Kansas
Department of Health and Environment
Division of Health Care Finance

Policy Memo	
KDHE-DHCF POLICY NO: SOC2018-12-01	**From: Jeanine Schieferecke**
Date: Dec 31, 2018	**Medical KEESM Sections:** 1322, 1610, 1611, 1612, 1613, 1614, 2150, 2671, 2672, 2675, 5130, 5331, 5724, 6220, 6322, 7430, 8200, 8218, 9310, 9320, 9331, 9332, 9340, 9350, 9360
RE: Summary of Changes (SOC) for Medical KEESM Revision #12	**Program(s): Elderly & Disabled Medical**

The purpose of this document is to identify the changes which have been included in the Medical KEESM effective January 1, 2019. In addition to this document, KDHE Policy Memo 2018-12-01 and 20148-12-04 have been issued. Manual changes are outlined below.

1322.1 **Mandatory Verification That Affects Eligibility for Program Benefits** – This subsection has been updated to reflect that for all programs, earned income shall be verified under the tiered process.

1322.4 **Special Verification Provisions** – This subsection has been updated to allow use of paystubs voluntarily provided by the employee or employer at the time of application or request for assistance as a Tier 1 payor source.

1610.1 **Reserved** – This reserved subsection has been eliminated.

1610.2 **Reserved** – This reserved subsection has been eliminated.

1610.3 **Medical Assistance** – This section has been eliminated as it has been merged with the body of 1610.

1611.1 **Medical Assistance** – This subsection has been eliminated as it has been merged with the body of 1611.

1611.2 **Reserved** – This reserved subsection has been eliminated.

1612 **Continuation of Benefits** – This section has been reorganized to remove subsections which were previously reserved.

1613 **Client's Rights Related to a Fair Hearing** – This section has been updated to include a reference to 1614.6 regarding the client's right to submit a request for an expedited fair hearing.

1614.1(5) **Standard Procedures** – This subsection has been updated to reference 1614.5(1) instead of 1614.3(9) when an appeal of the DDS disability determination is received.

1614.3 **Completion of Summary** – This subsection has been updated to reflect that one copy of the agency summary is sent to the Office Administrative Hearings and another copy shall be sent to the appellant or representative. This subsection has also been modified to reference 1614.5(1)(c) when a request for fair hearing involves a DDS disability determination.

1614.5 **Procedures For Requests Related to a Disability Determination** – This subsection has been revised to clarify the process eligibility staff shall follow when a request for fair hearing involves a disability determination rendered by either DDS or PMDT.

1614.6 **Expedited Fair Hearing** – This is a new subsection which provides policy and procedure information for when a request to expedite the fair hearing process is received.

1614.7 **Federally Facilitated Exchange (FFE) Fair Hearing** – This is a new subsection which provides policy and procedure information for when a request for fair hearing is received through the Marketplace Appeals Center.

2150 **Residence** – This section has been updated to remove reference to 2223 as that section is now reserved.

2671 **Qualified Medicare Beneficiaries (QMB)** – This section has been updated to reflect the increased resource limit for the Medicare Savings Programs (MSP).

2672 **Low Income Medicare Beneficiaries (LMB)** – This section has been updated to reflect the increased resource limit for the Medicare Savings Programs (MSP).

2675.4 **Benefits and Levels of Subsidy** – This subsection has been updated to remove information related to Part D copayment amounts. The benchmark subsidy premium for Kansas has also changed from $31.43 to $32.46 effective January 1, 2019. This figure impacts the amount of Medicare Part D subsidy a beneficiary can receive. The subsidy will provide coverage of the lowest premium a Part D plan offers, up to the basic premium level for the state. A beneficiary receiving the subsidy may elect an enhanced or high cost plan, but he/she is responsible for the difference between the benchmark and the actual premium amount.

5130 **Medical Assistance** – The resource limit for the Medicare Savings Programs (MSP – QMB, LMB, ELMB) has increased from $7,560 to $7,620 for a single individual and

$11,340 to $11,430 for a couple. The increase is mandated by federal law and is based on the annual change in the consumer price index (CPI).

5331.1 **Substantial Home Equity** – The substantial home equity limit for individuals applying for long term care coverage has increased from $572,000 to $585,000 effective January 1, 2018. This increase is mandated by the federal law and is based on the annual change in the consumer price index (CPI).

5724.5 **Effective Date** – This subsection has been updated to clarify the penalty period effective date as it relates to either an applicant or recipient.

6220(11) **Types of Countable Income - Other** – This subsection has been updated to reference 6322 for royalties instead of 7122.1, as that section is reserved.

6322 **Royalty Income** – This is a new section which provides policy instruction for counting royalty income. Royalty income is compensation paid to the owner for the use of property (usually copyrighted material such as books, magazine articles, manuscripts, music, or artwork), or natural resources (such as minerals, oil, gravel, or timber).

7430 **Program Standards** – This section has been updated to remove reference to Money Follows the Person (MFP) as that program is no longer funded as of December 31, 2018.

8200.3 **HCBS Plan of Care/Person-Centered Service Plan and Cost of Care** – This subsection has been updated to remove reference to the acronym PCSP for person-centered service plan.

8218 **Institutional Transitions** – This section has been updated to remove reference to Money Follows the Person (MFP) as that program is no longer funded as of December 31, 2018. This section now contains policy and procedure information related to the Institutional Transitions program.

9310.2 **Passive Reviews** – This section has been updated to remove reference to Money Follows the Person (MFP) as that program is no longer funded as of December 31, 2018.

9320 **Notice of Expiration** – This section has been updated to reflect that a notice of expiration of the review period shall be sent to households subject to a pre-populated review. A notice of expiration of review is not required for passively or super-passively reviewed households. The notice of expiration and pre-populated review form shall be mailed to the household on or about the 15th of the next to last month of the review period. This allows the household approximately 30 days to complete and return the review form to the agency.

9331 **Review Form** – This section has been revised to clarify that a signed pre-populated review must be returned to the agency by the 15th of the last month of the review period to be considered timely received. This section has also been updated to include policy related to the automatic discontinuance of eligibility if the signed review form is not returned to the agency by the closure processing deadline in the last month of the review period.

9332 **Continuance of Coverage Pending Completion of Review** – This section has been revised to include policy which allows eligibility at current levels to continue automatically when a review form is timely received but untimely processed by the agency. Months where coverage is extended past the end of the review period are called extended months and may be subject to correction.

9340 **Agency Action on Timely Review** – This section has been updated to define timely processing standards for review forms received timely.

9350 **Household Failure to Act Timely** – This section has been updated to clarify that a household which untimely submits a review form or timely submits a review form but submits all verification in an untimely manner loses the right to a prompt review of eligibility.

Additionally, a review reconsideration period is not applicable to an individual who is approved at review or is denied at review for not meeting eligibility criteria. When eligibility has been discontinued for failure to provide required verification, and the verification is later provided within the review reconsideration period, eligibility shall not be reinstated pending completion of the review. The discontinuance shall be rescinded, but no coverage past the end of the review period shall be provided, unless and until the review is fully processed.

9360 **Agency Failure to Act Timely** – This section has been updated to include policy related to evaluation of extended months of coverage and potential correction when eligibility has continued with coverage at the current level as a result of the agency failing to timely process a timely received review form.

CONCLUSION

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

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