Kansas Department of Social and Rehabilitation Services

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MEMORANDUM

To:	EES Program Administrators CFS Program Administrators HealthWave Clearinghouse	Date:	March 14, 2005
From:	Bobbi Mariani, EES Director Sandra Hazlett, CFS Director	RE:	Implementation of Level of Care/Patient Liability for Level VI and Head Injury Rehabilitation Facilities

The purpose of this memo is to provide implementation instructions for two new beneficiary level of care (LOC) coding combinations related to institutional expenses. The new levels of care are necessary to assign a patient liability for residents of these specific types of institutions. The new policy will impact both EES and CFS staff and is effective for all claims processed on or after March 21, 2005

I. **General LOC and Patient Liability Process:**

When an individual enters an institutional living arrangement and is determined eligible for Medicaid, a patient liability is established. The patient liability is the beneficiary's monthly share of the cost of institutional care and is based on income. Any Medicaid payments made to the institution are reduced by the amount of the patient liability. The facility is responsible for collecting the patient liability from the resident. More information about patient liability can be found in KEESM 8172 and subsections.

To ensure Medicaid is paying only for those who truly need long term care services, a level of care screening or assessment is required prior to payment of most institutional costs. There are many different types of speciality facilities and each has a different screening mechanism. The eligibility worker ensures the proper level of care criteria have been met before approving Medicaid payment. Persons who do not meet the necessary level of care are not eligible for Medicaid reimbursement of LTC/institutional expenses. More information about level of care/screening requirements can be found in KEESM 8112 and 8114.

Before paying a Medicaid claim to any institution, the MMIS must have a way to confirm a patient liability has been determined and the level of care has been confirmed. This is done through the KAECSES LOTC screen. The LOTC screen captures both living arrangement and level of care codes and then converts them to a special Beneficiary LOC code for the MMIS, which can be viewed on the 'Level of Care' window in the MMIS. When an institutional provider bills for services, a check is done to determine if

the beneficiary is authorized to receive the level of care provided by the facility. This will prevent payment for an individual who does not need long term care services or for someone who needs a different type of services.

Federal Medicaid rules require consideration of both patient liability and level of care prior to paying long term care expenses. Although these elements are new to both Level VI and Head Injury/Rehab facilities, policies have been in place for most nursing facilities for many years to provide for these situations. Specific instructions for each facility type are provided below.

II. **Level VI Facilities:**

Level VI facilities provide behavioral health care in an institutional environment. These facilities offer a highly structured setting to youth with behaviors such as severe emotional or mental disturbance, sexual acting out, substance abuse and combative behavior. For purposes of Medicaid eligibility, these arrangements are considered medical institutions. Level V and Level IV facilities are NOT considered medical institutions for Medicaid purposes and these policies do not apply to residents of those facilities. A list of all Level VI facilities recognized by the Medicaid program is included with this material.

With the full implementation of this policy, payment is dependent on an appropriate beneficiary level of care. If the LOC is present, patient liability will be considered. A monthly patient liability must be determined for each beneficiary ($00 when there is no patient liability). Payment to the facility is reduced by the amount of patient liability.

A. **FFS vs Contracted Care:** This policy will be implemented in two phases. This is necessary to accommodate the separate payment mechanisms that are currently used to reimburse Level VI facilities, as follows:

   1. **Children in SRS Custody under a FC (Foster Care) Medical Program -** Level VI services provided to children served under the private child welfare contracts are provided under the terms of the contract. The facility does not bill the MMIS for payment at this time.

      Note the change in the terms of the foster care contracts effective 07-01-05 will also require a change in the payment process for Level VI placements, as addressed below.

   2. **Children in JJA Custody under a FC (Foster Care) Medical Program and Other Medicaid Eligible Children -** Services for these youth are paid on a fee for service basis after a separate Medicaid claim is filed. Before paying the claim, a prior authorization (PA) must be obtained from the Mental Health Consortium. If the PA is in place, payment is made for eligible children.

B. **Processing Instructions:** The following general process is to be used for all individuals residing in a Level VI facility:

1. All Level VI placements are initiated when the CMHC, JJA Local Agency or the CFS worker contacts the Mental Health Consortium to request a screening. The Consortium is responsible for coordinating the process. See the Behavior Management Provider Manual for more information regarding the screening process.

2. If approved, a prior authorization (PA) is then entered on the MMIS by the Consortium. The Level VI facility will not be paid without a current PA on file.

3. Following placement of a youth in SRS custody, the facility will initially contact CFS for payment. For JJA youth, the facility shall continue to submit claims directly to Medicaid through MMIS. If the child is in custody and eligible for Medicaid through a foster care program (SRS or JJA custody), CFS will process the request. If the child is not in custody, CFS will refer to the case to EES for Medicaid determination. A Medicaid application for coverage is necessary.

