# Medicaid and VA Update

## Presented By:


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# Medicaid and VA Update

# Start with the obvious…


COVID-19
CORONAVIRUS DISEASE 2019


THANK YOU
CAPTAIN OBVIOUS


Laughing at corona memes like
February
March 1
Last week
This morning
A little later this morning

# Medicaid and COVID

- No one loses Medicaid

# Medicaid and COVID

- Policy Directive 2020-03-01Delayed Discontinuance – COVID-19
  - Provides immediate instruction to eligibility staff regarding the handling of reviews, premium delinquency, and other discontinuance processing during the COVID-19 public health emergency declared by the State of Kansas on March 23, 2020.
  - Discontinuances suspended except for certain circumstances
  - Coverage reinstated if already discontinued effective March 31, 2020
  - Applies to renewals

# Medicaid and COVID

- Policy Memo 2020-04-01
  - Policy Implementation Instructions and Information for COVID-19 National Public Health Emergency
  - Sets forth instructions for implementation of policy changes related to the COVID-19 National Public Health Emergency and processing guidelines for the duration of this emergency concerning applications and new coverage requests, situations where an applicant/recipient fails to provide requested information, and the receipt of Federal Emergency Relief funds.
  - Failure to Provide
  - Stimulus Funds
  - Not applicable to trusts, annuities and/or promissory notes
  - CARE Requirements Waived for 30 Days
  - Transfer of Property (not applicable unless active recipient)

# Medicaid and COVID

- Policy Directive 2020-06-01 Fair Hearing Extension – COVID-19
  - The purpose of this document is to provide immediate instruction regarding the timeline for appeal filing during the COVID-19 Public Health Emergency (PHE) declared by the State of Kansas on March 23, 2020.
  - Additional 120 days to request a state fair hearing (on top of normal 33)

# Medicaid and COVID

- KDHE-DHCF Policy No: 2021-03-01 Updated COVID-19 Processing Flexibilities
  - COVID-19 Stimulus Fund Resource Verification
  - Exempt through consumer's next review not to exceed 12 months
  - Some people may not have spent it.  If individual is found to be over resources and are denied, they can contact the agency and attest that the excess is due to accumulation of COVID-19 federal monies.  Must then provide documentation of when received, etc…..

# Policy Memos

# Policy Memos

- KDHE-DHCF POLICY NO: 2019-12-01
  - Voluntary Contribution for Long Term care and Resource Liquidation to Purchase Funeral Plan
  - Options to spend down without losing application filing date or current coverage
  - Voluntary contribution one option
  - Also
    - Funeral plan
    - Pay due and owing expenses
    - Pre-pay estate recovery
    - Spend down
    - Discontinue eligibility

# Policy Memos

- Policy Clarification 2020-02-02
  - Impact of Private Payment on Resource Eligibility
  - The purpose of this document is to provide guidance in situations where a consumer residing in a nursing facility has either partially or fully private paid the facility and what that means in terms of resource eligibility for the long term care program.
  - This one is a big deal.
  - What about a married couple?

# Policy Memos

- KDHE-DHCF POLICY NO: 2020-06-01
  - Transfer of property penalty cure clarification and glitch fix
  - Must be done during the penalty period

# Policy Memos

- KDHE-DHCF POLICY NO: 2021-02-02 Property Settlement - Divorce
  - Change in policy concerning the equitable nature of property settlement through a divorce proceeding
  - If the settlement is not equitable between the spouses, an inappropriate transfer may potentially attach to the spouse who receives less than his/her fair share
  - The property settlement could be “suspect” if the proceedings are not adversarial
  - Spouses use the same attorney
  - Value distributed not approximately equal between spouses

# Policy Memos

- KDHE-DHCF POLICY NO: 2021-02-01 Spouse's Resources Disregarded in Long Term Care Determination
  - Provide guidance when the resources of a community spouse may be disregarded in determining eligibility of LTC spouse
  - When couple is living apart and will be difficult or impossible to obtain income/resource information
  - Uncooperative Spouse
  - Whereabouts of Spouse Unknown
  - Abusive Spouse

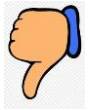
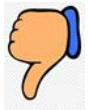
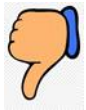
# Policy Memos

- https://www.kancare.ks.gov/policies-and-reports/kdhe-eligibility-policy
  - Click on Policy Log, then open XLXS policy log (currently 4-13-21-policy-log)

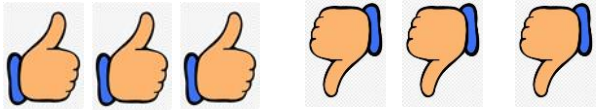
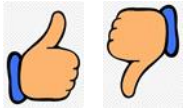
# KDHE Policy Log - Revised starting 09-17-2020

| Reference # | Date Issued | Date Effective | Name | Summary | Programs Impacted | Keywords | Attachments |
|---|---|---|---|---|---|---|---|
| PD2020-09-02 | 9/17/2020 | 9/17/2020 | Policy Directive: ES-3100.8 MSP Only Application and Prior Medical Coverage | If there is eligibility on MSP/LMB and or MSP/ELMB only it can be assumed that consumer has requested prior medica coverage. | Elderly and Disabled | MSP<br>Prior Medical coverage | |
| PD2020-09-01 | 9/1/2020 | 9/1/2020 | Policy Directive: Voter Registration | Instructions on implementing new requirements on voter registration process on applications. | All Medical Programs | Voter registration | KC-7203 Voter Registration Companion let<br>KC-7203S Voter Registration Companion I Spanish |
| SOC2020-09 | 8/21/2020 | 9/1/2020 | Summary of Changes (SOC) form Medical KEESM Revision 20 and KFMAM Revision 28. | Provides the detailed Summary of Changes for Medical KEESM Revision #20 and KFMAM Revision #28 | All Medical Programs | | |
| PM2020-08-02 | 8/21/2020 | 9/1/2020 | AVS Memo – Phase 2 Implementation, Applications | Instructions for implementation of Phase 2 of AVS on application and request for coverage on Non-MAGI programs | Elderly and Disabled | Asset Verication Solutions (AVS)<br>Direct Express accounts<br>Self-attestation of Excess Resources | KC-7202 Asset Verification Solution (AVS) Requested Months chart |
| PM2020-08-01 | 8/21/2020 | 8/23/2020 | August 2020 KEES Release Memo | Implements changes to E&D programs in regard to KEES now having I-013 Annuity Referral form and ES-3122 for pursuit of VA benefits. | Elderly and Disabled | I-1013 form Annuity Referral<br>ES-3122 VA- Potential Benefits Request | |
| PC2020-08-01 | 8/13/2020 | 8/13/2020 | Policy Clarification: HCBS and Aged-Out Foster Care | Provides clarification regarding treatment of co-existing HCBS and AGO coverage. | All Medical Programs | | |
| PM2020-06-02 | 6/26/2020 | 6/28/2020 | Policy Memo: Implementation instructions and information for June 2020 KEES changes | Provides instructions that are applicable to all eligibility actions, including system actions, taken on or after this June 2020 KEES Release. | All Medical Programs | | |
| SOC2020-07 | 6/26/2020 | 7/1/2020 | Summary of Changes (SOC) form Medical KEESM Revision 19 | Provides the detailed Summary of Changes for Medical KEESM Revision #19. | Elderly and Disabled | | |
| PM2020-06-01 | 6/26/2020 | 6/26/2020 | Policy Memo: Transfer of Property (TOP) Penalty Cure | Provides instructions for policy changes in regard to changes to the transfer of property (TOP) penalty cure policy | Elderly and Disabled | TOP cure | |
| PD2020-06-01 | 6/10/2020 | 3/23/2020 | Policy Directive: Fair Hearing Extension - | Provides immediate instruction regarding the | All Medical | Fair Hearing Extension | COVID- 19 Fair Hearing Extension Letter |

# What has come up for us lately?

- Authorizations 
- Reviews being extended 
- Farm accounts 
- Non-answers to specific questions 

# More lately…

- Access to caseworkers 
- Treatment of community spouse's IRA (do not have to show it's work-related) 
- Using grievance process more to avoid an appeal 
- SWITCH TO KDHE except for call center 
- Faster responses on Medicaid apps 

# And more…

- Inconsistent/out of order notices 
- 90 days after qualification to transfer 
- Promissory notes vs. annuities 
- Estate Recovery more aggressive (probates and liens)  

# Current Medicaid Numbers

- Minimum community spouse resource allowance: $26,076
- Maximum community spouse resource allowance: $130,380

- Minimum monthly maintenance needs allowance: $2,155
- Maximum monthly maintenance needs allowance: $3,216

- Home equity limit: $603,000

- Penalty divisor: Divide the value of the uncompensated transfer by $220.50; the resulting number is the number of penalty days.

# VA Update

# The big one.

- October 18, 2018
  - Lookback and penalty
  - Annuities
  - Net worth bright line
  - More medical expense deductions

# What’s new with us?

- Caregiver benefit
- Using the KanCare form
- Planning more limited after 2018 rule

# Current VA Numbers

- Maximum VA Resource Allowance: $130,773

- Monthly Pension Rate:
  - Single veteran:  $1,935
  - Married veteran:  $2,295
  - Widow or surviving dependent:  $1,244

# Summary

- Medicaid and COVID
- KanCare changes
- VA

# Thank you!


YEAH IF YOU COULD JUST WRAP IT UP
THAT'D BE GREAT


THANK
YOU


THE END
IS HERE

# Essential Numbers 2021

## Medicaid (Kansas)

Minimum community spouse resource allowance: $26,076
Maximum community spouse resource allowance: $130,380

Minimum monthly maintenance needs allowance: $2,155
Maximum monthly maintenance needs allowance: $3,216

Home equity limit: $603,000

Penalty divisor: Divide the value of the uncompensated transfer by $220.50; the resulting number is the number of penalty days.

