Kansas
Department of Health and Environment
Division of Health Care Finance

Policy Memo	
KDHE-DHCF POLICY NO: 2018-10-01	**From: Jeanine Schieferecke, Senior Manager**
Date: October 1, 2018	**KEESM/KFMAM Reference:**
RE: Loss of SSI Recipient Status and Verification of Resources	**Program(s): All Medical Programs**

This memo sets forth instructions for implementation of policy changes as indicated below. Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after October 1, 2018. 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:

- Loss of SSI Recipient Status

Applicable to Elderly and Disabled Medical Programs only:

- Verification of Resources

I. Changes Impacting All Medical Programs

The following changes are applicable to all medical assistance programs.

A. Loss of SSI Recipient Status

The following policy addresses the process for identifying when an individual loses SSI recipient status with Social Security and for determining continued eligibility for medical assistance under a program other than SSI medical assistance.

1. Background

When SSI medical assistance will be discontinued due to loss of SSI recipient status with Social Security, continued eligibility under another program must be considered.

See Medical KEESM 2636 and 2662.8. If continued eligibility can be determined without a new application, the individual is administratively transitioned to the new medical assistance program. If a new application is required, the SSI medical assistance program is discontinued and a new application mailed to the individual.

This reapplication process often results in a coverage gap due to the time involved in returning and processing the new application. This may create an unnecessary hardship for some individuals, particularly those under a prescribed medical treatment plan or those receiving HCBS services. This may be exacerbated by processing delays due to the large volume of applications received and pended.

The Centers for Medicare and Medicaid Services (CMS) has provided additional instruction that an individual who loses SSI recipient status be allowed the opportunity to establish eligibility under another medical assistance program prior to discontinuing medical coverage. This includes mailing, receiving, and fully processing a new application prior to discontinuance of SSI medical assistance. To ensure there is no disruption in coverage, SSI medical assistance must continue throughout the entire eligibility determination process.

2. POLICY

Effective with the issuance of this memo, an individual losing SSI recipient status with Social Security will no longer be discontinued from SSI medical assistance immediately upon report or discovery of the change in status. Instead coverage under the SSI medical assistance program shall continue until eligibility without a new application is established under another assistance program (if possible), or the individual has been given the opportunity to file a new application and the application is either timely returned and fully processed or is not timely returned (including not returned at all).

Any circumstance where eligibility can be determined under another program without the filing of a new application must first be considered. This may include situations where additional information is needed but is either obtainable by the agency or from the individual upon request. In general, if the only information needed from the individual is self-attestation of income or tax filing status, and there is an active program or recent application on file, a new application may not be required. In most other situations, a new application will likely be required. For programs subject to MAGI budgeting, verification of zero earnings is applicable when the individual attests they do not have earnings or only reports non-wage income, such as self-employment or unearned income. See KDHE-DHCF Policy Memo 2018-03-01 for additional information related to verification of zero earnings.

In all instances, eligibility staff shall make an attempt to contact the individual by telephone to both inform and assess the situation before taking any case action. Even though not possible in every case (i.e.: individual has no telephone or contact number, fails to answer call), eligibility staff are expected to make a reasonable effort to make telephone contact prior to proceeding.

Note: An applicant may not be denied for medical assistance (except MediKan) due solely to failure to apply for or receive SSI benefits. See Medical KEESM 2124.1 (3) and KFMAM 2022.02.

a. NEW APPLICATION NOT REQUIRED

Every effort should be made to determine continued eligibility without the individual having to file a new application. This would include adding the individual to an active program or determining eligibility under a new program. The active or new program may or may not be based on disability, and applies to both MAGI and non-MAGI programs. The individual must meet all eligibility requirements under the new program, including verification of income, resources (if applicable), household and tax filing status. In addition, the new resource reverification policy described below applies.

i. Added to Active Program

The individual may be added to any qualifying active medical assistance program in which all eligibility criteria are met. The active program must be based on an application or pre-populated review form with the recipient's (or responsible person's) signature on file that is less than 12 months old (for all medical programs) or a passive review was completed within the last 12 months (for Family Medical programs only). If the recipient cannot be added to an active program, eligibility under a new program without an application shall be considered. Otherwise, a new application is required.

Note: In all instances, a skipped or unprocessed review must be completed before an individual is added to an active medical program.

The following additional provisions apply.

1) No Additional Information Needed

When no additional information is needed, the individual may be administratively added to an active medical assistance program. A new application is not required. Eligibility staff may contact the

individual as a courtesy before processing the change, but it is not required.

The following examples illustrate:

a) Medically Needy (MDN) Spouse

An SSI recipient loses recipient status due to excess income (N01 Payment Status Code). The recipient is not eligible for coverage under a PMG. The recipient's spouse has an active Medically Needy (MDN) spenddown program. All income and resource information has been previously verified.

The recipient may be added to the active Medically Needy (MDN) program effective the month after the month of SSI medical assistance discontinuance. Timely and adequate notice of the discontinuance is required. Adequate notice of the new coverage is required.

b) Poverty Level Sibling(s)

An SSI recipient child loses recipient status due to excess parental income (N01 Payment Status Code). There is an active poverty level medical assistance program for the recipient's sibling(s). All program requirements have already been verified and are on file.

The recipient may be added to the active poverty level program effective the month after the month of SSI medical assistance discontinuance. Timely and adequate notice of the discontinuance is required. Adequate notice of the new coverage is required.

2) Additional Information Needed

When additional information is required to add the individual to an active program, contact with the individual is required. After the initial telephone contact, additional formal contact may be required by sending a written request for information. The ultimate type of contact required will depend on the specific information needed and the level of verification required.

a) Telephone Contact

Telephone contact is required where tiered verification applies and the information needed to add or open the individual either requires no verification or by policy may be verified by self-attestation. If hard copy verification is required, formal contact is required.

The following examples illustrate:

i.) Medically Needy (MDN) Spouse

An SSI recipient loses recipient status due to excess income (N01 Payment Status Code). The recipient is not eligible for coverage under a PMG. The recipient's spouse has an active Medically Needy (MDN) spenddown program. The recipient is contacted by telephone to determine the source and amount of the recipient's income. The recipient reports that he began receiving a KPERS benefit. The agency is able to independently verify the amount of the KPERS payment. No other information is needed.

The recipient may be added to the active Medically Needy (MDN) spenddown program effective the month after the month of SSI medical assistance discontinuance. Timely and adequate notice of the discontinuance is required. Adequate notice of the new coverage is required.

ii.) Caretaker Medical Spouse and Child(ren)

An adult SSI recipient loses recipient status due to cessation of disability (N07 Payment Status Code). The recipient's spouse and two minor children have an active Caretaker Medical (CTM) program. The recipient is contacted via telephone to confirm that she has no income now that SSI has ended. The recipient also confirms her tax filing status.

The recipient may be added to the active Caretaker Medical (CTM) program effective the month after the month of SSI medical assistance discontinuance. Timely and adequate notice of the discontinuance is required. Adequate notice of the new coverage is required.

b) Formal Contact

Where formal contact is required, a written request for information shall be mailed to the individual allowing 12 days to respond. Standard verification requirements apply. Failure to provide the requested information shall result in ineligibility.

The following examples illustrate:

i.) Medically Needy (MDN) Spouse

Same situation as in example 2.a.i. above, except eligibility staff are unable to contact the recipient by telephone. A formal request to verify the source and amount of income is mailed to the recipient allowing 12 days to respond. The recipient timely responds by providing the requested information. No additional information is required. The recipient may be added to the active Medically Needy (MDN) spenddown program effective the month after the month of SSI medical assistance discontinuance.

Timely and adequate notice of the discontinuance is required. Adequate notice of the new coverage is required.

ii.) Caretaker Medical Spouse and Child(ren)

Same situation as in example 2.a.ii. above, except eligibility staff are unable to contact the recipient by telephone. A formal request to verify income and tax filing status is mailed to the recipient allowing 12 days to respond. The recipient timely responds by providing the requested information. No additional information is required.

The recipient may be added to the active Caretaker Medical (CTM) program effective the month after the month of SSI medical assistance discontinuance. Timely and adequate notice of the discontinuance is required. Adequate notice of the new coverage is required.

ii. Transitioned to Another Program

The individual may be transitioned to a new non-active medical assistance program if there is an application or pre-populated review form with the recipient's (or responsible person's) signature on file that is less than 12 months old (for all medical programs) or a passive review was completed within the last 12 months (for Family Medical programs only). Otherwise, a new application is required. The following additional provisions apply.

1) No Additional Information Needed

When no additional information is needed, the individual may be administratively transitioned to another medical assistance program. A new application is not required. Eligibility staff may contact the individual as a courtesy before processing the change, but it is not required.

If additional information is required, contact with the individual will be required.

The following examples illustrate:

a) Medically Needy (MDN) Added

An SSI recipient loses recipient status due to excess income (N01 Payment Status Code). The recipient is not eligible for coverage under a PMG. Examination of the EATSS record indicates that presumptive SSI ended due to approval of an OASDI benefit of $1,200/month. The recipient had received PMD Tier 1 presumptive medical coverage within the last year based on an application filed 10 months ago, but was discontinued 5-months ago when presumptive SSI was approved. Based on the verified information associated with the earlier application, plus the new OASDI benefit, eligibility may be determined under the Medically Needy (MDN) spenddown program. No other information is needed.

The recipient is approved for Medically Needy (MDN) spenddown coverage with an unmet 6-month spenddown of $4,230 effective the month after the month of SSI medical assistance discontinuance. Timely and adequate notice of the discontinuance is required. Adequate notice of the new coverage is required.

b) Caretaker Medical Added to Active Poverty Level

An SSI recipient loses recipient status due to excess resources (N04 Payment Status Code). The recipient is not eligible for coverage under a PMG. There is an active Poverty Level program for the recipient's two minor children. The recipient's income self-attestation and tax filing status are already on file. No other information is needed.

The recipient is approved for Caretaker Medical coverage effective the month after the month of SSI medical assistance discontinuance. The Poverty Level program is likewise discontinued because the children are now covered under the Caretaker Medical program. Timely and adequate notice of the discontinuances is required. Adequate notice of the new coverage is required.

2) Additional Information Needed

When additional information is required to transition the individual to another medical assistance program, contact with the individual is required. Contact may be either informal by telephone or formal by sending a written request for information. The type of contact will depend on the specific information needed and the level of verification required.

a) Telephone Contact

Telephone contact is required where the information needed to transition the individual either requires no verification or by policy may be verified by self-attestation. If hard copy verification is required, formal contact is required.

The following examples illustrate:

i.) Medically Needy (MDN) Added to Active QMB

An SSI recipient loses recipient status due to excess resources (N04 Payment Status Code). The recipient is not eligible for coverage under a PMG. The recipient has an active QMB program that was not based on a MIPPA application. The recipient is contacted by telephone to determine the source and amount of the recipient's resources. The recipient reports that she received a $50,000 inheritance which

she used to purchase a certificate of deposit. No other information is needed.

Eligibility under the Medically Needy (MDN) program is formally processed and denied due to self-attested resources exceeding the allowable limit. A Medically Needy (MDN) program denial notice is mailed providing adequate notice. SSI medical assistance and QMB coverage (excess resources) are both discontinued, providing timely and adequate notice.

ii.) Poverty Level Added to Active CHIP

A 16-year old SSI recipient loses recipient status due to excess resources (N04 Payment Status Code). The recipient is not eligible for coverage under a PMG. There is an active CHIP program for the recipient's 18-year old sister. The recipient's responsible person is contacted via telephone to obtain income self-attestation, tax filing and household status. No other information is needed.

The recipient is approved for Poverty Level coverage effective the month after the month of SSI medical assistance discontinuance. Timely and adequate notice of the discontinuances is required. Adequate notice of the new coverage is required.

b) Formal Contact

Where formal contact is required, a written request for information shall be mailed to the individual allowing 12 days to respond. Standard verification requirements apply. Failure to provide the requested information shall result in ineligibility.

The following examples illustrate:

i.) Medically Needy (MDN) Added to Active QMB

The same situation as in example 2.a.i. above, except the recipient received a $5,000 inheritance which she used to purchase a certificate of deposit. A formal request to verify the value of all resources is mailed to the recipient allowing 12 days to respond. The recipient timely responds by verifying total countable resources of $6,500. No additional information is

required.

Eligibility under the Medically Needy (MDN) program is formally processed and denied due to excess resources. A Medically Needy (MDN) program denial notice is mailed providing adequate notice. SSI medical assistance is discontinued, providing timely and adequate notice. QMB coverage continues.

ii.) Poverty Level Added to Active CHIP

The same situation as in example 2.a.ii. above, except eligibility staff are unable to contact the recipient by telephone. A formal request to verify income, tax filing and household status is mailed to the recipient allowing 12 days to respond. The recipient timely responds by providing the requested information. No additional information is required.

The recipient may be approved for Poverty Level coverage effective the month after the month of SSI medical assistance discontinuance. Timely and adequate notice of the discontinuance is required. Adequate notice of the new coverage is required.

iii. Determined Ineligible

Should it become absolutely apparent based on information requested by the agency and provided by the individual, or obtained or known by the agency, that the individual is not eligible for medical assistance under any available program, eligibility under the SSI medical assistance program may be discontinued giving timely and adequate notice. In that instance, mailing a new application to the individual is not required. Nor is a formal determination under another program necessary.

