Kansas
Department of Health and Environment
Division of Health Care Finance

Policy Memo	
KDHE-DHCF POLICY NO: 2016-12-01	**From: Jeanine Schieferecke, Senior Manager**
Date: December 12, 2016	**KEESM Reference:** **KFMAM Reference: N/A**
RE: New LTC Aid Code and VA Benefit Clarification	**Program(s): All Medical Assistance Programs**

This memo provides policy and implementation instructions for changes to Long Term Care programs. These changes are implemented in conjunction with enhancements to the KEES system scheduled for October 02, 2016, with functionality available on Monday, October 3, 2016. This memo also provides policy and implementation instructions for how verification of Veterans Administration benefits is requested.

1. New Aid Code For Persons in Long Term Care with Incomes Over 300%

Effective with the KEES release on October 2, 2016 a new aid code is being implemented for persons in a long term care arrangement with incomes over 300% of SSI. Specifically, individuals with incomes over 300% of SSI with a cost of care that exceeds the expected patient liability will now be placed in a special Medically Needy category. Modifications have also been made to the MMIS to accept a patient liability/client obligation/participant obligation for recipients in the new category. The new codes are used for all types of LTC arrangements, including institutional care, HCBS, PACE and Money Follows the Person. The new aid codes will be in place for any action taken on or after October 2, 2016. This will include action taken for prior benefit months. However, cases will only be adjusted when EDBC runs. The previous Aid Code will remain in place until that time.

A. Current Procedure:

When income exceeds 300% of SSI income limit for an LTC consumer, EDBC returns an aid code of MDN. Two different processes resulted:

a. If the cost of care also exceeds the patient liability, staff are required to override EDBC to '300 aid code'. This would allow long term care payment to be made for the

individual with monthly share of cost (instead of a spenddown). The LTC Data Details page is completed with all applicable information.

b. When an individual with income over 300% has a patient liability that exceeds the cost of care, a Medically Needy Spenddown (6 month base period) is determined. The LTC Data Details page is not completed.

B. New Process

A new Aid Code – MN3 (Medically Needy 300%) is being implemented to support those individuals with incomes over 300% but have a cost of care that exceeds the patient liability (described in Item (a)) above. KEES will generate this aid code upon running EDBC and staff will no longer override these cases.

NOTE: EDBC should never be accepted and saved until the user is aware of the final outcome.

NOTE: Members with the MN3 aid code will have a Benefit Plan of Medically Needy in MMIS but will have a LOC and a patient liability.

The following instructions outline the proper process when processing a LTC request:

1. Evaluate the income. This is done for the person requesting LTC. If the income is over 300% of SSI (currently $2199/month), special processing is required.

2. Obtain the Cost of Care. Although a specific Cost of Care is not required for LTC persons with incomes under 300%, it is required for anyone with income exceeding this level. Note: HCBS consumers who are over 300% should be put into Medically Needy spenddown and cost of care requested from the MCO—eligibility for HCBS cannot be determined in these situations until the cost of care is known.

3. Complete the LTC Data Details Page. Complete the LTC information required on the page for the specific type of LTC. Also, enter the specific cost of care prior to running EDBC. Note: Staff shall continue to enter '$9999.99' for cases with incomes under 300% on the LTC Data Details page in KEES.

4. Run EDBC with an RMT of LTC. After completing all other necessary fields, run EDBC. If the patient liability exceeds the cost of care, the MN3 code will generate and no additional action is necessary**. A 300 Aid Code is no longer necessary and staff will not need to override.** Also, a manual form should no longer be required for the member – a notice should automatically generate. A facility form will still be required to be sent to notify the facility of the action.

5. Establish MDN If Necessary. If the patient liability exceeds the cost of care, the individual is not eligible for LTC payment and a regular Medically Needy determination is done according to current processes. The information from the LTC Data Details page is removed and a 6 month base is established. Do not use the LTC RMT. Use an RMT of Medical when establishing a Medically Needy case for a person in LTC. Facility costs are allowed against the spenddown by entering the information on the Expense page in KEES.

This change will be implemented on all cases processed after the update to KEES. For ongoing cases, the change will be implemented the next time EDBC is ran on the case.

