Kansas
Department of Health and Environment

Policy Clarification 2022-02-01

Title: Add Member Requests Received – COVID - 19

Date: February 22, 2022

From: Erin Kelley, Senior Manager

Program(s) Impacted: All Medical Programs

The purpose of this document is to provide clarified guidance for handling new requests for coverage on a case with active programs where renewals have been extended as a result of the Public Health Emergency (PHE) as outlined in PD2020-03-01. The direction provided within this clarification is effective upon release and may be applied retroactively effective when the COVID-19 PHE was declared by the State of Kansas on March 23, 2020. This clarification will remain in effect throughout the scope of the COVID-19 PHE and expire once the first renewal process for households post-PHE is completed.

Renewals

Per PD2020-03-01, all discontinuances at renewal due to failure to meet eligibility requirements with the exception of cases discontinued due to voluntary withdrawal, incarceration, death, or out-of-state residency are suspended. While the PHE remains in effect, if an application is received within the allotted timeframe of the review period (see Medical KEESM 9331 and KFMAM 7410.01), staff must review the reported information and case to determine which process to follow:

1. Additional Verification(s) Needed – Extend the review month four (4) months from the date of processing and do not pend for additional verifications.
2. No Additional Verification(s) Needed – Process the case as normal and approve for the full review period i.e., 12 months.

The first bullet above is also applicable for loss of income-based eligibility as well as for changes resulting in greater cost-sharing for the consumer or a negative change in program tier. See PD2020-03-01 for examples.

Add Requests

As outlined in PM2017-02-01, PM2019-01-01, Medical KEESM 1411.1 and KFMAM 1402, when a request is received on an existing program for additional household members, neither an application nor a signature is required unless the individual requesting coverage is without Medicaid/CHIP due to failure to return a renewal form.

With the current COVID-19 PHE policies in place and eligibility being extended for active programs, this eliminates “expired renewal periods” when addressing a new request for

additional household members. This document further clarifies that it is not appropriate to treat the mass renewal extension for the PHE as "expired" nor is it appropriate to request a signed application to address the new request for coverage. If all the necessary information needed to process the new request is on file, case processing will continue without a signed application. To process any new coverage request received within an existing review period, all required information must be gathered and verification requirements must be met, keeping PHE policies in mind, prior to authorizing additional coverage.

Example 1: A phone request for the primary applicant is received on 08/31/2021 requesting pregnant woman coverage. One child is currently active on CHIP with $0.00 premium. Due to PHE policies, the child has not had a renewal since December of 2019 and has been extended based on PD2020-03-01. A formal, signed application is not required to process the pregnant woman coverage as the renewal period for the active program has not expired but has merely been extended.

Example 2: A phone request for the spouse of the primary applicant is received on 01/07/2022. The primary applicant is currently active on a Medically Needy spenddown. Due to PHE policies, the primary applicant has not received a renewal since February 2020 but remains open based on PD2020-03-01. In this scenario, the renewal period has not expired; therefore, the phone request can be processed without a formal, signed application.

Example 3: A MS-2126 is received for an active MSP/QMB recipient on 1/14/2022. This recipient's MSP/QMB coverage began 9/1/2021 after the agency received and processed a MIPPA application. As income and resources were accepted as verified per MIPPA application policies, updated income and resource verification is required, along with the Transfer of Property questions being answered, prior to authorizing LTC Nursing Facility coverage. A new application is not required as the individual is still within their review period. However, the supplemental application may be used as a tool to obtain the information from the consumer. Staff may attempt to gather the needed information by collateral contact with the consumer prior to sending the supplemental application. However, any questions answered 'Yes' would require further verification. *Note: this scenario also applies to adding other E&D/LTC programs such as Medically Needy Spenddown, HCBS, Working Healthy, etc.

