Kansas
Department of Health and Environment
Division of Health Care Finance

Policy Memo	
KDHE-DHCF POLICY NO: 2023-03-02 v 3	**From: Erin Kelley, Senior Manager**
Date: Aug 4, 2023 **Updated 4/12/23 v2 -new section: I.A.3 & 4** **Updated 8/4/23 v3 specifics added**	**MKEESM References(s):** **KFMAM Reference(s):**
RE: PHE Unwinding - COVID-19	**Program(s): All Medical Programs**

This memo provides instructions for implementation of policy changes related to recent legislation regarding the expiration of the COVID-19 Public Health Emergency (PHE) continuous coverage requirement and the timeframe referred to as the "unwinding period." The unwinding period is the federally established 12-month timeframe granted to states for the resumption of normal eligibility operations following the end of the continuous coverage requirement related to the PHE. It includes requirements for full Medicaid and CHIP renewals and discontinuances of coverage for ineligible consumers. The effective date for this policy change is April 1, 2023.

NOTE: Based on updated guidance from the Centers for Medicaid and Medicare Services (CMS), the continuous coverage requirement is no longer contingent on the end-date of the PHE. The Department of Health and Human Services (HHS) declared May 11, 2023, as the official end-date to the COVID-19 PHE; however, this memo marks the resumption of medical reviews and other suspended actions effective April 1, 2023.

Applicable to all Medical Programs:

- Post-PHE Review Requirements
- Members No Longer Meeting Age Requirements
- SOBRA
- Reasonable Opportunity Period (ROP)
- SI Medical Recipients – Loss of SSI Recipient Status
- Premium Delinquency for CHIP and Working Healthy
- Waivers Remaining in Effect
- Up-to-Date Contact Information
- Returned Mail
- Employer Statements

Applicable to Family Medical Programs only:

- Partial Approvals When Prior Medical Income Is Needed - Extended
- Unknown Tax Filing Status

Applicable to Elderly and Disabled Medical Programs only:

- AVS Waiver
- Excess Resource Disregard
- Life Insurance Policy Verification Simplification
- Transfer of Property Penalty and Notification Requirements
- Spousal Resource Transfer Reverification
- Verification of Resources – PHE Tiered Verification (End-Dated)

This memo supersedes PD2020-03-01, PM2020-04-01, PD2020-10-01, PM2020-11-01, PC2021-02-01, PD2021-02-01, and PM2021-03-01 where applicable.

NOTE: The term "*standard*" (in reference to policy and processes) used throughout this memo shall be defined as Eligibility policy and processes that were effective prior to (*or outside of*) the onset of the COVID-19 PHE otherwise referred to as "pre" or "non" PHE policies.

I. Changes Impacting All Medical Programs

Beginning March of 2020, due to the onset of the federally declared COVID-19 PHE, Kansas implemented multiple PHE-related policies including continuation of coverage for both Medicaid and CHIP programs and additional processing flexibilities. As the continuous coverage requirement is now set to expire on April 1, 2023, it is necessary to retire, supplant, or extend the related policies as directed below.

A. Review Requirements and Unwinding Period (added section 3-4 as of April 12, 2023)

1. Background

During the PHE, all discontinuances were suspended per PD2020-03-01 with few exceptions. For this reason, many Medicaid and CHIP recipients have had their coverage, or existing level of coverage, extended beyond their 12-month review period despite changes reported that may have made them ineligible for continued coverage or resulted in greater cost-sharing (i.e., a higher premium). As the continuous coverage requirement ends and normal operations resume, it is necessary to assess consumer eligibility based on current circumstances and discontinue those who are no longer eligible, abiding by federal guidelines.

Per federal guidance received from CMS, as states resume routine operations for conducting renewals, it is necessary to do so in a way that minimizes the burden on consumers and promotes continuity of coverage to the greatest extent possible. As coverage was extended due to PHE-policies for many consumers who may have otherwise been determined ineligible, it will now be necessary to complete a full review/redetermination for these consumers based on current circumstances. All existing members whose coverage has extended past the standard timeframe without a formal review, with some exceptions described further in the memo, will be run through the

automated KEES Reviews Batch, and will receive either a passive review or a pre-populated review based on the information on file.

NOTE: Even if a consumer has reported changes during the PHE that would make them ineligible for continued coverage, they must be given the opportunity to provide updated information, and a full redetermination must be completed based on existing circumstances prior to discontinuance. This also applies to automatic notifications that would normally result in adverse action, such as Non-cooperation with CSS for CTM recipients.

The federal requirements for conducting medical reviews include the following:

- Attempting to complete a review using information found in data-sources or interfaces prior to requiring information from the consumer
- Sending a pre-populated review form when all required information cannot be obtained through electronic sources (or passive review process)
- Providing beneficiaries with at least 30 days* to return their review form, allowing the review form to be received through all available channels (i.e., mail, the Consumer Self-Service Portal, phone, or in-person)
- Determining eligibility on all bases (meaning for any applicable program) prior to ending coverage
- When discontinuing coverage due to ineligibility or failure to return the review, providing timely notice (at least 10 days prior to the last day of coverage) and appeal rights

*__NOTE__: While Kansas does allow consumers at least 30 days to provide a review form prior to the discontinuance batch running, the due date provided on the form is the 15th day of the following month. In order to align more closely with the requirement, this date will be updated to reflect a full 30 days going forward.

