Kansas Department of Social and Rehabilitation Services
Janet Schalansky, Secretary

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MEMORANDUM

To:	EES Chiefs and Staff Area Directors	**Date:**	December 26, 2002
From:	Jeanine Schieferecke	**RE:**	Implementation of Medicaid Changes Related to Allotment

The purpose of this memo is to provide instructions to EES staff for the implementation of changes in the Home and Community Based Service (HCBS) waivers and Nursing Facility programs. Changes involve a reduction in the Protected Income Level (PIL) for HCBS cases, an increase in the Level of Care (LOC) score for some HCBS waiver and NF cases and the elimination of adult coverage of several optional medical services. These changes are being made as a result of budget reductions imposed on both SRS and the Kansas Department on Aging (KDOA) by the Governor. The mandate reduced the budgets of most state agencies by 3.9% through the implementation of an allotment due to a budget shortfall. Although additional reductions are also planned as a result of the allotment, this memo provides instructions and information on those changes which require additional action by EES staff at this time.

A pen and ink change incorporating the new policies will be made to the Kansas Economic and Employment Support Manual (KEESM) and will be sent separately.

Policy Changes:

The following changes have been made as a result of the allotment:

1. Effective February 1, 2003 the HCBS income standard, or the PIL, is $645.00. This change is effective for benefit months beginning 02-03. For benefit months prior to 02-03 the PIL remains $716.00. All HCBS waivers are impacted by this change as well as the PACE program.

2. Effective February 1, 2003 the functional LOC threshold for NF, PACE and HCBS eligibility in the FE and PD waivers increases to 30. Persons currently on the waiting list for these waivers with lower a score will be removed from the waiting list.

   For the PD waiver, persons currently on the waiver with LOC scores less than 26 will be terminated from the waiver. Persons with scores between 26 and 30 will be grandfathered and may continue on the waiver.

   For the FE waiver and NF services, all current beneficiaries will be grandfathered and shall continue to be eligible for services. If the individual should leave the waiver in the future he/she will not be able to be placed back on the waiver (or the waiting list) unless the LOC score is met. Persons who no longer meet LOC in an NF arrangement will also be grandfathered, as will any current PACE participants.

3. In early 2003 the Medicaid program will terminate coverage of some optional medical services for non-Kan Be Healthy (KBH) participants. The exact implementation date of these changes are not known at this time. In addition to the coverage restrictions, service limitations and reimbursement rates for some Medicaid services will be reduced as well. Following are the services being eliminated:

- Vision Services - eye examinations and glasses for non-KBH participants
- Audiology Services - hearing tests, hearing aides and batteries for non-KBH participants
- Branded Prescription drugs in excess of 5 per month
- Incontinence Supplies - adult diapers for all Medicaid beneficiaries

Implementation Instructions- PIL Change:

To implement the new HCBS standard, the KAECSES table will be updated in preparation for a special emergency mass change, much like the process followed for COLA mass change. The mass change will run the weekend of January 3-5, 2003. This mass change will rebudget all MS programs and incorporate the new HCBS standard. The new standard will be applied to all MS programs with a medical program subtype of HC. Other income and expenses currently included in the budget will not be adjusted. Any resulting HCBS obligation will be computed and reflected on the SPEN screen for the benefit month of 02/03.

The LOTC screen will also be automatically updated to incorporate the new HCBS obligation amount and a 02-01-03 effective date. This update will also occur over the weekend of January 3 - 5. All cases with an effective date prior to 02-01-03 and an HCBS obligation different that the amount appearing on SPEN in February will be updated. The LOTC screen must be updated manually if these conditions are not met. LOTC will not update if a later effective date is present on LOTC.

Because the mass change will reprocess all MS cases, some NF, WH and IL cases may be adjusted because of this update.

The MR330, Mass Change Detail, will be available following the mass change. All cases impacted by the mass change will be listed. This report is accessible on SAR by entering SWY03854-158. Staff should be prepared to review this list and identify those cases which may require manual intervention, such as those cases copied past 02-03. Staff should also be prepared to view the Exceptions to LOTC Update, which lists those cases where LOTC did not update. It is expected that all AC living arrangements will also appear on this list, so staff may have to sort though the information to identify pertinent HCBS information. This report is accessible on SAR by entering SWY03873-R25. Both reports will be available 01-06-03.

