Policy Memo	
KDHE-DHCF POLICY NO: 2019-06-02	**From: Erin Kelley, Senior Manager**
Date: June 28, 2019	**Medical KEESM Reference(s): 1610 and subsections, 1725.7, 5720.2, 8200.2, 8215** **KFMAM Reference(s): 1501, 1503, 1504, 1505**
RE: Policy Implementation Instructions and Information for July 2019 Policy Changes	**Program(s): All Medical Programs**

This memo sets forth instructions for policy changes being implemented in July 2019. Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after July 1, 2019. Revisions to the Medical KEESM and KFMAM manuals will coincide with the release of this memo. Additional information related to the implementation of these changes is available through training material released to eligibility staff.

Applicable to all Medical Programs:
- Fair Hearings
- Administrative Roles Chart

Applicable to Family Medical Programs only:
- None

Applicable to Elderly and Disabled Medical Programs only:
- Effective Date of HCBS – SED and TA Waivers
- TBI Waiver Changes
- Pursuit of Veterans Benefits as a Potential Resource
- Pre-Payment of Estate Recovery Claim
- Medical Necessity

I. Changes Impacting All Medical Programs

The following changes are applicable to all medical programs.

A. Fair Hearings

Several provisions of the fair hearing process have been clarified and updated. A detailed description of the current process is provided in the 7.35 Job Aid – Fair Hearing Process.

Both eligibility manuals have been updated to include the following.

1. Request for Fair Hearing

A request for fair hearing may be made either in writing or orally. Earlier guidance indicated that all requests must be in writing. An oral request for hearing shall be accepted, however that request must be reduced to writing by the agency upon receipt.

2. Agency Contact

This provision has been updated to indicate an agency conference with the appellant is no longer required. However, the agency shall attempt a telephone contact with the appellant to explain the agency decision and the effective date of the action. The agency shall make at least two (2) attempts to contact the appellant and thoroughly document the contact and/or unsuccessful attempt(s).

a. Unable to Contact

If after two (2) documented unsuccessful attempts to reach the appellant by telephone to discuss the agency action being appealed, the agency is not obligated to make further outreach attempts to contact the appellant. The agency shall complete an Agency Summary and forward to the Office of Administrative Hearings (OAH) within 15 days after the date the fair hearing request was received.

b. Contact Completed

If the agency is able to contact the appellant by telephone to explain the agency decision, and the appellant is satisfied with the explanation, the agency should ask the appellant if he/she is willing to voluntarily withdraw the fair hearing request.

If the appellant agrees to voluntarily withdraw the fair hearing request, the agency shall complete a Motion to Dismiss based on the withdrawal and forward to the Office of Administrative Hearings (OAH). There is no need to complete an Agency Summary at this point. If the appellant does not agree to voluntarily withdraw the fair hearing request, the agency shall complete an Appeal Summary.

3. Withdrawal of Request

As indicated above, the appellant may voluntarily withdraw the request for fair hearing at any stage of the appeal process. The withdrawal must be in writing and signed by the appellant or the appellant's representative. The Notice of Withdrawal of Appeal form may be used for this purpose. The agency should offer this form to the appellant, but any signed writing evidencing the intent to withdraw shall be accepted by the agency. The appellant may file the withdrawal with either the agency or the Office of Administrative Hearings (OAH) and may be delivered by mail, fax or in person.

Note that the appeal process will continue until the written withdrawal request has been formally received by OAH.

4. Completion of Agency Summary

Unless the agency has filed a Motion to Dismiss, the agency shall complete an Agency Summary and send one (1) copy to the Office of Administrative Hearings (OAH) and one (1) copy to the appellant. The OAH copy shall be sent electronically to the designated email address. The appellant copy shall be mailed to the appellant's designated address, or to that of the appellant's representative.

5. Forms

The fair hearing request (Applicant/Beneficiary Request for Medicaid Fair Hearing) and fair hearing withdrawal (Notice of Withdrawal of Appeal) forms are both located on the Office of Administrative Hearing (OAH) website at https://www.oah.ks.gov/Home/Forms. This website should contain the official current version of the form to be used by eligibility staff. No other versions should be used, however hearing requests or notice of withdrawals submitted by the applicant/recipient on other forms shall be accepted as valid.

B. Administrative Roles Chart

The KC-6001, Administrative Roles Chart, has been updated to include case number as information that can be released to a nursing facility without the need to have a Release of Information form on file. This change will facilitate use of the Document Upload Portal by nursing facilities.

As with releasing other information to nursing facilities without a Release of Information on file, the nursing facility must provide their National Provider Identifier (NPI) which must be verified in the MMIS, or the nursing facility must be documented on the Nursing Home Active List found on the KEES Repository.

