Policy Memo	
KDHE-DHCF POLICY NO: 2017-02-01	**From: Jeanine Schieferecke, Senior Manager**
Date: February 3, 2017, revised 2/10/2017	**KEESM Reference: 9350** **KFMAM Reference: 7330**
RE: KEES Review Processing	**Program(s): All Medical Assistance Programs**

This memo provides implementation instructions regarding the Review Process in the KEES system. Several new review-related policies are also being implemented with the new system and clarification regarding the Review Reconsideration Period is also included. Policies are effective upon receipt of this memo, unless otherwise noted.

This memo supersedes Policy Memo 2014-05-01, Section D.

1. REVIEW PROCESS

Enhanced functionality included in KEES provides automation to support critical portions of the review process. This automation will replace steps that were completed manually prior to KEES implementation. The primary changes involve issuing review forms, as staff will no longer be required to issue review forms to households (except for a few exceptions noted in this memo), and processing reviews, as KEES will automatically complete the review process without human interaction for many medical programs. Automated processes are used to support areas where the risk of an inaccurate determination is lower, allowing higher-risk activities and situations to receive human attention. The new review processes are also in place to support requirements of the Affordable Care Act. Under the new rules, the state is required to complete a review using interfaces and other information available to the agency prior to contacting the member.

These processes will apply to all types of medical assistance reviews - both Family and Elderly and Disabled. Reviews are not completed for Child Welfare-related medical assistance (Foster Care and Adoption Support). Although a review is completed for the cash assistance component, because of the relationship between the cash and medical benefits, any changes will be subsequently reflected in the medical case. This will be the responsibility of the PPS staff.

2. REVIEW TYPES

The new review process in KEES includes several new review types. These types will be effective with the first full Review cycle initiated by KEES – reviews expiring on August 31, 2015. A description of each review type and criteria follows.

A. SUPER PASSIVE

A super passive review is one in which the medical program is automatically re-evaluated by the KEES system based on program type, income and resources to determine continued eligibility using the information already known or obtained by the agency. If eligible based on the review criteria, a new 12 month review period is established with notification issued to the beneficiary.

This is a completely no-touch automated process with no manual worker involvement required. The program types potentially subject to super passive reviews are the Deemed Newborns, Aged Out Foster Care, Poverty Level Pregnant Woman, and the Medicare Savings Programs (MSP – QMB, LMB and ELMB). The following is the specific qualifying criteria for MSP super passive reviews:

(1) has SSI income, or
(2) has zero income and countable resources are $2,000 or less, or
(3) only income is SSA and countable resources are $2,000 or less.

If the MSP program fails to meet the super passive criteria, it will result in either a passive or a pre-populated review as indicated below.

B. PASSIVE

A passive review is similar to a super passive review described above, in that information known to the agency is used to make a new eligibility determination. However, the member receives notification which includes what information was used to make their review determination and is required to inform the agency of any changes or incorrect information used in the determination. Once again, this is a completely no-touch automated process with no manual worker involvement. Eligibility is redetermined and reauthorized.

If the recipient has no changes to report, the review process is complete. If the recipient contacts the agency (either orally or in writing) with updated information based on receipt of the review notification, action is taken to update the case. See section 5 below.

In order to qualify for a passive review, when earned income exists it must meet reasonable compatibility under the automated RC test completed by KEES. In addition, each of the following program types may be subject to a passive review when specific criteria are met:

1. Protected Medical Groups (Pickle, ADC, EDW) – There is no earned income (including self-employment), countable resources are less than 85% of the limit and there is no trust.

2. Medically Needy (MN) – There is no earned income (including self-employment), countable resources are less than 85% of the limit, there is no trust and there are no due and owing medical expenses.

3. Medicare Savings Programs (MSP – QMB, LMB, ELMB) – Fails the super passive criteria described above, has no earned income (including self-employment), has no unearned income (other than SSA), countable resources are less than 85% of the limit and there is no trust.

4. Long Term Care Programs (NF, HCBS, MFP, PACE) – There is no earned income (including self-employment), no income allocation, countable resources are less than 85% of the limit, there is no trust and no due and owing medical expenses

5. Caretaker Medical, TransMed and Extended Medical – Earned income is reasonably compatible, there is no self-employment, no individuals outside the home are claimed as tax dependents, there is no discrepancy in the tax information for household members, and individuals do not move to a Protected Medical Group, Working Healthy, Medically Needy, or MSP.

6. Poverty Level Pregnant Woman (Medicaid) – Fails the super passive criteria, passes the income test, passes reasonable compatibility, does not contain self-employment income, no individuals outside the home are claimed as tax dependents, and there is no discrepancy in the tax information for household members.

7. Poverty Level Pregnant Woman (CHIP) – Income does not exceed 200% of the FPL, income is reasonably compatible, does not contain self-employment income, no individuals outside the home are claimed as tax dependents, and there is no discrepancy in the tax information for household members.

8. Poverty Level Newborns and Children (Medicaid and CHIP) – Income does not exceed 200% of the FPL, income is reasonably compatible, does not contain self-employment income, no individuals outside the home are claimed as tax dependents, and there is no discrepancy in the tax information for household members.

C. Pre-populated

Similar to traditional reviews, the pre-populated review is required for all other situations where a passive or super passive review isn't sent. A notice of expiration of the review period is sent along with a generated pre-populated review form for completion and return. KEES will generate the forms automatically. The forms are generated based on information that is contained within KEES. If information is not contained within KEES, the form will

display with ‘Nothing on File.’ Recipients are to update the form with new or changed information and return to the agency.

In situations where information is not on file, but is required to determine eligibility, it must be verified as part of processing the review. For example, tax household information is required for MAGI determinations. If there is not tax household information on file, it must be obtained as part of the review processing.

Failure to return the review form shall result in discontinuance of coverage.

Certain programs will always require a pre-populated review. Those programs are Working Healthy (WH), Working Healthy Medically Improved (WH/MI), MediKan and Qualified Working Disabled (QWD).

D. Targeted

A targeted review is one for a specific or limited purpose. The programs subject to a targeted review are Breast and Cervical Cancer (BCC), Working Healthy (WH) and Working Healthy Medically Improved (WH/MI) – 6 month review only. BCC completes a 12 month review using the KC-1400 (Medical Assistance – BCC) form. WH and WH/MI completes a 6 month income review using the system generated N812 (Working Healthy Desk Review) form.

E. Internal

The Tuberculosis (TB) program is subject to an internal review. Eligibility continues as long as the Tuberculosis Control and Prevention staff at KDHE deem coverage is necessary.

F. No Review

No review is necessary for the SI program, AIDS Drug Assistance Program (ADAP), Foster Care (FC), Adoption Support (AS), Inmate coverage, MediKan Reintegration and the State Supplemental Payment Program (SSPP). Nor is a review required for individuals determined eligible under Presumptive Eligibility (PE). A Review Due Date is still set for these cases, and they are a part of the KEES Review Cycle, but a Review is not generated.

3. Review Processing in KEES

The KEES system provides functionality to support the full review cycle. This includes identifying cases with required reviews, redetermining eligibility to support the Passive and Super-Passive processes, sending notices and forms and discontinuing eligibility when a required review was not received. It is important for staff to understand both the review processes and the elements that are critical to an accurate review.

A. Review Cycle:

The review cycle initiates on the 15th of each month with the execution of the Review Batch. The following outlines the general process the review batch utilizes each month. This process is repeated each month for the following month. Just as with the current review process, multiple review cycles are in progress at any given point.

1. All cases due for review the following month are identified. Example: July 15, 2015 cycle will pull cases with a review expiring August 31, 2015.

2. The review type is determined.

3. For Passive and Super-Passive Reviews, eligibility is redetermined and EDBC is accepted and saved effective the month following the review due month. The review date is reset and, for cases with Continuous Eligibility, the CE date is reset.

