



KANSAS

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DIVISION OF HEALTH POLICY AND FINANCE

MEMORANDUM

TO: SRS/EES Regional Office Staff
HealthWave Eligibility Clearinghouse Staff

DATE: December 19, 2005
End dated 12/05/2011

FROM: Scott Brunner, Medicaid Director
Bobbi Mariani, EES Director

RE: KEESM Revision 26 Implementation
Instructions for Medical Program
Changes

The purpose of this memo is to communicate implementation instructions for medical program changes included in KEESM Revision 26. A separate memo provides instructions for other program changes in the revision. Changes are primarily related to Medicare Part D and the Medicare Subsidy. Please note the following previous guidance:

- **EES Policy Memo 05-05-02** - Medicare Part D Subsidy Application Process, dated 05-09-05
- **DHPF Memo** - Auto Enrollment of Medicaid Beneficiaries into a Medicare Prescription Drug Plan, dated 10-31-05
- **EES/DHPF Memo** - Medicare Part D Protocol, dated 11-01-05
- **EES/DHPF Memo** - Implementation of Medicare Part D and the Medicare Part D Subsidy, dated 11-07-05
- **EES Training Material** - Medicare Part D Training, Session 1 and Session 2

Please reference these other sources for additional information regarding Medicare Part D. All changes are effective January 1, 2006 unless otherwise noted.

I. The ES-3100.8

Application for QMB, LMB, E-LMB and Medicare D Subsidy. This new application for coverage has been developed to provide an avenue for persons to apply for only a Medicare Savings Plan or Medicare D Subsidy. The application cannot be used to determine eligibility for other programs, including other Medicaid programs.

Because the application is designed only for Medicare Savings Plans and Medicare D Subsidy, it cannot be used to determine coverage under other medical programs. Persons requesting assistance under other Medicaid programs must complete an application appropriate for the requested program. The date the ES-3100.8 is received provides a protected filing date for all

medical assistance programs, if a new application and verification are received within 45 days. Persons initially approved for a Medicare-related group with an ES-3100-8 may be redetermined only for other Medicare-related programs until an application appropriate for another medical program is received.

Examples:

Betty Lou completes a 3100.8 for QMB coverage on 02-10-2006. On 02-17-06, while her application is pending, Betty Lou falls and moves into an NF. She is now requesting full Medicaid. An ES-3100.4 must be obtained in order to determine eligibility for LTC. If the new application and all documentation are received within 45 days of the original application (02-10-06), the original filing date is used. If the application is received within 45 days, but the verification has not been received, the date the new application arrived is considered the application date.

Mary Lou has an ongoing QMB only case, which was processed using an ES-3100.8. An ES-3160 is received with an HCBS - FE effective date of 05-25-2006. Because the ES-3100.8 can not be used to determine full Medicaid coverage, a new application is needed. QMB coverage continues until the end of the current review period, even if the new application is not received.

Please remember that Estate Recovery is not applicable to beneficiaries who only receive Medicare Savings Plan or Medicare Part D subsidy. It is critical that recipients being converted to new programs understand the implications of Estate Recovery prior to changing coverage.

An initial supply of the new application has been ordered and will be distributed to Regional SRS Offices when they are available. Additional supplies may be ordered through the warehouse.

II. Review Extension (KEESM 9310)

This revision implements a new option for completing eligibility reviews. A formal application is no longer required to complete a review when specific eligibility changes are being processed. When a change is processed which results in a change in eligibility a new review may also be completed. This special process is called a review extension. Review extensions are essentially a full review without an application.

Review extensions are only applicable for certain medical programs. It is not appropriate to use the extension for food stamps, cash assistance or other types of medical coverage. The extension is optional. When used, the fact that a review extension was completed must be documented in the case file.

The extension may only be used for medical programs involving Medicare-related coverage. The specific instances where a review extension may be completed include the following changes in coverage:

- QMB or LMB to Medicare D Subsidy;
- QMB to LMB or vice versa;
- Full Medicaid (including Medically Needy, but not programs where resources are not tested) to QMB, LMB or Medicare D Subsidy;

Review extensions may also be used for any scheduled TB review.

KAECSSES Note: Prior to completing an extension, a review dates must be entered on the KAECSSES RERE screen. The date the change is processed is used as the Review Received Date for this purpose.

Example1: Larry is a 70 year old ongoing QMB only recipient. In 03-2006, Larry reports he started working part time and provides proof of his earned income. His income is now over the QMB limit but he will be eligible for LMB. The TPQY verifies Larry's unearned income and Larry's resources were well below the limit at the last review. The worker determines a review extension may be processed. On 03-27-06, the case is processed and the change is made effective 05-2006, to meet notice requirements. 03-27-06 is entered on RERE as the date the review is received. On SPEN, a new "review through" date of 04-07 is entered. A review notice is then sent to Larry telling him about the change in coverage.

