



Policy Memo	
KDHE-DHCF POLICY NO: 2015-06-04	From: Jeanine Schieferecke
Date: June 24, 2015	KEESM/KFMAM Reference:
RE: Implementation of KEES – Medical Assistance Programs #1	Program(s): All Medical Assistance Programs

The purpose of this memo is to provide instructions for the full implementation of the Kansas Eligibility Enforcement System (KEES). Several policy changes are also implemented with the implementation of KEES. All policy changes are effective with the implementation of KEES, except where otherwise indicated. Full KEES implementation occurs on June 29, 2015 but these changes also apply to cases processed during the KEES Controlled Production Period beginning June 27, 2015.

This memo represents the second of four formal communications regarding the KEES implementation. The first covered the transition period between the existing legacy systems and KEES, this memo covers basic implementation issues, the third communication will cover detailed eligibility issues (income budgeting, notices, verification, etc) and the final memo will address reviews in the KEES system. Additional instruction will be provided as necessary.

1. Background and General Information

A. Purpose of KEES

This memo provides instruction for implementation of the second phase of the KEES system, a phase that includes an automated eligibility determination system to be used by eligibility staff as well as updates to the KanCare Self Service portal. The first phase of KEES implemented the initial version of the KanCare Self Service Portal in July, 2012. The third phase of KEES, implementation of human services programs, is scheduled to occur in 2016. Upon implementation, the KEES system replaces the Kansas Automated Eligibility and Child Support Enforcement System (KAECSES) as the system of record for eligibility.

The implementation of KEES represents a significant transition for medical assistance eligibility, with many key changes. These include:

- New service channels opened to medical assistance customers

- Business process redesign for staff and partners
- Reassignments of work responsibilities within the medical assistance programs
- Implementation of a completely automated eligibility determination process (No Touch)
- Focus on sharing information between all medical programs
- Implementation of a state-wide imaging system, resulting in paperless medical case files
- Significant changes to eligibility verification processes with the use of automated interfaces

B. Policy Effective Dates

As indicated above, most policy changes are effective with the implementation of KEES. Policies are applicable to all eligibility actions taken on or after the implementation of KEES. There is not a specific benefit month tied to these changes. This means an action taken in KEES could result in a different outcome than an action taken in KAECSES. However, income limits and other standards (such as poverty level amounts) are based on the benefit month of the change.

C. KEES Availability and Support

Normal operating hours of the KEES system will be 6am to 8pm, although the system will be brought down at 7 pm for the first few days. The KanCare Self-Service Portal will continue to be available 24 hours a day, 7 days a week, except for scheduled maintenance hours as determined necessary.

Support is available for KEES users by calling User Support at 1-877-782-7358. Additional support is available for eligibility staff and Presumptive Eligibility entities by contacting the KEES Help Desk at 1-844-723-KEES (5337).

Note: Staff should follow appropriate protocols that have been established locally and report issues through proper channels prior to contacting Support.

Support is also available through email:

KEESHHELP@KEES.gov – KEES Technical Support

KEESBusinessSupportTeam@kdheks.gov – KEES Business Support

KDHE Technical Agency HelpDesk

DCF Technical Agency HelpDesk

Staff are advised to take steps to ensure all emails containing PHI/PII are sent securely through proper agency/entity protocol.

The KEES User Manual provides detailed information for navigating and using the KEES system. It includes a complete list of screens and related fields that are available in the

system. Sections addressing Special Processes and Workarounds are included. The protocol for adding new KEES users or adjusting the profile of an existing user are also found in the user manual. The KEES User Manual is located on the KDHE website at <http://content.dcf.ks.gov/ees/KEESWebHelp/index.htm>

A complete list of screens and related fields available in the system can be accessed through the online help screens in KEES. Access these by selecting 'HELP' from the utility navigation bar in KEES.

In addition to the User Manual, several other helpful tools have been created to assist with the transition to KEES. Many Job Aides, Training Packets, Process Guides and other documents have been developed to provide special instruction for staff. These documents are referenced throughout this memo where instruction is required to ensure an accurate eligibility determination. A complete list of these tools is found at <http://www.kancare.ks.gov/kees-train/Info/Training/Content/KEES-Info-Training.htm>

The KEES system has a number of processing deadlines that users must note. These will be referenced throughout this document and other KEES-related material. A summary code card with these critical processing deadlines has been developed. See the Processing Deadlines Code Card.

2. Division of Work

Workload assignments and responsibilities are changing as a result of KEES implementation.

A. KDHE/DCF

The following apply with the implementation of KEES:

- Elderly and Disabled cases will continue to be processed by DCF offices.
- MAGI (Family Medical) will continue to be processed by the Clearinghouse.

The following also apply with the implementation of KEES:

1. File Clearance/Case Registration for all medical applications coming through the Self-Service Portal will be the responsibility of the Clearinghouse, including applications from the FFM and MIPPA.
2. All MAGI related determinations will be made by the Clearinghouse. Applications for both MAGI and non-MAGI medical programs will be accepted at DCF offices. DCF will complete a screening to determine if a MAGI determination is necessary. Requests that require a MAGI determination will be routed to the Clearinghouse. File Clearance/Case Registration for potential MAGI cases received through this process will be the responsibility of the Clearinghouse.

3. Requests received at DCF offices that do not screen for potential MAGI will be kept and processed by DCF.
4. The Clearinghouse will complete the MAGI determination on all cases. Cases with an elderly or disabled person requesting coverage who fail MAGI will be sent to DCF for final processing.
5. Child welfare medical (adoption & foster care) are the responsibility of DCF- PPS.
6. Aged-Out Foster Care will be the responsibility of the Clearinghouse. Permanent guardianship Subsidy medical is being eliminated, but members and applicants will be the responsibility of the Clearinghouse.
7. DCF will process MediKan programs. Although nearly all MediKan requests will be initially processed by the Clearinghouse for a MAGI screen, DCF will continue to determine initial eligibility and provide ongoing case maintenance of these programs.
8. Presumptive Eligibility for Pregnant Women, Children, and Adults will be managed by the Clearinghouse.
9. SOBRA applications for the elderly and disabled populations will be managed by DCF. All other SOBRA applications will be managed by the Clearinghouse.
10. Refugee Medical will be processed according to current workload assignment rules. Automatic Refugee Medical will be done by DCF, as will elderly and disabled programs. Other medical for refugees will be processed by the Clearinghouse.
11. Clearinghouse will maintain the Resource Data Bank (RDB).

B. Clearinghouse State/Contractor

The existing division of work between the Clearinghouse KDHE staff and the Clearinghouse contract staff will continue with the following exceptions:

KDHE staff will process all of the specialty applications. These include the Breast and Cervical Cancer, Inmate, and TB.

C. KDHE Outstationed Workers

The KDHE Outstationed eligibility staff will continue to process applications for Family Medical and MSP programs. The Outstationed staff will be responsible for the entire application process, from registration through completion. Approved Family Medical applications are then assigned to the Clearinghouse for ongoing maintenance activities. Approved MSP applications are sent to DCF for maintenance.

D. DCF Outstationed Workers

DCF Outstationed Workers continue to accept Family Medical applications and then route them to the Clearinghouse, following the same instructions used by all DCF staff.

3. Conversion

To create initial cases in KEES, data and information has been taken from existing sources during a conversion process. Information from KAECSES, the MMIS, KDHE Image Now, DCF OneNote and the PSI Platform has been combined to create the KEES case. To accommodate the new functionality and data elements in KEES, data and case information may have been altered or changed as part of the conversion process. Case persons and program persons may have changed or been eliminated.

Although conversion rules were applied to ensure the process was as smooth as possible, the resulting data in the KEES system will need to be reviewed in order to ensure accurate ongoing determinations. Information to complete the data clean-up was provided in KDHE Policy Memo 2015-06-03, Transition of Medical Assistance into KEES. Additional detailed information, as well as specifics regarding the conversion process can be found in the KEES user manual.

Because of the automation involved in KEES, particularly that involving review functionality, it is very important that the data be reviewed and corrected according to the deadlines established.

