



Policy Memo	
KDHE-DHCF POLICY NO: 2017-07-01	From: Jeanine Schieferecke
Date: July 31, 2017	Medical KEESM Reference: KFMAM Reference:
RE: Implementation of Medical KEESM with new Medical Policy Website and August 1 Policy Changes	Program(s): All Medical Assistance

I. PURPOSE

This memo serves multiple purposes and contains information for staff who process all types of medical assistance (Elderly/Disabled, Family and PPS) as well as internal and external staff with interest in medical assistance policy.

- A. The release of a new online medical-only version of the existing Elderly and Disabled medical assistance program eligibility policy manual. The new manual will be known as the Medical Kansas Economic and Employment Services Manual – Medical KEESM.
- B. The launch of the new Medical Policy website. This website will include both the new Medical KEESM as well as the Kansas Family Medical Assistance Manual (KFMAM). Other supporting policy materials, including forms and policy memos, will also be included on this website. This website is a part of the KanCare website and can be found at the following link:
<http://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy>
- C. Implementation instructions for policy changes effective August 1, 2017. These changes pertain to Elderly/Disabled and Family Medical programs.

In addition, this letter provides implementation instructions for all medical assistance program eligibility policy changes and clarifications which are effective August 1, 2017. Each section and/or subsection that has been updated in the new Medical KEESM due to the particular policy change or clarification is listed with a brief description of the change.

II. BACKGROUND

The current KEESM eligibility policy manual has been in place since October 1999 and has been the source policy for all assistance programs administered by the Department for Children and Families (DCF) and the Elderly and Disabled medical assistance programs administered by the Kansas Department of Health and Environment – Division of Health Care Finance (KDHE-DHCF). Eligibility staff for both agencies relied on this shared manual. DCF hosted the manual on their website and their staff were responsible for the actual maintenance and update of the manual for all assistance programs (including medical assistance) when necessary. KDHE-DHCF was responsible for their own medical assistance program policy, but any physical changes to the KEESM manual were completed by DCF.

Over time, responsibility for the medical assistance programs transitioned from DCF (formally Social and Rehabilitation Services – SRS) to the newly formed Department of Health Policy Finance (DHPF), then to the Kansas Health Policy Authority (KHPA) and finally to KDHE-DHCF. However, while KDHE-DHCF had administrative responsibility for most all of the medical assistance programs, DCF retained some responsibility for processing and maintaining applications for Elderly and Disabled medical assistance programs. In January 2016, KDHE-DHCF assumed full responsibility for processing and maintaining all medical assistance applications. DCF no longer has an official role in the process.

It was determined at that time that each agency (DCF and KDHE-DHCF) should operate and maintain their own separate eligibility policy manual. This began a process to separate the existing KEESM into two new manuals, each containing only the policies specific to that individual agency. This memo implements the medical portion of that process.

III. MEDICAL KEESM

The Medical KEESM contains general Medicaid eligibility policy as well as policy for the Elderly and Disabled programs. The KFMAM continues to serve as the policy manual for the Family Medical programs. Please note the following regarding the new KEESM

- A. The KEESM will continue to be used by DCF for non-medical programs. The DCF version of KEESM containing DCF program specific policy may continue to contain medical assistance program material for a period of time, but the medical material in the DCF KEESM is no longer valid and is not to be used as a source of medical eligibility policy. A disclaimer has been posted on the DCF KEESM website redirecting Elderly and Disabled medical assistance program users to the new online KDHE-DHCF Medical KEESM. In addition, the Medical KEESM website contains similar language indicating the DCF KEESM is no longer valid as a source for Elderly and Disabled medical eligibility policy. These banners may be removed at a later date.
- B. All forms and appendix items pertaining to medical have also been removed from the DCF website and are included with the medical manual. Although the existing naming and numbering conventions were kept in place for many forms, other updates were made to the

forms. The newer versions of all forms are to be used. This is applicable to Family Medical forms as well. See section below for details regarding new organizational structure of the forms.

- C. The new Medical KEESM retains the same structure and numbering system as the original KEESM. However, with the removal of non-medical provisions, several sections and subsections have been marked as “Reserved”. Those sections were devoted only to non-medical DCF programs. Instead of simply eliminating each section, the number was retained in order to preserve the integrity of the numbering system as indicated above.

