance programs.

I understand that the agency will determine eligibility for HCBS based on the choice made on this document. The amount of the client obligation may be adjusted by the agency if income or eligible expenses change.

Date: _____

_____
Applicant or Beneficiary Signature

**Please send this completed form to:**
**KanCare Clearinghouse**
**PO BOX 3599**
**Topeka, KS 66601**

**OR, Fax: 1-844-264-6285**

If you have questions and would like more information before completing and returning this form, please call KanCare at 1-800-792-4884 between the hours of 8:00am and 5:00pm Monday through Friday.

Kansas Department of Health and Environment

**NOTIFICATION OF KANCARE HCBS SERVICES**
**REFERRAL/INITIAL ELIGIBILITY/ASSESSMENT/SERVICE INFORMATION**

ES-3160
01-19

## I. CONSUMER INFORMATION

Name: _____ KanCare ID No.: _____
Address: _____
Phone: _____ SSN: _____ Date of Birth: _____
Responsible Person/Contact _____ Home Phone: _____
Address: _____ Work Phone: _____
Form Initiated By: Choose Name: _____ Date Sent: _____
**Reason for 3160:** Choose **HCBS Program Type**: Choose

## II. HCBS PROGRAM ELIGIBILITY INFORMATION (Functional Eligibility Assessor)

Person Completing Section: _____ Office Phone: _____
Address: _____ Office Fax: _____
Applicant MCO Choice: Choose Applicant Requesting PACE Referral: ☐Yes ☐No
HCBS Program Type: Choose Placed on Waiting List: ☐Yes ☐No If Yes, Date: _____
Program Threshold Met: ☐Yes ☐No Services Request Withdrawn: ☐Yes ☐No
Choose HCBS: ☐Yes ☐No If Yes, Choice Date: _____
Comments: _____

Signature Person Completing Section Date Sent

## III. KDADS PROGRAM MANAGER APPROVAL/DENIAL (IDD/PD/TBI/Autism)

**Program Manager Approval Required:** ☐Yes ☐No (If Yes, section must be completed by Program Manager)
Program Manager _____ Office Phone: _____
HCBS Program Type: Choose ☐Approved ☐Denied Effective Date: _____
Comments: _____

Signature of Person Completing Section Date Sent

## IV. MCO INFORMATION

MCO: Choose Estimated Cost of Care: _____ Anticipated Start Date: _____
If Transition, New Address: _____
Comments: _____

Signature of Person Completing Section Date Sent

## V. ELIGIBILITY INFORMATION

Eligibility Worker: _____ Office Phone: _____
KanCare Application Received: _____ Case Number: _____ App. Status: Choose
Approval Type: Choose Effective Date: _____
Estimated Client Oblig.: _____ HCBS Client Obligation: _____ Month: _____
Next Review Date: _____ HCBS Client Obligation: _____ Month: _____
Comments: _____

Eligibility Worker Signature Date Complete

Form Returned upon eligibility completion to: ☐ MCO ☐ KDADS ☐ Assessor ☐ DCF

Attachments: ☐Yes ☐No