For food stamp purposes, the new obligation shall also be allowed as a medical expense beginning in February. This change must be processed manually and the F708 can be used to notify FS households of changes in benefits.

To begin planning potential workload, a list of all open MS HC cases is attached. The list is sorted by section-unit-caseload, county and is meant to be used a guide only.

Notices:

For each case updated by the LOTC process, a notice situation will be created. The Z056, MS Mass Change/Chge in Patient Liability, will be produced. Because of the possibility of other changes occurring, such as non-covered medical expenses or other benefit changes, these notices will not be printed immediately after the mass run to allow the eligibility worker a window to make such adjustments. If no further changes are made and the mass change notice is not deleted, the system generated notice will be printed and mailed beginning 01-15-03. This mailing delay gives the worker until the close of business on 01-14-03 to make any necessary changes and delete the MS mass change notice. If action is taken to make other changes to the obligation prior to this time, the system-generated notice must be deleted and a new notice sent which describes the PIL change as well as the additional changes. Because the effective dates and amounts are driven by notice keywords, these fields cannot be changed through a notice update on NOHS. The N757, MS Mass Change/Chge in Obligation, has been created for this purpose. A sample notice is included with this memo.

To inform the case manager/independent living counselor (CM/ILC) of the change, a notice will be created with mass change for each HCBS individual whose obligation was updated. This notice provides the client name, case number, old and new liability amount with effective dates, the client's address and the worker name. A copy of the notice is to be made and put in the case file for documentation. The notice is then to be sent to the HCBS CM/ILC to inform them of the change. If adjustments are made to the obligation after this notice is produced, a pen and ink change will be made to the notice. Because the case manager notice will be sent, an ES-3161 will not be necessary for these obligation changes. All notices will be mailed to the area offices on or about 01-06-03. Notices are also available for viewing on SAR by entering report ID SWY03873-R17. For control purposes, an alpha listing of all HCBS case manager notices will also be available on SAR. The list, sorted by caseload, will be available on 01-06-03 by entering SAR report ID SWY0373-R35.

Upon receiving the notice of new obligation, the CM/ILC must adjust the plan of care. This involves notifying both the consumer and the provider(s) involved of the change in obligation. Because many new persons may now have an obligation, the CM/ILC may also have to provide initial client obligation education to the consumer. To provide the CM/ILC with as much time as possible to make changes, it is imperative that EES staff feed updated obligation information to them as quickly as possible and do so as cases are processed. Do not hold all CM/ILC notices until 01-15 to batch and send. By sending notices quickly, the workload is better distributed throughout the month.

Finally, please note that because all MS cases will be included in the mass change, notices for non-HC cases could also be produced. Printing and mailing of these notices will also be delayed, and should be deleted on or before 01-14-03. Those cases impacted can be identified through the MR330.

Implementation of new LOC Score:

For HCBS cases, the IL counselor/ case manager is responsible for communicating any waiver terminations according to standard procedures. An ES-3161 will be sent to the appropriate EES contact as notification of functional eligibility termination. Financial eligibility shall then be adjusted as per KEESM 8173. These terminations are effective 02-01-03.

Persons currently employed must be considered for Working Healthy. The ILC will also coordinate with the local Benefits Specialist and EES Specialist for persons interested in returning to work to ensure coverage under Working Healthy is considered.

Implementation of Non-covered Services:

Although EES staff do not have direct responsibility for the implementation of these changes, there may be an impact on eligibility determinations and benefit levels for some persons. For Medicaid, all of the newly non-covered expenses continue to be allowable against spenddown, HCBS obligation and NF patient liability (except that adult diapers, which are not allowable for NF residents and a doctors statement of medical necessity is required for independent living/HCBS). These items are also allowable medical expenses for food stamps. In addition, for QMB eligibles, there may be instances where some of these non-covered services are covered by Medicare. When this occurs, the service is also covered by Medicaid for QMB eligibles if the provider of the service is a Medicaid provider. The combination Medicare-QMB payment will then cover the bill, eliminating the client's obligation. For example, Medicare covers eyeglasses for persons following cataract surgery. If provided by a Medicaid provider, a QMB eligible would have no obligation for this expense.

If you have any questions or concerns about these changes, please contact me at (785)296-8866. Please report any concerns regarding mass change processing to SRSTSC at (785) 296-4357.

JS:jmm

Attachment: NOTICE: N757 - MS MASS CHANGE-CHGE IN OBLIGATION

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