Kansas
Department of Health and Environment

Policy Clarification 2022-07-01

Title: LTC Add Request - Denial

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Program(s) Impacted: E&D Medical Programs

The purpose of this document is to provide guidance in situations where a consumer admitted into a long term care (LTC) nursing facility (or other institutional living arrangement) has been determined ineligible for the additional level of care (LOC) coverage due to failure to provide requested information but submits the missing information at a later time. This document will formalize guidance on the applicable policies for application processing time frames versus change processing time frames.

When an LTC add request is received by the agency (via MS-2126 Notification of Facility Admission/Discharge) for an active recipient, there may be situations where additional information is needed to process the request. (See PC2022-02-01 Add Member Requests Received – COVID-19 for when additional information is needed.) When the consumer fails to provide (FTP) the requested information, the agency must take action to either deny the LTC request itself or determine if existing coverage must also be discontinued. The guidance below will assist eligibility staff in determining what next steps are appropriate per scenario, as well as how to react when information is received after the LTC add request is denied.

Note: During the scope of the COVID-19 Public Health Emergency (PHE), coverage may not be discontinued for failure to provide information as noted in PD2020-03-01 Delayed Discontinuance policy directive. COVID-19 PHE policies remain in effect during the scope of the PHE and are not superseded by this clarification. Some examples listed below contain policy and instruction for processing LTC add requests under standard policy.

Application Time Frames versus Change Processing Time Frames

When an MS-2126 is received for an active recipient, staff must first determine if the LTC add request is to be regarded as an “add request” for which application processing time frames apply or if it is regarded as a change. This is done by reviewing the consumer’s current active coverage.

Medicare Savings Program (MSP) to LTC

LTC add requests for consumers active on an MSP only program who admit into an LTC facility are treated as an application (for application processing time frames). This is because the MSP

program is considered a “side car” program as it is not full Medicaid, nor can it become full Medicaid (i.e. when an unmet spenddown becomes met). Full Medicaid must first be determined prior to adding additional LOC coding. As such, the LTC add request must follow the application processing time frames as noted in Medical KEESM 1413 and 1414 and subsections.

If the LTC add request is denied for failure to provide, the information must be provided within the 45-day application processing time frame or within 12-days from the date of denial (also known as the reactivation or IROD time frame), whichever is later. If the requested information is received within these time frames, the LTC add request shall be reconsidered and processed based on facility admission date as noted on the MS-2126.

If the requested information is not received within the 45-day application time frame or within 12 days of the date of denial, a new LTC request is needed. The first date of LTC eligibility coverage is dependent on the date of the new request and if prior medical coverage is requested. The month the request is received is considered the “application month” and LTC coverage could be approved (if otherwise eligible) within the three (3) prior medical months.

Note: Please refer to PC2022-02-01 Add Member Requests Received – COVID-19 for additional guidance on if the consumer’s active MSP program shall remain open or be discontinued.

Example 1: Original admit date was 10/5/2021, however that request was denied for FTP on 10/25/2021. A subsequent LTC request is sent with the same admission date (of 10/5/2021) but the agency receives the MS-2126 on 3/14/2022. As March 2022 is considered the application month the earliest coverage that may be approved is 12/1/2021 as this is the first day of the first prior medical month, if requested.

Example 2: Using the same scenario as Example 1, however, the second MS-2126 is received in January 2022, the date of admittance may be approved (if otherwise eligible and prior medical coverage was requested) as the date of admittance falls within the prior medical month dates.

Note: Prior medical coverage requests must be received by either the consumer or an authorized representative (medical representative, guardian, or conservator). As the MS-2126 cannot be acted upon without a formal request for coverage, contact with the consumer may be required to formally request any needed prior medical months. See Medical KEESM 8132.

Full Medicaid (MDN, PMDT, WKH, etc.) to LTC

LTC add requests for consumers who are active on full Medicaid (including an unmet spenddown) that admit into an LTC facility are treated as a change request. This is because the consumer has already been determined eligible for full Medicaid and the agency only needs to add the additional LOC coding. As such, the change reporting rules as noted in Medical KEESM 9121 apply. Information that is not received within the 12-day pending time frame (or subsequent IROD time frame) may either result in the LTC add request being denied, or the consumer’s existing Medicaid coverage being discontinued.

Note: Please refer to PC2022-02-01 Add Member Requests Received – COVID-19 for additional guidance on whether the consumer’s active Medicaid coverage shall remain open or be discontinued. Existing Medicaid coverage shall not be discontinued when the only missing

information is related to the required transfer of property questions as failure to provide that information does not impact E&D coverage.

If this LTC add request (reported change) is denied for failure to provide requested information and the consumer's full Medicaid coverage was discontinued, the consumer has until the end of the month following the month of discontinuance to provide all missing information to have their medical assistance reinstated per Medical KEESM 1423 (if otherwise eligible) allowing the LTC add request determination to be completed based on the date of admittance as noted on the MS-2126. The agency is obligated to determine LTC eligibility when a consumer has active full Medicaid coverage, including an unmet spenddown.

