



Policy Memo	
KDHE-DHCF POLICY NO: 2018-02-01	From: Jeanine Schieferecke, Senior Manager
Date: February 1, 2018	KEESM Reference: 1322.2(3), 1610.3, 1615, 1619, 1620, 2111, 2112, 8144.1(2), 8244.1(2) KFMAM Reference: 1225, 1501.01, 1505.05, 1521, 1530, 2010, 2011, 2320
RE: Implementation of new policies concerning Medical Hierarchy, Administrative Roles, and Community Spouse Resource Assessment (CSRA) Verification Process	Program(s): All Medical Programs

This memo sets forth instructions for implementation of policy changes specific to the Medical Assistance programs. Topics addressed in this memo are described below.

Applicable to all Medical Programs:

- Medical Hierarchy
- Administrative Roles

Applicable to Elderly and Disabled Medical Programs only:

- Community Spouse Resource Assessment (CSRA) Verification Process

1. CHANGES IMPACTING ALL MEDICAL PROGRAMS

The following changes are applicable to all medical programs.

A. MEDICAL HIERARCHY

The Medical Hierarchy refers to the order in which medical assistance aid codes are determined. This is important for individuals who may qualify under multiple aid codes. Several changes have been made to the Medical Hierarchy that is built into KEES. By changing the hierarchy, the individual who qualifies under multiple aid codes is enrolled in 'better' coverage. These changes are effective for determinations made for the benefit month of March, 2018 and following months. These changes are not applicable to months

prior to March, 2018. For existing consumers, all changes will be applicable with the next EDBC run. There is no mass run planned to effect these changes nor are there any specific implementation instructions for existing cases.

The following hierarchy changes are now included in KEES:

1. PREGNANT WOMEN

CMS mandates that eligibility under a pregnant woman category is only considered after eligibility under other Medicaid aid codes has been determined. This means that a pregnant female who can qualify under multiple aid codes will now be assigned the non-Pregnant Aid Code instead of the Pregnant Woman code. The following are impacted:

Pregnant Teens: A young woman under the age of 19 who is pregnant will now be considered under the Medicaid Child Aid Code (PLN/C3) before being determined under the pregnant woman code. This includes M-CHIP (PLN/C4) as it is a Medicaid category, but does not include CHIP (PLT/C2, PLT/C5). If the teen does not qualify under a child Medicaid program she will be determined under the Pregnant Woman category (PLN/PW). Women currently covered under the PW category will transition the next time EDBC is ran, accepted and saved.

Pregnant Caretakers: A similar concept is implemented for pregnant women eligible under the Caretaker Medicaid category. Women will now be placed in the general Caretaker Medical aid code (CTM/PA) instead of the Pregnant Woman aid code (CTM/PW). Again, this change will occur the next time EDBC is ran, accepted and saved.

SOBRA/Inmate Pregnant Women: The same policies are also implemented for pregnant women who qualify under the SOBRA or Inmate programs. Instead of being determined under a Pregnant Woman category, these women will be determined under non-pregnant aid codes first.

2. FOSTER CARE AGED OUT

CMS also requires that SSI recipient eligibility takes precedence over Foster Care Aged Out. An adjustment is made to the hierarchy to determine SSI eligibility ahead of Foster Care Aged Out. This eliminates the current work around in place. The new determination will be effective the next time EDBC is ran, accepted and saved.

3. REFUGEE MEDICAL

KDHE's responsibility for management of the Refugee Medical assistance program ended in 2016. However, the Refugee Medical aid code has continued to exist in the

KEES medical hierarchy. Refugee Medical is eliminated as a KEES outcome effective March 1. No additional implementation instructions are being issued.

