

Policy Memo	
KDHE-DHCF POLICY NO: 2019-08-02	From: Erin Kelley, Senior Manager
Date: August 21, 2019	Medical KEESM/KFMAM Reference(s): 7430, 8260, 1725.2, 5633.2
RE: Change in HCBS PIL, Estate Recovery - Medicaid Liens, Annuities - Purchase Refusal Letters	Program(s): Elderly & Disabled Medical Programs

This memo sets forth instructions for policy changes being implemented in September 2019. Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after September 1, 2019. Revisions to the Medical KEESM manual will coincide with the release of this memo. Additional information related to the implementation of these changes is available through training material released to eligibility staff.

A. HOME AND COMMUNITY-BASED SERVICES PROTECTED INCOME LIMIT

Effective September 1, 2019, the HCBS protected income limit is increasing from \$727.00 to \$1,157.00. This change will also affect PACE participants who reside in the community. Medical KEESM sections 7430 and 8260, form [ES-3104.5](#), and the [F-8 Medical Assistance Standard](#) chart have been updated with this change.

On the weekend of August 2nd, a batch was ran in KEES to apply the increased protected income limit (PIL) to cases in which HCBS was actively received. Applications received prior to this date that were pending authorization of HCBS were not affected by this batch; therefore, EDBC must be ran for the month of application through the come-up month for the change in PIL to be effective in September 2019 ongoing.

B. ESTATE RECOVERY – MEDICAID LIENS

1. BACKGROUND

When a consumer who has ownership interest in real property is authorized to receive funded care in a Medicaid approved facility, eligibility staff are required to obtain medical documentation to determine the likelihood of the consumer being discharged from the facility and returning home. To obtain said documentation, the ES-3152 (Medical Assistance Lien Physician Verification) is mailed to the consumer for completion by their attending physician and is then returned to the agency. If the attending physician indicates the consumer will not return home, eligibility staff will refer the case to the Estate Recovery Unit (ERU). After six (6) months of compensated care in the facility, ERU could then place a lien on the real estate owned by the consumer. Direction on this

subject was provided in the [SOC2004-10,KEESM Revision 20](#), Summary of Changes (SOC) – Section VII.A.4.a.

2. POLICY

Effective with the issuance of this memo, use of the ES-3152 is being discontinued and medical documentation from the consumer's treating physician is no longer required. Instead, once the consumer has been continuously institutionalized and has received six (6) months of compensated institutional care, there is a medical presumption that the consumer will not be discharged from the facility to return home. Therefore, eligibility staff will no longer be responsible for making a real estate lien referral to ERU. Instead, a report will be ran and sent to ERU each month listing all consumers (with real estate) who meet the six (6) month threshold.

ERU will evaluate the referral received from the agency and determine whether to place a lien on the consumer's real estate interest. ERU may contact the agency if additional information is needed. Otherwise, no action by eligibility staff in the real estate lien process is required.

Note: The placement of a Medicaid lien on real estate property interest shall not affect the consumer's eligibility for medical assistance. Medical KEESM 1725.2(1) will be updated with this change with the next scheduled manual update.

C. ANNUITIES – PURCHASE REFUSAL LETTERS

The purpose of this section is to provide additional guidance to eligibility staff concerning the valuation process for irrevocable, non-assignable annuities as described in [Policy Memo 2008-03-02 \(Availability of Non-Assignable Annuities\)](#).

1. BACKGROUND

When an applicant/recipient disagrees with the agency-determined valuation of their annuity, he/she may provide an alternative valuation from three (3) separate reliable sources. This verification is usually provided in the form of three (3) annuity purchase declination statements from companies in the business of purchasing irrevocable annuities. This process is outlined in Section F. of the cited memo.

Remember: All annuities (including any accompanying purchase refusal letters) shall be reviewed by Eligibility Policy before the availability and/or value of the annuity as a resource is considered in the eligibility determination by eligibility staff. No eligibility decision shall be completed prior to the receipt of a clearance/guidance from Eligibility Policy as described in the [Policy Memo 2008-03-02](#).