For example, a single non-aged adult without minor children living in the community who loses SSI recipient status due to loss of disability status and does not claim a new disability would also be ineligible for the only other program he/she may otherwise be categorically eligible for – Medically Needy (MDN) spenddown. Since there is no categorical eligibility for any other medical assistance program, SSI medical assistance may be discontinued (by providing timely and adequate notice) without the need to mail a new application.

However, if the loss of SSI recipient status was due to excess income or resources for that same single non-aged adult, a formal eligibility determination would be required since there is potential categorical eligibility for coverage under another medical assistance program. A new application may, or may not, be required.

It should be noted that discontinuance under this provision should be very uncommon. In most instances, mailing of a new application will be required. It is necessary to review the case journal for the last 12 months and contact the individual to confirm his/her circumstances before taking action. Whenever use of this provision is in doubt, a new application should be mailed and SSI medical assistance continued.

b. NEW APPLICATION REQUIRED

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 (KC1500 Medical Assistance for the Elderly and Persons with Disabilities or KC1100 Medical Assistance for Families with Children) shall be mailed to the individual with notification that the application must be completed and returned within 12 days or assistance will be discontinued.

i. Application Timely Returned

If the application is timely returned, assistance under the SSI medical assistance program shall continue until the new application is fully processed. Once the new application has been processed, SSI medical assistance coverage shall be discontinued providing timely and adequate notice. If approved for eligibility under another medical assistance program, that coverage shall commence effective the month after the month of SSI medical assistance discontinuance.

ii. Application Not Returned

If the application is not returned within 12 days from the date of mailing, the SSI medical assistance coverage shall be discontinued providing timely and adequate notice. If the application is still not returned after notification of SSI medical assistance coverage discontinuance, no additional case action is required.

iii. Application Untimely Returned

If the application is returned after notification of discontinuance for failure to timely return, the new application shall be processed. SSI medical assistance coverage shall be reinstated (discontinuance rescinded and reauthorized) if the application is received by the last day of the month after the month of discontinuance. SSI medical coverage shall continue while the new application is pending.

If the application is returned more than one month after SSI medical assistance was discontinued, SSI medical assistance shall not be reinstated pending processing of the new application. Normal application processing procedures and timelines apply.

iv. Request for Information

If a formal request for information is made, the individual shall be given 12 days to respond. If the individual fails to timely respond, the new application shall be denied and the SSI medical assistance shall be discontinued, providing timely and adequate notice. If the information is untimely provided, but within 45 days from the date of application or 12 days from the date of denial, both the application and the SSI medical assistance shall be reinstated. If the requested information is provided later than that, a new application is required and the SSI medical assistance may not be reinstated.

C. TIMELY ACTION

The individual is entitled to the continued SSI medical assistance coverage provided while his/her eligibility is being determined under another medical assistance program (either with or without a new application). The coverage is considered properly received, and therefore, there is no overpayment should the SSI medical assistance eventually be discontinued without continued coverage under another medical assistance program. However, it would be prudent to take action on the case as soon as possible to prevent the SSI medical assistance coverage from extending any longer than is necessary to determine eligibility under another medical assistance program.

Note: Since there may be a delay between the time the agency receives notification of the loss of SSI recipient status and the ultimate determination of continued eligibility under another medical assistance program, it would be prudent to recheck the individual's SSI status immediately prior to processing the continued coverage to ensure that recipient status has not been reinstated.

d. REVIEW AND CONTINUOUS ELIGIBILITY PERIODS

Review and CE periods must be considered and may be impacted when changes are processed for the former SSI recipient. Use the following guidelines when processing.

i. When a former SSI recipient is added to an existing program or new program without a new application, the current, unexpired review period remains in effect. If a new application (including a late review) is submitted and processed, a new review period is established. Note that for MAGI members who are added to an existing MAGI household with other eligible members, the review period is not reset. In this case, the review period is dependent upon the next applicable CE period.

ii. For those newly eligible for a MAGI program, a 12 month CE period is established.

iii. If it is necessary to create an application in KEES in order to add an individual to a new Program Block, the date the agency first became aware of the SSI termination is used. Generally, this is the date of the SDX task or client report.

iv. If a new application or review is received, the review period is reset. The new review and CE periods are based on the first month of new (non-SSI) coverage. Generally, this is the first unpaid month in KEES, but may be the month following given timely and adequate notice requirements. This is because SI medical coverage remains in effect until new coverage is established or denied.

    Example: Child's SSI cash ends 08-2018. A new application is received in August, and processed on October 11. He is eligible for PLN beginning November 1. The new Review period and CE period begin 11-18.

v. If the review period has already expired, a new application/review form must be obtained prior to processing the SSI change. An unprocessed review previously submitted by the family can be used for this purpose if it supplies the relevant information. This is true for Program Blocks that include only SSI recipients as well as those that include other members. In these instances, the existing review policy will apply and the new review period will be set based upon the month of processing. For Family Medical cases, a pre-populated review can

be obtained instead of a new application. Note that additional family members may impact the new review period.

Example: SSI child and PLN brother are covered on one program block with an expired review period of 06-2017. The child's SSI ends 08-2018. When processing the SSI change, the worker notes the review period is expired. Therefore, a pre-populated review is manually generated. It is returned in September. This is registered and is processed on Sept 19 for the month of October – the first available unpaid month. Both children are CHIP eligible and new CE periods are established for both children and run through 09-19. The review also expires 09-19.

3. PROCESSING PROCEDURES AND GUIDELINES

a. TASKS AND TRACKING

When making a formal request for information, including mailing a new application to the individual, eligibility staff must utilize task functionality in KEES to track progress and monitor completion of the eligibility determination following suspension or termination of SSI recipient status. Existing tasks (e.g. SDX/SSI Income Ended, LTC Communication, etc.) will be placed on hold with the due date set two days after the requested information or application is to be returned. In situations where no task is present, a future dated task shall be set to ensure proper action is taken within the appropriate timeframes. It is expected that tasks will be reviewed and dispositioned accordingly.

b. REVIEW DATE

Correct processing is dependent upon both the current circumstances of the case as well as the change being processed. As with any change, careful evaluation of the case is necessary prior to taking any action. In addition to following current protocol used when taking case action by carefully reviewing the current case situation, it is critical to identify the Review Dates tied to the existing Program Block and any new Program Block for which the consumer is being added. Different processes are used depending upon the review date of the Program Block: Reviews due in the Future, those Currently Due and those Past Due. It may be necessary for staff to manually change the review date in KEES to ensure the outcome is correct. If extending the review date is necessary, staff must follow the procedures outlined in this memo.

Note that the last paid month is usually the last month the individual has received SI medical coverage.

i. Review Due in the Future

For cases where the person is being added to an existing program block or new program block without an application, the review period does not change if the review is due in the future. The former SSI recipient is added to the new program block and the review period remains in the place. The same is true if the person remains on the same program block but is now covered under a different aid code – the existing review period remains in place. An exception to this is with new Medically Needy programs – the review is shortened to align with the end of the current base period if possible.

As indicated above, if an application is received, a new review period is established. The new review period is set based upon the date any new coverage is established. To accomplish this, the existing review date must be manually adjusted following the process outlined below.

Important: This is done at the point eligibility is finalized, when new benefits are being authorized. If SI medical coverage is being denied or discontinued, this process is NOT applicable.

Resetting the review period. Manually adjusting the review period is a two-step process that staff must take care to execute correctly. First, the review period is shortened to end with the last paid month (the last month that SI medical coverage will be provided). Then, the review period is reset while running EDBC with the RE Run reason in the come-up month.

Staff should use the following steps to accomplish this:

1. Run, accept and save EDBC for all months prior to the current month for any months that have not previously been authorized. This is not required for all cases, only when unprocessed months may exist.

2. Shorten the review period to end effective the last paid month (the last month of SI medical)

3. Run EDBC using the RE Run reason in the first unpaid month of new, non-SI medical coverage.

Example: Bob's SSI ended in May, 2019. He is the only person on his Program Block and the review period expires Sept 2019. A new application is obtained timely and the case is processed on June 14. The worker determines the review needs to be extended because a new application was received. The worker makes note that SI medical coverage is ending in June (timely notice). Also, June is the last paid month and July is the first unpaid month. The worker confirms there is no need to run any EDBC's for earlier months, so the first month of any action will be July 2019. The worker adjusts the Medical Condition, SSI income and any other data collection pages necessary to execute a correct determination. Then, EDBC is executed using the **RE Run Reason** to adjust the review date. The new program is formally processed and the Medically Needy program will have a base period of 07/19-12/19. The NOA is reviewed to ensure the correct information is included. The worker also checks the E-app status to ensure it has been correctly adjusted to 'Accepted' status. Note: if Bob also had QMB coverage, the same processes would apply.

ii. Review Currently Due

If the review date is current, staff will generally need to send a new application. A program is considered current if**:**

a. The review period has not expired and a pre-populated review has been sent, but not returned. Example, the SDX task is picked up on 08-24 and the review period expires in September. A pre-populated review was sent, but because the review period has not expired the review is considered current.

b. Or, the review is in the future but it is not reasonably expected to be completed prior to resolution of the SI termination. For example, an SSI task is picked up on February 12 with a review due of March. Even though the review is in the future, the new review batch will likely run prior to the resolving the SI termination issue. The worker does not know what result of the review batch will be in these cases.

When these situations are identified, staff must first evaluate the case, making note of both the review date and the aid codes that are covered.

c. If SI medical is the only program open, the case is treated as if the review date is in the future and a new application is generated. This is because SI programs are set to a 'No Review' type in KEES,

and, if the only aid code for the program block is SI medical there will not be any type of formal review. Staff can assume no review form will be sent with the review.

Note: Any adjustment to the review date will be made at the time the case work is completed for the new determination.

d. If the SSI recipient also has an open MSP program, the case is usually subject to a Super Passive or Passive review. The case is treated as if the review date is in the future and a new application is generated.

Note: Any adjustments to the review date will be made when the work is completed for the new determination this is true even if the review batch resets the review due date.

e. If other active members are also included on the same program block, manually send a new application to the consumer. Because of the timing of the action, the family may receive additional notices/review forms once the review batch runs. Staff cannot stop this action, but will inform the consumer of the likely upcoming correspondence. A special cut and paste fragment has been developed for this situation. The customer should focus on completing the new application for the entire family.

Example: Mary's SSI ended in April 2019 and the worker pulled the task on April 12. Mary's SI Program Block is the only open program block on the case and the review period expires May 2019. So, a new application is requested. The new application is obtained timely and is processed on May 25, 2019. The worker notes that the review batch has since executed on the case and the review is now May 2020. June has already been paid, so July is now the first unpaid month. The worker confirms there is no need to run any EDBC's for months prior to the last paid month, so the first month of any action will be July 2019.

The review period is shortened to end June 2019. The Medical Condition, SSI Income record and other changes are updated. EDBC is executed using the **RE Run Reason** to adjust the review date. The new program is formally processed and the Medically Needy program will have a base period of 07/19-01/20. The review period expires June 2020. The NOA is reviewed to ensure the correct information is included. The worker also checks the E-app status to ensure it has been correctly adjusted to

'Accepted' status. Note: if Mary also had QMB coverage, the same processes would apply.

iii. Review Due in the Past

Current policy requires any skipped or unprocessed review to be completed prior to adding any new individual or program. If a review has been received but not yet processed, the review form should be used to complete the existing review and/or add any new program/person. Additional information may be necessary and should be obtained over the phone to the extent possible.

If a review form has not been received, or if the review form was sent and not returned timely, follow existing procedures and generate a pre-populated review form. A V044 must also be sent that includes the correct review date and allows 12 days to return the form.

If the review form is not received, coverage is discontinued providing timely and adequate notice – for the SI recipient as well as the other members. If the review form is received, the review period is established based upon the date the case is processed – or the first available unpaid month. Note that in rare instances this will be extended out one month to allow timely and adequate notice of any SI discontinuance that may have occurred.

C. REINSTATING COVERAGE

As indicated earlier if an application is required, staff must formally send a new application to the consumer and allow at least 12 days to return. If not returned, SI medical coverage is discontinued, allowing for timely and adequate notice. Prior to taking negative action to discontinue, both the Medical Condition and SSI income record are updated to reflect the current SSI status. Coverage is discontinued and a Non-Compliance record (Failure to Provide) is added to the case.

In the event the consumer later complies by returning the application, coverage is reinstated back to previous levels. In order to qualify for reinstatement, the application must be returned no later than the last day of the month following the month the case was discontinued. The consumer is also eligible for reinstatement if he or she reports that SSI cash has been reinstated.

Note: The consumer is also eligible for reinstatement if SI medical is discontinued for failure to provide information – for situations related to an application or when attempting to determine new eligibility without an application. In either case, the information must be supplied no later than the last day of the month following the month the coverage was discontinued. However, if there is an application involved, the last day to provide information is extended to 45 days from the date of the application if later.