## Medicare Part A (varies depending on income)

Home Health Care: $0 for home health care services
20% of the Medicare-approved amount for durable medical equipment

Hospital Inpatient Stay:

Deductible: $1,484 per benefit period
Coinsurance per day: $0 for the first 60 days of each benefit period
$371 per day for days 61-90 of each benefit period
$742 per "lifetime reserve day" after day 90 of each benefit period

(up to a maximum of 60 days over your lifetime)

Skilled Nursing Facility Stay: $0 for the first 20 days of each benefit period
$185.50 per day for days 21-100 of each benefit period
All costs for each day after day 100 in a benefit period

## Medicare Part B

Average monthly premium: $148.50 (higher-income consumers may pay more)
Deductible per year: $203

## Federal Estate and Gift Tax

Annual exclusion: $15,000
Lifetime exclusion: $11,700,000

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# Essential Numbers 2021

## Veteran's Aid & Attendance (effective 12/01/2020, but impacting VA checks 01/01/2021)

Maximum VA Resource Allowance: $130,773
(Net Worth Limit)

Monthly Pension Rate:

| | |
|---|---|
| Single veteran: | $1,935 |
| Married veteran: | $2,295 |
| Widow or surviving dependent: | $1,244 |

Maximum Annual Pension Rate (MAPR):

| *If you are a veteran...* | *Your yearly income must be less than...* |
|---|---|
| Without a spouse or dependent child | $13,931 |
| *To be deducted, medical expenses must exceed 5% of MAPR, or $696* | |
| With one dependent | $18,243 |
| *To be deducted, medical expenses must exceed 5% of MAPR, or $912* | |
| Housebound without dependents | $17,024 |
| Housebound with one dependent | $21,337 |
| Aid and Attendance without dependents | $23,238 |
| Aid and Attendance with one dependent | $27,549 |

## Social Security (Cost of living adjustment increase for January 1, 2020 is 1.6%)

Social Security income for substantial gainful activity (amount a person on disability cannot exceed):
- Non-blind: $1,310/month
- Blind: $2,190/month

Trial work period: $940/month

Monthly (annual) earnings limits for retirement benefit recipients:

| | |
|---|---|
| Under full retirement age: | $1,580 ($18,960) |
| Year in which full retirement age is attained: | $4,210 ($50,520) |

Social Security reductions are $1 for every $3 in earnings above the limit. No reductions beginning the month an individual attains full retirement age.

Monthly maximum Federal SSI amounts:
- Individual: $794
- Couple: $1,191

Maximum earnings subject to Social Security tax: $142,800

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Kansas
Department of Health and Environment

# Policy Clarification 2020-02-02

# Title: Impact of Private Payment on Resource Eligibility

**Date: February 26, 2020**

**From: Erin Kelley, Senior Medical Eligibility Policy Manager**

**Program(s) impacted: Elderly and Disabled Medical Programs**

The purpose of this document is to provide guidance in situations where a consumer residing in a nursing facility has either partially or fully private paid the facility and what that means in terms of resource eligibility for the long term care program.

The following Medical KEESM provision states the basic policy:

**5410 Types of Personal Property –** "*Personal property consists of all property excluding real property. Cash assets which are a form of personal property consist of cash on hand, money in checking and savings accounts, stocks or bonds, cash surrender or loan value of life insurance policies, trust funds, monies or other property provided to a child under the Uniform Transfers to Minors Act (UTMA), and similar items on which a determinate amount of money can be realized. Personal property shall be considered available to the account owner/holder except for property held by a conservator or guardian is considered available to the conservatee or beneficial owner.*

*Other personal property as used in the definition include such items as personal effects, household equipment and furnishings, home produce, livestock, equipment, vehicles, inventory, prepaid funeral contracts, and contracts from the sale of real or personal property.*

*Unless exempt, the value of personal property owned by the individual must be considered."*

If a consumer has been determined otherwise eligible for long term care and Medicaid payment is authorized for months in which the consumer has already private paid the nursing facility, any funds paid to the facility in excess of the liability issued in that month will be held "on account" with the facility and will be subject to reimbursement. This creates a potential resource eligibility issue as once that money is placed on account with the facility, it is now an available asset which may immediately place the consumer over resources as soon as they were found to be otherwise eligible.

When a consumer has private paid the nursing facility for months in which medical assistance has been requested, staff shall contact the facility to determine how much was paid in each

month and/or how much of a private payment was attributed to each month. If the amount paid to the facility exceeds the estimated liability for any month, the difference between the liability and the amount paid shall be compared to the total countable resources owned by the consumer in that month. If the total countable resources owned by the consumer plus the amount of the excess payment results in resource ineligibility, the consumer's request for long term care medical assistance shall be denied in all months applicable.

> **Note:** If only a single month is impacted by resource ineligibility and the amount of excess resources plus the anticipated liability for that month is less than the facility's monthly cost of care, the voluntary contribution policy as outlined in PM2019-12-01 shall be considered. If the consumer agrees to the voluntary contribution and meets the general criteria, the voluntary contribution policy shall be followed. If the consumer does not meet the general criteria or does not agree to apply the voluntary contribution, long term care medical assistance shall be denied for the month impacted by the private payment.

If denied long term care, coverage under other medical programs shall be considered as the money held on account with the facility only becomes available if approved for long term care. However, as there is no way to differentiate between resources tested for long term care medical assistance and those tested for other medical programs, resource records reflecting the excess payment are not necessary and shall not be added to KEES. Rather, a V200 shall be sent with the following snippet added to the "Other Reasons Listed Here" section:

> *"Long Term Care medical assistance has been denied for the month(s) of {month(s) affected} due to a private payment made to the facility. Had Long Term Care been approved, the monies applied for the month(s) of {month(s) affected} would be subject to reimbursement and are therefore considered available assets for this program. However, as these monies are only available for the Long Term Care program, eligibility under other medical programs will be considered during this time. You will receive a separate notice regarding your eligibility for the other medical programs."*

Consider the following examples:

1. Meghan applies for long term care medical assistance in December and requests prior medical. In November, Meghan private paid the facility in full for the months of September through November. Since Meghan had the ability to private pay in the prior medical months, it's determined that she is not eligible for the months of September and October due to the accumulated funds in her personal bank account. However, due to her payment to the facility in November, Meghan appears to be resource eligible in this month. If Medicaid payment were to be authorized effective November, the funds used to private pay the facility in that month would be held "on account" with the facility and would be an available resource to Meghan. The worker calculates Meghan's liability and deducts that amount from the amount of the private payment for the month of November. The amount of payment in excess of the calculated liability far exceeds the $2,000 resource limit; therefore, Meghan's request for long term care medical assistance is denied for the month of November and a one-month Medically Needy Spenddown is established. Long term care is authorized effective December as only the prior medical months were impacted by Meghan's private payment to the facility. A voluntary contribution would not have been applicable for the month of November as it was a prior medical month.

2. Florence applies for long term care medical assistance in January and requests prior medical. In October, Florence private paid the facility in full for the months of October through December and paid a portion of January – the application month. Florence is otherwise eligible in all months due to the early payment to the facility; however, if Medicaid payment were to be authorized effective October, the funds used to private pay would be held "on account" with the facility and would be available to Florence. After determining that the amount of payment made to the facility in the months of October through December less the anticipated liability in these months exceeds the $2,000 resource limit, Florence's request for long term care medical assistance is denied and a Medically Needy Spenddown is established in these months. However, Florence only partially private paid for the application month. The amount of excess payment in the month of January does not exceed the cost of care in the facility; therefore, Florence is informed of the potential to make a voluntary contribution in order to become resource eligible in this month. Florence agrees to the voluntary contribution and medical assistance is authorized effective January.

3. Harvey applies for long term care medical assistance in February and does not request prior medical. Harvey has made a partial private payment to the facility for the month of February; however, this payment less Harvey's anticipated liability in this month do not exceed the $2,000 resource limit and there are no other countable resources. The excess payment is considered an available resource; however, because Harvey is within the resource guidelines, long term care medical assistance is authorized February.

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

Erin Kelley, Senior Manager – Erin Kelley@ks.gov
Kris Owensby-Smith, Elderly and Disabled Program Manager-Kristopher.OwensbySmith@ks.gov
Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov
Jerri Camargo, Family Medical Program Manager - Jerri.M.Camargo@ks.gov
Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@ks.gov

Kansas
Department of Health and Environment

# Policy Directive 2020-03-01

# Title: Delayed Discontinuance – COVID-19

**Date: March 31, 2020**

**From: Policy Managers**

**Program(s) Impacted: All Medical Assistance Programs**

The purpose of this document is to provide immediate instruction to eligibility staff regarding the handling of reviews, premium delinquency, and other discontinuance processing during the COVID-19 public health emergency declared by the State of Kansas on March 23, 2020. This instruction is effective immediately for all reviews (new, received, and in process) and all open CHIP and Working Healthy cases with delinquent premiums.

## All Programs - Discontinuances

Beginning with the issuance of this directive and continuing throughout the scope of the emergency, discontinuance will be suspended in all instances except for out-of-state residency, voluntary withdrawal, incarceration, and death. If coverage was already discontinued effective March 31, 2020 for any household member prior to the release of this policy directive, the coverage must be reinstated effective April 1, 2020.

**NOTE**: These policies related to COVID-19 do not apply to Presumptive Eligibility (PE) as PE recipients have not been determined eligible under the state plan. PE processes should continue as normal.

For all cases reinstated or coverage continued during this time, staff shall include the appropriate language from the Standard Copy and Paste (SCP) in the case journal.

For situations not covered in this directive, KDHE Policy should be consulted.

## Renewals

During the scope of the emergency, no discontinuances will take place at review due to failure to meet eligibility requirements or failure to provide information. Reviews will also not be pended at this time for additional information. For those cases that would have been discontinued March 31, 2020 or later, or pended for additional information, coverage will be extended out four (4) months from the date of processing. A specialized Notice of Action will

be sent manually, and a note will be included in the case journal referring to the State Plan Amendments (SPA's) and corresponding documents.

These cases will need to be manually tracked by operational staff and provided to the KEES team on the first business day of each month. Specific processing instruction will be provided by KEES for these cases.

Cases that will be approved at review with no additional information required may be processed using normal guidelines.

**NOTE**: Cases that were already discontinued at review as of February 28, 2020 or earlier do not fall under this directive, and reviews received during the Reconsideration Period for these cases should be processed using standard procedure.

**Renewal Actions**

Effective with the issuance of this directive, eligibility staff shall adhere to the following processes.

**All Programs:**

1. All actions shall be fully journaled and thoroughly documented in the case file. Actions that result in extended coverage shall also be fully journaled using the approved verbiage from the Standard Text for Cut and Paste (SCP).

2. Renewals that do not require additional information and can be approved shall continue to follow the standard review process.

3. Renewals that do require additional information and would result in a pending action or would result in adverse action (discontinuance) shall have coverage extended four (4) months from the date of processing. This action shall be fully journaled and thoroughly documented in the case file using the verbiage from the SCP.

    a. **Example:** At review, a new job is reported for the primary applicant, and the reported income cannot be verified through tiers I through III. Rather than placing the case on hold and requesting the income verification from the consumer, existing coverage will be extended four (4) months from the date of processing.

    b. **Example:** A new job is reported for the spouse, and with the new income, the children previously covered will now be ineligible for all programs. Rather than discontinuing coverage, existing coverage will be extended four (4) months from the date of processing.