4. Notices and/or Forms are generated and mailed for all review types.

5. For Pre-populated and Targeted reviews, forms/responses are recorded in KEES when returned. The review is registered by scanning the bar code on the form/envelope or by recording it on the Review/IR page.

6. Pre-populated and Targeted reviews must be processed by staff in order to redetermine eligibility.

7. Pre-Populated and Targeted reviews must be recorded in KEES before the 14th day prior to the end of the month or coverage is automatically discontinued through the Review Discontinuance Batch. Note: This batch has not been run consistently each month. See Section 9 for more information about the Review Discontinuance Batch.

8. Pre-Populated and Targeted Reviews that have been recorded in KEES but haven't been processed may also be discontinued by the Review Discontinuance Batch. However, at the present time, coverage for this group continues until the review is manually processed.

9. Passive review responses are processed according to when the report is received and when the change occurred. See Section 5 for more information about processing a Passive Review Response.

B. Review Criteria

1. Each program block is evaluated separately. Meaning that an E and D program block can have a review separate from a family medical program block. Except for people receiving a targeted review, each program block will only receive one review at a time.

2. KEES only allows one review date per program block.

3. Each member on the program block is evaluated to determine the review type. If there are multiple members on a program block, each will be evaluated but there will only be one review sent. The review sent will be the one that is the most comprehensive review type for all members.

4. For programs with Continuous Eligibility, the review date is set to match the earliest CE period on the case. For example, a case includes a mother and two children. The mother has a CE date through 08-2015 and the children have a CE date through 10-2015. The program review date is 08-2015 to match the shortest CE period.

5. Once the review is processed, the new review date will set to the earliest of the remaining CE dates for members on the program block. In the above example, the new review date will be 10-2015.

6. Where individuals have a CE date beyond the review period, the CE date is protected for those individuals. For example, in the above case the two children with CE dates of 10-15 are protected through 10-2015 if the mother fails to return her review in 8-2015.

7. Individuals are not discontinued based on the results of a passive review. If individuals would discontinue, a Pre-populated review will be generated instead of issuing a discontinuance. In the event that KEES discontinues an individual at the time of Passive Review, a special process is to be followed. See the attached instructions 'Discontinued at Passive Review'.

8. A passive review will not execute if the last two reviews have been passive. A pre-populated review will be required at that time.

9. In addition to the criteria in Section 2 above, a passive review will only be completed if the following conditions are met:

    a. All MEM's and FRI's must have an SSN recorded in KEES
    b. If any MEM or FRI on the program block has earned income, it must be reasonably compatible. An automated RC test is completed by comparing the amount of budgeted earnings with any information available through the Dept. of Labor and the Work Number/TALX. The Reasonable Compatibility test is by individual. Income from the interface(s) must not exceed the amount reported/budgeted by 20%.
    c. Interface information (KDOL Wages/TALX) must be available for any MEM or FRI on the program block with earned income.
    d. If interface information (KDOL Wages/TALX) for any MEM or FRI is found, there must be an earned income record in KEES.
    e. If a MEM or FRI has Unemployment Income, a comparison with KDOL-UI is completed. The record must be within 20% of the budgeted Unemployment

f. All critical data elements must be completed and verified. If some critical elements are not completed and verified, a Super-Passive or Passive review cannot be completed.
g. Newly converted cases subject to the resource test that have not yet had an EDBC executed will not result in a Super Passive or Passive review. Once EDBC is executed, a Passive review may be completed.
h. The latest EDBC is not an overridden EDBC.

10. Regarding Reasonable Compatibility: KEES will set an internal indicator when the reasonable compatibility test is met for purposes of a review. This indicator was not viewable by end users, at the time of KEES Implementation, but is critical for the review process. For non-review situations, the Verification indicator is the critical element for the RC test. For reviews, the income verification indictor can be adjusted, but isn't an indicator of the results of the RC test. As with all interface updates, the verification indicator will only change from Pending to Verified, not vice versa when the Review Batch is executed. Effective 6/19/2016, KEES was updated with a Reasonable Compatibility Results screen so staff can now view the results of the RC test completed by the review batch.

    When the review is being processed, a Reasonable Compatibility test may not be required. If the consumer has not reported any changes in income, and the income passed the Reasonable Compatibility Test that was executed by the Review Batch, it is not necessary to re-run the RC Test. The passing RC test executed by batch is used for the determination. If the RC test executed by batch did not pass, it should still be re-run by the worker, even if no income change has been reported as there may be new data present in KDOL or TALX for the comparison.

11. Regarding Interfaces: The only automatic interface checks that are completed at review are part of the Reasonable Compatibility check explained above where KDOL – Wages and KDOL-Unemployment as well as the TALX interface are called. A SVES request is sent just prior to review, but the result is independent of the review process. This means any resulting tasks or online updates would occur outside of the review process.

4. Review Correspondence

KEES will automatically generate correspondence related to the review process, but staff are also required to send notices regarding the review results.

A. KEES–Generated Correspondence

Correspondence (a NOA and/or form) will be sent for all reviews (with the exception of the No Review type) coming out of the Review Batch on the 15th of the month. The specific type of correspondence is dependent upon the type of review that is generated. Copies of the various forms are included with this memo.

For Passive and Pre-Populated reviews, the forms are populated based on information from the KEES system. This means that incomplete or incorrect records in KEES could be written to the review form and may cause some confusion by the recipient of the form. Staff are not required to reissue a review form solely on the fact that information is missing or confusing. However, contact with the member to clarify the information may be required when processing the review form.

Correspondence coming from KEES will include a barcode to facilitate registration when the form is returned.

1. Super-Passive: A NOA is sent informing the Member the review was completed and whether any change in coverage has occurred.

2. Passive: Both a NOA and a form are sent. The member must review both documents. The NOA serves as a cover letter to the Review Form and informs the consumer of their new review period, specific eligibility, and requirement to respond if information contained within is incorrect. The form includes detailed information (household size, income, resources, etc.) used to make the eligibility determination. Persons are required to tell us about changes based on this form. Updates and changes are accepted by phone or by mail. The following two forms are used:
    - KC-1300 Family Medical Passive Review
    - KC-1700 Elderly and Disabled Passive Review

3. Pre-Populated: A form is sent to the member outlining the detailed information currently on file for the case. Members are required to sign, complete and return the form. The process to complete the form involves noting changes to the information on file. Keep in mind that if information is missing from KEES, the information will not be populated on the form. The following forms are used:
    - KC-1200 Family Medical Pre-Populated Review
    - KC-1600 Elderly and Disabled Pre-Populated Reviews

   When the review form is returned, staff are required to evaluate any changes that have been reported. Where required, elements must be verified using the same policies that are applicable at application. The tiered verification policy is applicable. This means interface information and other sources must be used to the extent possible before asking the member for verification.

4. Targeted: A pre-populated form is generated and sent to the member. Forms produced for a targeted review are:
    - Notice of Review – Medical Assistance BCC Programs
    - Working Healthy – 6 Month Review (see section 12 for more information about processing the WH reviews)

B. Re-Issuing Review Forms From KEES

KEES allows the user to issue review forms to the consumer outside of the normal review process by using the Generate feature in Document Control. It is used when the original was reported lost or not received, or when a review form must be generated as part of a KEES-issued work around or when specifically instructed to do so by Policy or Help Desk.

C. Other Correspondence

Additional notification to the consumer is required upon completing processing of a pre-populated review form or when processing a change following a Passive Review Response.

Review Determination – After completing the review determination for a pre-populated form or a targeted review, notification of case action is required.

Passive Review Response – After making changes to a case based on information received via a Passive Review Response, a change notification is required.