2. POLICY

- a. Effective with the issuance of this memo, eligibility staff shall adhere to the following processes:
 - i. Unless the consumer has voluntarily provided the agency with an alternative valuation or three (3) purchase refusal letters, the value of the annuity, as determined by the agency, shall be used in the eligibility determination [see Medical KEESM 5633.1(3) and 5633.2(2)]. The agency *shall not* be initiating a verification request from the consumer to prove that the annuity has no value by providing three (3) purchase refusal letters (see ii. below). Notification of the eligibility decision based on the agency-determined valuation of the annuity shall be issued to the consumer.
 - 1) If the consumer voluntarily provides three (3) purchase refusal letters at the time of application or before the eligibility determination has been completed, eligibility staff shall include this information in the annuity clearance request. Once cleared, the agency shall use that additional information to make the eligibility decision. The agency shall not; however, request this verification if not volunteered by the consumer.
 - ii. If upon notification of the eligibility decision, the consumer contacts the agency with concerns regarding the agency-determined valuation of the annuity, the agency may properly advise that the decision may be reevaluated if three (3) purchase refusal letters are submitted within 12 days from the date of the agency notification using the following snippet that has been specifically created for this purpose. This snippet has been added to the Standard Text for Copy and Paste spreadsheet.

“We have reviewed your medical assistance case based on concerns regarding the valuation of property used by the agency in determining your eligibility. A value of $\{annuity\}$ was assigned to the following annuity: $\{name\}$, policy number of $\{annuity\}$. This value was based on the amount and number of payments remaining under the contract. This is in accordance with Medical KEESM 5633.2 (2).

If you disagree with this valuation, you may submit an alternate valuation for the annuity by providing written statements from three (3)

separate companies that are in the business of purchasing annuities on the secondary market. The statements must be on the company's letterhead and must be signed and dated by the company representative. We cannot accept valuation statements from companies that do not purchase annuities.

If you provide these three (3) statements to the agency by {12 days from date of determination}, we will review our decision on your eligibility for medical assistance. We will notify you of any changes in our decision.

If you have any questions, please contact KanCare at 1-800-792-4884 between 8:00 AM and 5:00 PM Monday through Friday.”

If the three (3) purchase refusal letters are timely provided, eligibility staff shall request an additional clearance from the KDHE Policy unit. The KDHE Policy unit will reevaluate the annuity based on the additional information and advise the eligibility worker of any changes in the previously determined valuation and whether the three (3) purchase refusal letters are acceptable. If the letters are not timely provided, the case shall remain denied/discontinued. If discontinued, Medical KEESM 1423 may apply.

- iii. If the consumer challenges the agency-determined valuation of the annuity and has not or declines/refuses to provide the three (3) purchase refusal letters after consultation with the agency, he/she may appeal the agency's determination through the normal fair hearing process.

Note: To be considered valid, the purchase refusal letters must be from entities that are actually in the business of purchasing annuities (or the income stream from the annuity). Letters from entities that simply evaluate an annuity's availability, but do not purchase annuities as a core element of their business shall be disregarded in determining availability of the annuity in the eligibility determination.

- b. The guidance provided in this section conforms with the direction given in [Policy Memo 2007-02-01](#) (Guidelines Regarding Medicaid Planning Advice), which is still valid. Eligibility staff shall respond to, but not initiate, inquiries concerning the use of the purchase refusal letters in gaining eligibility. Nor shall eligibility staff ever tell a consumer that this is the prescribed action he/she needs to take – it shall only be presented as one option available to the applicant/recipient. The consumer, not the agency, chooses their own course of action.

D. QUESTIONS

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

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov

Kristopher Smith, Elderly and Disabled Program Manager – Kristopher.C.Smith@ks.gov

Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov

Jerri Camargo, Family Medical Program Manager – Jerri.M.Camargo@ks.gov

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