It is the responsibility of eligibility staff to ensure the data in KEES is correct according to established policies and procedures. This is done the first time the case is touched following implementation, no later than the next scheduled review.

Although eligibility staff are required to review and update cases to ensure accuracy, KEES is designed to ensure existing beneficiaries do not lose coverage as a result of the conversion. Members will continue to receive medical coverage until EDBC is run. This is not just when an individual runs EDBC, but includes an automated EDBC run as well.

4. Medical Assistance Application Channels

All medical assistance channels currently available to medical customers will continue to be available following KEES implementation. These channels include: Self Service Portal, Paper, FFM, MIPPA, Telephone and Fax. With the exception of enhancements to the SSP, there are no changes to the way the customer completes the application process. There are, however, significant changes in the business process staff use to process the application once it is received through the E-Application and Worker Portal functions in KEES. Both features are designed to record information and reuse as necessary without duplicating data entry. Effective with KEES go-live, all applications received through an electronic source - the SSP, FFM and MIPPA - will be taken into KEES through the E-Application process. Data will be taken directly from these sources into KEES without additional data entry by staff. For paper, fax and telephone applications, the Worker Portal provides similar functionality.

A. SSP Enhancements

The current version of the SSP will be disabled when the Medical Processing Downtime begins (7:00 pm on 06-19-15, see policy memo 2015-06-03). A new version of the SSP will then be available for applicants when KEES is live on June 29, 2015. The application is modified to include several new questions. Although applicants are encouraged to complete the application to the extent possible, an application may be submitted with incomplete or unanswered questions. The majority of applications can be processed despite the unanswered questions, but in some cases a missing response will require action on the part of the worker. Staff must use the SSP Application Job Aid to determine when a response/additional information is necessary in order to process the application.

With the new version of the application, applicants will also have the ability to upload and attach documents to an application. When submitted with the application the documents will be associated to the ID number of the application. At this time, documents can be submitted until the end of the day the application is submitted. They are linked to the application in the same manner as documents submitted with the application.

As indicated in Item 2 (A), beginning with KEES implementation, all SSP applications will be routed to the Clearinghouse for screening and registration. The Clearinghouse will complete a MAGI determination when applicable and route applications that require a non-MAGI determination to DCF. See item 8 for more information.

B. Telephone Applications

Following KEES implementation, telephone applications will continue using the same process. Staff complete a paper application on behalf of the consumer, which is then imaged and treated like a paper application. Telephone Applications are currently handled by the Clearinghouse

C. Paper Applications

No changes are being made to the paper application forms or supplements at this time. Continue to use the versions issued in 03-2015. DCF Offices or Community partners continue to request a bulk supply of applications via the process outlined in KDHE-DHCF Policy Memo 2013-0901. Forms are also available for download from the following link:

http://www.kdheks.gov/hcf/medical_assistance/apply_for_assistance.html

D. Worker Portal

The Worker Portal is a screen in KEES that is used to key data received from non-electronic sources into KEES. The worker portal will facilitate the acceptance and

processing of applications and will enable KEES functionality to be used consistently regardless of the application source. Staff are expected to complete all data fields in the Worker Portal. Once data has been entered, clicking the Submit button generates an e-App task and transfers the application data over to the e-application.

At this time, only the Clearinghouse and the Out stationed workers will be using the Worker Portal. DCF will data enter application directly into the KEES data collection screens. Also, the Worker Portal does not support specialty applications, such as Breast and Cervical Cancer, Inmate or Tuberculosis applications.

See the KEES User Manual and Worker Portal job aids for more information

E. FFM and MIPPA Applications

Applications that originate with the FFM and SSA (MIPPA) will continue to be sent according to existing criteria. The Clearinghouse will be responsible for registration of all FFM and MIPPA applications and will route applications requiring a non-MAGI determination to DCF. This will include MIPPA applications. Use existing criteria to determine if an FFM requires a non-MAGI determination.

1. FFM Applications:

A PDF version of the FFM application will not be produced at KEES go-live, although a version is planned for a later implementation. Instead, applications will go through the e-Application process. Verification indicators will not be available on the e-application. Staff are to use the automated interfaces to complete verification to the extent possible. Instructions on using the automated interfaces will be included in a later memo. It is especially important to use the Federal Hub to verify citizenship/identity and non-citizenship. With the exception of income verification, most FFM applications should generally not require client-provided verification in order to determine MAGI eligibility.

Results from Medicaid/CHIP determination on FFM applications will now be sent back to the FFM. This is generated automatically through an interface.

FFM applications will be held starting the evening of June 11 to allow for the transition to KEES. Applications accumulated during the conversion will be released just after the beginning of Full Production. Thereafter, applications will come in to the KEES system as they are sent from the FFM. They will no longer be held for weekly releases.

QHP Indicator:

All non-FFM MAGI applications that are denied will be screened for potential eligibility for a qualified health plan (QHP) offered by the FFM. These applications

will be sent automatically to the FFM. Cases deemed potentially eligible for FFM will have a QHP indicator of Y in the KEES system.

Note: Although it appears staff can update this indicator in KEES, the update is not always accepted. For that reason, staff are NOT to change the code generated by the system.

2. MIPPA Applications:

Only an e-Application will be available at go-live. Although a PDF application is planned for the future, one will not be produced at this time. Staff will need to use the e-Application Summary Screen to view information. All information currently received from Social Security will be available to staff through the e-Application.

Once registered, the Clearinghouse will ensure a DCF program block is established and the application is routed to the appropriate DCF office. No additional processing will occur on the application, as the MIPPA request, by definition, is limited strictly to the MSP programs. DCF is responsible for all additional case processing.

Only MSP programs are determined from a MIPPA application. If full medical eligibility is requested, additional information must be obtained. MIPPA applications will have a Requested Medical Type (RMT) of MSP in KEES, which will limit the coverage that can be approved from EDBC.

In addition, most incoming information from the MIPPA application will be verified upon receipt. Income used for the MIPPA determination will use a MIPPA income record. This is used instead of other income record types.

Note regarding data acceptance: KEES currently reads all income and resource records from the MIPPA application for each individual on the case, including \$0 records. This means that persons with a spouse on the application could have the same records replicated. Staff must pay close attention to the records being displayed and counted and may need to remove the \$0 income and resource records and remove the duplicate records.

Applications that were received from Social Security on or after June 13 will be available for staff as e-Applications in KEES through the new process. These applications will be available at the beginning of Full Production.

Thereafter, applications will be sent to KEES as they are received from Social Security. They will no longer be held for periodic release and will be available to staff as they are received.

F. Applications Sources in KEES – Summary

Applications for medical programs can arrive from various sources. The chart below gives general guidance about each source and serves as a reference regarding application avenues.

<p>Medical Consumer Self-Service Portal (SSP)</p>	<p>The consumer will apply online and have the ability to upload supporting documentation.</p> <ul style="list-style-type: none"> • The app will appear in the e-Tools/e-Application Search • Select the application and proceed to Link e-app to Case • Find the PDF version of the app in ImageNow for use in registration • Also find any attachments the consumer may have submitted
<p>Federally-Facilitated Marketplace (FFM, aka HealthCare.gov)</p>	<p>This source comes from a consumer using HealthCare.gov. If the FFM assesses an applicant may be eligible for Medicaid/CHIP or E&D, the app will be sent to the State of Kansas. We will also receive an app if the consumer asks for a “full determination.”</p> <ul style="list-style-type: none"> • The app will appear in the e-Tools/e-Application Search • Select the application and proceed to Link e-app to Case or Edit • Find the PDF version of the app in ImageNow for use in registration • These apps will not have any kind of a signature • A response will be sent back to the FFM with the results of the determination
<p>MIPPA (Medicare Improvements for Patients and Providers Act of 2008)</p>	<p>Persons potentially eligible for Medicare Savings Plans will be sent to Kansas through an interface with Social Security.</p> <ul style="list-style-type: none"> • The app will appear in the e-Tools/e-Application Search • Select the application and proceed to Link e-app to Case • There will be no PDF version of the app at go-live
<p>Paper</p>	<p>Paper applications will be imaged and data entered through the Worker Portal (Clearinghouse and Outstationed Workers) or Data Collection Screens (DCF and BCC, TB, Inmate) in ABMS.</p> <ul style="list-style-type: none"> • The paper application will need to be scanned first so the ImageNow ID can be entered. • The app will appear in the e-Tools/e-Application Search • Select the application and proceed to Link e-app to Case or Edit • No PDF of the Worker Portal will be generated. Find the PDF version of the paper application in ImageNow for use in registration.