II. Changes Impacting Family Medical Programs

There are no changes applicable to Family Medical programs.

III. Changes Impacting Elderly and Disabled Medical Programs

The following changes are applicable to Elderly and Disabled medical programs.

A. Effective Date of HCBS – SED and TA Waivers

The date in which Home and Community Based Services (HCBS) are effective for the Severe Emotional Disturbance (SED) and Technology Assisted (TA) waivers is changing. This change is applicable to all actions taken to approve HCBS for the SED and TA waivers on or after July 1, 2019.

1. Background

HCBS waivers allow individuals to receive services in a non-institutional setting. Services are designed to provide the least restrictive level of care which maintains or improves the overall well-being of consumers who may otherwise be placed in an institutional setting. Depending on the specific waiver, HCBS can help persons avoid placement in a nursing

facility, hospital, or intermediate care facility for the intellectually disabled.

Kansas currently has seven (7) approved HCBS waivers, each focused on serving a unique population. For purposes of this policy implementation, the SED and TA waivers are described below.

a. Severe Emotional Disturbance (SED) Waiver

The SED waiver serves individuals age 4-18 with severe emotional and behavioral difficulties. Individuals may continue to receive services until the age of 22 if approved by the Community Mental Health Center. Currently, the effective date of the SED waiver is the date the individual chooses HCBS if services are expected to begin by the following month. If services are expected to begin in the second month following the month of choice or later, the date services actually begin is considered the HCBS effective date. Typically, for the SED waiver, services always begin the date HCBS is chosen and therefore the choice date is the effective date.

b. Technology Assisted (TA) Waiver

This waiver services chronically ill and medically needy individuals under age 22 who are hospitalized or at imminent risk of hospitalization. This waiver provides eligible individuals with ongoing daily care by a nurse to prevent death or further disability and keep them in their home and integrated in the community. Currently, the effective date for the TA waiver is the date the individual is functionally assessed for services.

To be eligible for HCBS, an individual must meet basic program criteria as well as the functional threshold for the specific waiver, in addition to Medicaid eligibility requirements. These are separate tests and are completed by different entities. The functional assessment is completed by an entity with specialization in aspects of the waiver population (e.g. Community Mental Health Center (CMHC) and Children's Resource Connection (CRC)). If the applicant meets criteria for the waiver and chooses to receive HCBS services, the date the HCBS choice is made is called the 'Choice Date'. The functional assessor will notify eligibility staff of the results of the assessment.

Eligibility staff are responsible for making a final eligibility determination receiving the results of the functional assessment. This determination is made by combining both functional and financial eligibility to determine waiver eligibility. If the consumer is found eligible for the waiver, the information is sent to the Managed Care Organization (MCO) to establish and/or finalize the person-centered service plan. The person-centered service plan is a document that delineates the various services the consumer will receive to maintain a healthy and safe environment in the community. The MCO is responsible for assigning providers to each of the various services. When a consumer is new to Medicaid and not previously connected to an MCO, the person-centered service plan can require additional time to develop and finalize.

The HCBS effective date is of special significance, as this is the date the consumer is considered eligible for HCBS and services can be provided and reimbursed. Current policy regarding initial establishment of HCBS under the SED waiver considers the Choice Date a critical element of the eligibility determination, as in most situations the eligibility worker will backdate financial eligibility to coincide with this date.

2. New Policy

Services may begin when an individual has been determined to meet the financial and non-financial eligibility requirements for Medicaid, has been assessed and determined functionally eligible for the requested HCBS waiver, has been found in need of at least one HCBS service offered under the specific waiver requested, and an available slot on the waiver exists. For purposes of this implementation, the individual is found in need of HCBS at the time the functional assessment is completed. This means for the SED and TA waivers the effective date of HCBS is the date in which the eligibility worker takes action to complete final authorization of coverage and an ES-3160 is sent to the MCO.

Consider the following example:

Penny is screened for the SED waiver by the CMHC on July 15th and chooses to receive HCBS. The CMHC helps Penny's mother complete a Medicaid application and it is submitted on July 25th. The application is processed on August 6th. The HCBS effective date is established the date the eligibility worker authorizes eligibility – August 6th.

The following subsections (a) through (d) apply to all the HCBS waiver programs.

a. Transferring HCBS Waivers

The possibility exists for individuals currently receiving HCBS to transfer to a different waiver. For example, an SED waiver recipient turns 18 and requests to begin receiving services under the Intellectual and Developmental Disability (I/DD) waiver. The KanCare Clearinghouse will be notified via the ES-3160 when an individual has been approved to transfer from one waiver to another. When this occurs, the MCO must develop a new person-centered service plan as different services may be provided by new providers.