Full SI coverage is reinstated while the application/new program is processed. Coverage must be reinstated within 10 days of receipt. If the application/information is processed the same day, coverage must be provided even if the application is denied.

When processing the reinstatement in KEES, staff must ensure the resulting Review and CE dates are correct and must also consider the impact on other members of the HH. Use the following processes:

1. **Rescind**: If the application is received on or before the last day of the month following the month of closure, rescind the program and reauthorize coverage. SSI coverage remains in place until the new application is processed. It is not necessary to process the application at this time, but it is necessary to reinstate coverage. Both the Medical Condition and SSI Income record must be updated and the Non-Compliance reason ended prior to running EDBC. The RMT will remain 'Medical' or 'LTC', depending upon the type of coverage the individual is receiving. **For cases with a late review, do not run with the RE run reason to reset the review until the full determination is processed.**

   Example: A new application/request was sent on 11-25-18 for a former SSI recipient. It was not returned and the program is discontinued effective 12-31-18. The application is returned on 01-1-19, but is not ready to process. The program is rescinded, the Medical Condition and SSI payment information are updated to reflect the same information prior to the discontinuance. SI medical coverage is reauthorized for January 2019. It may also be necessary to run February 2019 in order to receive a high-dated EDBC. The full determination will continue to pend.

2. **Reapply**: If the application is received after the end of the month following the month of closure, the individual is not eligible for reinstatement. Select the Reapply function to register the application.

Unless exempt from a MAGI determination based upon the MAGI screening criteria (i.e. The Big Five), a MAGI RMT is used for the determination.

d. PROCESSING THE NEW DETERMINATION

Special instructions are needed when processing a new determination following an SSI reinstatement. A number of different factors must be considered – including the Review Date, protecting other individuals on the case and the new program.

i. Staff must evaluate the circumstances of the case. Consider the review due of the current program block as well as any new application that may have been received. If there is a past or current review, staff must obtain/process a review form or application. If there is a future review, staff will need to use the special reset process outlined above if there is a new application (exception: MAGI members added to an existing MAGI program block).

   To reset the review, first shorten the current review and then lengthen the new review period by running with the RE Run Reason in the first month the new program (not the SI medical) is authorized. In some cases where there are other members covered, the current policy of resetting the review beginning with the first month of unpaid coverage is applicable. Note this is only required where the review period must be extended.

ii. It may also be necessary to reinstate coverage for only the SSI individual while the rest of the HH continues to await a determination. When this occurs, the Partial Approval process is used to continue one member on while assistance for another member pends. This process requires staff to temporarily adjust the SSN verification indicator for the pending member(s) while verification pends. The process is fully outlined in the KEES User Manual.

iii. The former SSI recipient is still considered to be an SI medical recipient for the determinations of others until action is taken to end coverage. This means that the income and resources of an SI recipient that are not countable for the other HH members would continue to be exempt until the actual SI medical has ended. Example, a wife's SSI closes but she can be added to her husband's medically needy program. The income and resources of the wife now impact the medically needy program of the husband. But, wouldn't be countable toward the husband until the SI medical is formally terminated. Note that the failure of an SSI recipient to provide any information or

application will also impact others on the program if the information is necessary to process under the new program. In the above example, if a request was made for current income for the wife and she failed to comply, both the SSI and the Medically Needy would terminate because the income is needed for the husband's determination.

iv. Additional examples are provided in Section 8 of this memo

e. SUMMARY OF REQUIREMENTS

When faced with a case decision, staff must consider all of the above factors when deciding appropriate approach for the case – specifically if the new determination can be made without an application, if information is required, or if a full application is needed. This may require that staff utilize prudent person/reasonable judgement when making case processing decisions. This section is provided to assist staff with the process of determining the best course for the situation at hand. In all cases, a journal entry detailing such decisions is necessary.

a. Is a New Application Required?

One goal of the policy is to process any new coverage for the individual without obtaining a new application. However, as indicated earlier, there are instances where a new application is required – when there is not an application/signed review (or passive review for Family Medical) within the past 12 months. If there is a viable application/review then staff should continue to attempt to process without an application. Note that consideration must also be given to the review date of the program. Also, there may be instances where a new application is considered the best way to obtain information even though there may be a viable application on file.

b. What do we know about the Household?

After establishing there is a valid application that could be used to make the new determination, an evaluation is conducted to determine if sufficient information is available and if the information is verified. This evaluation is completed for all applicable eligibility elements (income, resources, etc.) Pay special attention to persons requiring a zero-earnings test.

c. Is there any indication of a Change?

Finally, staff must consider if there is any indication of a change. This may be an obvious change or an indication that a change may have occurred, but hasn't been reported. Although consumers are required to report most changes within 10 days, there are times when information is not reported. We generally assume that information is reported according to the rules. However, there are times when this doesn't occur. Staff must consider if

the case circumstances appear to be reasonable based on what is known about the case. For example, SSI is terminated for excess resources, but the client has not previously reported owning any resources. This is an indication of a change that should be addressed. These situations always require documentation in the journal.

d. Examples

Consider the following examples. In each situation, the consumer lost SSI because of excess income and there is an application on file that is 6 months old.

1. **No New Information Required.** After receiving the task, the worker notes the following:
    - While evaluating the TPQY, he sees new SSA income was just approved. This explains why the SSI was lost.
    - She reported no other income and there is no reason to believe there is any other source of income.
    - The only resource reported was a bank account for $250 and it was verified 6 months ago – so the verification is still valid given the new 85% rule.
    - She is a single person, so information is not needed for any other person
    - All other general and non-financial information was previously verified.
    - A phone call is attempted to explain the situation, but no answer.
    - The worker determines it is appropriate to transfer her to a new program without any additional information.

2. **New Information is Required**
    - While evaluating the SSA record, there is no indication of any new income. She is a single woman, so the worker suspects she may have obtained other income.
    - The worker also notes she only reported two resources – a term life insurance and a Direct Express card worth $26.
    - Although the resources and household status seem explainable, her income does not.
    - A phone call is made to the consumer and she reports she received a pension from her former husband who lived in Chicago. It's $924.00/month.
    - The worker tells her to send in verification and determines that a new application is not required. A V044 is sent.
    - The verification is submitted and the worker is able to transfer her to a new program without a new application.

3. New Application is Needed

- While evaluating the SSA record, there is an indication of an increase in Social Security. She notes the SSA record is from a B claim number (indicating there may be a spouse). Since the SSA increase is also related to COLA, the worker thinks she may be a potential Pickle.
- Upon pulling her last application, the client didn't report any resources (questions were left blank) nor did she tell us if she is married. In fact, most of the questions were left blank. It is unknown if she cares for minor children or is pregnant.
- A phone call is attempted, but no answer.
- Rather than send out a lengthy request for information, the worker determines that a new application is best to capture the information, since nearly every question needs to be answered.
- A new application is requested and she is given 12 days to return. Her SI Medical stays in tact while waiting.

4. SSI PAYMENT STATUS CODES

An SSI payment status code will appear on the EATSS SDX record for every eligible SSI recipient. That code will provide guidance for eligibility staff on what action, if any, to take concerning continued SSI medical assistance coverage.

a. BACKGROUND

When an SDX Income Start or SDX Income Ended task appears in the KEES eligibility system, SSI Payment Status Codes on the SDX data interface shall be reviewed. The SSI Payment Status Code will indicate if payment has been suspended, stopped, or terminated. The following will provide guidance on whether SSI medical assistance may continue based on the specific SSI Payment Status Code.

i. Suspended

Payment of the SSI benefit has been suspended. No payment is being made during a period of suspension because the individual is no longer eligible for benefits according to SSA policy. However, payment may be reinstated at any time during a suspension (without a new SSA application) if the individual regains eligibility. Suspension may last up to 12 months. After that period, eligibility is terminated. At that point, the individual would have to reapply for SSI benefits by filing a new application with SSA.

ii. Stop Payment

Payment of the SSI benefit is stopped because the individual is eligible for SSI, but the benefit is not payable that month because it is the first month of eligibility or there is excess income in a month, or the benefit is payable but the payment is being withheld pending resolution of an issue such as naming a representative payee. Stop payment is an interruption in payment, not a loss of SSI eligibility.

iii. Terminated

Just as the term indicates, the SSI benefit has been terminated. SSI recipient status has ended. The individual would have to reapply for SSI benefits by filing a new application with SSA if interested in continued SSI assistance.

b. PROCESS

If an SSI Payment Status Code other than those identified below appear on the SDX record which indicate payment has been suspended, stopped, or terminated (according to the SSI Payment Status Codes Table), SSI medical assistance shall be discontinued due to loss of SSI recipient status.

i. Administrative Suspension

These SSI payment status codes indicate that there is an administrative suspension or stopped payment where the recipient may still be eligible for SSI but payment is being withheld:

N20 – Failure to provide information. Payment is suspended.
S06 – Whereabouts of recipient unknown. Payment is suspended.
S07 – Check returned for miscellaneous reason other than address. Payment is suspended.
S08 – Developing for representative payee. Payment is stopped.
S09 – Temporary institutionalization. Payment is stopped.

These instances warrant further investigation and may require contact with either Social Security or the recipient, or both. If the situation causing the suspension or stoppage of benefits is determined to be temporary with anticipated resolution within two months, SSI medical assistance may continue. Otherwise, SSI medical assistance shall be discontinued giving timely and adequate notice. However, eligibility staff are expected to be prudent. Exceptions may apply.

ii. Excess Income

These SSI payment status codes indicate that the recipient's SSI benefits have been either suspended or stopped due to excess income:

N01 – Excess income. Payment is suspended.
N01 – Excess income, 1619(b) eligible. Payment is stopped.

In these instances, SSI medical assistance may continue, if the excess income is anticipated to be temporary (such as receipt of a 3rd or 5th paycheck in a month or periodic Native American per capita payments), or if the individual is 1619(b) eligible (even though the excess income is anticipated to continue). If payment is suspended for more than two months due to excess income, SSI medical assistance shall be discontinued. A 1619(b) individual shall continue to be eligible as long as he/she retains that status.

To determine if this is a temporary situation, eligibility staff should review the case history, the case journal, and the EATSS SDX record. This should give an indication as to whether or not there is a pattern of temporary SSI payment gaps. In addition, as always, eligibility staff are expected to use a prudent person approach in making this determination.

iii. Excess Resources

This SSI payment status code indicates the recipient's SSI benefits have been suspended due to excess resources:

N04 – Excess resources. Payment is suspended.

SSI benefits may be suspended due to ownership of resources that exceed the allowable SSA resource standard of $2,000. If SSI payments have been discontinued due to excess resources, SSI medical assistance shall be discontinued. However, if contact with Social Security indicates that the amount of excess resources is minimal and the recipient is likely to regain SSI resource eligibility within the next two months, SSI medical assistance may continue.

iv. Cessation of Disability/Blindness

The following SSI payment status codes appear when benefits are being terminated due to cessation of disability or blindness:

N07 – Cessation of disability. Payment is terminated.
N08 – Cessation of blindness. Payment is terminated.

These codes indicate that the individual is no longer disabled or blind. SSI medical assistance shall be discontinued. Continued eligibility could only be determined under a non-disability/blindness medical assistance program. A new referral to DDS or PMDT would not be appropriate, unless the SSI discontinuance was more than 12 months ago or the individual reports a new or worsened medical condition.

If the recipient's SSI discontinuance was more than 12 months ago or the recipient reports a new or worsened medical condition within 12 months of the SSI discontinuance, eligibility may be determined under a disability/blindness medical assistance program by completing a new DDS or PMDT referral.

C. TABLE

A table has been created for use by eligibility staff which lists relevant SSI Payment Status Codes found on the EATSS SDX record. The codes reflect action by SSA to suspend, stop payment, or terminate SSI benefits. There are five columns on the table:

i. Payment Status Code

The first column lists the actual payment status code reported on the EATSS SDX record. Included is a precise reason for the code, such as "Excess Income" or "Cessation of disability".

ii. Type of Event - SSA

The second column indicates the type of event (action) taken by SSA concerning the SSI benefit. For purposes of this table, one of three payment events will be listed: suspension, stop payment, or termination.

iii. SSA Effective Date – SSI Payments End

The third column provides an explanation of the effective date of the SSA action to suspend, stop payment, or terminate the SSI benefit. This is

provided for informational purposes only so eligibility staff are aware of why and when the SSA action was taken.

iv. SSA Reinstatement Date – SSI Payments Resume

The fourth column provides an explanation of the date SSI benefits may be reinstated by SSA. Again, this is provided for informational purposes only so eligibility staff are aware of how and when SSI benefits may be reinstated pursuant to the suspension, stop payment, or termination.

v. Action to be Taken by Medical Assistance Staff

The fifth column provides guidance to eligibility staff as to the appropriate action to take concerning continued SSI medical assistance. Action to be taken, depending on the particular SSI payment status code, include: no action, monitoring to determine if payment will be reinstated within the next two months, and discontinuing coverage.

The table is attached to this memo.

