



Policy Memo

KDHE-DHCF POLICY NO: 2012-12-01	From: Russell Nittler Senior Manager – Medicaid Eligibility
Date: December 31, 2012	KEESM Reference: 2600 KFMAM Reference: 2000
RE: KanCare Implementation	Program(s): All Medical Programs

The purpose of this memo is to provide instruction to medical eligibility staff concerning implementation of the new statewide managed care initiative, known as KanCare. Effective January 1, 2013, most of the state’s medical assistance beneficiaries will be assigned to a Managed Care Organization (MCO) which will coordinate all of the beneficiary care. The changes contained in this memo will be incorporated in the Kansas Economic and Employment Support Manual (KEESM) and the Kansas Family Medical Assistance Manual (KFMAM) at the next scheduled revision.

A. Background

In January of 2012, the Governor tasked the Lt. Governor and a working group of cabinet members with fundamentally reforming Medicaid. The goal of this reinvention process was to serve Kansans in need with a transformed, fiscally sustainable Medicaid program that provides high-quality, holistic care and promotes personal responsibility. After months of public input from providers, beneficiaries, and other stakeholders from around the state, the KanCare initiative was conceived.

B. KanCare

- 1. General** – KanCare is the state’s plan to transition Kansas Medicaid into an integrated care model. Kansas has contracted with three new health plans (MCOs) to begin coordinating health care for nearly all Medicaid beneficiaries. The KanCare program is scheduled to begin in January 2013. The current HealthWave and HealthConnect Kansas programs will end December 31, 2012 with services provided through the new health care plans beginning January 1, 2013.

All current Medicaid services will be provided through the KanCare plans. This includes physical health services such as doctor appointments and hospital visits, behavioral health services, dental and vision care, pharmacy, transportation, nursing facility care, and home and community based services (see below

Rm. 900-N, Landon Building, 900 SW Jackson Street, Topeka, KS 66612-1220
www.kdheks.gov/hcf/

Medicaid and HealthWave:
 Phone: 785-296-3981
 Fax: 785-296-4813

State Employee Health
 Benefits and Plan Purchasing:
 Phone: 785-368-6361
 Fax: 785-368-7180

State Self Insurance Fund:
 Phone: 785-296-2364
 Fax: 785-296-6995

for IDD exception). The new health plans also offer additional new services (called value-added) not typically covered under Medicaid.

- 2. Managed Care Organizations** – The state of Kansas has contracted with the following three MCOs: Amerigroup of Kansas, Inc. (**Amerigroup**), Sunflower State Health Plan (**Sunflower**), and United Healthcare Community Plan of Kansas (**United**). Each Medicaid beneficiary will be assigned to one of these plans. The company link to each plan for additional information follows:

Amerigroup <http://myamerigroup.com/ks>

Sunflower <http://www.sunflowerstatehealth.com/>

United <http://www.uhccommunityplan.com/>

All current beneficiaries subject to managed care under either Unicare or Coventry will be transitioned from these plans to one of the three new MCOs effective 01/01/2013.

- 3. Covered Programs** – Under KanCare, the majority of medical beneficiaries will be subject to managed care assignment. However some groups will still be provided coverage under a fee for service model.

Note: Traditionally, most Medicaid consumers received coverage under a “fee for service” model, meaning that when they received care the provider was paid directly for a specific service. Under the KanCare program Medicaid will fund the MCOs who will coordinate care for consumers.

MCO Assignment – Beneficiaries of the following programs will be assigned to one of the three MCOs:

- Title 19 (including presumptive)
- Title 21 (including presumptive)
- Medically Needy (met or unmet)

Fee For Service – Beneficiaries of the following programs will not be assigned to an MCO, but will be covered under fee for service:

- MediKan
- SOBRA
- TB
- Inmate Inpatient
- QWD
- ADAP-only
- QMB-only
- LMB-only
- ELMB-only
- State Hospital Residents (SH/SD)
- Nursing Facility Residents – No State Payment (NS/NA)
- Mental Health Nursing Facility Residents (age 22 thru 64)
- IDD HCBS Waiver Services (thru 12/31/2013)

Program of All-Inclusive Care for the Elderly (PACE) – PACE program beneficiaries will neither be assigned to an MCO under KanCare nor be covered under fee for service. Coverage for these individuals

will continue under the PACE entity's existing provider network through either Via Christi HOPE (Sedgwick county) or Midland Care Center (Douglas, Jackson, Jefferson, Pottawatomie, Shawnee, and Wabaunsee counties).

