Kansas Department of Social and Rehabilitation Services
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MEMORANDUM

To: EES Chiefs and Staff
HealthWave Clearinghouse Staff

Date: August 15, 2003

From: Bobbi Mariani
Christiane Swartz

RE: Implementation Instructions for Spenddown and Long Term Care Changes Effective October 1, 2003

The purpose of this memo is to provide implementation instructions for changes in spenddown and long term care processing included in KEESM Revision 16. These changes are being made in conjunction with the implementation of the interChange MMIS by EDS, the Medicaid fiscal agent. The primary function of the interChange MMIS is that of a billing system to provide claims processing for all Kansas Medical Assistance Programs (KMAP), including Medicaid, Medikan, Title XXI, ADAP and other state-only medical assistance programs. To support these functions in the interChange MMIS, several changes are being made in eligibility policy and process. The most significant of these changes are the new spenddown and long term care processes and detailed instructions for implementation of these are provided in this memo. Instructions for other changes, such as Medicare buy-in, will be provided in a separate memo. EDS will provide operational instructions for the interChange MMIS. In addition, face to face training will be provided to SRS field staff from both EES Central Office and EDS staff prior to implementation.

Unless otherwise noted, all policy changes are effective October 1, 2003. However, most process changes will not be in place until conversion to the interChange MMIS is complete, as dates are noted throughout the memo.

I. BACKGROUND

Detailed background information regarding the impetus and philosophy behind these changes were previously provided in the Spenddown Pre-Conversion Memorandum issued on 04-14-03. Please refer to this memo for background information

II. NEW SPENDDOWN PROCESS

Beginning with the implementation of the interChange system, most bills used to meet spenddown will no longer be itemized on the KAECSES MEEX screen. Instead, the MMIS will accept direct bills for services from the provider and, if appropriate, apply the bill toward the spenddown. The MMIS will track the date spenddown is met and will pay subsequent bills during the base period. Detailed procedures and instructions for this processes follow.

1. **Identification of Persons in the Medically Needy Benefit Plan -** In order to accurately pay medical benefits for person enrolled in a KMAP program, it is essential that coverage be accurate in the MMIS.

    a. **Benefit Plans:** The interChange MMIS groups beneficiaries under general categories called benefit plans. Benefit plans are a grouping of services/products that beneficiaries are eligible to receive. Benefit plans are similar to 'types of coverage' in the current MMIS and tell the MMIS how to handle claims. The benefit plan establishes what services are covered and not covered for persons in the plan. However, there are still differences in coverages for persons in the same benefit plan. For example, variations may be dependent upon age, sex and medical necessity.

    There are many different benefit plans in the MMIS. Much of the information used to establish benefit plan assignment comes from eligibility information from KAECSES. However, benefit plan information can also come from other sources within the MMIS, such as managed care assignment. Some benefit plans are broad and general, such as Title XIX (Medicaid) and Title XXI (HealthWave 21). Others are smaller and further define specific service limitations, such as HealthConnect, SOBRA and Hospice. QMB, LMB and the HCBS waivers are also examples of benefit plans.

    Medically needy is also a benefit plan. The medically needy benefit plan tells the MMIS that the spenddown for the base period must be met before any claims may be considered for payment. All persons eligible under the spenddown provisions, regardless of whether the spenddown has actually been met, will be assigned a medically needy benefit plan. If the medically needy benefit plan isn't reflected on the MMIS, it isn't recognized as a spenddown case.

    Persons may have more than one benefit plan, if necessary. For example, a client may have benefit plans of Title XIX and QMB or medically needy and LMB or Medikan and HealthConnect. There are literally hundreds of combinations. A complete list of possible benefit plans is included with this material, see Attachment A. Additional information on benefit plans will also be provided through the fiscal agent.

2. **KAECSES Coding:** Assignment of a medically needy benefit plan will trigger spenddown processing in the MMIS. This assignment is determined by the information the MMIS receives from KAECSES. The Pre-Conversion Memo provided KAECSES coding instructions to accurately denote eligibility apart from those persons enrolling only in a Medicare Savings Plan (QMB or LMB), or Family Medical coverage (MA CM). At that time, staff were instructed to begin utilizing the QO and LO program subtypes as the determining factor for true spenddown cases. Although the program subtype continues to be a determining factor in Benefit plan assignment, additional coding details are being provided to further define correct eligibility.

First, three new Special Medical Indicators (PICK codes) are being added to clearly distinguish those eligible for QMB and LMB only from persons also attempting to meet spenddown. These codes will be available on 10-13-03. The new PICK codes are:

LO - LMB Only: This is for persons eligible for LMB only, not trying to meet a spenddown and not eligible for other medical assistance. The LO PICK code is used in combination with the program subtype of LO (SEPA).

QO - QMB Only: This is for persons eligible for QMB only, not trying to meet a spenddown and not eligible for other medical assistance. It is used in the first quarter of the year when the QMB indicator on MSID is not accurate because of the COLA disregard. For other months, denote QMB eligibility with a Y in the QMB field on MSID. The QO PICK code is used in combination with a program subtype of QO (SEPA).

QM - QMB + Medicaid: This is for persons eligible for full coverage Medicaid, such as persons in HC or AC living arrangements but not spenddown cases. For MS cases, it is used in the first quarter of the year when the QMB indicator on MSID is not accurate because of the disregard of the COLA disregard. For other months, denote QMB eligibility with a Y on MSID.

The QM code is also used when QMB eligibility is authorized on a program other than MS where a separate indicator is not available. It may be entered on the PICK screen for the MA, MP, CI, AS, FC and RE programs. In these situations, the code shall be left in place as long as the individual remains eligible.

Rules for using the existing Special Medical Indicators are also being changed. Current coding rules are effective through the close of business of 10-10-03. On 10-13-03 the following rules apply:

QE: This code is no longer needed and will be end dated

QS - QMB + Spenddown: This is for persons who are eligible for QMB and spenddown. It is used regardless of met/unmet spenddown status. For MS programs, it is used only in the first quarter of the year when the QMB indicator on MSID is not accurate because of the COLA disregard. For other months, denote QMB eligibility with a Y on MSID. No program subtype is needed in these situations. For MA spenddown programs (not MA CM), the QS code is also used.

LS - LMB + Spenddown: This is for persons who are eligible for LMB and spenddown. It is used regardless of met/unmet spenddown status. It can be used on either the MS or MA program. No program subtype is needed in these situations.

LM - LMB + Medicaid: This is for persons who are eligible for LMB and full coverage Medicaid, such as persons in HC or AC living arrangements. It is not appropriate for persons attempting to meet a spenddown.

Other rules for establishing QMB/LMB:

- No changes are being made to current rules for the Working Healthy codes. The WQ, WL and WH codes will continue to operate as they do currently.

- QMB for a GA eligible is accomplished by establishing an MS program on the same case number as the GA program. Cash and Medikan are authorized on the GA program and QMB is authorized on the MS program, using a Y on the MSID screen.

- The procedure has changed for processing an initial case for QMB only. Once it has been determined that the individual is eligible for QMB only, a proration date equal to the start date of QMB eligibility shall be entered on APMA. It isn't necessary to formally process the initial months, or input a formal denial code for these months, but it is necessary to include a reference to the ineligible months in the formal notice of action.

  For example, a QMB only application is received 12-21-03 and is approved on 01-15-04. Because of the delayed start date for QMB, eligibility is not effective until 02-01-04. Prior to authorizing benefits, a proration date of 02-01-04 is entered on APMA and coverage is approved.

3. **Nursing Facility/HCBS/PACE Cases:** Persons receiving long term care on an MS program must also be clearly delineated from those attempting to meet spenddown. The new MMIS will key off of the CC medical indicator for these cases. This is set by placing a Y in the 'Cost of Care > Remaining Spenddown' field on the KAECSES SPEN screen. If the MMIS doesn't see the CC indicator on the file, it will think the client is on a spenddown and set the medically needy benefit. plan. Although it is possible for NF consumers to have a spenddown, especially if the client is temporary care, it is more likely not the case. We therefore cannot assume all MS programs with LOTC completed are Medicaid.

   Because of this change, it is critical that the eligibility worker (EW) place a Y in the CC override field for all cases where LTC or HCBS budgeting applies and/or payment possibility exists for the LTC provider(s). This includes situations where the income is less than the protected income level. For example, a person with total countable income of $680.00 and receiving HCBS services would not have an obligation and the 'Rem Spenddown' would be $0.00. The Y must still be entered on this screen. However, the Y is not used for those LTC cases where NF payment is not a possibility, such as instances where independent living budgeting applies. This practice should begin immediately to ensure all benefit plans are correctly determined.

4. **Conversion of Existing Cases in the MMIS:** Eligibility files for thousands of individuals currently exist in the MMIS. Each of these records will be converted into the interChange system. Although many of these records are for persons whose coverage has terminated some time ago, in order to maintain an adequate history and support claims payment processes, every record will be converted and assigned a benefit plan. The conversion process is completed by reading the information on the MMIS and applying the new logic for benefit plan assignment. However, because many of the older records were not approved with the new

QO and LO rules, it is not possible to utilize the same logic for assignment to the medically needy benefit plan.

Because of these variances in both policy and system coding instruction that have evolved over the years, it is impossible to account for every situation within the conversion process as such, there may be some records that are not converted with eligibility displayed correctly. If these cases are discovered, contact HelpDesk for guidance. The following conversion rules for the MS program are important to note:

- Records without a QMB indicator or a QMB indicator of N, no PICK code and a program subtype other than AC, HC or WH, will be assigned a medically needy Benefit plan

- Records with an MMIS type of coverage of spenddown that also have a medical expense on MEEX for a base period that includes this month will be assigned a medically needy benefit plan.