When an ES-3160 is received indicating an existing HCBS recipient has been approved to transfer from one waiver to another, eligibility under the new waiver shall be effective the day after the date the prior waiver program ends. This will generally be a future date coordinated between the Program Waiver Managers which provides timely notification of the change to the recipient.

b. Effect on Transfers of Property

The lookback and penalty period applicable to individuals requesting HCBS is changing with this implementation. The penalty period start date for an applicant requesting HCBS is no later than the point at which the applicant would otherwise be receiving HCBS waiver coverage based on an approved application or request for such coverage except for a penalty. For an HCBS applicant, this would be at the point in which the applicant has been determined to meet the financial and non-financial eligibility criteria for Medicaid, functional eligibility for the applicable HCBS waiver, found in need of at least one HCBS service offered under the requested waiver, and an available slot on the waiver exists.

The penalty period for an HCBS applicant begins no later than the date on which all of

these requirements are met. In most cases, this will be the date action is taken to complete the final eligibility determination for HCBS.

Transfers subject to penalty are those that were completed on or after sixty (60) months prior to the date in which eligibility criteria outlined immediately above are met. This means that, for individuals seeking coverage under an HCBS waiver, the lookback period dates back from the point at which all of the requirements for HCBS coverage are met. Again, in most cases, this will be the date action is taken to complete the final eligibility determination.

c. Effect on Community Spouse Resource Allowance (CSRA) Determination

Implementation of this policy has no impact on community spouse resource allowance (CSRA) determinations for married couples where one spouse is requesting HCBS coverage and the other resides in the community or where both spouses are requesting HCBS. The CSRA is determined by comparing the amount of combined nonexempt resources owned by the couple in the month of application with those owned by the couple in the month the spouse requesting HCBS is assessed and chooses services or the month in which the spouse is placed on a waiver waiting list, except when the spouse has been previously in an institution for a stay longer than thirty (30) days. If the spouse had a previous institutional stay of thirty (30) days or more, combined nonexempt resources owned by the couple in the first month in which the institutional stay occurred shall be compared with those owned in the month of application.

d. Effect on Review Processing

If an untimely review is received for an HCBS recipient, coverage may be reinstated without a break in assistance if otherwise eligible and the review is received during the Review Reconsideration period. For the I/DD and PD waivers, if case action is taken more than a month after the end of the review period, the HCBS Program Manager must be contacted for approval to reinstate coverage. If the HCBS Program Manager does not approve reinstatement of coverage, eligibility would have to be determined under another program, such as Medically Needy (MDN).

If the review is returned after the Review Reconsideration Period has expired, it is treated as a new application. A new referral to the screening entity is required and an HCBS effective date shall be authorized based on the date the eligibility worker takes action to complete the final eligibility determination. See Medical KEESM 9350 and Policy Memo 2017-02-10 (KEES Review Processing), for more information related to the Review Reconsideration period.

Note that Policy Memo 2017-03-01 (Living Arrangement Changes Including HCBS Termination – Special Project) does not apply. As indicated in the title, the policy in that memo was specific to a special one-time clean-up project addressing HCBS recipients with inappropriate coverage.

3. Eligibility Determination Process

Information within this section provides special processing instruction for eligibility staff when completing HCBS eligibility determinations. Note that the following subsection (a)

applies to all the waiver programs. Subsections (b) and (c) only apply to the SED and TA waivers.

a. Documenting the MCO in KEES

The MCO selection indicated by the consumer on the application for each individual is entered by eligibility staff on the Individual Demographics page in KEES for transmission (along with the eligibility record) to the MMIS. It is critical that the correct MCO selection is entered to prevent the consumer from being assigned to the incorrect plan.

Eligibility staff must also confirm the LTC Data Details page is completed with the applicable MCO information for each individual requesting or receiving HCBS, including individuals eligible for Institutional Transition. While the LTC Data Details page does not send MCO information to the MMIS, provider information on this page is used to generate reports at COLA or after the monthly Reviews Batch is run.

The MMIS provides the most up-to-date MCO assignment information, as KEES may not reflect changes that have occurred since the last application was received. To ensure the correct MCO is documented on both data collection pages, eligibility staff must check the MMIS prior to determining HCBS eligibility for new applicants and current recipients, whether it be a new request, review, or case maintenance action for a current HCBS recipient.

i. Applicants Requesting HCBS

When determining eligibility for an applicant requesting HCBS, it is not uncommon for the MCO choice reflected on the application to differ from the MCO choice documented on the ES-3160. Eligibility staff must compare both the application and the ES-3160 and list the MCO chosen most recently on the Individual Demographics and LTC Data Detail page.

ii. Current Recipients Requesting HCBS

When a consumer chooses a new MCO during their initial 90 day choice period or their annual open enrollment period, the change in MCO is not communicated back to KEES from the MMIS. This means the MCO documented on the Individual Demographics page and the LTC Data Detail page may not be accurate.