Information received outside of this time frame would require a new application. It is important to note that any requested information received outside of this time frame must have a pending application for the agency to take action.

Example 3: An MS-2126 is received for a consumer actively receiving Medically Needy coverage on 4/22 with a NF admit date of 4/19. After reviewing the case file, it is noted that the consumer is within their review period and their income and resources were last verified within the past 12 months. Therefore, further verification of the known information is not required. However, the consumer reported that their annuity had recently annuitized and are now receiving an additional $356 per month. Verification of the annuity was requested; however, verification was not provided within the 12-day pending time frame. The agency took action on 5/18 to discontinue the consumer's Medically Needy coverage allowing for timely and adequate notice. The consumer's Medically Needy coverage ended 5/31. On 6/14, the agency receives the missing verification. After review of the documents, the consumer is determined otherwise eligible for LTC coverage, eligibility staff would shorten the current Medically Needy base period to end 3/31 (see Medical KEESM 7330 (1)(b)) and approve LTC coverage effective 4/19.

Note: When processing during the scope of the COVID-19 PHE, coverage may not be discontinued for failure to provide and this scenario should be processed following COVID-19 PHE policies.

Example 4: Using the same information as Example 3, however the missing verification documents were received by the agency on 7/1. As the information was not received within the month following the month of discontinuance, the agency is not required to take action on the verification documents. Out of best practice, the eligibility worker contacts the consumer (or authorized representative) advising that the verification was received outside of the allowable time frame, therefore a new application would be required. An application is received on 7/12 requesting LTC coverage with prior medical. As the date of admission is within the prior medical months of the 7/12 application, the agency is able to determine eligibility for LTC coverage to potentially cover the date of admission (if otherwise eligible). Note: Had the application been received in August or later, LTC coverage may only begin starting the first month of the first prior medical month if otherwise eligible.

Denial for Failure to Provide Transfer of Property (TOP) Questions/Information

When processing this change and the only missing verification documents pertain to a potential transfer of property penalty, the active E&D coverage may not be denied as TOP verification is not a requirement to determine E&D eligibility. The LTC add request may be denied, but existing coverage may continue, depending on if they are eligible based on their living

arrangement. Therefore, if the TOP information is returned later (while actively receiving coverage) the LTC add request may be redetermined effective the date of admission.

Example 5: An MS-2126 is received for a consumer actively receiving Medically Needy coverage with a met spenddown on 5/3 with a NF admit date of 4/29. The worker reviews the case file and finds that the consumer received a passive review at the last annual review, noting that the TOP questions have not been answered in the last 12 months. The worker sends a verification NOA requesting answers to these questions and pends the case for 12 days. The worker checks the case after the pending time frame has passed and denies the LTC add request as the consumer failed to provide (either in writing or verbally) answers to the TOP questions. The consumer's Medically Needy coverage remains active. On 7/10 the agency receives a duplicate MS-2126 form reporting the same admit date of 4/29. As the TOP questions were still not answered, the agency pends the case again to request the information. On 7/19 the agency receives written attestation that there were no transfers in the look back period. As this was the only missing information and as PA is actively on Medically Needy coverage, the worker approves LTC coverage effective 4/29. The existing Medically Needy spenddown base period may need to be shortened. See Medical KEESM 7330 (1)(b).

Note: As the form was received a second time for this active consumer the agency is required to take action on the second MS-2126 even though the initial LTC add request was denied. Eligibility staff should review the case to determine what (if any) information is needed to process the LTC add request.

SSI (Dual SSI and OASDI) to LTC

Active SSI recipients whose countable income exceeds $30/month (typically dual SSI and OASDI) are assumed that their SSI recipient status will cease when they admit into an LTC facility for a long-term stay, see Medical KEESM 2637. A new application is required to determine continued eligibility. SSI medical coverage continues until eligibility is processed under the new application. LTC coverage is delayed until the new application is processed (see PM2018-10-01 Loss of SSI Recipient Status and Verification of Resources).

Unlike section **"Full Medicaid (MDN, PMDT, WKH, etc.) to LTC**" found above, SSI (Dual SSI and OASDI) to LTC is treated as a new application (for purposes of application time frames). While the SSI coverage is active Medicaid, the consumer is no longer eligible to receive the SSI coding due to the anticipated loss of their SSI recipient status. Therefore, a new application is required to determine if the consumer is eligible for continued coverage under a new program. As such, the LTC add request must follow the application processing time frames as noted in Medical KEESM 1413 and 1414 and subsections.

If the LTC add request is denied for failure to provide, the information must be provided within the 45-day application processing time frame or within 12-days from the date of denial (also known as the reactivation or IROD time frame), whichever is later. If the requested information is received within these time frames, the LTC add request shall be reconsidered and processed based on facility admission date as noted on the MS-2126.

If the requested information is not received within the 45-day application time frame or within 12 days of the date of denial, a new LTC request is needed. The first date of LTC eligibility coverage is dependent on the date of the new request and if prior medical coverage is requested. The month the request is received is considered the "application month" and LTC coverage could be approved (if otherwise eligible) within the three (3) prior medical months.

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

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