



Policy Directive 2020-03-01

Title: Delayed Discontinuance – COVID-19

Date: March 31, 2020

From: Policy Managers

Program(s) Impacted: All Medical Assistance Programs

The purpose of this document is to provide immediate instruction to eligibility staff regarding the handling of reviews, premium delinquency, and other discontinuance processing during the COVID-19 public health emergency declared by the State of Kansas on March 23, 2020. This instruction is effective immediately for all reviews (new, received, and in process) and all open CHIP and Working Healthy cases with delinquent premiums.

All Programs - Discontinuances

Beginning with the issuance of this directive and continuing throughout the scope of the emergency, discontinuance will be suspended in all instances except for out-of-state residency, voluntary withdrawal, incarceration, and death. If coverage was already discontinued effective March 31, 2020 for any household member prior to the release of this policy directive, the coverage must be reinstated effective April 1, 2020.

NOTE: These policies related to COVID-19 do not apply to Presumptive Eligibility (PE) as PE recipients have not been determined eligible under the state plan. PE processes should continue as normal.

For all cases reinstated or coverage continued during this time, staff shall include the appropriate language from the Standard Copy and Paste (SCP) in the case journal.

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

Renewals

During the scope of the emergency, no discontinuances will take place at review due to failure to meet eligibility requirements or failure to provide information. Reviews will also not be pended at this time for additional information. For those cases that would have been discontinued March 31, 2020 or later, or pended for additional information, coverage will be extended out four (4) months from the date of processing. A specialized Notice of Action will

be sent manually, and a note will be included in the case journal referring to the State Plan Amendments (SPA's) and corresponding documents.

These cases will need to be manually tracked by operational staff and provided to the KEES team on the first business day of each month. Specific processing instruction will be provided by KEES for these cases.

Cases that will be approved at review with no additional information required may be processed using normal guidelines.

NOTE: Cases that were already discontinued at review as of February 28, 2020 or earlier do not fall under this directive, and reviews received during the Reconsideration Period for these cases should be processed using standard procedure.

Renewal Actions

Effective with the issuance of this directive, eligibility staff shall adhere to the following processes.

All Programs:

1. All actions shall be fully journaled and thoroughly documented in the case file. Actions that result in extended coverage shall also be fully journaled using the approved verbiage from the Standard Text for Cut and Paste (SCP).
2. Renewals that do not require additional information and can be approved shall continue to follow the standard review process.
3. Renewals that do require additional information and would result in a pending action or would result in adverse action (discontinuance) shall have coverage extended four (4) months from the date of processing. This action shall be fully journaled and thoroughly documented in the case file using the verbiage from the SCP.
 - a. **Example:** At review, a new job is reported for the primary applicant, and the reported income cannot be verified through tiers I through III. Rather than placing the case on hold and requesting the income verification from the consumer, existing coverage will be extended four (4) months from the date of processing.
 - b. **Example:** A new job is reported for the spouse, and with the new income, the children previously covered will now be ineligible for all programs. Rather than discontinuing coverage, existing coverage will be extended four (4) months from the date of processing.
4. If an approval will result in greater cost-sharing by the consumer, such as an increase in premium, Spenddown, or Client Obligation, the original coverage should be extended an additional four (4) months from the date of processing. ***Note:** This applies to renewing the same coverage type. This does not apply to living arrangement changes from Independent Living to HCBS, PACE, or NF.

Note: It important to remember that negative changes because of an increase in income are not appropriate during the scope of this emergency. However, for LTC institutional coverage, the consumer's protected income limit is \$62. If there is an expense received that results in an increased PL, this is not considered adverse action because there is no change in the consumer's PIL.