When determining eligibility for a current recipient requesting HCBS or processing a review or case maintenance change for an existing HCBS recipient, eligibility staff must check the MMIS to verify the consumer's current MCO and make necessary changes to the LTC Data Details page. Doing so will prevent the ES-3160 from being sent by the eligibility worker to the incorrect MCO after the eligibility determination has been completed. Eligibility staff shall not update the MCO selection on the Individual Demographics page.

b. Eligibility Months Prior to the HCBS Effective Date

With this change in policy, it becomes likely that HCBS eligibility will not begin in the

month of application or request. This may be due to the date the application was received, with additional time allowed for information required to complete the financial eligibility determination to be requested by the agency and returned by the applicant, as well as time allowed to finalize the eligibility determination once information has been returned.

Eligibility under other programs must be considered in months prior to the month in which HCBS begins. This includes requests for prior medical assistance.

i. Children Requesting HCBS

For children requesting HCBS who are currently covered under a MAGI program or receiving SSI-related coverage, coverage under that program shall continue until the month in which HCBS is effective. Action must be taken to properly end MAGI-related coverage and establish a new program block for LTC/HCBS, when appropriate.

For children not currently receiving coverage, eligibility under MAGI programs shall be considered in months prior to HCBS beginning. It may be necessary to contact the child's parent by telephone to obtain their self-attestation of income and tax household to complete the MAGI determination. If the child's parent indicates eligibility in months prior to HCBS beginning is not needed, the "Voluntary Withdrawal" Negative Action reason is used to deny eligibility in those months.

If the child's parent cannot be reached by telephone, a V044 shall be sent to request the information needed to complete a MAGI determination at the same time eligibility for HCBS is authorized. If the requested information is not returned, any months pending in KEES prior to the month HCBS is effective shall be denied for failure to provide. Eligibility in pending months shall be rescinded and processed accordingly if the requested information is received within the later of forty-five (45) days from the date of application or twelve (12) days following the date action is taken to deny for failure to provide the requested information. See Medical KEESM 1414.2(3) or KFMAM 1410.02(2).

ii. Adults Requesting HCBS

For adults requesting HCBS who are currently receiving medical assistance, coverage under the existing program shall continue until the month in which HCBS is effective. Action must be taken to shorten any Medically Needy (MDN) spenddown base period to end in the month prior to the month HCBS begins. Instructions for shortening a Medically Needy (MDN) spenddown may be found in the KEES User Manual.

In situations where a new application is received from an adult not currently receiving medical assistance, an eligibility determination must be completed for months prior to HCBS beginning, including prior medical months if requested. Eligibility under any medical assistance program for which the adult may qualify, including Medically Needy (MDN) with a spenddown or Medicare Savings Programs (MSP), shall be considered and authorized if otherwise eligible.

It is necessary to contact individuals requesting HCBS who meet eligibility criteria for a Medically Needy (MDN) spenddown or Expanded LMB, as Expanded LMB cannot coexist with any other type of medical assistance. This will assist with determining the type of medical assistance in months prior to HCBS beginning that is most beneficial to the applicant.

c. Examples

Consider the following examples.

i. **MAGI Child Requesting SED Waiver** – A child is receiving coverage on a MAGI program block with one sibling. The child is assessed by the CMHC and found functionally eligible for the SED waiver. The CMHC sends an ES-3160 to the KanCare Clearinghouse listing the choice date as July 5th, the same day the child was assessed. On July 8th, an eligibility worker takes action to authorize HCBS. A new program block is added with an RMT of LTC for only the child requesting HCBS. The MMIS is checked to verify the child's current MCO and an LTC Data Details record is added. EDBC is run in the come-up month to discontinue eligibility for the child requesting HCBS on the MAGI program block. Then EDBC is run on the new program block for the month of July to authorize HCBS on the SED waiver effective July 8th, the date eligibility is authorized. The ES-3160 is updated to reflect eligibility approval and sent to the MCO and CMHC.

ii. **Non-Recipient Child Requesting SED Waiver** – An application received July 16th requesting HCBS for a child and prior medical assistance. An ES-3160 is received from the CMHC a few days later showing the child was assessed, determined functionally eligible for the SED waiver, and chose HCBS on July 12th. On July 15th, an eligibility worker takes action to authorize HCBS. The worker contacts the child's parent to obtain their self-attested monthly income and information related to their tax household, as this information was not included on the application. Two program blocks will be needed to complete the determination – one for MAGI which includes the child and parents, and one for LTC/HCBS with only the child. MAGI coverage for the months of April, May, and June are denied as the parent's income exceeds the limit. HCBS is effective July 15th, the date eligibility is authorized. The ES-3160 is updated to reflect eligibility approval and sent to the MCO and CMHC.