2. THE UNWINDING PERIOD

To account for the time needed to complete renewals, CMS has allowed a 12-month unwinding period during which all reviews processing must be initiated. States will have an additional two months following the 12-month unwinding period to complete eligibility actions initiated during that timeframe. Kansas has elected to begin its unwinding period as of March 2023, meaning the review batch process will resume in March for the initiation of April 2023 reviews. **Regardless of the unwinding dates, coverage extended due to the continuous enrollment requirement may not be discontinued for any Medicaid/CHIP recipient prior to April 1, 2023.**

The following groups are exceptions to the review requirements and/or standard review processes. Coverage for these groups may not be ended prior to April 1, 2023. While these groups are not subject to the standard review policies/procedures, they do have special processes that shall be followed during the unwinding period, discussed further on in the memo.

- Members no longer meeting age requirements (“aged-out”)
- SOBRA recipients
- Members on a Reasonable Opportunity Period (ROP)
- SI Medical Recipients – Loss of SSI Recipient Status

3. Applications Received During the Unwinding Period

The policies noted within this memo are specific to "Review Related" activities and are not applicable to applications processed as of April 1, 2023 (even if the application was received on or before March 31, 2023. Applications processed during the unwinding period are processed using standard policy which is applied to both the application month and the prior medical months, even if the prior medical month(s) begin prior to April 2023.

4. Consumer Changes in Circumstance During Unwinding

During the unwinding period staff will continue to process case maintenance related tasks that are created based on changes in the individual's circumstances. These changes may be income changes, resource changes, living arrangement changes, etc. When staff process these case maintenance tasks, it will be important for the worker to determine if the individual is within their 12-month review period, or outside of the 12-month review period (i.e., continued on coverage due to the continuous enrollment policy). Once this is determined, the worker will assess if the change is positive or adverse and apply the following policies:

a) Consumer(s) Are Outside of Their 12-month Review Period

Individuals who remained active during the scope of the PHE due to the continuous enrollment criteria *must* receive a full review eligibility determination or the opportunity to submit a review prior to adverse action being taken. These individuals are outside of their 12-month review period. Positive changes reported to the agency may be processed, noting that any additional coverage given to a consumer must be maintained until the individual's review eligibility determination is completed.

Example: An individual actively receiving MSP/QMB only coverage admits into a nursing facility April 7th, 2023. The facility submits the admission MS-2126 and the worker processes the task and determines that the Unwinding Review Month is not until 08/2023, however, the individual is otherwise eligible for Long Term Care Nursing Facility coverage and updates the individual's coverage. This change is allowable as it is a positive change to the consumer.

The agency is later notified that the individual discharged from the nursing facility back to their private home on May 1st, and the worker begins processing the task. As the individual is now actively receiving both MSP/QMB and full Medicaid due to the level of care coding, the individual must continue to receive full Medicaid (per PHE Policies) until the eligibility

review determination is completed for the 08/2023 review month. Staff should follow the specific KEES processing instructions for completing this in KEES.

b) CONSUMER(S) ARE WITHIN THEIR 12-MONTH REVIEW PERIOD

Individuals who applied and were approved for medical coverage within the past 12 months who report a change in circumstances are not subject to the unwinding policies as their 12-month review is not yet due. In these scenarios, the change in circumstances may be acted upon without first requiring the individual go through the review process. This includes changes in circumstances that result in adverse action and standard policy is applied.

Example: An individual actively receiving Medically Needy coverage with a $3,000 spenddown admits into a nursing facility on May 5th. The facility submits the admission MS-2126 form, and the worker processes the change in circumstances and approves LTC-NF coverage.

On June 11th the individual discharges from the facility and submits the discharge MS-2126 and the worker begins processing the task. The worker notes that the individual was newly approved on Medicaid in January 2023 and is within their 12-month review period and processes the case to discontinue the individuals Title 19 coverage effective June 30th, providing timely and adequate notice. The individual is placed back on Medically Needy coverage effective July 1st with the $3,000 spenddown.

B. MEMBERS NO LONGER MEETING AGE REQUIREMENTS

As noted above, with the onset of the PHE, all discontinuances were suspended. This suspension also extended to include members who were anticipated to “age-out” of all Medicaid and CHIP programs unless a change in circumstances occurred making them otherwise eligible. “Aged-Out” refers to individuals on MAGI programs who have turned 19 years old. It also refers to AGO recipients over the age of 26. As the PHE continuous coverage requirement is now concluding, these individuals must be provided the opportunity to apply on their own behalf prior to discontinuance.

1. PROCESSING AGED-OUT MEMBERS

In order to meet unwinding requirements for reviewing all Medicaid and CHIP recipients, the aged-out individuals extended due to PHE policies will be sent an application at least 30 days prior to discontinuance along with a notification that they will need to apply on their own behalf in order to be determined for ongoing coverage.

These individuals will remain open on existing coverage until one of two scenarios occurs:

1.) No application for them has been received by the 30-day deadline in which case they are discontinued on their existing case with timely notice (either at review for the other household members or prior).
2.) Their application is received, and a new case is registered for the aged-out member and processed accordingly.

For those who return an application and are eligible for coverage going forward, coordination between eligibility functional areas may be needed to end coverage on the previous case the month prior to coverage beginning on the new case. If an application is returned but the applicant is found ineligible for any program, the application will be denied and coverage on the previous case will be discontinued with timely notice.

