Kansas Department of Social and Rehabilitation Services

Gary J. Daniels, Acting Secretary

Health Care Policy / Medical Policy

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POLICY MEMO:	
To: All SRS Staff	**From:** Kristi Scheve, Senior Manager, Family Medical Eligibility Program Policy
HCP Eligibility Policy No: 2004-11-17a	**KFMAM:** 2430
RE: Dual Eligibility & Medically Needy	**Program(s):** Medicaid Programs & HealthWave 21

Background

Retroactively approving Title 19 (or Medically Needy) coverage over previous HealthWave 21 eligibility can cause multiple problems for billing and managed care payments on behalf of the beneficiary. Inappropriate approval of retroactive HW 21 coverage impacts the success of the managed care model (refer to HCP Eligibility Policy Memo No. 2004-11-17b for more information about Retroactive HW 21 enrollment).

Medical Policy has been reviewing problematic cases where managed care and/or payment issues are encountered. As a result, areas have been identified in which policy clarification and additional guidance on proper procedure may have a positive affect on the number of problems seen in the managed care population. One area continually surfacing within problematic cases is the Medically Needy program. Another common issue is the approval of dual eligibility.

The following policy and procedure clarification is intended to provide you with knowledge about when coverage under the Medically Needy program is considered, implement procedures to offer consumers coverage under Medically Needy, and reduce the instances in which dual eligibility might occur.

A. Dual Eligibility Is Problematic - The interChange MMIS system was not designed to accept both HW 21 and Medically Needy eligibility for the same month. When Medically Needy is subsequently approved over HW 21 months, a special workaround is needed in order for the MMIS system to accept the Medically Needy benefit plan information.

The MMIS will accept retroactive Title 19 coverage over HW 21 eligibility. In some instances this type of dual eligibility is appropriate (e.g., an HW 21 child is approved for Home and Community Based Services). You must exercise caution when approving dual eligibility and evaluate each case individually.

In some instances, it may not be necessary to overlay all HW 21 months with Title 19 eligibility. For example, a child has an open HW 21 case and is retroactively approved for SSI benefits. The past HW 21 coverage most likely covered all of the child's medical needs. Unless there is an identified need or request for retroactive Title 19 coverage, you will take action to end HW 21 and approve Title 19 prospectively.

If questions arise about an individual case, you may consult with HCP/MP Eligibility Policy Staff for additional guidance (see contact information at the end of this memo).

B. Dual Eligibility and Managed Care - It is important for you to be aware of the impact of dual eligibility to the managed care model.

Each month a capitation payment is made to the Managed Care Organization (MCO) for HW 21 beneficiaries. The MCO is responsible for paying any provider within their network who provides a medical service to the consumer in that month.

If the benefit plan changes, the State must recoup their capitation payment from the MCO. The MCO then recoups payments they have made to each provider. As a result, the provider will have outstanding medical expenses. Not all HW 21 providers are also Medicaid providers, meaning the provider may or may not be able to seek payment under the new benefit plan.

When the procedures outlined in this memo are followed, coverage options under Title 19 or Medically Needy benefit plans are exhausted prior to HW 21 approval and the number of instances of dual eligibility decreases.

Additional Managed Care Notes:

✓ The Managed Care Organization, FirstGuard Health Plan of Kansas, is available to HW 21 beneficiaries in all 105 counties in Kansas.

✓ FirstGuard Health Plan of Kansas is also available to HW 19 (MA CM and PLE) beneficiaries in 62 Kansas counties. Depending on the county of residence and program type, this managed care option may not be available for all Title 19 beneficiaries.

✓ The State's Primary Care Case Management Model, HealthConnect Kansas, is available to MA CM, PLE, SSI, and MKN beneficiaries in all 105 Kansas counties.

I. Recommended Procedures for Newborns

When you receive a request for medical coverage for a newborn, it is highly probable there are medical bills for the month of birth. It is important for you to review the application, or case information, to see if the newborn falls within the HW 21 income guidelines. If it appears the newborn is HW 21 eligible, consider additional options to assist the family with medical bills for the month of birth by using the following procedures.

