Kansas
Department of Health and Environment
Division of Health Care Finance

Policy Memo	
KDHE-DHCF POLICY NO: 2020-04-01	**From: Erin Kelley, Senior Manager**
Date: April 17, 2020	**Medical KEESM/KFMAM Reference(s):**
RE: Policy Implementation Instructions and Information for COVID-19 National Public Health Emergency	**Program(s): All Medical Programs**

This memo sets forth instructions for implementation of policy changes related to the COVID-19 National Public Health Emergency and processing guidelines for the duration of this emergency concerning applications and new coverage requests, situations where an applicant/recipient fails to provide requested information, and the receipt of Federal Emergency Relief funds. For purposes of this directive, the COVID-19 National Public Health Emergency is defined as the events transpiring beginning March 1st, 2020, the beginning of the national emergency proclaimed by President Trump on March 13th, 2020.

Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after March 18th, 2020.

For situations not covered in this memo, KDHE Policy should be consulted.

Applicable to all Medical Programs:

- Failure to Provide
- COVID-19 Federal Stimulus Funds
- Journal Requirements

Applicable to Family Medical Programs only:

- Partial Approvals When Prior Medical Income Verification is Needed
- Employer Statements

Applicable to Non-MAGI Programs only:

- Verification of Resources
- Verification of Income/End of Income
- AVS for Applications and New Coverage Requests
- Long Term Care – CARE Scores
- Expenses

- Medicare Buy-In
- Transfer of Property

I. Changes Impacting All Medical Programs

A. Failure to Provide

When an applicant/recipient fails to timely provide requested information and the application is denied or coverage is discontinued, that action may be rescinded if the applicant/recipient later contacts the agency to report the failure was due to circumstances associated to the outbreak of COVID-19. The explanation must be plausible, and directly related to the outbreak of COVID-19 to qualify under this directive. Each situation shall be examined on a case-by-case basis following the direction provided in the PD2019-06-01 Failure to Provide – Natural Disaster Policy Directive.

This would include 14-day quarantines, access to authorized representatives or businesses, transportation, and other plausible impacts the consumer may report.

Note: This policy directive is reactive, not proactive in nature. The applicant/recipient must contact the agency citing the outbreak of COVID-19 as the reason the requested information was not timely provided. The extension request must still come from the applicant/recipient or authorized representative.

B. COVID-19 Federal Stimulus Funds

The Phase III, H.R. 758 (116) or CARES Act Mar. 25, 2020, also known as the stimulus bill, provides most adults with a one-time payment of $1,200 ($2,400 for couples filing jointly). Each child aged 16 and under would get an additional $500. These payments will start distribution in April 2020. For purposes of this implementation, these payments are exempt as income in the month received and exempt as a resource through the consumers review period, not to exceed twelve (12) months. Additionally, there may be additional funds (ex: increased unemployment funds) that may also be exempt under this policy.

> Example: Consumer receives $200 per week in regular unemployment income, however, because the cause of unemployment was because of the COVID-19 emergency, the consumer receives an additional $600 in unemployment income.
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> The standard unemployment income of $200 is countable unearned income. The $600 additional unemployment income for COVID-19 is exempt.

C. Journaling Requirements

For all case actions taken in accordance with this policy memo, staff shall include the appropriate language from the Standard Copy and Paste (SCP) in the case journal.

II. Changes Impacting Family Medical Programs Only

A. Partial Approvals when Prior Medical Income Verification is needed

Current policy states that when prior medical coverage is requested, and there was a change in household or income during the prior medical months that would fundamentally alter the expected income to be received, and the Prior Medical simplification found in KFMAM 6132.01 using KDOL wages cannot be used to approve Prior Medical coverage, proof of actual income for those months must be requested from the consumer. For the duration of the COVID-19 Public Health Emergency, cases requiring actual income for prior medical months that can be approved in the month of application should be authorized beginning that month and the case placed on hold for the prior medical income.

B. Employer Statements

Current policy states that when there is an income change reported that will result in either a decrease or elimination of premium or a change in program from TransMed (TMD) or Extended Medical (EXT) to Caretaker Medical (CTM), a statement from the employer must be provided as verification of the change. For the duration of the COVID-19 Public Health Emergency, this requirement will be waived, and we will consider the income change verified through the consumer's self-attestation.

III. Changes Impacting Non-MAGI Programs Only

A. Verification of Resources

1. Tiered Verification

Eligibility staff shall continue to follow the Tiered Verification policy when requesting proof of income and resources to determine eligibility. During the scope of the COVID-19 Public Health Emergency, the verification policy has been modified to include AVS requests being completed following the direction in section III(4)(B) of this memo and client attestation acceptance prior to denying a request for failure to provide if a consumer or their authorized representative advises the agency of their difficulty in obtaining verifications specifically because of the COVID-19 Public Health Emergency. This request must be made prior to the last day of the verification due date or before the maximum 20-day extension date expires.