NOTE: The above policy and process applies to individuals who aged out prior to March 1, 2023. Aged out members may not be discontinued until they have either been determined ineligible based on an application/renewal or they have been given the opportunity to send in an application/renewal form no less than 30 days prior to discontinuance. For those turning 19 years old *during* the unwinding period (or 26 for AGO recipients), standard policy and process shall be applied.

C. SOBRA

During the PHE, non-citizens with a non-qualifying immigration status (i.e., undocumented or failing to meet the non-citizenship criteria for Medicaid) who qualified for coverage of a qualifying emergency service under the SOBRA program were allowed to continue SOBRA through the end of the PHE. SOBRA coverage is fee-for-service (FFS) and only covers special hospital services as approved by the SOBRA Program Manager and the Fiscal Agent. There are no review requirements for this program.

For this reason, SOBRA recipients who remained active during the scope of the COVID-19 PHE will not be included in the reviews batch after the expiration of the continuous coverage requirement and will not receive a formal review. Instead, a simplified desk review will be completed for this group to determine if there have been any changes in their immigration status which could now qualify them for another program. If it is ascertained that there have been no changes, either reported or found in the case file or non-citizenship record, SOBRA coverage may be discontinued allowing timely and adequate notice. A specialized append snippet can be found on the Standard Copy and Paste (SCP) to include in the discontinuance NOA.

If it is determined that there may have been a change based on case file findings, staff must allow the consumer the opportunity to be re-determined for coverage based on the updated circumstance. The case will be held for the standard pending timeframe and an application form sent to the consumer. If received, the applicant will be processed according to standard procedures. SOBRA coverage will be discontinued once the pending due date has passed regardless of whether the application has been received.

D. Reasonable Opportunity Period (ROP)

1. Background

Under standard (non-PHE) rules, individuals who qualify for KanCare and are approved for a Reasonable Opportunity Period (ROP) pending verification of U.S. citizenship/identity or an eligible immigration status are granted a 90-day timeframe to provide supporting documentation before eligibility can be discontinued. At the time of processing when an individual is approved on an ROP, a request for information is sent to the individual requesting the necessary proof of citizenship/identity or immigration status with the standard 90-day timeframe listed as the due date. If verification of citizenship/identity or immigration status is provided or obtained through interfaces prior to the due date, the ROP ends and full eligibility is established. If the information is not received by the due date, action is taken to discontinue eligibility allowing for timely and adequate notice.

NOTE: The ROP begins the date the notice is sent to the consumer.

2. ROP - Unwinding

As a result of the PHE, individuals approved with an ROP were allowed to continue past the standard 90-day timeframe through the end of the PHE continuous coverage requirement, per PD2020-03-01. However, as the continuous coverage requirement is expiring, flexibility has been granted temporarily throughout the duration of the unwinding period to allow post-enrollment verification of citizenship or immigration statuses to be completed during the review process.

It is important to note that these individuals are receiving benefits pending a determination of eligibility that relies on the verification of their citizenship or immigration status. Staff reviewing cases on which someone was approved on an ROP will need to confirm 1) that the correct ROP NOA was sent, and 2) whether documents or updated verifications have been received either from the consumer or through the VLP.

3. ROP Notice Sent

If it is determined proper procedure was followed during the PHE to establish an ROP for a consumer and verification has not been provided or cannot be verified through case research, the consumer will be discontinued with timely notice as outlined in MKEESM 1431.2 and KFMAM 1422.02.

4. ROP Notice Not Sent

If it is determined that an ROP notice was not sent or the notice did not include the appropriate documentation the consumer must supply, a new notice must be sent to provide the consumer an additional 90 days to provide supporting citizenship or immigration documents. If after the 90-day timeframe documentation has not been provided, the consumer will then be discontinued with timely noticed as outlined in MKEESM 1431.2 and KFMAM 1422.02.

After the 12-month unwinding period has ended, standard ROP processes will need to be followed as outlined in PM2015-06-01 for both U.S. Citizens and Non-Citizens. The KDHE Standard Copy & Paste (SCP) spreadsheet has been updated with several fragments relating to Reasonable Opportunity on both the FM and E&D tab (G-406 G-407, G-113, G-114, G-115, and G-116).

NOTE: At this time, the KEES NOA that generates for ROP will automatically include verbiage specific to U.S. citizens only. For a non-citizen ROP, the generated NOA must be deleted, and the one from the SCP must be sent via V008.

E. SI Medical Recipients – Loss of SSI Recipient Status

Due to the continuous enrollment requirement, beneficiaries receiving SI Medical coverage were required to maintain their full Medicaid benefit for the duration of the COVID-19 PHE even if they lost their SSI recipient status with Social Security. During the unwinding period, individuals that lost their SSI recipient status must have eligibility determined under all bases prior to discontinuing their coverage, per PM2018-10-01 Loss of SSI Recipient Status and Verification of Resources. The policy contained in PM2018-10-01 shall continue to be followed during the unwinding period, with exception to the twelve (12) day pending time frame noted in section I.A.2.b “New Application Required”.

1. Superseded Policy During Unwinding – Pending Application

If eligibility under another non-active program cannot be established or the individual cannot be added to an active program without a new application, eligibility under the SSI medical assistance program shall continue. An application (KC-1500 Medical Assistance for the Elderly and Persons with Disabilities or KC-1100 Medical Assistance for Families with Children) shall be mailed to the individual with notification that the application must be completed and returned within thirty (30) days or assistance will be discontinued.