5. SPECIAL PROCESSES

The following specialized processes are applicable to this policy.

a. OVERSTATED ELIGIBILITY

The new policy requires that SSI medical assistance continue while eligibility under another program, either with or without an application is determined. The continued coverage pending that determination is not considered to be overstated eligibility subject to a claim for recovery. This anticipates that all transitions will be processed in a timely manner. However, when timely action is not taken by the agency and SSI medical assistance continues for an individual who has lost recipient status, overstated eligibility may have occurred.

The following provisions apply:

i. Timely Processed

If the transition is timely processed, there is no overstated eligibility regardless of the length of time SSI medical assistance continued. To be timely processed, action must commence within 10 days of the date the loss of SSI recipient status was reported or became known to the agency.

Action includes requesting additional information, sending a new application if appropriate, as well as situations where SSI recipient status is suspended and medical assistance continues for a period not to exceed two months while waiting to determine whether SSI recipient status will resume.

ii. Not Timely Processed

If the transition is not processed timely, overstated eligibility has occurred based on the additional time added to the process due to the following:

1.) Action to process the loss of SSI status was not initiated within 10 days from the date of report or when it became known to the agency.

2.) Action to obtain or request information needed to determine continued eligibility without a new application was not initiated within 10 days.

3.) Action to process requested information that was returned was not initiated within 10 days.

4.) Action to process a new application which was timely returned, or to act on a failure to return a new application was not timely completed.

In all instances, overstated eligibility will be based on the number of months the agency delay added to the process. Any overstated eligibility determined in this manner shall be classified as agency error.

Overstated eligibility will not be established where the agency demonstrates good cause for a delay in timely processing.

b. RESOURCES

If the medical assistance program the individual is being added to or determined eligible for, with or without a new application, is subject to a resource test, the new resource verification provisions applicable to this process apply. See section 3.A.

Previously verified resources need not be reverified if the following conditions have been met:

i. An application (other than a MIPPA application) or pre-populated review form was filed within the last 12 months;

ii. Resources were verified within the last 12 months;

iii. The reported value of all countable resources does not exceed 85% of the applicable program resource limit;

iv. There is no indication from either internal or external sources that there has been a change in resources, such as:

1.) A resource no longer exists,

2.) There is a new resource,

3.) A potential or actual resource transfer has occurred; and

v. There are no resources being monitored for continued exempt status, including the following:

1.) Countable resources with no market value.

2.) Resources that are exempt due to a legal impediment.

3.) Real property that is exempt due to a bona fide effort to sell.

4.) Real property that is unavailable because sale of the property would cause loss of housing for a joint owner.

5.) Resources that are exempt for a specified period of time, such as a retroactive SSA/SSI payment for 9 months.

vi. In addition, this policy does not apply and reverification of resources is required when any of the following exist:

1.) A trust (countable or exempt),

2.) Countable life insurance, or

3.) A community spouse.

In addition, if the original verification of resources occurred within the last 3

months (i.e.: current month plus the 2 prior months), the 85% test does not apply. Total countable resources must be under the applicable resource limit. All other factors listed above apply.

If the above conditions have not been met, reverification of all resources is required. Standard verification requirements apply.

C. INSTITUTIONALIZATION

The agency may be notified of a recipient's institutionalization in a number of ways – written or telephone contact from the recipient or his/her representative, receipt of an MS-2126 (Notification of Facility Admission/Discharge) from the facility, or the creation of an SDX interface task in KEES indicating a change in SSI benefit due to institutionalization (SDX Income Ended or SDX Income Change). Once notified of the change in living arrangement, the agency shall check the SSI payment status on the EATSS SDX and ensure that a fully completed MS-2126 is on file.

Information contained on the MS-2126 provided by the facility will determine how medical assistance eligibility is determined. The information reflected in the SSI SDX record may conflict with the information contained on the MS-2126. However, the information provided on the MS-2126 is controlling for eligibility purposes. No action shall be initiated until a fully completed MS-2126 has been received which includes the admission date and the anticipated length of stay.

The anticipated length of stay in the facility will determine what case action to take.

i. Anticipated Length of Stay – MS-2126

For medical assistance purposes, the anticipated length of stay shall be determined using the information reported by the facility on the MS-2126 form. If this information is contrary to the SSI Payment Status Code on the SDX record, staff shall use the MS-2126 information to determine eligibility, unless that information is verifiably suspect. Contact with the nursing facility and/or recipient/representative may be required to resolve any discrepant or missing information. In some instances, it may be necessary to also contact SSA to clarify the recipient's institutional and SSI status.

1) Temporary Stay

For medical assistance purposes, a temporary stay is one anticipated to be less than the month of entry and the following 2 months. If the stay is anticipated to be temporary, the agency shall assume that SSI benefits will continue and the individual remains in recipient status. SSI medical assistance shall continue.

2) Long Term Stay

For medical assistance purposes, a long term stay is one anticipated to be more than the month of entry and the 2 following months. If the stay is anticipated to be long term, the agency shall assume that SSI benefits will continue in full, be reduced, or be suspended beginning with the first full month of institutionalization, based on the directions provided below. The individual would no longer be in recipient status and therefore SSI medical assistance shall be discontinued.

Note: Social Security will take no action to change the recipient's payment status until the recipient's institutionalization has been reported. The recipient (or representative) is responsible for reporting the change in living arrangement to SSA. In addition, the facility has a legal obligation to report the admission of an SSI recipient to SSA within 14 days of entry.

The following considerations apply to an anticipated long term stay:

a) Only Income is SSI

If the recipient's only income is SSI, the payment will not be suspended, but instead reduced to $30/month beginning with the first full month of residence in the Medicaid (title 19) facility for an anticipated long term stay. Since SSI payments continue, the individual remains in recipient status.

Note: SSI medical assistance recipients whose SSI benefit has been reduced to $30/month by SSA due to institutionalization will be issued an additional $32/month payment by the state under the State Supplemental Payment Program (SSPP) to bring their total income up to the $62/month institutional protected income limit (PIL).

b) Mental Health Nursing Home (NF/MH)

SSI payments should continue for a recipient age 21 to 64 who enters a mental health nursing home (NF/MH) because there is no Medicaid (title 19) coverage for those residents.

The SSI payments continue in the full amount and are not suspended or reduced to $30/month. Since SSI payments continue, the individual remains in recipient status. Note that the SSI benefit will be reduced to $30/month for residents in a mental health nursing home (NF/MH) who are under 21 or 65 or older.

Note: If the institutionalization has been reported to Social Security, but Social Security is unaware the facility is a mental health nursing home (NF/MH), SSI benefits may be incorrectly suspended or reduced to $30/month. Staff shall continue to deem the recipient as receiving full SSI benefits for eligibility and budgeting purposes. It is appropriate for eligibility staff to contact SSA and report that SSI benefits were suspended or reduced in error.

c) State Psychiatric Hospital

SSI payments should be suspended for a recipient age 21 to 64 who enters a state psychiatric hospital because there is no Medicaid (title 19) coverage for those residents and the state must discontinue medical assistance. Since SSI payments have been suspended, the individual is no longer considered to be in recipient status. For residents under 21 or 65 or older, there is Medicaid eligibility in the facility and the SSI payment should continue at a reduced rate of $30/month.

d) Psychiatric Residential Treatment Facility

The SSI recipient status for children and young adults who enter a PRTF should continue for most recipients. The SSI benefit amount should be reduced to $30/month, unless the individual has other income.

e) Penal Institution

SSI payments should be suspended the first full month the recipient enters a penal institution. SSI medical assistance shall be discontinued due to the individual's incarceration. However, an individual serving time in a Kansas Department of Corrections (KDOC) facility may be eligible for coverage

of inpatient hospital services under the Inmate program. See Medical KEESM 8111.1 (2) and KDHE-DHCF Policy No. 2012-09-01.

ii. Processing

When an SSI recipient enters an institution for either a short term stay or a long term stay, as defined above, the following processes apply.

1) Short Term Stay

When an SSI recipient receiving coverage under the SSI medical assistance program becomes institutionalized for an anticipated short-term stay, SSI medical assistance shall continue with the living arrangement updated to long term care. A new application is not required. The amount of the SSI benefits received by the recipient shall be disregarded in determining the patient liability for each month of the short-term stay. If the recipient has other income, such as an OASDI benefit or earnings, that income shall be budgeted to determine the patient liability.

Note: Should a resident who is originally anticipated to be a short-term stay extends beyond the second month after the month of entry, the long term stay policies shall apply beginning with the third month after the month of institutionalization.

2) Long Term Stay

When an SSI recipient receiving coverage under the SSI medical assistance program becomes institutionalized for an anticipated long term stay, the resident may or may not lose SSI recipient status as indicated above. Regardless, eligibility shall be budgeted as follows:

a) Dual SSI and OASDI Recipient

If the recipient receives both SSI and OASDI benefits, assume payment of SSI benefits will be discontinued. Since this is a long term care individual, a new application is required to determine continued eligibility. SSI medical assistance shall also continue until eligibility is processed under the new application. Eligibility for institutional coverage shall be delayed until the new application is returned and processed.

If continued eligibility is approved under another program, institutional coverage may then be determined. Assuming no other income, only the OASDI benefit shall be budgeted in determining the monthly patient liability. No SSI income shall be budgeted, even if payments have not yet been discontinued or were not immediately discontinued by Social Security.

If the recipient fails to timely return the new application, SSI medical assistance shall be discontinued giving timely and adequate notice. Institutional coverage may not be processed. There is no overstated eligibility due to the extended SSI medical assistance coverage pending the new application.

Exception: If the OASDI benefit is less than $50/month ($30 reduced SSI benefit plus the $20 disregard = $50), the recipient is entitled to a reduced SSI benefit payment equal to the difference between $50 and the amount of the OASDI benefit. In that instance, SSI medical assistance coverage shall continue and a new application is not required. Based on the math, the recipient should have no patient liability since total countable income will be less than the $62 PIL.

b) SSI Only Recipient

If the recipient's only benefit from Social Security is SSI (no OASDI benefit), the following applies:

i.) No Other Income

If the recipient's only income is SSI, assume the benefit will be reduced to $30/month as indicated above. Since the recipient continues to receive an SSI payment, SSI medical assistance shall also continue. A new application is not required. Institutional coverage shall be processed. The recipient will have no patient liability and is eligible for the $32/month state supplemental payment as indicated above.

ii.) Other Income

If the SSI recipient has additional income other than

OASDI, such as a small pension, child support, alimony, or earnings from employment, assume the SSI benefit will be discontinued, unless the SSI benefit amount is within $30 of the maximum benefit amount (currently $750/month). If the SSI benefit amount is within $30 of the maximum amount ($721/month or more), assume the SSI payment will continue in a reduced amount. SSI medical assistance shall continue. A new application is not required. Institutional coverage may be processed. All income, including the reduced SSI benefit shall be counted in determining the patient liability.

If the SSI benefit amount is assumed to be discontinued, a new application is required. SSI medical assistance shall also continue until eligibility is processed under the new application. Eligibility for institutional coverage shall be delayed until the new application is returned and processed.

If continued eligibility is approved under another program, institutional coverage may then be determined. Only the other verified income shall be budgeted in determining the monthly patient liability. No SSI income shall be budgeted, even if payments have not yet been discontinued or were not immediately discontinued by Social Security.

If the recipient fails to timely return the new application, SSI medical assistance shall be discontinued giving timely and adequate notice. Institutional coverage may not be processed. There is no overstated eligibility due to the extended SSI medical assistance coverage pending the new application.

3) SSI Recipient Status Continues

If SSI recipient status continues, the SI medical assistance coverage will also continue. As indicated above, a new application will not be required to determine eligibility for institutional care. However, the following information may still be required before eligibility is processed.

a) Transfer of Property

Since eligibility for long term care coverage is being determined, transfer of property issues must be addressed.

If there is a KC-1500 application on file less than 12 months old attesting to no transfers, this requirement has been met. Otherwise, contact with the individual is required.

i.) Telephone Contact

The individual may verbally attest via phone that there have been no transfers within the last 5 years. If the individual reports that a transfer has occurred, or if phone contact cannot be made, formal contact is required.

ii.) Formal Contact

A formal request for information must be sent to the individual allowing 12 days to respond. Failure to timely respond shall result in ineligibility for long term care coverage. SI medical assistance may continue.

b) Income

Income, other than SSI or OASDI (which is verified through the EATSS interface), must be verified. If the income cannot be verified independently, a formal request for the information is required. Failure to timely respond shall result in ineligibility for long term care coverage. SI medical assistance may continue.

c) Income Allocation

There may be rare situations where the individual is able to allocate income under the spousal impoverishment provisions to either a community spouse or dependent family member. This option would only be applicable where the individual's countable income exceeds the $62/month protected income limit. To reduce or eliminate the patient liability, family household and income information must be obtained.

A formal request for the information is required. Failure to timely respond shall result in a long term care eligibility determination without income allocation.

d. HOME AND COMMUNITY BASED SERVICES

Special processes apply to HCBS recipients who lose SSI recipient status. Continued eligibility under an Elderly and Disabled medical program, with or without a new application, must be explored before eligibility is considered under Family Medical programs or discontinued for failure to meet categorical eligibility requirements. Both SSI medical assistance and HCBS services will continue while this determination is processed.

