KanCare Implementation Meeting: January 4, 2013
Questions & Answers

9:00am-12pm

1. **Does it matter what position the PRAP coding is in?**

   It should not. It is noted that there are concerns regarding the position and KDHE will monitor for potential problems.

2. **Is example 3 on page 5 of the KanCare Policy Memo an example of a 90 day reattachment?**

   Due to the failure to complete the review process, this example reflects a new application with a request for prior medical. The case exceeds the 90 day limit for reattachment.

3. **Is it correct that each individual on a case can choose a different MCO? (West)**

   Yes. However, the application only asks for the MCO choice for the entire household. If in an interview, the household indicates they wish to choose different MCOs for each individual, the worker can then update the case accordingly.

4. **What will happen if the eligibility worker codes PRAP with a KanCare MCO code and the individual should not be assigned to an MCO? (West)**

   It is always important that cases are coded correctly. However, if an MCO PRAP code is sent on a non-KanCare approval (ie: MediKan, QMB-only) no assignment will occur.

5. **Will there be any edit message if the eligibility worker forgets to enter the KanCare PRAP code? (West)**

   No. In this instance, random auto-assignment will occur.

6. **If the eligibility worker does not put the PRAP code in until the next day, is it correct that it will not go over to MMIS? (West)**

   Correct. As soon as the initial KanCare eligibility record is received in MMIS without an MCO selection, an MCO will be auto-assigned. MMIS will receive any MCO PRAP code sent the next day (or thereafter), but it will not override the initial auto-assignment.

7. **Will the transfer check list to the Clearinghouse be updated with a section to check the PRAP code? (West)**

   Not at this time. Unless the worker is transferring the case the same day eligibility is processed, it will be too late to enter and send a new or corrected MCO PRAP code.

8. Will the "case manager" still tell the eligibility worker if it is a temporary stay or a long term stay? (Wichita)

Yes. In addition, the institution remains responsible for sending an MS-2126 to eligibility staff indicating the anticipated length of stay.

9. Who are the "case managers"? Who does DCF send their obligation changes to?

Each MCO will employ their own Case Managers. Eligibility staff shall use the MCO contact from the contact list for initial referrals/changes. The MCO contact will then forward the referral/change to the appropriate Case Manager.

10. How does the worker know if a spenddown has not been met for two consecutive spenddown bases? (Kansas City)

The eligibility worker will need to review the spenddown information on MMIS.

11. Do eligibility workers need to wait until the annual review to close cases with unmet spenddowns?

The agency is not to change the way they have been processing spenddowns. However, per KEESM 2911.1, the worker is not to keep the spenddown case open for the sole purpose of continuing buy-in. KEESM 1411.1 (2) indicates the application will be put in a spenddown status if there appears that the spenddown will likely be met in the six month spenddown base period using the evidence provided by the applicant.

12. Can KDHE Policy send a list of facilities that are NF-MH? (Wichita)

Yes. The list was distributed to DCF eligibility staff on 1/4/2013.

13. Is the 3160/3161 a fillable form? (Wichita)

Not at this time.

14. Does DCF need to be involved in the opt-out process for American Indians or Alaska Natives? (Wichita)

No. The Manage Care Enrollment Center (HP) handles the opt-out process. See page 3 of the KanCare Policy Memo (section D).

15. If a consumer has medical bills that are in the prior 90 day medical period, will the change to KanCare impact getting these bills paid? (Wichita)

No. The MCO is still responsible for the 90 day prior medical period.

16. What was the one exception to QMB? (West)

There aren't actually any exceptions. A QMB-only recipient is not in KanCare – they are fee for service. However, if the recipient has KanCare (ie: Medically Needy, SSI) coverage in addition to QMB, then they are assigned to an MCO.

17. Does the beneficiary still need to pay their HCBS obligation to the MCO if they did not receive services in that particular month? (West)

There are no changes to this process. If the consumer did not receive any services, then the individual would not pay their obligation that month (e.g. initial month of eligibility). Additionally, the HCBS obligation is still paid to the actual service provider(s) and not to the MCO.

18. Do individuals on the I/DD HCBS waiver need to use their old Medicaid card for services other than waiver services? (West)

It doesn't matter which card they use. Both cards (HP – fee for service, and MCO – managed care) will use the same ID number for billing purposes.

19. What are the differences between the 3160 and 3161? (West)

The ES-3160 is for notification of a referral/initial eligibility/and assessment services information. The ES-3161 is for changes and updates.

