ATTACHMENT A

Processing HCBS Applications/Requests Under KanCare

As indicated in the KanCare Implementation Memo (KDHE-DHCF Policy No: 2012-12-01), the method of processing a request/application for HCBS services will depend on the applicant's KanCare status at the time of request/application. If the HCBS applicant is a KanCare recipient at the time of request, then the referral and processing method is fairly straightforward between eligibility staff and the assigned MCO contact and the MCO Case Manager. If the applicant is not a KanCare recipient at the time of request/application, then the referral/processing methods are more involved and more waiver program specific. These processes are effective January 1, 2013.

Note: As a reminder, all recipients covered under Title 19 (including presumptive), Title 21 (including presumptive), and Medically Needy (spenddown – met and unmet) are KanCare recipients and thus assigned to one of the MCO plans. All other recipients are covered under fee for service and therefore not assigned to an MCO plan.

A. Current KanCare Recipient – If the applicant is a current KanCare recipient, a Case Manager will be assigned to them by their MCO. This Case Manager is responsible for coordinating all of the recipient's medical care, including HCBS services. Eligibility staff should complete the following steps once a current KanCare recipient requests HCBS services.

Step 1: Eligibility staff complete a referral via the ES-3160 to the MCO contact indicating the recipient has requested HCBS services.

Note: Staff may find the current MCO assignment in MMIS by selecting the "Options" drop down from the "Beneficiary Search" window. Click on "PMP Assignment" to pull up the MCO assignment information.

Step 2: The MCO contact will forward the ES-3160 referral to the Case Manager. The Case Manager will determine if a functional screening assessment has already been completed. If a screening is needed, they will contact the appropriate screening entity to request an assessment.

Step 3: Once the Case Manager receives the functional screening assessment, they will meet with the individual to complete a plan of care. The Case Manager will then complete the ES-3160 and send it to eligibility staff.

Step 4: Based on the information provided by the Case Manager on the ES-3160, eligibility staff will process the HCBS request. Staff will then complete the ES-3160 with the eligibility outcome and forward to the Case Manager.

Step 5: If HCBS services have been approved, that information will transmit from KAECSES to MMIS, and then from MMIS to the MCO. Once the individual appears on the MCO roster as HCBS eligible, the Case Manager may commence services.

Step 6: Any continued communication after HCBS approval between eligibility staff and the Case Manager concerning case changes or updates will be via the ES-3161.

Budgeting For Current KanCare Recipient – The current budgeting rules apply to a KanCare recipient approved for HCBS coverage. The HCBS effective date is the choice date if regular services are to begin by the following month. If HCBS services are expected to begin the second month following the month of choice, the date services actually begin is the effective date. For individuals on a waiting list, HCBS is not effective until a slot becomes available.

Example 1: A current Medically Needy recipient requests for HCBS services (FE waiver) on 2/13/2013. Since this individual is covered under KanCare, an ES-3160 referral is sent to the assigned MCO contact on 2/15/2012. The MCO Case Manager requests a functional screening assessment, develops a plan of care, and returns the ES-3160 to eligibility staff on 2/25/2013 with a choice date of 2/19/2013 and a proposed service start date of 3/5/2013. Since services are anticipated to commence within the month after the month of choice, the HCBS effective date is the choice date (2/19/2013) with the first HCBS budgeting month being 2/2013.

Example 2: An SSI medical recipient requests HCBS coverage under the SED waiver on 3/28/2013. An ES-3160 referral is sent to the MCO contact on 4/9/2013. The MCO Case Manager returns the ES-3160 to eligibility staff on 4/25/2013 with a choice date of 4/22/2013 and anticipated services start date of 5/2/2013. The HCBS effective date is the choice date of 4/22/2013 with the first HCBS budgeting month of 4/2013.

Example 3: Same situation as Example 1 above, except the applicant is not able to accept services right away so the anticipated start date is delayed until 4/4/2013. Since the anticipated start date is the second month after the choice date, the HCBS effective date is now the anticipated start date of 4/4/2013 with 4/2013 as the first HCBS budgeting month.

B. Not a Current KanCare Recipient – If the applicant is not a current KanCare recipient at the time of the HCBS request, they will not currently be assigned to an MCO, nor will they have a Case Manager. The referral and processing methods for this group will depend on the specific HCBS waiver program.

Remember to always include the applicant's KanCare ID number on the ES-3160 referral form in the identifying information section. The functional screening entity needs this number in order to bill the state for their services.