A NOA will be generated by KEES. Staff must thoroughly review the NOA to determine if it contains all necessary data elements. Refer to Policy Memo 2015-06-05, section 15 for specific elements required in an approval, discontinuance, or change.

In situations where the NOA is not acceptable, the NOA shall be deleted and the V700 General Change form shall be generated instead.

In situations where a change is reported, but does not have any impact on the case, a notice is generated to the consumer to inform them that their change has been processed. Use 'Passive Review Response – No change' template found on the Standard Text for Copy and Paste spreadsheet.

5. Passive Review Responses

After being passively reviewed, the consumer is required to contact the agency (either orally or in writing) if any of the information used in the passive review needs to be updated. Reaction to this change is based on when the change occurred, when it was reported, and the type of eligibility being received.

A. Recording the Passive Review Response in KEES

In all circumstances, staff must evaluate whether the change occurred on or before the 15th of the last month of the old review period.

1. If the change occurred on or before the 15th of the last month of the old review period, the change is processed as a Passive Review Response. In KEES, the Document

Status on the Review and IR record must be updated from ‘Sent’ to ‘Received’ in order for it to be reported as a Passive Review Response.

2. If the change occurred after the 15th of the last month of the old review period, the change is not considered a passive review response. It is treated like any other change that is reported outside of the review process. No changes are made to the Review and IR record.

B. Passive Response Run Reason

Effective 6/19/2016, KEES was updated with a new run reason: Passive Response. This run reason will be used to process a Passive Review response. It is used for reporting purposes, to record the processing of a Passive Review Response, and for family medical programs, it allows the continuous eligibility rules to be bypassed when processing the change. While it might be necessary to react to the change in the month following the month the change is reported, the Passive Response Run Reason is only used when running the first unpaid month.

When the consumer calls to report a change and it is determined to meet the definition of a Passive Review Response, staff update the case with the changes, run eligibility to process the change in the appropriate month. Then, using the Passive Response run reason in the come-up month the eligibility can change to another aid code or coverage can be discontinued rather than being protected by the continuous eligibility period that was set. When the coverage changes, the Review Date and the CE dates won’t be changed. They will remain set for the initial 12 months that were established when the Passive Review was processed. If the individual is no longer eligible after processing the Passive Review Response, coverage is discontinued. See section 11G for more information.

C. Processing a Passive Review Response

The impact of the passive review response is dependent on the type of coverage being received.

1. For Family Medical programs, a passive review response is processed for the first unpaid month and can result in a change in coverage and/or premium. If the passive review response includes a request for medical assistance for a new individual, the change to add the individual is processed for the month of request but coverage for existing members is protected for any paid months by continuous eligibility rules. When a premium is involved, if a positive change, the change is made for the month after the month of report.

2. For Elderly & Disabled programs, a passive review response is processed following standard change processing guidelines. If a positive change, the change is made for

the month after the month of report. If a negative change, (i.e. an increase to patient liability/obligation or change to lesser coverage), the change will be made when timely and adequate notice can be given. If the change was not reported timely, then the months when the change should have been acted upon will be added to the overpayment spreadsheet.

In all circumstances, staff must evaluate whether or not the change was reported timely and whether an overpayment (which includes an understated patient liability) has occurred.

Example 1: Two children were due for review in February 2016 and were passively reviewed. They were determined eligible for PLN and given a new CE and review period of March 2016 – February 2017. The consumer calls on March 10th after receiving the Passive Review letter to report an increase of income. The income change occurred on February 1, 2016. The change is processed on May 13th. The change is processed in the first unpaid month: June. The Passive Response Run Reason is used. The children's eligibility changes to PLT from June 2016 through February 2017.

Example 2: Two children were due for review in February 2016 and were passively reviewed. They were determined eligible for PLN and given a new CE and review period of March 2016 – February 2017. The consumer calls on March 10th after receiving the Passive Review and requests coverage for herself and reports a change of income. The income change occurred on February 1, 2016. Income is updated in 3/2016 and EDBC is run for 3/2016-05/2016 to add the mother to the case. Mom is approved for CTM 3/2016-02/2017. CE is protected for the two children already approved for PLN. Then, 6/2016 (the first unpaid month) is run with the Passive Response Run Reason. Based on the income change reported, the children's coverage changes to CTM/CH for 6/2016-02/2017.

Example 3: One child was passively reviewed in February 2016. The child was approved for CHIP with a $30 premium and given a new CE and review period of March 2016 – February 2017. The consumer calls on March 15th to report that the spouse was no longer employed as of January 10th. Because the change occurred prior to February 15th, the income change is processed as a passive review response. The task is claimed for processing on July 21st. August is the first unpaid month, however because the child was a premium-payer and a reduction of income was reported – it must be processed in the month following the month of report. The income record is end dated 3/31/2016. EDBC is run in 4/2016 and the premium is removed. Each month is run through the come-up month to adjust the premiums. The Passive Response Run Reason is used in the come-up month (August 2016). The children's coverage remains PLT with no premium and the CE and Review period remains through February 2017.

Example 4: Consumer is open on a spenddown based on a Tier 1 decision and is due for review in 08/2016. They are passively reviewed and a new base period of 09/2016 – 02/2017 is established with a new Review Due in 08/2017. On 10/11/2016, they call and report they are now receiving Social Security Disability (SS DS). They got their first check on

09/1/2016. Because the change occurred prior to 9/15/2016, it is a passive review response. If the consumer has a met spenddown, the change is made for the first month the Spenddown Met to UnMet deadline can be met. However, if the spenddown is unmet, timely notice is required and the increased income can be made for 11/2016 of the current base period.

Example 5: Consumer is open on a spenddown and is due for review in 08/2016. They are passively reviewed and a new base period of 09/2016 – 02/2017 is established with a new Review Due in 08/2017. On 9/3/2016 the consumer calls to report they purchased cancer insurance (first premium was paid on 8/22/2016) and were wondering if the premiums can be allowed against their spenddown. Because the change occurred after 8/15/2016, this is not a Passive Review Response. On 10/14/2016, the change is processed. Because the change is positive, once the expense is verified, the expense can be allowed beginning 10/1/2016 (the month after report) and following.

6. KEES Registration:

When a prepopulated review is sent, it must be signed, completed, returned, registered and processed. Passive Review Reponses must also be registered and recorded into the system.

A. Registering The Review:

The KEES system uses the Review/IR 12 month reporting detail page to record the receipt of the review. The Report Status and Document Status codes entered on this page are used to track the status of the review. Staff are required to update these as per the KEES User Manual. The KEES Batch will automatically create a Review IR/Record according to the following criteria:

1. For super-passive reviews, The Report Status is set to ‘Not Applicable’ and the document status is set to ‘Sent’.

2. For passive reviews, the Report Status is set to “passive’ and the document status is ‘Sent’.

3. For Pre-Populated and Targeted reviews, the Report Status is set to ‘Incomplete’ and the document status is set to ‘Sent’.

B. Late Reviews

When a review is received after the due date, an evaluation must be completed to determine if a Review Reconsideration applies. The status of the case will determine how an application/late review is recorded in the KEES system. Because a late review can also be an application document, come in from the SSP, or the FFM, all incoming requests for coverage must be evaluated to determine the actual type of request at hand.

1. **REGISTER AS A REVIEW:**

If the coverage was discontinued for no review or for failure to provide information for the review and the request is received within 3 months of discontinuance, register the request as a review.

If the coverage remains open because the Review Discontinuance Batch has not been run for that Review month, register the request as a review.

2. **REGISTER AS AN APPLICATION:**

If the request was received within three months of the discontinuance and coverage was discontinued for failure to meet program requirements, or coverage was discontinued more than three months ago, register the request as an application.

