Kansas
Department of Health and Environment
Division of Health Care Finance

Policy Memo	
KDHE-DHCF POLICY NO: 2021-03-01	**From: Erin Kelley, Senior Manager**
Date: March 9, 2021	**Medical KEESM/KFMAM Reference:**
RE: Updated COVID-19 Processing Flexibilities	**Program(s): All Medical Programs**

This memo sets forth instructions for implementation of policy changes related to the COVID-19 Public Health Emergency and processing guidelines for the duration of the pandemic.

Applicable to all Medical Programs:
- COVID-19 Federal Stimulus Funds
- Pandemic Unemployment Assistance

Applicable to Family Medical Programs Only:
- Continuing Medicaid for Previous FCM Recipients

Applicable to Elderly and Disabled Medical Programs only:
- Medically Needy Spenddown Discontinuance Clarification
- Income Change Impacts on MSP Programs
- Income Change Clarification for Medically Needy and LTC
- COVID-19 Stimulus Fund Resource Verification

This memo supersedes PD2020-03-01, PM2020-04-01, and PM2020-11-01 where applicable and is effective upon issuance.

I. Changes Impacting All Medical Programs

A. COVID-19 Federal Stimulus Funds

Policy was previously implemented with the release of PM2020-04-01 Policy Implementation Instructions for COVID-19 National Public Health Emergency (PHE) pertaining to the stimulus funds provided to most adults and children aged 16 and younger. This policy was specific to Phase III, H.R. 758 (116), otherwise known as the CARES Act of

Mar. 25, 2020. Federal guidance stated that these funds are exempt as income in the month received and exempt as a resource, not to exceed twelve (12) months.

This policy extends the policy guidance implemented in section I(B) of PM2020-04-01 to cover all future Federal Stimulus funds issued for the COVID-19 PHE, including the $600 stimulus funds issued with the approval of the Consolidated Appropriations Act, 2021 signed by Congress on December 21, 2020.

This policy will apply to all future COVID-19 Federal Stimulus funds through the end of the COVID-19 PHE or until otherwise notified.

Note: Transfer of an otherwise exempt resource, including retained stimulus funds during the 12 month exemption period, shall be treated according to the provisions contained in Medical KEESM 5721 (5).

B. Pandemic Unemployment Assistance

Similar to the Federal Stimulus funds implemented in section A. above, this policy expands previous policy released with the implementation of PM2020-04-01 pertaining to the Federal Pandemic Unemployment Compensation (FPUC) released with the CARES Act stating that unemployment money received for the COVID-19 PHE is exempt as income in the month received. Any FPUC monies not spent in the month of receipt shall be counted as a resource in the month after month of receipt.

These policies will apply to all future COVID-19 Federal Stimulus funds and Federal Pandemic Unemployment Compensation through the end of the COVID-19 PHE or until otherwise notified.

II. Changes Impacting Family Medical Programs Only

A. Continuing Medicaid for Previous FCM Recipients

1. Background

Due to the COVID-19 Pandemic and a special federal provision, anyone enrolled in state Medicaid on or after March 18, 2020 must continue on Medicaid benefits through the end of the month in which the PHE ends unless the individual voluntarily withdraws, moves out of state, becomes incarcerated, or dies. This provision is addressed in the previously issued PD2020-03-01 Delayed Discontinuance which states that discontinuance will be suspended with the above stated criteria and goes onto address the handling of reviews under these conditions.

2. CHIP ELIGIBLE FCM RECIPIENTS

Here it is further clarified that children enrolled in the Foster Care Medical (FCM) Program through the Department of Children and Families (DCF) on or after March 18, 2020 who return home or otherwise leave state custody and for whom KanCare receives a request for coverage must resume coverage on a Medicaid program (i.e. Title XIX). In situations where the child is ineligible for any program, no action is needed as DCF is for the most part allowing coverage to continue and will only close once notified that the child is eligible for KanCare. Staff should continue to utilize the established communication process with DCF to facilitate the transfer of coverage between FCM and KanCare. However, in cases where children in this category are found eligible for CHIP, the decision will be suspended, and Medicaid authorized with a review date of four (4) months from the date of processing.

Example: Application is received 2/15/2021 requesting coverage for a child. Case history shows that the child is currently active on FCM as of or after March 18, 2020, but the child is now in caretaker custody. Child is determined eligible for CHIP beginning the month of processing. The worker notifies DCF that the FCM may be closed as the child is now eligible on the caretaker's case. Due to the COVID-19 policy, however, the child will be approved for PLN effective 2/2021-6/2021 (4 months from the processing date) rather than CHIP.