SSI medical assistance and HCBS services are reinstated following discontinuance for failure to provide a new application or requested information if provided within the redetermination timeframes described in section I.A.2.b. above.

An ES-3161, Notification of KanCare, HCBS/MFP Changes and Updates, must be sent to the MCO, HCBS Program Manager, and assessing entity when HCBS is terminated and again if services are subsequently reinstated.

e. 18 YEAR OLD RECIPIENT

When a child who receives SSI benefits turns 18, Social Security will complete an "age 18 redetermination". That redetermination is required because the disability criteria between children and adults is different. A child's disability is based on level of functionality, while an adult's disability is based on ability to work. This means some children may lose SSI eligibility when they turn 18 and are reevaluated under the adult disability criteria.

Once an 18 year old loses SSI recipient status due to cessation of disability, and thus SSI medical assistance eligibility, the young adult has the following options:

i. Added to Active Program

An 18 year old losing SSI recipient status may be added to an active poverty level, caretaker medical, or CHIP program without a new application. There is no potential eligibility under a disability program due to loss of that status with Social Security. Additional information, such as attestation of income and tax filing status, may be required to add the individual to the active program.

Note: An HCBS eligible 18 year old should not be added to an active family medical program which causes the loss of HCBS coverage without first considering eligibility under a compatible non-MAGI program. The

young adult may be added to an active caretaker medical program or opened on a new non-MAGI program without an application, if otherwise eligible.

ii. Approved Under Another Program

If there is no active program the young adult can be added to, or there is an active family medical program, but the young adult chooses to apply on his/her own behalf, a new application is required. If the individual can be opened on a new program, a new application shall always be required because the individual is now acting in his/her own behalf as an adult.

iii. Long Term Care

The following special provisions apply to a long term care recipient who loses SSI recipient status due to turning 18 years old.

1) Institutionalized

An institutionalized child who loses SSI recipient status due to cessation of disability upon turning 18 may continue to be eligible for Institutional coverage without a disability determination, if all other eligibility criteria are met. Once the young adult turns 21, if still institutionalized, a disability determination is required.

2) Home and Community Based Services (HCBS)

An HCBS eligible child who loses SSI recipient status due to cessation of disability upon turning 18 may continue to be eligible for HCBS coverage, if all other eligibility criteria are met. However, once that young adult turns 19, a disability determination is required to be eligible for the I/DD, PD, and TBI HCBS waiver programs. A disability determination is not required for the TA and SED waiver programs.

f. COMPANION QMB COVERAGE

An individual receiving SSI medical assistance may also have QMB coverage. The loss of SSI recipient status with SSA should not normally affect the QMB coverage, even if SSI medical assistance is discontinued. However, unverified information used for QMB eligibility purposes, such as resources, shall not be used to determine continued eligibility under another medical assistance program. This is particularly true where QMB coverage was approved under a MIPPA application which has not been formally

reviewed. In those instances, a new application will be required to determine continued eligibility under another program.

Note: In a rare circumstance, the individual could have LMB coverage, such as a 1619a recipient with countable earnings in excess of the QMB limit who loses SSI recipient status. The same principal described above for QMB would apply to LMB coverage as well.

g. Impact on Medicare and Buy-in

There may be situations where Medicare entitlement terminates upon loss of SSI recipient status. When researching EATSS to determine the reason SSI recipient status was lost, eligibility staff must also determine whether the individual is entitled to Medicare and, if so, whether Medicare entitlement has ended. Individuals who have lost Medicare entitlement are no longer eligible for any Medicare Savings Program (MSP) or buy-in.

In situations where Medicare entitlement has terminated, eligibility staff must discontinue MSP eligibility, allowing timely and adequate notice, and complete a TBQ update through the Medicare Expense page in KEES to send the date Medicare entitlement ended to the MMIS. Failure to complete a TBQ update when Medicare entitlement has ended is problematic for medical providers who are attempting to bill for services provided.

h. Disability Determination Services (DDS)

The following Disability Determination Services (DDS) referral requirements apply where the individual loses SSI recipient status for reasons other than cessation of disability or blindness, such as excess income or resources, or admittance to a state hospital. A referral is not required if the individual retains disability status under SSA or continued eligibility is determined under another medical assistance program not based on disability.

i. Eligibility Without a New Application

If continuing eligibility is established under an active program based on disability without a new application, a referral to DDS is required so that an on-going disability review period (diary date) can be initiated. Eligibility may be provided while the DDS decision is pending. If the disability status

is eventually denied, eligibility shall be discontinued giving timely and adequate notice. If disability is approved, the case shall be re-referred to DDS periodically based on the review date (diary date) specified by DDS, assuming the individual does not requalify for Social Security disability benefits in the interim. See Medical KEESM 2662.3 (4) and 2662.8.

ii. Eligibility Requiring a New Application

If continuing eligibility under either an existing or new medical assistance program cannot be established, a new application is required, and eligibility will be determined under a disability program, a referral to DDS is required upon receipt of the new application. If the new application is received no later than the fourth month after the month of the SSI termination date, the application may be processed even though the DDS determination is still pending. The individual shall be deemed to meet the disability criteria until the actual DDS determination is completed.

If approved for disability related medical assistance based on the new application prior to the DDS decision, follow the same process described in subsection **i.** immediately above. If DDS denies the disability status, eligibility shall be discontinued giving timely and adequate notice. If DDS approves the disability, the case shall be re-referred to DDS periodically based on the review date (diary date) specified by DDS. See Medical KEESM 2662.3 (4) and 2662.8.

If the SSI termination date from SSA is outside of the three (3) month prior medical eligibility period based on the date of receipt of the new application, the individual is not deemed to meet the disability criteria. The new application cannot be processed until the DDS disability decision has been received.

Consider the following examples.

1) Application Requested and Timely Returned

An SSI recipient loses recipient status due to their spouse's earnings (N01 Payment Status Code). The recipient is not eligible for coverage under a PMG. The recipient's spouse is not a recipient of KanCare medical assistance. A KC1500 is mailed to the recipient allowing 12 days to respond. The recipient timely responds by completing and returning the requested KC1500 application. The spouse's income is determined reasonably compatible and resources are verified using bank statements.

Eligibility under the Medically Needy (MDN) program is determined while the DDS determination is pending. SSI medical assistance is discontinued, providing timely and adequate notice.

2) Application Requested and Returned within Three Months following SSI Termination

An SSI recipient loses recipient status due to their spouse's earnings (N01 Payment Status Code). The recipient is not eligible for coverage under a PMG. The recipient's spouse is not a recipient of KanCare medical assistance. A KC1500 is mailed to the recipient allowing 12 days to respond. The recipient fails to return the application and SSI medical assistance is discontinued allowing timely and adequate notice.

The consumer returns the application two months after SSI recipient status is terminated. Eligibility under the Medically Needy (MDN) program is determined while the DDS determination is pending.

3) Application Requested and Untimely Returned

An SSI recipient loses recipient status due to their spouse's earnings (N01 Payment Status Code). The recipient is not eligible for coverage under a PMG. The recipient's spouse is not a recipient of KanCare medical assistance. A KC1500 is mailed to the recipient allowing 12 days to respond. The recipient fails to return the application and SSI medical assistance is discontinued allowing timely and adequate notice.

The consumer submits a new application six months after SSI recipient status is terminated. A DDS referral is completed. Eligibility under a disability program is determined upon receipt of a favorable DDS disability determination.

iii. PMDT Referral

There may be instances where a referral to PMDT is appropriate, including the following:

1) 12 Months

If SSI discontinuance was more than 12 months ago and the agency is just discovering (or acting upon) the discontinuance of SSI recipient status, the individual may be referred to SSA to re-apply and a PMDT referral is completed.

2) New/Worsened Condition

If the recipient reports a new or worsened medical condition to the agency within 12 months of the SSI discontinuance, a referral to PMDT would be appropriate. Re-application to SSA for disability benefits will also be required.

Note: The DDS referral process does not apply to individuals who continue to be eligible for SSI related medical assistance coverage as a 1619 recipient (see Medical KEESM 2634), to individuals eligible for Qualified Working Disabled (see Medical KEESM 2674), to individuals qualifying under one of the protected medical groups (see Medical KEESM 2680), and to individuals who have turned 65 years old. However, it may still be necessary to mail a new application to the individual to capture income and resource information required to determine eligibility under these programs.

i. NOTICES

Staff shall use existing notices to inform the recipient when eligibility transitions from SSI medical assistance to coverage under another medical assistance program. In addition, the following snippets for use on the V044 (Request for Information) have been created and placed on the KEES Repository, KDHE Standard Text for Copy and Paste.

i. Request for Information

When the recipient has lost SSI recipient status and information is being requested to determine eligibility under another program without an application, the following snippet may be used:

We have been notified by the Social Security Administration that your coverage under the SSI medical assistance program will be ending because you no longer get SSI. Your SSI medical assistance coverage will continue while we determine if you are eligible for coverage under another medical assistance program. To help us determine your eligibility under another medical assistance program, please provide the following information by {insert date – 12 days from today} or your medical assistance coverage will be discontinued.

ii. New Application Required

When the recipient has lost SSI recipient status and a new application is required to determine eligibility under another medical assistance program, the following snippet may be used:

We have been notified by the Social Security Administration that your coverage under the SSI medical assistance program will be ending because you no longer get SSI. Your SSI medical assistance coverage will continue while we determine if you are eligible for coverage under another medical assistance program. To help us determine your eligibility under another medical assistance program, we are sending you a new application for assistance. Please complete, sign, date and return the application to us by {insert date –12 days from today} or your medical assistance coverage will be discontinued.

When the recipient lost SSI recipient status because they turned 18 and a new application is required to determine eligibility under another medical assistance program, the following snippet with additional language may be used:

We have been notified by the Social Security Administration that your coverage under the SSI medical assistance program will be ending because you no longer get SSI. Your SSI medical assistance coverage will continue while we determine if you are eligible for coverage under another medical assistance program. To help us determine your eligibility under another medical assistance program, we are sending you a new application for assistance. Please complete, sign, date and return the application to us by {insert date – 12 days from today} or your medical assistance coverage will be discontinued.

Because you have turned 18 and are now an adult, you must complete and sign the application in your own name. We will determine your eligibility based on your own information.

When a new application is required and a review under another medical assistance program is due or will soon be due which prompts a passive review letter or a pre-populated review form to be mailed, the following snippet may be used to instruct the consumer to disregard the other review related documents:

We have been notified by the Social Security Administration that your coverage under the SSI medical assistance program will be ending because you no longer get SSI. Your SSI medical assistance coverage

will continue while we determine if you are eligible for coverage under another medical assistance program. To help us determine your eligibility under another medical assistance program, we are sending you a new application for assistance. Please complete, sign, date and return the application to us by {insert date – 12 days from today} or your medical assistance coverage will be discontinued.

We may also be mailing you a separate review letter or a review form for other medical assistance you or other members of your household already have. You may disregard that letter or form. Instead, please complete and return the new application we are sending. We will use the new application to determine if you or others in your household are eligible for continued medical assistance. Include your information as well as information for all others in your household on the new application. If you do not return the new application, medical assistance coverage for you and all other household members may be discontinued.

iii. Responsibility to Notify SSA

SSI recipients are required to notify the Social Security Administration (SSA) when they change their address and living arrangement by entering a long term care facility. The following snippet may be used to inform the consumer of this responsibility:

We have been notified of your admission to a long term care facility. This is a reminder that you must tell the Social Security Administration (SSA) of your change in address and living arrangement. You may report this information by contacting your local Social Security office. Failure to report this change to Social Security may result in you receiving incorrect benefits that may have to be repaid.

Note: The nursing facility is also required by statute to notify Social Security within 2 weeks of admission when an SSI recipient enters the facility.

iv. Transfer of Property

When SSI recipient status continues and the individual enters an institution, the following snippet may be used to determine if a transfer of property has occurred:

We have been informed that you are now living in a medical facility. We

need more information to determine if we can pay for your care in the facility. Please answer the following question and respond back to us.

Have you or your spouse sold, traded, given away or changed ownership of any property such as a house or money, or any other property in the last 5 years? If the answer is yes, please report the type of property transferred, the value of the property, the date transferred and the purpose of the transfer. Please provide the information by {insert date – 12 days from today} or coverage to pay for your care in the facility may not be approved.

v. ***Whereabouts Unknown***

When the recipient's SSI benefits have been suspended by SSA because his/her whereabouts are unknown, the case should be researched. If KDHE has the recipient's current address, SSI medical assistance remains open, but the consumer should be directed to report his/her current address to SSA. In that instance, the following snippet may be used:

We have been notified by the Social Security Administration that your SSI benefits have stopped because they do not know your current address. Contact Social Security to provide your current address so you can get your SSI benefits again. If Social Security does not start your SSI benefits again soon, we may have to discontinue your SSI medical assistance.

After researching the case, and it is discovered that KDHE does not have the recipient's current address, the following snippet may be used to request an updated address:

We have been notified by the Social Security Administration that your SSI benefits have stopped because they do not know your current address. Contact Social Security to provide your current address so you can get your SSI benefits again. We also need your current address. Please provide us with your current address by {insert date – 12 days from today} or your medical assistance coverage will be discontinued.

j. CONTRACTOR/STATE INTERACTION

While contract staff are allowed to assist with case development, federal rules require a state employee to make the final determination of Medicaid eligibility. The State Interaction Chart is used to document specific case situations which require involvement of state staff.