Note: When coverage is already open for another person on the case, it is treated as an add-a-person request.

C. KEES FUNCTIONALITY

When registering the case in KEES, the action is dependent upon the situation.

1. When a request is received up to three months after the end of the discontinuance, this is still within the review reconsideration period. It is registered as a review; use the Rescind feature.
2. When a request is received in the fourth month or later, after the end of the discontinuance, use the Reapply feature. If requesting prior medical, the prior medical months are then selected on the Medical Person Detail page.

7. REVIEW RECONSIDERATION PERIOD

An individual subject to review that fails to complete the review process shall be provided a special three (3) month reconsideration period to provide any required form(s), documents(s) or other information necessary to complete the review process and renew coverage. The standard review reconsideration period ends on the last day of the third month following the review discontinuance. This period may be extended in specific instances to allow additional time to provide requested information. The reconsideration period applies only when the review failed due to failure to return the review form or failure to provide requested information. This policy applies to all medical assistance programs subject to review.

A Review Reconsideration period is NOT applicable to the following:

- An individual who is approved at review
  - Any information that is reported following review approval is treated like a change, and the case is updated following current policy.
- An individual is denied at review for not meeting eligibility criteria

An important point to note about processing cases with a review reconsideration period is that this retro coverage is *not* processed like a prior medical period. Eligibility is still determined using point in time income and current circumstances, but if eligible, the start date is set to the first day of the new review period.

Example 6: Consumer has a July 2015 review and is mailed a Pre-Populated review form. The consumer fails to return their review, so the case closes July 31, 2015. The consumer returns their review form on 10/14/15. This is within the Review Reconsideration Period and because the closure was due to failure to provide a review, they qualify for retro coverage. Eligibility is based on a point in time determination using current income and circumstances. If eligible, coverage is backdated to 8/1/2015. A new review period and continuous eligibility period (when applicable) are established for July 2016.

A. Review Form

When a form is required, it must be returned by the 15th of the last month of the current review period to be considered timely. The form must still be returned (and registered) prior to the KEES Discontinuance Batch being run to prevent the case from auto closing. However, as long as the review is returned by the last day of the review reconsideration period it is still considered a review for processing purposes.

A review form received after the three (3) month period is treated like a new application, including any request for prior medical coverage. The 45 day application reactivation policy remains in place for these applications.

B. Requested Information

Requested information must still be returned within 15 days from the date of request in order to prevent adverse action. However, if the requested information is provided after adverse action is taken, but during the review reconsideration period, the adverse action may be rescinded and the review reinstated for processing. This is true regardless of the length of time that has passed from the initial request.

If the requested information is timely provided, but outside of the three (3) month review reconsideration period, the review may still be reinstated for processing. This will most commonly occur when the review form is received at the very end of the three (3) month reinstatement period and there are less than 15 days remaining in the reinstatement period, or where the agency has failed to request the information in a timely manner which causes the response time to fall outside of the reinstatement period. For example, an October review is returned in January, within the review reconsideration period. It is screened by the worker in January, and pended for additional information with a due date of February 10th. Information is provided by the requested due date. Even though the information was received outside of the three month reconsideration period, the review is still reinstated for processing.

C. Coverage Start Date

If the review is processed during the reconsideration period, the effective date of coverage will be the first day of the new review period. For the vast majority of persons impacted by the new reconsideration period, coverage will 'fill the gap''. This includes persons eligible for QMB and CHIP. If a premium is required for the coverage, the premium will be applicable to the months of retro coverage as well.

D. HCBS Reviews

If a late review is being completed for an HCBS recipient under this policy, coverage may be reinstated without a break in assistance if otherwise eligible and case action is taken during the month after the previous review period ended. If case action is taken more than a month after the end of the review period, the HCBS Program Manager must be contacted for approval to reinstate coverage. If the HCBS Program Manager does not approve reinstatement of coverage, eligibility would have to be determined under another program, such as Medically Needy (MN).

E. Review and Continuous Eligibility (CE) Periods

The review period for all medical programs and the continuous eligibility (CE) period for the family medical programs shall be 12 months for all reviews processed under the new review reconsideration policy. The first month of the review period is either the month after the last month of the previous review period for all medical programs, or the first month of coverage for the QMB program subject to the exception described in subsection 7C above.

F. Passive Reviews

Individuals subject to a Super Passive or Passive Review don't have the same need for a 3 month review reconsideration period. Individuals approved for ongoing medical benefits following a Passive Review have already been processed without any interruption of benefits. Therefore changes reported in response to the Passive Review continue to be processed based on when the change occurs as explained in Section 5. Coverage changes will not occur retroactively. However, when an individual is closed at the time of a Passive Review or Passive Review Response, a reconsideration period is applicable. Eligibility shall be determined using the guidelines outlined above.

Note: In the event that KEES discontinues an individual at the time of Passive Review, a special process is to be followed. See the attached instructions 'Discontinued at Passive Review'.

8. Changes Following Closure

Eligibility for a Review Reconsideration Period determines how to react to changes reported following closure. If closed due to:

A. Failure to return the review

If a signed review form is returned by last day of the third month following the initial review period, eligibility is processed as a review. Eligibility is determined using point in time income and current circumstances, but if eligible, the start date is set to the first day of the new review period. If returned after the Review Reconsideration period has expired, the form is registered as an application and processed as an application. Prior Medical may be determined if requested.

B. Failure to provide information

If requested information is returned by the last day of the Review Reconsideration Period or reinstatement period for cases processed at the end of the review period (as defined in section 6B above) eligibility is processed as a review. Eligibility is determined using the income originally reported on the review. The exception would be if the reported income terminated in the first month of the new review period and is no longer countable. If the requested information is returned after the reinstatement period, a new application (or verbal request if allowed by policy) is required. Prior Medical may be determined if requested.

C. Not Eligible Due to Program Requirements

When not eligible due to program requirements, consumers are not eligible for a Review Reconsideration period. A new application is required. The new request is processed as a new application, using all policies applicable to new applications.

9. Review Discontinuance

A Review Discontinuance process is scheduled to occur on the 14th day prior to the end of the month as part of normal processing. This batch job is designed to discontinue all individuals for the intended review month, whether or not they have returned their review form. For those cases where the review has not been returned, the coverage is discontinued and the consumer is notified of their discontinuance based on failure to return the review form. For those cases where the review form has been returned and recorded in KEES, the coverage is discontinued, but a notification is not sent to the consumer.

This batch job ran normally for the month of August 2015. The Discontinuance batch job for the months of July, September, October, November and December were not run in their respective months due to issues with the batch job. The issues were resolved in the November 19th Release and the Discontinuance batches for the previous months were run, however the discontinuance was only run for the individuals who failed to return the review form. The Discontinuance Batch has excluded all cases where a review form has been returned, even when that form has not been processed. Coverage continues for these individuals until the time that their review is processed.

An additional defect was identified and fixed for the January 14th Discontinuance batch job. This defect caused a small number of individuals that should have been discontinued in the previously run Monthly Discontinuance batch jobs, to not be picked up. The batch job that ran on January 14th discontinued those individuals as of 1/31/2016.

The discontinuance batch job that was run for review months of November 2015, December 2015, and January 2016 was only run for the MAGI programs. An automated discontinuance was not run for E&D Medical programs.

Below is a list of Monthly Discontinuance batch jobs that have been run, when the batch job ran, and which programs and actions it was run for.