F. Premium Delinquency for CHIP and Working Healthy

With the onset of the PHE, all discontinuances and penalties for premium delinquency for the CHIP and Working Healthy (WKH) programs were suspended until further notice per PD2020-03-01 and PD2021-02-01. Additionally, any delinquent premiums prior to January 2020 were excluded from future premium penalties for the CHIP program.

In addition to waiving all premium penalties through March 31, 2023, effective with this memo, the consumer’s responsibility for all past, outstanding premium balances is removed. For the CHIP program, outstanding premiums will be reset to zero. While outstanding WKH premiums shall not be reset or waived, special system process will be followed to stop collection efforts to recoup unpaid premiums accrued from 01/01/2020 through 3/31/2023.

1. CHIP

Effective April 1, 2023, CHIP premiums will resume. In order for CHIP recipients to receive a review prior to being penalized or discontinued due to failure to pay premiums, the premium discontinuance batch will be temporarily delayed. If someone is found to be CHIP eligible at review but is delinquent on premiums, coverage may be discontinued due to failure to pay premiums at that time.

2. WORKING HEALTHY

Effective April 1, 2023, Working Healthy premiums will resume. Similar to CHIP, the premium discontinuance batch will be temporarily delayed, and individuals impacted by the continuous coverage requirement must receive a review prior to discontinuing coverage, regardless of there being delinquent premiums. Delinquent premiums accrued prior to January 1, 2020 and/or after March 31, 2023 shall continue to be the responsibility of the consumer. Individuals found to be eligible for Working Healthy at review but are delinquent on premiums may be discontinued due to failure to pay premiums at that time.

G. ZERO INCOME FLEXIBILITY

CMS has granted the State of Kansas temporary waiver authority to permit passive reviews for households attesting to zero-dollar earnings and verified up to twelve (12) months prior to the beginning of the PHE or the last income determination when the following criteria is met:

- At initial application or the previous renewal, an attestation of zero income was verified.
- No information is received/returned from data-sources (i.e., KDOL and TALX) via the Reasonable Compatibility (RC) income test in KEES.

Along with meeting the above criteria, all other non-financial criteria must be met as outlined in KFMAM 2000 and MKEESM 2000 and subsections. When these criteria are met, a 12-month determination will be completed, and appropriate notices sent advising the consumer to contact KanCare if there are any reported changes.

H. WAIVERS REMAINING IN EFFECT

In an effort to reduce administrative burden as states resume routine operations, CMS has approved several waivers for the State of Kansas. These waivers temporarily permit certain actions to be taken prior to and during the unwinding period. The following guidance remains in effect through the end of the unwinding period or until further notice:

- PD2022-09-03 (In-State Address Changes Provided by MCO's – COVID-19)
- PD2022-10-01 (In-State Addresses Received via Returned Mail – COVID-19)

These waivers allow agencies to accept in-state address changes directly from MCO's and USPS Returned-mail without additional outreach to the consumer if certain criteria are met. Staff should continue to reference the two directives above for detailed policies pertaining to in-state address changes.

NOTE: Two additional waivers have been approved by CMS and are noted in the E&D section below.

I. UP-TO-DATE CONTACT INFORMATION

Effective April 1, 2023 through December 31, 2023, in order to comply with federal requirements introduced in the Consolidated Appropriations Act (CAA) of 2023, certain criteria must be met in order to avoid a negative impact to state funding. These criteria require the state to ensure it has up-to-date contact information (including mailing addresses, phone numbers, and e-mail addresses) for each individual for whom it conducts a renewal or determination of ongoing eligibility. (This policy does not apply to authorized administrative roles, such as Medical Representatives and Facilitators. Please refer to section I.J.5 below for additional policy information.)

To do this, the state must utilize all available resources to locate a current address and phone number prior to renewal. In addition to standard case file research, the U.S. Postal Service National Change of Address (NCOA) database will be utilized. Kansas has obtained temporary waiver authority to use the database for this reason. In-state addresses received from MCOs or USPS return-mail may also be treated as verified under current wavier authority, see section I.H.

NOTE: While EATSS is considered a Tier 1 payer interface for income, EATSS is not considered a tier 1 verification source for contact information, but rather a "3rd party source". This is because addresses in EATSS are sometimes outdated due to SSA delays in processing address changes. KDHE also cannot verify that the address in EATSS belongs to the consumer or the representative payee. As such, addresses in EATSS are considered leads. Staff are required to obtain verification from the consumer (or authorized representative) that the address is accurate, prior to updating KEES.

J. RETURNED MAIL

In addition to the advanced effort to obtain up-to-date contact information for all active consumers prior to the initiation of the review process, there are also specific requirements for staff handling of returned mail received from mailings related to the renewal process (i.e., the review form or verification request related to review processing). During unwinding, staff will do the following when returned mail (related to the review process) is received:

- Make a good faith effort to reach the consumer using more than one modality (or method) before action can be taken to close coverage due to loss of contact,
- provide additional time to send in the review form when contact is reestablished, and
- reinstate coverage when returned mail and/or an updated address is received within 30 days of discontinuance.

See below for more detailed instruction on each scenario related to returned mail and address changes reported for the consumer. This policy is not applicable to authorized administrative roles.

1. *Returned Mail - Outreach*

During the unwinding period, any time returned mail is received with either an out-of-state address or no forwarding address for a pre-populated review or verification request that was mailed out, all available methods/modalities (i.e., phone and mail when a new mailing address is available) of contact must be attempted to confirm a new address with the consumer.