4. Person-Centered Service Plan Development

Eligibility for HCBS is determined with the assumption the MCO will have the person-centered service plan completed within thirty (30) days of receiving HCBS eligibility information via the ES-3160. Notification must be sent to the KanCare Clearinghouse each week when the MCO is unable to complete the person-centered service plan. As part of this implementation, a process has been developed for the MCO to communicate this information back to the KanCare Clearinghouse.

a. MCO Spreadsheet

The existing MCO spreadsheet has been modified to include new data elements for the MCO to report when the person-centered service plan has or has not been completed, in addition to the general changes currently reported. The MCO will notify the KanCare

Clearinghouse if they are unable to complete the person-centered service plan within thirty (30) days, or upon reaching the consumer, the consumer indicates they no longer wish to receive HCBS.

b. Eligibility Action

No eligibility action is needed when the MCO reports the person-centered service plan has been completed. However, eligibility staff are required to take prompt action to terminate HCBS when either the MCO reports the person-centered service plan has not been completed after thirty (30) days or the consumer indicates they no longer wish to receive HCBS. Since HCBS services are being provided under an interim service plan, timely notice is required to discontinue coverage. When action is taken to terminate HCBS, the termination date listed on the LTC Data Details page will be the last day of HCBS coverage, allowing for timely and adequate notice.

For example, HCBS was effective 7/15 but the MCO was unable to complete the person-centered service plan. Eligibility staff take action to discontinue HCBS coverage on 8/22. Allowing for timely notice, coverage is discontinued effective 9/30. The termination date listed on the LTC Data Details page is 9/30. Eligibility must be considered for other programs following HCBS termination.

B. Traumatic Brain Injury (TBI) Waiver Changes

The following changes to the Traumatic Brain Injury (TBI) waiver are planned for July 1, 2019, but are contingent on The Kansas Department of Aging and Disability Services (KDADS) receiving approval from CMS for the changes. If CMS approval is not granted, these changes will be rescinded and eligibility staff notified.

1. Background

The TBI waiver serves individuals who have traumatically acquired head injury which caused structural brain damage resulting in residual deficits and disabilities and who would otherwise require care in a rehabilitation facility. This waiver serves individuals between the ages of 16 and 65. Some individuals may continue on the TBI waiver past the age of 64, as approved by the waiver manager.

2. New Policy

As part of the 2019 legislative session, additional funding was approved for the TBI waiver. The following changes are included as part of the additional funding.

a. Acquired Brain Injuries

Effective July 1, 2019, the TBI waiver will no longer be limited to individuals who have traumatic brain injuries. Now, individuals with acquired brain injuries may also qualify under the waiver. This includes brain injuries caused by (but not limited to) stroke, brain trauma, infection of the brain, brain tumor, and anoxia. As a result of this change, the TBI waiver will now be referred to as the Brain Injury (BI) waiver.

b. Age Limit

The lower age limit for the BI waiver is changing by eliminating the lower limit. This means the BI waiver will serve individuals from birth (0) to age 64. At this time, KEES is not being modified to account for this change. A workaround will be needed to authorize BI waiver services for qualifying individuals from birth through age 15. This workaround will be communicated through the KEES Dispatch and published in the KEES User Manual.

3. Form Updates

The following form updates are effective with this policy implementation.

a. ES-3160 (Notification of KanCare HCBS Services)

The ES-3160 has been modified to remove references to the TBI waiver and replace them with BI waiver. There have been no policy or process changes surrounding this form.

b. ES-3161 (Notification of KanCare HCBS Changes and Updates)

The ES-3161 has been modified to remove references to the TBI waiver and replace them with BI waiver. There have been no policy or process changes surrounding this form.

C. Pursuit of Veterans Benefits as a Potential Resource

As part of this policy implementation, the process for requiring an individual to pursue potential resources from the Department of Veterans Affairs (VA) is being simplified.

1. Background

As a condition of eligibility, current policy requires an applicant/recipient to pursue and cooperate in obtaining any potential resource which the individual may be entitled to receive. This includes applying for VA benefits when appropriate. Failure to do so may render the individual ineligible for medical assistance.