- Records with a QMB indicator of Y and a program subtype other than AC, HC or WH will be assigned a coverage type of spenddown in the current MMIS. Only those records with a medical expense on MEEX will be assigned a medically needy benefit plan in the new MMIS. Other records will be assigned a QMB only benefit plan.

- Persons with a PICK code of QS and a program subtype other than AC, HC or WH and no evidence of current or past spenddown met date, will be assigned only a QMB benefit plan.

- Persons with a PICK code of LS and a program subtype other than AC, HC or WH and no evidence of a current or past spenddown met date, will be assigned only an LMB benefit plan.

- Persons eligible under Pickle, Adult Disabled Child and Special Widows/Widowers benefits will be assign a medically needy benefit plan for converted records only. New records will display a Medicaid benefit plan.

- As indicated above, persons with a CC override indicator on the record will be converted to a Medicaid benefit plan. To accommodate existing cases where the policy allowed medically needy coverage for some HCBS plans, the conversion process will recognize this combination (HCBS + medically needy) for eligibility dates through 10-31-03. Eligibility dates after that must be established with a CC indicator.

- **Eligibility Processing:** No changes are being made to financial eligibility rules, such as the length of the base period, the amount of the protected income level or the resource level for the medically needy program. In addition, aside from the program subtypes and special medical indicators discussed above and the changes in MEEX discussed below, no significant changes are being made to

actual eligibility case processing. Cases will continue to be reviewed annually with a check at 6 months to establish a new 6 month base.

Significant changes are being made to spenddown processing, however. Medical expenses will no longer be itemized entirely on KAECSES and sent to the fiscal agent when the spenddown obligation is satisfied. Instead, the MMIS will be used to provide much of this tracking.

Once the spenddown amount and base period is determined on KAECSES, the information will be sent to the MMIS. At this point, all persons assigned a medically needy benefit plan will be issued a medical card. The card will be issued monthly, as will other medical cards. Cards for medically needy beneficiaries will have the word 'purple' printed at the bottom of the card. This, along with an 'MN' in the benefit plan indicator, will distinguish medically needy cards from those eligible for other benefit plans. In addition, the amount of remaining spenddown at the time the card is printed will also be listed on the card. The consumer should be instructed to present this medical card every time a medical service is rendered.

3. **Methods for Allowing Expenses:** Expenses may be applied to a spenddown in one of three possible methods. Each method is used for specific situations. An explanation of these methods follows.

    1. **MEEX:** In a limited number of situations, expenses will continue to be listed on the MEEX screen in KAECSES. As a general rule of thumb, these are expenses which can't be tracked on the MMIS. Any medical bill listed on MEEX will reduce the total spenddown amount sent to the MMIS. Expenses may be allowed at the time the case is processed or during the base period. Following conversion to the new process, ONLY the following expenses, which continue to be allowable against spenddown, are to be listed on MEEX:

        - **Medical Insurance Premiums -** Insurance premiums, including Medicare premiums not subject to buy-in.

    b. **Due and Owing Bills -** Medical expenses due and owing on the first day of the base period.

    c. **Expenses for Non-participating Assistance Plan Members -** Expenses for persons whose needs, income and resources are included in the assistance plan, but who are not actually eligible for benefits. This would include those expenses incurred by non-aged, non-disabled spouses as well as parents of minor children.

    d. **Nursing Facility Expenses -** Most residents of LTC facilities are not receiving medical assistance under the medically needy group. However, there are a limited number of situations where

it is necessary to determine eligibility for NF payment using a spenddown arrangement. Examples of these situations are persons in temporary care and those with income above the monthly rate of the facility. Medically needy plans are sometimes used to provide persons with coverage for other medical expenses. Anytime it is necessary to apply a nursing facility expense toward a spenddown, the expenses must be entered on the MEEX screen. If NF payment is also approved for a client in the medically needy program, LOTC must also be completed. An example is a person in a TC living arrangement.

2. **Direct Provider Billing:** Beginning October 16, medical expenses direct billed to KMAP can be applied toward spenddown. Medicaid providers will be instructed to use the information on the medical card to bill KMAP according to routine billing procedures. For clients with an unmet spenddown, incoming claims will be processed if the expense is allowable against spenddown. Claims which are not billed properly will not be allowed. This would include instances where key elements are missing, such as the dates of service and provider name. However, some edits, such as those which limit amounts of prescription medication, will not be utilized by the spenddown process. TPL editing will also be applied prior to allowing a claim.

   Allowable claims will be cycled through the claims process, reducing the amount of spenddown remaining. The MMIS will utilize the spenddown amount and base period coming from KAECSES as the baseline. When the full spenddown has been satisfied, the spenddown will be considered met and incoming claims will then be considered for payment.

   When billing KMAP for bills to be used against spenddown, providers should use the actual amount the patient will be responsible for, following any adjustments or write offs the provider will make. It is the amount the provider actually bills, not the Medicaid allowed amount, that will be allowed against the spenddown. Providers are not to bill amounts in excess of their routine and customary charge for the service. Monitoring of these claims will be done on a random basis to ensure adherence to this procedure. Providers may bill for non-covered services and items as well as those that are covered by Medicaid. Both types may be applied to the spenddown.

   Potential Provider Payment Indicator: All provider billed claims coming into the MMIS will have a Potential Provider Payment (PPP) status determined and assigned. For covered services, which could potentially be paid under the Medicaid program, the PPP indicator will by ‘Y’. Services which can never be paid (those not covered by Medicaid or provided by a non-Medicaid provider) will have a PPP indicator of ‘N’. This indicator is critical to processing adjustments and to the EW when processing

certain living arrangement, status changes and allowing medical expenses for food stamps.

Please note that providers are not required to bill KMAP if a card is not presented at the time of service. This applies to those providing services and items to persons in the medically needy program as those fully eligible for Medicaid. However, all providers should be encouraged to direct bill KMAP whenever possible for spenddown consumers. SRS and fiscal agent staff share the responsibility for education of the new process.

3. **Beneficiary Billed (BB) Claims:** It is not always possible for a provider to direct bill KMAP for expenses incurred by beneficiaries. However, the program does not exclude expenses from the spenddown process solely on the basis of the provider. As long as the provider is a legitimate medical practitioner or other qualified entity, the expense is allowable.

   To allow clients the ability to utilize these expenses, a special form has been created, the ES-3170, Beneficiary/Patient Spenddown Billing Form. Information on the form will be directly input into the MMIS for spenddown editing. The form and process is to be used for all expenses which are not submitted to the MMIS through the provider or are not included in the MEEX rules above. These can include situations where the provider is not a Medicaid enrolled provider. It can also include situations where the provider will not or cannot bill. As such, when services or items are provided prior to the issuance of the Medicaid ID card and the provider did not know at the time of service the individual is Medicaid. In addition, there are some services or items which are allowable against spenddown but are not billable to the MMIS because there are no medical codes available. This would include certain over-the-counter items and some home modifications.

   Eligibility staff are responsible for the review and approval of expenses received through the BB process as well as entering the information in the MMIS system. Input of this information should generally be accomplished within ten days of receipt of the expense. Where TPL is indicated, proof of TPL reimbursement must be obtained prior to allowing. Once input into the MMIS, edits will be applied for all incoming claims in the event the provider elects to bill Medicaid at a later date. The information on the BB claim form will prevent the new claim from being allowed a second time or from being paid if the spenddown is later met. Detailed instructions on how to enter these claims will be provided by EDS staff.

In the event the spenddown amount for the base period is later reduced or eliminated, bills entered into the MMIS through this process will not be considered for provider payment unless the expense is direct billed by the provider. The PPP indicator for any BB claim is always 'N'.

Please note, it is very important that eligibility staff take sufficient time to correctly enter these expenses as BB claims. Having this information on the MMIS is critical to the design of the new spenddown process. The information will not only provide for more adequate claims tracking, but will also allow for improved reporting of the types of expenses used to meet a spenddown.

- **Meeting a Spenddown:** A spenddown is considered met when allowable expenses equal to the total spenddown for the base period have been incurred and applied. A combination of the above methods may be used to actually meet the spenddown.

  The amount of spenddown sent to the MMIS is the amount in the 'REM Spenddown' field on the KAECSES SPEN screen. When this amount changes within a base period, the total spenddown sent to the MMIS will also change. Several factors can adjust this amount, such as income and household size, expenses listed on MEEX and amounts entered on the Override Spnd field on SPEN.

  Except for those expenses entered on MEEX, all expenses are applied in the order in which they are received. This may result in some expenses incurred later in the base being used toward the spenddown. It also means that the client will no longer have total control over which bills are used toward the spenddown.

  When the final expense is received to ultimately satisfy the spenddown, the expense will be evaluated to determine if there is a possibility of payment for the expense (the PPP indicator will tell us). If the PPP indicator is N for this final expense, the file will be sent to a special fiscal agent adjustment unit to potentially manipulate the expense(s) used for the spenddown. The process to send the file to the adjustment unit will be done automatically by the fiscal agent. If the adjustment unit staff person sees there are other bills already allowed against the spenddown with the potential for provider payment (PPP=Y), the spenddown list will be changed to use the non-provider payment bill against the spenddown. This will allow the possibility of the bill with potential provider payment to be considered for reimbursement.

  Example: a base period of January through June, a spenddown of $500.00 exists. The following expenses are received:

  - the client provides a due and owing bill of $200, which the worker places on MEEX when the case is set up. This reduces the amount of the spenddown sent to the MMIS to $300.00.

- on March 5 a provider bills covered prescription drugs of $250.00, the claim is assigned a PPP indicator of Y, leaving a remaining balance of $50.00.