A. New Application with a Newborn - When you receive an application for a newborn, screen it as soon as possible to determine if the reported income falls within Title 19 or HW 21 guidelines. You may need additional information from the family, and want to be sure to meet the timely processing guidelines.

1. Screen the application. If you see that the reported income falls within Title 19 guidelines, follow the normal application processing procedures. Make sure all requests for prior medical assistance are pursued.

   If you see that the reported income falls within HW 21 guidelines, consider other options to assist the family with the unpaid medical bills for the month of birth or the prior medical months.

   Option 1 - Ensure the mother is not eligible for Title 19 using the Pregnant Woman guidelines for the month of birth or a prior medical month. Remember that prior medical eligibility is based on actual income. If actual income is needed, the notice specified below may be used to request this information.

   If the mother is eligible for PW coverage in one of those months, she would have continuous eligibility through her postpartum period. The newborn would automatically be eligible for Title 19 for the month of birth and continuously eligible for the following 12 months. If this option is not applicable to the case, proceed to Option 2.

   Option 2 - Make contact with the household to explain that HW 21 coverage will not begin until you finalize the case, so coverage under HW 21 is not possible for the birth expenses. Let the family know about other coverage options. If possible, include an estimated spenddown for the six-month current medical period (or three-month prior medical time period). After contacting the family, send the M802 notice. This is a new notice developed to explain the coverage options and request additional information within a 10-day deadline. If you are unable to make contact with the family, send the M802 notice.

   If you do not receive a response from the family by the deadline in the notice or the family indicates they do not want a spenddown, proceed with the HW 21 eligibility determination. Recognize that the family may subsequently request the prior medical assistance in the two months following the month of application.

   If the family provides additional information and requests a spenddown, process coverage through a six-month current medical or three-month prior medical MA spenddown. When a spenddown is established, coverage for HW 21 cannot begin until the base period ends or it is indicated that the spenddown cannot be met. Coverage under HW 21 must be considered when ending the MA spenddown participation.

B. Adding a Newborn to an Open Case - When you receive a request to add a newborn to an open case, realize that there are probably outstanding expenses from the month of birth and ensure that all coverage options are investigated.

1. First check to see if the mother was receiving coverage at the time of birth. If the mother was Title 19 eligible, the newborn is Title 19 eligible from the month of birth through their first birthday.

If the mother was open and receiving coverage under HW 21, the newborn is deemed eligible for HW 21 from the date of birth through the end of the family's continuous eligibility period. Note, this is only applicable to mothers who are under the age of 19.

If the mother was not receiving coverage, add the child, the income of the child, and any legally responsible person for the child to the open case. Income verification is not routinely requested in this situation. The determination is made with the income already known to the system. If there is new income, not previously known to the agency, verification is required. When the newborn is added, check to see if the income falls within Title 19 or HW 21 guidelines.

If you see that the income falls within Title 19 guidelines including the newborn, continue processing the case and authorize the Title 19 coverage.

If you see the income falls within HW 21 guidelines including the newborn, recognize that the newborn's coverage will not begin until enrollment in managed care. Would the mother have been Title 19 eligible in any of the prior months? If not, a spenddown may be the only option available to assist the family with unpaid medical bills for the birth.

Make contact with the household to explain that HW 21 coverage will not begin until you finalize the case, so coverage under HW 21 is not possible for the birth expenses. Ensure the family income has not changed. Often there may be Title 19 eligibility using current income verifications or actual income for prior medical eligibility determinations.

If no changes have occurred that would make Title 19 coverage an option, let the family know about coverage under the Medically Needy program. If possible, provide them with an estimated spenddown for the six-month current medical period (or three-month prior period). After contacting the family, send the M802 notice. This is a new notice developed to explain the coverage options and request additional information within a 10-day deadline. If you are unable to make contact with the family, send the M802 notice.