The following guidelines were developed in 2009 as part of the implementation of Policy Memo 2009-09-01 (Applying for VA benefits as a Potential Resource). These guidelines are still valid and determine which applicants/recipients shall be required to apply for VA benefits as a condition of medical eligibility based on their potential for qualifying for those benefits.

a. Veteran

Any individual who indicates that they have served in the military by answering “yes” to the question in Section C on page 5 of the KC1500 application shall be required to apply for VA benefits as a condition of medical eligibility and must verify that they have done so.

b. Spouse of a Veteran

Any individual who indicates that they have ever been married to an individual who has served in the military by answering "yes" to the question in Section C on page of the KC1500 application shall be required to apply for VA benefits based on the following guidelines.

i. Un-Remarried Surviving Spouse

An un-remarried surviving spouse of a deceased veteran shall be required to apply as a condition of eligibility and must verify that they have done so.

Example: The applicant/recipient's veteran husband is deceased. The surviving wife (widow) has never remarried. She is potentially eligible for VA survivor benefits and must apply for benefits as a condition of medical eligibility.

ii. Remarried Surviving Spouse

A remarried surviving spouse of a deceased veteran shall not be required to apply since he/she is no longer considered a spouse for VA purposes and therefore not eligible for survivor benefits.

Example: The applicant/recipient's veteran husband is deceased. The surviving wife (widow) has since remarried. Once she remarries, she is no longer potentially eligible for survivor benefits. She would not be required to apply for VA benefits as a condition of medical eligibility based on her widow status.

iii. Ex-Spouse of Veteran

An ex-spouse of a veteran (either living or deceased) shall not be required to apply for VA benefits since they are no longer considered a spouse and therefore not eligible for benefits.

Example: The applicant/recipient is divorced from his/her veteran ex-spouse. Since the marriage has been dissolved, the non-veteran spouse is no longer potentially eligible for VA benefits. He/she would not be required to apply for VA benefits as a condition of medical eligibility.

iv. Spouse of Living Veteran

A spouse of a living veteran shall not be required to apply for VA benefits since only surviving un-remarried spouses of deceased veterans are eligible for survivor benefits.

Example: the applicant/recipient is currently married to his veteran wife. Since survivor benefits are only available to the surviving spouse of a deceased veteran, he would not be potentially eligible for VA benefits. He would not be required to apply for VA benefits as a condition of medical eligibility.

c. Exceptions

As indicated above, veterans and un-remarried surviving spouses of deceased veterans shall be required to apply for VA benefits as a medical eligibility requirement and verify they have done so, except in the following situations:

i. The individual verifies that they have been formally denied by VA for benefits within the last twelve (12) months.

ii. The individual provides a written statement from the VA that they are not potentially eligible for benefits.

iii. The individual provides any other sufficient verification that they are not potentially eligible for benefits.

d. Timeline to Apply

Currently, an individual is allowed twelve (12) days to apply for benefits with the VA and provide proof of that application being filed. This is problematic as the application process for VA benefits takes longer than twelve (12) days, resulting in frequent Medicaid eligibility denials and/or discontinuances, or requests for extensions to provide the verification as an unintended consequence of the policy.

2. New Policy

Effective July 1, 2019, applicants/recipients who have been identified as meeting the criteria to apply for VA benefits as either a veteran or the surviving spouse of a deceased veteran, outlined in Section III.C.1. above, will be referred to the Kansas Commission on Veterans Affairs Office (KCVAO) to pursue the benefits as a potential resource. While pursuit of this potential resource is an eligibility requirement, an application for medical assistance or continued medical coverage shall not be pended or delayed while benefits are being pursued.

a. Referral to Kansas Commission on Veterans Affairs Office (KCVAO)

Once an applicant or on-going recipient of medical assistance has been identified as needing to pursue VA benefits, he/she shall be referred to the KCVAO to schedule an interview. Eligibility staff shall formally notify the individual of the responsibility to contact the KCVAO and schedule an interview in pursuit of potential VA benefits by using the following Standard Text for Copy and Paste fragment:

You reported that you are a veteran or the spouse of a deceased veteran. You may be eligible for cash benefits from the Department of Veterans Affairs (VA). You must apply for those benefits.

Please contact the Kansas Commission on Veterans Affairs Office (KCVAO) nearest you by calling {insert phone number} between 8 AM and 5 PM weekdays. They will schedule an appointment to help you apply for benefits through the VA. They can also tell you about other benefits

offered through the VA, including medical.

We are sending you a form (ES-3122 – Veterans Administration – Potential Benefits) in a separate envelope that you must take to your appointment with the KCVAO.

The KCVAO staff will fill out and sign the form. This will tell us if KCVAO is helping you apply for VA benefits. You must return the completed form to the KanCare Clearinghouse. If we do not receive the form within 12 days from the date you meet with the KCVAO, your medical coverage may be denied or ended.

If the KCVAO helps you apply for VA benefits, you must cooperate with them until your VA application has been filed and a decision has been made. If you do not cooperate with the KCVAO or fail to apply for VA benefits on your own, your medical assistance may be denied or ended.