4. Determine Medicaid status.

    a. Persons covered under a Foster Care Medicaid or SSI Medicaid program at the time of placement remain in the FC or SI Medicaid group throughout the stay as long as requirements continue to be met.

    b. Persons covered under another Medicaid program at the time of placement may remain covered under the same Medicaid program if the stay will not exceed 30 days. If the stay exceeds 30 days, eligibility is redetermined under a CI program. Eligibility is never determined under a CI program until the youth is actually a resident of the facility.

    c. Persons who are not Medicaid-covered upon entrance may apply for Medicaid. For stays exceeding 30 days, a CI program is used. For stays under 30 days, another Medicaid program may be established considering the child's prior living arrangement. For example, a child living with his parents could be considered under the MP or MA program.

    d. There is no payment for services if eligible under HealthWave 21. It will be necessary to determine eligibility for Medicaid for any HealthWave 21 child who enters a Level VI facility.

5. For individuals who are Medicaid eligible, determine the patient liability. Generally, only the individual's own income is used.

6. Complete the KAECSES LOTC Screen. See the KAECSES User Manual for instructions. For Level VI facilities, use the following guide for coding.

Living Arrangement :	BF

Level of Care:	MH
LA/LOC Payment Date:	Use month, day and year Level VI payment begins, usually the date of entrance into the facility
Patient Liability:	Use amount computed. Use $0 if none.
Patient Liability Eff Date:	Month and Year of Patient Liability
Date Screen Completed:	Same date as LA/LOC date above

The example below reflects how to complete LOTC for an individual who entered a Level VI facility on 02-08-05, where payment is to begin immediately. Becky has a patient liability of $225.00 for the month of April. The patient liability will remain this amount each month unless a change in income occurs. The eligibility worker must tell the resident/responsible person and the facility about any change in patient liability.

LOTC LONG TERM CARE 022505 14:48 JEANINE S	
CASE NAME: BENE, BECKY B	CASE NUMBER: 00000001
POS ON APP/NAME: 01	BECKY B
LIVING ARRANGEMENT:	BF
LEVEL OF CARE:	MH
LA/LOC PAYMENT EFF DATE:	020805
PATIENT LIABILITY:	225.00
PAT LIABILITY EFF DATE:	0405
DATE SCREEN COMPLETED:	020105
PEND DATE	

1. Send notices to both the beneficiary and the facility informing them the status of the case (approved/denied) and any amount of patient liability, along with effective dates .

2. As changes occur, adjust the patient liability accordingly. Notify the resident/responsible person and the facility giving timely and adequate notice as required.

3. When the individual is discharged, discontinue the LOTC living arrangement and level of care codes by changing the combination to LA of IL and an LOC of NA.

It is the responsibility of the facility to inform SRS of discharge. Because a notice will be sent to the facility telling them about payment, the facility will have the name of the assigned worker on the case. The communication will typically come to this worker. However, if the facility is unsure who the individual is, or if they have never received a notice, communication will

come through the CFS worker. The CFS worker shall communicate the information to others that also need to know the information.

C. **Implementation Instructions:** Follow the instructions below for all individuals residing in a level VI facility, depending on the case type. Failure to follow the proper procedures will result in payment denial for the facility.

1. **Children in SRS Custody under a FC (Foster Care) Medical Program:** Because payment of this expense is the responsibility of the contractor, neither the LOC or patient liability are necessary until July 1, 2005. Prior to 07-01-05, the KAECSES LOTC screen must be completed for all Level VI placements. This must be completed by close of business on 06-17-2005. Patient liability must be determined and included on the LOTC screen. Detailed instructions for determining the patient liability for foster care situations will be sent under separate cover.

2. Children in JJA Custody under a FC (Foster Care) Medical Program: Unlike SRS custody situations, payment is made on a fee for service basis for these residents. This means the appropriate Living Arrangement and Level of Care codes must be in place. The LA/LOC effective date is the first date of payment in the Level VI facility, usually the date of entrance. This is true regardless of the length of time that has passed since the individual was placed. LOTC must be completed by close of business 03-18-05. A patient liability will not be computed at this time. A patient liability of ‘00.00' is to be entered for each eligible resident. Implementation of the patient liability for the JJA custody youth will be implemented with the regular FC population and will be in place no later than 06-17-05. Separate instructions will be issued.

3. **Children in other Medicaid programs (including CI and SI):** LOTC must be completed with appropriate codes by close of business 03-18-05. The LA/LOC effective date is the first date of payment in the Level VI facility, usually the date of entrance. This is true regardless of the length of time that has passed since the individual was placed. Because of timely notice, patient liability cannot be implemented prior to 04-01-05.