4. *INMATE-JJA*

With the consolidation of the Juvenile Justice Authority (JJA) into the Kansas Department of Corrections (KDOC), separate aid codes for the Inmate Medical program are no longer needed to distinguish JJA and KDOC individuals. Aid codes for the JJA population are end dated in KEES with this change. All inmates will fall under the jurisdiction of KDOC. No additional implementation instructions are being issued

B. ADMINISTRATIVE ROLES

In KEES, Administrative Roles are used as a method to add individuals who are not case persons to a specific case. The Administrative Role assigned depends on the functional role of the individual and the method of appointment. The information below relates to Administrative Roles used by Medical programs. The PPS Payee and Placement Provider roles are not included as they are used by Non-Medical programs.

1. *MEDICAL REPRESENTATIVE*

A medical representative is an individual that has been specifically granted written authority to act on behalf of a consumer. A medical representative may be a person holding a durable power of attorney (for financial purposes), an attorney representing the consumer, or someone else designated by the consumer. If the individual appointed as a Medical Representative is also the consumer's representative payee for Social Security, the Representative Payee for Social Security administrative role takes precedence. See section 1.B.5 below for more information.

In very rare instances where the consumer is unable to file his or her own application and obtaining written consent is not possible, a Facility Administrator is allowed to act as Medical Representative and apply on a consumer's behalf. If this should occur, the application shall be accepted and a referral completed to Adult Protective Services to have a guardian or conservator appointed if appropriate. Otherwise, persons collecting a medical debt, Care Coordinators, Nursing Facility Administrators, and Case Managers may not serve as a Medical Representative unless proper documentation is on file and there is no one else available to assist the consumer or they are court appointed.

An individual serving as a medical representative may complete and sign an application, make decisions related to the consumer's case, request a fair hearing or grievance, and appoint an additional Medical Representative, Facilitator, or Additional Correspondence Recipient. The medical representative also receives copies of all notices and forms, receives a separate review form, and is responsible for completing and submitting the consumer's review. Additionally, information in KEES related to the Medical

Representative is sent to the MMIS. This allows them to communicate with the fiscal agent, DXC, and the Managed Care Organization (MCO). It is important to note that the appointment of a Medical Representative does not remove the rights of the consumer to act on their own behalf.

The Medical Representative form within the KanCare paper application or the KC6100 Medical Representative Authorization form may be used to appoint a Medical Representative. Both forms require the signature of two witnesses if the consumer signs with a mark, such as an 'X'. Attorneys representing an applicant or recipient must provide a letter written on their agency's letterhead stating they are representing the consumer in their Kansas Medicaid matter. There is no need for the attorney or consumer to submit any other information or form to verify they are able to act on the consumer's behalf.

Once appointed, a Medical Representative shall have authority to act on behalf of the consumer until revoked or the Medical Representative passes away. If appointed by the consumer, the consumer may make a verbal request or submit a written request to the KanCare Clearinghouse to revoke the appointment of a Medical Representative. However, as noted in section 4 below, consumers cannot revoke the appointment of a Medical Representative when a guardian or conservator has been appointed by a court to act on their behalf.

The Medical Representative Administrative Role shall be routinely assigned to community spouses of Long Term Care applicants and recipients to allow the spouse to receive information about the case. Eligibility staff shall use the prudent person concept outlined in Medical KEESM 1310 in situations where the Long Term Care spouse is separated from the community spouse or pursuing divorce when determining whether to add the community spouse as a Medical Representative. For all other situations, including Family Medical programs, the spouse can be added as a Medical Representative at the consumer's request. For example, Mom, Dad, and two children reside together. Mom is the Casehead and the Primary Applicant. Dad is in the home and is the one who manages the children's health care for the family. At their request, Dad can be added as a Medical Representative in order for the MCO to be able to speak with him. The KC6100 or Medical Representative form within the KanCare paper application is not required because the spouse is legally responsible and may act on the consumer's behalf.