Note: In some instances, if possible, it may be appropriate to process the application for non-HCBS program eligibility (SSI, presumptive SSI, Medically Needy) before making the HCBS referral. If the applicant is expediently approved for non-HCBS KanCare coverage, eligibility staff may then follow the "KanCare Recipient" referral process described above. Once the referral comes back from the Case Manager, the case may then be updated to reflect HCBS coverage (if approved) for the appropriate months.

1. Frail Elderly (FE), Physically Disabled (PD), and Traumatic Brain Injury (TBI) Waivers – The referral and eligibility processes for these waiver programs will flow through the ADRC (as described in the implementation memo). Follow the steps below.

   Step 1: Eligibility staff complete a referral to the ADRC via the ES-3160 form. The anticipated monthly client obligation should be included on the referral.

   Step 2: The ADRC completes a functional screening assessment. If determined functionally eligible, the applicant is counseled on available services and given a choice. They may choose HCBS services, withdraw their request for HCBS services, or opt for services under a PACE plan.

   Step 3: The ADRC will complete the ES-3160 and return it to eligibility staff with the applicant MCO choice, the HCBS waiver type, and the HCBS choice date. If the applicant is subject to a waiting list for services, this will also be included.

   Note: If a new application has been filed indicating an MCO choice that is different than the one selected on the ES-3160, contact with the applicant may be necessary to resolve the discrepancy.

   Step 4: At this point, a plan of care has not been developed, nor are any services scheduled to commence. However, based on the information reported on the ES-3160

by the ADRC or otherwise known to the agency, eligibility staff may now complete an HCBS eligibility determination.

Note: Since the cost of services will not be known until eligibility has been approved and the MCO case manager develops the plan of care, the income test (ie: cost of care vs. client obligation) will be deferred until that time.

Step 5: If approved for HCBS coverage, eligibility staff will update KAECSES, including entry of the appropriate MCO PRAP code, complete the ES-3160 and send to the MCO contact. If HCBS coverage is not approved, the ES-3160 is not sent to the MCO contact. The ADRC should always be notified of the eligibility outcome via the ES-3160.

Step 6: The MCO contact will forward the ES-3160 to the Case Manager once KanCare eligibility and assignment has been verified. The Case Manager will meet with the recipient to complete a plan of care and commence services. The Case Manager will then complete the ES-3160 and send it to eligibility staff.

Step 7: Based on the information provided by the Case Manager on the ES-3160, if the cost of care is less than the client obligation, action must be taken to end HCBS coverage (giving timely notice), including sending the ES-3161 to the Case Manager. If the cost of care exceeds the client obligation, no other action is needed.

Note: At this time there is a waiting list for the PD waiver. HCBS services should not be approved unless a crisis exception has been granted or a slot has opened and the individual has chosen to receive services.

2. Intellectual/Developmental Disabilities (I/DD) Waiver – While KanCare recipients eligible for I/DD waiver services will still be assigned to one of the MCO's for their basic medical coverage, their specific HCBS services will continue to be subject to fee for service until 12/31/2013. Therefore, the HCBS referral and processing methods for this waiver have not changed at this time.

   Step 1: Eligibility staff complete a referral to the Community Developmental Disabilities Organization (CDDO) via the ES-3160 form. The anticipated monthly client obligation should be included on the referral.

   Step 2: The CDDO completes a functional screening assessment. If determined functionally eligible and the individual chooses services, a plan of care is developed.

Step 3: The CDDO will complete the ES-3160 and return it to eligibility staff with the waiver type, choice date and cost of care.

Step 4: Based on the information reported on the ES-3160 by the CDDO, eligibility staff will complete a financial determination of eligibility. If the cost of care exceeds the client obligation, the individual may be approved for HCBS coverage (assuming all other eligibility factors are met).

Step 5: Eligibility staff will update KAECSES, including entry of the appropriate MCO PRAP code, complete the ES-3160 and send to the HCBS Case Manager with the HCBS start date and client obligation amount. If HCBS coverage is not approved, the ES-3160 is still completed and sent to the HCBS Case Manager indicating that coverage has been denied.

Note: At this time there is a waiting list for the I/DD waiver. HCBS services should not be approved unless a crisis exception has been granted or a slot has opened and the individual has chosen to receive services.

3. Technology Assisted (TA) Waiver – The following steps apply to the Technology Assisted (TA) waiver.

Step 1: Eligibility staff complete a referral to the TA Waiver Manager via the ES-3160 form. The anticipated monthly client obligation should be included on the referral.