Out-of-State Address – Staff will attempt contact through a phone call and a notice sent to both the address on file and the out-of-state address received via returned mail to request updated contact information (staff may use the Returned Mail verification fragment from the SCP), providing 12 days to respond. If no response is received by the due date, coverage will be allowed to close via the discontinuance batch or closed by the worker for failure to respond to a request for verification. If contact is made with the consumer prior to the due date, and the out-of-state address is confirmed, coverage may be closed due to out-of-state residency.

No Forwarding Address – Staff will attempt contact through a phone call. If contact cannot be reestablished or if an out-of-state address is confirmed by the consumer, coverage will be discontinued for the appropriate reason (i.e., failure to return review through the discontinuance batch, or failure to provide for verification requests).

NOTE: As stated previously, an *in-state* address received via returned mail during the unwinding period is considered verified, so no additional outreach is required. Again, these policies are specific to reviews and review-related verification requests during the unwinding period.

The requirement for outreach based on review-related returned-mail is for initial return-mail only. If outreach is attempted through all available methods and additional returned mail is received, the outreach requirement has already been met through the initial attempt. Likewise, if returned mail is received in response to material already re-sent to an updated address, the unwinding requirements have already been met by the initial attempt. Any additional attempts to reach out would be considered best practice only. Note: This policy does not relate to outreach (prior to the unwinding period) by eligibility staff that is not related to review processing.

2. *Updated Contact Prior to Discontinuance – In-State Only*

When contact is made with the consumer to confirm an updated in-state address after the review form has been sent but prior to discontinuance, certain steps must be taken to ensure that the consumer has the full 30-day opportunity to provide the review form and be determined for ongoing coverage. This requirement applies to the following:

- The consumer responds to a phone call and provides an updated address
- The consumer responds to a letter and provides an updated address
- The consumer calls to report an updated address

- The consumer submits an address change through any other channel

In these instances, coverage cannot be discontinued as the consumer has provided us with updated contact information and has not had the full 30 days to provide the review form. A new review form will be mailed to the updated address, and a separate V008 notice located on the SCP will be sent with a new 30-day due date from the date mailed. The case will be placed on hold for 30 days pending receipt of the review form. Coverage must remain open until the review form has been returned and processed or until the due date has passed. A KEES business process has been created for this purpose and will be issued to the appropriate staff separately from this memo.

Example: On May 15th, a June review is mailed out. On June 1st, the review form comes back as returned mail with an in-state forwarding address. A review form is re-mailed to the new address. Eligibility updates the address (during unwinding, no additional outreach is needed to consider the address verified), sends the V008 with the new 30-day due date, and follows the KEES process to keep coverage open until the review has been received, or the due date has passed.

Once the due date has passed, if the review form (or requested information) still has not been returned, coverage will be manually discontinued due to failure to return the review or failure to provide the requested information.

3. UPDATED CONTACT AFTER DISCONTINUANCE - REINSTATEMENT

In some cases, coverage may have already been terminated due to failure to return review at the time returned mail or an updated address is received. If in-state returned mail is received or an in-state address is reported by the consumer within 30 days of the last day of coverage, steps must be taken to ensure the consumer is reinstated on their previous level of coverage and given a new 30 days to return the review form. A KEES business process has been created for this purpose and will be issued to the appropriate staff separately from this memo.

A specialized notice has been added to the SCP to inform the consumer that coverage has been reinstated.

Example: On May 15th, a June review is mailed out. On June 30, 2023, coverage is discontinued due to failure to return review. On July 15th, returned mail is received with an in-state address. A new review form is mailed out. The eligibility worker will reinstate coverage as of July 1, 2023, send the V008 with the new 30-day due date, and keep the case on hold awaiting the review form.

Once the due date has passed, if the review form still has not been returned, coverage will be manually discontinued due to failure to return the review.

If an updated address is received via returned mail or reported by the consumer more than 30 days after coverage was discontinued by the Review Discontinuance Batch, but within the 3-month reconsideration period, coverage will not be reinstated. Mailroom will re-send the review form to the new address, and eligibility staff will update the address in KEES and follow standard processes for in-state return mail, but no

additional action to reinstate is needed. Likewise, if a consumer calls and reports a new address after coverage ended the second time, standard processes apply, and reinstatement is not needed.

4. VERIFICATION REQUESTS

During the unwinding period, if a review is pended for additional information and the verification request notice comes back as returned mail, or if a new address is received/reported through any other channel, actions must be taken to contact/locate the consumer prior to coverage ending due to failure to provide the requested information. If contact is reestablished, additional time must be provided for the requested information to be returned. See below for specific instructions for each type of reported address:

Out-of-State Address – Staff will attempt contact through a phone call and a notice sent to both the address on file and the out-of-state address receive via returned mail. If no response is received by the due date, coverage will be closed. If contact is made with the consumer prior to the due date, and the out-of-state address is confirmed, coverage may be closed due to out-of-state residency.

No Forwarding Address – Staff will attempt contact through a phone call. If contact cannot be reestablished or if an out-of-state address is confirmed by the consumer, coverage will be discontinued for the appropriate reason.

In-State Forwarding Address – Staff will update the address and re-send the verification request with a new 12-day due date.

Similar to the directions above regarding reinstatement, if coverage is closed at review due to failure to provide requested information needed to determine eligibility, and an updated in-state address is received via returned-mail or some other channel within 30 days of discontinuance, coverage must be reinstated, and additional time (12 days) is given to provide the requested information.