The current State Interaction Chart may be found on the KDHE Eligibility Policy website: http://kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy

6. *CONTACT WITH SOCIAL SECURITY*

Staff may contact Social Security when responding to an SDX Income Begin, Change, Ended task created in KEES if the action to be taken is not obvious or if additional clarification is required. It may be prudent in some instances to contact the SSI recipient (or representative) as well. Remember contact with Social Security is a privilege. Do not abuse the privilege. Only call when absolutely necessary.

The basis for calling Social Security will generally fall into one of two categories – to either clarify the SDX information because it is confusing or unclear, or to ask specific questions concerning program requirements for the protected medical group (PMG) programs.

a. CLARIFICATION OF SSA ACTION

If the information reported on the SDX record is not obvious, contact with Social Security may be required. To clarify, eligibility staff should ask for confirmation of the payment status code and what it means. The effective date of the payment status and whether the status is temporary or permanent should also be confirmed. If temporary, ask how long the status is anticipated to continue.

If the payment status adjustment is income based, confirm the source of the income and how long the status is anticipated to continue –temporary or long term. If the payment status adjustment is resource based, confirm the resource type and amount. Also ask if conditional SSI payments will be made pending an agreement to liquidate the disqualifying resource.

b. PROTECTED MEDICAL GROUP (PMG)

When the SDX record indicates that the SSI payment status has been suspended or terminated due to income, potential eligibility under one of the protected medical group (PMG) programs exists. Social Security should be contacted to ask the following questions. These instructions are intended for individuals who have just recently lost SSI eligibility.

i. Pickle

To qualify for Pickle eligibility, the individual must currently be receiving OASDI benefits, concurrently received both OASDI and SSI during any month since April 1977, lost SSI since April 1977, and would otherwise be eligible for SSI if the total OASDI cost-of-living adjustments (COLA) received since they became ineligible for SSI was deducted from current income.

If there is no current OASDI benefit, there is no potential Pickle eligibility, and therefore no need to contact Social Security concerning this program. If there is a current OASDI benefit and SSI payments have just been discontinued, staff should be able to determine Pickle eligibility without contacting Social Security.

ii. Qualifying Disabled Widows and Widowers (QDW)

Individuals eligible for QDW coverage must have lost SSI eligibility in 1984 and applied for coverage by July 1, 1988. Since this memo is concerned with individuals who are losing current SSI eligibility based on information contained in the SDX payment status code record, this program is not applicable to this process and will not be addressed here.

iii. Adult Disabled Children (ADC)

To qualify for ADC eligibility, the individual must currently receive ADC benefits from Social Security, have received SSI benefits based on disability/blindness with an onset prior to age 22, lost SSI benefits on or after July 1, 1987 due to initial eligibility for ADC benefits or due to an increase in those benefits, and would be currently eligible for SSI benefits if not for the ADC benefit.

Again, if there is no current OASDI benefit of any kind, there is no potential ADC eligibility, and therefore no need to contact Social Security. If there is a current OASDI benefit which is not an ADC payment, again, there is no eligibility and no need to contact Social Security. However, if the source of a current Social Security payment is unknown and SSI eligibility has just ended, Social Security should be contacted.

iv. Early or Disabled Widows and Widowers (EDW)

Individuals eligible for EDW coverage must currently be receiving a widow's or widower's benefit, are 60 years old, or between 50 and 59 and

disabled, lost SSI eligibility due to the widow or widower benefit, would be eligible for SSI if not for that benefit, and are not eligible for Medicare Part A.

If the individual is eligible for Medicare Part A, is 65 or older, under 60 and not disabled, or receives no current OASDI of any kind, there is no need to contact Social Security concerning this program. If there is a current OASDI benefit which is not a widow/widower payment, again, there is no eligibility and no need to contact Social Security. However, if the source of a current Social Security payment is unknown and SSI eligibility has just ended, Social Security should be contacted.

7. SSA APPEAL

An individual losing SSI recipient status with Social Security may file an administrative appeal with SSA challenging the action to suspend, stop payment or terminate benefits. The timing of the appeal will determine if SSI benefits continue pending the outcome of the appeal. A timely appeal is one filed within 60 calendar days of the date of the SSA adverse action.

a. Continuation of Benefits

If the recipient files an appeal with SSA within 10 calendar days of notification of the suspension, stop payment or termination, he/she can choose to continue SSI benefits throughout the entire SSA administrative appeal process and would therefore continue to be considered an SSI recipient for purposes of SSI medical assistance.

1) Non-Disability Related

If the adverse action is not disability related, unreduced SSI benefits may continue only through the decision issued at the first level of SSA administrative appeal. The first level of administrative appeal is Reconsideration.

2) Disability Related

If the adverse action is disability related, unreduced SSI benefits may continue throughout all three levels of the SSA administrative appeal process. The three levels of administrative appeal are Reconsideration, Administrative Law Judge Hearing, and Appeals Council Review.

Note: Any SSI benefits received by the individual pending an unsuccessful appeal are subject to recoupment by SSA. However, continued SSI medical assistance coverage received pending an unsuccessful SSA administrative appeal is not considered to be overstated medical eligibility subject to repayment.

b. No Continuation of Benefits

If the individual files an appeal with SSA within 60 days (but after 10 days) of notification of the suspension, stop payment or termination, the appeal is timely but the recipient is not entitled to continued SSI benefits throughout the appeal process. The recipient would not be considered an SSI recipient for purposes of SSI medical assistance because benefits have been discontinued. However, since the recipient has timely appealed the loss of SSI benefits, SSI medical assistance may continue throughout the entire SSA administrative appeal process. Verification of the SSA appeal status is required.

Note: SSA adds an additional 5 calendar days for mail time to the 10 day and 60 day timely filing time frames listed above. The appeal request must be in writing.

8. EXAMPLES

The following demonstrate the policy change.

a. Bitsy Example:

Bitsy has ongoing SSI and QMB medical coverage. She has a review due in April 2019 and has not filed an application for several years. On 03-11 Bitsy is approved for Social Security and her SSI cash is terminated. The worker receives an SDX SSI End task regarding the SSI termination and determines a new application is needed. The task is claimed on 03-16. Even though the review due is a current month, the worker assumes no form will be sent (SSI only case) and sends a new application with a due date of 03-29-18. The Task is placed On Hold and the due date is adjusted. Bitsy's SI medical stays in place while we wait for the application.

On 04-03-18, Bitsy has not yet returned the application. Her SI medical assistance must be terminated – for failure to complete an application. Her QMB coverage must also be terminated. Prior to processing the discontinuance, the worker updates the Medical Condition, the SSI income record and the Non-compliance record. A discontinuance notice is sent and all tasks are completed.

On 04-10-18, the application is received. Because the application is received timely, Bitsy's medical assistance (both SI and QMB) must be reinstated within 10 days. This is done by using the Rescind functionality, returning the Medical Condition and Income Records to what they were previously when Bitsy was receiving SI medical coverage and by end dating the Non-compliance record. At this point the worker also determines that she does not require a MAGI determination (so the RMT remains Medical) and resource verification is needed. A notice informing Bitsy of the reinstatement and the Request For Information request is sent. The task is placed On Hold and the due date adjusted.

The bank statements arrive on 04-20-19 and the task is claimed on 04-25-19. The worker determines that all information is present and that she will have Medically Needy coverage. In the meantime, on 03-15, the review batch ran and her review was reset to 04-2020. The review will now be set to correspond to the new Medically Needy base period, so it must first be shortened and then reset. This is appropriate because we have a new application.

First, the worker determines the last month of SSI coverage – that will be May to allow for timely notice. The means June is the first unpaid month and the first month of new coverage. To process, the worker adjusts the current review date to end May 2019. Then, after selecting June, he begins processing the new determination. All data collection pages are updated, including the Medical Condition and income pages. When EDBC is executed in June, the RE Run Reason is used to reset the review due to 05-2020. Medically Needy is approved with a base period of June – November. She remains eligible for QMB. The worker checks the review/change notice to ensure all new information is sent. Because a new Medically Needy program was approved, a Spenddown Information notice, N836 is also sent. The e-app status is checked, the journal completed and the tasks are cleared.

b. Bill and Betsy Example:

Bill and Betsy have ongoing medical coverage – Bill under a Medically Needy program and Betsy under SI Medical. Bill has an existing base period of November – April and a review due of April 2019. On 01-11 Betsy is approved for Social Security and her SSI cash is terminated. The worker receives a task and sees neither an application nor a pre-pop review form has not been received within the past 12 months, so she sends one to the couple and calls the couple to explain. Betsy's SI medical coverage continues and so does Bill's Medically Needy. The Task is put On Hold and the date is adjusted.

Bill and Betsy do not return the application by the due date and coverage is discontinued for both Bill and Betsy on 02-05-19 effective 02-28. The worker

updates the Medical Condition and SI income records before taking action. Bill's coverage is also terminated because Betsy's information is needed to determine Bill's ongoing eligibility. Upon getting the notice they hurry to get the application returned on February 10. The program is rescinded and Betsy's SSI is reinstated for March coverage (after returning the Medical Condition and SI income records to previous status), however Bill's coverage is not because the full application cannot be processed without more information. A request for information is sent and the Task is put On Hold. The information is returned on March 3 and the case is picked up to be processed on March 10 with everything needed.

The worker determines that Betsy will be added to the Medically Needy plan, but not until April (she already has coverage for March), but Bill still needs Medically Needy for March.

The first thing to do is reinstate the Medically Needy program for Bill. EDBC is ran for the month of March before updating Betsy's SSI information. The worker makes note of the Review Date -next month and realizes the application needs to be used to process the review. Before working in the month of April, the worker shortens the review to end in March 2019 to allow a review period to be established.

The worker then selects the month of April. The data collection pages are updated with the new information, including the Medical Condition and SI income. EDBC is ran with the RE Run reasons and the spenddown is updated for April. Because it is important to keep the review period aligned with the spenddown base period, the review period is then shortened to end at the end of the next 6 month base (10-2019). But, the new base cannot be established because the month of May isn't available yet. The worker carefully journals this action, so the person establishing the next base period is aware of the circumstances. The notice regarding the review and the adjusted spenddown are sent. The task is updated.

c. Charlie and Carly Example

Charlie, a 16-year-old SSI recipient, and Carly, his 13-year-old PLN sister are both covered under the same program block. There is an outstanding review due of 04-2017. On January 4, mother calls to report that Charlie's SSI has ended because he is no longer considered disabled by SSA. However, she is worried about his medical assistance. The call center creates a task for the worker.

On 01-13, the worker picks up the task and notes the overdue review. The worker determines that a new application/Pre-Populated Review is needed prior to taking any action. The review is generated and a V044 is created

explaining that this is due back 01-25. The Task is placed in On Hold status and the due date is reset.

On 01-30-19 the review hasn't been returned, so action is taken to terminate coverage for both kids effective 02-28-19. Charlie's medical condition and SSI income are updated. A notice is sent.

On 03-15-19, the application is received – the program is rescinded because it was received back within the review reinstatement period. And, because it is within the month following the month of SI medical termination, Charlie's coverage must be reinstated. The worker determines Charlie is potentially eligible under a MAGI program and attempts to complete all action at the same time, so the RMT is updated to MAGI and the worker begins processing for the month of March. However, the mother fails RC and income verification must be requested. Because the worker can't approve new coverage for Charlie right now, the worker must reinstate Charlie's SI medical. To do this, the 'Partial Approval' process must be used and Carly's SSN verification indicator is adjusted. Charlie's SI medical is reinstated (updates to the RMT, the Medical Condition and SSI Income are also made). The RE Run Reason is NOT used for this action. A request for information is sent. Task is created and the action is journaled.

Mom supplies income verification on 03-28-19. The worker picks up to process on 04-03-19. The worker analyzes the situation and can see that Charlie has coverage for March and April, but Carly does not. First, the worker must process March to provide coverage for Carly. After updating all of the data collection pages for pertinent information (but still leaving Charlie's Medical Condition and SSI income in place) and using a Medical RMT and an RE Run reason, EDBC is executed and PLN coverage is approved for Carly. The RE Run reason is used because this is the first unpaid month for Carly. Carly's CE will run through 02-2020. This is also the new review period. EDBC is also ran for April, to approve Carly.

Next the worker must process ongoing for Charlie – beginning in May. This is done by updating the Medical Condition and the SSI income. Since only MAGI is being considered, the RMT remains MAGI and EDBC is executed. Charlie's coverage is switched to PLN and his CE will run through 04-2020. The worker also runs June to obtain a high-dated EDBC. A notice is sent information the family of the changes. The task is resolved and the case is journaled.

d. **Harold and Haley Example**

Harold is a 7-year-old SSI/HCBS recipient (SED Waiver). He is open on a Program Block with a review due date of 05-2019. His sister, Haley, is a 14-year-old PLT member open on a second program block with a review/CE date of 07-2019. Mother is the case head.