Telephone-Clearinghouse Only	<p>Telephone applications will need to be recorded on a paper application..</p> <ul style="list-style-type: none"> • The paper application will need to be scanned first so the ImageNow ID can be entered. • The app will appear in the e-Tools/e-Application Search • Select the application and proceed to Link e-app to Case or Edit • No PDF of the Worker Portal will be generated. Find the PDF version of the paper application in ImageNow for use in registration. • Voice signatures are recorded and retained as part of the telephonic application process.
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5. Electronic Case Files and Case Logs

KDHE is implementing an Electronic Case File across all Medical Assistance programs. This is done by integrating the ImageNow system into KEES. All documents associated to the Medical Case will be available electronically through KEES. ImageNow will also be used for DCF non-medical cases. This memo only covers implementation of the medical functionality. DCF will provide separate instruction regarding the use of ImageNow for non-medical cases.

A. Common Documents/Document Types

Effective with KEES implementation, all documents associated with a medical case are part of the electronic case record. Paper records are no longer applicable except as noted in section XX below regarding paper retention. All paper documents as well as electronic communications and documents, such as emails, are imaged and made part of the case file.

The KEES imaging system provides for shared access to documents. Documents are not exclusive to an entity or a program block and are shared across medical assistance programs, except where specifically prohibited.

1. Document Types and Indexing

Because the Imaging System is used across the medical enterprise, it is critical that all users follow a standard procedure to organize documents. Each document recorded in KEES is organized by a Document Type (or Doc Type). Labeling the document by Doc Type not only organizes, but also initiates automated workflow and tasks (see item XX). Staff must ensure the appropriate Doc Type is used. A list of Doc Types and associated Workflows – In Development is included with this memo. Note that two of the Doc Types, (PPS Legal and PPS Forms) contain highly confidential information and are only to be used for PPS staff. Other staffs are not to view or use these documents unless specific authority has been granted.

- A. **Case Level Documents.** Most documents are imaged at the Case Level in KEES. This means that the document is tied to the case and will be easily accessible by all program blocks on that case number. Documents imaged at the Case Level will also be available to other cases, through searches through ImageNow.
- B. **Person Level Documents.** PII will also be imaged at the Person Level. These documents will be associated to the person and will be available to anyone who is

viewing the individual. Examples of PII are birth certificates, Driver's license, citizenship and immigration documents.

- C. **Conversion.** Documents currently part of either the Clearinghouse ImageNow files or DCF's One Note will be imaged and available through KEES. They will not use the existing DocTypes.
- D. **PMDT Documents and LTC Forms.** PMDT and LTC partners are not part of KEES. Therefore, documents tied to these processes will continue to be sent through existing processes. This impacts all PMDT referrals, MS-2126 for NF Placements and communications through the MS-3160 and MS-3161 for HCBS, WORK, and the MS-3166 for PACE. Since many of these processes involve e-mail communication, staff must make sure emails are sent securely.
- E. **Review of Trusts.** All documents associated to trusts, transfers and other legal instruments will continue to be reviewed by KDHE-Policy. These documents will now be imaged with a Doc Type of Trust/Annuity and a task created. The tasks will be retrieved and an email response will be provided to the person initiating the task and the Manager/PA of the Management Region.
- F. **Retention.** Imaged documents are retained for a period of 60 days from the date of receipt. The management region is responsible for ensuring documents aged beyond this period are properly destroyed.

B. Electronic and Automatic Journal/Case Log

A critical part of the eligibility case is the Case Log. KEES implements an electronic case log with this implementation. In KEES, it is called the Journal. The KEES Journal is used as the common case log for the case and is used for all medical programs. It is kept in chronological order. The log includes manual entries as well as automated entries, including updates by Batch Jobs. Additional detail is available in the KEES User Manual, including information regarding specific entries created by worker and system actions. It is the responsibility of staff to ensure the log/Journal is kept in order and up to date.

1. **Deleting and Appending Case Log Entries:** Once documented, case log entries are never deleted from a case. Instead, a new entry must be made with the correct information. However, if a log is entered for someone on the wrong case and involves PHI, the log is not to be shared with the consumer or with others requesting the file

Although KEES has an append feature, it cannot be used at this time.

2. **Conversion:** The electronic log currently kept by the Clearinghouse will be converted and will be part of the new KEES Journal. The electronic log kept by DCF will convert as images and be available through ImageNow.

C. Definition of a Case File

The case file is still considered part of the overall eligibility record. It is the responsibility of eligibility staff to ensure the case file documentation supports the eligibility determination.

The definition of the case file is changing to recognize the new technology. The case file now includes the following: The case log (electronic journal), applications, documents in ImageNow, call records, system coding, eligibility determination history, notices/forms and other information that is part of KEES. Also included are paper documents that haven't been imaged to the case.

The case file also includes interface information. However, these records are confidential per user agreements and may not be disclosed to another agency or the consumer in the event of a case file request.

6. Medical Eligibility in KEES

A. Client ID Number

Every individual recorded in KEES is assigned a Client ID Number. It is much like the Client ID assigned in KAECSES today. Only one Client ID is assigned to each individual and it remains through the lifetime of the individual regardless of changes in their demographics, situation, circumstances, etc. In addition, the Client ID is the base number for the MMIS Member ID number. The Client ID is assigned through the File Clearance process in KEES. The KEES User Manual provides instruction on assigning a Client ID

In KAECSES, medical and non-medical cases share the data base that generates the Client ID with other DCF programs. It is known as the High Level Client Index (HLCI). All persons who are part of the HLCI will be converted to KEES and will retain their existing Client ID. The converted number is used for any individual subject to File Clearance upon the implementation of KEES. A new number is generated through KEES only when an existing number does not already exist.

It is the intent of DCF and KDHE that medical and non-medical will eventually share a single Client ID service when Phase 3 is live. Until then, separate Client ID services will be used for medical and non-medical with a plan to reconcile the numbers at the time of Phase 3 implementation. Non-Medical will continue to use the existing HLCI service and KDHE will use KEES. So, the same individual can be assigned two numbers if an application is received for a non-medical and a medical program. It is critical that registration staff and others who are responsible for File Clearance follow the protocol regarding the use of the Alternate ID in the KEES User Manual for clean conversion of the Client ID at Phase 3 implementation.

In addition, it continues to be very important to avoid duplicating an existing client in the File Clearance process. There are significant downstream consequences in the event an individual is assigned two or more ID numbers. With the exception of the interim process outlined above, staff should make every effort to avoid creating multiple ID's for the same

person. In the event a client is given multiple ID numbers, follow the process outlined in the Duplicate Person Process outlined in the KEES user manual.

B. New Social Security Numbers

Most applicants must supply a Social Security Number as a condition of eligibility. That number must also be verified. There are times when a number is supplied, but the agency is not able to verify the number or a client has used multiple Social Security numbers. Policy is updated to distinguish instances such as these from the formal issuance of a new SSN by the Social Security Administration. These instances will be rare and include adoption of a child, the number is too similar to another family member, more than one individual has been assigned or is using the number, identity theft, domestic violence, or religious objection to the assigned number.

If a new number is issued by the Social Security administration, the new number becomes the current SSN for the individual. Do not issue a new Client ID unless instructed to do so by KDHE Policy. Change the SSN in the KEES system and record the old number in the Previous Social Security Number field as addressed in KEES User Manual. The Previous Social Security Number field is not to be used for any other reasons.

In these cases, the former SSN and other information is retired and is not to be used again.

Note: When an individual has history of multiple or unverified Social Security numbers, make a note in Journal. In addition, create a case flag indicating the individual has used different multiple numbers in the past.