- Tier 1 – Confirmed/Payer Source
- Tier 2 – Interface/Reasonable Compatibility
- Tier 3 – Research (including collateral contact)
- Tier 4 – Contact the consumer

2. Collateral Contacts

Staff shall make every concerted effort to obtain verification of resources by collateral contact prior to requesting information from the consumer. When a consumer is unable to provide verification and this request has been communicated to the agency, it is appropriate for the agency to provide additional information or other options for obtaining the necessary information as an initial step as KEESM 1321.2 indicates the agency shall offer assistance to the household in obtaining documentary evidence when it is difficult or next to impossible for the household to obtain it.

Note: The obligation of the agency to assist does not release the consumer of their responsibility to report/provide information.

3. CLIENT ATTESTATION

Once all options have been exhausted, and proof of liquid resources (bank accounts, CD's, Stocks, etc.) have not been received or verified via AVS, staff shall use information attested on the application if available or contact the consumer or authorized representative by phone to verify, or obtain, client attestation of the missing resources.

All assets verified by client attestation shall be considered *Verified* and will be accepted throughout the program's current review period. All verification decisions to approve or deny an extension request to provide requested information must be journaled thoroughly using the approved COVID- 19 journal noted in section I(C) of this memo.

4. TRUSTS, ANNUITIES, AND PROMISSORY NOTES

Consumer's that report ownership of Trusts, Annuities, and/or Promissory Notes must continue to provide physical verification of these resources. Therefore, these resources shall follow established policy, and are not included in the verification process for COVID-19. Trust and Annuity clearance process established in Policy Directive 2020-01-01 Separation of Trust/Annuity Clearance Request Form (B-6) shall continue to be completed prior to case approvals.

Failure to provide verification of these specific resources shall result in a denial for failure to provide.

B. AVS REQUESTS FOR APPLICATIONS AND NEW COVERAGE REQUESTS

During the scope of this emergency, either the AVS response or verification voluntarily provided by the applicant at the time of application or request for assistance shall be used to verify all bank account related resources without exception. Accounts verified by AVS will use the amount found on the AVS results as the verified amount unless that amount is in excess of the applicable resource limit. Known income shall not be subtracted from the verified AVS amount. This process shall be used for application and new coverage requests during the scope of the COVID-19 National Public Health Emergency.

1. AVS REQUEST AND VERIFICATION REQUESTS

The AVS request shall be sent during the initial application or coverage request process. This request may be completed prior to the worker initially reviewing the application or new coverage request. To avoid any unnecessary delays in processing there may be situations where a dual AVS and formal applicant request for verification may be completed.

a) If the AVS request is not completed prior to the eligibility worker reviewing the application or new coverage request, an AVS request shall be requested at the time a V044 verification notice is sent.

b) If the AVS request was completed prior to the eligibility worker reviewing the application or new coverage request but the AVS response is not received, eligibility staff shall proceed with tiered verification of the accounts from the consumer per section III(3)(A) of this policy.

c) If the AVS response is received and imaged to the case file prior to the eligibility worker reviewing the application/new coverage request and the accounts are verified by AVS along with other known or reported resource amounts:

1. **Does not** make the consumer resource ineligible, the verified account does not require further verification from the consumer.

2. **Does** make the consumer resource ineligible, continue with the tiered verification of the accounts per section III(3)(A) to verify the true account value.

   Note: There may be situations where excess resources in these accounts are caused from the Federal COVID-19 Stimulus package. Remember, these funds are exempt per this policy, therefore, verification of the cause of excess resources must also follow the tiered verification steps noted in this policy.

2. AVS RESPONSE VERSUS ACCOUNT VERIFICATION

There may be instances where both the AVS and the applicant provide valid verification of the bank account(s). It is prudent as a general rule, to use the applicant verification provided over the AVS response because in most cases, that amount will be lower. However, if the AVS response verifies a lower account balance than the verification provided by the applicant, the AVS verification shall be used.

Assets that are not verified by AVS or if no AVS results are received prior to the last day of the verification due date or before the maximum 20-day extension date expires, staff shall attempt to verify the accounts following the instructions in section III(A) (2 – 3) of this memo.

C. VERIFICATION OF INCOME/END OF INCOME

1. EARNED AND UNEARNED INCOME

Eligibility staff shall continue to follow the Tiered Verification policy when requesting proof of income to determine eligibility. During the scope of the COVID-19 Public Health Emergency, accepting client attestation once the tiered verification process has been exhausted shall be accepted for both earned and unearned income and proof of end of income. The process noted in section III(A) 1-3 above shall be the same with the exception of AVS for verification of income/end of income.

2. SECA VERIFICATION FOR WORKING HEALTHY

For the self-employed, Social Security and Medicare tax is paid through the Self-Employment Contributions Act (SECA) rather than FICA. Proof of this SECA payment is a requirement for the Working Healthy program, therefore, there will be no change to the requirement that verification be provided of these payments prior to authorizing Working Healthy coverage.