- a. **Example:** Worker is processing an expense change task on an LTC/NF case. The expense document received states that effective next month, the consumer's Dental Insurance is ending, and the consumer will no longer pay for the \$100 monthly premium. It is appropriate to end-date the expense and increase the PL amount to the NF because there is no impact to the consumer. This is money that was being paid to one expense and will now be paid as another expense. The consumer continues to keep the \$62 PIL.
- b. **Example:** At review, with the new income verified, the child on the case previously covered on PLN (Medicaid) will now be CHIP eligible with a \$20.00 premium. Rather than authorizing the program with a premium, the existing Medicaid will be extended four (4) months from the date of processing.
- c. **Example:** An LTC Pre-populated review is received. Consumer is active on HCBS coverage with a \$150 Client Obligation. The consumer reports an increase in earned income and provides proof of wages with the review form. Per this directive, the increase in income would result in an increased client obligation, which cannot be done. Therefore, staff shall extend the review month out four (4) months from the date of processing.
- d. **Example:** An E&D Pre-Populated review is received. Consumer is active on Medically Needy Spenddown coverage with MSP/QMB. The spenddown for the last base-period was previously un-met. Consumer reports on his application that he now has earned income. Verification of income through RC verifies that there is earned income that would both increase the consumer's spenddown and disqualify him from MSP/QMB. Because this change would result in adverse action, the worker determines a new 6-month base period at the previous spenddown amount and the consumer's MSP/QMB continues. It is not appropriate to increase the spenddown or discontinue MSP/QMB with his policy. ***Note:** Specific processing instructions will be provided by KEES.
- e. **Example:** While processing an E&D Pre-Populated review, you find an LTC Communication task advising that the consumer has moved from his apartment into a nursing facility for a permanent stay. While the protected income limit is \$475 for the spenddown coverage and only \$62 for the LTC/NF coverage, this is not considered adverse action because the LTC/NF coverage is an increase in Medicaid coverage for the consumer. Financial and non-financial eligibility is then verified following the verification provisions for the COVID-19 National Public Health Emergency, and LTC/NF coverage. See *section 10. below.*

5. Cases on which a pre-populated review form was sent but not received will have coverage extended an additional four (4) months from the date of processing.
6. Cases on which a pre-populated review is due in the months of April 2020 and May 2020 will have the review due month systematically extended four (4) months.
7. For passive review responses that will result in a negative change, the review period will be shortened to four (4) months from the date of processing the change.
 - a. **Example:** The review batch runs and authorizes a case with a new review period of March 2021. A passive review response is received with changes reported and is processed during the month of April 2020. The changes will have a negative impact in program or cost-sharing, so the review period will need to be shortened to August 2020 and the existing level of coverage extended.

***Note:** Any consumer request to voluntary withdraw from coverage shall be honored per Medical KEESM 1211.10. This may occur for many reasons including, but not limited to, agreeing to the share of cost.

Renewal Actions E&D and LTC Programs:

1. Medically Needy Spenddown renewals that would result in adverse action because the recipient has either not met the previous spenddowns, is not meeting the current spenddown, and/or is unlikely to meet a future spenddown, shall not be discontinued from the Medically Needy program. Instead, a new 6-month base period needs established for continued coverage with the new spenddown not to exceed the amount of the previous spenddown.
 - a. For cases with where the previous spenddown was met and the consumer was receiving full Medicaid benefits at the time of renewal, verified in MMIS, the consumer's new 6-month spenddown that is to be established shall also be met, as creating a new un-met spenddown is considered Adverse Action and is not allowed per this directive.
2. Long Term Care (LTC) Nursing Facility (NF) and Psychiatric Residential Treatment Facility (PRTF) renewals that include a separate Living Arrangement task to discontinue LTC NF or LTC PRTF coverage to a program other than Title XIX, shall be processed following the delayed CARE Score process as discontinuing LTC coding would result in adverse action. Title XIX coverage shall continue from the date of discharge with no level of care.
3. LTC Home Based Community Services (HCBS) renewals that include a separate living arrangement task to discontinue LTC HCBS coverage to a program other than Title XIX, shall continue to have the LTC HCBS coding remain for the consumer as discontinuing the HCBS coding would result in adverse action. These cases should be tracked for future follow up once the scope of this emergency has ended.
4. Renewals that include a separate Living Arrangement task to add additional LTC level of care shall also be processed in accordance with approved policy and follow the

tiered verification process approved for the COVID-19 Public Health Emergency. Verification of income and resource policies are to be applied. Level of care shall not be granted without verification of financial and functional eligibility.