You must tell us within 10 days if you are denied or approved for VA benefits. Any cash benefit you receive may affect your medical assistance. We will tell you if there is a change in your medical coverage.

Note: The KCVAO field office locations and telephone numbers may be found at https://kcva.ks.gov/veteran-services/office-locations. Eligibility staff shall identify the field office nearest the applicant's/recipient's residence and enter the telephone number for that field office in the fragment above.

b. New Form

A new form, ES-3122 (Veteran's Administration – Potential Benefits Request) has been developed for the applicant/recipient to take to their scheduled appointment with the KCVAO. Eligibility staff shall send this form to the applicant/recipient and to any responsible persons on the case at the same time the notification described in subsection (b) above is sent. The form is to be completed by the KCVAO representative to document potential eligibility and whether the applicant/recipient intends to file for VA benefits with the help of the KCAVO.

As indicated in subsection (a) above, the applicant/recipient is instructed to return the completed form to the KanCare Clearinghouse within 12 days of the scheduled interview. The form must be completed and signed by the KCAVO representative. Eligibility staff are not responsible for tracking the form once it is sent to the applicant/recipient or determining when the form is due back to the KanCare Clearinghouse.

c. Disposition of the Form

Eligibility staff shall take the following action based on whether or not a completed and signed form is returned to the KanCare Clearinghouse, and if returned, the information reported by the KCVAO representative on the form.

i. Form Returned

If the form is returned and indicates the applicant/recipient is not potentially eligible for VA benefits, no further action by either the applicant/recipient or eligibility staff is required. Since the KCVAO representative has evaluated this individual's circumstances and determined that there is no potential eligibility, there is no need to file an application for VA benefits. VA benefits are no longer considered a potential resource for this individual.

If the form is returned indicating potential eligibility and reports the applicant/recipient intends to file an application for VA benefits with help from the KCVAO, again, no further action at this time is required. The applicant/recipient has an obligation to cooperate with the KCVAO throughout the VA application process. In addition, once the decision has been made on the VA application, the applicant/recipient must report the outcome (approved or denied) within ten (10) days of notification.

If the form is returned indicating potential eligibility but that the applicant/recipient refuses to apply for VA benefits or cooperate in the process, medical eligibility may be denied or discontinued for failure to pursue a potential resource. A pending medical application may be denied for failure to pursue, with adequate notice. On-going medical coverage may be discontinued, with timely and adequate notice.

ii. Form Not Returned

Even though the applicant/recipient has been instructed to contact the KCVAO to schedule an appointment, attend that appointment, have the KCVAO representative complete, sign and date the form, and then return the form to the KanCare Clearinghouse within twelve (12) days from the date of the appointment, it is possible that the applicant/recipient may not comply with that requirement.

The process developed for this new policy does not currently require eligibility staff to monitor the applicant's/recipient's compliance once formal notification for the requirement to pursue has been sent. Staff are only required to react to a returned form. See subsection (d) below. Therefore, if the ES-3122 form is not returned, eligibility staff shall take no action at this time. Should this process change in the future, KDHE-DHCF Policy will issue additional instructions and guidance at that time. See subsection (f) below.

d. Application for VA Benefits Adjudicated

As indicated above, the applicant/recipient is required to report the outcome of his/her application for VA benefits. Assuming the outcome is timely reported, eligibility staff shall take the following actions.

i. Denied for Benefits

If the applicant/recipient received assistance from the KCVAO in filing an application for VA benefits, it is unlikely that benefits will be ultimately denied. However, in that occurrence, the denial shall be fully noted in the case file and no additional action by

either the applicant/recipient or eligibility staff is required. Note though that if the denial was due to non-cooperation by the applicant/recipient, medical eligibility shall be denied or discontinued for failing to pursue the potential resource.

ii. Approved for Benefits

If the applicant/recipient has been approved for VA cash benefits, initial or on-going medical eligibility shall be determined based on the assistance received. Adverse action shall require timely and adequate notice. If the approval of VA benefits was not timely reported, overstated eligibility may have occurred.

e. Transition

This new policy is effective July 1, 2019 and shall apply to any action taken by eligibility staff on a new application or existing eligibility on or after that date. The old policy shall apply to any action taken before that date.

f. Cooperation

As indicated above, an applicant/recipient potentially eligible for VA benefits must apply for those benefits and cooperate throughout the application process. Failure to fully cooperate may result in denial or discontinuance of medical assistance. However, since eligibility staff are not required to monitor that cooperation under this new policy, a secondary process is being developed.