4. If an approval will result in greater cost-sharing by the consumer, such as an increase in premium, Spenddown, or Client Obligation, the original coverage should be extended an additional four (4) months from the date of processing. ***Note**: This applies to renewing the same coverage type. This does not apply to living arrangement changes from Independent Living to HCBS, PACE, or NF.

**Note:** It important to remember that negative changes because of an increase in income are not appropriate during the scope of this emergency. However, for LTC institutional coverage, the consumer's protected income limit is $62. If there is an expense received that results in an increased PL, this is not considered adverse action because there is no change in the consumer's PIL.

a. **Example:** Worker is processing an expense change task on an LTC/NF case. The expense document received states that effective next month, the consumer's Dental Insurance is ending, and the consumer will no longer pay for the $100 monthly premium. It is appropriate to end-date the expense and increase the PL amount to the NF because there is no impact to the consumer. This is money that was being paid to one expense and will now be paid as another expense. The consumer continues to keep the $62 PIL.

b. **Example:** At review, with the new income verified, the child on the case previously covered on PLN (Medicaid) will now be CHIP eligible with a $20.00 premium. Rather than authorizing the program with a premium, the existing Medicaid will be extended four (4) months from the date of processing.

c. **Example:** An LTC Pre-populated review is received. Consumer is active on HCBS coverage with a $150 Client Obligation. The consumer reports an increase in earned income and provides proof of wages with the review form. Per this directive, the increase in income would result in an increased client obligation, which cannot be done. Therefore, staff shall extend the review month out four (4) months from the date of processing.

**d. Example:** An E&D Pre-Populated review is received. Consumer is active on Medically Needy Spenddown coverage with MSP/QMB. The spenddown for the last base-period was previously un-met. Consumer reports on his application that he now has earned income. Verification of income through RC verifies that there is earned income that would both increase the consumer's spenddown and disqualify him from MSP/QMB. Because this change would result in adverse action, the worker determines a new 6-month base period at the previous spenddown amount and the consumer's MSP/QMB continues. It is not appropriate to increase the spenddown or discontinue MSP/QMB with his policy. ***Note**: Specific processing instructions will be provided by KEES.

**e. Example:** While processing an E&D Pre-Populated review, you find an LTC Communication task advising that the consumer has moved from his apartment into a nursing facility for a permanent stay. While the protected income limit is $475 for the spenddown coverage and only $62 for the LTC/NF coverage, this is not considered adverse action because the LTC/NF coverage is an increase in Medicaid coverage for the consumer. Financial and non-financial eligibility is then verified following the verification provisions for the COVID-19 National Public Health Emergency, and LTC/NF coverage. *See section 10. below.*

5. Cases on which a pre-populated review form was sent but not received will have coverage extended an additional four (4) months from the date of processing.

6. Cases on which a pre-populated review is due in the months of April 2020 and May 2020 will have the review due month systematically extended four (4) months.

7. For passive review responses that will result in a negative change, the review period will be shortened to four (4) months from the date of processing the change.

    a. **Example:** The review batch runs and authorizes a case with a new review period of March 2021. A passive review response is received with changes reported and is processed during the month of April 2020. The changes will have a negative impact in program or cost-sharing, so the review period will need to be shortened to August 2020 and the existing level of coverage extended.

*__Note:__ Any consumer request to voluntary withdraw from coverage shall be honored per Medical KEESM 1211.10. This may occur for many reasons including, but not limited to, agreeing to the share of cost.

**Renewal Actions E&D and LTC Programs:**

1. Medically Needy Spenddown renewals that would result in adverse action because the recipient has either not met the previous spenddowns, is not meeting the current spenddown, and/or is unlikely to meet a future spenddown, shall not be discontinued from the Medically Needy program. Instead, a new 6-month base period needs established for continued coverage with the new spenddown not to exceed the amount of the previous spenddown.

    a. For cases with where the previous spenddown was met and the consumer was receiving full Medicaid benefits at the time of renewal, verified in MMIS, the consumer's new 6-month spenddown that is to be established shall also be met, as creating a new un-met spenddown is considered Adverse Action and is not allowed per this directive.

2. Long Term Care (LTC) Nursing Facility (NF) and Psychiatric Residential Treatment Facility (PRTF) renewals that include a separate Living Arrangement task to discontinue LTC NF or LTC PRTF coverage to a program other than Title XIX, shall be processed following the delayed CARE Score process as discontinuing LTC coding would result in adverse action. Title XIX coverage shall continue from the date of discharge with no level of care.

3. LTC Home Based Community Services (HCBS) renewals that include a separate living arrangement task to discontinue LTC HCBS coverage to a program other than Title XIX, shall continue to have the LTC HCBS coding remain for the consumer as discontinuing the HCBS coding would result in adverse action. These cases should be tracked for future follow up once the scope of this emergency has ended.

4. Renewals that include a separate Living Arrangement task to add additional LTC level of care shall also be processed in accordance with approved policy and follow the

tiered verification process approved for the COVID-19 Public Health Emergency. Verification of income and resource policies are to be applied. Level of care shall not be granted without verification of financial and functional eligibility.

a. If verifications show the consumer is financially and non-financially eligible for the additional coverage request, the renewal process shall be completed following standard review policy and process and LTC Level of Care approved.

b. If verifications show the consumer is not financially and non-financially eligible for the additional coverage request, or proof of verifications are not received, the additional coverage request shall be denied. Current coverage shall remain active and the review month extended four (4) months from the date of processing.

5. Working Healthy 6-month Desk Reviews that are received and determined eligible per current policy shall be approved for the remaining 6 months when their annual review will be processed.

6. Working Healthy 6-month Desk Reviews that are either not returned or, are received and result in a pending action or adverse action (discontinuance), shall not have EDBC Accepted and Saved. Coverage will continue until the annual twelve (12) month review is processed without accepting EDBC.

   A manual notice will shall be created using verbiage from the COVID-19 tab of the Standard Copy and Paste (SCP).

7. Future Working Healthy Desk Reviews will not be sent to consumers during the scope of this emergency.

8. Working Healthy Annual reviews that are processed and the consumer is determined eligible to continue Working Healthy coverage shall be approved following standard review policies and process.

9. Working Healthy Annual reviews that are received and would require additional information or would result in adverse action shall have coverage extended four (4) months from the date of processing.

**Verification and Application of Expenses on Cases with Extended Coverage**

For E&D and LTC programs, verified medical expenses can reduce the share of cost and spenddown amounts and the verification and application of expenses shall follow current, established policy. These expenses may be received at any time and are processed as either case maintenance tasks or at review.

Failure to provide proof of an expense will not affect eligibility, however, the expense will not be used to lower the share of cost or spenddown until physical verification is received by the agency.

There may be situations where verification of an expense is received for a consumer who is determined resource ineligible but is receiving extended coverage because of the COVID-19 directive. In these situations, it is important to compare the amount of the expense to the amount of excess resources. This is because there are certain situations where it would not be reasonable to lower a consumer share of cost if the amount of excess resources far exceeds the amount of the expense. Prudent person should be used to determine the reasonability of applying these expenses.

- Example: LTC/NF consumer submits a Passive Review Response to the agency and verification of resources, income, and expenses is received. This consumer reports a new monthly recurring expense of $210 per month. However, verification of resources shows that the consumer has $5,000 in the savings account. Because the $210 expense is significantly lower than the excess resources and would take months of out of pocket payments to become resource eligible, the expense is not applied, and the consumer's LTC/NF coverage remains in place with no change in patient liability.

- Example: Pre-Populated review is worked by the agency for an LTC/HCBS consumer and proof of income, resources, and expenses is received. The consumer reports a new recurring expense of $119 per month. However, resource verification shows the consumer has $2100 in resources. Because the $119 expense is more than the excess resources, the $119 is used to lower the monthly client obligation.

- Add Sterling Dental example.

***Note:** For cases that are determined to have excess resources, it is imperative that a call is placed to the consumer or authorized representative advising of the future impact this will have on their eligibility, and policy provided on how they can appropriately spenddown their resources.

**Premium Delinquency for CHIP and Working Healthy**

Beginning March 2020 and continuing throughout the scope of the emergency, discontinuances for failure to pay premiums will be suspended. A file provided by the fiscal agent has been used to update the Delinquency CHIP Premiums and Delinquent WH Premium status from 'Yes' to 'No' on all active cases with a 'Yes' delinquency status, temporarily removing the delinquency and allowing coverage to continue. Many of these will continue to show delinquent in Premium Billing, and this is acceptable.

Likewise, for cases on which a *Reinstate CHIP Coverage – Premium Paid* task is generated, coverage should be reinstated by the worker.

For Working Healthy cases, the *PB No Delinquent Premium* task generated during this update, for Working Healthy programs that were previously closed for delinquent premiums. The age on these tasks varies. It is appropriate to reinstate cases discontinued effective March 31st, 2020. The program block should be rescinded and EDBC re-run to high date the EDBC. In situations where a member would have been discontinued due to categorically not being eligible, further action in KEES may be required. Please review current Job Aids and Manuals. If needed, consult Policy and KEES staff to determine the proper action needed.

When a Notice of Action is not generated, a manual notice will need to be created using verbiage from the COVID-19 tab of the Standard Copy and Paste (SCP). If a Notice of Action is generated, staff should append the notice using the append language also found on the COVID-19 tab of the SCP.

Any unpaid premiums for the months of March through the end of the emergency period will not be penalized. It is anticipated that any outstanding premiums incurred from January 1st, 2020 through the end of the Public Health Emergency shall be waived.

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


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Kansas
Department of Health and Environment

# Policy Directive 2020-06-01

# Title: Fair Hearing Extension – COVID-19

**Date: June 10, 2020**

**From: Policy Managers**

**Program(s) Impacted: All Medical Assistance Programs**

The purpose of this document is to provide immediate instruction regarding the timeline for appeal filing during the COVID-19 Public Health Emergency (PHE) declared by the State of Kansas on March 23, 2020. This instruction is effective retroactively, see details below.

## All Programs – State Fair Hearings

In the event a negative decision is made regarding consumer eligibility, the consumer has 33 days from the date on the Notice of Action to request a fair hearing. Due to the COVID-19 emergency, the Centers for Medicare and Medicaid Services (CMS) has approved a temporary waiver allowing applicants and beneficiaries an additional 120 days to request a state fair hearing. The State will allow an applicant or beneficiary an additional 120 calendar days to request a state fair hearing if the 33-day deadline occurs between March 1, 2020 and the end of the Federally declared PHE.