In addition, many medical sections and subsections were slightly reworded due to the removal of DCF, KAECSSES and non-medical language within the section. The underlying medical policy was not changed, but the wording was adjusted to ensure the remaining provision makes sense and is easy to understand. The new Medical KEESM manual should reflect only Elderly and Disabled medical assistance related policy with any non-medical related material removed.

Be advised that was an imperfect process and some odd non-medical elements may have been missed and therefore remain in the new Medical KEESM manual. Those lingering identified non-medical program elements should be ignored. The same is true for the new DCF KEESM version of the manual. Staff are to ignore any medical elements remaining in that manual since it is no longer the source policy for the Elderly and Disabled medical assistance programs.

- D. The Medical KEESM sections are organized as follows (no change from the original KEESM format). As indicated, all the original sections have been retained, however, some have been designated as “Reserved” since it contained no medical program policy material.

1. **Section 1000** – The title of this section remains “Administrative Information”. The section covers all general program administration information including rights and responsibilities, the application process, prudent person, required verifications, notice requirements, fair hearings, confidentiality, case records, and estate recovery.
2. **Section 2000** – The title of this section remains “General Eligibility Requirements”. The section covers general eligibility requirements common to all the elderly and disabled medical programs as well as specific program requirements.
3. **Section 3000** – The title of this section has been “Reserved” and the content of the entire section removed because it contained no medical assistance material.
4. **Section 4000** – The title of this section has been changed to “Assistance Planning”. The section covers assistance planning, household composition and case structure policies.
5. **Section 5000** – The title of this section has been changed to “Resources”. This

section covers all policies regarding consideration of resources as either a countable or exempt asset.

6. **Section 6000** – The title of this section remains “Income”. This section covers all policies regarding consideration of income as either countable or exempt.
7. **Section 7000** – The title of this section remains “Budgeting”. This section covers all income deduction and budgeting rules, base periods, budgetary standards, allowable expenses, and determination of eligibility.
8. **Section 8000** – The title of this section remains “Institutional and Home and Community Based Services Living Arrangements”. This section covers all long term care policies including nursing facility, HCBS, PACE, and WORK.
9. **Section 9000** – The title of this section has been changed to “Reporting Changes and Reviews”. The section covers all policies related to the review process and reporting responsibilities, including acting on reported changes.
10. **Section 10000** – The title of this section has been “Reserved” and the content of the entire section removed because it contained no medical assistance material.
11. **Section 11000** – The title of this section has been changed to “Incorrect Coverage”. The section covers all policies and procedures regarding handling of incorrect coverage, including fraud.
12. **Section 12000** – This entire section was already “Reserved” and remains so.
13. **Section 13000** – The title of this section has been “Reserved” and the content of the entire section removed because it contained no medical assistance material.

E. **A Summary of Changes (SOC)** is being released that will include detailed section-by-section updates. Substantive policy changes contained in the manual and implementation instructions are included in Section V below. A single policy change may affect multiple sections and/or subsections. Simple removal of non-medical language, reference to DCF or KAECSES instructions, minor wording changes or subtle restructuring of sections due to the removal of non-medical material are not included in this material, but are noted in the SOC.

IV. POLICY WEBSITE

In addition to the new Medical KEESM, KDHE is also implementing a new Medicaid Eligibility Policy website. The website will house both policy manuals – the Medical KEESM and the KFMAM – as well as all forms, appendix items, Policy Memos, Directive and Clarifications as well as a Policy Log.

The website is located at : <http://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy>

The website can also be accessed through the KanCare website (<http://www.kancare.ks.gov>) by hovering over the Policy and Reports tab and selecting KDHE Eligibility Policy. The user will then be taken the summary page where the following documents can be accessed:

A. Eligibility Policy Manuals:

The Medical KEESM and the KFMAM are located here. Each manual will continue to operate as a separate document.

B. Appendix:

The Appendix contains documents and materials that support all medical programs. These include financial documents, such as the Medical Assistance Standards, as well as the Application forms. Documents that were previously released to support a policy implementation have now been added to the Appendix list. It is noted that some documents do not have a form number. Only documents previously assigned are listed with a form number. Staff may note that all documents are not sorted by Elderly/Disabled and Family Medical – they are sorted by the purpose of the item, not the program.