Monthly Discontinuance Batch Job	Date Batch Job Ran	Additional Defect Fix Correction	Notes
July 2015	11/19/2015	1/14/2016	All Medical Programs Only non-returned reviews
August 2015	8/15/2015	1/14/2016	All Medical Programs All reviews
September 2015	12/17/2015	1/14/2016	MAGI Programs only Only non-returned reviews
October 2015	1/14/2016		MAGI Programs only Only non-returned reviews
November 2015	9/2/2016		MAGI Programs only Only non-returned reviews
December 2015	9/28/2016		MAGI Programs only Only non-returned reviews
January 2016	10/7/2016		MAGI Programs only Only non-returned reviews
February 2016	10/27/2016		MAGI Programs only Only non-returned reviews
March 2016	11/1/2016		MAGI Programs only Only non-returned reviews
April 2016	11/30/2016		MAGI Programs only Only non-returned reviews
May 2016	12/1/2016		MAGI Programs only Only non-returned reviews
June 2016	1/5/2016		MAGI Programs only Only non-returned reviews
July 2016	1/13/2016		MAGI Programs only Only non-returned reviews
August 2016	1/19/2016		MAGI Programs only Only non-returned reviews

A. Review Discontinuance Fall-Out Processes

After completion of the special automated batch, there are several types of cases that require some form of manual action in order to complete the discontinuance. Note these items are

specific to the special delayed Review Discontinuance process. These are not necessarily applicable to the regular Review Discontinuance batch. These are outlined below.

1. The case appears to have been processed but the Review/IR record has not been fully updated, or, an application has been received on the case that may be used to complete the review.
2. One or more members on the case have a CE date that extends beyond the current month.
3. Members were active under an elderly or disabled program. Because forms were not being sent to the Administrative Roles on all cases, these programs must be evaluated to determine if a discontinuance action can be taken. Manual notification to the PACE entity, Nursing Facility or MCO for HCBS cases must also be taken.
4. The case includes a child with a CHIP aid code. A problem with the notice that is produced for CHIP children has been discovered. These cases WILL be discontinued by the batch, but manual action is required to generate a proper notice. Note – this issue was fixed in October, 2016.
5. An SSI recipient was targeted for closure. Because an SSI recipient is not subject to review, these individuals will not be automatically discontinued. However, the case must be updated to ensure the member is eligible for ongoing coverage.

Error reports have been produced for each of the above situations and are assigned to staff for manual processing.

B. Manual Review Closure

Due to the discontinuance batch jobs not being run, individuals have continued to receive eligibility following the end of their initial review period. At any time, when taking case action for individuals who have not completed their review, coverage shall be ended in the first available month, allowing for timely notice.

The review reconsideration period for these cases is based on when they are actually discontinued, not from when they should have been discontinued. For example, if the review was due in November 2015, but not discontinued until 9/30/2016, the three month Review Reconsideration period is October, November, and December 2016.

Before taking action to discontinue an individual, it is necessary to determine if the individual has an administrative role who should have received the review form (i.e. medical representatives, guardians/conservators/legal custodians or representative payee for Social Security). Due to a defect in KEES, some administrative roles were not mailed a copy of the consumer's review form. Therefore, when one of these administrative roles exist, it is necessary to ensure that the review form was sent to that individual before taking action to discontinue coverage. If the review was sent to the administrative role and has not been returned, then it would be appropriate to discontinue coverage for failing to return the review form. If a review form was not sent to the administrative role, then the review form must be re-mailed, following the instructions applicable to the issue described in section 9.A.3.

C. Establishing the New Review Period

Currently, when processing a review for cases where coverage continued beyond the initial review period, the new eligibility period is established based on when the review should have been completed. For example, if the review was due in September 2015, and being processed in February 2016, the new eligibility period established is October 2015 through September 2016.

However, effective with the release of this memo, the new review period is established based on the first available unpaid month at the time the review is processed. Because of the delay in running the Review Discontinuance Batch and in processing returned reviews, establishing a new eligibility period based on when the review should have been completed may be too late.

When processing the review, eligibility is processed in KEES for the come-up month or first unpaid month, whichever is earlier, and the new review period shall be established based on this date.

Example 7: November 2015 review was not returned. Coverage was discontinued effective 9/30/2016 by the Review Discontinuance Batch. The consumer returns their review form in December 2016, still within their review reconsideration period. The worker is taking action to process the review on 1/15/17. Based on processing the action on 1/15/17, February 2017 is the come-up month and October 2016 is the first unpaid month. The review is processed in October 2016 and the new eligibility period is established for October 2016 through September 2017.

Example 8: April 2016 review was not returned. Coverage has continued because the Review Discontinuance Batch has not been run for this month and no action was taken by a worker to manually discontinue. The consumer returns their review form in September 2016. The worker is taking action to process review on 10/13/2016 so the come-up month is November 2016. The review is processed in November 2016, EDBC is run using the RE Run Reason and the new eligibility period is established for November 2016 through October 2017.

In situations where the consumer returned their review timely and it was processed untimely by the agency, if it is determined that the consumer reported an income or expense change that would have reduced their share of cost, adjustments should be made to the case.

If the share of cost is a CHIP or Working Healthy premium, it shall be adjusted for all months following the month of the new income report.

Example 9: April 2016 review was returned on April 10, 2016. The coverage received under the old review period is continued until the review is processed. The consumer has been receiving CHIP coverage with a $30 premium. The review is processed on 10/18/2016.

Eligibility is run in the come-up month of November 2016. New eligibility is established as CHIP with a $20 premium for the new eligibility period of 11/2016 through 10/2017. However, because the review was processed untimely and resulted in a reduction in the CHIP premium, it is necessary to adjust the premium for all months following the month of report. In order to process the premium adjustment, staff must extend the original CE period to 10/2016. Then, re-run EDBC for all months May 2016 through October 2016 to adjust the premium amount. A review approval and a premium change notice must be sent to the consumer.

If the share of cost is a patient liability or client obligation, follow existing policy to determine what retro months are adjusted.

D. Requests to Add a Household Member or Program to an Existing Program When Coverage has Continued Beyond the Original Review Period

Due to the Review Discontinuance batch not being run, individuals have continued to receive coverage beyond their continuous eligibility dates and review period. Adding a person or program to a case in this situation requires some special processes.

A new individual or program can only be added to an existing program when the review form has been returned. A verbal request to add a person or program to an open case will not be taken if the review due date is in the past and the review form has not been returned. At the time of the verbal request, the consumer will be instructed that no further actions can be taken on their case unless the review form is returned. A review form will be manually generated if the consumer needs a new form.

For requests to add a person or program which have already been accepted, determine if the request was received prior or after the end of the review period. If prior to the end of the review period, the individual/program shall be added to the case. For individuals who are continuously eligible, a 12-month CE period will be established. If the request was received after the end of the review period, no action will be taken to add the individual/program until the review form is returned. Eligibility staff shall manually generate the appropriate Pre-Populated review form (KC1600 – E&D Pre-Pop or KC1200 – Family Med Pre-Pop). The review form will display the original review due date. In addition to re-mailing the review, staff shall also send a V008 notice informing the consumer that they must return the review form within 15 days in order to complete the determination for the family as well as the new request that was received verbally. A new template has been created and is available on the Standard Text for Copy and Paste spreadsheet.

If the review form is returned timely, the original application date recorded for the request to add the new person/program will be honored. Otherwise, action is taken to discontinue all household members in the first available month, allowing for timely notice.

However, prior to processing the request for the new person/program, it is necessary to determine when the existing members will be discontinued. Use the Timely Notice Closure

Date on the KEES Dispatch to determine the appropriate closure date, allowing for timely notice. The expired continuous eligibility dates for existing individuals must then be modified to match the last month of coverage which can be provided giving timely notice. For pregnant women, the CE period shall be extended through the postpartum period if that is more beneficial. Failing to extend the CE periods before processing to add the new person will result in a Read-Only EDBC, the individual being given an Ineligible status, or a change in coverage in paid months with a new 12 month CE period.