2. FACILITATOR

A Facilitator is an individual or a role within an organization who is granted limited authority to assist a consumer throughout the medical application process, which includes assisting the consumer with obtaining required verifications and providing those documents to the Clearinghouse. Because the Facilitator is often involved in the verification process, they are allowed to request an extension if the request is

reasonable as well as request escalation based on an Urgent Medical Need. See Policy Clarification 2017-03-03 and Policy Clarification 2017-07-02 for examples of reasonable requests for an extension. The Facilitator also receives copies of all notices and forms, including a separate review form if they remain appointed at the time the review is generated and mailed. The Facilitator cannot complete the application or review, request services, or request a fair hearing or grievance on behalf of the consumer.

The Facilitator form within the KanCare paper application or the KC6200 Facilitator Authorization form may be used to appoint a Facilitator and may be completed by the consumer or an individual able to act on their behalf as defined above in Section 1.B.1. Both forms require the signature of two witnesses if the consumer or the individual able to act on their behalf signs with a mark, such as an 'X'. If only the organization is listed on the KC6200 or the Facilitator form within the KanCare paper application, the assumption is the Organization-Administrator is being appointed by the consumer and will be listed as such in KEES. Example: The KC6200 lists Medicalodges as the Facilitator. Medicalodges-Administrator is added as the Facilitator in KEES.

Once appointed, the length of time a Facilitator can serve is based on the method of appointment. If the KC6200 form is used, the length of appointment is six (6) months from the date the form is signed or until the application is completed, whichever is later, unless a specific date of expiration is provided by the individual. If a specific date of expiration is listed which exceeds six months, the length of appointment shall last through the date specified or twelve (12) months from the date the form was signed, whichever is later. When the Facilitator form within the KanCare paper application is used, the appointment remains in effect through the application period. The application period ends the month following the month the eligibility determination takes place. Following a denial for failure to provide, the Facilitator role is reactivated when requested information is provided within the application period.

3. *ADDITIONAL CORRESPONDENCE RECIPIENT*

The Additional Correspondence Recipient Administrative Role is used to allow an individual other than a Medical Representative or Facilitator access to information related to the consumer's eligibility benefits, payment or lack of payment of benefits, or claims, reports, and other documents related to claims for benefits for an injury or illness.

Individuals assigned the role of additional correspondent do not have authority to act on behalf of the consumer. The additional correspondent cannot complete the consumer's application or review, request services, or request a fair hearing or grievance on behalf of the consumer. Individuals serving as an additional correspondent are allowed to request an extension if the request is reasonable as well as request escalation based on an Urgent Medical Need. See Policy Clarification 2017-03-03 and Policy

Clarification 2017-07-02 for examples of reasonable requests for an extension. The additional correspondent shall receive copies of all notices and forms, including a separate review form if they remain appointed at the time the review is generated and mailed.

The Authorization for Release of Protected Health Information form is used to appoint an Additional Correspondence Recipient. The length of appointment for an additional correspondent shall be the date listed on line eight (8) of the form or 12 months, whichever is shorter. The consumer may revoke the appointment of an additional correspondent at any time by notifying the individual appointed, shown on line 1 of the form, in writing. The consumer must also notify the agency by making a verbal request or submitting a written request to the KanCare Clearinghouse to revoke the appointment of an additional correspondent.

4. *GUARDIAN/CONSERVATOR/LEGAL CUSTODIAN*

A Guardian or Conservator is an individual or corporation who is appointed by a court to act on behalf of an individual. When the court appoints a Guardian or Conservator it means that the individual cannot act on their own behalf and the Guardian/Conservator must act for them.

An individual serving as a Guardian or Conservator must complete and sign the application and make decisions related to the consumer's case. They may also request a fair hearing or grievance and appoint another individual to serve as the Medical Representative, Facilitator, or Additional Correspondence Recipient. The Guardian/Conservator also receives copies of all notices and forms, receives a separate review form, and is responsible for completing and submitting the consumer's review. Additionally, information in KEES related to the Guardian/Conservator is sent to the MMIS. This allows them to communicate with the fiscal agent, DXC, and the Managed Care Organization (MCO).