- a. If verifications show the consumer is financially and non-financially eligible for the additional coverage request, the renewal process shall be completed following standard review policy and process and LTC Level of Care approved.
 - b. If verifications show the consumer is not financially and non-financially eligible for the additional coverage request, or proof of verifications are not received, the additional coverage request shall be denied. Current coverage shall remain active and the review month extended four (4) months from the date of processing.
5. Working Healthy 6-month Desk Reviews that are received and determined eligible per current policy shall be approved for the remaining 6 months when their annual review will be processed.
 6. Working Healthy 6-month Desk Reviews that are either not returned or, are received and result in a pending action or adverse action (discontinuance), shall not have EDBC Accepted and Saved. Coverage will continue until the annual twelve (12) month review is processed without accepting EDBC.

A manual notice will shall be created using verbiage from the COVID-19 tab of the Standard Copy and Paste (SCP).

7. Future Working Healthy Desk Reviews will not be sent to consumers during the scope of this emergency.
8. Working Healthy Annual reviews that are processed and the consumer is determined eligible to continue Working Healthy coverage shall be approved following standard review policies and process.
9. Working Healthy Annual reviews that are received and would require additional information or would result in adverse action shall have coverage extended four (4) months from the date of processing.

Verification and Application of Expenses on Cases with Extended Coverage

For E&D and LTC programs, verified medical expenses can reduce the share of cost and spenddown amounts and the verification and application of expenses shall follow current, established policy. These expenses may be received at any time and are processed as either case maintenance tasks or at review.

Failure to provide proof of an expense will not affect eligibility, however, the expense will not be used to lower the share of cost or spenddown until physical verification is received by the agency.

There may be situations where verification of an expense is received for a consumer who is determined resource ineligible but is receiving extended coverage because of the COVID-19 directive. In these situations, it is important to compare the amount of the expense to the amount of excess resources. This is because there are certain situations where it would not be reasonable to lower a consumer share of cost if the amount of excess resources far exceeds the amount of the expense. Prudent person should be used to determine the reasonability of applying these expenses.

- Example: LTC/NF consumer submits a Passive Review Response to the agency and verification of resources, income, and expenses is received. This consumer reports a new monthly recurring expense of \$210 per month. However, verification of resources shows that the consumer has \$5,000 in the savings account. Because the \$210 expense is significantly lower than the excess resources and would take months of out of pocket payments to become resource eligible, the expense is not applied, and the consumer's LTC/NF coverage remains in place with no change in patient liability.
- Example: Pre-Populated review is worked by the agency for an LTC/HCBS consumer and proof of income, resources, and expenses is received. The consumer reports a new recurring expense of \$119 per month. However, resource verification shows the consumer has \$2100 in resources. Because the \$119 expense is more than the excess resources, the \$119 is used to lower the monthly client obligation.

***Note:** For cases that are determined to have excess resources, it is imperative that a call is placed to the consumer or authorized representative advising of the future impact this will have on their eligibility, and policy provided on how they can appropriately spenddown their resources.

Premium Delinquency for CHIP and Working Healthy

Beginning March 2020 and continuing throughout the scope of the emergency, discontinuances for failure to pay premiums will be suspended. A file provided by the fiscal agent has been used to update the Delinquency CHIP Premiums and Delinquent WH Premium status from 'Yes' to 'No' on all active cases with a 'Yes' delinquency status, temporarily removing the delinquency and allowing coverage to continue. Many of these will continue to show delinquent in Premium Billing, and this is acceptable.

Likewise, for cases on which a *Reinstate CHIP Coverage – Premium Paid* task is generated, coverage should be reinstated by the worker.

For Working Healthy cases, the *PB No Delinquent Premium* task generated during this update, for Working Healthy programs that were previously closed for delinquent premiums. The age on these tasks varies. It is appropriate to reinstate cases discontinued effective March 31st, 2020. The program block should be rescinded and EDBC re-run to high date the EDBC. In situations where a member would have been discontinued due to categorically not being eligible, further action in KEES may be required. Please review current Job Aids and Manuals. If needed, consult Policy and KEES staff to determine the proper action needed.

When a Notice of Action is not generated, a manual notice will need to be created using verbiage from the COVID-19 tab of the Standard Copy and Paste (SCP). If a Notice of Action is generated, staff should append the notice using the append language also found on the COVID-19 tab of the SCP.

Any unpaid premiums for the months of March through the end of the emergency period will not be penalized. It is anticipated that any outstanding premiums incurred from January 1st, 2020 through the end of the Public Health Emergency shall be waived.

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

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