C. Enrollment Process – The following provisions apply to the MCO assignment process.

- 1. Existing Consumers** – All active recipients subject to managed care with coverage continuing into 01/2013 were automatically assigned to one of the three MCOs effective 01/01/2013. In late November or early December 2012, each consumer received an enrollment packet in the mail notifying them of the automated assignment. The packet also provided information on each of the three plans, and the process to change plans if so inclined.

Change Before 01/01/2013 – If the consumer changed plans prior to 01/01/2013, then the new plan they selected is effective 01/01/2013.

Change After 01/01/2013 – The consumer still has the option to change plans on or after 01/01/2013 for 90 days from that date. The change will be effective the first of the following month. After the 90 day choice period, the consumer is committed to the plan through the end of 2013. The next opportunity to change plans will be during their annual open enrollment period – generally 12 months after the initial assignment.

- 2. New Consumers** – All new applicants have the opportunity to choose their MCO at the time they apply. Both the paper and online applications have been revised to allow the applicant to select an MCO through that process. In addition, the Aging and Disability Resource Centers (discussed below) may provide assistance to applicants/beneficiaries in the selection of an MCO.

If an individual does not make a selection on the application, they will be automatically assigned a plan. Once an individual has been assigned to a plan, they have 90 days to change plans. The 90 days begins with the date of approval/enrollment. Once assigned to a plan, consumers may only change their plan during their annual open enrollment period. The open enrollment period is generally 12 months after the initial assignment and every 12 months thereafter. Each beneficiary will be notified when it is time for their open enrollment.

There are a few good cause reasons that will allow a consumer to change their plan outside of their initial 90 day choice period and their annual open enrollment. Consumers should call the Managed Care Enrollment Center if they have any questions.

- 3. Enrollment Phone Number** – The phone number for the Managed Care Enrollment Center is **1-866-305-5147**, available 8:00am to 5:00pm Monday through Friday.

- D. Opt Out** – American Indian and Alaska Native beneficiaries are not required to enroll in an MCO plan. They will initially be assigned to one of the MCOs upon KanCare approval, however, they may choose to opt out of managed care by contacting the Managed Care Enrollment Center. Proof of tribal affiliation is required. Once opted out, the beneficiary will be covered under fee for service. Native American CHIP consumers are not permitted to opt out of managed care as there is no CHIP fee for service program.

- E. Medical Card** – Each beneficiary will receive only one medical card. The card is valid and may be used as

long as coverage under the entity issuing the card continues.

- 1. Managed Care** – Each KanCare beneficiary will receive a medical card from the assigned MCO. If there is a break in coverage for 30-60 days (depending on the MCO), a new card will be issued – even if coverage is simply being re-instated/re-authorized.
- 2. Fee For Service** – Every fee for service beneficiary will receive a medical card issued by the medical billing agent, HP Enterprise Services. A new card will be issued if there has been a break in assistance of more than 12 months.
- 3. PACE Recipients** – Beneficiaries enrolled in the PACE program will receive a medical card from the PACE entity serving them – either Via Christi HOPE or Midland Care Center.
- 4. Replacement Cards** – The issuing entity should be contacted for card replacement. A KanCare beneficiary may contact the MCO for a replacement card. The HP Customer Service Unit may be contacted by the beneficiary for replacement of the fee for service card. A PACE beneficiary should contact the PACE entity for card replacement.

F. Extra Services – As indicated in section B.1. above, each of the KanCare health plans offer additional new services, also called value-added services, not typically covered under Medicaid. Some of these services are medical in nature, while others are more in the form of a financial benefit. Those value-added services which are a financial benefit will not impact eligibility.

All membership enhancement benefits provided to KanCare beneficiaries by the contracting MCO such as debit card credits, gift cards, membership fees, credits toward product purchase, clothing and gear, cell phones and minutes, are exempt as income in the month received and as a resource in the following months.

A chart with the extra services offered by each MCO is included as an insert in the KanCare family application and as an attachment to the ES-3100 and ES-3100.1 applications.

G. KAECSES Coding – The MCO selection indicated by the consumer on the application for each individual is entered by eligibility staff in the KAECSES system for transmission (along with the eligibility record) to MMIS. Four new “person only” PRAP codes have been created for this purpose.