C. Living Arrangement Changes

Policy for establishing base periods related to living arrangement changes is not changing with this implementation. Follow the existing policies/processes when an individual moves from a Medically Needy spenddown/ independent living to Long Term Care. As with any case involving medically needy changes, it is critical that staff check the MMIS both before and after their actions to ensure eligibility is properly displayed.

a. New Base Period

For most individuals in an existing base period, the month of entrance in an LTC arrangement breaks the existing base. This is true for individuals falling into the MN3 group as well the '300 Aid Code' individuals. For persons in either aid code, an independent living (IL) protected income level of $475 is used for the month of entrance. To successfully shorten the base period, staff must run EDBC for the month of LTC entrance (using an LTC RMT). Then, run EDBC beginning with the first month of the spenddown base period and all additional months through the month prior to the month of LTC entrance for each month of remaining IL Base with a Medical RMT. If more than one base period exist, begin with the earliest base period.

b. Existing Base Period

If individual has income over 300% and their cost of care does not exceed the patient liability (see B (5) above), the existing base period remains in place. The LTC Data Details screen is not completed and staff do not use the RMT of LTC.

This section of the Memo supersedes the KEES User Manual P2, EDBC, EDBC Results, and Medical Summary. It also eliminates instructions regarding the override for population noted in KDHE Policy Memo 2015-06-05

D. Other Medically Needy Programs

Because the MMIS establishes spenddown by case number, only one Medically Needy program block can exist on any given KEES case. Households that require both a Medically Needy determination and an MN3 determination must be supported on separate case numbers. This is an exception to the case number rule with KEES to use a single case number whenever possible. If a Medically Needy case already exists, always open the new MN3 program on a new case number. Coordination with Central Office and/or the KEES HelpDesk may be necessary.

2. VETERANS ADMINISTRATION BENEFIT

A. Current Procedure:

When a consumer reports receiving VA Benefits, an IM-3121 is sent to the VA Fiduciary Hub for verification and a breakdown of benefits; specifically, what amounts are for pension, Aid and Attendance (A&A), and Unusual Medical Expenses (UME) and whether any of the benefit is intended for other household members (e.g. spouse and/or children). Since return of this form from the Hub has become problematic, a new procedure is being implemented.

B. New Procedure

Effective with the release of this memo, when a consumer reports receiving VA Benefits, an IM-3121 will be sent to the VA Fiduciary Hub and proof of the VA Benefit will also be requested from the consumer as well. [New wording for this consumer request has been added to the Cut and Paste Template on the KEES Repository site.]

1) If the due date passes and neither the VA nor the consumer has provided the information, the consumer will be denied due to failure to provide the requested information.

2) If the consumer provides proof of the VA benefit and the IM-3121 has NOT been received when the case is being processed, the proof sent by the consumer will be used. If the consumer provides proof of the breakdown of the VA benefit with Aid and Attendance (A&A) and Unusual Medical Expenses (UME), then these amounts will be budgeted per current policy. However, if the proof provided from the consumer does not include proof of UME or A&A amounts, then the assumption will be that they do not receive UME or A&A and the full amount of the VA benefit will be counted.
NOTE: If the consumer provides proof of the total VA Benefit and indicates that a portion of the benefit is earmarked for UME or A&A but does not provide proof of these amounts, they are not allowable. The entire VA Benefit will be countable. In these situations, the approval or denial NOA must be appended to notify the consumer that the full VA Benefit was counted as the UME or A&A reported were not verified.

3) If the IM-3121 has been received at the time of processing and appears to provide correct information, the amounts reported on the IM-3121 will be budgeted. If the information on the IM-3121 is inconsistent with the information reported by the consumer, then the VA toll free number (1-800-827-1000) will be called for clarification. If the discrepancy cannot be resolved, the case will be referred to policy for review.

C. Procedure for Currently Pending Cases

For cases screened prior to implementation of this policy, the case will need to be reviewed before action can be taken.

1) If the IM-3121 has been received, follow the instructions outlined in B.3) above.

2) If the IM-3121 has NOT been received but proof of the VA benefit is available in Image Now, assume no portion of the benefit is for A&A or UME. Consider the entire VA benefit as a pension which is countable. In these situations, the approval or denial notice must be appended to notify the consumer that the entire VA benefit is being counted and that if any

portion of it is for A&A or UME, they can provide proof of these amounts within 15 days and the agency will re-determine their eligibility.

NOTE: If verification of A&A or UME is provided after the 15 day deadline, it will be processed as a regular change the month after the month the change is reported.

3) If the IM-3121 has NOT been received and proof of the VA benefit is not in Image Now, a request for information must be sent to the consumer requesting proof of the VA benefit with any breakdown prior to taking any action on the case.

a. If the consumer fails to provide proof and an IM-3121 still has NOT been received, follow the instructions in B. 1) above.

b. If the consumer subsequently provides proof of the VA Benefit before an IM-3121 is received, follow the instruction in B. 2) above.

c. If an IM-3121 is received before the request is processed, follow the instructions in B. 3) above.

3. QUESTIONS

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

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