- On March 15 a beneficiary bill of $200.00 for dental services provided by a non-Medicaid provider, is entered by the EW. This claim is assigned a PPP indicator of N.

Sufficient bills have been submitted to satisfy the spenddown for the base. Before the case is finalized, the fiscal agent considers the last bill received toward the spenddown. In this case the last expense is a BB claim, which has no potential for provider payment. But, the prescription drug bills received earlier in the base do have the potential for provider payment. This case is then sent to the fiscal agent adjustment unit. The following adjustments are then made to the spenddown:

- no adjustments are made to the due and owing bill because it came from MEEX. The amount coming from KAECSES remains unchanged at $300

- the dental bill, which has no potential for provider payment, is considered first, since it is the last claim received and is without potential of provider payment. The $200.00 expense is allowable in full. The remaining spenddown is now $100.00

- the $250.00 prescription bill is then considered. The first $100.00 is used to satisfy the spenddown. The remaining portion of the expense, 150.00, is now considered for provider payment.

- for payment purposes, the amount SRS pays the provider is based on the Medicaid allowed amount, not the full amount billed. Medicaid may or may not pay a portion of the expense, but the client is only obligated for the first $100.00 of this bill.

Once the spenddown is satisfied, the MMIS will begin evaluating incoming claims for possible provider payment. However, claims and expenses used to meet the spenddown, are not further altered to allow for non-covered expenses to be allowed instead of covered expenses.

E. **Special Situations**

1. **Expenses Paid by Other Government Programs:** Expenses paid by state or local funds continue to be allowable against the spenddown, regardless of the client's obligation to actually pay the

expense. With the new spenddown process, some providers may need to alter how these expenses are billed.

When the Medicaid provider responsible for billing the service is also the actual recipient of the funding, the full amount of the service, less any third party insurance payments, may be billed. The provider should not bill just the sliding scale fee. Examples of these providers are the CMHCs and CDDOs.

When the provider is not the recipient of the funding, such as those expenses paid by Voc Rehab or APS, the actual provider should bill only the portion actually billed to the recipient. The portion paid by the other funding cannot be billed by the provider and a BB claim form will have to be used for the remaining portion of the expense.

Examples: For a situation where the provider receives the funding directly consider a client who receives 2 hours of psychosocial treatment group from the CHMC. The CMHC's normal rate is $40.00/hour for this service, $80 total charge. The client is charged a sliding scale fee of $5.00/hour for this service, or $10.00 total. The CMHC has received funding from the state to provide this service. The full amount is therefore allowable. The CMHC should bill Medicaid the full $80.00 and it is allowable toward the spenddown.

For a situation where the provider does not receive the funding directly, consider a client who receives a walker from a DME provider. The normal cost of the walker is $200.00. APS funds paid for half of the cost of the walker, or $100.00. The client paid the other half. The DME provider should bill Medicaid for the client's portion only, or $100.00. A BB claim is to be completed for the remaining $100.00.

2. **AIDS Drug Assistance Program (ADAP):** Special instructions will be issued in a separate memo regarding treatment of expenses paid by ADAP

3. **Persons eligible for other Benefit Plans:** Claims received for persons eligible for other benefit plans in addition to the medically needy plan, will first be evaluated under the other plan for payment. If the claim is subject to reimbursement under the other plan, it will not be allowed against spenddown. However, if the bill is not subject to reimbursement, it may be allowed. For example, a person who also has QMB coverage is eligible for payment of Medicare copayments and deductibles. Because QMB will pay for those claims which are also covered by Medicare, the claims will not be allowed. However, a claim that is not covered by Medicare, such a prescription drug expense, may be allowed to meet spenddown.

4. **Medicare Crossover Claims:** Claims coming through the Medicare crossover process will be evaluated for allowance against spenddown without a separate billing by the provider. However, claims for QMB

beneficiaries will not be allowed, as they are subject to reimbursement through QMB as noted above.

5. **Due and Owing Bills Previously Allowed:** An expense allowed against a spenddown in a previous base period in which the spenddown was ultimately satisfied, is not allowable in subsequent base periods. This is true even if the bill is still due and owing. However, in a situation where the spenddown was never met, the due and owing portion of the expense is allowable in the current base period. When this occurs, it is necessary to remove the expense from the first base period to avoid allowing the same bill twice. Because of the automated billing features with the new MMIS, a special procedure has been developed to accomplish this.

   First, it is important to understand that eligibility staff cannot alter claims received through the normal MMIS billing process but can alter those entered through the BB billing process. So in this instance if the now past due and owing expense is a BB claim, the initial expense is voided on the MMIS and the expense is then allowed in the new base period. But, if the provider billed the service initially, it will not be possible to adjust this expense for the old base period. Because the allowance cannot be removed, the actual amount of the spenddown will be adjusted for the old base to account for the expenses. EW's must hyper-inflate the amount of spenddown in the prior base by the amount of the due and owing expense to accomplish this adjustment. The bill can then be allowed on MEEX in the current base period.

   Example: Eugene's spenddown for the base of Jan - June is $3000. On April 15, a hospital billed the interChange $2500 for Eugene's stay earlier in the month. The spenddown was never fully met. Eugene indicated he was now taking expensive medicine and a new base period of July - December is established with a spenddown of $3000. On July 8 he calls to report he has received a bill from the hospital for $2500 and wants to allow it as a due and owing expense. Because the bill is still due and owing, it is an allowable expense for the new base as if it hasn't been allowed in a previously met SD period. Because this is a provider billed expense, it is not possible for the EW to manipulate this claim. The EW must adjust the total amount of spenddown for the old base by adding the portion of the bill which will be used in the current base to the amount of remaining spenddown in the old base. This will successfully increase the spenddown in the prior period.

   For Eugene's Jan - June base period, the amount of remaining spenddown on KAECSES is $3000.00. However, in MMIS, the remaining spenddown is $500.00 because the $2500.00 bill has been allowed. Because the full $2500 will be allowed in the new base, the Jan - June spenddown is to be increased by $2500 through KAECSES. The amount on the Rem Spenddown field on SPEN,

$3000, is added to the amount of the expense, $2500. The total of $5500 is now placed on the Override Spnd field on the SPEN screen for the old base. Now, KAECSES will send this new spenddown amount of $5500.00 to the MMIS. The MMIS still has a record of the bill, so the total spenddown will be reduced by $2500.00. The MMIS will see the spenddown for the Jan - June base period as $3000.00. When the due and owing bill is then allowed against the July - Dec base, it will be reduced to $500.00. It is critical that the EW carefully document the action taken when these situations occur.

F. **Processing Changes for Medically Needy Cases:** Several modifications are being implemented in regards to change processing for medically needy cases to support the new spenddown process. Two policy changes are effective 10-01-03:

Effective Date of Change - For cases with a base period exceeding one month, changes are now acted upon the month following the month the change becomes known. These changes must also be budgeted given timely and adequate notice requirements. Changes which have a positive impact do not require such notice and are made effective the month following the month the change is reported. Previously, changes were made effective the month of change, and timely notice was not required.

Under the new policy for unmet spenddowns, timely notice will be given when budgeting the change which increases a spenddown amount but the new spenddown amount will be effective immediately. For met spenddowns, the status change to unmet spenddown is effective based on timely notice requirements. This policy includes changes in the assistance plan as well as income changes. This change is effective 10-01-03 and is implemented with all changes reported on or after this date.

Two Assistance Plans Combine - When two medically needy (MS or MA) households combine, the existing base periods shall be shortened to end the month of change. A new base period is established beginning the month following the month of change.

To understand the impact of these changes, it is important to understand how changes are processed in the interChange MMIS, especially given timely and adequate notice requirements. As indicated above, timely and adequate notice is required for the change in the budget. Because spenddown status is determined by information in MMIS as well as KAECSES, it is no longer possible for the eligibility worker to ensure such notice requirements are met simply by the effective date of action, as the interface which updates the amount of spenddown in the MMIS is sent every day.

For example, Sandy has a spenddown of $500 for base period July - December. It has not been met. On August 18 she reports a new source of income from a pension; she received her first check on August 15 and will receive monthly payments of $100. Verification of the new benefit is

received August 26 and the EW is taking action on August 30. Under the new policy, the change is budgeted the month following the month of report, given timely notice requirements. Because Sandy timely reported her new income source and it is after timely notice deadline, the income will not be budgeted for September. It is budgeted beginning in October. Her new spenddown is increased by $300.00 ($100/mo for each of October, November and December) and is now $800.00. Even though the income was not budgeted until October, because the spenddown is unmet, the new spenddown is effective immediately. However, if the spenddown were met it would continue to be met through September 30.

To ensure notice requirements are adhered to, a negative action deadline table has been built into the interChange MMIS. Anytime a new spenddown amount is received for a particular base period, the system will evaluate the change. Based on the date processed , the current spenddown status and the amount of spenddown, the system will determine the effective date of the new status. This special negative action table operates under the following rule:

An increase in the amount of the spenddown received after 10 day change deadline will not be applied until two months following the month the MMIS receives it if it negatively impacts the status of the spenddown in the MMIS Changes which negatively impact the status of the spenddown in the MMIS and are received prior to the 10 day change deadline will be applied in the following month. See item 4 below.

This rule applies not only to changes in spenddown amount, but also to changes in base periods. When processing a change, the actions and responsibilities of the EW are dependent upon the type of change.