Note: In situations where the income determination exceeds PLN guidelines, it will be necessary to remove or end-date the income record prior to approval. Once the authorization is complete, the record will need to be restored for documentation purposes.

Cases where this occurs should be tracked and fully journaled along with other cases where discontinuance or program change was suspended.

III. CHANGES IMPACTING ELDERLY AND DISABLED MEDICAL PROGRAMS ONLY

With the issuance of PM2020-11-01 COVID-19 Processing Flexibilities and PD2020-10-01 Processing Instruction for Medically Needy Spenddown and MediKan Coverage During COVID-19 Public Health Emergency, guidance was provided to staff with instruction on processing adverse changes and discontinuing coverage within the Medicare Savings Plan (MSP), MediKan, and Medically Needy Spenddown programs. Since the release of those instructions, further guidance from CMS has been received.

A. MEDICALLY NEEDY SPENDDOWN DISCONTINUANCE CLARIFICATION

Effective with the release of this memo, it is no longer appropriate to discontinue an individual's spenddown for failure to meet their last spenddown. This supersedes the

direction given in PD2020-10-01. The exception to this rule pertains to individuals dually eligible who receive MSP coverage with their Medically Needy Spenddown as advised in section 1. below. This policy will also be implemented retroactively to apply to any case affected by the previous direction given in PD2020-10-01. This separate instruction was previously provided.

1. *Spenddown with MSP Coverage*

Individuals receiving Medically Needy coverage with a spenddown and MSP who fail to meet their spenddown may have their Medically Needy coverage discontinued, so long as, their MSP coverage, at any level, remains active. This direction comes from new CMS guidance that states individuals dually eligible receiving Medically Needy coverage with MSP, no longer need to continue receiving spenddowns that are unmet. There is no change in policy when an individual meets their spenddown. Staff shall continue to follow current processes when a spenddown is met.

Example: Worker receives case from the spenddown ending report and is reviewing a case where the consumer is currently receiving Medically Needy spenddown and MSP/QMB. Upon review of the case finds that this consumer did not meet their spenddown, nor do they meet the criteria to have a new spenddown base period authorized. Because the spenddown is unmet and this individual has Medicare and is receiving coverage under the MSP program, it is appropriate to discontinue Medically Needy coverage at the end of the current base period allowing for timely and adequate notice.

2. *Medically Needy Spenddown Only Coverage*

Individuals receiving Medically Needy with a spenddown *only,* must maintain this coverage throughout the scope of the Public Health Emergency (PHE), regardless if the spenddown is met or unmet. Further clarification from CMS has been received on how the state is to address met versus unmet spenddowns.

a) Met Spenddown

During the scope of the PHE, once a consumer has met their spenddown and receive full Title XIX coverage, they must continue to receive the Title XIX coverage through the end of the month the PHE is declared over. This means that once a Medically Needy spenddown has been met, met status shall be continued through any and all subsequent spenddown base periods thereafter.

b) Unmet Spenddown

In situations where a consumer has not met their spenddown and end of the current six (6) month base period is approaching, a new base period will be created allowing for continued coverage.

Note: This memo does not supersede the policies allowing coverage to close appropriately during the PHE per PD2020-03-01 Delayed Discontinuance policy or when coverage was authorized due to agency error per PM2020-11-01. Any cases where the individual's spenddown was closed for reasons not listed in this policy must be reopened and their spenddown coverage reactivated with no gap in coverage.

B. Income Change Impacts on MSP Programs

Previously, guidance was provided to staff in PD2020-03-01 and PD2020-10-01 stating that an individual's MSP coverage could not change to a lesser level of coverage (i.e. QMB to LMB or LMB to ELMB) within the MSP program. Effective with the release of this memo, changes within the MSP program are allowable. However, MSP changes are dependent on whether the recipient is receiving other medical assistance or is MSP only.

1. QMB to LMB

Increases in income for recipients active on the MSP/QMB program, that when verified, move the recipient from QMB to LMB are allowable, regardless if there is other medical assistance. This change should be processed following current policies and processes.

2. QMB to ELMB

Increases in income for recipients active on the MSP/QMB program, that when verified, move the recipient from QMB to ELMB is allowable if there is no other medical coverage (i.e.: LTC Coverage or Medically Needy with a Met Spenddown).

Follow the policy in section C.2 below if the recipient is receiving other medical coverage and MSP together.

3. LMB to ELMB

Increases in income for recipients active on the MSP/LMB program, that when verified, move the recipient from LMB to ELMB is allowable if there is no other medical coverage (i.e.: LTC Coverage or Medically Needy with a Met Spenddown).