20. Are TPL referrals to be handled the same way? (East)

Yes. TPL referrals continue to be sent to HP via fax to (785) 274-5918 or by mail to:

Office of the Fiscal Agent
TPL Department
P.O. Box 3571
Topeka, KS 66601-3571

21. DCF has been receiving calls that the beneficiary did not receive any KanCare information. DCF is referring these individuals back to the enrollment center as DCF does not have the ability to enroll them. Is this the correct procedure? If yes, why is the enrollment center referring the individuals back to DCF? (East)

Yes, this would be the correct procedure. However, it would also be important to make sure that the individual should actually be enrolled in KanCare, and that you have the correct address. Only DCF can update the system with the correct address. If DCF updates the address, they must also reauthorize the case in order for the address to update. Enrollment information cannot be sent out without the correct address information on the system.

22. Does the CARE process remain the same for nursing home care? (East)

Yes.

23. We have several of our beneficiaries that go to Nebraska for services. Will they be able to continue to do this? (East)

The out-of-state provider would need to be contracted with the MCO before services can be covered.

24. The eligibility worker has sent HCBS referrals using the old process. Does the eligibility worker need to resend? (East)

If it is the PD waiver, then you should resend.

25. Does DCF need to resend the two cases in which there was a February client obligation established? (East)

As this process is still being worked out, DCF should forward these to the waiver manager.

26. Can the agency still use the I007? (East)

Yes.

27. Section III. of the 3160 is normally completed by the case manager. However, this is where it talks about the MCO Choice. Should DCF now be completing this? (East)

No. The consumer will receive counseling on the MCO choice from the entity completing the functional screening assessment. The ES-3160 was updated to allow the screeners to enter the MCO choice.

28. Did the KanCare enrollment packet go to the responsible person when applicable? (KC)

No. The enrollment packet was sent to the consumer at the mailing address listed on the KAECSES ADDR screen.

29. How does DCF know whether or not any medical bills submitted by the consumer are now covered by the value-added benefits? (KC)

The eligibility worker needs to make sure that the entity has billed it through the MCO first. The eligibility worker may need to also look at the claims on MMIS and/or contact the Medicaid Liaison if assistance is needed. As in the past, the eligibility worker is responsible for making sure that the bill is not covered before allowing the expense.

30. Why can't the consumer's "case manager" just tell DCF if any of the medical bills submitted are covered or not? The "case manager" is to submit them to DCF per Section III. of the 3160. (KC)

As is the current process, the eligibility worker is not to just accept the information provided by the Case Manager without making sure the medical bills are not covered. Additionally, not everyone will have a care coordinator ("Case Manager").

31. Does the agency use the old applications before using the new applications? (Wichita)

The agencies are to discard the old HealthWave applications and use the new KanCare ones. For the ES-3100 and ES-31001.1, staff should continue to use the old stock until it is gone. A half-sheet attachment was created to capture the MCO choice. This, along with the KC-2120 Extra Services Highlights document should be stapled to the application. When the old stock is gone, then staff will only need to attach the KC-2120 document to the application.

32. In the new application there is an insert regarding the selection of the MCO. However, there is not any additional information available to help the individual make the determination. When will this material be available and should DCF go ahead and use the MCO selection insert without the additional information? (Wichita)

KDHE provided the KC-2120 Extra Services Highlights document to DCF on 1/7/13.

33. We often have MS cases that are pending for SSA benefits. Do we put in an MCO code at that time? (Wichita)

For applications that were received and pending before the implementation of KanCare, eligibility staff are not required to contact the applicant for an MCO choice upon approval. Staff may enter a PRAP code of K4 (No Selection). The recipient will be randomly auto-assigned to an MCO. They will then have 90 days to change plans if they so choose. See page 4 (section G) of the KanCare Policy Memo.

34. Are the Breast and Cervical Cancer (BCC) cases in KanCare? (East)

Yes. The ES-3100.7 application has been updated.

Questions after presentation of Attachment A.
Processing HCBS Applications/Requests Under KanCare

35. Does the "case manager" still make the determination of a temporary stay in a nursing home? (Wichita)

Yes. The MCO Case Manager will indicate if they anticipate the institutional stay to be temporary and leave the case open for HCBS coverage. The institution will also complete the MS-2126 for eligibility staff indicating the date of admission and the anticipated length of stay. Staff will continue to use these two sources to make the final determination for eligibility and budgeting purposes.