> **Scenario 3.A:** Using Example 3, in this scenario, the supplemental application was sent as a tool to gather information regarding the consumers income, resources, and Transfer of Property (TOP) information. After the 12-day pending timeframe, it is found that the Supplemental application was NOT received back by the agency. In this situation, the new additional request for coverage is denied for failure to provide. However, the consumer's MSP/QMB coverage remains in place. A manual denial NOA must be sent advising the consumer of the reason for the denied request, as EDBC would not be ran in this situation.
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> **Scenario 3.B:** Using Example 3, in this scenario, the supplemental application was received with newly reported information (not previously known by the agency) by the consumer. The worker pends the case for further verification of the income, resources, and any attested TOP information. After the 12-day pending timeframe, it is found that the consumer failed to provide any (or all) of the requested information. As this newly reported information is required to make the new eligibility determination and was not provided, the additional coverage request is denied. The existing MSP/QMB coverage is addressed as follows:

Outcome 3.B.i: During the scope of the COVID-19 PHE, as the newly reported information is now known to the agency and verification was not provided, PA's existing MSP/QMB coverage must remain in place per existing COVID-19 policies. Notification must be sent to the consumer to inform them of the add request denial.

Outcome 3.B.ii: After the PHE has ended and normal eligibility policies apply, in this scenario, as the newly reported information is now known to the agency and verification was not provided, the consumer's existing MSP/QMB coverage is discontinued for failure to provide allowing timely and adequate notice.

***Note**: The exception to the outcome listed in 3.B.ii is if the only newly reported information are the TOP questions, as they do not apply to the MSP programs.

Scenario 3.C: Using Example 3, in this scenario the information requested after receiving the supplemental application (or information requested after a collateral contact was made) was received by the agency within the pending time frame. The worker reviews the verification received and finds the consumer is eligible and approves the additional coverage request.

Example 4: Active Medically Needy recipient (PA) contacts the agency within the active review period to report they are now married and is requesting the spouse (SP) be added to their Medically Needy Spenddown coverage. As the assistance plan is now changing from a household of 1 to a household of 2, the spouse's disability information, income, and resources (and expenses if reported) are requested. Similar to Example 3, this can be done by way of a collateral contact or by sending the supplemental application. Any information answered 'Yes' requires further verification.

Scenario 4.A: If the supplemental application and/or any verifications requested are not received by the agency within the pending timeframe the add a person request is denied for failure to provide. Additionally, PA's existing coverage shall be addressed as follows:

Outcome 4.A.i: During the scope of the COVID-19 PHE, while the additional add request is denied, PA's Medically Needy coverage must remain in place per existing COVID-19 policies. Notification must be sent to the consumer to inform them of the add request denial.

Outcome 4.A.ii: After the PHE has ended and normal eligibility policies apply, in this scenario, PA's Medically Needy coverage is discontinued for failure to provide as SP's information is required to determine eligibility for the household of two. NOAs must be sent to the household advising as to the reason for the denial.

Scenario 4.B: Using Example 4, in this scenario the information is received and both PA and SP are verified to be income and resource eligible. The worker reviews MMIS and finds that PA's existing spenddown base period is unmet. The worker runs EDBC for the month of request, which increases the existing spenddown amount by SP's income. NOAs are sent to the household advising of the change.

Scenario 4.C: Using Example 4, in this scenario the information is received and both PA and SP are verified to be income and resource eligible. The worker reviews MMIS and finds that PA's existing spenddown base period is met.

Outcome 4.C.i: During the scope of the COVID-19 PHE, PA's coverage may not change from met to unmet. The new spouse, however, is now eligible for new coverage, and must be authorized on Medically Needy coverage with an Unmet Spenddown (unless expenses are provided verifying the spenddown would be met). Specific KEES processes must be followed to ensure PA's coverage is not altered, while authorizing SP's new coverage.

Outcome 4.C.ii: After the PHE has ended and normal eligibility policies apply, in this scenario, it would be appropriate to add SP to PA's existing spenddown. The SP's income is added to PA's met spenddown, thus increasing the spenddown amount and moving the spenddown from met to unmet status, allowing for timely and adequate notice.

Example 5: A MS-2126 is received for an active Medically Needy recipient within their active review period. As the consumer's original coverage was approved after the KC-1500 application and income and resource verifications were received (and verified) in the last 12 months, there is no requirement to request further verification of the consumer's income and resources. This also applies to the Transfer of Property (TOP) questions being answered and noted in the case journal or case file in the last 12-months. *Note: In situations where income verification, resource verification, and the TOP questions were last verified more than 12-months from the coverage request, further verification is required. Refer to Example 3 for the correct action that is required when verifications are (or are not) received back by the agency.

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

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