C. Case Numbers

Much like KAECSSES, individual cases are established in the KEES System. Specific rules are established for establishing cases in the KEES system. Follow the rules below when establishing cases

1. Case Head and Primary Applicant

In KEES the Case Head is the owner of the case. Each case number has one Case Head. For the vast majority of situations, this person is an adult (except for situations noted below). Once a Case Head is established it cannot be changed. If the Case Head is no longer a part of the family, a new case number is required. 18 year olds and unrelated adults on a single application are given their own case and therefore, are the Case Head.

As explained below, a case can include several Program Blocks. A Primary Applicant is considered the 'owner' of the Program Block and is unique to each Program Block on a case

2. Program Blocks

A Program Block displays the requests for medical assistance and the details of each program on a case. Multiple program blocks can exist on a case. These allow a case to be organized by various factors, including:

- The Program Persons (applicants and Case Persons financially responsible for them)
- The type of medical coverage being requested, also known as Requested Medical Type(RMT)
- The Status of the Medical Request
- The worker or work team assigned to the program block

Multiple Aid Codes may exist in one program block. For example, if a household consists of a parent and two children, the program block may include Caretaker Medical for the parent and Poverty Level Medical for a child.

3. Single Case Number –Multiple Program Blocks

Traditionally, medical programs have been managed on separate case numbers, depending on which agency was responsible for managing the application. Aside from a few exceptions, with the implementation of KEES, medical programs will be maintained on one case number. There may be one or multiple program blocks on the single case number. Some medical program blocks on a case may be managed by DCF staff and others by the Clearinghouse, but all of the program blocks for the household will be on the same case number and have the same Case Head. However, each program block may have their own Primary Applicant

1. PPS Cases

PPS cases are an exception to the single case number rule. Each individual receiving medical assistance based on foster care or adoption support will have their own case number. These cases will have their own number both at conversion and ongoing.

2. Rules for Program Blocks:

As indicated above, where multiple types of medical are provided, different Program Blocks are used to manage the case. There are some programs that are incompatible and MUST NEVER be placed in the same Program Block. The rules below are used for managing Program Blocks

1. Where necessary, a Family Medical Program block is used for Clearinghouse or OSW-managed programs and a DCF Program Block for DCF-managed programs. Never place a medical program managed by DCF on a Program Block that will be used for family medical programs.

This is true even for closed cases. If an old case number is used, a new program block is used for a new management region.

2. Long Term Care: Each LTC recipient (including HCBS, MFP, PACE) must have an individual program block.
3. AIDS Drug Assistance Program (ADAP): If on the same case with other medical, a separate program block is needed
4. Presumptive Eligibility. Each PE type must have its own program block. PE Children, PE Pregnant Women and PE Adults will each have a separate block. If other eligible members exist on the case, they are on a separate Program Block. The full eligibility determination for the PE recipients is done on the same program block as the existing members.
5. Foster Care/Adoption Support. As each PPS recipient has his/her own case, each will have her/her own Program Block.
6. SSI Recipients. SSI recipients are on a different program blocks if they receive LTC. They are also on a separate program block from the rest of the Family Medical case if they are managed by the Clearinghouse. This only applies to converted cases. New cases are on the same Program Block as the rest of the family.

Please refer to KEES Training – Medical Eligibility: Registration module for additional information about Program Block functionality and workarounds identified.

4. Registering A New Request For Coverage

All requests for coverage, regardless of the source, are recorded in KEES. Functionality in KEES permits individual requests to be registered and tracked, regardless of the status of the Case or Program Block. KEES provides several options to facilitate registration, including the Rescind and Reapply features.

The Single Case Number approach is used when registering new applications/requests for coverage. Applications and coverage requests for all family members are registered and processed on the same case, regardless of MAGI/Non-MAGI designation. The criteria below are used when determining the appropriate case number to use. Additional information is found in the KEES User Manual ('Usable Case Number').

1. No Previous Application History - All requests are recorded on a new case number.

2. Open/Active Program Exists - When an open/active program exists for at least one member of the family, the new application or request shall be registered to the open case. The following exceptions exist:

- When the only open case is for an E and D program and a family medical program closed within the four months prior to the month of application/request, reopen the Family Medical case and add the E and D program to the case.

Example: An ongoing HCBS case/DCF Program Block exists for a 10 year old child. The mother is the PA. No other application history exists and the rest of the family has not requested or received coverage in the past. A MAGI request is received for his 5 year old brother. The family medical program block is added to the existing case number.

- When the only open case is for an E and D program and the case does not have an appropriate PA, open a new case with an appropriate PA and add the open E and D program as well as the new request to the new case number.

Example: An ongoing HCBS case/DCF Program Block exists for a 10 year old child. The child is the PA. A MAGI request is received for his 5 year old brother. A new case number is necessary as the current case number is no longer valid because a person < 18 years old is the PA.

3. More than One Open/Active Program Exists - If more than one open/active program exists, add the E & D program block to the case with the Family Medical program.

4. Open Program Does Not Exist – When there are closed cases for the family, a case number should be reused if possible. The PA on the case must be the PA on the application. If not, a new case number is required. If multiple closed cases exist with the same PA, select the case with the most current history to register the new programs.

Follow the same rules outlined above regarding imaging protocol when an ongoing case is closed and eligibility reestablished on a new case number. See the Registration Job Aids on the KEES Repository.

5. **Implementation Instructions/Merging Cases:**

As part of ongoing case maintenance, cases may need to be combined, or merged. These will arise as circumstances change for our members, such as marriage or living arrangement changes. Action will also be required for certain cases coming out of conversion. Although it is the ultimate goal of the medical programs to have all program blocks on a single case number for the family, merging of converted cases will be delayed in all but limited situations. For situations involving converted cases, the cases are to be merged at the time of

the next case action, no later than the next review.

Specific instances requiring cases to be combined/merged include:

1. When two current recipients marry. If the individuals that marry are both the PA, combine the cases and use the rules in Section 4 above to determine the most usable case number.
2. For cases with spousal impoverishment income allocation, the community spouse is added to the LTC spouse case. If the community spouse is also an applicant or recipient, the cases are combined/merged at the next case action. If the Community Spouse has a Medically Needy base period, add the LTC spouse on a separate program block to the community spouse's case. Otherwise, use the rules in Section 4 above.
3. For cases converted with a PA < 18 years old, a critical error will occur on the case the first time EDBC is run. A new case must be established for the youth with an adult PA. Use the case number rules in Section 4 above. So, if a case already exists for a family member, the cases will be merged.
4. Foster Care Aged Out and Permanent Custodian medical programs are merged to the existing Clearinghouse case where applicable.
5. ADAP cases are added to the Medicaid/CHIP cases when converted as separate cases. ADAP staff are responsible for identifying these cases and facilitating the merge.
6. For converted cases, when separate cases exist for family members and earned income is countable on both cases. For example, a Working Healthy parent with a CHIP child. Special rules apply when managing income records that will be very difficult if the programs are on different case numbers. These cases shall be merged at the next case action by either agency.
7. For converted cases, when a new household member needs to be added to both cases. For example, a Medically Needy parent of a Poverty Level child is married to a non-recipient. The new spouse must be added to both cases. The cases will be merged at that time.
8. For converted cases, when a workaround is needed that requires manipulation of data or special processes in order to ensure an accurate determination. Because the risk of an error is escalated if these are on separate cases, these should be merged.

The merge consists of taking manual action on the case with multiple program blocks. The entity taking the first action will notify the partner agency of the action and initiate the merge through creation of a contact log.

When both an E and D case and a Family medical case exist, the Clearinghouse

case will be primary. When two cases exist at a single location (example, two family medical cases at the Clearinghouse) the case with the most history will be primary. Once added to the primary case, negative action will be taken on the secondary case and the program discontinued. A notice is not required, as this is an administrative action.

To ensure the integrity of the E & D medical program, DCF will be responsible for adding the E&D program to the Family Medical case. Each entity is responsible for reacting to changes, processing reviews, running EDBC and other case actions on programs under their area of responsibility once the merge is complete.