1. **Decrease in Unmet Spenddown:** When action is taken that results in a decrease in the amount of an unmet spenddown, the EW is responsible for notifying the recipient of the new spenddown amount. In addition, the following apply:

    - If expenses are allowed on MEEX at the time of the change, which result in a met spenddown (Rem Spenddown = 0), the EW is required to notify the client of the newly met spenddown. The new spenddown amount sent to MMIS will be 0. If the MMIS had received claims prior to receiving the $0 spenddown amount, the expenses may now be considered for payment if the provider requests an adjustment.

    b. If MEEX expenses are not sufficient to meet the spenddown, the new spenddown amount will be sent to the MMIS and is effective upon receipt (because there is not a negative spenddown status change). If claims existing in the MMIS for the base period exceed the amount of the new spenddown, the spenddown will be

considered met and the claims will be evaluated by the fiscal agent adjustment unit and those with a PPP of Y will be reprocessed if there is truely potential for provider payment. If the spenddown is met with claims in the MMIS, the fiscal agent will notify the client the spenddown has been met.

2. **Decrease in Met Spenddown:** Much like the situation above, processing is dependent upon the method used to meet the spenddown. However, in either situation below, the EW is responsible for notifying the recipient of the new spenddown amount:

    - If the spenddown was met entirely with MEEX expenses, the EW must reduce the amount of expenses allowed on MEEX. Because the interChange MMIS already views this as a case with no spenddown, no changes will take place on the MMIS. The EW will notify the client the spenddown remains met.

    b. If a portion or all expenses used to meet the spenddown are in the MMIS, the fiscal agent adjustment unit will determine which claims must be adjusted because of the reduced spenddown. Claims with a PPP of Y will be adjusted. The fiscal agent will issue a notice informing the client of any adjustment.

3. **Increase in Unmet Spenddown:** The EW is responsible for notifying the recipient of the increased spenddown amount. The new amount will be effective immediately upon receipt in the MMIS. The fiscal agent will not send out routine notifications when this change occurs.

4. **Increase in Met Spenddown:** The EW is again responsible for notifying the recipient of the new spenddown amount. The resulting action in MMIS is dependent upon the date the amount of the new spenddown is received, given the negative action table described above. The spenddown will continue to be considered met, and claims processed accordingly, until the increased spenddown is applied.

    For example, Betty has a $600 spenddown for base period March - August. The spenddown was met with a single provider billed claim on 03-15. On 04-25, the client reports an increase in a pension received on 04-20. New policy requires the change in income be budgeted effective June 1, given timely and adequate notice. When the change is processed, the MMIS will receive the new spenddown amount and will see the spenddown would no longer be met. This is a negative change. Therefore, the date the action is received is considered:

- If the change is processed on 04-26, it is after the negative action deadline on the table. Therefore, the change won't be effective until the second month following the month it is received, for June. The spenddown status of 'met' will be protected through the month of May.

b. If the change is processed on 05-03, it is before the negative action deadline on the table. Therefore, the change will be effective the month following the month received, for June. Again, the spenddown status of 'met' will be protected through the month of May.

In both situations, claims received with dates of service though May 31 will be considered for payment by the MMIS according the 'met' spenddown status.

Although the above situations are treated differently by the MMIS, the current spenddown status may not always be known to the EW. Claims are received continually during the day, and a new cycle is run each evening, giving the opportunity for the situation to change at any minute of the day. Because of this possibility, the EW must rely on the MMIS to provide actual notification to the beneficiary in some situations.

When reacting to a change in the amount of spenddown, the EW must always send the notice informing the recipient of the new base spenddown amount and any changes in the base period. The EW will provide the following information regarding spenddown status:

(1) if MEEX expenses are or were used to fully meet the spenddown, the EW must notify the consumer of the spenddown status. This includes situations where the spenddown is moving from met to unmet.

(2) indicate that spenddown status may be modified and refer the client to the fiscal agent for spenddown status information. Note that current notices are being modified to refer the client to their medical card or to the Medicaid Assistance Customer Service Center for the current spenddown balance.

G. **Medical Necessity:** Only those services and items which are considered medically necessary are allowable against spenddown. The definition, as well as the list of medically necessary items, continues to be found in Appendix item 84. The form has been rewritten and reformatted with this revision. In addition, several changes have been incorporated to better reflect medical needs given current health care trends.

These rules also apply to HCBS when determining the amount of client obligation. However, services covered by Medicaid are not allowable for months in which the client received medical coverage. For NF cases, only those services and items which are not the responsibility of the NF to provide are allowable against the patient obligation. The list of services can be found in the Adult Care Home Provider Manual on the SRS website at http://www.srskansas.eds.com/manuals.html.

H. **Please make note of the following changes implemented with this revision:**

1. **Definition:** A definition has been added to use as a guide in making decisions regarding the necessity of a particular item or service.

2. **Limitations:** Limitations in the quantity and the rate/amount which can be allowed toward spenddown are being implemented. The item or service is allowable at the quantity and duration ordered by the medical practitioner. Requests for allowances above these limits are not allowed. If excessive quantities are ordered and presented, the expense is to be reviewed by central office. Amounts up to the usual and customary rate for the service or item charged by the provider are allowable.

3. **Documentation:** All services or items must be ordered by a medical practitioner to be allowed. A statement documenting medical necessity must be given to the agency for services or items which are not provided by a medical practitioner or are available without the consent of the practitioner, such as over the counter medication. The Statement of Medical Necessity can be used to capture this information and is included in KEESM as Appendix item 84A. The EW is responsible for ensuring these requirements are met for beneficiary billed expenses. It is not necessary to have this information on file for provider billed expenses because the provider will have a prescription prior to billing.

4. **Review:** For any service or item not included on the list, staff must continue to submit the request to central office for review prior to allowing. However, these requests shall now be sent to EES Central Office, c/o Medical Assistance Manager. Responses are coordinated with Health Care Policy medical staff and other agency staff as necessary.

5. **Assisted Living/Adult Day Care/Home Health Care:** Further definition of allowable home health related expenses is implemented in this revision. Nursing services provided by a licensed practitioner are always considered medical-related treatment and are allowable in full. Other home health related expenses are dependent upon individual's need for home and community based services. The

following limitations are allowable with proper documentation of medical need. If additional services are submitted the request along with proper documentation must be submitted to central office for approval.

- For persons screened eligible for HCBS but have been placed on a waiting list for services, home health care expenses up to $1000/month may be allowed against the spenddown with an appropriate statement from a medical practitioner. If the actual costs exceed this limit, only $1000/month may be allowed. This amount is directly tied to the average cost for HCBS. In addition, the costs of residing in an assisted living facility, less the portion related to room and board costs, are also allowable for those on an HCBS waiting list only.

b. For persons who are not on an HCBS waiting list or who do not meet level of care, including persons on a transfer of property penalty, a limited allowance may be given. If ordered by a medical practitioner, allowable expenses up to $250.00/month may be used against the spenddown. Expenses in excess of this amount are not allowable.

6. **Service Dogs or Animals:** The policy for medical is changing to mirror existing food stamp rules. The costs of obtaining and maintaining the animal, including costs of dog food and veterinarian bills, are allowable.

7. **Home Modifications:** The limit on home modifications to be submitted to central office is increasing from $200.00 to $500.00 per modification. If a single contractor is providing multiple modifications, they are considered separate when evaluating toward the $500.00 maximum. However, if an individual is having multiple renovations made toward a single modification, they are considered a unit. For example, a bathroom remodel frequently consists of reworking the tub, sink and toilet. Because these are completed at the same time, it is considered a single modification. However, if the individual were also having a ramp installed at the same time, it would be considered a separate modification because it is not necessarily completed with the renovation of the bathroom.

8. **Transportation:** The costs of transportation to and from Medicaid covered or otherwise medically necessary expenses is allowable. This would include those services on an HCBS plan of care. Ambulance transportation is allowable.

   When private vehicles are used, expenses are allowable at the state reimbursement rate, including the enhanced rate for persons who need a specially equipped vehicle. Waiting time is allowable for commercial providers only. For overnight trips, lodging costs may be

allowed for one attendant if medically necessary and if the consumer is responsible for paying the expenses for the travel attendant.

I. **Impact on Food Stamps:** Because medical expenses will no longer be presented to the EW in every situation, procedures for determining the amount of the food stamp medical deduction are being modified. Food stamp households continue to have the choice of using certain bills as one time deductions or having them averaged over the remainder of the review period. However, for spenddown households, the following limitations apply:

- Provider billed expenses cannot be allowed until the spenddown is met or at the end of the base period. At that time, the client has the option of which method to use.

- Since no third party will be responsible for BB and MEEX expenses can be allowed as one time medical deductions or averaged per client choice.

- The Beneficiary Spenddown Summary will be sent to the EW when the spenddown is met and will provide documentation of the consumers responsibility for those medical expenses listed.

- If the spenddown is not met at the end of the base period, all expenses listed on the MMIS as allowable toward the spenddown may be considered for food stamp deductions at that time.

- Expenses used for spenddown purposes may not all be allowable for food stamps. A review of the expenses will be necessary to determine which are allowable. For example, if the expense was paid with other state or local funds only the portion that the consumer is obligated for is allowable. In addition, 'due and owing' medical expense may or may not be allowable as a food stamp medical deduction (see 7227.5). For example a due an owing expense may be allowable for food stamps if an installment plan was agreed to prior to the due date of the original billing and monthly installments are still being billed for the expense.

  It continues to be important to document the method the individual chooses to have expenses allowed, either as a one time expense or averaged over the remaining months of the review period, making special note of any special billing issues.

1. **New Base Periods:** There are no significant process changes to note when establishing a new base period. However, it is important to stress the need to evaluate the situation before choosing to set up a new base. If the previous spenddown was not met, contact with the client may be necessary to determine if there is a need for medically needy coverage. Failure to meet two consecutive six month base

periods will generally result in termination unless a significant change is communicated to the EW. Under no circumstances should beneficiaries be reinstated solely to keep them on buy-in, unless eligible for a Medicare Savings Plan.