C. Forms:

All forms from both the prior KEESM and the KFMAM have been combined and are now located on the website. Forms are sorted by those that are strictly for internal purposes and communication and those that are sent outside of the agency. Again, they are not sorted by Family vs Elderly and Disabled. Forms have retained their original form number where applicable, but have been updated to include KDHE letterhead/logo as well contact information.

D. Policy Memos:

This section contains a list of Policy Memos, Implementation Memos and Summary of Change documents. These include documents originally released by SRS/DCF as part of a KPAM/KEESM revision. Memos pertaining to Family Medical and Elderly/Disabled are listed accordingly, but memos pertaining to both may be listed twice. They are further sorted by year. Attachments that accompanied each memo are also listed.

E. Policy Directives:

Policy Directives issued by the agency are listed according to the type of directive: Those that impact all medical programs, Elderly/Disabled, Family Medical and PPS. Note that only formal directives issued since 2016 are included.

F. Policy Clarifications:

Policy Clarifications are displayed in the same manner as Policy Directives. Only formal clarifications issued since 2016 are listed.

G. Policy Log:

The Policy Log is a new tool that provides a compilation of all Policy Memos, Directives and Clarifications in a single list. The document provides a summary of the content of each policy correspondence and users can link directly to the document from the Log. The Policy Log also serves as a record of all issued policy communication.

V. POLICY CHANGES – EFFECTIVE 08-01-17

The following section provides implementation instructions for all Policy Changes included in both the KEESM and the KFMAM revisions. Other minor wording changes were made to the KEESM to support the implementation of the Medical KEESM can be found in the Summary of Changes.

Policies that impact both Family Medical and Elderly/Disabled:

A. Request for Information Timeframes

The minimum time period to request information has been changed from 15 calendar days to 12 calendar days. In addition, when an application has been denied for failure to provide information, the applicant has until the later of 45/90 calendar days from the date of application or 12 calendar days from the date of denial to provide the information.

KEESM 1414.2 (3) and KFMAM 1406 previously required the agency to allow individuals at least 15 calendar days to provide any required verification. The agency has used this standard since 8/26/2016 (when it changed from the traditional 10 calendar days standard) when sending any requests for information. Effective August 1, 2017, all requests for information shall routinely allow the individual 12 calendar days to provide any necessary information.

This new time frame is applicable to requests for new applications, reviews, and case maintenance actions.

For Information Received On Denied (IROD) cases the new 12 day standard is applied in a similar fashion. The request is reconsidered if the information is provided within the later of the allowable time frame to process the request (45 calendar days for most, 90 calendar days if a disability determination is required) or 12 calendar days from the date the application was denied. These cases, commonly referred to as Information Received on Denied (IROD), have coverage determined according to the original application date.

The new 12 calendar day standard shall be used for all medical assistance requests and is applicable to all requests for information issued on or after August 1, 2017. For requests previously issued, but not yet acted upon, the original 15 calendar day standard shall be honored.

The Cut and Paste templates have been updated to include the new timeframes.. Applicable forms have also been updated. The staff member issuing the notice is responsible for ensuring the correct timeframe is stated.

B. Civil Rights Complaints:

This revision also implements a new process when a civil rights complaint is received. Upon receiving the complaint, staff are required to notify local supervisory/management staff. The KC6500, Civil Rights Complaint, is required to be completed and sent to KDHE Policy for further guidance regarding the resolution of the complaint. A log of all Civil Rights complaints is maintained by Policy staff. KEESM 1600 has been updated.

Policies Applicable to Elderly and Disabled Medical Only:

C. Reinstatement of Assistance:

Clarification has been added to indicate that assistance may be reinstated in the month following the month of closure or suspension if the reason for the adverse action has been cured by the end of the month after the month of closure or suspension. This clarification was previously added to the KFMAM.

D. Gift Cards and Certificates:

Clarification has been added to indicate that gift cards and certificates are exempt as a resource if the card or certificate cannot be converted to cash. In addition, receipt of gift cards and certificates that can be converted to cash are included in the definition of gift income. This is applicable to all decisions made on or after August 1.

E. Base Periods – MediKan to Medically Needy:

Guidance was issued to staff following the implementation of the new Protected Filing Date rules for persons claiming disability status regarding establishing based periods for persons who are ultimately approved for SSDI and were eligible for Medically Needy. KEESM is now being updated to include these clarifications.