Beginning May 7th, letters will accompany all KEES mailings advising of this change and will need to be included with any locally printed mailings as well. The letter consists of the following text:

*This letter is to tell you about extra time the State of Kansas is giving you to ask for a state fair hearing during the COVID-19 public health emergency. If the 33-day deadline to ask for a state fair hearing is between March 1, 2020 and the end of the COVID-19 emergency, you may have 120 more days to ask for a hearing. This letter does not change anything else about your right to request a hearing.*

**Note**: The letters will be managed by the central print vendor for any correspondence sent through KEES and will not be imaged to the case. Staff printing a form or NOA locally will need to print out a copy of the letter, attached to this directive, to include with the outgoing correspondence.

These mailings will continue through the end of the Federally declared PHE.

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

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Kansas
Department of Health and Environment
*Division of Health Care Finance*

| Policy Memo | |
|---|---|
| **KDHE-DHCF POLICY NO: 2019-12-01** | **From: Erin Kelley, Senior Manager** |
| **Date: December 9, 2019** | **Medical KEESM/KFMAM Reference(s): 5200 (5), 5200 (14), 5430 (26), 6410 (71), 8142 (3), 8172.4, 8243 (4), 8270.4** |
| **RE: Voluntary Contribution for Long Term Care and Resource Liquidation to Purchase Funeral Plan** | **Program(s): Elderly and Disabled Medical Programs** |

This memo sets forth instructions for policy changes being implemented in January 2020. Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after January 1, 2020. 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.

# I. VOLUNTARY CONTRIBUTION FOR LONG TERM CARE

## A. BACKGROUND

When a consumer applies for Long Term Care medical assistance and owns resources in excess of the program standards, or, when it is discovered that an ongoing recipient now owns excess resources, there are very few options available to the consumer to pursue resource eligibility without losing their application filing date or their current coverage.

### *1. EXCESS RESOURCES IN MONTH OF APPLICATION*

It is not uncommon for an applicant for nursing home coverage to have excess resources in the month of application. When the amount of the excess resources is not enough to fully private pay for that month, the applicant is left in a difficult situation. If denied for assistance due to excess resources, he/she does not have enough funds available to private pay the facility. If the excess resources are used to pay towards the cost of care in the facility to achieve resource eligibility, coverage may be approved for that month.

However, if the agency approves coverage for that month and determines the patient liability, if the patient liability is less than what the applicant has already paid towards the cost of care, the facility will refund the difference back to the applicant. This could cause the applicant to again possess resource in excess of the allowable limit. One solution is to simply deny coverage for this month and use the unpaid portion of the nursing home cost of care as a due and owing expense to be applied beginning with the first month of coverage. But, that solution denies Medicaid coverage for the month the applicant is otherwise entitled to receive.

### *2. Excess Resource at Review*

It is also not uncommon to discover at review (or earlier) that a long term care recipient is over the allowable resource limit. This could have occurred for several reasons, but most likely from the acquisition of resources after approval or from accumulation of monies from an exempt income source not considered in the share of cost determination.

#### a. After Acquired

A recipient may have acquired additional resources after eligibility for long term care coverage has been approved. Unless promptly reported by the recipient, this may not have been discovered until the annual case review. The additional resources may have originated from an inheritance, lottery winnings, or are the proceeds from the sale of an otherwise exempt resource. Whatever the source, eligibility may not be reestablished until countable resources are again within the allowable limit. If the recipient is unable to expend the excess resources on exempt goods or services by the end of the month after the end of the review period, a gap in coverage for medical assistance may occur.

#### b. Exempt Income

When the recipient has income that is exempted in determining the long term care share of cost, there is the potential that accumulated income, if unspent, may over time cause the countable resources to exceed the allowable limit. This is not un-common for a nursing home recipient who receives the $90/month reduced VA payment. That income does not count in determining the monthly patient liability, and if unspent, may over time cause countable resources to exceed the allowable resource limit.

## B. Policy

Effective with the issuance of this memo, applicants for nursing home coverage and long term care recipients may voluntarily contribute excess resources or ongoing exempt income towards a long term care cost of care in order to achieve and/or maintain resources within the allowable limit. This formalizes a policy that eligibility staff have previously been informally following.

## 1. *When to Apply the Voluntary Contribution Policy*

This policy only applies to long term care applicants and recipients who have a share of cost obligation. The Voluntary Contribution is applied to increase the calculated share of cost by the amount of the excess resources or ongoing exempt income. This policy cannot be used by independent living applicants or recipients to increase a spenddown or to inflate the amount of a premium.

### a. Applicants

For applicants, this policy only applies to those requesting services for institutional care coverage (including institutional PACE) – it does not apply to applicants for HCBS or community PACE. In addition, only excess resources may be applied toward the share of cost as a Voluntary Contribution to achieve initial resource eligibility. Ongoing exempt income may not be applied as a Voluntary Contribution for applicants.

### b. Recipients

This policy applies to all long term care recipients – those receiving institutional care, HCBS or PACE. In addition, both excess resources and ongoing exempt income may be applied toward the share of cost as a Voluntary Contribution to retain resource eligibility.

## 2. *Application of Voluntary Contribution*

The Voluntary Contribution policy shall be applied in the following manner:

### a. Excess Resources

When an applicant for institutional coverage has resources in excess of the allowable limit in the month of application, the excess amount may be applied towards the patient liability for that month. A long term care recipient with excess resources may increase the share of cost obligation in the next available month, allowing for timely notice of the increase.

#### *i. Calculation*

The amount of the Voluntary Contribution shall be no less than the amount of the excess resources needed to make the applicant/recipient resource eligible. Therefore, the amount in excess of $2,000 is the *minimum* Voluntary Contribution. A lessor amount will not ultimately result in resource eligibility. A greater amount may be applied (within limitation described below), subject to the amount agreed upon by the applicant/recipient. See subsection (3)(a) below.

### *ii. Application*

Once the amount of the Voluntary Contribution has been established, the share of cost obligation and countable resources shall be adjusted as follows:

#### *1) Share of Cost*

The normal share of cost for the month of application for applicants, or next available month for recipients, shall be increased by the amount of the Voluntary Contribution. The amount of the Voluntary Contribution shall be entered in KEES as countable income for that month only – resulting in an increase in the patient liability by that amount. The Voluntary Contribution income record shall be end-dated no later than the month it is applied for purposes of this subsection.

Since the Voluntary Contribution is only entered into KEES administratively as income, care should be taken to ensure that this entry does not adversely affect MSP eligibility. That additional income, intended for purposes of increasing the share of cost only, should not be counted in determining MSP eligibility or towards the 300% special income limit. To accomplish that, the following action shall be taken depending on the type of long term care coverage involved:

***a) Institutional*** – For institutional coverage (including institutional PACE), the Voluntary Contribution shall be entered in KEES with an income type of "Other – Exempt". The income will then be included in the patient liability determination but excluded when determining MSP eligibility and the 300% special income limit.

This appears to be counterintuitive, but due to the post-eligibility treatment of income, all otherwise exempt income (other than that listed in Medical KEESM 8150) will be counted in determining the patient liability for an institutionalized individual. At the same time, that income will then be exempted and therefore not counted in the MSP and 300% determinations.

***b) HCBS and PACE*** – For HCBS and community PACE, the Voluntary Contribution shall be entered in KEES with an income type of "Other – Countable". The income will be correctly included in the determination of client obligation or participant obligation, but also incorrectly included in determining MSP eligibility and the 300% special income limit.

If the additional income does not adversely affect the MSP or 300% determination, then no further action is required. If the recipient is already on Medicare buy-in and the amount of the

Voluntary Contribution causes the recipient to go from LMB eligible to not LMB eligible, no further action is required since payment of the Medicare Part B premium will continue.

However, if the amount of the Voluntary Contribution causes the recipient to lose QMB coverage (regardless of whether the individual is already on buy-in), or the additional income causes total income to exceed the 300% special income limit, eligibility staff shall contact KDHE-DHCF Eligibility Policy for further guidance on how to proceed.

### *2) Countable Resources*

Countable resources shall be reduced by the amount of the Voluntary Contribution. This reduction is effective the month of application for applicants and the month the Voluntary Contribution is applied for recipients. This shall be accomplished administratively by subtracting the amount of the Voluntary Contribution from a liquid resource, such as a checking or savings account.

If the applicant/recipient has no (or not enough) liquid resources to count towards the Voluntary Contribution needed to reduce assets below the allowable resource limit, then this process is not an option. If most or all of the applicant/recipient's countable resources are non-liquid, such as life insurance, real estate, or vehicles, those assets may have to be sold (or borrowed against) to create a cash asset which could then be used to fund a Voluntary Contribution.

**Note**: If reducing the liquid resource in this manner does not result in resource eligibility, then either the amount of the Voluntary Contribution was not enough, or the resource was reduced by an incorrect amount. Eligibility staff shall confirm that the amounts are correct.

## b. INCOME

When a long term care recipient accumulates excess resources over time due to the ongoing receipt of exempt income which is not counted in determining the share of cost, he/she has the option of voluntarily applying some or all of that income towards the monthly share of cost. The share of cost would be increased in the next available month, allowing for timely notice of the increase.

**Note**: If accumulation of exempt income results in excess resources, those excess resources will also have to be spent down in some manner – either as a separate Voluntary Contribution or towards exempt goods or services for the benefit of the recipient.

### *i. Calculation*

The amount of the Voluntary Contribution is entirely up to the recipient. In most instances, it will be prudent to apply the entire amount of the exempt income towards the share of cost. In other instances, a lessor amount may be sufficient to prevent resource ineligibility over time. However, the amount of the Voluntary Contribution is ultimately up to the recipient. See subsection (3)(a) below.

### *ii. Application*

Once the amount of the Voluntary Contribution has been established, the share of cost obligation and otherwise exempt income shall be adjusted as follows.

#### *1) Share of Cost*

The normal share of cost for the next available month (allowing for timely notice) shall be increased by the amount of the Voluntary Contribution. The amount of the Voluntary Contribution shall be entered in KEES as indicated in subsection (a)(ii)(1)(a) and (b) above for that month and each month thereafter. This should correctly increase the share of cost by that amount.

As noted above, care should be taken to ensure that entry of this administrative income does not adversely affect MSP eligibility or count against the 300% special income limit. To accomplish this, eligibility staff shall follow the same procedure outlined in subsection (a)(ii)(1) above. Again, contact with KDHE-DHCF Eligibility Policy may be required.

#### *2) Income Record*

Even though all or part of an existing exempt income source is now being voluntarily counted in determining the long term care share of cost by adding a new income record, the exempt income record in KEES shall not be adjusted. That record shall remain in place. This will allow the agency to identify and track the income if necessary. This will also allow the pre-populated review form to accurately reflect that income.