J. **SOBRA Spenddown:** For individuals placed on spenddown under the SOBRA provisions, these rules are NOT applicable. The MMIS will not accept medically needy coverage in association with SOBRA coverage. Therefore, an alternate process has been developed and will be addressed in implementation in a separate implementation memo.

K. **Notices of Action:** SRS and EDS will now share responsibility for notification when activity occurs on a spenddown case.

1. **SRS Responsibility:** Eligibility staff shall continue to notify clients of any action impacting financial eligibility, including initial notification of eligibility/ineligibility. For approvals, the notice will also provide the amount of the total spenddown, expenses which have already been accounted for and the base period.

   Any action the EW subsequently takes to alter the amount on the Rem Spenddown field in KAECSES, such as an income change, household change, base period change, allowance of an item on MEEX, shall require a new notice. However, if the action is applied in the MMIS such as processing an incoming claim which is allowed against the spenddown or allowing a BB claim, the MMIS is responsible for the notice. This is true for actions taken by the EW or fiscal agent staff.

   The general spenddown notice, the N836 has been rewritten to reflect to reflect the new procedures. This notice shall be sent in every instance in which the spenddown is new to the client. This will minimally include new approvals, but may also be needed at reviews when changes in living arrangements occur or other changes which cause an individual to have a spenddown. In addition, all KAECSES notices related to spenddown have been rewritten to accommodate these changes, including the spenddown approval, review and change notices. A complete list of notices is attached to this memo.

L. **EDS Responsibility:** EDS is responsible for notification of action taken through the MMIS. Two special notices will be used:

   Weekly Summary Notices - EDS will send weekly summary notices of all spenddown activity. The summary will provide information on the provider, the date of service and the amount allowed. It will be sent when spenddown activity has occurred in the week. Separate notices will be sent for each base period. The purpose of this summary is to inform the client of spenddown activity. The summary

will include all provider billed and beneficiary billed claims. Denied claims used toward the spenddown will also be included on the summary. This notice will provide official notice to a beneficiary when a bill has been allowed through the BB claim process.

Spenddown Met Summary - EDS will send a full summary notice to the client when the spenddown has been met. The notice will list all expenses used toward the spenddown for the base period. The summary will not include those items listed on MEEX because they haven't been sent to the MMIS. The EW will also be sent a copy of this notice.

Note that the notice will not be generated when a spenddown is fully met with MEEX expenses (such as health insurance). In these instances, the KAECSES notice provides information about the change.

Example: an existing base period of 04-04 through 09-04 exists with a $500.00 spenddown. This information is sent to MMIS. On 03-14-03 a provider bills for a doctor visit that reduces the remaining spenddown to $400.00. At the end of the week, EDS will send the client a notice telling about allowing the claim. The notice will also include information about other claims processed during the week that were also used to reduce the remaining spenddown. Then, on 05-15-04, the client reports a pension has stopped effective 05-15-04. Because these changes are now effective the month following the month the change is reported for cases with six month base periods, the change is made for 06-01-03. The spenddown now remaining on KAECSES is reduced to $50.00 and this is sent to MMIS. The worker sends a notice of action telling the client of the reduction of the total spenddown because of the change in income. Because the spenddown has now been met by a bill on the MMIS, the MMIS will also generate a special notice telling him his total spenddown has been satisfied.

- **Outreach/Other Notices:** Because of the scope of these changes, other materials are also being developed to assist with the education and awareness.

    - **ID Card Stuffers -** Two separate ID card stuffers are planned. The first will be included with all medical cards in September and October. It will tell clients about the upcoming changes with the medical card. The second will be a targeted stuffer directed at only those people with a medically needy benefit plan. It will remind people that they need to show their medical card to the providers when receiving a medical service, so it can be allowed against the spenddown.

    - **Special Mailing -** A special mailing will occur in late September or early October directed at persons in the medically needy benefit plan.

The flyer will tell clients about the upcoming changes and how the new spenddown process will work. Copies of this flyer will be distributed at training.

- **Outreach Mailing -** A targeted mailing is also being planned for our community partners and advocate organizations. The material included in this mailing would provide a general overview of the changes recipients are going to see with the new system as well as some of the key changes for providers. At this printing, the mailing is still in development and has not been finalized. Additional information will follow when it becomes available.

- **Long Term Care Processing Changes**

In addition to changes in spenddown processing, significant changes are also being made to long term care processing. The interChange system will continue to accept eligibility and LOTC information from KAECSES to determine if payment for long term care has been approved. The same basic elements used by the current system are also used by the new MMIS; including patient liability, effective dates and level of care information. The fiscal agent will provide additional information on these changes in the new MMIS at a later date. Please make note of the following changes:

1. The living arrangement and the level of care information sent from KAECSES will be combined into a single field, the MMIS Level of Care (LOC). The MMIS LOC replaces the LAC.

2. MMIS LOC's will be a three digit number. The first 2 digits of the MMIS LOC will be the same as the LAC code in the existing MMIS. The third digit will be a 1 (for TC arrangements) or a 0 (for other arrangements)

3. LTC clients in the MMIS with an MMIS LOC other than 0 will be exempt from copay

4. TC code processing rules continue to apply. Both HCBS and NF providers may be paid for dates of service when the TC code is used in combination with an HCBS level of care. For TC codes used in combination with facility levels of care only the facility can receive payment.

5. LTC provider billing through the turn around document (TAD) will no longer be possible. The TAD is being eliminated with the implementation of HIPAA billing requirements. LTC providers will now bill on a traditional medical claim form called a UB-92. This is the same billing document hospital providers currently use. LTC providers can also bill electronically. All institutional providers, with the exception of Level VI facilities, will utilize this process. Additional information regarding the LTC billing and payment process will be provided through the fiscal agent. Facilities will receive instructions on how to tell the MMIS about special situations, such as when clients are using reserve days or therapeutic days, when clients are absent from the facility and when TPL is involved. There will be flags in the MMIS when facilities are placed on Do Not Pay (DNP) penalties and

other payment limitation statuses. The EW is not expected to monitor clients in facilities with DNP penalties.

6. Each MMIS LOC is mapped to specific types of LTC providers which can be paid when the MMIS LOC is present. Other LTC providers cannot be paid for that stay.

   For example, the MMIS LOC for persons coded NF SN is 130. Facilities listed as nursing facilities can be paid for persons with the 130 MMIS LOC on file. However, facilities listed as other types, such as ICF-MR's or Head Injury/Rehab Hospitals cannot. If a person moves from one type of facility to another, it is considered a living arrangement change for purposes of the MMIS.

7. LTC provider numbers will no longer be used on the KAECSES LOTC screen and the fields are being eliminated. When the provider number field was added on KAECSES, it was originally intended to allow payment only to that facility. However, the edits that were built into the existing MMIS have never been fully functional. The new MMIS will not attempt to assign payment to specific long term care providers but will allow payment by facility type, as explained above. Provider numbers will continue to be assigned, however, and information associated with the provider will be of importance to the EW. The presence of a provider number will be an indicator that a facility has been certified. Information on the facility's daily rate and provider type will also be available on the MMIS.

8. For MS programs, the new MMIS will set a Medicaid benefit plan if the CC indicator (established when a 'Y' in entered in the 'Cost of Care > Remaining Spenddown field on SPEN) is read. It is important that the field be completed for those situations where LTC or HCBS budgeting is used. This is true even when there is no patient liability. However, if NF payment is approved for an individual while in a medically needy base period (such as a TC living arrangement), the CC code should not be used.

   - **Single Patient Liability:** The MMIS will use a single patient liability each month. For the EW, it means a patient liability no longer must be split between two providers or living arrangements when changes occur mid-month. The KAECSES LOTC screen is being updated to remove the day fields from the screen, so the effective date of patient liability will simply be a month and year. These rules in this section are not applicable to PACE consumers, as monthly LOTC segments are established for those individuals.

     When changes in residence or living arrangement occur mid-month, the MMIS will use the following rules to determine how the patient liability is assigned:

     1. When a change is made on LOTC that creates a change in the first two digits of the MMIS LOC, any patient liability is assigned in full to the first LTC arrangement of the month, regardless of the length of each arrangement or whether the entire obligation was consumed by the provider(s) in the first living arrangement. The MMIS LOC is

based on living arrangement and level of care information from KAECSES. If a change is made to either the KAECSES living arrangement or level of care a new MMIS LOC will be created. The exception is for changes involving the TC code as noted in item (3) below.

Examples: Consider a change in living arrangement on LOTC. A client moves from an NF to HCBS on the 2nd of the month. The patient liability was initially $954.00 but is now $268 when rebudgeted. The entire $268.00 is assigned to the facility, even if the facility has a very low daily rate. LOTC would be updated with the new patient liability and the living arrangement and level of care codes.

Consider a change in the KAECSES level of care. A person changes facilities mid month and the facilities have different KAECSES levels of care. The patient liability will be assigned to the first facility. Specific instances would involve moves from a swing bed to a regular NF or an NF MH to a regular NF. A move from a state hospital to an ICF MR would also apply because a change in KAECSES living arrangement occurred. When this occurs, it is not necessary to update the patient liability field on KAECSES, as the MMIS will assign the liability appropriately.

2. When a change in residence occurs, but the KAECSES living arrangement or level of care codes do not change, the patient liability is not adjusted. The patient liability will be applied to the first provider billing for the month. If the provider in the later half of the month bills first, the patient liability will be applied to that claim first. Patient liability may be applied to both facilities, or as necessary to account for the full amount. The EW must update the address with the new facility's information.