- Persons who are eligible for Security disability payments (SSDI) may request three months prior eligibility for Medically Needy (MN) from the date of discovery or report that the recipient receives SSDI, if the date of the discovery or report is more than 90 days after the original request for medical assistance. For example, an application is received on April 1 and the individual is approved for MediKan. On September 15 they notify the agency they have been approved for SSDI and want Medicaid coverage determined. September 15 is considered the date of discovery. Because it is more than 90 days from the original application date, prior medical is now based on September 15 – so coverage back to June 1 can be determined.
- The base period for a person receiving MediKan and transitioning to Medically Needy begins the month of report or discover if the individual will be eligible without a spenddown or if the spenddown will be met.

- For other persons transitioning to Medically Needy, the base period begins the month following MediKan closure, allowing timely notice.

F. Reviews – 85% Resource Test

Section 9000 has been rewritten to include detailed information regarding eligibility for various review types of super passive, passive and pre-populated. This information was previously included in Policy Memo 2017-02-01. A clarification is included in the revision that LTC cases with Spousal Impoverishment involvement are not eligible for a passive review.

In addition, this revision implements an extension of the 85% resource rule used for Passive Reviews to some Pre-Populated reviews. When determining if a case is eligible for an Elderly/Disabled Passive Review, the listed value of non-exempt liquid resources is one of the factors considered in the review-type determination process. If the total value of all non-exempt, liquid assets is within 85% of the applicable resource limit, and the consumer does not own other non-exempt assets the case is eligible for a passive review.

This memo clarifies the verification policy established with the passive review process is also applicable to situations where the consumer received a pre-populated review. If the household attests to total non-exempt liquid resources, with the exception of non-exempt life insurance, within 85% of the applicable resource limit and the household does not own other non-exempt resources and the household does not report any changes to the type of resources owned, self- attestation of the value of the liquid resources is acceptable and additional verification is not required. Although considered a liquid resource, non-exempt life insurance is excluded from this policy.

In addition, self-attestation is not acceptable in the following situations:

- Cases with other non-exempt resources (e.g. countable life insurance policies or real property)
- Cases with a community spouse
- Cases with a trust (regardless of exempt/non-exempt status)
- Cases where the review indicates a resource no longer exists or other potential transfers may have occurred.
- Cases that include exempt resources, but the exempt status must be redetermined periodically (e.g. bona fide effort)

In the above cases, standard verification requirements apply and liquid resources, along with other resources the household may own, must be verified. This is true regardless of the attested value of the liquid resource.

When determining if the value of liquid resources is below the 85% threshold, the countable value is reduced by the amount of income deposited into the specific account. The deposit must be previously verified or, in the case of Social Security, verified through EATSS. Documentation is required.

The table below provides the 85% limit for various medical programs:

Program	Resource Limit	85% Value
Single Person – Medically Needy, Protected Medical Groups, 300%, MN3	2000	\$1700
Couple - Medically Needy, Protected Medical Groups	3000	\$2550
Single Person - MSP	7390	\$6281.50
Couple – MSP	11090	\$9426.50
Working Healthy	15,000	\$12750

The new policy is applicable to reviews processed on or after August 1, 2017.

G. Spousal Impoverishment:

The Intent to Transfer Resources (M-2) and Intent to Allocate Income (M-3) forms were revised with Policy Directive 2017-07-01 to require completion and return of the forms by the applicant prior to the eligibility determination. Modifications to the forms were made at this time to support the process.

The M-2 is being further modified with this revision to eliminate the requirement for the applicant to select a transfer option. An older version of the form was incorrectly issued that included a 'Select One' option requirement for the couple and this is being eliminated on the new form. All three items listed are required.

The Directive is being reissued with an additional update that clearly states the couple is required to complete all necessary transfers within 90 days from the date of approval. Verification of the transfer is required. The Standard Text for Copy and Paste Spreadsheet has been modified to include new notice fragments to support the new process. The following fragments will be used:

Request for Signed M-2

Request for Signed M-3

Request for Verification of Resource Transfers after Approval for LTC

VI. CONCLUSION

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 KEES issues are directed to the KEES Help Desk: KEES.HelpDesk@ks.gov