**Note**: The Voluntary Contribution process shall not be used where the excess resources are attributed to a recipient who has failed to pay the monthly share of cost obligation. In those instances, the recipient should be instructed to make payment for all delinquent months. That should reduce countable resources below the allowable resource limit, unless other factors are involved. If the recipient refuses or fails to comply, discontinuance due to excess resources is appropriate.

## *3. ADDITIONAL REQUIREMENTS*

The following additional requirements shall be met before approving a Voluntary Contribution.

### a. AGREEMENT

The applicant or recipient must agree to the Voluntary Contribution either verbally or in writing before the agency may take action to increase the long term care share of cost. If the agreement is verbal, eligibility staff must thoroughly journal that agreement. To expedite the process, eligibility staff shall attempt to contact the applicant or recipient by phone to obtain a verbal agreement to make a Voluntary Contribution of either excess resources or otherwise exempt income. For the verbal agreement to be valid, the individual must be very clear what they are agreeing to, including the amount of the Voluntary Contribution, the effective month, and the source (resources, income, or both).

In addition, it must be stressed that this action is purely optional and not mandated by the agency. As indicated above, the contact with the applicant or recipient and the terms of the agreement must be thoroughly journaled to document the agency decision to apply the Voluntary Contribution.

If eligibility staff are unable to contact the applicant or recipient by phone to establish a Voluntary Contribution agreement, eligibility shall be processed applying the normal resource counting rules. Eligibility staff have no further obligation to make contact with the individual other than by phone.

### b. OTHERWISE ELIGIBLE

The applicant or recipient must otherwise be eligible for long term care coverage. If there is ineligibility for a reason other than excess resources, there is no need to pursue a Voluntary Contribution agreement since solely reducing resources will not result in eligibility. Likewise, if the applicant or recipient is not applying for or receiving long term care coverage, there is no appropriate share of cost under this policy to adjust.

### c. COST OF CARE

When adding the Voluntary Contribution to the normal share of cost, the new increased share of cost cannot exceed the cost of care for the long term care services. If the increased share of cost exceeds the cost of care amount then this is not an option since there is no eligibility for long term care coverage. reduced, or excess resources must be disposed of in another manner [See subsection (d) below].

**Note**: If the amount of the excess resources is greater than that which can be applied in a single month to reduce resources within the allowable limit, this Voluntary Contribution policy cannot be used. The applicant/recipient will have to reduce resources in another method. See subsection (d) below.

## d. OTHER OPTIONS

While a Voluntary Contribution agreement is an option available to an applicant or recipient, in most instances, it should be offered only after consideration of all other options to reduce resources, including the following:

### *i. Purchase Funeral Plan*

Applicants or recipients with excess liquid resources may purchase an exempt burial plan to reduce resources. See Medical KEESM 5430 (3) (burial spaces) and (10) (funeral agreements). In the alternative, if the individual does not already have monies set aside for burial and the amount of excess resources is relatively small, he/she may designate up to $1,500 in a separate and identifiable account for burial. See Medical KEESM 5430 (2) (burial funds).

### *ii. Pay Due and Owing Expenses*

A Voluntary Contribution should generally not be used when the applicant or recipient has due and owing medical expenses. The individual shall always be encouraged to meet his/her own medical needs to the fullest extent possible. Using excess resources to pay outstanding medical bills is always preferable to a Voluntary Contribution.

### *iii. Pre-Pay Estate Recovery*

A recipient (but not an applicant) may choose to make a pre-payment against the future Estate Recovery claim. If this option is chosen, verification of the payment, including the amount, is required. The recipient should be referred to Estate Recovery at **1-800-817- 8617** or e-mail at KSestaterecovery@hms.com. Estate Recovery will assess the amount of the proposed payment against the current size of the recovery claim to determine if this is an acceptable option. Estate Recovery cannot accept a payment that exceeds the current amount of the claim. The amount of the claim will be reduced by the amount of any pre-payment accepted by Estate Recovery.

See Medical KEESM 1725.7 and PM2019-06-02 (Section III.D.).

**Note**: The option to reduce resources by pre-paying Estate Recovery may also be used by non-long term care recipients who received services on or after age 55 since those claims are also subject to recovery. This would include an individual eligible under Medically Needy (MDN), but not a recipient of QMB, LMB, or QWD only as those programs are not subject to Estate Recovery.

### *iv. Spend Down Assets*

An applicant or recipient may choose to reduce countable resources by paying outstanding bills, purchasing items for personal use (i.e. clothing, television, books, etc.) or any other asset that will not count against the

resource limit. There are few, if any, parameters on what may be purchased in this manner other than adequate consideration must be received for all purchases. Gifting of assets to reduce resources may be considered an uncompensated transfer affecting eligibility for long term care programs. See Medical KEESM 5720 and subsections.

**Note**: Pre-paying for care in a nursing facility to reduce resources is not an option since any amount on account held in the facility for the resident is considered an available resource and therefore will not reduce his/her countable assets. That includes creating a separate pre-paid account at the facility that will pay for the difference between a shared room and a private one.

#### *v. Discontinue Eligibility*

In general, the use of the Voluntary contribution option is only available where the amount of excess resources is relatively small. There may be instances where a recipient receives a large lump sum cash asset, such as an inheritance, or proceeds from the sale of an otherwise exempt resource (i.e. home, income producing property) or substantial winnings from a lottery ticket. In that situation, there may be no reasonable option other than to close the case due to excess resources. The former recipient would then private pay for services with the option of reapplying for assistance once resources have been spent down and are again within the allowable limit.

## *4. NOTICES*

The following notice fragments have been created for use when the share of cost has been increased due to a Voluntary Contribution and when the share of cost has been decreased due to the removal of a Voluntary Contribution. These fragments are available on the KDHE Standard Text for Copy and Paste on the E&D Specific tab.

### a. APPLICATION OF VOLUNTARY CONTRIBUTION

The following notice fragments may be used when a Voluntary Contribution has been applied to increase the share of cost.

#### *i. Excess Resources*

This notice fragment may be used where a Voluntary Contribution of excess resources are applied to increase the share of cost in a single month.

"*The normal amount of your share of cost has been increased because you agreed to a Voluntary Contribution in the amount of ${insert amount} to reduce your resources under the allowable limit. Your share of cost, including the amount of your Voluntary Contribution, is ${insert amount} effective {insert month and year}.*

*This is in accordance with Medical KEESM 5200 (14), 5430 (26), 6410*

*(72), 8142 (3), 8172.4, 8243 (4), 8270.4."*

#### *ii. Exempt Income*

This notice fragment may be used where a Voluntary Contribution of exempt income is applied to increase the share of cost on an on-going monthly basis.

"*The normal amount of your share of cost has been increased because you agreed to a Voluntary Contribution in the amount of ${insert amount} from your exempt income to keep your resources under the allowable limit. We will continue to count this additional amount on your share of cost each month until you tell us to stop.*

*Your share of cost, including the amount of your Voluntary Contribution, is ${insert amount} effective {insert month and year}.*

*This is in accordance with Medical KEESM 6410 (72), 8142 (3), 8172.4, 8243 (4), 8270.4."*

### b. REMOVAL OF VOLUNTARY CONTRIBUTION

The following notice fragment may be used when the Voluntary Contribution from either excess resources or ongoing exempt income has been removed to decrease the share of cost.

"*Your share of cost has been changed to ${insert share of cost} effective {insert month and year} because your Voluntary Contribution in the amount of ${insert amount} to reduce resources is no longer counted.*

*This is in accordance with Medical KEESM 5200 (14), 5430 (26), 6410 (72), 8142 (3), 8172.4, 8243 (4), 8270.4."*

## II. RESOURCE LIQUIDATION TO PURCHASE FUNERAL PLAN

### A. BACKGROUND

Normally an applicant is ineligible for medical assistance in any month until countable resources are at or below the allowable limit. However, an exception was developed to allow retroactive coverage for an applicant who was in the process of liquidating an otherwise resource-disqualifying asset in order to purchase an exempt burial fund or plan. This exception was documented in Medical KEESM 5200(5)(b).

The process is complex and difficult to administer, and in most instances, requires the application to pend beyond the 45-day timely processing threshold. To qualify under this special provision, the applicant must initiate the liquidation process within 15 days from the date of the application and complete the process within 90 days. Eligibility staff are then required to pend the application until whichever occurs first – the resource is liquidated, and a burial plan or fund is purchased, or the 90th day.

## B. POLICY

Effective with the issuance of this memo, this policy has been eliminated. The regular verification and resource counting rules apply to situations where a liquid resource is being accessed to fund a burial fund or plan. The liquid resource is a countable resource up until the month accessed and converted to an exempt resource – including a burial fund or plan. This means the application will no longer pend while the applicant pursues this process.

Even with this change in policy, the following provisions remain unchanged.

### *1. REDUCING COUNTABLE RESOURCES*

The agency, as a policy, shall continue to encourage applicants and recipients to reduce excess resource by providing for their own final needs in the form of funeral or burial plans. However, should the applicant choose this option of reducing countable resources, the application shall no longer pend throughout the conversion process. Assuming there are no other outstanding issues, this shall allow the application to be processed in a timely manner.

#### a. ADDITIONAL TIME

An applicant may request, and the agency may grant, additional time to provide information requested by the agency. However, the agency shall be under no obligation to grant additional time exclusively for an applicant to verify that he/she is liquidating or will be liquidating an otherwise resource-disqualifying asset with the funds to be used for some other purpose – including purchasing an exempt burial fund or plan.

#### b. REACTIVATION

A denied application or discontinued coverage due to excess resources may be reactivated in the following circumstances.

##### *i. Application*

If the application is denied due to excess resources, the applicant may reactivate the original application by providing verification that the excess resource has been liquidated and was used to purchase an exempt burial fund or plan. The verification must be provided within 45 days from the date of application in order to reactivate the application. Otherwise, a new application is required. See Medical KEESM 1414.2(1)(b).

##### *ii. Discontinuance*

If eligibility has been discontinued due to excess resources, coverage may be reinstated if verification that resources are within the allowable limit is provided by the end of the month after the month of discontinuance. This could include verifying that countable resources have been liquidated to purchase an exempt burial fund or plan. If verification is not provided by the end of the month after the month of discontinuance, a new application

is required. See Medical KEESM 1423.

### 2. *TRANSITION*

Any current application that is pending due to the previous policy at the time the new policy was implemented shall continue to pend and be processed based on the old policy. To qualify, the process to liquidate the disqualifying resource must have been initiated within 15 days of the date of application (or report of excess resources by a recipient) with the process to purchase and verify the exempt funeral fund or plan completed within 90 days. Otherwise, this special policy does not apply.