When the merging cases share the same Primary Applicant, the cases are automatically joined as Companion Cases. When this occurs, the images associated to the old case will be readily accessible through the new case. Journals will also be merged with correct entry dates. No additional action by staff is necessary.

When cases have different PA's , they are not Companion Cases and manual action is necessary to fully complete the merge. Because the images and journal entries will not be automatically combined, a notation can be made in the journal regarding the merge. At a minimum, the entry must include information on the specific action and the old case number. Information in the previous case must be retained as per policy.

D. Test Categories

All medical coverage is divided into test categories. A test category is a broad grouping of similar types of medical coverage. For example, all SSI medical programs belong in the 'SSI Recipients' test category. When determining eligibility in KEES, the system will display both the test category and medical aid code for the individual. KEES will use the Test Category to determine the Best Medical Plan for the individual.

E. Medical Aid Codes

In KEES, medical programs are called Medical Aid Codes. Medical aid codes include more detail than just the category of assistance. An aid code is similar to a combination of the medical program and medical subtype used in KAECSES. For example, instead of lumping all children and pregnant women together under MP, the Medical Aid Codes will now further define them by their age or pregnancy status. Aid codes are made up of 7 characters. The first three characters are the type of coverage, such as CTM for Caretaker Medical or PMG for Protected Medical Group. The next two characters further define the category, such as PW for Pregnant Woman or PA for Pickle Amendment – Aged. The last two characters are Y/N fields that identify SOBRA and Inmate individuals. The sixth character is for SOBRA and the seventh is for Inmates.

A Job Aid, Medical Aid Codes – Job Aid, is available on the KEES repository. The Job aid will assist you in understanding the new names for each group. It identifies what program the coverage is processed on in the KAECSES system and then the new name. It also identifies whether or not the aid code is MAGI or non-MAGI. The Test Category is also included.

F. Medical Hierarchy

Historically, the Medicaid Management Information System (MMIS) has been responsible for assigning eligibility to the individual. If eligibility is approved in KAECSES for two different medical programs, the MMIS applies a set of rules that decide which program is best. With the implementation of KEES, this responsibility is now held within the KEES system.

KEES rules are built to insure individuals eligible for medical assistance receive the best coverage of all types they are eligible to receive. First, KEES will determine, based on eligibility criteria which medical aid code an individual is eligible to receive. When an individual qualifies for multiple aid codes, the Medical Hierarchy determines how KEES chooses the coverage that is the best for the individual. The aid codes are ranked according to the best medical plan while also considering any potential share of cost that may be assigned to the individual. A share of cost could be a spenddown, premium obligation, or patient liability.

While KEES will not allow multiple benefit plans to be in place for one person on one medical program block at the same time, some benefit plans like QMB, LMB and ADAP are allowed to be active with many other plans at the same time. The rules for which benefits plans can co-exist are also held within the KEES rules.

It is important to know that KEES will not prevent users from approving different types of medical coverage for an individual for the same time period if that coverage is authorized on different 'program blocks' or on different cases. When this happens a batch job will sort out the best eligibility for the individual and only send the best record to the MMIS.

A medical hierarchy chart will be released with a future memo.

G. Requested Medical Types (RMTs)

The Requested Medical Type (RMT) is used to restrict the medical aid codes for which a person may potentially qualify. Based on the RMT chosen, when EDBC is run, only specific medical aid codes will be considered for the determination.

The type of medical coverage being requested will display in the Program Block. There are eight different Requested Medical Types. The Requested Medical Types are:

- LTC (Long Term Care)

- MAGI
- Medical
- PPS
- Working Healthy
- MSP (Medicare Savings Program)
- Resource Assessment Only
- Inmate

The RMTs are generally selected based on the type of application submitted, the need for a MAGI screening, or a request for a special medical program. For applications which originate from the SSP, the system assigns the RMT based on answers to specific questions in the online application. A request for Long Term Care of HCBS services will assign the LTC requested medical type. A request for Medicare Savings Programs only will set a RMT of MSP.

The chart below provides additional information about the requested medical types.

Requested Medical type	Description
LTC	Only looks to determine eligibility for test categories that allow LTC, FC LTC plus minor sub-Programs. Will not allow for authorization of any non-MAGI determination.
MAGI	Runs thru the entire hierarchy, identifies all potential test categories, but only builds budgets for MAGI HHs and can only authorize MAGI.
Medical	Looks at the entire hierarchy with the exception of FC, AS, Working Healthy, and LTC.
PPS	Only looks to determine FC or AS test categories.
Working healthy	Only looks to determine eligibility for Working healthy test categories plus the minor aid codes.
MSP	EDBC will only try to determine eligibility for the MSP programs
Resource assessment only	EDBC will be used only to calculate for a resource assessment as of the 'Assessment Date'. Eligibility will be assessed for the benefit month. The EDBC will also be marked 'Read Only'
Inmate	This will Test only categories for which there are Inmate aid codes. Will exempt the 'Incarcerated' living arrangement as an ineligible living arrangement type.

H. Eligibility Determination and Benefit Calculation (EDBC)

The EDBC functionality in KEES is what determines the eligibility for medical assistance. There is a lot of information about EDBC in other resources, such as training sessions and job aids. These resources are identified in section 29. This section of the implementation

memo will focus on defining EDBC, main highlights about EDBC, and then identifying when staff have to do something special with the eligibility determination.

1. EDBC Source

There are three sources of EDBC: Online EDBC, Manual, and Batch.

- The Online EDBC is a User-Initiated run and is used for most medical programs. This EDBC runs through the KEES rules engine which contains eligibility policies for the various medical programs.
- The Manual EDBC is used by staff for programs that do not have rules built into the system. A manual EDBC requires staff to have knowledge of the policies to complete a determination 'off-system'. The worker then enters this determination into the EDBC.
- The Batch EDBC is run by the system on a set of cases

2. Overriding EDBC

When information is entered completely and correctly into KEES, EDBC will produce an accurate result in the vast majority of situations. However, there are instances where EDBC will not produce a correct result. There are a number of reasons when this will occur, including system defects and changes that are pending in KEES. When this occurs, staff are responsible for overriding the EDBC to produce a correct result.

Several common situations have been identified as areas where an incorrect result will likely occur given the system limitations. A full list will be provided just prior to KEES go-live. These workarounds generally include several steps, including notice impacts.

While it is the responsibility of eligibility staff to ensure the final eligibility determination is accurate, it is not necessary for staff to complete an off-system determination each time an EDBC is produced. Staff should review the results of all determinations to ensure the outcome appears correct and reasonable. If the determination appears out of the ordinary, a further check of the determination is necessary.

7. Automatic Eligibility Determinations (No-Touch)

KEES implements a fully automated eligibility determination. Commonly referred to as "No Touch" This literally means that eligibility is fully determined and authorized without intervention of a human staff person at any time in the process. A full determination resulting from No Touch is considered valid and eligibility/coverage is provided as with any other determination. KEES has been designed, built and executed to the specifications and policies approved by the State.

The following apply to the No Touch Determination. Note that the same No Touch process is used for many other application types, but only applications meeting all of the below criteria should fully execute. Note that detailed interface information will be provided in a later memo.

1. The application must be received through the SSP or the FFM. Paper applications, telephone applications and MIPPA applications are not eligible for a full No Touch Determination.
2. All required elements /questions must be completed on the application submitted by the consumer. This includes necessary elements identified by the state and documented in the KEES System Documentation
3. Only MAGI determinations will fully execute through No Touch. Non-MAGI determinations will not.
4. General Eligibility requirements must be met as determined by the self-attestation of the client. For example, the household must provide a valid Kansas address. If these are not met, the No Touch will not execute.
5. Only an application with persons who have never been known to the KEES system can result in a No Touch determination. If at least one individual has previously been part of a medical case, No Touch will not fully execute.
6. The HUB will be called to execute SSN and Citizenship/Identity or Non-Citizen Verification depending on what the individual has reported through the application. All applicants must be successfully verified for No-Touch to execute.
7. For Unearned Income – verification must be obtained through interfaces. If income is reported that cannot be verified through an interface (for example – Trust income) or interface information is not available to verify income for a particular case member, the case will not execute through No Touch.
 - a. Payer income interfaces will be called for unearned income – KPERS, SSA and KDOL for Unemployment. If any of these incomes are reported and are verified through an interface, the case may go through No Touch. If these incomes are reported and not verified through these interfaces, the case will not go through No Touch.
 - b. If unearned income that is not subject to verification requirements is reported, No Touch can execute regardless of verification availability.
8. For Earned income – verification must be obtained through KDOL or TALX interfaces. Earned income must be verified according the Reasonable Compatibility verification

standards. If all wages do not meet the Reasonable Compatibility test, the case will not fully execute through No Touch.