Again, it is critical to stress the coding must be in place on the LOTC screen, as bills processed on or after 03-21-2005 will not be paid if proper coding isn’t present.

D. **Level VI Beneficiary Printout:** To assist with identifying current Level VI residents, a printout of all individuals where a Level VI billing was made in the last 60 days to the MMIS is being sent to the regional program contacts (CFS and EES). This list should be used as a guide for identifying current residents whose payment may be impacted by the new policy.

The list is sorted by worker and includes both the case number and the client ID number. The list also includes a JJA custody indicator. This indicator is set to ‘Y’ if the MMIS indicates the youth was in a JJA custody situation in the month of March, 2005. For all other youth, the indicator is not present.

The facility name if not included. If the worker was not aware of the Level VI placement, an MMIS claim inquiry may be completed to determine which facility has made a claim for payment. Contact with the facility may be required to determine the date of entrance and the date of discharge, if applicable. Because the policy applies to all claims processed on or after 03-21-05, LOTC should be completed even for those youth who are no longer living in the facility as additional bills may be submitted. Check with the facility to determine the date of placement, if unknown as well as any potential date of discharge.

All new Level VI approvals made after receipt of this memo must include proper LOTC coding.

III. **Head Injury Rehabilitation Facilities (aka Traumatic Brain Injury Rehabilitation Facilities) :**

Head Injury facilities provide health and rehabilitation related care to persons who have experienced severe brain injury and are in need of active treatment programming for retraining in independent living skills. Residents receive professional services on a 24-hour basis due to their cognitive and physical condition. For purposes of Medicaid eligibility, these arrangements are considered medical institutions. A list of all Head Injury Rehab Facilities recognized by the Medicaid program is included with this material.

Like Level VI facilities, with the implementation of this policy, payment to the facility is dependent upon an appropriate beneficiary level of care. If the LOC is present, patient liability will then be considered. A monthly patient liability must be determined for each resident ($00 when there is no patient liability). Payment to the facility is reduced by the amount of patient liability.

A. **Processing Instructions:** Prior to approving payment for a HI facility stay, the eligibility worker must ensure the individual meets appropriate level of care through a functional assessment. The Independent Living Center has responsibility for the function assessment. When a request for payment is received, a request is to be generated to the appropriate ILC for level of care/payment approval information. For out of state placements, permission of the HI Manager in HCP-Community Supports and Services is required. In addition, the MMIS required all out of state placements be prior authorized. If approved, eligibility is determined per KEESM 8112. The KAECSES LOTC screen must be completed as well. The information described above under Level VI is also appropriate for Head Injury Rehab facilities, with the followi ng

exceptions:

Living Arrangement:	NF
Level of Care:	HI

The example below shows an appropriate LOTC screen for an individual who entered the facility on 02-08-05 and payment begins that day:

LOTC LONG TERM CARE 022505 14:48 JEANINE S	
CASE NAME: KAT, KATY K	CASE NUMBER: 00000002
POS ON APP/NAME: 01	KATY K
LIVING ARRANGEMENT:	NF
LEVEL OF CARE:	HI
LA/LOC PAYMENT EFF DATE:	020805
PATIENT LIABILITY:	123.00
PAT LIABILITY EFF DATE:	0405
DATE SCREEN COMPLETED:	020105
PEND DATE	

Appropriate notices, as required with any NF situation must be sent to notify the resident/responsible party and the facility of any approval, suspension or termination in payment as well as any patient liability change.

B. **Implementation Instructions:** As with level VI facility payments, appropriate LOTC coding must in place for all current residents prior to 03-21-05 for the provider to receive Medicaid payment.

Because of timely notice issues, patient liability will not be effective prior to 04-01-05, unless the resident and facility have been previously notified about the patient liability.

To assist with implementation a list of Medicaid beneficiaries with a HIR billing within the past 60 days is included with this material. The list, sorted by worker number also includes the case number and Medicaid ID number. If the eligibility worker is not aware of the placement, contact with the facility is required to determine admission date, etc. Contact with the ILC is required to ensure LOC has been met prior to approving payment.

Please note that approval for payment of individuals residing in a Head Injury Rehab facility is a distinct process different from approval for the HI HCBS waiver. Although short term care may be paid while the individual is on the HI waiver, such situations must be approved through the HI HCBS Case Manager and are allowable if the length of stay will not exceed the month of entrance and two following months (see KEESM 8113. This will be communicated to the eligibility worker through the ES-3161.

Appropriate KAECSES LOTC codes are Living Arrangement - TC; Level of Care - HI.

Your cooperation and effort meeting the implementation deadlines defined above is very much appreciated. If you have any questions about the material, please contact Jeanine Schieferecke, Medical Assistance Manager in EES, at (785) 296-8866. Please report any system problems to SRSTSC.

BM:SH:JS:jmm

Attachment