Example 2: Terry is a 54 year old Working Healthy recipient. She is afraid of Estate Recovery and asks to be switched to Expanded LMB effective 07-2006, prior to reaching age 55. Terry has reviewed the plan with her Benefits Specialist. Changing from Medicaid to LMB only is listed in KEESM 9310.1 as a reason to complete a review extension, so the eligibility worker elects to complete the extension. The review is registered with the current date. A review through date of 06-2007 is entered on SPEN.

Example 3: Mary and Jerry are married Medicare beneficiaries who are LMB eligible and receive food stamps. Jerry received the final payment on a contract sale in 04-2006. When the case is rebudgeted for 05-2006 without the payment, the couple become QMB eligible. The food stamp case is also adjusted. The worker elects not to complete the review extension in this situation, because the review extension is not an option for food stamps. Reviews for both the medical and food stamp programs currently occur in the same month and the worker determines it is best to keep the reviews consistent. The case is adjusted for 05-2006 and a notice is sent.

III. Medicare Part D Updates -

There are several updates to address since the release of the implementation memo. Issues involve automated systems, CMS implementation changes and general policy guidance.

A. Automated Systems -

1. **MMIS Changes:** The changes to the MMIS are scheduled to be migrated in stages. The first change will be made immediately prior to the production of January medical cards. Because Part D information will be displayed on the medical card, a special process to determine this date is being incorporated into medical card production for January, 2006. Medicare D entitlement will be printed on the card for anyone with either Medicare Part A or Medicare Part B entitlement indicators in the MMIS. However, Medicare Part D coverage will not be reflected for the beneficiary in a specific window in the MMIS until a later stage of implementation.

The exact migration date for other MMIS changes has not been determined, but is anticipated to occur during the last week of December. However, most fields on the new windows will not be populated until early January when the majority of eligibility changes are made. Updates to the windows and batch processing to populate the windows is scheduled to run on January 6.

2. **KAECSSES Changes -** All KAECSSES changes will be available to users beginning

January 9. Changes include updates to the MEIN, MERE and MSID screens, a new SUDD screen and the new MD PICK code. A batch process to update existing MEIN records with Part D information is scheduled to run prior to January 9 as well. Subsidy applications may be processed beginning January 9. In addition, numerous MS and SI notices will be revised to reflect the Medicare Part D Subsidy changes and some new notices will be created. A separate announcement will be sent at a later date regarding these notices.

3. **MMIS Delay in Processing KAECSES Records** - In order to accommodate the migration scheduled for both systems, MMIS will delay processing KAECSES records received on Friday, 01-06-06 until Sunday evening, 01-08-06. This means that MMIS data will not reflect approvals and changes processed on Friday (January 6) until early Monday morning (January 9). Central office recommends processing any priority case on Thursday, January 5 to ensure that full eligibility is displayed. All information processed during the delay will be stored with a date/time stamp to ensure a correct record is displayed upon processing.

- B. **Spenddown, Patient Liability and Client Obligation** - As previously indicated, out of pocket costs to the Medicare beneficiary for prescription drug expenses are allowable against spenddown, patient liability and client obligation. Copayments and prescriptions used to meet a deductible are allowable. Expenses which are non covered due to formulary restrictions are only allowable after the Medicare beneficiary has requested a coverage exception. See attachment A for more information about the Medicare appeals process.

For patient liability and client obligation reductions, there is no change to the process previously outlined for allowing these expenses. However, it is important to make note of the new coverage protections CMS provides prior to allowing an expense (listed below), as all other payment sources must be utilized prior to allowing the expense.

For spenddown purposes, instructions are being updated. Based on current information available, it does not appear that pharmacy providers will electronically bill cost sharing associated with a Medicare D drug. The claim format which pharmacy providers must use does not easily support documenting partial payment of an expense. Without a routine method of billing, it is not possible for the MMIS to determine the amount the client was actually responsible to pay. Therefore, provider billed claims for cost sharing related to Medicare D covered drugs will not be possible at this time.

Copayments and deductibles related Medicare D covered drugs must be submitted to the eligibility worker and entered as a beneficiary billed expense. Expenses for non-Medicare beneficiaries and non-Medicare covered drugs may continue to be billed electronically through the MMIS. As with any expense, these costs are only allowable if the expenses is actually charged to the individual. If the pharmacy decides to waive the copayment, the expense is not allowable.