Once the CE periods have been modified, run EDBC beginning with the month the new person is being added to the plan through the month PRIOR to when discontinuance will occur. Once you've reached the month in which existing members are to be discontinued, negative action is taken for the reason of Failed to Return Review. This will allow the individuals subject to review to be discontinued for no review but will match the review due to the earliest CE period of persons on the case who remain continuously eligible.

Example 10: Two children are receiving PLN. Their review and CE had been set for 2/2016. They have not returned their review, but their PLN coverage continues. In 12/2015, a request was received to add a child to the case and it is being processed on 4/22/2016. Because the request to add the child was received prior to the end of the review period, action is taken to add the child. However, coverage for the other two children must end for failing to return their review. Before processing 12/2015 to add the new child, you must determine when you will discontinue existing members. Use the Timely Notice Closure date on the KEES Dispatch. Based on taking action on 4/22, the existing members will be discontinued effective 5/31/2016. Modify their CE date to end 5/31/2016. Run EDBC in 12/2015 to determine eligibility for the new individual; the new individual is approved for PLN with a CE period of 12/2015 through 11/2016. Run eligibility through 5/2016. Discontinue the original children by running Negative Action in the Come-up Month (6/2016) with the Failed to Return Review reason. Only the two original children are discontinued for failing to return the review. The child that has been newly added in 12/2015 has a new CE and review period through 11/2016.

Example 11: Two children are receiving PLN. Their review and CE had been set for 2/2016. They have not returned their review, but their PLN coverage continues. In 3/2016 a new request is received to add a child to the case and it is being processed on 4/22/2016. Because the request to add the child was received after the end of the review period, the review must be returned before adding the child. The worker generates the KC1200 – Family Medical Pre-Populated Review form and sends a V008 informing the consumer that they have 15 days to return the review form in order to process the review and add coverage for the new request.

- *IF* the review form is returned timely, the request to add the individual is processed in 3/2016, and the review is processed for the other two children.
- *IF* the review form is not returned timely, the request to add the individual is denied for failure to provide information.

Example 12: An individual is receiving MSP. Their review had been set for 2/2016. They have not returned their review, but their MSP coverage continues. In 3/2016 a new request is received to add Medically Needy to the case. The request is being processed on 4/22/2016. Because the request to add Medically Needy was received after the end of the review period, the review must be returned in order to add the new program. The worker generates the KC1600 – Elderly & Disabled Pre-Populated Review form and sends a V008 informing the consumer that they have 15 days to return the review form in order to process the review and add the new program.

- *IF* the review form is returned timely, the request to add the Medically Needy program is processed in 3/2016, and the review is processed.
- *IF* the review form is not returned timely, the request to add Medically Needy is denied for failure to provide information.

10. Using an Application Form as a Review

An application form shall be used as the review in the following circumstances:

- Received within two months prior to the Review Due month
- Received any month after the Review Due month through the current month when the Review Discontinuance Batch has not been run.

In the above situations, the application shall be considered a valid review provided the first month of the new review period is available (come-up month) at the time the application is processed. If the come-up month for the new review period is not available at the time the application is processed, the consumer must comply with the normal review process.

When the come-up month is available, the application is used to complete the review when all members of the household are listed on the application. The application must be reviewed for consistency with the known case information. If additional information is needed to process the review, it shall be requested from the consumer, but another application form or review form is not required. Although a pre-pop form was not received, the Review and IR record for the Pre-Pop review must still be updated to show the pre-pop review was received and EDBC-Complete.

In order for the application form to be used as a review, it also must include all of the existing household members. It is not necessary for the applicant to have requested coverage for all household members on the application. If individuals who are due for review, are listed on the application form, it is assumed that they wish for coverage to continue, and the form shall be used as a review for them. If the form does not include all household members, it shall be used to determine eligibility for the newly requested individual. If the Review Due date is in the past, manual action shall be taken to discontinue the remaining household members for failing to return their review.

Note: In instances where an application form is submitted that does not include all household members, it is acceptable to contact the applicant by phone to inquire whether or not the other individuals are still members of the household and whether they wish for coverage to continue. In these situations, the form can then be used to process the review for existing household members.

For cases which have been closed for failure to return the review, an application submitted during the review reconsideration period shall be used to process the review.

11. Review Extensions

A special review extension process has occurred for some cases. This process extended coverage and the review date for one year for the following:

- Family Medical programs with an expired Review Due Month, where the review had been returned but not yet processed.
- Family Medical programs with an expired Review Due Month and a determination was completed but the Review Due Month and Review/IR were not updated.

EDBC was not used to extend the coverage and review dates on these medical programs. This was done systematically, so staff should not expect to see an EDBC for this process. The Process Review Task was voided and no notices were sent. Staff will see the following Journal entry for cases that were identified for this process:

'Per KDHE Directive, the Review Due month for this medical program block was extended through (Insert Date). CE dates for members included on this program block also extended to match the review period. No EDBC was run to complete this action however the Report Status for the review on the Review and IR/ 12 month Reporting List page was updated to "Complete-EDBC Accepted" to indicate that the review process was completed. Previous Process Review task has been void. Notice not required for this action.'

The Review Extension Job was run based on the KEES Review Due Month. The chart below outlines which review months were extended, what month they were extended to and when the extension occurred. Additional review extension jobs may be run.

Original Review Due Month	New Review Due Month	Date Batch Job Ran
November 2015	November 2016	10/13/2016
December 2015	December 2016	10/13/2016
January 2016	January 2017	11/22/2016
February 2016	February 2017	11/22/2016
March 2016	March 2017	11/22/2016
April 2016	April 2017	1/31/2017
May 2016	May 2017	1/31/2017
June 2016	June 2017	1/31/2017
July 2016	July 2017	1/31/2017
August 2016	August 2017	1/31/2017

September 2016	September 2017	1/31/2017
October 2016	October 2017	1/31/2017

Example 13: Family Medical program had a Review Due Month of 11/2015. The Review was received and registered. The 11/2015 Pre-populated Review and IR record's Document status was updated to Received. No EDBC has been run on or after 11/01/2015. In this scenario, on 10/13/2016, the Review Due Month and individual's CE dates were extended to 11/2016 and the 11/2015 Pre-populated Review and IR record's Report status was updated to Complete-EDBC Accepted. Note: The 11/2016 Review batch was run on 10/17/2016 so this case was picked up then for a regular review.

Example 14: Family Medical program had an EDBC ran on 08/14/2015 for benefit month 09/2015. Coverage was authorized and a new CE period of 09/2015 through 08/31/2016 was established. The Review Due Month however remained 12/2015 and therefore the medical program was not picked up in the 08/2016 Review Batch. In this scenario, on 10/13/2016, the Review Due Month and the individual's CE date were extended to 12/2016 and the Review and IR record for the 12/2015 Pre-populated review was set to Received and Complete-EDBC Accepted.

12. KEES Workarounds Related to Reviews

Defects and or design gaps exist in KEES that require the use of special processes. Follow the special processes indicated below:

A. 300 Aid Code

At the time of KEES Implementation, the KEES Review process did not recognize individuals eligible under the 300 Aid Code. This was corrected in KEES in December 2015. To support the review process the following workarounds were required for reviews in the months of July 2015 through December 2015.

1. Persons with MSP

When an MSP program exists with a 300 aid code in KEES, a review will be automatically generated for both programs, including passive and pre-populated. Until system modifications have been completed, the review type generated for the MSP program will also be used for the 300 aid code program as well. Staff must ensure that the LTC data details are completed on the case in order for the review to properly process.

2. Persons without MSP

A special report was generated 45 days before the end of the review period and distributed to DCF staff for processing. The report identified all individuals with a 300 aid code with no MSP coverage that are up for review. The report indicated the type of review to be completed for each case – passive, administrative or pre-populated.