On 11-28 an SDX SSI end task is received from SSA. Worker pulls task on 12-05 and discovers SSI closed because of income. After contact with SSA and with the mother, it turns out mom got a promotion at work and the income is expected to continue at this level. The SSI has ended, but mom said Harold still needs HCBS.

The worker knows she must keep Harold's SSI-HCBS program running until a new determination is made. The worker can process the same day by using Haley's application. Although there hasn't been an application for Harold for two years, a review was completed for Haley within the past 12 months. The application listed Harold and didn't report any other income for him. The worker has determined the application can be used to establish coverage under the 300 Aid Code for Harold.

Since the review is due in the future and there hasn't been a new application, the review date for Harold remains in place. In January, the worker updates the Medical Condition and the SSI income and runs EDBC with an RMT of LTC. The Aid Code is changed, but the client obligation remains $0. A notice is sent and the action is journaled.

e. Homer and Gomer Example

Homer is receiving SI medical coverage and QMB on his own program block and his child, Gomer, is receiving PLN coverage on his own program block with an expired Review Due month of 01/2019. Homer's SI ends on 03/2019. Gomer's pre-populated review was sent on December 15, 2018 and was received on January 20, 2019 but has not been processed.

The task is pulled on March 28. The worker looks over the review form and determines it can be used to review Gomer and determine Homer under MAGI programs only. The worker notes that the only income in the household is SSA – for both Homer and Gomer. There is no resource information on the form, and E and D determination will require more information. On March 28, 2019 Homer is added to Gomer's program block as an applicant. The date of the review form is used to complete this action. Because the worker doesn't know if Homer will be CTM eligible, no other action is taken to stop the SSI coverage until EDBC results are returned.

Working in the month of March, all data collection pages are completed from the review for both Homer and Gomer. EDBC is run in March with a RE run reason and Gomer is eligible for PLN, but Homer is not eligible for CTM. The RE RUN Reason was used so a new CE and review dates are set 05/19-

04/20. Gomer's coverage is all set now. The notice is reviewed and completed.

The worker refocuses her attention on Homer. The worker calls Homer to obtain resource information, but there is no answer. The worker determines an E&D supplement is adequate to determine if Homer may be eligible for other coverage, and Homer's SI medical coverage is left open on his separate program block. The supplement, along with the V044, is sent allowing for 12 days to return the forms and needed information. The information is received timely on April 09, 2019 and the worker determines all information is now available to process. Homer must remain on his own Program Block. April is the last paid month for the SI medical coverage, so action to redetermine coverage and will be effective May 2019. The worker notes a review date of 07-19 for Homer's block, so she knows it must be reset with the new application.

First, the worker shortens the review to end 04-2019 and then she selects May 2019. The Medical Condition and other data collection pages are updated for May. EDBC is ran with the RE Run reason for May and Medically Needy coverage is approved on Homer's program block effective May 01, 2019 with a 6 months base period 05/19- 11/19. Homer's MSP also changes from QMB to LMB for May. Notices are sent, tasks are finalized and the action is journaled.

II. Changes Impacting Elderly and Disabled Medical Programs Only

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

A. Verification of Resources

The following resource verification policies apply to situations where initial resource eligibility is being determined, an individual is being added to an active resource-tested medical assistance program, a new non-active resource-tested program is being added with or without a new application, a pre-populated review is being completed for a resource-tested program, or a passive review response for a resource-tested program is being processed.

1. Background

The following is the current resource verification policy:

a. Application

When determining resource eligibility at initial application, all resources must be verified as indicated in Medical KEESM 1322.1(9), 1322.3(3) and 1322.4(2).

b. Adding a Person

When adding an individual to an active resource-tested medical assistance program, resources need not be reverified if already verified within the last three months (for liquid resources, except countable life insurance) or within the last twelve months (for all other resources, including countable life insurance). Otherwise, the standard verification process for an initial application applies.

c. Adding a Program

When adding a new non-active resource-tested medical assistance program, with or without a new application, resources need not be reverified if already verified within the last three months (for liquid resources, except countable life insurance) or within the last twelve months (for all other resources, including countable life insurance). Otherwise, the standard verification process for an initial application applies.

d. Pre-Populated Review

For a pre-populated review of a resource-tested medical assistance program, self-attestation of the value of resources is allowed if the total value of liquid resources is no more than 85% of the allowable resource limit, there are no other countable resources, there is no community spouse, there is no trust, there has been no loss or transfer of assets, and no otherwise exempt asset is being monitored. Otherwise, the standard verification process for an initial application applies, except for bank accounts which will be verified through the AVS process.

e. Passive Review Response

A change in resources reported via a passive review response is processed following standard change processing guidelines.

To somewhat simply the process, the verification policies for adding a person, adding a program, and pre-populated reviews are being aligned. There is no change to the

application and passive review response processes.

2. POLICY

Effective with the issuance of this memo, when an individual is being added to an active program or approved under a new non-active program with or without a new application, or a pre-populated review is being processed, resources need not be reverified if the following conditions have been met.

a. POLICY REQUIREMENTS

The following policy requirements apply.

i. An application (other than a MIPPA application) or pre-populated review form was filed within the last 12 months;

ii. Resources were verified within the last 12 months;

iii. The reported value of all countable resources does not exceed 85% of the applicable resource limit;

iv. There is no indication from either internal or external sources that there has been a change in resources, such as:

1. A resource no longer exists,

2. There is a new resource,

3. A potential or actual resource transfer as occurred: and

v. There are no resources being monitored for continued exempt status, including the following:

1. Countable resources with no market value.

2. Resources that are exempt due to a legal impediment.

3. Real property that is exempt due to a bona fide effort to sell.

4. Real property that is unavailable because sale of the property would cause loss of housing for a joint owner.

5. Resources that are exempt for a specified period of time, such as a retroactive SSA/SSI payment for nine months.

vi. In addition, this policy does not apply and reverification of resources is required when any or all of the following exist:

1. A trust (countable or exempt).

2. Countable life insurance.

3. A community spouse.

When applying the 85% countable resource threshold, income known to be deposited into a countable financial account shall first be deducted from that account in determining the countable resource value.

b. 85% Threshold Waived

If all resources have been verified within the last 3 months (i.e.: current month plus the last two months), the 85% countable resource threshold does not apply. Instead, as long as countable resources are within the allowable resource limit, and all other policy criteria described above are met, reverification of resources is not required.

c. Resource Values

If the requirements of this policy are met, the following resource values shall be used.

i. If this is an add-a-person or add-a-program eligibility determination without an application, the previously verified resource values in place at the time of the new determination shall be used.

ii. If this is an add-a-person or add-a-program eligibility determination with a new application, or a pre-populated review determination, the self-attested value of liquid resources provided from the consumer and the previously verified value of all other resources shall be used.

If the above conditions have not been met, reverification of all resources is required. The standard verification process for an initial application applies. Except, verification of bank accounts (excluding Direct Express accounts) for pre-populated reviews that fail to meet the policy requirements described

above shall be requested through the electronic Asset Verification Solution (AVS). See Medical KEESM 9333(2)(b).

B. Self-Attestation of Excess Resources

The following policy applies to situations where an applicant or recipient self-attests to ownership of countable resources with a value which exceeds the allowable resource limit.

1. Background

Agency policy is to allow an applicant/recipient to self-attest to resource ineligibility. However, there are no clear guidelines provided to eligibility staff to administer the policy, other than to use prudent person policy. The prudent person concept is easy to apply when reported resources are well over the limit, but more problematic when resources are only marginally over. To aid eligibility staff in this sometimes difficult determination, additional guidance is needed.

2. Policy

Eligibility staff may deny or discontinue eligibility for a resource-tested medical assistance program when the individual self-attests to ownership of excess resources. However, the use of prudent person shall be applied in making this determination on a case-by-case basis. The following are elements to consider:

a. Amount of Excess

Substantial consideration should be given to how much the self-attested countable resources exceed the allowable resource limit. Obviously, resources which substantially exceed the limit are given greater weight than resources which only minimally exceed. Therefore, it would make more sense (and therefore be more prudent) to deny/discontinue coverage when the individual is $50,000 over the resource limit as opposed to only $500 over.

Before making this assessment, eligibility staff should remember to subtract any known income deposited into a countable financial account before arriving at a value. In addition, should the countable/exempt status of a resource be in question, assume the asset is exempt for purposes of this policy.

b. Resource Type

The type of resources reported should always be considered. The more liquid the asset, the less inclined eligibility staff should be in applying this policy. Financial accounts may fluctuate in value more readily than real property or other personal property due to the nature of the asset. It is not unreasonable to assume that a checking or savings account balance may actually be substantially less than reported a few days or weeks later.

c. CIRCUMSTANCES

The particular circumstances of the applicant/recipient should also be factored into the determination. An individual with large outstanding debts may be in the immediate process of paying those debts and thereby reducing countable resources within allowable limits. This could include someone who receives a cash inheritance or wins a relatively small lottery amount, but also has substantial outstanding credit card debt, owes several months of back rent, has unpaid taxes, or has borrowed from friends and family over a long period of time.

The individual's household situation (living arrangement) should also be considered. Someone in a nursing facility may be reducing resources at an accelerated rate as opposed to someone living in the community, therefore making liquid resource values more fluid.

d. OTHER FACTORS

Any other known factors which may affect this determination should be considered. Those factors could include, the specific medical program(s) applied for or currently receiving, the reason the individual is either applying for or receiving medical assistance, how long the individual has owned or had access to the resource(s), information known from previous contacts with the agency.

e. EXAMPLES

Consider the following examples.

Example 1: A married individual applies for nursing home coverage and reports countable resources well in excess of the allowable limit. Since spousal impoverishment is involved, it would never be appropriate to deny the application without making a formal resource assessment and determination of countable resources. Verification of resources should be requested.

Example 2: A married couple apply for Medically Needy (MDN) for both. They report countable resources of a $1,000 checking account and a vacant city lot valued at $4,000 that they use as a garden plot. Since the value of the city lot by itself exceeds the allowable resource limit ($3,000) and the resource is non-liquid, it would be prudent to deny the application due to self-attestation of excess resources.

Example 3: Single individual applies for Medically Needy (MDN) coverage. Reported resources are a $100 checking account, a $500 savings account, and two newer vehicles. The Kelley Blue Book (KBB) lists the value of each vehicle at $7,500. One of the vehicles is exempt as primary, the other is a countable resource. Since the value of this vehicle by itself exceeds the applicable resource limit ($2,000) and that value is by nature static in the near term, it would be appropriate to deny the application due to self-attested excess resources.

Example 4: Single individual applies for Medically Needy (MDN) and MSP coverage. The total value of countable resources reported is $5,000. It would not be appropriate to deny the application due to self-attestation of resources because while over the Medically Needy (MDN) resource limit ($2,000), the applicant is under the MSP limit ($7,560). Verification of resources should be requested.

Example 5: A married couple apply for MSP only, for both of them. The reported countable resources are a checking account of $2,200 and a savings account of $12,000. The couple receive a total of $1,900/month in Social Security benefits that appear to be deposited into the checking account. They also report an unpaid dental bill of $1,750. After deducting the Social Security payments from the checking account balance and taking into consideration that savings may be used to pay off the dental bill, it is uncertain as to whether countable resources exceed the allowable limit ($11,340). In this case, it would not be prudent to deny due to self-attestation of excess resources. Verification should be requested.

Example 6: Single individual receiving HCBS and QMB reports receiving a $100,000 cash inheritance from his deceased parent. He also reports that he has no immediate plans for the money. It would be prudent to discontinue coverage due to self-attested excess resources. However, if the recipient reported that he was going to establish a special needs trust for himself to shelter the asset, it would then be prudent to request verification before taking any action.

Example 7: A single Medically Needy (MDN) recipient reports she just received a check from Social Security in the amount of $12,000. She says she doesn't know what it is for. If it is a retroactive Social Security benefit, the monies are exempt as a resource for 9 months from the month of receipt. Since further investigation is required, it would not be appropriate to discontinue coverage due to self-attested excess resources. Verification of the source and amount of the payment should be requested.

Example 8: A single Working Healthy (WH) recipient reports he received a tax refund of $3,500, which in addition to other previously verified countable resources exceeds the allowable program limit ($15,000). Since the tax refund by itself does not result in resource ineligibility, it would not be prudent to discontinue coverage due to self-attestation. Verification should be requested.

Whenever there is a doubt, this resource self-attestation policy should not be applied. Verification of assets should be requested. If eligibility is denied or discontinued based on self-attestation of excess resources under this policy, that decision must be thoroughly journaled in the case to fully support the action taken.

III. QUESTIONS

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

Jeanine Schieferecke, Senior Manager – Jeanine.Schieferecke@ks.gov
Erin Petitjean, Elderly and Disabled Program Manager- Erin.Petitjean@ks.gov
Vacant, Family Medical Program Manager

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

Kansas
Department of Health and Environment
Division of Health Care Finance

KC-7005 SSI Payment Status Codes

Use the guide below to determine impact on the Medical case when an individual is found with the listed SSI Payment Status Code.

The SDX and TPQY provide payment status codes for SSI applicants and recipients.