   It is also important to recognize that in some situations the first facility in a month may have collected the full liability from the client and then discover upon billing that the liability was actually applied to the second provider. When this occurs, it is the responsibility of the client to work with the facilities to ensure payments are properly made and accounted for.

3. When the TC code is used in combination with and HCBS level of care (such as TC FE or TC PD), the patient liability will continue to be assigned to the HCBS provider(s) and no patient liability will be assigned to the facility. When a person moves from HCBS to a TC arrangement, the first two digits of the MMIS LOC remain unchanged. The last digit will change from 0 to 1. This will ensure the special patient liability rules for TC codes are correctly applied.

4. The EW must send appropriate notices of action to both the client and facility. It is always necessary to notify a new facility when payment

has been approved. When the client is moving from one facility to another, the N976, Transfer to New ACH, has been modified to tell the new facility of payment approval and any liability amounts. The notice will also explain liability distribution. It is generally not necessary to tell the old facility of the change, as the administrator should be aware the client has left the facility. However, at the EW's discretion, a copy of the completed Transfer to New ACH notice may be screen printed and mailed locally. Approval notices must be sent to the facility when the client transfers from HCBS, including TC living arrangements.

B. **HCBS Start Date:** After current cases are converted, the new MMIS will not support HCBS payment for medically needy benefit plans. Therefore, current recipients transitioning to HCBS must have any medically needy plan ended before HCBS payments will be made. Policy is changing the effective date of HCBS budgeting to eliminate instances where an individual may have both HCBS and a medically needy benefit plan.

   Beginning with all cases processed on or after 10-01-03, it will no longer be necessary to begin HCBS budgeting and actual payment in separate months. Instead, both key dates will be evaluated to determine the HCBS start date. HCBS services are only considered in effect if there is a slot for the individual. This does not apply to persons on a waiting list for services. The following rules apply:

   1. For the PD, SED and TA waivers, the screening date is the effective date of service. This is also considered the first date of service as the screening is a waiver service for these cases. This is current policy and reflects the fact that the screening equates to eligibility for the waiver if the individual subsequently chooses HCBS. This is true regardless of the actual amount of services used in the initial month. If the plan of care costs exceed the client obligation on an ongoing basis, HCBS shall begin in the month of screening.

      For example, Blitz is screened for HCBS -PD on 10-14. There is a slot for him and he chooses HCBS. His formal plan of care will begin 11-05. The HCBS start date is the date of screening for this waiver so HCBS budgeting begins in October. The full client obligation is entered on the LOTC screen beginning in October.

   2. For the FE, MR/DD and HI waivers, the choice date is the effective date of HCBS if services will begin within the following month. If services are expected to begin in a later month, the HCBS start date is the month services actually begin.

      For example, Fritz is screened for HCBS-FE on 10-28. The case manager comes back with the choice form on 11-03 and he signs it. There is a slot available for him on the waiver. Services will begin 12-06. In this situation, services are set to begin within the month following the month of choice, so HCBS begins in November. Again,

the full client obligation is entered on LOTC for November and December.

Contrast with Ritz, whose services do not begin until 01-15. Because services began the second month following the month of choice, the HCBS start date is January. HCBS budgeting begins in January. Eligibility for the months of October - Decameter would be determined using independent living (including medically needy) rules.

Impact on Spousal Impoverishment - For persons who wish to have HCBS established for purposes of a spousal impoverishment assessment, the applicable date of HCBS is the date the client chooses HCBS. This is current policy and is not changing. However, for persons placed on the waiting list, the date of the waiting list placement is the date considered the effective date of services for spousal impoverishment assessments.

C. **New Facility Types:** Beginning with the implementation of the new MMIS, long term care payment procedures will apply to three new facility types. This will mean that payment to these type of facilities is dependent upon appropriate LOTC coding. The new facility types are Swing Bed hospital, Level VI facilities and Head Injury/Rehab hospitals.

   This issue is still in development with SRS and the fiscal agent and will be provided in a separate implementation memo.

D. **Retroactive Patient Liability Process -** With the implementation of the new MMIS, the process to apply retroactive patient liability changes is changing. The new process applies to both LTC/institutional and HCBS situations. However, if retroactive changes must be made to PACE cases, the implications of changing the capitated rate to the PACE provider must also be considered and therefore, are not to be made unless approved by EES Central Office in conjunction with KDOA.

   A retro liability change is a change made to the patient liability or client obligation on or after the first day of the month. This is driven by the actual date action is taken. For example, a change made to the liability on 05-31 effective 06-01 is not a retroactive change. But, if that change were processed on 06-01 it would be considered a retro change. For the MMIS, this is an issue because of the way medical providers bill. Institutional/LTC providers have the patient liability deducted from the total amount billed. In addition, they are able to bill at any point in the month. Some choose to bill monthly or less frequently while still others bill more frequently. If a patient liability change is made after the provider has already billed and been paid, it is never applied.

   However, there are some situations which necessitate a retroactive change in the liability as dictated by policy. These situations are clarified in KEESM Revision 16 and are as follows:

1. **Living Arrangement Changes:** When a budgeting change occurs because of a change in living arrangement. For example, an individual moving from NF to HCBS may result in a liability change.

2. **Agency Error:** When an agency caused error has resulted in an overstated patient liability for past months. At this point, it is important to clarify exactly what is considered appropriate in these situations. Agency errors are the result of actions such as the failure to react to a reported change timely and incorrect budgeting. The agency has a responsibility to correct errors in these situations. However, when changes are not timely reported, the agency is not responsible for the error and these situations are never to be corrected through the retro liability process. To demonstrate the difference, an LTC client reports to you on 04-05 of an upcoming change in his health insurance effective 05-01. Verification is provided. The EW simply forgets about the report and doesn't realize it until 05-15 when the responsible person inquires about the liability. In this case, the change was timely reported and the premium should have been adjusted but the agency failed to make a proper determination. The May liability would be adjusted retroactively as soon as possible.

   However, if in the same case, the individual neglected to inform the EW until 07-15 of the increase in premium in May, the liability would not be retroactively adjusted and the new liability would begin 8-01.

   Retro adjustments are not appropriate to apply non-covered medical bills toward a patient liability, even for consumers who have recently died.

   Understated liabilities are not to be adjusted through the retro change process, and are usually prohibited by timely notice requirements. Instead, an overpayment is to be established and recovery procedures initiated, where appropriate. The only exception is if both the consumer and NF were notified of the correct liability but a data entry error result in an incorrect patient liability being sent the MMIS, therefore impacting claims processing. For NF/institutional cases, it is appropriate to correct the liability for all past months. For HCBS cases, future months obligations should be adjusted (if possible) to provide the proper credit to the client. If it is not possible to adjust a future months obligation, retroactive adjustments shall be made to the past obligations.

   Because editing does not occur when updating LOTC, each change made to this screen must be carefully considered. History is not retained either, making it impossible to research changes solely on KAECSES. Therefore, the MMIS is the primary source of long term care information and eligibility staff are responsible for ensuring updates made are appropriate.

The eligibility supervisor or designee is now required to authorize each retroactive liability change in which a billing adjustment will result or a plan of care will need to be adjusted. The MMIS will facilitate this requirement once the change is made by the EW. Upon making a change, the worker must notify the appropriate supervisor of the change and the need to authorize the change. The new liability will be sent to the MMIS nightly and will update a pending patient liability file. If approved, the eligibility supervisor must then authorize each individual month to update the patient liability file. Once updated, claims will be flagged for adjustment for institutional providers. For HCBS cases, an alert message will be sent to the case manager/ILC owning the HCBS case, as the plan of care must now be adjusted for each past month. It is because of the extra work involved in updating the plan of care that the two situations are handled differently. The ES-3125 is being eliminated as it is no longer necessary.

E. **Long Term Care Insurance:** Beginning with the implementation of the new MMIS, EDS will begin extensively using the services of Health Management Services (HMS) to locate current third party resources, usually in the form of other health insurance coverage. When these coverages are discovered, they will be loaded on the TPL file in the MMIS. Cost avoidance editing tied to the policy will then begin applying immediately once the policy is confirmed by fiscal agent staff. Long term care insurance will be included in this process.

Because of this, it is no longer possible to allow an individual or family currently drawing benefits from such a policy the option of budgeting benefits as income, instead of including the policy on the TPL file. Current policy allows such an option because budgeting the benefits as income would result in an increased patient liability, which would ultimately result in a reduced Medicaid payment to the facility or LTC provider. For other cases, the facility is required to provide proof of third party reimbursement, to appropriately reduce any allowed Medicaid payment. With the new TPL process, it will no longer be feasible to pinpoint which cases fall into which category. All LTC insurance must now be listed on the TPL file.

Because there are no special income codes to pinpoint these income types, implementation and conversion to this new process will be done by the EW. The EW should evaluate their caseload for instances where insurance payments are budgeted as income. The income must be removed, the patient liability adjusted and a TPL segment added. It is acceptable to inform the facility the individual has long term care insurance that may need to be resolved prior to billing Medicaid. This conversion process may be completed at any time, with a target completion date of 11-01-03. However, if some cases are missed during the initial review they shall be adjusted at the point of discovery.