Follow the policy in section C.2 below if the recipient is receiving other medical coverage and MSP together.

4. QMB/LMB to MSP Ineligible

Income changes that result in a consumer being over income for MSP are not appropriate to take. In these situations, the consumers should be moved from either QMB or LMB coverage and placed on ELMB coverage (if receiving MSP only) until either the end of the PHE or until proof is provided to the agency confirming their income is within the QMB or LMB income limits.

Follow the policy in section C.2 below if the recipient is receiving other medical coverage and MSP together.

These individuals should be tracked for processing once the PHE is deemed to have ended at which point the individual's information should be reviewed to determine if they are still ineligible for MSP.

C. Income Change Clarification for Medically Needy and LTC

1. Income Changes for LTC Consumers

Previous guidance implemented in PM2020-11-01 addressed action to increase (or decrease) an individual's Long Term Care (LTC) share of cost when there is an income change. This policy remains unchanged for individuals whose income both passes the 300% test or those who fail the 300% test but whose share of cost is less than the LTC cost of care. The new policy contained in this memo applies to individuals whose income fails the 300% test and the share of cost exceeds the LTC cost of care.

When processing an income change for an LTC individual whose income fails the 300% test and whose share of cost exceeds the actual cost of care, the individual shall retain the underlying Title XIX coverage. However, because the individual's income covers the cost of care, it is appropriate to remove the level of care coverage for the individual. This will result in the consumer paying the cost of care while still keeping full Medicaid benefits to cover any additional medical costs that may be incurred through the end of the PHE.

2. Income Changes Impacting MSP Minor Aid Code

Previously, direction was provided in PD2020-03-01, surrounding income changes and the state being unable to take adverse action with consumer's coverage. This included when the agency was notified that a consumer receiving a Medically Needy spenddown had an increase in income. Effective with the release of this memo, income changes may be taken to increase an individual's spenddown, so long as, the income change does not affect the consumer's MSP program eligibility. Changes within the MSP program may still be made per section III.B. above.

If the income change moves the consumer's income outside the MSP program limits, the consumer's MSP must be placed (or remain) on the MSP/LMB coverage. It would not be appropriate to keep the MSP/QMB coverage if the income exceeds the limit of the MSP/QMB program. Nor is it appropriate to discontinue MSP, if the consumer's income exceeds the MSP/LMB program limits, while receiving either Medically Needy or LTC coverage. This section clarifies the policies and actions that shall be taken on cases with Medically Needy or LTC with MSP while processing income increases.

Note: This policy does not supersede current policy and process when a consumer contacts the agency to choose ELMB versus other coverage. Current policy and processes are appropriate and discontinuing the major program coverage may take place when the consumer chooses ELMB. It is not considered an error if the agency does not proactively reach out to the consumer to request this during the scope of the COVID-19 PHE, however, is also not required with this policy.

a) MET SPENDDOWN OR LTC WITH OR WITHOUT MSP

As stated in section A.2.a. above, once a spenddown is met during the scope of the PHE and the consumer receives full Medicaid benefits, the consumer must continue to receive these full benefits through the end of the PHE. This policy remains the same when the agency is advised of an increase in income, that would typically increase the spenddown amount. Current process allows for income changes to be applied so long as the spenddown remains in a met status in KEES and the MMIS.

Consumers with a met spenddown or LTC program that have an increase in income may have their share of cost increased if the increase does not move the consumers MSP program to the ELMB coverage or render them ineligible for any MSP coverage. Note: Specific processing instructions will be provided by KEES.

Example 1: An LTC with MSP/LMB consumer provides the agency with verification that their income has increased by $50 per month. The worker reviews this income verification and confirms that this increase does *not* move the consumer from the LMB program to ELMB. The income change is processed, and the consumer's share of cost is increased without affecting the MSP/LMB program.

Example 2: Same scenario as above, however, the income increased by $300 per month. The worker reviews the income change and verifies that this change would move the consumer into the ELMB program. Because of this,

the $300 increase is applied to the LTC share of cost and the MSP/LMB program is left alone. The case is then tracked for later processing.

Example 3: A consumer receiving Medically Needy with a met spenddown and MSP/QMB provides the agency verification that their income has increased by $75 per month. The worker reviews the income verification and confirms that this increase would move the consumer from the MSP/QMB program to the MSP/LMB program. As this is allowable, the income increase is processed and the consumer's spenddown is increased, while remaining in a met status, and the MSP is changed from QMB to LMB allowing for timely and adequate notice.