Court documents that have been signed by a Judge are used to appoint a Guardian or Conservator. The appointment of a Guardian or Conservator remains in effect until revoked by a court of appropriate jurisdiction.

5. *REPRESENTATIVE PAYEE FOR SOCIAL SECURITY*

A representative payee for Social Security is a person or an organization who is appointed to receive Social Security or SSI benefits for individuals who cannot manage or direct the management of his or her own benefits. The representative payee must apply and be appointed by Social Security.

An individual serving as a representative payee for Social Security may complete and sign the application, make decisions related to the consumer's case, request a fair

hearing or grievance, and appoint a Medical Representative, Facilitator, or Additional Correspondence Recipient. The Representative Payee for Social Security Administrative Role shall be routinely assigned in situations where a Representative Payee for Social Security expresses involvement in a consumer's case. Involvement may be expressed by signing the consumer's application or by contacting the KanCare Clearinghouse by phone or in writing. Once appointed, the representative payee role continues until payee status is terminated by Social Security. Verification of the representative payee status can be obtained through EATSS.

Representative Payees for Social Security who are assigned an administrative role shall receive copies of all notices and forms as well as a separate review form. It is important to note that while the representative payee may receive a separate review form, the consumer is still responsible for completing and submitting their review. Information in KEES related to the representative payee is sent to the MMIS if an Administrative Role of Representative Payee for Social Security is assigned. This allows them to communicate with the fiscal agent, DXC, and the Managed Care Organization (MCO).

6. REQUESTS FOR REDETERMINATION

Requests for redetermination may be made by a consumer, their spouse, a Medical Representative, Guardian/Conservator/Legal Custodian, Representative Payee for Social Security, or a Facilitator. Additional Correspondence Recipients appointed on the basis of submitting an Authorization for Release of Protected Health Information form may not request a redetermination. While not specifically able to request a redetermination, an additional correspondent may report instances where it is believed an incorrect eligibility determination has been made to the KanCare Clearinghouse. Once a report of incorrect eligibility has been received, it is the obligation of the KanCare Clearinghouse to review the consumer's case for accuracy and process any necessary corrections.

2. CHANGES IMPACTING ELDERLY AND DISABLED MEDICAL PROGRAMS ONLY

The instructions below are related to the resource verification requirements when completing a Community Spouse Resource Assessment (CSRA). These instructions are effective with the issuance of this memo.

A. BACKGROUND

A married couple is allowed to protect a portion or all of their combined nonexempt resources when either spouse enters a long term care living arrangement. The amount to be protected is assigned to the community spouse and is called the Community Spouse Resource Allowance (CSRA). The CSRA is based on the status and value of resources

owned at the time the long term care arrangement began. The arrangement may have commenced months or years prior to the month of application.

The current resource verification policy requires all assets to be verified. Failure to provide verification results in denial for failure to provide because the agency is unable to determine eligibility without the information. This becomes increasingly problematic for the applicant when trying to verify the existence, status, and value of resources from some point in the past. Some assets may continue to exist, while others may have been liquidated, sold, or transferred. The farther back in time, the more difficult it becomes to produce the verification. The more prolific and robust the resource history, the more complicated verification becomes.

To compound the problem, there are instances where there is no eligibility benefit to verifying a particular resource, yet eligibility is still denied for failure to verify. This outcome is possible under a strict policy requiring all assets to be verified.

B. NEW POLICY

For purposes of determining the Community Spouse Resource Allowance (CSRA), verification of all resources shall be requested, but not required. Therefore, a CSRA can still be established even if verification of some or all of the reported resources has not been provided. Verified resources shall be used to determine the CSRA, while unverified resources shall not be included in the determination.

1. SCOPE OF POLICY

This policy only applies to determining the CSRA. It does not apply to determining the status and value of assets owned by the couple at the time the application was filed. That verification policy remains unchanged. Once the CSRA has been established, the normal resource verification rules apply to determine the status and value of current resources. It is important to keep the two processes separate. The CSRA essentially determines how much to increase the eligibility program resource limit. The status and value of current resources determine actual eligibility for assistance.