9. The MAGI Individual Budget Units are built according to information provided on the application. If there is information missing that prevents the IBU determination, No Touch will not fully execute.
10. Medicaid and CHIP financial and non-financial rules are tested and applied when EDBC is ran on the case. All applicants must be determined eligible, or No Touch will not complete. Neither individuals nor cases can be denied through a No-Touch determination. If all applicants are approved, the case may execute through No Touch. CHIP eligibility will not be authorized through No-Touch.
11. Coverage is only tested for the month of application. If prior medical is requested, a task is generated for staff to determine eligibility for those months.
12. For cases fully executed resulting in an expedited PW determination with postponed verification, a task is generated for staff person to request the postponed verification and complete the application process.
13. For cases fully completed by No-Touch, notices are produced for the application and mailed according to KEES rules.
14. The case file is updated when automatic entries are written to the KEES Journal.
15. Once eligibility is authorized, coverage information is sent to the MMIS as with any other approval. Premium information is sent to the Premium Billing system.

Although the instances of a full No Touch determination are expected to be rare, nearly every application will be impacted by the No-Touch Process as the No-Touch workflow applies to most applications in the KEES system and will be addressed in future guidance.

Applications that initially execute through No Touch but fail to fully execute are considered determined through the point of failure. This will be addressed in future guidance.

8. MAGI Screening and Determination (aka The Big Four)

This memo implements the full and final phase of the MAGI determination process. Although MAGI methodologies and determinations have been in place since October, 2014, this implementation of the full screening and determination will facilitate the automatic referral to the FFM.

All Family medical cases and most elderly and disabled medical applications require an initial MAGI determination before processing. The initial MAGI determination will ensure the applicant

is receiving the most advantageous coverage available. Because some cases will never be eligible under a MAGI program, a screening has been developed to facilitate processing. This MAGI screening is commonly referred to as 'The Big Four'.

All cases must undergo an initial MAGI screen – using The Big Four. Cases that fail the MAGI screen are subject to a full MAGI determination. If a case fails the MAGI determination, a non-MAGI determination is completed if potential non-MAGI eligibility is identified. The Clearinghouse is responsible for all MAGI determinations, but all entities may complete the MAGI screen.

A. Criteria

Cases exempt from MAGI determination are those where every individual requesting coverage meets one of the following criteria:

1. Requesting LTC (institutional or HCBS or PACE)
2. Requesting Medicare Savings Programs only
3. Age 65 or older and NOT pregnant or the caretaker of a minor child
4. A Medicare beneficiary and NOT pregnant or the caretaker of a minor child

B. Coordination between eligibility staff

DCF and KDHE staff are accustomed to sharing information and coordinating coverage when there are medical programs being managed by both agencies. With the implementation of KEES, how and when the agencies coordinate and share information is changing.

1. The Agency that 'owns' the Program Block is displayed on the Person view page. When a Program block is created for a medical program processed by KDHE a "K" will be displayed as the first letter of the 'Worker' that is assigned to the program block. A "D" will be displayed as the first letter of the 'Worker' that is assigned to programs processed by DCF.
2. KDHE managed medical programs and DCF managed medical programs may be on the same case number, but should NEVER be in the same Program Block.
3. Once a KDHE program block or a DCF program block becomes Active it remains a program block for that agency. Even if it becomes inactive, it should NOT be used as a program block for the other agency.
4. A Family Medical program block is used for the initial MAGI determination done by the Clearinghouse. If a subsequent Non-MAGI determination is required, a DCF program block is established.
5. Both Family Medical and DCF program blocks are established at initial determination if an individual may potentially qualify under multiple programs and

it is unclear the type of coverage that is requested. The agencies may need to coordinate coverage when this occurs. Note there is an automated batch that will create a task for the Clearinghouse worker if and HCBS program is approved for a current recipient.

6. For OSW applications with both MSP and Family determinations, two program blocks are established – one for the Clearinghouse and one for DCF. The OSW will reassign the case when the case is ready to be transferred.
7. When a recipient is covered under a Clearinghouse –managed program block but also receives Medicare, a DCF program block is established for any MSP determination.

9. Data Acceptance and Data Entry

Consumer information received via an e-application or interface data populates information on the data collection pages. When new, differing, or updated information is received it is necessary to determine if the data should be accepted or rejected. This is called Data Acceptance.

A. Data Acceptance

When data is brought into KEES, the system will identify when it contains new information compared to information that already existed. A 'New' data indicator will appear next to individuals with new information. When the detail pages are accessed, the new data will appear below the existing data with a checkbox. Clicking the checkbox to accept the data will populate the field with the new data. Any data left that has not been checked when the Save and Return button is clicked will be rejected. There are critical decisions that are made when accepting and rejecting data. Some data will overlay what existed previously, requiring a worker to make a journal entry to record the prior data. Other times, decisions are made to end-date old information and replace with the new information.

Please refer to the E-Applications section of the KEES User Manual and the Populated Data Desk Aid for the policy requirements for accepting and rejecting data.

B. Valid Codes

The Master Code Table contains a list of values used by KEES for everything from Kansas counties to verification status codes. The codes are grouped by categories. Many of the codes used by the system are not of interest to staff. However, having access to the code table can be helpful in viewing reports or investigating issues. The Master Code Table is an Excel workbook with filters to facilitate lookup. There is a tab for categories and another for values. See attachment KEES – Code List.

10. Managing Work in KEES

Work is managed in KEES by using manual and automated processes. Workflow is the general term used to describe the automated processes.

A. Workflow

KEES includes an automated workflow as a primary tool for managing work. User-driven workflow is also used. This will be described in later guidance.

B. Batch Processing and Reports

1. Batch Processing

KEES includes several batch processes. These are processes that update multiple cases within defined criteria without user intervention. Some of these batch jobs run in order to support the automated interfaces that are part of KEES and those will be addressed in future material. There are also batch processes that update KEES data and/or run EDBC to recalculate eligibility.

A list of batch processes planned to run in KEES will be released with future communication.

2. Reports

KEES includes reporting functionality that provides both canned and ad-hoc reporting capabilities. Full reporting information will be provided in a later memo. This memo provides instructions for reports that have been produced to support system workarounds. Batch jobs may be available in the future to process these changes but reports are used at implementation. Although a number of reports have been identified, only those that are considered priority are produced at this time. Instructions will be provided for the additional reports when they are produced and distributed.

Note: These reports are in addition to the Post-Conversion Clean Up and Post Conversion Inconsistent Coverage Reports described earlier. The Post Conversion and Inconsistent Coverage report remain a very high priority for processing immediately after Go-Live.

1. *Forms For Medical Reps*: This report is produced daily to support the Admin Role Workaround described in item 14(B). The Clearinghouse is responsible for working this report according to instructions provided by KDHE.
2. *Reviews Coming Due*: This is an informational report that provides a listing of all reviews coming due in the next three months. It is to be used as an input to working the required Post Conversion Clean Up Report. The Clearinghouse and DCF are responsible for working this report.

3. *Pending Applications with No Tasks:* This report identifies pending applications received after go-live without associated tasks. The application is at risk of being lost without a task. Evaluate the cases on this report and set any necessary task. The Clearinghouse and DCF are responsible for working this report daily.
4. *19 Year Old on Poverty Level T19 or CHIP – Current Month and 19 Year Old on Poverty Level T19 or CHIP – Month After* - These reports provide a list of individuals near the time of their 19th birthday who are receiving coverage under CHIP or poverty level Medicaid. Their coverage is likely to end due to age. Redetermine eligibility for each individual on the report and determine if continued coverage is available. If not, discontinue coverage for the individual with timely and adequate notice. The Clearinghouse works this report.