Billing forms and methods used by pharmacy providers continue to be discussed at both the state and national levels. Other options are currently being explored to accommodate several special billing processes, including those related to spenddown.

- C. **ADAP Coverage** - Payment for medications under the AIDS Drug Assistance Program will also be changing with Medicare Part D. ADAP will continue to provide coverage for non-Medicare beneficiaries at current levels. Persons with Medicare coverage will continue to

be eligible for ADAP coverage, but Medicare drug coverage must be used first. ADAP will provide the following assistance to persons with Medicare Prescription Drug coverage:

- For persons who are Medically Needy with an unmet spenddown - ADAP will cover medications on the ADAP formulary, including copayments and other cost sharing. These costs will be paid with state funds and will be allowed against the spenddown. Providers are given a special paper-billing process to follow in order to be reimbursed for these expenses. This coverage will stop once the spenddown is met.
- For persons who are ADAP without any type of Medical Assistance - ADAP will cover medications on the ADAP formulary as for Medically Needy persons.

Please keep in mind that a person who only receives ADAP coverage is not a dual eligible and auto enrollment and deemed subsidy eligibility will not be applicable to the individual.

D. CMS Announces Contingency Plan for Dual Eligibles - A special type of facilitated enrollment will allow a full dual eligible, not enrolled in a plan, to obtain a prescription at the subsidized copayment amount before leaving the pharmacy. The person must present proof of Medicaid eligibility at the pharmacy, or provide enough information for the provider to verify coverage through the Eligibility Verification System. It also provides a rapid enrollment process into a PDP with a fully subsidized premium. This essentially enables new Medicaid beneficiaries to be quickly enrolled in a Medicare prescription drug plan without waiting for auto enrollment to occur.

CMS is using two contractors to help with the process. Wellpoint, a national PDP will provide point-of-sale access to prescription drugs at the subsidized level. Z-Tech will provide assistance in verifying Medicaid and Medicare eligibility. The special process is only for Full Dual Eligibles. It is not applicable to Partial Dual Eligibles.

This special point-of-sale process works as follows:

1. The beneficiary presents at the pharmacy with proof of Medicaid (e.g. a medical card) and other identifying information as determined by the pharmacy (e.g. photo ID).
2. The pharmacist bills Medicaid and the claim is denied.
3. The pharmacist verifies Medicare entitlement and determines the beneficiary is not enrolled in a PDP. If the beneficiary is enrolled in a plan, the appropriate plan is responsible.
4. The pharmacist follows a special process to bill the claim to Wellpoint. The beneficiary is charged a copayment of \$1.00 or \$3.00, depending on the prescription.
5. Additional validation steps are completed by the contractors and pharmacies which will generally result in the beneficiary being enrolled with Wellpoint.
6. Normal rules for opting out of the assignment apply. If the beneficiary wishes to change the plan assignment, he may do so by following standard rules.

Please note the addition of this special process provides the beneficiary with another option for obtaining prescription drug coverage quickly. Central office is encouraging case workers

to inform beneficiaries who have not enrolled in a drug plan to take advantage of this option through the pharmacy. Beneficiaries who do not take advantage of this process, which CMS expects to be in place one year, will be auto enrolled according to the schedule previously outlined.

- E. Special One-Time Fill for Dual Eligibles** - CMS requires each Medicare prescription drug plan to establish a transition process from Medicaid to Medicare for all enrollees. These plans must include at least a one-time fill of a prescription drug excluded from the plan's formulary where the beneficiary has a prescription he has previously filled but is not on the formulary. CMS recommends plans provide a 30-day supply. Plans may have additional transition processes available to ensure consumers receive medically necessary drugs as well. For ongoing exceptions to coverage, the plan shall render a decision of coverage within 24 hours for expedited determinations and 72 hours for standard determinations.

- F. Dual Eligible Nursing Facility Residents** - Special protections for beneficiaries who live in long term care facilities and get their prescriptions from long term care pharmacies have been specified by CMS. All PDPs must have a plan to provide in-network coverage to all enrollees who live in any nursing home in the region.

Plans are also required to offer an emergency supply of non-formulary drugs for long term care residents as part of the previously mentioned transition process. This special process will provide a temporary supply of drugs while an exception to coverage is being processed.

- G. Non-Covered Drugs for NF Residents** - KDOA has determined that non-covered medication expenses are the responsibility of the NF for Medicaid eligible residents who do not have a patient liability. If a patient liability is applicable, the eligibility worker reduces the patient liability to account for the expense. However, where there is no liability this expense is the responsibility of the facility.

Attachment