Passive – A manual passive review shall be completed when there are no earnings, expenses or income allocation on the case. The review will be completed based on the information already existing on the case. The KC1700 (E&D Passive Review Form) and letter must be generated and mailed. The review must be processed by the 1st of the month to allow the customer an opportunity to report any changes.

Administrative – A manual administrative review shall be completed when there are no earnings, expenses or income allocation, but there are medical expenses budgeted on the case. Staff must review the case to determine if any additional information is needed to complete the review. If no additional information is needed, the KC1700 (E&D Passive Review Form) and letter must be generated and mailed. Again, the review must be processed by the 1st of the month to allow the consumer an opportunity to report any changes.

If upon review it is determined additional information is needed to process the review, a request for information shall be mailed, allowing 10 days to provide the information. If the information is provided, process the review and send notification of the outcome. If the information is not provided, the following case action is required:

a. If continued eligibility cannot be determined without the information, action must be taken to discontinue coverage due to failure to provide.

b. If the only information not provided is verification of medical expenses, the review may still be processed without allowing the expense. Once the review has been completed, the KC1700 (E&D Passive Review Form) and letter must be sent.

Pre-Populated – A pre-populated review form (KC1600) shall be manually generated and sent. The form should be sent during the last week of the month prior to the review month to allow the consumer sufficient time to complete and return the form. The review shall then be processed like any other automated pre-populated review.

B. SI Aid Code

SI Aid Codes converted with a Review Date of 07-2016. This does not mean these individuals are subject to a review. At the time the July 2016 review batch was run, these individuals were extended and given a future Review Due date of November 2016. These individuals are currently being monitored via reports to ensure that they are not being subject to review requirements.

C. Resource Test

Some programs rely on a resource test to determine if the review will be pre-populated or passive (resources less than 85% of the limit). The test will not be completed until a full

EDBC has been executed. Until then, these cases are expected to have a Pre-Populated Review.

D. EDBC Batch Error Report

With the review cycle each month, it is expected some cases will fail for a variety of reasons. When this happens, staff must complete the review process manually. This could involve running EDBC or sending/generating forms. This is expected to be a small number each month. Additional instructions will be issued when applicable.

E. Auto Journals

Auto journals will not be written as part of the review cycle. This means no journal entry will be made as part of the passive/super-passive review cycle or when a review form is received. Staff are not required to develop a journal entry specifically related to the passive or super-passive processes. Additional research may be required to identify if a review was completed. For example, evidence of a review form/notice in the distributed documents and a record on the Review/IR page. Journal/log entries are still expected to be recorded for all manual actions taken as part of the review process.

F. Forms for Facilities

KEES does not automatically send forms to facilities. The facility must be notified when there is a change in eligibility or patient liability. The facility will need to be notified via a KEES Form when the Pre-Populated Review is processed. The appropriate Forms are as follows:

- Pre-Populated Review Complete - Facility Notice-Review Complete-Remains Eligible
- Income in excess of 300% of SSI limit and cost of care is less than the income - Facility Notice-Review Complete-Excess Liability
- Returns the Pre-Populated Review but fails the review process - Facility Notice-General Denial
- Failure to Return the Pre-Populated Review - Facility Notice-Failure to Complete Review

Note: When a review is completed due to a Passive Review, the facility does not need to be notified because there have been no changes to eligibility or liability. However, if the client reports changes to the Passive Review, then a Form would need to be generated to notify the facility of the change.

G. Passive Review Responses – No Longer Eligible

If the change reported by the consumer as part of a Passive Review Response causes ineligibility for the program, KEES is attempting to protect the continuous eligibility and not discontinue coverage. A special process must be followed when it is identified that the consumer is no longer eligible. See KEES Workaround 451 on the KEES Repository.

13. SPECIAL PROCESSES FOR MEDICALLY NEEDY/SPENDDOWN REVIEWS

This section provides special instructions for processing late reviews where a Medically Needy program is involved. Two areas are covered.

First, the Review Discontinuance batch is designed to run monthly to identify and discontinue medical programs that have a required review, but the review has not been processed. This occurs when the Document Status is "Sent" or "Received" and the Report Status is anything but, "Complete – EDBC Accepted", "Not Applicable", or "Passive". KEES automatically sends the appropriate Review form or NOA to the consumer and records that it was sent on the Review and IR/12 Month Reporting List page. Users can perform a Distributed Documents Search to view the sent review form. The Discontinuance process has not routinely executed since KEES go-live. See section 9 above.

Second, for cases where a review was returned and not processed timely, coverage in KEES was designed to continue. However, complete coverage information may not be present in the MMIS. These instructions address reviews that have not been timely processed.

A. IMPACT OF UNTIMELY REVIEW PROCESSING

As noted earlier, the discontinuance batch has not been executed on a regular schedule, and eligibility has been allowed to continue past the review month. For most programs, this means that eligibility is passed to the MMIS and coverage continues to be provided under the same Benefit Plan/Aid Code active for the member prior to the month of review. However, the link between KEES and the MMIS isn't as straightforward for Medically Needy programs. Coverage may not always pass to the MMIS cleanly when a Medically Needy program exists.

Most programs were discontinued through special discontinuance automated batch jobs that were executed months after the review was due, as explained in Section 9. However, all Elderly and Disabled programs were excluded from this process. Staff were previously issued instructions regarding processing non-Medically Needy late reviews that fail to return the review. This memo provides instructions for processing those Medically Needy programs that didn't return the review as well as guidance to follow when a review was returned.

For reviews that were returned, coverage was automatically extended for most Family Medical programs, as explained in Section 11. Elderly and Disabled programs, including Medically Needy, were not included. These processes are used when processing late reviews.

For either situation, special processes are needed when working late reviews on Medically Needy programs to ensure coverage is accurately reflected in both the MMIS and KEES systems. Processes below are needed when determining eligibility on a late review for a program block with any of the following programs:

a. Medically Needy (MDN) with MSP – Make note of eligibility where the MDN coverage is not current in the MMIS but the MSP is current in the MMIS.
b. MDN only with new MSP coverage requested
c. Medically Needy only without MSP
d. MSP only. Note there is specifically an issue when the RMT on the Program Block is Medical.

Actions are dependent upon several factors, outlined below. Note that coverage is not always automatically continued.

B. PROCESSING REQUIREMENTS

The following processes are to be followed for all reviews that involve a Medically Needy Program that are processed untimely. With these instructions, there may be situations created where eligibility in KEES may not always match the eligibility showing in the MMIS. Because of the nature of this action, consultation with supervisory staff and/or policy will likely be necessary. Thorough journaling of all actions is required.

For most case actions, it is appropriate to match KEES and MMIS eligibility. However, there are situations when it is allowable for KEES to display coverage that is inconsistent with MMIS.

Note: Consumers have a three month reconsideration period when the program is discontinued and a review is provided. This would include the QMB program which is normally authorized the month after the month of processing. (QMB eligibility may be reinstated without a break in assistance if approved during the review reconsideration period.)

C. ADMINISTRATIVE ROLE DETERMINATION

The first step when processing a program that has not yet returned a review is to determine if the consumer had any Administrative Roles listed that did not receive a review form. When this occurs, the agency must ensure those Roles receive the appropriate form.

- Check the program block on the Case Summary page for the Administrative role.
- Check Distributed Documents to determine if a review was sent to both the consumer and the Administrative Role(s)

If not, then the review is regenerated to all appropriate individuals with a 15 day return time.

If the review is not returned, the program block is usually discontinued (given timely and adequate notice). However, if one of the special situations (a-d above) exist, additional steps are necessary before taking negative action.
If the review is returned, eligibility may be continued. However, special processes also apply if one of the special situations (a-d above) exist.