Any new request received after issuance of this memo to pend an application based on liquidation of resources under the old policy shall be denied.

## III. 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

Kansas
Department of Health and Environment
*Division of Health Care Finance*

| **Policy Memo** | |
|---|---|
| **KDHE-DHCF POLICY NO: 2020-04-01** | **From: Erin Kelley, Senior Manager** |
| **Date: April 17, 2020** | **Medical KEESM/KFMAM Reference(s):** |
| **RE: Policy Implementation Instructions and Information for COVID-19 National Public Health Emergency** | **Program(s): All Medical Programs** |

This memo sets forth instructions for implementation of policy changes related to the COVID-19 National Public Health Emergency and processing guidelines for the duration of this emergency concerning applications and new coverage requests, situations where an applicant/recipient fails to provide requested information, and the receipt of Federal Emergency Relief funds. For purposes of this directive, the COVID-19 National Public Health Emergency is defined as the events transpiring beginning March 1st, 2020, the beginning of the national emergency proclaimed by President Trump on March 13th, 2020.

Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after March 18th, 2020.

For situations not covered in this memo, KDHE Policy should be consulted.

Applicable to all Medical Programs:

- Failure to Provide
- COVID-19 Federal Stimulus Funds
- Journal Requirements

Applicable to Family Medical Programs only:

- Partial Approvals When Prior Medical Income Verification is Needed
- Employer Statements

Applicable to Non-MAGI Programs only:

- Verification of Resources
- Verification of Income/End of Income
- AVS for Applications and New Coverage Requests
- Long Term Care – CARE Scores
- Expenses

- Medicare Buy-In
- Transfer of Property

# I. Changes Impacting All Medical Programs

## A. Failure to Provide

When an applicant/recipient fails to timely provide requested information and the application is denied or coverage is discontinued, that action may be rescinded if the applicant/recipient later contacts the agency to report the failure was due to circumstances associated to the outbreak of COVID-19. The explanation must be plausible, and directly related to the outbreak of COVID-19 to qualify under this directive. Each situation shall be examined on a case-by-case basis following the direction provided in the PD2019-06-01 Failure to Provide – Natural Disaster Policy Directive.

This would include 14-day quarantines, access to authorized representatives or businesses, transportation, and other plausible impacts the consumer may report.

**Note**: This policy directive is reactive, not proactive in nature. The applicant/recipient must contact the agency citing the outbreak of COVID-19 as the reason the requested information was not timely provided. The extension request must still come from the applicant/recipient or authorized representative.

## B. COVID-19 Federal Stimulus Funds

The Phase III, H.R. 758 (116) or CARES Act Mar. 25, 2020, also known as the stimulus bill, provides most adults with a one-time payment of $1,200 ($2,400 for couples filing jointly). Each child aged 16 and under would get an additional $500. These payments will start distribution in April 2020. For purposes of this implementation, these payments are exempt as income in the month received and exempt as a resource through the consumers review period, not to exceed twelve (12) months. Additionally, there may be additional funds (ex: increased unemployment funds) that may also be exempt under this policy.

> Example: Consumer receives $200 per week in regular unemployment income, however, because the cause of unemployment was because of the COVID-19 emergency, the consumer receives an additional $600 in unemployment income.
>
> The standard unemployment income of $200 is countable unearned income. The $600 additional unemployment income for COVID-19 is exempt.

## C. Journaling Requirements

For all case actions taken in accordance with this policy memo, staff shall include the appropriate language from the Standard Copy and Paste (SCP) in the case journal.

# II. Changes Impacting Family Medical Programs Only

## A. Partial Approvals when Prior Medical Income Verification is needed

Current policy states that when prior medical coverage is requested, and there was a change in household or income during the prior medical months that would fundamentally alter the expected income to be received, and the Prior Medical simplification found in KFMAM 6132.01 using KDOL wages cannot be used to approve Prior Medical coverage, proof of actual income for those months must be requested from the consumer. For the duration of the COVID-19 Public Health Emergency, cases requiring actual income for prior medical months that can be approved in the month of application should be authorized beginning that month and the case placed on hold for the prior medical income.

## B. Employer Statements

Current policy states that when there is an income change reported that will result in either a decrease or elimination of premium or a change in program from TransMed (TMD) or Extended Medical (EXT) to Caretaker Medical (CTM), a statement from the employer must be provided as verification of the change. For the duration of the COVID-19 Public Health Emergency, this requirement will be waived, and we will consider the income change verified through the consumer's self-attestation.

# III. Changes Impacting Non-MAGI Programs Only

## A. Verification of Resources

### *1.* Tiered Verification

Eligibility staff shall continue to follow the Tiered Verification policy when requesting proof of income and resources to determine eligibility. During the scope of the COVID-19 Public Health Emergency, the verification policy has been modified to include AVS requests being completed following the direction in section III(4)(B) of this memo and client attestation acceptance prior to denying a request for failure to provide if a consumer or their authorized representative advises the agency of their difficulty in obtaining verifications specifically because of the COVID-19 Public Health Emergency. This request must be made prior to the last day of the verification due date or before the maximum 20-day extension date expires.

- Tier 1 – Confirmed/Payer Source
- Tier 2 – Interface/Reasonable Compatibility
- Tier 3 – Research (including collateral contact)
- Tier 4 – Contact the consumer

### *2.* Collateral Contacts

Staff shall make every concerted effort to obtain verification of resources by collateral contact prior to requesting information from the consumer. When a consumer is unable to provide verification and this request has been communicated to the agency, it is appropriate for the agency to provide additional information or other options for obtaining the necessary information as an initial step as KEESM 1321.2 indicates the agency shall offer assistance to the household in obtaining documentary evidence when it is difficult or next to impossible for the household to obtain it.

**Note**: The obligation of the agency to assist does not release the consumer of their responsibility to report/provide information.

### *3.* CLIENT ATTESTATION

Once all options have been exhausted, and proof of liquid resources (bank accounts, CD's, Stocks, etc.) have not been received or verified via AVS, staff shall use information attested on the application if available or contact the consumer or authorized representative by phone to verify, or obtain, client attestation of the missing resources.

All assets verified by client attestation shall be considered *Verified* and will be accepted throughout the program's current review period. All verification decisions to approve or deny an extension request to provide requested information must be journaled thoroughly using the approved COVID- 19 journal noted in section I(C) of this memo.

### *4.* TRUSTS, ANNUITIES, AND PROMISSORY NOTES

Consumer's that report ownership of Trusts, Annuities, and/or Promissory Notes must continue to provide physical verification of these resources. Therefore, these resources shall follow established policy, and are not included in the verification process for COVID-19. Trust and Annuity clearance process established in Policy Directive 2020-01-01 Separation of Trust/Annuity Clearance Request Form (B-6) shall continue to be completed prior to case approvals.

Failure to provide verification of these specific resources shall result in a denial for failure to provide.

## B. AVS REQUESTS FOR APPLICATIONS AND NEW COVERAGE REQUESTS

During the scope of this emergency, either the AVS response or verification voluntarily provided by the applicant at the time of application or request for assistance shall be used to verify all bank account related resources without exception. Accounts verified by AVS will use the amount found on the AVS results as the verified amount unless that amount is in excess of the applicable resource limit. Known income shall not be subtracted from the verified AVS amount. This process shall be used for application and new coverage requests during the scope of the COVID-19 National Public Health Emergency.

### *1.* AVS REQUEST AND VERIFICATION REQUESTS

The AVS request shall be sent during the initial application or coverage request process. This request may be completed prior to the worker initially reviewing the application or new coverage request. To avoid any unnecessary delays in processing there may be situations where a dual AVS and formal applicant request for verification may be completed.

a) If the AVS request is not completed prior to the eligibility worker reviewing the application or new coverage request, an AVS request shall be requested at the time a V044 verification notice is sent.

b) If the AVS request was completed prior to the eligibility worker reviewing the application or new coverage request but the AVS response is not received, eligibility staff shall proceed with tiered verification of the accounts from the consumer per section III(3)(A) of this policy.

c) If the AVS response is received and imaged to the case file prior to the eligibility worker reviewing the application/new coverage request and the accounts are verified by AVS along with other known or reported resource amounts:

1. **Does not** make the consumer resource ineligible, the verified account does not require further verification from the consumer.

2. **Does** make the consumer resource ineligible, continue with the tiered verification of the accounts per section III(3)(A) to verify the true account value.

   **Note:** There may be situations where excess resources in these accounts are caused from the Federal COVID-19 Stimulus package. Remember, these funds are exempt per this policy, therefore, verification of the cause of excess resources must also follow the tiered verification steps noted in this policy.

### *2. AVS RESPONSE VERSUS ACCOUNT VERIFICATION*

There may be instances where both the AVS and the applicant provide valid verification of the bank account(s). It is prudent as a general rule, to use the applicant verification provided over the AVS response because in most cases, that amount will be lower. However, if the AVS response verifies a lower account balance than the verification provided by the applicant, the AVS verification shall be used.

Assets that are not verified by AVS or if no AVS results are received prior to the last day of the verification due date or before the maximum 20-day extension date expires, staff shall attempt to verify the accounts following the instructions in section III(A) (2 – 3) of this memo.

## C. VERIFICATION OF INCOME/END OF INCOME

### *1.* EARNED AND UNEARNED INCOME

Eligibility staff shall continue to follow the Tiered Verification policy when requesting proof of income to determine eligibility. During the scope of the COVID-19 Public Health Emergency, accepting client attestation once the tiered verification process has been exhausted shall be accepted for both earned and unearned income and proof of end of income. The process noted in section III(A) 1-3 above shall be the same with the exception of AVS for verification of income/end of income.

### *2.* SECA VERIFICATION FOR WORKING HEALTHY

For the self-employed, Social Security and Medicare tax is paid through the Self-Employment Contributions Act (SECA) rather than FICA. Proof of this SECA payment is a requirement for the Working Healthy program, therefore, there will be no change to the requirement that verification be provided of these payments prior to authorizing Working Healthy coverage.

Client attestation shall not be accepted for this verification. Failure to provide proof of the SECA verification per Medical KEESM 2664.3 shall result in ineligibility for the Working Healthy program and coverage under a different Medicaid program shall be considered.

## D. Long Term Care – CARE Requests

### *1.* CARE Requirements Waived for 30 days

a.) In accordance with the state's 1135 Waiver, Pre-Admission Screening and Annual Resident Review (PASRR) or CARE Level I and Level II assessments are waived for 30 days. All new admissions can be treated like exempted hospital discharges and if otherwise eligible may be coded temporarily based on the Level of Care indicated on the 2126.

b) After 30 days, new admissions with mental illness (MI) or intellectual disability (ID) should receive a Resident Review as soon as resources become available. There is not a set timeframe for when a Resident Review must be completed, but it should be conducted as resources become available.