Step 2: The referral is assigned to an Independent Case Manager who completes a functional screening assessment. If determined functionally eligible and the individual chooses services, a provisional plan of care is developed.

Step 3: The Independent Case Manager will complete the ES-3160 and return it to eligibility staff with the applicant MCO choice, HCBS choice date, waiver type, and anticipated cost of care.

Step 4: Based on the information reported on the ES-3160 by the Independent Case Manager, eligibility staff will complete a financial determination of eligibility. Since a plan of care has not been formally developed yet, staff shall use the anticipated cost of care provided by the Independent Case Manager to measure against the client obligation. If the cost of care exceeds the client obligation, the individual may be

approved for HCBS coverage (assuming all other eligibility factors are met).

Step 5: Eligibility staff will update KAECSES, including entry of the appropriate MCO PRAP code, complete the ES-3160 and send to the MCO contact with the HCBS start date and client obligation amount. If HCBS coverage is not approved, the ES-3160 is still completed and sent to the Independent Case Manager indicating that coverage has been denied.

Step 6: The HCBS eligibility will be transmitted from KAECSES to MMIS, and then from MMIS to the assigned MCO. Once the MCO identities the recipient as HCBS eligible, a Case Manager will be assigned to develop a plan of care and commence service delivery.

Step 7: The MCO Case Manager will complete the ES-3160 and send to eligibility staff. If the cost of care is less than the client obligation, action must be taken to end HCBS coverage (giving timely notice), including sending an ES-3161 to the Case Manager. If the cost of care exceeds the client obligation, no other action is needed.

4. Severe Emotional Disturbance (SED) Waiver – The following steps apply to the Severe Emotional Disturbance (SED) waiver.

Step 1: Eligibility staff complete a referral to the Community Mental Health Center (CMHC) via the ES-3160 form. The anticipated monthly client obligation should be included on the referral.

Step 2: The CMHC completes a functional screening assessment. If determined functionally eligible and the individual chooses services, the CMHC will complete a provisional plan of care.

Step 3: The CMHC will complete the ES-3160 and return it to eligibility staff with the applicant MCO choice, HCBS choice date, waiver type, and anticipated cost of care.

Step 4: Based on the information reported on the ES-3160 by the CMHC, eligibility staff will complete a financial determination of eligibility. Since a plan of care has not been formally developed yet, staff shall use the anticipated cost of care provided by the CMHC to measure against the client obligation. If the cost of care exceeds the client obligation, the individual may be approved for HCBS coverage (assuming all other eligibility factors are met).

Step 5: Eligibility staff will update KAECSES, including entry of the appropriate MCO PRAP code, complete the ES-3160 and send to the MCO with the HCBS start date and client obligation amount. If HCBS coverage is not approved, the ES-3160 is still completed and sent to the CMHC indicating that coverage has been denied.

Step 6: The HCBS eligibility will be transmitted from KAECSES to MMIS, and then from MMIS to the assigned MCO. Once the MCO identities the recipient as HCBS eligible, a Case Manager will be assigned to develop a plan of care and commence service delivery.

Step 7: The MCO Case Manager will complete the ES-3160 and send to eligibility staff. If the cost of care is less than the client obligation, action must be taken to end HCBS coverage (giving timely notice), including sending an ES-3161 to the Case Manager. If the cost of care exceeds the client obligation, no other action is needed.

5. Autism (AU) Waiver – The following steps apply to the Autism (AU) waiver.

Step 1: An individual seeking HCBS services under the Autism (AU) waiver files the specially designed Autism application directly with the Autism Waiver Program Manager.

Step 2: The request is referred to a Functional Eligibility Specialist (FES) to complete a functional screening assessment. If determined functionally eligible and the individual chooses services, a provisional plan of care is developed.

Step 3: The FES will complete the ES-3160 and return it to eligibility staff with the applicant MCO choice, waiver type, HCBS choice date and anticipated cost of care.

Step 4: Based on the information reported on the ES-3160 by the FES, eligibility staff will complete a financial determination of eligibility. If the anticipated cost of care exceeds the client obligation, the individual may be approved for HCBS coverage (assuming all other eligibility factors are met).

Step 5: Eligibility staff will update KAECSES, including entry of the appropriate MCO PRAP code, complete the ES-3160 and send to the MCO contact with the HCBS start date and client obligation amount. If HCBS coverage is not approved, the ES-3160 is still completed and sent to the FES indicating that coverage has been denied.