NOTE: Failure to follow these instructions may result in incorrect eligibility transmitted to the MMIS – resulting in rework and incorrect coverage for the member.

D. Determine the next step by checking MMIS and KEES

For both situations when the review is not returned as well as when it is, it is essential to check MMIS and KEES when one of the special situations exist. This will determine the correct procedure for processing the case**.** These two steps are essential. A consumer can show as an Active MEM on a spenddown in KEES, but not have any eligibility in MMIS. This occurs when a base period has expired in KEES, but a new base period is not established in KEES before MMIS Monthly. This causes eligibility to end in the MMIS even though KEES still shows they are an Active MEM. If they have ongoing MSP coverage, the MSP will continue in KEES, but the Medically Needy will not. The inconsistency is evident and worker intervention is always required.

The only way an ES will know if such a situation exists is by checking both systems. If inconsistencies exist, the worker must then determine if it is necessary to 'fill in' the MMIS with the months shown as Active MEM in KEES. For these late reviews, the 'gap; period could be months or years. Staff must determine if it is appropriate to extend coverage in those 'gap' months – we call this 'Filling the gap'. This determination requires analysis and documentation.

If eligibility is consistent (e.g. all base periods in MMIS match, etc.) then these special processes are not required.

E. Work Case Depending Upon Information found in KEES and MMIS

Once you have identified you have a special case, it is important to determine the next step. Additional processing details are found in the **Medically Needy Late Review Guide**, attached.

a. For situations where both Medically Needy and MSP exist in KEES, but MSP is the only active program in MMIS:

    1. If A Review Is Not Returned: Discontinue the program block giving timely and adequate notice. Evaluate if a new Spenddown should be established based on the guidelines in Item G below. Follow the steps listed in the Medically Needy Late Review Guide.

    2. If A review is Returned: Following the determination, if the MEMs are no longer eligible for any program, discontinue the program block giving timely and adequate notice and evaluate if a new Spenddown should be established based on the guidelines in Item F below.

If eligible MEMs exist, determine the potential programs. MSP is always authorized, although coverage changes are not processed until the month following the month the review is processed. See Item F below to determine if a new Spenddown should be established.

b. Previous Medically Needy Coverage with new MSP requested and Medically Needy does not exist in KEES

   1. If a Review is Not Returned: Discontinue the program block giving timely and adequate notice and follow the procedures in G below to determine if a 'Fill the Gap' spenddown is established. The MSP program is not determined until a review is provided.

   2. If a Review is Returned: Determine eligibility for MSP based on current policy. Following the determination, if the MEMs are no longer eligible for any program, discontinue the program block giving timely and adequate notice and evaluate if a 'fill the gap' Spenddown should be established based on the guidelines in Item F below

      If eligible MEMs exist, determine the potential programs. MSP is always authorized based on first effective month of coverage according to policy. See Item F to determine if a new spenddown or a 'fill the gap' spenddown should be established.

c. Medically Needy only without MSP exists.

   1. If a Review is Not Returned: Discontinue the Program block giving timely and adequate notice. Follow the procedures in G below to determine if a 'Fill the Gap' spenddown is established.

   2. If a Review is returned: Determine eligibility for ongoing coverage. IF eligible MEMs do not exist, discontinue giving timely and adequate notice. Follow the procedures in F below to determine if a 'Fill the Gap' spenddown is established.

      If eligible MEMs exist, follow the procedures in F below to determine if a new spenddown or a 'fill the gap' spenddown is established. If neither is going to be processed, discontinue the case given timely and adequate notice.

d. MSP Only with an RMT of 'Medical'

   Regardless of the situation, if eligibility is only determined for an MSP program ALWAYS change the RMT to 'MSP' before running EDBC. This will ensure Medically Needy coverage is not accidently authorized.

F. Establishing a New Medically Needy Base Period for a Late Review - Review Returned

A new spenddown base is not automatically established when a review is returned. Additional processing details are found in the **Medically Needy Late Review Guide**, attached. For late reviews, the following apply:

a. Fill The Gap Period: If the consumer has returned a review, a new Base Period is routinely established. The only exception is if the consumer has specifically requested s/he no longer wants coverage. The action is always carefully journaled. If MMIS will not match KEES an additional journal entry is required that details the decision making process.

b. New Spenddown Period: This is only applicable if the consumer has returned a review. Existing policy is followed to determine if a new spenddown period is applicable. In essence, this means the consumer must have met, or have met at least 67% of the last amount of the base period.

G. Establishing A Medically Needy Base Period for a Late Review – No Review Returned

If the consumer has not returned a review the Fill the Gap base period is not automatically established. The ES is responsible for evaluating the situation and carefully determining if a new base should be established. The following principles are considered:

- Fill the Gap Period: What type of notice was sent to the recipient?
- Did the consumer call asking about the status of the spenddown?
- The amount of the potential spenddown
- Historic activity regarding spenddowns – has s/he met them in the past?
- Special circumstances- e.g. Mental Health expenses; Uncovered, regular OTC drugs; Old due and owing bills; Other health insurance coverage
- If the eligibility worker encounters questionable or unfamiliar situations, consultation with supervisory or policy staff will be necessary

If the gap is not filled with a new base period, this means the MMIS and KEES will not match. Careful journaling of the action is required. See sample logs in the Medically Needy Late Review Guide.

It would not be a routine action to establish a new spenddown period in this situation. Consultation with Policy is necessary prior to taking this action.

H. Special Processes

Please note the following special processes that apply to multiple situations.

a. When cases have been determined for ‘fill in the gap’ base periods and spenddown amounts, they will need to be sent to the HelpDesk to have the MMIS updated. The ‘fill in the gap’ months will start after the last paid base period in the MMIS. Once notification from the HelpDesk has been received, Run EDBC for the first month determined and continue to Run EDBC in sequence through the come up month. This process could create more than one six month. Remember to run the come up month with the RE run reason. This will set the new review date.

b. For MSP eligibility, social security income coverage must be verified through a reliable source (e.g. TPQY). It is important to change the RMT to match the eligibility approved (ex. RMT is ‘MSP’ for MSP only cases. RMT is ‘Medical’ for MDN and MSP combined cases).

14. Special Processes for Working Healthy Targeted Reviews

Consumers on WH, WH/MI or WORK will be sent a Targeted Desk Review via the N812. The purpose is to gather current income information to determine if the consumer should have a premium or if the premium amount needs adjusted. A task will be created in KEES when the form is mailed. When the form is returned or 15 days after the form is mailed, the worker will claim the task and search the imaging system for the form and income verification.

A. If the WH Targeted Review form has been returned with income verification, the Income Page will be updated with new income amounts. The Expense Page shall also be updated if needed. Run EDBC for the seventh WH month. If the WH individual remains eligible, use the ‘WH six month review with premium or without premium’ templates found on the Standard Text for Copy & Paste spreadsheet. Delete the NOA generated by KEES.

B. If the WH Targeted Review form is not returned, the worker will check the imaging system for 30 days of income verification from the 4th or 5th Working Healthy month. The Work Number will also be checked for wage verification if the consumer has not already supplied the information. If the agency has appropriate wage verification, a desk review can be processed without the returned Targeted Review form. The Income Page will be updated with the new income amounts. The Expense Page shall also be updated if needed. Run EDBC for the seventh WH month. If the WH individual remains eligible, use the ‘WH six month review with premium or without premium’ templates found on the Standard Text for Copy & Paste spreadsheet. Delete the NOA generated by KEES.

C. If the WH Targeted Review form is not returned and the worker cannot obtain wage verification, the case will be closed at the end of 6th Working Healthy month, or earliest possible month allowing for timely notice. The closure reason is Failure to Provide information. Create a Non-Compliance record and run EDBC in the 7th month to close the case.

15. CONCLUSION

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

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