> If you do not receive a response from the family by the deadline in the notice or the family indicates they do not want a spenddown, add the newborn to your case and authorize HW 21 coverage.
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> If the family provides additional information and requests a spenddown, process coverage through a six-month current medical or three-month prior medical MA spenddown. When a spenddown is established, you cannot authorize HW 21 coverage for the newborn until the base period ends or it is indicated that the spenddown cannot be met. Coverage under HW 21 must be considered when ending the MA spenddown participation.

II. Recommended Procedure for Prior Medical Requests

It is important to screen every application to see if there is an indication of unpaid medical bills for the three prior medical months, but particularly important on HW 21 applications. To prevent dual eligibility from occurring, make a point to carefully check this portion of the Family Medical application.

If the family has not checked that there are unpaid medical expenses, process the HW 21 application. Be sure to pay careful attention to applications involving a newborn and ensure that there are no outstanding birth expenses from a prior medical month, prior to authorizing the HW 21.

Recognize that the family is able to submit a request for prior medical assistance in the month of application and the two following months. Subsequent requests for prior medical are unavoidable. Therefore, there is always a possibility you will be required to approve dual eligibility.

A. Prior Medical Requested And The Child(ren) Are HW 21 - If the family has checked that there are unpaid medical expenses, consider other options to assist the family before you authorize HW 21 for the current medical period.

Option 1 - First, check to see if the family was within Title 19 guidelines during the prior medical period. Remember to use actual income verifications. The notice specified below may be used to request this information, if needed. If the children are Title 19 eligible, they are continuously eligible for a twelve-month period. If this option is not applicable to the case, proceed to Option 2.

Option 2 - Make contact with the household to explain that HW 21 coverage will not begin until you finalize the case, so coverage under HW 21 is not possible for the medical expenses incurred by a child. Let the family know about the Medically Needy program. If possible, include an estimated spenddown for the six-month current medical or three-month prior medical time period. After the contacting the family, send the M802 notice. This is a new notice developed to explain the coverage options and request additional information within a 10-day deadline. If you are unable to make contact with the family, send the M802 notice.

If you do not receive a response from the family by the deadline in the notice or the family indicates they do not want a spenddown, process the HW 21 application.

If the family provides additional information requested in the notice and requests a spenddown determination, process a three-month prior medical MA spenddown. If the unpaid expenses are in the month of application, consider a six-month MA spenddown. When you establish a spenddown, HW 21 coverage cannot be authorized until the base period ends or it is indicated that the spenddown cannot be met. Coverage under HW 21 must be considered when ending the MA spenddown participation.

III. Recommended Procedure for Dual Eligibility Situations

It is expected that even when following the newborn and prior medical recommended procedures outlined above, there will be times you will authorize Title 19 or Medically Needy coverage retroactively over months in which HW 21 already exists.

A. Retroactive Title 19 Coverage Over HW 21 Months - If you approve Title 19 coverage, you need to end HW 21 as soon as possible because coverage would continue under Title 19 continuous eligibility periods. The MMIS system will recognize that Title 19 is better coverage and override the previous HW 21 eligibility record. It is important to recognize the payment problems this creates with the Managed Care Organization and if at all possible keep these situations to a minimum.

B. Retroactive Medically Needy Coverage Over HW 21 Months - It is important to note that you should **not** be issuing duplicate Medical ID numbers for consumers in order for the spenddown records to transmit to the MMIS. **This was a temporary solution which is now replaced with a new procedure for these situations**.

New Procedure: Clearinghouse and Regional SRS office staff should contact Kristi Scheve or Patty Rice in HCP-Central Office for approval **before** retroactively authorizing Medically Needy coverage over HW 21 benefit months. The case will be reviewed to ensure that policy has been followed appropriately in each situation. Instructions will be provided in order to complete the necessary workaround procedure for the interChange MMIS to accept the Medically Needy record over previous HW 21.

Conclusion

If you have questions about this memo or the recommended procedures, please send them to Kristi Scheve, Senior Manager, Family Medical Eligibility Program Policy at kaxg@srskansas.org or Patty Rice, Manager, Family Medical Eligibility Program Policy at psys@srskansas.org .

Attachment: Draft Copy of the M802 KAECSES System Notice.