36. Who are the "case managers" for our on-going customers? To whom does the eligibility worker send their obligation changes? (Wichita)

Each MCO has provided a contact for initial referrals/changes. Eligibility staff shall use this contact until the actual Case Manager is known.

37. What is the time frame that referrals will be processed? (Wichita)

No specific time frame has been established. However, the MCO should be processing these fairly quickly.

38. If the agency has an applicant that is new to the system but information is still needed to process the case, should the eligibility worker go ahead and do a referral?

Yes. Staff should indicate on the ES-3160 referral that the application is still pending.

39. Where do we find the KanCare ID number? (KC)

The medical ID number is not changing. The current medical ID number has simply been re-named KanCare ID number for purposes of this new initiative.

40. Can KDHE Policy provide an example of when you might set up an individual that is not currently a KanCare recipient on another program? (East)

This may not be possible all instances. However, an example might be setting a person up on a spenddown or SSI. Children might be able to be set up on a Family Medical program, but often many waiver children have parental income that is too high for Family Medical.

41. Can the agencies get a list of MCO assignments for their beneficiaries versus having to look it up on MMIS? (East)

No. Any recipient list created will be time sensitive and therefore error prone. Staff should verify the MCO assignment through MMIS.

42. What will be the process for children that are open on Family Medical and then become HCBS eligible? Will the Clearinghouse ever get the 3160? (Clearinghouse)

The current process will remain in place. The Clearinghouse could get the ES-3160 on occasion. If so, the Clearinghouse would send the information to DCF.

43. Does KanCare affect a child in a PRTF?

Yes. Children in a PRTF are subject to KanCare. However, the eligibility process is not changing.

Note: Foster care children are also included in the KanCare population. The foster care parent may request a replacement card for the child, but the foster parent cannot change the MCO assignment. Additional information about Foster Care in KanCare can be found on the KanCare website in the following documents: Foster Care in KanCare and Foster Care FAQs

44. Does DCF still open the HCBS case? (East)

Yes. DCF eligibility staff retain responsibility for processing HCBS applications/requests.

45. What is the DCF process for the initial 3160 referrals? (West)

If the individual is a KanCare recipient at the time of HCBS request, DCF will send the initial referral to the MCO contact. If the individual is not a KanCare recipient at the time of the HCBS request, the referral process will depend on the HCBS waiver type.

FE/PD/TBI Waivers: DCF sends the ES-3160 referral to the ADRC. Also, note the additional requirement per step 5 listed on page 4 of Attachment A.

I/DD Waiver: DCF sends the ES-3160 to the Community Developmental Disability Organization (CDDO). Also, note the additional requirement per step 5 listed on page 5 of Attachment A.

TA Waiver: DCF sends the ES-3160 to the TA Waiver Manager. Also, note the additional requirement per step 5 listed on page 6 of Attachment A.

SED Waiver: DCF sends the ES-3160 to the Community Mental Health Center (CMHC). Also, note the additional requirement per step 5 listed on page 7 of Attachment A.

Autism Waiver: The Functional Eligibility Specialist completes the 3160 and returns to the eligibility staff. Also, note the additional requirement per step 5 listed at the bottom of page 7 of Attachment A.

46. Previously, DCF would send a list of reviews due to the "case managers". This information is listed on the 3161 already. Should this practice continue or should this now be sent to the MCO?

Alerting the case manager to recipients scheduled for review was a good case management process that benefited everyone involved. We will investigate to see how this process might continue under the new KanCare initiative.

47. Can KDHE further explain the process for the Intellectual/Developmental Disabilities (I/DD) Waiver? (West)

Recipients eligible for I/DD waiver services are still assigned to one of the MCOs for their basic medical coverage. However, their specific HCBS services will continue to be subject to fee for service until 12/31/2013. The HCBS referral and processing methods have not changed. See Page 4 of Attachment A for further information.

48. How long does it take for information regarding the MCO selection to show up on MMIS? (West)

The eligibility worker should be able to look it up the next day.

49. Do e-mails to the MCOs need to be encrypted? (West)

Yes. All e-mails containing protected health information should be encrypted.

50. Regarding page 3, step 4 of Attachment A. Although, the actual HCBS services may not start until several months later, does DCF go ahead and approve HCBS?

Yes. As noted, the cost of care vs. client obligation test is deferred until the assigned MCO Case Manager has developed the plan of care and reported back to eligibility staff.