The individual must be evaluated for the possibility of coverage through any medical assistance program, including non-MAGI programs. If there is any indication of a disability, coverage is continued until sufficient information to make a determination is received. However, if it is not provided while a disability determination pends. Coverage must be under the Medicaid program for CHIP recipients beyond the month of their 19th birthday.

5. *26 year old Foster Care Recipient:* This report identifies young adults receiving coverage under the Foster Care Aged Out program who have reached their 26th birthday. They have reached the end of coverage under this category. Redetermine eligibility for each individual on the report and determine if continue coverage is available.
 - a. If the individual is pregnant she is continuously eligible, so establish coverage in the Poverty Level Pregnant Woman program through the end of her post partum period.
 - b. The individual must be evaluated for the possibility of coverage through any medical assistance program, including non-MAGI programs. If there is any indication of a disability, coverage is continued until sufficient information to make a determination is received. Coverage is continued until sufficient information is received, but is not provided while a disability determination pends. The Clearinghouse works this report.
6. *Presumptive Eligibility Discontinuance:* This report identifies beneficiaries whose PE period is ending and have no ongoing coverage established. IF the individual has not filed a full application, discontinue coverage. If there is a pending medical assistance application, action is delayed to discontinue the PE coverage until the application is processed. The Clearinghouse works this report.
7. *Reviews Discontinuance Report:* See Section 16, Reviews, for more information. This report may be released if necessary.

8. *Spenddown Base Period Ending* – This report is necessary because there is no automated process in KEES to create a new Medically Needy (MN) 6 month base period once the current base has expired within an established review period. Eligibility staff will be required to manually create the new base period. A monthly report, titled “Spenddown base period ending”, will be run on the first of each month identifying Medically Needy (MN) spenddown cases where the current base period expires at the end of the month. In addition, staff can manually create a future task to review the case at the end of the 6 month base period.

Eligibility staff shall review identified cases to determine what action to take:

- a. If there is no spenddown amount or the spenddown has been met with non-covered or due and owing expenses in the current base period, a new 6 month base period shall be established with notification sent to the individual.
- b. If there is an unmet spenddown in the current base period, staff shall review the spenddown record in MMIS to determine if the spenddown has been met. Based on the information contained in MMIS, the following action shall be taken:
 - i. If the spenddown has been met, a new 6 month base period shall be established with notification sent to the individual.
 - ii. If the spenddown has not been met, but significant progress has been made towards meeting the spenddown, a new 6 month base period shall be established with notification sent to the individual. Significant progress is being made where one-third or less of the spenddown remains unmet..

Example: The MMIS indicates that \$4,000 in medical claims has been applied against the \$5,400 spenddown amount. The spenddown is unmet, but a substantial amount of claims have been incurred and applied against the spenddown. Since this is considered to be a significant amount, a new 6 month base period is established.

- iii. If the spenddown has not been met and no or few medical claims have been applied against the spenddown, the Medically Needy (MN) program shall be discontinued at the end of the current base period due to failure to meet spenddown, giving timely and adequate notice.

Example: The MMIS indicates that \$123 in medical claims has been applied against the \$900 spenddown amount. The spenddown is unmet and few claims have been incurred and applied against the spenddown.

Since this is considered an insignificant amount, the Medically Needy (MN) program shall be discontinued at the end of the current base period due to failure to meet spenddown, giving timely and adequate notice.

- c. Staff have a limited amount of time to update eligibility once the report is generated at the first of the month.
 - i. Timely Notice Deadline – Action to discontinue coverage for failure to meet the spenddown must be taken by the timely notice deadline. Discontinuance of spenddown coverage within an existing review period requires timely notice.
 - ii. Month End Medical Run – Action to continue coverage must be taken by the month end medical run or Help Desk involvement will be required to send the eligibility record to MMIS. In those instances, once eligibility has been processed and authorized through the come up month, staff must contact the KEES Help Desk to have the record manually sent to MMIS.
 - iii. Task Created – A task will be created at the month end medical run when the existing base period has ended and the new 6 month base period has not been set up for the following month. Action must be taken to either continue or discontinue coverage as indicated above.

11. Medical Eligibility and the MMIS

With the implementation of KEES, the interaction between the new eligibility system and MMIS is changing. Prior to KEES, MMIS was required to perform several eligibility functions that could not be completed in KAECSSES. Those eligibility functions will now be completed in KEES before being transmitted to MMIS.

Even though there is a shift in some eligibility functions from MMIS to KEES, the ultimate eligibility record is still reflected in MMIS. For eligibility, coverage and claims purposes, the MMIS record is of primary importance. If MMIS isn't correct, the case isn't correct. A check of the MMIS is considered part of the eligibility determination.

A. Transferred Functions

The following eligibility functions existing in the MMIS nightly batch eligibility update process have been removed from MMIS and will now be performed in KEES:

- Benefit plan assignment
- Population code assignment
- Patient Liability and Long Term Care Type

- Benefit plan hierarchy to determine valid eligibility changes and overlays
- Start and end date calculation for benefit plan, population code, Level of Care, spenddown base period, and patient liability
- Start or end date modifications to prevent overlapping segments

B. Retained Functions

The following MMIS functions will not change with the implementation of KEES:

- MMIS screens
- Issuance of medical cards
- Claims processing
- Managed care
- TPL
- Retro patient liability processing

C. Triggers

A trigger is an action in KEES that will prompt a transmission of data from KEES to MMIS. This transmission is usually performed overnight in a “batch” run. There are two types of “triggers” that send KEES eligibility information to MMIS in a batch run – regular triggers and super triggers.

1. Regular Triggers

A regular trigger is an action which will send eligibility information whenever EDBC is run by the worker or by an automated mass change run. KEES will “batch” all the individual files created during the day into one transmission file sent to MMIS. This is the standard trigger which sends all updated data elements from all cases to MMIS (usually in an overnight process). This process is dependent on a new eligibility record being created.

2. Super Triggers

A super trigger is an action which updates a specific data element in KEES that is not dependent on creation and transmission of a new eligibility record to MMIS. Only the updated data element is transmitted. This will occur overnight in a singular batch process. Super triggers include updates to the following non-eligibility related data elements:

- Person Data
- Other Name (Alias)
- Address
- Telephone Number
- Other Health Insurance

KAECSES required eligibility to be authorized for these updates to transmit to MMIS overnight. This process transmitted all data elements, not just those that were updated. This new process will allow nightly transmission of just the updated data elements without having to run EDBC.

D. Failed Transmissions

There may be times when the eligibility record transmitted from KEES to MMIS is not received or errors off for some reason. As indicated in the note above, it doesn't matter how "correct" the information appears in KEES if it isn't correct in MMIS.

When staff note eligibility has not been correctly transmitted to the MMIS, contact the KEES Help Desk. Unlike the current interface, it is unlikely that simply 'reauthorizing' the case will correct the problem. In fact, it may actually create additional problems. The KEES team will then be responsible for ensuring eligibility is correctly recorded in the MMIS. Staff will be notified according to procedures announced by the KEES team.

12. Coverage Group Changes

A. Permanent Custodian/Legal Guardian

This medical program for children who have been released from foster care into the care of a Permanent Custodian or Legal Guardian will end with the implementation of KEES. Currently, there is not an application requirement and they qualify in KAECSES on a Foster Care medical program.

Under new policies, these children qualify for medical assistance as part of the MAGI population and therefore a separate medical category isn't needed. The permanent custodian or legal guardian must file an application and request medical assistance for the child in their care. They apply for assistance using either the SSP or the KC1100 Family Medical Assistance application. As they are transitioning from a Foster Care program, coordination between the Clearinghouse and PPS may be necessary. All policies and processes applicable for poverty level children apply to these children following the transition

During the KAECSES to KEES conversion, these individuals will automatically convert into a Medicaid Poverty Level child aid code. A new program block will be created for these youth with a poverty level program. The Review date and CE date for the child will be the same as the existing Foster Care review date.