Example: A June review is received timely and pended for additional information on 6/7/2023. The information is not returned, so coverage ends 6/30/2023 due to failure to provide requested information. On 7/14/2023, the verification request comes back via returned mail with an in-state forwarding address within 30 days of the last day of coverage (6/30/2023). Coverage is reinstated back to 7/1/2023, and a pending notice is sent to the updated address with a new 12-day due date.

5. EXCEPTIONS

Cases that have medical representatives designated by a consumer are an exception to the above rule so long as mail is not returned for both the consumer and the medical representative for the same mailing. This exception is allowable because the consumer has authorized the medical representative to act on the consumer's behalf. So long as either the consumer OR their authorized medical representative is assumed to have received the mailing, the multiple modalities information listed above is not required.

Example 1: A Medically Needy consumer is sent a pre-populated review that is due

June 15th. A pre-populated review form is also sent to the authorized medical representative (that was authorized by the consumer and may also act on the consumer's behalf.) The case was closed by the Review Discontinuance Batch as the consumer's review form was not received. After closure, the agency received returned mail with an out-of-state forwarding address for the consumer. When staff process the returned mail task, the worker verifies that the pre-populated review was sent to both the consumer and the medical representative. Since returned mail was received for only the consumer and not the medical representative, the returned mail policy above does not apply. The case will remain closed for failure to return the review.

Additional contact is not required as specified in the policy above when returned mail is received unless it is also received for the medical representative.

Example 2: An LTC nursing facility consumer is sent a pre-populated review that is due August 15th. This consumer's court appointed guardian is also sent the pre-populated review from, as they are the responsible person, and the consumer is unable to act on their own behalf. The case was closed by the Review Discontinuance Batch due to failure to return the review. 10 days later after closure, the guardian's copy of the pre-populated review form is received as returned mail with an in-state forwarding address.

As the consumer cannot act on their own behalf, the return mail policy above applies and the case must be reopened since the updated address was received within 30 days of the discontinuance. Staff shall update the guardian's address via the RDB process, and the review is resent. The SCP is also sent on the V008 providing a new 30-day timeframe for the review to be returned.

K. Employer Statements Requirement

Throughout the scope of the PHE, when consumers reported the loss of a job, the requirement to obtain employer verification prior to making changes to eligibility and/or the cost-sharing for the household was waived per PM2020-04-01.

1. Family Medical Programs – Extended

This flexibility will remain in place through the end of the unwinding period and/or until further notice.

NOTE: Under normal policies, see PM2018-03-01, we only require an employer statement to verify a reported job loss when it will 1) reduce or eliminate a premium, or 2) transition the household from TMD to CTM.

2. Elderly & Disabled/Long Term Care Programs

This policy shall be implemented to the Elderly & Disabled/Long Term Care Programs upon the effective date of this memo.

NOTE: Under normal policies, proof of end of income is required for all programs except Working Healthy unless verification can be obtained through Tier 2 or Tier 3 interfaces and failure to provide this information would result in a denial or discontinuance (see MKEESM 1322.1 (c).

II. Changes Impacting Family Medical Programs Only

At the time of the PHE declaration in March of 2020, the State of Kansas implemented numerous Family Medical processing flexibilities/simplifications to aid the consumer due to the health emergency. As the continuous coverage requirement is now expiring, the following flexibilities will apply, and normal processing and policies will be waived until the 12-month unwinding period has ended or until further notice.

A. Partial Approvals When Prior Medical Income is Needed - Extended

To ensure efficient medical coverage for consumers, throughout the duration of the PHE, partial approvals were granted when actual income was needed to process a prior medical request, see PM2020-04-01. This flexibility will remain in place through the end of the unwinding period and/or until further notice.

B. Unknown Tax Filing Status

Per current policy found in PM2014-01-01, much of the MAGI determination is based on an applicant's planned tax household, i.e., whether or not the applicant plans to file taxes and whom they intend to claim. This determines the Individual Budget Unit (IBU) for each applicant on which the financial determination is based. Due to this we are required to collect certain tax information in the application process. When the information is not reported or is unclear, current processes require eligibility to request this information from the consumer as a condition of eligibility.

Effective with this memo, KDHE Policy is waiving this requirement in all situations where the tax filing status is unknown and cannot be resolved through consumer contact at initial processing. In these situations, a tax filing status of "non-filer" will be recorded for the applicant(s) in KEES and the case processed in full.

In the event that other information is being requested from the consumer, the tax filing status should also be requested; however, if the information is not provided by the deadline, the non-filer status should be used. In any case, processing should not be delayed for lack of tax information alone.

When a household or household members are denied due to income using non-filer rules due to an absence of tax information on file, append verbiage must be included in the NOA indicating that this was done. A specialized append snippet has been added to the SCP for this purpose. If a consumer provides updated tax household information once the determination has been made, the case record should be updated with this information and any changes to eligibility should be evaluated if received within the reactivation timeframe (45 days from the date of application) or the review reconsideration period (3 months following case closure).

III. Changes Impacting Elderly and Disabled Medical Programs Only

At the time of the PHE declaration in March of 2020, the State of Kansas implemented numerous Elderly and Disabled and Long-Term Care processing flexibilities/simplifications to aid the consumer

due to the health emergency. As the continuous coverage requirement is now expiring, the following flexibilities and requirements (as noted below) will apply throughout the 12-month unwinding period has ended or until further notice.