1. LTC/NF and LTC/MH admissions, if otherwise eligible, may be approved without the ES-3164 on file as these are treated as exempt hospital stays. Once this time frame has passed and resources become available to complete the Level 1 and Level II assessments, KDADS will complete the ES-3164. LTC coding on the case shall then be completed according to sections A-F of the ES-3164 to either continue or discontinue coverage.

    i. If the ES-3164 shows that the consumer is not authorized on a Level 1 or Level 2 CARE, coverage already authorized shall not be retroactively terminated. Instead any level of care coverage already authorized shall cease effective the date the ES-3164 is completed by KDADS. The consumer's Title XIX shall continue following the Delayed CARE Score policy and process.

## E. Verification and Application of Expenses

For E&D and LTC programs, verified medical expenses can reduce the share of cost and spenddown amounts and the verification and application of expenses shall follow current, established policy. Failure to provide proof of an expense will not affect eligibility; however, the expense will not be used to lower the share of cost or spenddown until physical verification is received by the agency.

## F. Medicare Buy-In

Medicare Buy-In policy per Medical KEESM 2911 shall continue to be applied. PD2020-03-01 COVID-19 Delayed Discontinued Policy Directive states that discontinuances shall not be acted on with the exception of consumers who have moved out of state, become incarcerated, voluntary withdraw from coverage, or are deceased. Another exception to acceptable discontinuances of coverage is when a consumer loses their Medicare Eligibility as reported to the agency by Social Security. If the agency is advised that a consumer's Medicare coverage is terminated by Social Security and the consumer is currently receiving Medicare Savings Program (MSP) Only in Kansas, it is appropriate to discontinue the consumer's MSP coverage.

1) The consumer should then have coverage established on the Medically Needy program with a 6-month base period. This is because the MSP program's purpose is to cover Medicare costs and MSP is not required if there is no Medicare eligibility.

Any case that was active on Buy-In effective March 18th, 2020 shall remain active on Buy-In throughout the scope of this emergency. Cases in the Buy-In Deletion process as identified by the agency shall

have their same coverage reinstated and authorized per PD2020-03-01 COVID-19 Delayed Discontinued Policy Directive unless discontinuance is appropriate because of state residency, become incarcerated, voluntary withdraw from coverage, are deceased, or have had their Medicare Enrollment ended by Social Security.

### G. Transfer of Property

During the scope of the emergency, there shall be no change in the effective date of applying a transfer of property for both applicants and recipients. The effective dates shall continue to be applied per Medical KEESM 5724.5.

However, for active recipients that have a transfer of property applied effective March 2020 throughout the scope of this emergency, coverage shall not be discontinued, and level of care shall continue. The effective date will still be applied as appropriate; however, the penalty will not affect coverage until the month after the month the National Public Health Emergency is declared to end. Coverage continued under this provision is not considered overstated eligibility. This action is taken in accordance with PD2020-03-01, COVID-19 Delayed Discontinued Policy Directive.

**Example:** Consumer is actively receiving LTC/NF coverage. Verification that the consumer's home was gifted to a relative is received and processed by the agency on 3/19/20. The transfer amount is $75,000. As the consumer is an active recipient, per Medical KEESM 5724.5, the start date of this transfer is 5/1/2020 and will end 4/19/2021. As the consumer was actively receiving coverage at the start of this emergency, LTC/NF coverage is left active until the emergency is declared over.

On 5/20/2020, the emergency is declared over. Therefore, the worker re-enters the case to apply the penalty. LTC/NF is discontinued effective 6/30/2020 allowing for timely and adequate notice. A spenddown is established with a 6-month base period beginning with the correct penalty start date of 5/1/2020. Although the spenddown start date is May 1st, 2020, the consumer will have July 1st, 2020 through 10/31/2020 to meet this spenddown because the LTC/NF coverage granted during the months of May 2020 and June 2020 cannot be taken away.

**Example:** Application is received requesting LTC/NF coverage and is processed on 4/3/2020. Verifications received confirm the applicant had a transfer of property. The consumer is verified as otherwise eligible for LTC/NF coverage 4/1/2020, however, as the applicant was not active on coverage at the start of the National Public Health Emergency, the transfer is applied and a Medically Needy Spenddown with a 6-month base period is established effective 4/1/2020.

## 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

Kansas
Department of Health and Environment
*Division of Health Care Finance*

| Policy Memo | |
|---|---|
| **KDHE-DHCF POLICY NO: 2020-06-01** | **From: Erin Kelley, Senior Manager** |
| **Date: June 26, 2020** | **Medical KEESM Reference: 5721.10** |
| **RE: Transfer of Property (TOP) Penalty Cure** | **Program(s): Long Term Care Medical Assistance Programs** |

This memo sets forth instructions for policy changes being implemented in June 2020 regarding changes to the transfer of property (TOP) penalty cure policy. Unless otherwise indicated, this policy shall be effective with the issuance of this memo. Revisions to the Medical KEESM manual will be made with in July 2020 revision. Additional information related to the implementation of these changes is available through training material released to eligibility staff.

# I. Background

A transfer of property (TOP) penalty imposed due to an uncompensated transfer may be cured (in whole or in part) when the property is returned to the individual who transferred the property. The timing and value of the returned property determine how the transfer penalty is modified.

## A. Current Policy

The following explains the current policy and the difference between a full and a partial cure.

### *1. Full Cure – TOP Voided*

A full cure of the TOP occurs where all property (or the fair market equivalent value) has been returned to the individual who transferred the property. In that instance, the TOP penalty is voided. The returned property is considered available continuously back to the date of the original transfer through the month the property was returned. Eligibility for long term care coverage may be redetermined based on the value and/or exempt/countable status of the returned property.

### *2. PARTIAL CURE – TOP MODIFIED*

A partial cure of the TOP occurs where some, but not all, of the property (or the fair market equivalent value) has been returned to the individual who transferred the property. In that instance, the TOP penalty is not voided, but instead modified. The returned property is again considered available continuously back to the date of the original transfer through the month the property was returned.

A new modified TOP penalty is not applied unless and until the individual is otherwise eligible (including resource eligible) for long term care coverage. Assuming the returned property is resource-disqualifying, this means that the modified penalty will not be imposed (if at all) until the countable resources are less than or equal to the $2,000 allowable resource limit. Therefore, unless the returned property is an exempt resource, or of such nominal value there is immediate resource eligibility, a modified penalty period will always commence on a date sometime after the start date of the original transfer penalty.

## B. UNINTENDED CONSEQUENCES

There is one exceptionally concerning unintended consequence of the current TOP cure policy. When the TOP is partially cured, and a modified TOP is applied because the individual is otherwise eligible for payment of long term care services, the new modified penalty period may very well extend beyond the original TOP penalty end date. To that affect, a partial return of property has actually extended the transfer penalty period rather than shortened it.

This occurs because the new modified transfer penalty cannot start until the individual is otherwise eligible for payment of long term care services. By counting the returned property as available back to the date of the original transfer through to the date returned (and thereafter if not immediately expended on exempt resources or services), in most instances there will be no resource eligibility until sometime after the original transfer penalty start date. By floating the penalty period forward in this manner, even a shorter modified penalty period may extend beyond the original transfer penalty period end date since it begins later than the original transfer penalty period start date.

The reason for counting the returned property as available back to the date of the original transfer is rather complex but in simple terms is intended to prevent the gifting and subsequent return of property as an effective mechanism to inappropriately shelter additional property from the Medicaid resource spend down process.

## C. ADDITIONAL GUIDANCE NEEDED

In addition to the unintended consequences mentioned above, guidance to eligibility staff concerning several issues in administering the current TOP penalty cure process has never been adequately provided. Those include the timing of the cure, whether a new application

is required, and how returned property is treated if it has increased or decreased in value. Those issues will be addressed in the new policy below.

## II. TRANSFER OF PROPERTY (TOP) PENALTY CURE

Effective with the issuance of this memo, the TOP penalty cure policy shall be as follows.

### A. NEW POLICY

A transfer of property that would otherwise be subject to a transfer of property penalty per Medical KEESM 5724 which has been returned to the individual or spouse prior to the filing of an application or request for long term care assistance shall not be considered an inappropriate transfer. The value of the returned property shall not be subject to a transfer of property penalty. In this instance, a TOP penalty cure is not required because no penalty has been applied. However, unless the transfer was specifically exempted, any transferred property that remains unreturned at the time of application or request shall be subject to a TOP penalty.

When transferred property (or the fair market equivalent) which is subject to a TOP penalty is returned, the established penalty shall be adjusted by either voiding the penalty entirely or modifying, but not eliminating, the penalty depending on the timing, status and extent of the property returned. In general, a full return of transferred property shall result in the penalty being voided. A partial return of transferred property may result in a modified penalty, but not in all instances.

### B. APPLICATION OF POLICY

The TOP penalty cure policy shall be applied in the following manner.

#### *1. FULL CURE*

When the property subject to a TOP penalty (or the fair market equivalent of that property) has been returned, the penalty shall be voided. However, the returned property shall be considered when determining eligibility, including back to the date of the original transfer. This means for eligibility purposes the returned property will be treated as if it had never been transferred and had been continuously owned by the applicant/recipient. This may or may not result in eligibility depending on the exempt or non-exempt status of the returned property.

#### *2. PARTIAL CURE*

When only some or a portion (but not all) of the property (or the fair market equivalent of that property) subject to a TOP penalty has been returned, the penalty shall be modified (but not eliminated) if the returned property is exempt as a resource. Again, the returned property shall be considered when determining eligibility, including back to the date of the original transfer as though the property had never been transferred.

However, if the returned property is an exempt resource, it should not impact resource eligibility.

#### a. Return of Exempted Property

As indicated above, the partial return of transferred property in the form of an exempt resource shall result in the modification of the established TOP penalty. If the returned property is both exempt and non-exempt in nature, the TOP penalty shall not be modified unless the value of the non-exempt property in combination with all other non-exempt property owned by the applicant/recipient is less than or equal to the $2,000 allowable resource limit.

#### b. Return of Non-Exempted Property

The partial return of transferred property in the form of a non-exempt resource shall not result in the modification of the established TOP penalty unless the value of the non-exempt property in combination with all other non-exempt property owned by the applicant/recipient is less than or equal to the $2,000 allowable resource limit. This means that in most instances, the established TOP penalty will not be modified when non-exempt property is returned.

### *3. Return of Property Defined*

The return of transferred property shall be defined as the direct transfer of property back to the applicant/recipient, any payment made which indirectly results in a gain or benefit to the applicant/recipient, and a modification or revision to a financial instrument which makes the instrument Medicaid compliant.