The following are the KAECSES PRAP screen MCO plan codes:

- K1** – Amerigroup
- K2** – Sunflower
- K3** – United
- K4** – No Selection

If more than one of these codes is present on the PRAP screen for an individual and transmitted to MMIS, the case will default to an automated assignment. The same is true if no plan code is entered. Therefore, it is critical that only the correct plan code is entered and any other plan code on PRAP should be removed.

These codes are tied to the application date and only used for the initial assignment. Once assigned to a plan, as long as there is continuous KanCare eligibility, the codes will no longer affect assignment. If KanCare coverage ends and a new application is later filed, these codes may once again determine plan

assignment.

Note: If an application is received without an MCO choice because it was an old application with no choice information or the applicant simply failed to choose a plan, eligibility staff are not required to contact the applicant. If KanCare coverage is approved, the K4 (No Selection) PRAP code shall be entered. After an automatic MCO assignment has been made, the recipient then has the opportunity to select a different plan during the 90 day change period.

H. Retro Assignment – There are three situations in which an applicant will be retro-assigned to managed care: prior medical eligibility, 90-day reattach period, and newborn eligibility. There is no change to the policy for retro CHIP eligibility.

- 1. Prior Medical** – When eligibility is approved within 60 days of the application date, the three months prior medical under Title 19 or Medically Needy coverage will be assigned to managed care.
- 2. 90 Day Re-attach** – When a consumer loses eligibility, their managed care assignment ends. However, if eligibility is re-established within 90 days of the end of coverage, the individual will be re-attached to the original MCO selection. This could occur at the end of a review period if the consumer does not return their review timely, but also will occur if a case is accidentally de-authorized. To avoid churning of coverage from managed care to fee for service and back to managed care, eligibility staff should take particular care to make sure that every case is rolled forward and authorized in the current month whenever case maintenance is performed.
- 3. Newborn Eligibility** – Newborns born to a KanCare consumer will be automatically assigned to the same health plan which the mother was assigned to.

Any eligibility approved for months greater than 3 months prior to the month of application will be covered under fee for service. Approval for a gap in coverage greater than 90 days (ie: case inadvertently de-authorized and then re-authorized several months later) will also be fee for service. An overlay of Title 19 - Medicaid, CHIP, or Medically Needy (spenddown) coverage on a fee for service program will continue as fee for service for the months of the overlay. In addition, any new or pending application approved on or after 01/01/2013 for months prior to 01/2013 will be fee for service for the months prior to 01/2013.

Example 1: An application for Title 19 coverage is received on 04/10/2013 with a request for prior medical. Coverage is approved on 05/07/2013, including prior medical. Eligible individuals will be assigned to managed care beginning 01/01/2013.

Example 2: An application for Title 19 coverage is received on 5/10/2013 with a request for prior medical. Coverage is approved on 8/1/2013, including prior medical. Eligible individuals will be fee for service for February 2013 – July 2013. They will be assigned to managed care effective 8/1/2013.

Note: Because the approval occurred more than 60 days past the application date, there is no retro eligibility. The managed care assignment is effective the current month.

Example 3: A Medically Needy recipient is closed effective 01/31/2013 for failure to complete the review process. A new application is received on 04/18/2013 with a request for prior medical. The application is approved on 5/25/2013; therefore eligible individuals will be assigned to managed care

beginning 02/01/2013.

Example 4: Coverage for a Title 19 recipient is discontinued effective 02/28/2013 due to an inadvertent de-authorization of the case. The error is discovered on 10/17/2013 and coverage is re-authorized back to 03/01/2013. The recipient will be fee for service for March 2013 – September 2013. Managed care assignment begins again on 10/1/2013.

Example 5: A MediKan recipient receives a favorable disability determination from SSA on 09/23/2013. On 10/04/2013, Medically Needy coverage is overlaid back to 03/01/2013. The recipient will be assigned to managed care effective 11/01/2013 (the month after case action). All other overlaid prior months (03/2013 through 10/2013) will remain fee for service.

Example 6: A Medically Needy application filed on 12/21/2012 with a request for prior medical is approved on 1/28/2013. The months prior to 01/2013 (09/2012 through 12/2012) are fee for service. Managed care assignment begins 01/2013.

I. Programs – The following programs are affected by the KanCare initiative.

1. Home and Community Based Services (HCBS) – The HCBS process will be changing for most of the waiver programs. In addition to the involvement of the MCOs, a new entity, the Aging and Disability Resource Center (ADRC) has been contracted to provide counseling, referral, and assessment services for those seeking assistance under the Frail Elderly (FE), Physically Disabled (PD) and Traumatic Brain Injury (TBI) HCBS waiver programs.