A. Asset Verification Solution (AVS) Waiver

As the continuous coverage requirement is ending, KDHE has opted to utilize an AVS flexibility option to assist with asset verification during the unwinding period of the PHE ending, as allowed by CMS. This policy will remain in effect for renewals initiated through the end of the agency's 12-month unwinding period.

Standard AVS policy per PM2017-12-01 requires staff to review if the self-attested value of all non-exempt resources does or does not exceed 85% of the requested program's resource limit. Standard policy also requires staff to request additional verification when an AVS response is not received within the 10-day "reasonable timeframe".

1. Policy Waiver

This AVS waiver allows the agency flexibility to assume there are no changes in resource value when the AVS response is either not received within the 10-day reasonable timeframe, or not received at all. This waiver is applicable regardless of if the self-attested non-exempt resources (on the review form) meet the 85% rule, so long as all of the following conditions are met:

- The review being processed is not following approval based on a MIPPA application,
- The AVS response is not received within the 10-day reasonable timeframe,
- The self-attested value of resources does not place the individual over the applicable resource limit for the program being determined,
- There are no newly reported resources, that require additional verification from the consumer.

The purpose of this waiver is to mirror the resource verification process of pre-populated reviews more closely to the passive review process. However, this waiver is not applicable when the AVS response is received within 10 days (or at the time the review is processed) and standard review resource verification policies apply. Consider the following examples.

2. Examples

Example 1: Consumer is receiving LTC coverage as they reside in a nursing facility. One savings account and one NF account are listed in KEES. At review, the consumer's bank account information is requested through the AVS. The consumer returns their pre-populated review timely and reports their savings account has a value of $1,673 and the NF account has a value of $50. An eligibility worker claims the review and begins processing and notes that more than 10 days have passed since the AVS request was completed, therefore the AVS response is not considered timely received.

Standard policy would require the worker to request hard copy verification as more than 10 days has passed since the AVS request was sent and the self-attested value of the consumer's countable resources exceeds 85% of the program's resource limit.

This AVS waiver allows the agency to assume that there is no change in any of the consumer's countable resources, regardless of if they are typically verified using the AVS or not (i.e., the NF account), and the existing verified resource record in KEES is left-high dated and is considered verified (so long as the previously verified resources does not place the consumer over resources).

If the existing record in KEES does place the consumer over resources, then the tiered verification process per standard review policy must be followed.

Example 2: Consumer is receiving coverage under the Medically Needy program with one checking account and one countable life insurance policy listed in KEES. At review, bank account information is requested through the AVS. The consumer returns their pre-populated review and reports that the value of their checking account is $350, and the life insurance policy has a cash value of $750. An eligibility worker claims the review and begins processing and finds.
that more than 10 days has passed since the AVS request was completed, therefore the AVS response is not considered timely received.

Standard Policy would require the worker to request hard copy verification of the life insurance policy's cash value. Verification of the checking account would also be requested as the 85% rule does not apply due to the consumer owning a non-exempt life insurance policy.

This AVS waiver allows the agency to assume there is no change in the consumer's resources, and the previously verified record in KEES for both the checking account and the life insurance policy remain high-dated and are considered verified.

B. Excess Resource Disregard

At the beginning of the COVID-19 PHE, consumers active on long term care coverage with a share of cost retained their eligibility with no adverse changes. This meant that any income or expense changes resulting in an adverse change (increased share of cost or discontinued level of care) that occurred from March 2020 when the PD2020-03-01 Delayed Discontinuance directive was released until PM2020-11-01 COVID-19 PHE Processing Flexibilities memo was released, were not to be acted on.

Effective with the release of PM2020-11-01, the agency began to act on those income and expense changes. Depending on the individual's circumstances, those excess monies not included in the share of cost from March 2020 through November 2020 may have accumulated during that time, and it is possible that the monies may not been spent down by the end of the PHE. Excess funds over the applicable program limit would otherwise render the individual ineligible for coverage.

1. POLICY WAIVER

During the 12-month PHE unwinding period, the agency will disregard those excess resources for the individuals who both actively received Long Term Care (LTC) coverage during the months of March 2020 through November 2020 and had income that was not attributed to their monthly share of cost. (Both criteria must be met for this waiver to apply.) Income that was not attributed to the share of cost could either be from an income increase or an expense reduction, either of which would have resulted in an adverse change had those policies not been in place.

While processing reviews during the unwinding period, individuals who are determined ineligible due to excess resources must be researched prior to discontinuing coverage. Staff must review the individual's coverage to see if the individual was active on LTC (HCBS, NF, or PACE) coverage during any of the months of March 2020 through November 2020. If so, staff should research if there was an income increase or expense reduction that was not acted upon during that time that would have increased the share of cost. Staff must also determine if the total excess resources would make a difference in resource eligibility. If so, staff should calculate the amount not applied throughout that time and "disregard" those excess resources when completing the review determination. KEES processing instructions will be provided separately.

It is important to remember that this policy is not applicable to excess resources that accumulated:

- Prior to March 2020 (the first month of the declared PHE),
- During the months of March 2020 through November 2020 that were accrued for reasons not relating to increasing the share of cost,
- After November 2020 when the agency began to act on income or expense changes that increased the share of cost.

Example: On June 5th, the eligibility worker begins processing a LTC – NF review. AVS results were returned timely and report the consumer has a $2,950 balance in their checking account. As this would place the consumer over resources, hard copy verification is required and is requested from the consumer.