Normally, cooperation would be manually reviewed by eligibility staff at the time of the annual redetermination of eligibility. However, that process would only be practical for those recipients undergoing a pre-populated review. The process would be impractical for recipients subject to either a passive or super passive redetermination. Therefore, to ensure that all recipients, regardless of the review type, are properly monitored for cooperation at review, the following monitoring process is proposed (but not implemented) at this time:

i. Report

A report shall be run to identify all cases where the ES-3122 form has been mailed within the current review period and there is no indication in the case file that VA benefits are being received. The report will be run the month prior to the last month of the current review period. When the report will be run and what staff will work it will be determined at a later date.

ii. Request for Information

The case journal shall be reviewed to determine if verification has been received to indicate that either the recipient was determined to not be eligible for VA benefits and therefore was not required to file or, filed and was determined not eligible for benefits. A review of imaged documents may also be required to fully substantiate. A request for information shall be sent on all other cases identified on the report concerning verification of the individual's VA application status. A Standard Text for Copy and Paste fragment will be created at a later date for use by eligibility staff specifically for

this purpose.

iii. Disposition of Request

If the recipient fails to respond to the request for information or, responds that an application for VA benefits was never filed, medical assistance shall be discontinued based on either a failure to provide or failure to pursue, giving timely and adequate notice.

If the recipient verifies that he/she was denied for VA benefits, other than for failing to cooperate with the application process, the denial shall be noted in the case file and no further action by either the recipient or eligibility staff is required. If verification is provided that VA benefits were denied for failure to cooperate, medical assistance shall be discontinued for failure to pursue, giving timely and adequate notice.

If the recipient verifies that he/she has been approved for VA cash benefits, medical eligibility shall be adjusted prospectively, giving timely and adequate notice. However, if the recipient failed to timely report the approval of VA benefits (i.e.: within the (10) days of receipt of the first payment), overstated eligibility may have occurred. See Medical KEESM 11121.2(2)(b).

As indicated above, this monitoring process is currently only in the developmental stage. Eligibility staff will be notified when this additional process has been fully formulated and implemented. No action by eligibility staff is required at this time. Once the process has been fully developed and finalized, additional instruction and guidance, including effective date, will be provided at that time.

D. Pre-Payment of Estate Recovery Claim

Previous policy allowing the pre-payment of an Estate Recovery claim prior to the death of the recipient or the surviving spouse of the recipient is being formalized. This is a voluntary option available where a current recipient is reducing excess resources to retain or regain eligibility, or a previous recipient no longer receiving assistance wants to satisfy the outstanding claim in full or in part prior to his/her death,

A recipient (current or former) choosing this voluntary option should be referred to the Estate Recovery Unit at 1-800-817-8617 or e-mail at KSestaterecovery@hms.com. Estate Recovery will assess the amount of the proposed payment against the current size of the outstanding claim to determine if the pre-payment can be accepted. Estate Recovery cannot accept a payment that exceeds the current amount of the claim. The claim will be reduced by the amount of any pre-payment accepted by Estate Recovery.

If a current recipient who would otherwise be resource ineligible chooses this method as a means to reduce resources to the allowable limit, the agency shall verify that the pre-payment has been made and accepted by Estate Recovery, and that the amount is sufficient to make the recipient resource eligible. If eligibility has been discontinued due to excess resources, eligibility may be reinstated without a new application if this pre-payment process has been completed and verified before the end of the month after the month of discontinuance. See Medical KEESM 1423.

Note that the option to pre-pay Estate Recovery may also be used by non-long term care recipients who received services on or after age 55 since those claims are also subject to Estate Recovery. This would include an individual eligible under Medically Needy (MDN), but not a recipient of QMB, LMB, or QWD only as those programs are not subject to Estate Recovery. See Medical KEESM 1725.1.

E. Medical Necessity

The P-1 (Medical Necessity) document in the Eligibility Policy Appendix Section has been updated with some minor wording and numbering changes. In addition, three (3) substantive changes have been incorporated and are effective with the issuance of this memo.

The address for sending items and/or services which need to be reviewed by KDHE-DHCF has been changed. Previously, the request for review and all supporting material was to be mailed to the agency office in Topeka. Effective with this change, the material shall be sent electronically to the KDHE Medicaid eligibility policy mailbox at kdhe.medicaideligibilitypolicy@ks.gov.

Services and items provided outside of the United States has been removed from the list of items considered to be non-medically necessary. Those services and items were not allowable as a medical expense, even if otherwise deemed to be medically necessary. Effective with this change, any service or item provided outside of the United States shall be considered under the normal medical necessity criteria established in this document.

CBD (Cannabidiol) Oil has been added to the list of items considered to be medically necessary. A prescription from a licensed practitioner or statement of medical necessity is required. See Section D (7) of the P-1 (Medical Necessity) document.

IV. Questions

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

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov
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