IV. Living Arrangement Changes

The primary policy changes associated with the new spenddown process are those involving living arrangement changes. Current policy allows for numerous situations in which an individual receiving long term care services also has a spenddown. As indicated above, the new MMIS will only recognize HCBS plans for people with a Medicaid benefit plan. HCBS won't pay for persons with benefit plans of medically needy, even if the spenddown is met. In addition, nursing facility expenses must be entered on MEEX if used against the spenddown and will not be considered if billed through the MMIS. However, payments for nursing facility expenses must still be approved on LOTC. Through these policy changes, the system is better able to accommodate any changes in the existing spenddown.
The following rules apply when processing living arrangement changes. It is important to note that several additional procedural modifications are also necessary for other types of living arrangement change, such as those involving moving to a medically needy program. However, because significant policy changes are not involved the information is not included with this material and is instead incorporated into the training packet associated with these changes. The material provides detailed information for instances when these changes are reported timely as well those not reported timely.

- **Medically Needy to HCBS:** Policy is changing to shorten the base period the month prior to the month HCBS begins, regardless of the status of the spenddown. The previous policy allowing an existing base period to remain in tact if the spenddown had been met at the time HCBS began is being eliminated. HCBS budgeting is applicable in the month HCBS begins, and an obligation may be established. The change in the existing base period will be communicated to the MMIS. If the status of the new, shorter base period is altered in any way by expenses on MEEX, (e.g., it is now met with an expense on MEEX) the EW must inform the client of the met spenddown. The change in the amount of spenddown will be sent to MMIS as previously indicated.

  This new policy is applicable for all new HCBS plans in which action is taken to approve on or after 10-01-03. See item VI (D) for implementation instructions.

B. **Medically Needy to NF:** For persons moving to a Medicaid approved institution independent living budgeting ends the month of entrance (except for children or where spousal impoverishment applies). For existing spenddown cases, the base period is shortened to end the month of NF entrance. Although the same basic practices exist for processing the LTC stay, as LTC budgeting begins the month following the month of entrance, there are several new factors to consider and actions the EW must follow for the shortened spenddown. When processing the medically needy base period, first consider if the resulting spenddown has been met, which will require the EW to review information on the MMIS.

   If the spenddown is met, payment to the NF can begin the day of entrance to the facility. In some cases the spenddown will be met once the base period is shortened. MEEX allowances may also need to be adjusted to remove any expenses no longer included in the base period, such as insurance premiums for other months. In either case, because the spenddown has been met, there is no patient liability for the first month of the stay. LOTC is completed to reflect this.

Important: Although the Y in the CC override field must be in place for all cases in which LTC budgeting is used, the Y in the CC override field will not be used when LTC is provided in a medically needy base period.

If the new spenddown is not met, any resulting patient liability can be used to meet the spenddown. Other expenses can also be used to meet the spenddown, and some expenses may have already been received by the MMIS. These expenses must be considered when establishing the patient liability for the month. Keep in mind these expenses may be from a variety of billing methods.

Before establishing a patient liability, determine the potential cost of the NF for the month. This is established by multiplying the number of days in the NF by the Medicaid daily rate. This figure will be used as a gauge in determining if NF payment will be made by comparing it to the determined patient liability.

The patient liability is based on a modified remaining spenddown amount. The existing base is shortened to end the month of entrance in the facility. Then, information on both KAECSES and the MMIS spenddown files, including expenses that have already been allowed, are considered. If claims exist in the MMIS which won't be paid by Medicaid (PPP = N), credit is given for these expenses, just as is done for non-covered patient liability reductions.

Because of the variation in the type of claims that may have been received in the MMIS, the actual process to determine the amount of allowable claims, and ultimately the patient liability, is outlined in the training material.

Once the patient liability is determined, it is compared to the cost of the NF for the month of entrance. If the NF costs exceed this amount, payment is approved for the initial month and the patient liability is formally put into place. Because the month of entrance is still included in a medically needy base period, the patient is must be listed on MEEX to give proper credit. A new Rem Spenddown amount will appear on SPEN and will be sent to MMIS. If this amount is greater than 0, there should be claims present on the MMIS to satisfy the spenddown amount, so it will be met in MMIS.

To approve NF payment, complete LOTC with the new patient liability amount and other appropriate coding. In the event the total of non-covered claims (PPP = N or BB claims) exceed the spenddown amount they may be allowed against future months obligations.

If the NF costs do not exceed the patient liability, the actual costs of the NF are allowable against the spenddown. The amount should be listed on the MEEX screen. This amount will be sent to MMIS and, if other expenses exist, the spenddown may be met. Again, do not use the Y in the cost of care override field for this situation. LOTC may be completed with payment effective dates determined by the initial month. However, the patient liability would be the full cost of the NF for the month.

Temporary Care: Although the six month base remains in tact, a patient liability must still be computed. If no bills have been allowed as of yet, the remaining

spenddown becomes the patient liability. If the cost of the facility will allow the collection of the entire obligation in the first month, it is appropriate to consider this the patient liability for the first month only. Subsequent liabilities are $00.00 for each month in the base. IF it is not sufficient, the patient liability should be divided accordingly among the following month(s) to account for the full spenddown amount. It is important that the liabilities also be entered on the MEEX screen, so the amount of spenddown sent to the MMIS is $00.00.

However, if bills have been already been allowed, the above process must be followed to determine the amount of actual liability.

If the stay becomes long term, the base period will be shortened to end the final month of the temporary stay, or the third month of LTC. Worker action in these situations can vary depending on if the temp stay spans more than one base period, please refer to the spenddown training material for a detailed explanation of these processes.

C. **Medically Needy to Working Healthy:** The policy for a change from medically needy to WH is similar to policy for those moving to HCBS, as discussed above. The fact that a spenddown is met or unmet is no longer relevant to the base period for these cases. The existing base period is shortened to end the month prior to the month Working Healthy begins. Although some adjustments on MEEX may need to be made (such as adjusting allowance for health insurance premiums), the resulting new spenddown amount and new base period will be sent to the MMIS. Premiums are determined and established beginning the first month of WH coverage.

For some individuals, it may be advantageous to remain in the medically needy program through the end of the existing 6 month base period. For example, a person with a met spenddown. The individual may choose the month WH coverage begins in these instances, provided all other eligibility criteria are met. A referral to the Benefits Specialist is required in these instances and a conference with the Ben Specialist is to be greatly encouraged. This is especially important where the consumer must choose a program path.

V. KAECSES Changes

As a result of policy changes and the new interChange MMIS system, effective 10/13/03, the MEEX and LOTC KAECSES screens are changed as follows:

A. **MEEX:** To support the new spenddown process the following fields and all edits associated with these fields have been removed from the MEEX screen:

DATE SPENDDOWN MET: The interChange MMIS system will calculate and display the spenddown date range.

COV'D EXP: No longer needed as workers will enter medical expenses directly in the interChange MMIS via BB claims, or Medicaid providers will submit medical claims.

SEND DATA TO MEDICAL KAECSES no longer sends
FISCAL AGENT and information to the fiscal agent.
DATE SENT TO AGENT:

During the weekend of October 10th, all medical expenses for base periods that include the month 05/03 will be copied and sent to the interChange MMIS system. EDS will use this information to create BB Claims. As part of this process, the client obligation amount for all medical expenses which the worker identified as a covered expense will be changed to $0.00.

NOTE: After 10/10/03 for the medically needy programs, only the 4 medical expense types outlined in this memo should be entered on MEEX. This is true regardless which benefit month or base period to which these expenses are being applied.

B. **LOTC:** As with MEEX, policy and process changes have obsoleted some LOTC information captured and sent to the current MMIS system. Following is a description of these LOTC changes:

1. Information for an individual now displays in one vertical column instead of horizontal fields. LOTC still accommodates two individuals for those situations when two LTC individuals are on the same case.

2. There is only one effective date for both the Living Arrangement and Level of Care. You will update the date whenever there is a change in either of these two codes.

3. The Provider number and effective date are no longer pieces of information needed so no longer display on LOTC.

4. The Care Plan INDEX (CPI) and CPI Effective Date fields have never been used and are removed from the screen.

Examples of both new screens will be included in the training material. In addition, the KAECSES User Manual will also be updated with this information.

NOTE: With the implementation of the LOTC changes, KAECSES will use the Living Arrangement effective date as the single date to display on LOTC. See item VI (B) below for more information.

C. **Alerts:** As a result of the changes in the MMIS, two new long term care related alerts will now be generated:

"MMIS Retro PL chg pending" - This alert will be produced when a retroactive patient liability change is received by the MMIS except when a corresponding living arrangement change is also received. It will be sent for NF paid claims, an HCBS plan of care or PACE cap payment exist for the month. When NF paid claims don't exist for the month, the update will occur. When the EW receives

this alert, the information on the MMIS should be reviewed carefully by the worker and the supervisor authorized to approve the request to determine which retro liabilities are appropriate

"MMIS HCBS POC CM changed"- This alert will be produced when the case manager's name on the HCBS PA file has been changed. The EW should make note of this. It may also be necessary to share any collateral contact information included on the case.

Several existing alerts are produced when certain information is discovered through the nursing facility billing process. These alerts will continue to be produced, with the information being obtained from the new claim format. Changes in the frequency and accuracy of these alerts is not anticipated. The following alerts are impacted:

"NF says (resident name) died MMDDYY"
"NF says (resident name) to hospital MMDDYY"
"NF (resident name) to other NF MMDDYY"
"NF says (resident name) when home MMDDYY"

The alert, "LTC provider # error", has been eliminated due to the LOTC change described above.

VI. Implementation/Conversion

Information which exists in the MMIS today must be moved to the IC MMIS. It most cases, the information must also be adjusted so that various data elements appear in the correct fields and in the correct formats. This conversion process will be phased in, beginning in September and lasting through the month of October. Although all subsystems in the current MMIS will be converted, complete information is not expected to be available on the new MMIS until late October. To provide access to this information, both the old and new MMIS systems will continue to be operational for a short period of time, with the old MMIS available to select staff for problem resolution for a longer period.