2. NOTIFICATION REQUIREMENT

With the implementation of this new policy, eligibility staff will be responsible for notifying applicants/recipients of the consequences for failing to verify requested resource information needed to complete the CSRA. The notice requirement applies to both the initial request for information and to notification of the outcome of the CSRA.

a. REQUEST FOR VERIFICATION

The initial request for information sent to the applicant by eligibility staff shall include clear language indicating that failure to verify past resources will result in those resources being excluded from the CSRA determination. The notice should also note that the exclusion of unverified resources could result in a smaller CSRA, adversely affecting eligibility for the long term care spouse.

b. CSRA NOTIFICATION

The final notification sent by eligibility staff to the applicant reporting the outcome of the CSRA shall include clear language identifying unverified resources (if any) which were not included in the determination. The notice should also note that the exclusion of these unverified resources (if any) may have adversely affected the amount of the CSRA as well as eligibility of the long term care spouse.

New notice snippets have been created for both the request for information and to report the outcome of the CSRA to the applicant. The snippets can be found on the KDHE Standard Text for Copy and Paste spreadsheet in the KEES Repository.

C. IMPLEMENTATION OF POLICY

The new CSRA past resource verification policy shall be implemented as follows:

1. VERIFICATION REQUEST

The following provides guidance on when eligibility staff shall request verification of past resources necessary to complete a CSRA under the new policy.

a. REQUESTED

Verification of past resources shall be requested in all instances where the self-attested value of all current countable resources owned by both the spouse in long term care and the community spouse appear to exceed the minimum community spouse resource allowance (plus \$2,000). If it is not apparent from the application whether the self-attested value of all current countable resources exceed the minimum community spouse resource allowance (plus \$2,000), verification of past resources shall be requested. Eligibility staff shall use the prudent person concept outlined in KEESM 1310 when determining whether the consumer's current resources are near or equal to the minimum community spouse resource allowance (plus \$2,000).

b. NOT REQUESTED

There may be instances where there is no need to request verification of past resources.

i. Current Resources

If the combined current countable resources of both spouses are less than the current minimum community spouse resource allowance plus \$2,000, then verification of past resources is not required. The amount of a determined CSRA is irrelevant when the value of all current countable resources (plus \$2,000) are at or below the minimum. The individual cannot shelter more assets than they currently own, so the minimum allowance is entered as the CSRA. If, after receiving the requested documentation of current resources, the total value of the current resources is greater than the minimum community spouse resource allowance (plus \$2,000), verification of all past resources shall be requested.

Note: The CSRA is never recalculated after the fact due to a later change in resources. Nor may additional resources be sheltered after approval when acquired by the long term care spouse. This may occur where the couple own less than the minimum allowance at the time of application and therefore a portion of their CSRA goes unused at approval. Assets later acquired by the long term care spouse may not then be sheltered for the community spouse to make up the difference. Those later acquired assets must all be spent down by the long term care spouse in order to become resource eligible.

ii. Past Resources

Verification of one or some of the past resources may have already been provided or obtained by the agency. If the value of those past resources alone would cause the CSRA to equal or exceed the current maximum community spouse resource allowance plus \$2,000, then there is no need to request verification of additional past resources. Since the individual cannot shelter more assets than the maximum allows, the current maximum community spouse resource allowance shall be entered as the CSRA.

Note: Information provided in this section does not absolve the individual from the responsibility to provide verification of any resources owned at the time the long term care arrangement began when the information is being used to determine eligibility. The information provided in this section only allows the

eligibility worker to complete the CSRA. Any other reason for the eligibility determination, such as the determination that a transfer of property occurred, a determination of whether the resource is income producing, or the determination of the countable or exempt status of the resource, would require verification of the resources.

2. VERIFICATION RESPONSE

How the applicant responds to the request for past resource verification will determine what actions eligibility staff can take.