Example 4: A consumer receiving Medically Needy with a met spenddown and MSP/QMB provides the agency verification that their income has increased $550 per month. The worker reviews the income verification and confirms that this increase makes the consumer's monthly gross income exceed the MSP program limit. As the consumer cannot lose the MSP coverage, the income increase is processed and the consumer's spenddown is increased, while remaining in a met status, and the MSP/QMB is changed to MSP/LMB. The case is then tracked for later processing.

b) UNMET SPENDDOWN WITH MSP

For individuals receiving Medically Needy coverage with MSP whose spenddown has not been met, action shall be taken to increase the consumer's spenddown due to an increase in income allowing for timely and adequate notice provided to the individual, while not allowing the consumer's active MSP program to move to either MSP/ELMB or become ineligible for the MSP program.

With this policy, when an income increase would move the consumer over the MSP program limits, the consumer's MSP coverage in KEES shall be placed within the MSP/LMB program. These cases will need tracked for post PHE processing follow up. Note: Specific processing instructions will be provided by KEES.

Example 1: Eligibility worker receives income task for a MDN with MSP/QMB consumer who's monthly income is $1,000. The worker verifies the consumer started receiving a 2nd pension of $200 per month making the countable gross income $1,200 per month. Eligibility worker processes the task to increase the consumer's spenddown and changes the MSP program from QMB to LMB allowing for timely and adequate notice.

Example 2: Same example as above, however, the new monthly pension is $450 per month increase, making the consumer's countable gross income $1,450. The eligibility worker processes the task and increases the consumer's spenddown. The eligibility worker follows special processes so that the consumer's MSP coverage is moved from the QMB program to the LMB program. The case is then tracked for later processing.

Overstated eligibility shall not be considered for consumers whose share of cost would have otherwise increased notwithstanding the COVID-19 PHE.

D. COVID-19 Stimulus Fund Resource Verification

The purpose of this document is to provide immediate guidance on the verification of COVID-19 Federal Stimulus Funds issued to applicant/recipients as part of the CARES Act issued on Mar. 25, 2020 at the time of processing applications during the PHE period and to applications, changes, and reviews processed after the PHE has expired. This guidance shall apply to both the federal stimulus checks as well as the extra unemployment benefits.

1. Background

With the implementation of PM2020-04-01, guidance was issued advising staff that the federal stimulus funds, including the extra unemployment benefits provided to consumers were to be exempt through the consumer's next review period not to exceed twelve (12) months from the month of receipt. The goal of these funds was to be spent; however, some applicant/recipients may not have disposed of these funds prior to their annual review and/or prior to applying for Medicaid assistance resulting in resource ineligibility.

2. Verification

In the instance that the individual is found to be in possession of assets that exceed program standards at application or review, staff shall follow normal processes as currently outlined and deny the case for resource ineligibility (see note below). If, after denial, the applicant contacts the agency and attests that the excess resources were due to the accumulation of unspent COVID-19 federal monies, staff shall advise the consumer that documentation of when the monies were received as well as how much was received must be provided within 45 days of the application date, three months from the review date, or 12 days after denial (if processing outside of normal eligibility periods) in order for eligibility to be reconsidered. Obtaining documentation of the amount of the funds, the source of the funds, and the date the funds were received is important in determining the beginning of the 12-month timeframe that these funds are exempted. If the information provided is received outside the applicable timeframe, a

new application will be required if the consumer wishes to continue pursuing medical assistance.

If the consumer attests to excess resources due to the accumulation of unspent COVID-19 federal monies prior to denial, staff shall first contact the consumer and request the attestation of when these monies were received and how much was received (see note below). If attestation is received from the consumer, staff shall only request verification via bank statements from the month(s) attested. If attestation cannot be obtained, staff shall then request documentation by using the following verification fragment found on the COVID-19 tab of the Standard Text for Copy and Paste Spreadsheet:

"You reported to the agency that you received federal stimulus funds due to the COVID-19 public health emergency. In order to accurately determine the amount of resources you own, please provide bank statements from any accounts in which a Federal Stimulus Check and/or extra unemployment benefits were deposited. Please provide statements for each month in which these funds were received."

Note: If documentation is already on file that verifies the consumer received COVID-19 federal monies in addition to when these funds were received and how much was received, no contact with the consumer is necessary. Staff shall calculate the amount of monies to be exempted along with the timeframe these monies are to be exempted based on the documentation on file. Staff shall thoroughly log these details on the case.

IV. QUESTIONS

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

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