Step 6: The HCBS eligibility will be transmitted from KAECSES to MMIS, and then from MMIS to the assigned MCO. Once the MCO identities the recipient as HCBS eligible, a Case Manager will be assigned to develop a plan of care and commence service delivery.

Step 7: The MCO Case Manager will complete the ES-3160 and send to eligibility staff. If the cost of care is less than the client obligation, action must be taken to end HCBS coverage (giving timely notice), including sending an ES-3161 to the Case Manager. If the cost of care exceeds the client obligation, no other action is needed.

Note: At this time there is a "proposed waiver recipient list" for those requesting placement on the AU waiver. HCBS services should not be approved unless a slot has opened and the individual has chosen to receive services.

Budgeting For a Non-KanCare Recipient – The HCBS start date for budgeting purposes is the choice date for the Frail Elderly (FE), Physically Disabled (PD), Traumatic Brain Injury (TBI), Intellectual/Developmental Disabilities (I/DD), and Severe Emotional Disturbance (SED) waivers. The start date for the Technology Assisted (TA) and Autism (AU) waivers is the assessment date. For individuals on a waiting list, HCBS is not effective until a slot becomes available.

However, if the application/eligibility is not processed by the end of the month after the applicable choice date or assessment date, the HCBS start date shall be the first day of the month the application/eligibility is actually processed. Where HCBS coverage is delayed, eligibility must still be determined under other programs for the non-HCBS months (ie: Medically Needy – spenddown).

Example 1: A new application for medical assistance under the FE waiver is received on 1/17/2013 for an individual with no current medical coverage. A referral to the ADRC is sent on 1/21/2013. The ES-3160 is received from the ADRC on 1/29/2013 indicating the applicant has met the level of care threshold with a choice date of 1/28/2013.

If the application is processed/approved by the end of 2/2013 (the month after the month of application), then 1/2013 is the first HCBS budgeting month and the HCBS start date is 1/28/2013 (the choice date).

If the application is processed/approved on or after 3/1/2013 (the second month after the month of application), then the first HCBS budgeting month is the month the application is

actually processed and the HCBS start date is the first day of that month.

Example 2: An application for medical assistance under the PD waiver is received on 2/11/2013 for an individual currently receiving QMB-only coverage. A referral to the ADRC is sent on 2/15/2013. The ES-3160 is received from the ADRC on 2/21/2013 indicating that the applicant has met the level of care threshold and placed on the waiting list.

The applicant meets disability and financial criteria for Medically Needy and is approved for spenddown coverage. Several months later, an ES-3160 is received reporting a slot has opened with a 6/21/2013 choice date. If the case is updated/approved for HCBS coverage by the end of 7/2013, the first HCBS budgeting month is 6/2013 and the HCBS start date is 6/21/2013 (the choice date).

C. Referrals for Assessment Only – When a functional screening assessment is needed for spousal impoverishment resource assessment purposes only, the referral should be sent directly to the screening entity (ADRC, CDDO). Assessment only referrals should never be sent to the MCO contact. The ES-3160 should be clearly marked "HCBS Assessment Only".

D. PACE – The ADRC will provide counseling to applicants as to the services available in the community. Even though the individual may have been referred to the ADRC due to a request for HCBS services, they may instead choose coverage under the PACE program. The ADRC will return the ES-3160 indicating this choice. At this point, eligibility staff should immediately complete a referral to the appropriate PACE entity via the ES-3166 form.

E. MCO Contacts – The contact for each of the MCO's for referral/communication purposes is listed below. This contact is to be used for the initial HCBS referral (until an actual Case Manager has been assigned by the MCO) and for first time changes/updates on existing HCBS cases (where the Case Manager is unknown).

Amerigroup
Contact: Regina Conner
Phone: 913-749-5955, ext. 50263
Fax: 913-563-1680
Email: Regina.Conner@amerigroup.com
Mailing Address: Amerigroup Kansas Inc.
9225 Indian Creek Parkway
Building 32, Suite 400
Overland Park, KS 66210

Sunflower

Contact: Trudi Shouse
Phone: 913-333-4618
Email: trshouse@sunflowerstatehealth.com

Contact: Karen Winiarczyk
Phone: 913-333-4695
Email: Kwiniarczyk@sunflowerstatehealth.com

United

Contact: Nan Kartsonis
Phone: 913-375-4264
Email: nanette_r_kartsonis@uhc.com