SSI Payment Status Code	Type of Event- SSA	SSA Effective Date- SSI Payments End	SSA Reinstatement Date- SSI Payments Resume	Action to be Taken by Medical Assistance Staff
E01 Eligible – No Payment Due	Stop Payment	A month the recipient is eligible based on the SSI determination, but no SSI payment	Any month countable income is less than the SSI Federal Benefit Rate (SSI payment).	Negative action not required. This is the first month of SSI eligibility where no payment is made. The individual is considered to be in SSI recipient status.
N01 Excess Income	Suspension	A month where countable earned income exceeds the SSI Federal Benefit Rate (SSI payment)	The month where countable income is less than or equal to the SSI Federal Benefit Rate	SSA phone contact to determine if SSI payment will resume within the next 2 months. If so, SI medical assistance continues. Otherwise, the SSI medical assistance program must be discontinued. SI medical remains open while establishing eligibility under another program.
N01 Section 1619(b) Eligible, no payment due	Stop Payment	A month countable earned income exceeds the Federal Benefit Rate	The month countable income is less than the Federal Benefit Rate	Confirm 1619(b) status. If confirmed, SSI medical assistance continues as long as the 1619(b) status continues. EATSS record does not always include 1619(b) indicator- phone contact with SSA is required.
N02 Resident of a public institution	Suspension	The first full month a recipient is a resident for a long term stay. SSI payments may be made for up to 3 months for a temporary stay.	The day the recipient is no longer a resident of a public institution.	SSI medical assistance shall be discontinued. SI medical remains open while establishing eligibility under another program.

SSI Payment Status Code	Type of Event- SSA	SSA Effective Date- SSI Payments End	SSA Reinstatement Date- SSI Payments Resume	Action to be Taken by Medical Assistance Staff
N03 Absence from the United States	Suspension	The first full month the recipient is (or expects to be) outside the United States.	The 31st consecutive day back in the United States	SSI medical assistance shall be discontinued. SI medical remains open while establishing eligibility under another program.
N04 Excess Resources	Suspension	The month resources exceed the limit. Note that conditional payments may have continued	The first day of a month where countable resources are within the limit.	SSI Medical assistance shall be discontinued. Contact with consumer to obtain resource information. SI medical remains open while establishing eligibility under another program.
N05 Failure to provide information for children overseas	Suspension	The first month the system can stop benefits	The first month that evidence establishes eligibility/payment amount	SSI medical assistance shall be discontinued.
N05 Failure to give permission to contact financial institutions	Suspension	The first month the system can stop benefits.	The month after the month permission is given.	SSI medical assistance shall be discontinued. SI medical remains open while establishing eligibility under another program
N05 Ineligible for a past nonpay period	Suspension	Only for a past nonpay month.	The first month that evidence establishes eligibility	None. This status code is no longer used, but may appear on historical records. Call SSA to determine status If terminated, SI medical remains open while establishing eligibility under another program.
N06 Failure to file for title II (OASDI) benefits or other benefits	Suspension	The month the recipient received written notice to file for/pursue benefits.	The day the recipient takes appropriate steps to obtain other benefits,	SSI medical assistance shall be discontinued. SI medical remains open while establishing eligibility under another program
N07 Cessation of disability	Termination	The third month after the month of cessation.	The month of termination, or a later month or day in a month when the	SSI medical assistance shall be discontinued. SI medical remains open while establishing eligibility under another program

SSI Payment Status Code	Type of Event- SSA	SSA Effective Date- SSI Payments End	SSA Reinstatement Date- SSI Payments Resume	Action to be Taken by Medical Assistance Staff
			cessation is reversed or reopened.	
N08 Cessation of blindness	Termination	The third month after the month of cessation.	The month of termination, or a later month or day in a month when the cessation is reversed or reopened.	SSI medical assistance shall be discontinued. SI medical remains open while establishing eligibility under another program
N13 Loss of U.S. citizenship, eligible alien status or residency	Suspension	The first full month the recipient lost eligible status.	The day the recipient meets eligible status again.	SSI medical assistance shall be discontinued. New verification of non-citizenship is required for new program determination
N19 Voluntary Termination	Termination	The first month the system can stop benefits.	The month the request can be cancelled.	SSI medical assistance shall be discontinued. SI medical remains open while establishing eligibility under another program.
N20 Failure to provide information	Suspension	The first month the system can stop benefits under GK procedures.	The first month of suspension or a later month that evidence establishes eligibility/payment amount.	SSA Phone Contact Determine if SSI payment will resume within the next 2 months. If so, SI medical assistance continues. Otherwise, the SSI medical assistance program must be discontinued. SI medical remains open while establishing eligibility under another program
N22 Inmate of a penal institution	Suspension	The first full month that the recipient is a residence of a penal (public) institution.	The first day that a recipient is no longer a resident of a penal (public) institution.	Contact SSA to determine current status and obtain incarceration information from facility. If recipient is in facility, SI medical assistance is discontinued. If not, SI medical remains open while establishing eligibility under another program

SSI Payment Status Code	Type of Event- SSA	SSA Effective Date- SSI Payments End	SSA Reinstatement Date- SSI Payments Resume	Action to be Taken by Medical Assistance Staff
N23 Not a United States resident	Suspension	The first full month in which a recipient is no longer a United States resident.	The first day in a month that the recipient meets both residency requirements	SSI medical assistance shall be discontinued.
N24 Administrative sanction	Suspension	Two months after recipient provided false information	When sanction period expires.	SSI medical assistance shall be discontinued. SI medical remains open while establishing eligibility under another program
N25 Fugitive Felon or Parole/Probation Violator	Suspension	The first day of a month of an arrest order.	The month following the month the issue is resolved	Contact with SSA to confirm status. SI medical assistance discontinued if SSI payment has not been reinstated SI medical remains open while establishing eligibility under another program
S06 Whereabouts unknown	Suspension	The first month the system can stop benefits based on the recurring tape cutoff.	The effective month of suspension or a later month that there is a correct address and /or living arrangement information.	Research case. If KDHE has a more current address, SSI medical remains open. Notice to consumer to notify SSA of new address. If KDHE does not have a current address, RFI to consumer to provide updated address. If new address provided update and SSI remains open. If no response, discontinue for Whereabouts Unknown.
S07 Check returned for a miscellaneous reason other than death, identification,	Suspension	The first month the system can stop benefits	The effective month of suspension or a later month when the recipient is SSI eligible.	SSA phone contact Determine if SSI payment will resume within the next 2 months. If so, SI medical assistance continues. Otherwise, the SSI medical assistance program must be discontinued.

SSI Payment Status Code	Type of Event- SSA	SSA Effective Date- SSI Payments End	SSA Reinstatement Date- SSI Payments Resume	Action to be Taken by Medical Assistance Staff
address, death of payee, or duplicate check				SI medical remains open while establishing eligibility under another program
S08 Developing for representative payee	Stop Payment	The first month the system can stop benefits	The first month benefits stopped.	SSA phone contact Determine if SSI payment will resume within the next 2 months. If so, SI medical assistance continues. Otherwise, the SSI medical assistance program must be discontinued. SI medical remains open while establishing eligibility under another program.
S09 Temporary Institutionalization	Stop Payment	The first month in long term care. Defaults to temporary stay until information received regarding status	The effective month of suspension.	SSI medical assistance shall be discontinued, unless the benefit will be reduced to $30. SI medical remains open while establishing eligibility under another program
T01 Death of a recipient	Termination	Eligibility ends the month of death.	N/A	SSI medical assistance shall be discontinued.

Eligibility Actions Following Loss of SSI Recipient Status

The purpose of this chart is to assist eligibility staff in determining whether a new application is required following a consumer's loss of SSI recipient status. This chart also provides instruction for addressing the consumer's review period at the time eligibility under a new program is determined.

<table>
<tr><td rowspan="7">New Application Not Required

A new application is not required if any of the following conditions are met:
Application (not MIPPA) received in the last 12 months
Pre-Populated Review received within the last 12 months
For Family Medical programs, Passive Review completed in the last 12 months</td><td rowspan="3">Added to Active Program</td><td>No Additional Information Needed</td><td colspan="2">Administratively Added to Another Program</td></tr>
<tr><td rowspan="2">Additional Information Needed</td><td>Telephone Contact</td><td>Required when the information needed to add or open the individual either requires no verification or may be verified by self-attestation.
Formal contact is required if the individual is not available for contact by phone.</td></tr>
<tr><td>Formal Contact</td><td>A written request for information is mailed to the individual allowing 12 days to respond.
Failure to provide the requested information results in ineligibility.</td></tr>
<tr><td rowspan="3">Transitioned to Another Program</td><td>No Additional Information Needed</td><td colspan="2">Administratively Transitioned to Another Program</td></tr>
<tr><td rowspan="2">Additional Information Needed</td><td>Telephone Contact</td><td>Required when the information needed to transition the individual either requires no verification or may be verified by self-attestation.
Formal contact is required if the individual is not available for contact by phone.</td></tr>
<tr><td>Formal Contact</td><td>A written request for information is mailed to the individual allowing 12 days to respond.
Failure to provide the requested information results in ineligibility.</td></tr>
<tr><td>Determined Ineligible</td><td colspan="3">If the individual is not eligible for medical assistance under any available program, the SSI medical assistance program may be discontinued allowing timely and adequate notice.
Mailing a new application to the individual is not required.
Formal determination under another program is not necessary.</td></tr>
</table>

Kansas Department of Health and Environment
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Eligibility Actions Following Loss of SSI Recipient Status

New Application Required	Application Timely Returned		• SSI medical assistance continues while the new application is fully processed. • Once the new application has been processed, SSI medical assistance coverage is discontinued providing timely and adequate notice. • If approved, eligibility under another program begins the month following SSI medical assistance discontinuance.
	Application Not Returned		If the application is not returned, SSI medical assistance coverage is discontinued providing timely and adequate notice.
	Application Untimely Returned	App rec'd before discontinuance is effective	SSI medical assistance coverage is reinstated (rescinded and reauthorized) and continues until a new determination is made.
		App rec'd in the month following discontinuance	SSI medical assistance coverage is reinstated (rescinded and reauthorized) and continues until a new determination is made.
		App rec'd later than the month following discontinuance	• SSI medical assistance is not reinstated while the new application is being processed. • The application is registered using Reapply functionality and normal application processing procedures and timelines apply.
	Request for Information	Information Timely Provided (within 12 days of request)	• SSI medical assistance continues while the new application is being processed. • Once the new application has been processed, SSI medical assistance coverage is discontinued providing timely and adequate notice. • If approved, eligibility under another program begins the month following SSI medical assistance discontinuance.
		Information Untimely Provided (within 12 days of denial for FTP)	Both the application and SSI medical assistance are reinstated (rescinded and reauthorized) and continue until a new determination is made.
		Information Untimely Provided (within 45 days of Application Date)	Both the application and SSI medical assistance are reinstated (rescinded and reauthorized) and continue until a new determination is made.
		Information Untimely Provided (More than 12 days after denial or 45 days from Application Date)	A new application is required and the SSI medical assistance may not be reinstated.

Kansas Department of Health and Environment
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Eligibility Actions Following Loss of SSI Recipient Status

<table>
<tr><td rowspan="3">Review Due in the Future</td><td rowspan="2">Added or transitioned to a new program <u>without</u> a new application</td><td>Medically Needy (MDN) with a Spenddown</td><td colspan="2">• Existing review period remains if expiring before the end of the first spenddown base period.
• If review does not coincide with the end of a base period, review period is shortened</td></tr>
<tr><td>Non-Medically Needy (MDN)</td><td colspan="2">Existing review period remains in place</td></tr>
<tr><td>Added or transitioned to a new program <u>with</u> a new application</td><td colspan="3">• Review period is reset
• Manually shorten existing review period to end in the last month of SSI medical assistance
• Run EDBC with the RE Run Reason in the first month of new coverage
• For Medically Needy (MDN) with a spenddown, it may be necessary to shorten the newly established review period to coincide with the end of the spenddown base period.</td></tr>
<tr><td>Review Currently Due
• Review period has not expired, Pre-Populated Review has been sent but not returned
• Review in the future, not reasonably expected to be completed prior to resolution of loss of SSI recipient status</td><td>• SSI Only
• SSI with MSP
• SSI with other Active MEMs in the Program Block</td><td>A new application is requested.</td><td colspan="2">A new review period will be established at the time the new determination is completed.</td></tr>
<tr><td rowspan="3">Review Due in the Past

Policy requires any skipped or unprocessed review to be completed before adding new person to an existing program</td><td>Review received, not processed</td><td>Process review including add person/add program for SSI recipient</td><td colspan="2">• Review and CE period (if applicable) will be set at the time the review is processed
• EDBC is run with the RE Run Reason in the first unpaid month</td></tr>
<tr><td rowspan="2">Review not received or review sent and not returned timely</td><td rowspan="2">V044 sent with Pre-Populated Review allowing 12 days to return the form</td><td>Review received</td><td>• Process review
• New review period is established for all household members</td></tr>
<tr><td>Review not received</td><td>Discontinue eligibility allowing timely and adequate notice for all household members, including SSI recipient</td></tr>
</table>