Eligibility workers will not be actively involved in the conversion of the MMIS information. However, because the information coming from KAECSES directly updates the MMIS, this information must also conform to these new standards. The pre-conversion process discussed last spring was the first important step to ensuring the formats are consistent. The KAECSES changes described above also help ensure the information sent to the MMIS will be accepted.

Although some of the information stored in KAECSES will also be converted, it is not possible or efficient, to rely solely on an automated conversion process. Manual action will be needed in some instances. The following describes required conversion activity:

- **Special Medical Indicator Coding (PICK codes):** The implementation and elimination of identified PICK codes requires staff to manually adjust those cases where these codes are currently used. The new codes will be available and the old codes will be end dated beginning 10-13-03. Cases may be converted

starting 10-13. 10-10 is the last day to use the old codes.

Because many individuals already have October eligibility in the MMIS, the conversion of these cases must be completed by November medical card deadline of 10-24-03. If any change is made on the case between 10-13 and 10-24, the new PICK code must be entered at that time. Cases converted to the new PICK codes by the close of business on the first day of the new MMIS will be included on the first file. A printout of all cases with a QE or LM PICK code or a medical program subtype of LO is included. All persons on this list must be reviewed for potential coding changes.

For new cases processed before 10-11-03, the old PICK coding applies and these cases must be converted after 10-13-03. For cases processed on or after 10-13-03, coding should be completed according to the new rules.

B. **Long Term Care Coding (LOTC):** The elimination of the provider number and provider number effective date fields along with the consolidation of the living arrangement and level of care codes will require staff to review potential anomalies in current coding on LOTC. Primarily at issue are situations where effective dates differ. Although it is understood that these coding variations are perfectly acceptable under the current system, these situations could result in an incorrect date being sent to the MMIS. This could result in payment problems and errors when providers ultimately bill.

   To correct, the true effective date must be placed in the Living Arrangement Effective Date field. This date is the date the last living arrangement/level of care became effective. For example, a client was on the HCBS -PD waiver beginning 01-01-99 moved to the FE waiver on 03-01-03. The LOTC screen would most likely reflect a living arrangement effective date of 01-01-99 and a level of care effective date of 03-01-03. In this instance, the latest information is the HC-FE service. Therefore, 03-01-03 should be entered in the Living Arrangement Effective Date field. A printout, sorted by worker, identifying cases where such inconsistencies exist, is attached. To ensure proper conversion, staff should have these cases reviewed and the new codes entered by 10-10-03. Therefore, when the KAECSES file is converted the correct date will be in place.

   Also of concern are cases where the KAECSES living arrangement code is inconsistent with the actual facility billing for the care. An example would be a state hospital billing for a consumer but the LOTC screen reflects a living arrangement code of NF for regular nursing facility. In the new system, the state hospital would not be paid until the living arrangement code was updated to a SH. These instances have been identified and are included on the report 'Living Arrangement/Level of Care Facility Type'. Staff are to review these cases and make any necessary updates to LOTC. If staff discover instances where facilities are billing for non residents or other discrepancies, please report these to the local Medicaid liaison. As above, this action should be completed no later than 10-24-03, but work may begin on these corrections immediately.

C. **Retro Patient Liability:** With the implementation of the new retro liability process, the current process will terminate. All requests for adjustments must be

received by the proper authorizer by close of business on 09-30-03. Requests received after that date will not be acted upon. Unless dealing with an urgent issue, policy recommends holding all such requests until after the new process is operational.

D. **HCBS:** As per item VI (B) above, HCBS cannot be approved for persons with medically needy benefit plans. For MS programs, the Y in the CC override on SPEN must be present to allow HCBS to exist. The policy change to always begin HCBS budgeting with the month HCBS begins will support this new rule in the MMIS. It is applicable for HCBS plans in which action is taken to approve on or after 10-01-03. However, several cases currently exist in the MMIS where this combination does exist because policy allowed it. Therefore, the system will accept combination medically needy and HCBS benefit plans only through 10-31-03. Following that date, HCBS will only be allowed on Medicaid (Title XIX) plans.

   To support this change, all cases where LOTC indicates HCBS is appropriate, but no CC override is present on the file must be reviewed. A report identifying such persons is included with this material. For cases win a one month base, the 'Y' should be added to the existing case beginning in the benefit month of 10-03. For cases currently in a base period exceeding one month, a 'Y' should be added to only those months in the base period in which HCBS budgeting and services are effective. At the end of the existing base period, HCBS budgeting begins, including one month bases.

   For example, Susie has an existing base of July - December. She met her spenddown effective July 5th. On August 5 she is approved for HCBS beginning July 23. Because the spenddown was met, LOTC was completed without an obligation. New MMIS rules require the Y in the CC override field to correctly set the benefit plan on MMIS. The CC override Y is coded for 10-03, 11-03 and 12-03. HCBS budgeting, including one month bases begins in January.

   This report must be reviewed and all appropriate changes made by 09-30-03

   Clean up Report: A report will also be issued that lists cases currently coded HCBS but an HCBS claim has not been received in 6 months. Although this isn't critical to these MMIS implementation issues, it is important that these cases be cleaned up and eligibility adjusted if necessary. It may be necessary to contact the appropriate case manager for additional information.

E. **Medically Needy/Spenddown:** The vast majority of implementation work with the new medically needy procedure will be completed by an automated conversion program. This is possible because of the pre-conversion work to enter provider numbers and change the coverage indicator on the KAECSES MEEX. KAECSES will now send this information to the MMIS and place it in the same type of file that will be used with the new system. The information on the system will look like a BB claim. If a provider bills, the MMIS now has the KAECSES information to determine if the bill has been allowed against the spenddown already. Please keep in mind, however, that the special conversion process is only applicable to base periods which include months on or after May, 2003. Manual intervention maybe necessary when altering any base period prior

to this date. Please contact HelpDesk to determine proper procedures for making such changes.

The spenddown program will officially be switched over on 10-13-03, when the KAECSES changes are migrated. Prior to this date, the current rules for MEEX entry still apply. Therefore all expenses must be entered on MEEX by close of business on 10-10-03 or they must be applied under the new rules, using one of the 3 billing methods. For this reason, beneficiaries will be notified in the special newsletter that all expenses must be submitted to the agency prior to 10-01-01 in order to ensure they are allowed. Staff are encouraged to act upon these even when received after this date, especially if the spenddown will be met. This is because there will be no eligibility update for two days, which could delay provision of coverage.

F. **Special October Procedure:** The implementation of the new spenddown process mid-month presents some special challenges. Because medical cards for the month of October will be sent out under current rules and, persons currently on spenddown will not be sent a card through the batch process. These beneficiaries will receive their first medically needy card in November through the monthly cycle. Brand new approvals will receive a card through the daily cycle, beginning 10-13, but only if the case is authorized during that week. In addition, the agency discourages beneficiaries from submitting expenses to the local office, as we want the provider to bill MMIS directly where possible. These factors would result in a beneficiary potentially unable to meet a spenddown during most of the month of October unless an alternative plan were developed.

To provide beneficiaries sufficient information about the month of October, a special notice will be sent to all persons we anticipate will be assigned a medically needy benefit plan. Recipients of the notice will be instructed to show the letter to their medical providers, as they will probably not receive a medical card for October. The purpose of the notice will be to provide information to the provider to bill KMAP: beneficiary ID number, name and date of birth. The notice instructs providers that it is NOT a guarantee of payment and they must verify eligibility through other means.

The letter will be sent with the special flyer telling the client about the new spenddown process describe in section II (L) above.

The letter and flyer will be produced on the night of 09-26-03. All cases current cases and new approvals processed on or before this date will receive the information, this includes pending and later reviews. For cases approved after this date, the EW must provide information on the new spenddown process directly to the beneficiary. The EW may produce a copy of the special spenddown letter or can elect to reauthorize the case during the week of 10-13, and rely on a card be mailed through the batch process.

A copy of the special letter for October is included with this material. One letter will be sent per household which lists all persons currently participating on the case. It is important to remember that providers will not be able to input bills until the new system is operational, about 10-16-03.

In closing, it is important to again stress the importance of the information in this memo. The instructions are numerous, but were developed with the goal of using this memo as an ongoing resource. It is also important to keep in mind that some aspects of the interChange MMIS are still in development, and are quite likely to change some of the instructions in this material at some future point. If significant changes are made, we are prepared to reissue this material.

This material was coordinated and developed by the Spenddown Implementation Team. Those participating include Cheryl Woods, Lauri Corcoran, Kristi Scheve, Susan Craig and Mark Wunder with EES Central Office; Candy Cunningham, Thelma Bowhay, Linda Davidson and Patty Shoemaker with HCP; Mary Inman and Nancy Carpenter from Topeka SRS; Kay Wiese, Abilene SRS; Kirk Maher, Medicaid Liasion, Topeka and Diane Dreyer, HealthWave Clearinghouse.

f you have any questions about this material please contact Jeanine Schieferecke at (785) 296-8866. System-related questions or concerns should be sent to SRS HelpDesk.

BM:JS:jmm

Attachments: Guide to Spenddown/LTC Implementation Memo
Notice to Medically Needy Client
KAECSES Notices Flagged for Update
Spenddown/Long Term Care Changes

cc: Bob Day
Nialson Lee
Spenddown Imp Team
EES Central Office Staff
HCP-MP Senior Managers
SRS HelpDesk
Mary Ellen Wright
HCBS Waiver ManagersMargaret
Zillinger
Fran Seymour-Hunter
Bill McDaniel, KDOA
Joyce Smith, KDOA
Dave Halferty, KDOA
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Lona Hoffsommer, EDS