Note: This section is only applicable to requests for an eligibility determination. Information included within this section does not apply to requests for a resource assessment only.

a. FULL RESPONSE

If the applicant provides verification of all requested past resources, an exact CSRA determination may be completed. The additional snippet described in section B.2.(b) above need not be included in the outcome notification sent to the applicant.

b. PARTIAL RESPONSE

If the applicant provides only partial verification of a requested past resource, a CSRA determination shall be completed by including only the verified resources. Unverified resources shall not be included. The additional snippet described in section B.2.(b) above shall be included in the outcome notification sent to the applicant.

Note: The applicant has until the later of 45 days from the date of the application or 12 days from the date notification of the outcome of the CSRA was sent to provide missing past resource verification. If the verification is received within this timeframe, the original CSRA shall be recalculated and eligibility redetermined. No action shall be taken on information/verification received outside of this timeframe.

c. NO RESPONSE

If the applicant fails to respond to the request for verification of past resources, eligibility staff shall establish the minimum community spouse resources allowance as the CSRA. Since all past resources are unverified, there are no assets to use in the calculation, thus the applicant is entitled to only the current minimum allowance. The additional snippet described in

section B.2.(b) above shall be included in the outcome notification sent to the applicant.

Note: The applicant has until the later of 45 days from the date of the application or 12 days from the date notification of the outcome of the CSRA was sent to provide missing past resource verification. If the verification is received within this timeframe, the original CSRA shall be recalculated and eligibility redetermined. No action shall be taken on information/verification received outside of this timeframe.

3. TIME TO PROVIDE VERIFICATION

The timeframe to provide the requested verification of past resources depends on the type of assessment request received.

a. RESOURCE ASSESSMENT ONLY

If the individual has requested an assessment only without an eligibility determination, the following timelines for providing the requested verification apply:

i. Initial Assessment

If past resource verifications are needed, eligibility staff shall send a request giving the applicant 12 days to respond. The snippet described in section B.2.(a) above shall be included in the notice. Whatever the response, the CSRA shall be determined based on the past resources that have been verified. If there are any unverified resources excluded from the CSRA determination, those assets shall be listed on the outcome notification by using the snippet described in section B.2.(b) above.

ii. Reassessment

Since this is a request for assessment only without an eligibility determination, no eligibility decision has been (or will be) made on the case. Therefore, the applicant may provide any missing past resource verifications that were not previously provided in order to redetermine the CSRA. The verifications may be provided any time after the original assessment was completed and the agency shall be obligated to recalculate the CSRA. Notification of the new outcome shall be sent to the applicant, including the snippet described in section B.2.(b) above (if appropriate).

iii. *Application Filed After Assessment*

If an application is filed after a CSRA has been completed, that initial CSRA shall be used in the eligibility determination. However, if unverified resources were excluded from the CSRA determination, the applicant shall be given additional opportunity to provide the missing verifications. If provided, the CSRA shall be recalculated. Eligibility staff should follow the processes described in section (b) below to obtain additional verifications.

b. RESOURCE ASSESSMENT WITH APPLICATION

If the individual has requested a resource assessment with an eligibility determination, the following timelines for providing the requested verification apply:

i. *Initial CSRA Determination*

As with all requests for information, the applicant shall be given 12 days to provide the requested verifications. If the applicant provides some, but not all of the requested past resource information, the application shall then be processed with whatever information has been provided at the end of the 12-day period.

Note: The application may still be reconsidered (including the CSRA determination) if required verifications are provided by the later of 45 days from the date of application or 12 days from the date of notification of denial.

ii. *Requests for Additional Time*

The agency should generally honor a reasonable request from the applicant for additional time to provide the requested information. This is particularly true when the application includes a CSRA determination since the applicant will in most cases (see section 4 below) be responsible for the difficult task of verifying two sets of resource information (past and current). Eligibility staff may grant up to twenty (20) days additional time for a consumer to provide information. Requests for an extension beyond 20 days shall be submitted to the Policy team for evaluation.