After pending, the worker verifies the countable value of the bank account is $2,700. The worker checks the LTC Data Details record and verifies the consumer resided in the nursing facility during March 2020 through November 2020 and that an annuity payment had been reported to the agency timely. The worker then calculates the excess resource disregard by multiplying seven (7) months (May through November) by the $120 per month payment, totaling $840. The worker acknowledges the $840 as the excess resource disregard and subtracts that from the $2,700 value resulting in the countable bank account value being $1,860. The worker updates the KEES records accordingly and approves continued LTC coverage.

C. Whole Life Insurance Policy Verification Simplification

Per MKEESM 9333 (2)(b)(vi) countable life insurance policies require reverification at review. This is because the cash value is anticipated to change during the consumer's 12-month review period. Normal policy and process requires verification of the cash surrender value, typically provided as a statement from the life insurance company.

The cash surrender valuation table has historically not been accepted as verification because the table does not capture life events such as withdrawals or loans taken from the cash surrender value.

During the COVID-19 PHE unwinding period, life insurance cash surrender valuation tables may be accepted as verification of the cash surrender value if the following criteria are met:

- Updated verification was requested from the consumer when processing the review and the documents received include the face value of the policy, but the current cash value is not listed.
- All other required* verifications were received (see note below).
- The documents received verify that the valuation table is a part of the specified life insurance policy.
- The calculated cash surrender value shown on the valuation table does not cause all total countable resources to exceed 85% of the applicable program's resource limit.
- The cash surrender value does not place the individual(s) over the program's resource limit.

When the cash surrender value (using the valuation table) results in excess resources of the applicable program limit, the valuation table is not acceptable verification to complete the review determination. It is never appropriate to deny or discontinue eligibility due to excess resources based on this value. Instead, the case would be denied for failure to provide the life insurance policy's current cash value.

The intent of this policy simplification is to expediate review processing while lessening the burden on the consumer to obtain the current cash value. Therefore, staff should use this table as a tool when the requirements above are met and the AVS Waiver policies described in section III.A of this memo are not applicable. Please also see PD2022-09-01 Implementation of ES-3172 Life Insurance Information Request form for additional verification options related to life insurance policies.

*Note: Required verification applies to mandatory income and resource verification needed to complete review processing. Requested expense verification or community spouse income verification not being received are not "mandatory" to complete a review determination and failure to provide this information is not allowable.

D. Transfer of Property Penalty (TOP) and Notification Requirements

With the implementation of PM2020-04-01, staff were advised that while transfer of property penalty policies during the scope of the PHE remained in place, the penalty could be assessed but not enforced for active recipients. This meant that the transfer penalty period was determined, and a penalty start date assessed but the individual's long term

care coverage was left in place per PD2020-03-01. This policy is end-dating effective March 31, 2023, and any remaining penalty (not served during the PHE) shall be enforced to each individual's coverage upon completion of their review allowing timely and adequate notice. The consumer must also receive updated written notice of this adverse action.

Per standard policy, individuals serving a TOP penalty must receive written notice that a penalty has been assessed against them, even if their coverage remained in place during the scope of the PHE. If it is found, during processing, that written notice advising the consumer of their previously assessed penalty was not sent, staff are then required to send written notice to the consumer. This notification is required regardless of the penalty being assessed and "served" in its entirety or if the penalty is still being served.

The KDHE Standard Copy & Paste (SCP) spreadsheet has been updated to include specialized notices for enforcing TOP penalties during the PHE unwinding period, as well as notification of penalties that were served in their entirety.

E. Spousal Resource Transfer Reverification

When eligibility has been approved based on application of the Community Spouse Resource Standard (CSRA), the M-2 must be sent to the individual for completion and returned to the agency. By signing this form, the individual agrees to transfer resources attributable to the community spouse within 90 days of the LTC approval. During the scope of the PHE, failure to provide that verification did not result in adverse action due to the continuous eligibility requirement.

As the continuous coverage requirement ends and normal operations resume, it is necessary to assess consumer eligibility based on current circumstances and discontinue those who are no longer eligible. For couples that failed to provide verification that resources were transferred from the LTC spouse to the community spouse during the PHE, reverification of their current situation is required prior to taking any adverse action.

If it is determined during the unwinding period that documentation verifying the transfer of either all or some of the necessary resources was not received within the requested timeframe, the consumer must be provided a new notice with an additional 12 days to return the requested verification. If after the 12-day timeframe documentation has not been provided, the resources will be considered in the redetermination based on ownership, which may result in adverse action allowing timely and adequate notice. (See MKEESM 8144.1(3) and 8244.1(3).

F. Verification of Resources – PHE Tiered Verification (End-Dated)

As stated in PM2020-04-01 Section III.A.1, eligibility staff shall continue to follow the tiered verification policy when requesting proof of income and resources to determine eligibility and allowed staff to accept client attestation once the tiered verification process had been exhausted and the consumer or authorized representative had expressed difficulty in obtaining the verifications and that the difficultly was specifically related to the COVID-19 PHE.

This policy shall be end-dated March 31, 2023, and the Verification Provisions policy per MKEESM 1322.4 shall be followed with the exception of the unwinding policies contained within this memo.

IV. QUESTIONS

For questions or concerns related to this document, please contact the KDHE Medical Policy Staff at KDHE.MedicaidEligibilityPolicy@ks.gov.

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