51. What is taking place regarding referrals for the PD waiver since there is a waiting list? (West)

Reassessments for those on the waiting list will take place yearly. The date the individual was placed on the waiting list will be included on the ES-3160 by the ADRC. The ADRC will have "read-only" access to the waiting list maintained by the PD Waiver Manager.

52. Is the case coordinator an employee of the MCO?

Yes.

53. Who contracts with the providers?

The MCO.

54. What is the correct coding for individuals that are in mental health nursing facilities?

Eligible individuals in a mental health nursing facility shall be coded as NF/MH on the LOTC screen. The type of facility determines the LOTC coding. Even though an individual with mental health issues may be residing in a skilled nursing facility, since it is not a mental health facility, the correct coding is NF/SN. On 1/4/2013 a list of the current mental health nursing facilities in the state were provided to DCF eligibility staff.

55. Has the billing process changed for the nursing homes regarding temporary stays or long term stays?

If the agency receives a billing question from a nursing home, the facility should be referred to the KanCare web-site under provider information. The provider should continue to do their front-end billing through the KMAP system which is then sent on to the MCO.

56. If it takes over 45 days to process an application due to a delay in third party involvement, does the consumer need to submit a new application?

No. The consumer would not have to submit a new application – it should still be pending.

57. What code will the agency be using for untimely processing?

That is ultimately a DCF decision. However, assuming the delay in processing eligibility was indeed caused by a third party entity, PV (Partner Verification) would appear to be an appropriate choice.

58. Will we (DCF) still have the ability to request medical cards in MMIS? (Wichita)

Yes – for non-KanCare recipients who receive their card from HP. Staff will not be able to request cards for KanCare or PACE recipients.

59. In the implementation memo (Attachment A, page 4, step 5) it states "The ADRC should always be notified of the eligibility outcome." Does this mean that for any referral that we (DCF) send over to the ADRC we need to send them an ES-3160 back when we approve or deny the case? (Wichita)

Yes.

60. Once we (DCF) send a referral over to the ADRC for a PD person, is that all we will do, or when the ES-3160 comes back and says that they are on the waiting list for the PD waiver, do we need to send that to anyone else? (Wichita)

Eligibility staff shall process the HCBS application/request, send notification to the applicant, complete the ES-3160 with the outcome and send back to the ADRC. No other action is necessary.

61. On Attachment A (page 8 – Budgeting for a Non-KanCare Recipient), the start date for the TA waiver is listed as the assessment date. In the past, we did not start the TA waiver until they were dismissed from the hospital. Has that changed? (Wichita)

No. The TA waiver start date remains the date of the hospital discharge.

62. If we (DCF) have a customer who does not get the review in on time and the case closes, but they return it within 30 days of the closure, will the process for HCBS have to start all over again or will they be reinstated? This has varied from one waiver to the other in the past, so would like some clarification on this. (Wichita)

Eligibility for HCBS coverage may be reinstated in this situation.

63. On Attachment A (page 9, section D. PACE), it states that once we get an ES-3160 back from the ADRC, we would immediately need to complete a referral to the PACE entity via the ES-3166 form. At this time we have no access to initiate this form. We have contacted KDADS to see if this is a possibility. (Wichita)

Eligibility staff should use the existing PACE referral process currently in place.

64. The ADRC cannot complete the choice date anymore since they don't do that part. According to Attachment A, Section B, Number 1, Step 3 it says they will fill out the choice date so that we can set up HCBS while waiting on MCO to set up cost of care. They do have an FAI date - can we use that? (West)

Yes.

65. I have been getting 3160's from ADRC for clients that already have a MCO (Current KanCare Recipient). ADRC is being contacted by the family to do this. My question is can I set these up then send a referral to the MCO, or do I need to wait till the MCO gets back with us on this? According to the training, the family needs to contact the MCO first and the MCO will contact ADRC. Nursing are telling clients to contact ADRC. (West)

Eligibility staff shall send the ES-3160 referral directly to the MCO contact when the applicant is already a KanCare recipient. The MCO contact will then forward the ES-3160 to an assigned Case Manager. The Case Manager will then contact the ADRC to request a functional screening assessment. If the ADRC has already completed the assessment because the family has initiated contact, the screening result will be sent to the Case Manager. The Case Manager will then complete the plan of care and send the ES-3160 back to eligibility staff. Staff may now complete the eligibility determination for HCBS coverage.