Client attestation shall not be accepted for this verification. Failure to provide proof of the SECA verification per Medical KEESM 2664.3 shall result in ineligibility for the Working Healthy program and coverage under a different Medicaid program shall be considered.

D. Long Term Care – CARE Requests

1. CARE Requirements Waived for 30 days

a.) In accordance with the state's 1135 Waiver, Pre-Admission Screening and Annual Resident Review (PASRR) or CARE Level I and Level II assessments are waived for 30 days. All new admissions can be treated like exempted hospital discharges and if otherwise eligible may be coded temporarily based on the Level of Care indicated on the 2126.

b) After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a Resident Review as soon as resources become available. There is not a set timeframe for when a Resident Review must be completed, but it should be conducted as resources become available.

1. LTC/NF and LTC/MH admissions, if otherwise eligible, may be approved without the ES-3164 on file as these are treated as exempt hospital stays. Once this time frame has passed and resources become available to complete the Level 1 and Level II assessments, KDADS will complete the ES-3164. LTC coding on the case shall then be completed according to sections A-F of the ES-3164 to either continue or discontinue coverage.

    i. If the ES-3164 shows that the consumer is not authorized on a Level 1 or Level 2 CARE, coverage already authorized shall not be retroactively terminated. Instead any level of care coverage already authorized shall cease effective the date the ES-3164 is completed by KDADS. The consumer's Title XIX shall continue following the Delayed CARE Score policy and process.

E. Verification and Application of Expenses

For E&D and LTC programs, verified medical expenses can reduce the share of cost and spenddown amounts and the verification and application of expenses shall follow current, established policy. Failure to provide proof of an expense will not affect eligibility; however, the expense will not be used to lower the share of cost or spenddown until physical verification is received by the agency.

F. Medicare Buy-In

Medicare Buy-In policy per Medical KEESM 2911 shall continue to be applied. PD2020-03-01 COVID-19 Delayed Discontinued Policy Directive states that discontinuances shall not be acted on with the exception of consumers who have moved out of state, become incarcerated, voluntary withdraw from coverage, or are deceased. Another exception to acceptable discontinuances of coverage is when a consumer loses their Medicare Eligibility as reported to the agency by Social Security. If the agency is advised that a consumer's Medicare coverage is terminated by Social Security and the consumer is currently receiving Medicare Savings Program (MSP) Only in Kansas, it is appropriate to discontinue the consumer's MSP coverage.

1) The consumer should then have coverage established on the Medically Needy program with a 6-month base period. This is because the MSP program's purpose is to cover Medicare costs and MSP is not required if there is no Medicare eligibility.

Any case that was active on Buy-In effective March 18th, 2020 shall remain active on Buy-In throughout the scope of this emergency. Cases in the Buy-In Deletion process as identified by the agency shall

have their same coverage reinstated and authorized per PD2020-03-01 COVID-19 Delayed Discontinued Policy Directive unless discontinuance is appropriate because of state residency, become incarcerated, voluntary withdraw from coverage, are deceased, or have had their Medicare Enrollment ended by Social Security.

G. Transfer of Property

During the scope of the emergency, there shall be no change in the effective date of applying a transfer of property for both applicants and recipients. The effective dates shall continue to be applied per Medical KEESM 5724.5.

However, for active recipients that have a transfer of property applied effective March 2020 throughout the scope of this emergency, coverage shall not be discontinued, and level of care shall continue. The effective date will still be applied as appropriate; however, the penalty will not affect coverage until the month after the month the National Public Health Emergency is declared to end. Coverage continued under this provision is not considered overstated eligibility. This action is taken in accordance with PD2020-03-01, COVID-19 Delayed Discontinued Policy Directive.

Example: Consumer is actively receiving LTC/NF coverage. Verification that the consumer's home was gifted to a relative is received and processed by the agency on 3/19/20. The transfer amount is $75,000. As the consumer is an active recipient, per Medical KEESM 5724.5, the start date of this transfer is 5/1/2020 and will end 4/19/2021. As the consumer was actively receiving coverage at the start of this emergency, LTC/NF coverage is left active until the emergency is declared over.

On 5/20/2020, the emergency is declared over. Therefore, the worker re-enters the case to apply the penalty. LTC/NF is discontinued effective 6/30/2020 allowing for timely and adequate notice. A spenddown is established with a 6-month base period beginning with the correct penalty start date of 5/1/2020. Although the spenddown start date is May 1st, 2020, the consumer will have July 1st, 2020 through 10/31/2020 to meet this spenddown because the LTC/NF coverage granted during the months of May 2020 and June 2020 cannot be taken away.

Example: Application is received requesting LTC/NF coverage and is processed on 4/3/2020. Verifications received confirm the applicant had a transfer of property. The consumer is verified as otherwise eligible for LTC/NF coverage 4/1/2020, however, as the applicant was not active on coverage at the start of the National Public Health Emergency, the transfer is applied and a Medically Needy Spenddown with a 6-month base period is established effective 4/1/2020.

IV. Questions

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