4. ASSESSMENT MONTH AND APPLICATION MONTH THE SAME

There may be instances where the applicant files an application the same month the long term care arrangement begins. In that case, there is essentially no time gap

between the two measured points in time – assessment date and application date. Therefore, only one set of verifications is required in order to process the application.

When the CSRA assessment month and the application month are the same, the regular verification rules apply. All assets must be verified. Failure to provide requested verification of all assets shall result in ineligibility due to failure to provide.

5. APPLICATION DENIED

If the application is denied for any reason, with the exception of failure to provide a signed M-2 as outlined in Policy Directive 2017-10-02, the agency still has an obligation to complete the CSRA and notify the applicant of the outcome. If unverified resources were excluded from the CSRA determination, the snippet described in section B.2.(b) above shall be included in the outcome notification.

D. FAIR HEARING

The following fair hearing provisions apply to this new policy.

1. ASSESSMENT ONLY

There is no right to a fair hearing regarding an assessment only outcome. This is because there has been no actual eligibility determination made by the agency. Only applicants and recipients are allowed to request a fair hearing. Since an application has not been filed yet, there is neither an applicant nor a recipient. This is existing policy.

Should an appeal be filed on an assessment only, the agency shall complete the Appeal Summary, including a Motion to Dismiss (based on Medical KEESM 1619) to the Office of Administrative Hearings (OAH).

2. ASSESSMENT WITH APPLICATION

When an application has been filed, the applicant has the right to request a fair hearing based on either the CSRA determination and/or the eligibility decision. If the applicant is appealing the CSRA determination, the following provisions apply:

a. RESOURCE ASSESSMENT

The applicant has the right to request a fair hearing concerning how the CSRA was calculated by the agency. That could include the following:

i. Calculation

The applicant may simply be challenging the math behind the CSRA calculation, or they may be contesting the resource status (countable or exempt) assigned to specific resources by the agency. In either case, the agency shall complete the Appeal Summary and present documentation supporting the decision, similar to any other fair hearing response.

ii. Unverified

The applicant may be challenging the CSRA because unverified resources were excluded from the determination. The manual has been updated to support this new policy. The agency shall complete the Appeal Summary and once again present documentation supporting the agency determination, including citing the new policy provisions contained in Medical KEESM 1322.2(5), 1619, 8144.1(2), and 8244.1(2).

b. INCOME ALLOCATION

In a completely separate process, the applicant may request an increase in the CSRA established by the agency in order to create more income by filing the request as a fair hearing. In these instances, the applicant is not challenging the CSRA calculation as being incorrect. This is a special provision allowing the hearing officer to judicially grant an increase in the CSRA to provide additional resources to the community spouse so he/she can invest those resources to produce additional income.

This provision is only allowed where the community spouse's income (including the amount allocated from the long term care spouse) is less than the minimum community spouse income allowance.

i. Income Exceeds Minimum Income Allowance

If the community spouse's income is already at or above the minimum community spouse income allowance, then this appeal process is not appropriate. Should the applicant request a fair hearing, the agency should complete the Appeal Summary, present documentation supporting the agency determination and cite the new policy provisions in Medical KEESM 1322(5), 1619, 8144.1(2), 8244.1(2).

ii. *Less Than Minimum Income Allowance*

If the community spouse's income is less than the minimum community spouse income allowance, then this appeal process is appropriate. Should the applicant request a fair hearing, the agency should complete the Appeal Summary, along with documentation supporting the agency determination of the CSRA.

Should the hearing officer increase the CSRA through this process, including by counting previously unverified resources in the calculation, the agency is bound by the new CSRA amount and shall redetermine eligibility as appropriate.

3. CONCLUSION

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff listed below.

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Questions regarding any KEES issues are directed to the KEES Help Desk at KEES.HelpDesk@ks.gov