Aging and Disability Resource Center (ADRC) – The Aging and Disability Resource Center (ADRC) is a statewide network of 11 Area Agency on Aging centers. These centers will be responsible for counseling individuals on available services and providing assistance in the selection of the MCO plan most beneficial to their needs. If an individual chooses HCBS services, the ADRC will complete the functional screening assessment for the FE, PD, and TBI HCBS waiver programs. Individuals requesting assistance under these waiver programs may contact the ADRC directly for assistance or be referred by DCF eligibility staff as part of the formal application process.

Please note that the ADRC will not set up a plan of care for individuals who pass the functional screening assessment and choose HCBS services under one of these three waivers. Development of a plan of care will be the responsibility of the assigned MCO Case Manager once KanCare eligibility has been established and transmitted to the MCO.

A list of the 11 regional ADRCs may be located on the Kansas Aging and Disability Resource Center web site at http://www.ksadrc.org/Local_ADRC_Locations.pdf. The ADRC statewide call center number is **1-855-200-2372**.

Communication – Communication between eligibility staff and the HCBS assessment/case management entities will be via the newly modified ES-3160 (Initial Referral/Eligibility) and ES-3161 (Changes/Updates) forms. The forms have been updated to capture additional information.

Processing – The method of processing a request/application for HCBS services will depend on the applicant's KanCare status at the time of request/application. A separate attachment (Attachment A) to

this memo outlines the new processes in some detail.

2. **Money Follows the Person (MFP)** – The eligibility processes for individuals qualifying for Money Follows the Person (MFP) coverage is not changing. If eligible, the MCO Case Manager will send an ES-3160 to eligibility staff indicating eligibility, associated waiver type (i.e.: FE, PD, I/DD, or TBI) and planned nursing facility discharge date. Eligibility staff will respond to the Case Manger via the ES-3160 and notify of any subsequent changes/updates via the ES-3161.
3. **Institutional Living** – The eligibility processes for individuals in long term care institutional arrangements are not changing. The facilities remain responsible for sending the MS-2126 to eligibility staff upon admittance and at discharge. Eligibility staff will continue to notify the individual and facility of eligibility and patient liability via system notice.
4. **PACE** – As PACE is not part of the KanCare managed care initiative, the eligibility processes are not changing. Eligibility staff and the PACE entities will continue to communicate via the ES-3166.
5. **Working Healthy/WORK** – In general, the eligibility processes for the Working Healthy and WORK programs are not changing. Eligibility staff will continue to refer interested individuals to the Working Healthy Benefit Specialists via the ES-3160. The Benefit Specialists will communicate with eligibility staff in the same manner.

With the initiation of KanCare, it has become more important than ever to ensure that a Working Healthy/WORK recipient is not delinquent on their premiums. To enable staff to better monitor premium payment status, the following process has been developed:

Alert/Report – A KAECSES alert is created once a recipient is a full 2 months behind in premium payment, indicating the Working Healthy/WORK coverage should end due to delinquency. A delinquency report is also generated and sent to the Working Healthy Program Coordinator. Absent information to the contrary, eligibility staff are to end coverage giving timely notice.

Non-Delinquency – The Working Healthy Benefit Specialists will continue to monitor those cases where coverage has ended due to premium delinquency. If the individual makes payment and becomes non-delinquent during the month coverage ends, the Benefit Specialist will notify eligibility staff. Action should then be taken to re-instate coverage.

Further Monitoring – The Working Healthy Program Coordinator will continue to monitor the delinquency report. Should a delinquent individual remain open into the second month, the Benefit Specialist will send an ES-3161 to eligibility staff to end coverage. If no action has been taken to end coverage by the second day prior to adverse action deadline, the Benefit Specialist may send another ES-3161 requesting closure.

Note: Whenever an individual is no longer eligible for coverage under the Working Healthy program, staff should always determine if eligibility is appropriate under any other program (such as Medically Needy – spenddown).

6. **LOTIC Coding** – As a continuing point of emphasis, it is vitally important that all cases are processed correctly, timely and coded properly to ensure appropriate coverage for the beneficiary and correct

payments to the MCO's. The level of care received by the individual will determine the capitation rate paid by the state to the MCO. For recipients in long term care, that rate will be based in part on the Living Arrangement (LA) and Level of Care (LOC) information transmitted from the KAECSES LOTC screen to MMIS. Incorrect or missing coding will result in inaccurate coverage and payments. Therefore, additional care should be taken to double check the work performed when processing a long term care case.