#### a. Direct Transfer

A direct transfer is where ownership is given to the applicant/recipient. That could include return of the actual property that was originally transferred, such as a vehicle, real estate, or a coin collection. Also included is anything of measurable value, even if not the actual property originally transferred, given back to and possessed by the applicant/recipient.

#### b. Indirect Transfer

An indirect transfer is where ownership of the property is not being returned directly to the applicant/recipient. Instead, a payment has been made on behalf of the applicant/recipient which results in a gain or benefit to the applicant/recipient. Even though the applicant/recipient exercised no ownership or control of the indirectly returned property, the value of the payment shall be considered a return of property. This would include payment of any expenses or debts of the applicant/recipient such as nursing home bills, home mortgage, credit card balance, or non-covered medical bills.

An indirect payment made on behalf of the applicant/recipient shall be considered returned property in the form of a cash asset. Multiple payments

made in this manner shall be totaled and treated as though returned back to the date of the original TOP penalty start date.

**c. MODIFICATION OF FINANCIAL INSTRUMENT**

There are instances where the language or structure of a financial instrument, such as an annuity or promissory note, make the instrument subject to a TOP penalty. See Medical KEESM 5722 (4) and (6) concerning actuarial soundness.

Should a TOP penalty be applied due to actuarial unsoundness, the penalty may be cured by modifying the financial instrument to make it actuarially sound. In that instance, there is no technical return of resource to the applicant/recipient, but the TOP penalty has been cured nonetheless. A proper modification making the financial instrument Medicaid compliant shall be considered a full cure (or return of property) for purposes of this policy.

## *4. VALUATION OF RETURNED PROPERTY*

To determine what extent, if any, the TOP penalty has been cured, the value of the returned property must be determined. The value of the returned property shall be determined as follows.

**a. CASH ASSET**

A cash asset is cash or other property that is readily convertible to cash, such as bank accounts, life insurance, stocks, or bonds. This also includes indirect payments made on behalf of the applicant/recipient as indicated in subsection (3)(b) immediately above. The value of a cash asset is the assigned or market value at the time returned to the applicant/recipient.

**b. NON-CASH ASSET**

A non-cash asset for purposes of this policy is property [other than cash assets as described in subsection (a) above] that has a subjective measure of value. That would include a vehicle, real estate, or any other property where the value is based on an appraisal. The value of a non-cash asset is the appraised value at the time returned to the applicant/recipient, with one exception.

If the same property that was originally transferred (such as a vehicle or real estate) is returned, the agency shall assume the full value of the property has been returned, even if the value at the time of return is different. The agency shall disregard any depreciation or appreciation in the value of the property that is due to normal wear-and-tear or market fluctuation. However, if there has been a substantial change in the property value due to an improvement (new structure added to real estate increasing the value) or wasting (existing structure demolished decreasing the value), the new verified value of the

property shall be used.

For example, if a new $25,000 vehicle was transferred and then returned five (5) months later, the agency would accept this as a full return of the transferred property, disregarding any devaluation due to normal use and age. However, if the vehicle was totaled in an accident before return, the diminished value of the property would be used to determine how much of the original $25,000 value had been returned since the change in value would not be attributed to normal use and age.

#### c. Annuity or Promissory Note

As indicated in subsection (3)(c) above, modification of an otherwise Medicaid non-compliant annuity or promissory note (due to actuarial unsoundness) to make the financial instrument compliant shall be deemed a full return of the transferred resource and therefore a total cure of the TOP penalty. As such, there is no need to determine the value of the returned resource.

For example, a promissory note that was deemed to be actuarially unsound because the terms of the note failed to fully pay back the transferred amount within the lender's life expectancy, the scheduled payments were unequal or provided for deferred or balloon payments, or there was no provision prohibiting cancellation of the note upon the death of the lender would be subject to a TOP penalty based on the value of the note. If the note language was modified to make it actuarially sound, the TOP penalty would be voided without the need to determine the value of the note at the time of the modification.

The same would be true for an annuity that is not considered actuarially sound and a TOP penalty has been applied. Modification of the annuity to be Medicaid compliant would void the penalty. There is no need to determine the value of the annuity as modified since a full return of property has been deemed to have occurred.

## C. Modifying the TOP Penalty

A properly established TOP penalty shall be modified in the following manner when a return of property occurs.

### *1. Full Cure*

Where the property, or the fair market equivalent of that property, subject to the TOP penalty has been returned, the penalty has been fully cured. The TOP penalty shall be voided as though never implemented. However, for eligibility purposes the returned property shall be considered continuously available to the applicant/recipient back to the date of the original transfer and for all months forward.

If the applicant/recipient is resource eligible (and otherwise eligible), eligibility may be determined for all months (if appropriate) beginning with the month of the original transfer. If the applicant/recipient is not resource eligible, there is no eligibility for any month beginning with the month of the original transfer through the month the property was returned. The returned property will continue to result in ineligibility until the value of all countable resources have been spent down to the allowable resource limit.

## *2. PARTIAL CURE*

Where the full value of the property subject to the TOP penalty has been only partially returned, the TOP penalty shall be modified, but not eliminated.

The returned property will be considered continuously available to the applicant/recipient back to the original TOP penalty start date. This means that unless the returned property is an exempt resource or a countable resource with a value (in conjunction with all other countable resources owned by the individual) less than or equal to the $2,000 allowable resource limit, the new modified penalty period cannot be imposed because the individual is not otherwise eligible for long term care coverage.

### a. NOT OTHERWISE ELIGIBLE

When the applicant/recipient is not otherwise eligible, the existing TOP penalty period remains in place. The return of property does not result in a modification of the transfer penalty. In addition, eligibility for any non-long term care coverage the individual currently receives may need to be discontinued prospectively due to excess resources. Timely notice of the discontinuance is required. However, any non-long term care coverage received from the date of the original transfer through the month of discontinuance is not considered to be overstated eligibility since that coverage has been properly received.

### b. OTHERWISE ELIGIBLE

When the applicant/recipient is otherwise eligible (including resource eligible) after the return of the transferred property, the transfer penalty shall be modified. The new modified penalty period shall begin on the date the original TOP penalty period began. The new modified TOP penalty period end date shall be based on the value of property that was transferred but not returned. Since the TOP penalty start date does not change, the same private pay penalty divisor used in the original penalty determination shall be used in calculating the new modified TOP penalty period. See Medical KEESM 5724.4.

If the applicant/recipient is not otherwise eligible back to the original TOP penalty period start date, but eligible in some month thereafter, then the new modified transfer penalty period policy does not apply. The not-otherwise-eligible policy described in subsection (a) above applies. The

applicant/recipient would not be entitled to a new modified TOP penalty period.

**Note:** Return of property does not change a properly determined community spouse resource allowance (CSRA). Even though returned property is considered to be continuously available back to the start date of the original penalty period, that provision shall not be used to retroactively adjust the CSRA. Only countable property actually owned at the time the long term care arrangement began shall be used for that determination. See Medical KEESM 8144.1 and 8244.1.

## D. Additional Factors

The following additional factors will determine how the modified TOP penalty is applied.

### *1. Date Property Returned*

In order to void or modify an established TOP penalty period, the return of property must occur prior to the end date of the penalty period. If the return of property occurs after the TOP penalty end date, there is no need to adjust the penalty because the entire penalty period has already been served. In that instance, receipt of the returned property will be considered a gift to the recipient for eligibility purposes rather than a return of property. See Medical KEESM 6410 (27) for the treatment of gift income.

### *2. New Application Required*

If the individual provides verification of a full or partial cure of the TOP penalty period after forty-five (45) days from the application date, a new application requesting long term care coverage is required. If verification of the return of resources is timely provided [within forty-five (45) days from the date of application], the cure (full or partial as appropriate) shall be completed and eligibility redetermined without a new application. See Medical KEESM 1414.2 (1)(b).

If a new application is required, eligibility for long term care coverage based on a full or partial TOP penalty cure may begin no earlier than the first day of the prior medical assistance period if prior medical is requested and the applicant is otherwise eligible. The agency shall not be required to act on information provided outside of the forty-five (45) day application window which verifies a purported TOP penalty cure unless a new application has been filed.

## E. Notices

The following notice fragments have been created for use when a TOP penalty period has been applied and property has been returned to potentially cure the penalty either in full or in part. These fragments may be found on the KEES Repository, KDHE Standard Text for Copy and Paste.

## 1. TOP Penalty Cured in Full – Voided

This notice may be used where an established TOP penalty period has been voided due to a full return of transferred property.

"*We removed your transfer of property penalty because the property was returned to you. We will tell you if you are eligible for long term care coverage.*

*This is in accordance with Medical KEESM 5721 (10).*"

## 2. TOP Penalty Partial Cure - Modification

This notice may be used where an established TOP penalty period has been partially cured and modified due to a return of some, but not all, of the transferred property.

"*We changed your transfer of property penalty period because some of the property was returned to you. Your penalty is shortened to {insert penalty start date} through {insert penalty end date}. You are not eligible for payment of long term care services until this penalty period ends.*

*This is in accordance with Medical KEESM 5720.1 and 5721 (10).*"

## 3. Property Returned – No Modification

The following notices may be used where transferred property has been returned but does not result in a modification of the existing TOP penalty period.

### a. Non-Exempt Property Returned

When the property returned is non-exempt and will not result in a modification of the existing TOP penalty period, the following fragment may be used.

*"We received proof that some of the property you transferred was returned to you. Your transfer of property penalty period will not be changed at this time. Your transfer of property penalty period remains {insert penalty start date} through {insert penalty end date}. You are not eligible for payment of long term care services until the penalty period ends.*

*This is in accordance with Medical KEESM 5720.1 and 5721 (10).*"

### b. TOP Penalty Already Served

When some, or all, of the transferred property has been returned after the TOP penalty period has expired, the following fragment may be used.

**"***We received proof that some, or all, of the property you transferred was returned to you. Your transfer of property penalty period ended on {insert*

*penalty end date}. Because your penalty period has already ended, the penalty period will not be changed. You are not eligible for payment of long term care services prior to the penalty period end date.*

*This is in accordance with Medical KEESM 5720.1 and 5721 (10).*"

## III. QUESTIONS

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

Erin Kelley, Senior Manager – Erin.Kelley@ks.gov
Jessica Pearson, Elderly and Disabled Program Manager – Jessica.Pearson@ks.gov
Kristopher Owensby-Smith, Elderly and Disabled Program Manager – Kristopher.OwensbySmith@ks.gov
Amanda Corneliusen, Family Medical Program Manager – Amanda.Corneliusen@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