7. **Medically Needy (Spendedown)** – Medically Needy cases will continue to be processed in the same manner under KanCare. The assigned MCO will be responsible for covering services once the spenddown has been met. The individual remains responsible for the cost of services applied against the spenddown amount.
8. **Family Medical** – As indicated above, all individuals receiving coverage under the family medical programs and previously assigned to managed care under either HealthWave or HealthConnect Kansas will end that assignment effective 12/31/2012. Beginning 01/01/2013, all family medical recipients will transition to one of the three new MCOs. Since this population has always been subject to managed care, the transition to KanCare is anticipated to be less eventful than the groups where this will be new.
9. **MACM** – Individuals approved for the caretaker medical program should be approved on the MA program with a CM program subtype. Setting up the program as MA only, without the CM subtype is a common coding error that is found. Always double check the program codes to ensure correct payment to the MCOs.
10. **Breast and Cervical Cancer (BCC)** – Individuals eligible for the BCC program have special coding on the PICK screen. Once eligibility for BCC ends, the PICK codes must be removed in order to prevent future payment errors.
11. **Medical Transportation** – The medical transportation contract with Medical Transportation Management, Inc. (MTM) is ending 12/31/2012. KanCare recipients in need of medical transportation effective 01/01/2013 may call their assigned MCO for assistance or the direct numbers listed below. Native Americans or Alaska Natives who choose to opt out of KanCare and are covered under fee for service should call Customer Assistance at **1-800-766-9012** for assistance. There is no medical transportation assistance for non-KanCare individuals.

Amerigroup – Amerigroup has contracted with Access2Care: **1-855-345-6943**.

Sunflower – Sunflower has contracted with MTM: **1-877-722-2308**.

United – United has contracted with Logisticare: **1-877-796-5847**.

12. **Medical Subrogation** – The MCOs will handle medical subrogation for the beneficiaries assigned to them. Eligibility staff shall send all medical subrogation referrals to the KDHE-DHCF TPL Unit at the address below. The TPL Unit will then distribute the referrals to the appropriate entity for processing.

Office of the Fiscal Agent
TPL Department
P.O. Box 3571

Topeka, KS 66601-3571
Fax: 785-274-5918

The two medical subrogation referral forms, R-1 (Adoption) and R-2 (Injury) in the KEESM Appendix have been updated with these changes.

J. Updated Forms – The following forms/guides have been updated or created with the KanCare implementation.

- 1. Applications** – The HealthWave application has been updated and is now called the KC1100 (KanCare Family Medical Application). ES-3100 (Family Application), ES-3100.1 (Elderly & Disabled Application), and ES-3100.7 (BCC Application) have all been updated to include a section allowing the applicant to choose an MCO. The KC1100 and ES-3100.7 are for immediate use. A stuffer (attached) will be added to the current ES-3100 and ES-3100.1 to capture the MCO choice. Once the existing stock of these applications has been exhausted, the updated ES-3100 and ES-3100.1 will be available for use.
- 2. HCBS Referral/Change Forms** – The ES-3160 (Initial Eligibility/Assessment Referral) and the ES-3161 (Changes/Updates) have both been updated effective 01/2013 to capture additional information.
- 3. Medical Subrogation Forms** – The two medical subrogation referral forms, R-1 (Adoption) and R-2 (Injury) located in the KEESM Appendix have been updated with the new mailing address.
- 4. New Forms/Guides** – The following new forms/guides have been created for use beginning 01/01/2013.

MCO Contact List – This form lists the HCBS contact for each of the MCOs.

Extra Services Highlights (KC2120) – This form outlines the extra services provided by each of the KanCare health plans. It is included as an insert in the Family Application packet and should be attached to the ES-3100, ES-3100.1, and ES-3100.7 applications.

MCO Choice Stuffer – This form was created for temporary use to allow new applicants using the existing ES-3100 and ES-3100.1 application forms to document an MCO selection.

- 5. KAECSES Notices** – Most of the medical notices in KAECSES have been updated with changes associated to KanCare. These changes include rebranding of the program names and instructions to consumers about receipt of their managed care packets and ID cards. In addition, most of the names were changed for the MP notices. The notices remain the same and are still used for the same purpose, but the name was reworded for clarity.

Conclusion

If you have any questions or concerns about the information in this memo, please contact:

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