To complete the conversion, PPS staff will image current Permanent Custodianship documentation into the ImageNow system after KEES goes live. This case file will include any PII, the Custodianship agreement and any relevant notes. DCF is responsible for identifying these cases and completing the work by September 30, 2015.

For transition purposes, DCF will process and establish medical on any new PCG cases identified before COB on June 18, 2015. Youth approved for a PCG payment on or after June 19 must complete an application and the Clearinghouse will be responsible for processing the medical request.

B. Foster Care Aged Out

The expansion to the Foster Care Aged Out program was effective January 1, 2014. Eligibility rules are found in Section 2.6 of KHDE Policy Memo 2014-04-01. These applications have been processed on the Foster Care program in KAECSSES using procedures already in place for the original FC-AO program. Designated DCF-PPS staff have been responsible for these determinations.

With the implementation of KEES, the responsibility for processing these applications shifts to the Clearinghouse.

All Foster Care Aged Out cases (both FC-AO and FC-AJ) will transition to the Clearinghouse as part of the conversion to KEES. The electronic case for all current recipients will be reassigned to the Clearinghouse caseload. To complete the transition, PPS staff will image pertinent information from the PPS file into ImageNow. This will include the application and citizenship/identity verification. Imaging will be completed by September 30, 2015. If information is needed for any case where the imaging hasn't been completed, the Clearinghouse will contact PPS and request the information.

PPS will process all pending requests received prior to COB Thursday, June 18. The Clearinghouse will be responsible for processing all applications pending or received on or after June 19. If any applications are still pending with DCF at the time of conversion, PPS will initiate contact with the Clearinghouse and coordinate completion of the application.

Instructions for processing the Foster Care –Aged Out program in KEES are found in the following job aid: KEES Aged Out Foster Care (Clearinghouse Job Aid)

C. Presumptive Eligibility

The Presumptive Eligibility program is expanding to include pregnant women, and other adults. Additional information will be available in a future release.

1. Presumptive Eligibility for Pregnant Women

Effective with the implementation of KEES, temporary medical assistance is available to pregnant women determined eligible by staff of one of our Qualified Entities (QE). This program is designed for adult pregnant women, ages 19 and up. Pregnant women approved for PE have access to ambulatory prenatal care up through the date of delivery. This benefit

package does not cover inpatient care, labor and delivery, or services related to a miscarriage.

2. Hospital Presumptive Eligibility

Designated hospitals will participate in a special presumptive eligibility program in addition to the program for children and pregnant women. The Hospital PE program allows hospitals to approve individuals for temporary medical assistance that fit into one of the following categories: Low-income caretakers, individuals screened eligible for the Breast and Cervical Cancer (BCC) program by one of the Early Detection Works providers, and individuals who were in Foster Care in Kansas on their 18th birthday.

D. M-CHIP – Initial Implementation

This memo will implement initial phases of the M-CHIP program. With this implementation, the insurance tests for children in the M-CHIP age/income group are eliminated. For applications processed on or after receipt of this memo, no child in the M-CHIP shall be denied coverage due to an insurance related reason. Children do not need to meet the uninsured provisions and are not subject to Crowd- Out penalty. The F-8, Medical Program Assistance Standards has been updated and is attached to this memo. Instructions to process in KEES will be provided at a later date.

E. CHIP Effective Dates

The effective date for CHIP coverage is changing to the date the case is authorized in KEES. CHIP eligibility is still date-specific, but eligibility currently begins the day following the day the case is authorized. In most cases, this will change the effective date by one day.

F. Child in an Institution

Children in an institution for other than a temporary stay are currently identified in the KAECSSES system under the Child in an Institution (CI) program. Once existing CI cases are converted to KEES that program designation will no longer exist. All of the current CI eligibility rules will continue to apply to these individuals. However, eligibility will be determined based on the same institutionalization rules and processes as any other individual in a facility. These converted children will be distinguished in KEES by an institutional aid code of 300/CH/N/N.

New applications processed for institutionalized children after KEES is operational will require a special procedure. A Requested Medical Type (RMT) of Long Term Care (LTC) must be selected. Even though a disability determination is not required for a child, an active Medical Condition of DDS Disabled must be entered on the Medical Condition List page. If approved, the child will have an aid code of 300/DS/N/N.

In addition, the aid code for converted institutionalized children whose eligibility is updated in KEES after conversion will change from 300/CH/N/N to 300/DS/N/N due to the disability designation required to authorize coverage.

Note: The intent is to update KEES at some future date to eliminate the need for this special process.

G. Pregnant Women

When determining eligibility for a pregnant woman, with no other children in the home, eligibility shall be determined on the Poverty Level medical program. An unborn does not qualify an individual as a caretaker, therefore the pregnant woman shall not be placed on the Caretaker Medical program.

13. Sharing Information

The following provisions provide guidance on sharing information between assistance programs and on the communication process between agencies. Some information is shared automatically because they are shared fields in the system.

A. Sharing Between Medical Programs

Information reported, known or obtained by the agency for any medical program shall be shared with any other medical program associated with the individual or family unit. Some of this information is shared via shared data fields in KEES. By updating these fields, staff are making that information available to the other medical program. Other times, staff will create a task as a method of notifying the other responsible worker that action may be needed to review or update the program based on a change report. The table below outlines what information is shared between medical programs. Items marked with an * require the staff to create a task. See Attachment – All Communication Guide

Income*	Resources
Address*	Expenses
Personal Identifiers	Citizenship and Identity
Non-citizenship	Relationship*
Tax Household	Medical Conditions
Employer Information	Verification
Death*	Household Changes
Pregnancy	PPS – Child taken into custody
PPS – Baby born to a Foster Care child	

B. Sharing Between Medical and Non-Medical Programs

Limited information shall be shared between medical and non-medical programs. Only the following information shall be shared:

- Medical Condition
- Personal Identifiers
- Death

The following information need not be shared:

- Address
- Household Changes
- Relationships
- Residency
- Income and Employers

If the worker on the medical program and the non-medical program is the same person, then all reported, known, or obtained information shall be considered for both programs. In addition, information reported on a review form received for a non-medical program shall be treated as a change for purposes of the medical program.

Note: During the period between the Phase 2 and Phase 3 implementations, eligibility staff are not required to search in either KAECSES or KEES for the existence of additional programs for information sharing purposes.

See Attachment – All Communication Guide

14. Administrative Roles and the Resource Data Bank

A. Administrative Roles

All non-case individuals (guardian and conservators, Social Security payees, medical representatives, facilitators and additional correspondence recipients) will be assigned an Administrative Role in KEES in order to be associated with a particular case. These individuals should never be registered as a case person. For standardization purposes, each individual assigned an Administrative Role will be entered and maintained in the Resource Data Bank (RDB) as indicated below. The Administrative Role assigned will depend on the functional role of the individual. In addition, each individual should be assigned a RDB Resource Category Type for search purposes.

1. Guardian or Conservator

An individual serving as a guardian, conservator, or legal custodian may apply on behalf of that person. Since this individual is not a case person,

he/she shall be assigned an Administrative Role of “Guardian/Conservator/Legal Guardian.” These individuals will be listed with a “Medical Representative” type in the Resource Data Bank (RDB.)

2. Social Security Payee

An individual serving as a Social Security payee may apply on behalf of that person. Since this individual is not a case person, he/she shall be assigned an Administrative Role of “Representative Payee for Social Security.” These individuals will be listed with a “Medical Representative” type in the RDB.

3. Medical Representative

An individual serving as a medical representative may apply on behalf of that person. A medical representative is either a person holding a durable power of attorney (for financial purposes) or someone specifically granted written authority to act on behalf of that person. Since these individuals are not a case person, he/she shall be assigned an Administrative Role of “Medical Representative.” These individuals will be listed with a “Medical Representative” type in the RDB.

4. Facilitator

An individual acting as a facilitator may not apply on behalf of that person and is restricted to assisting the applicant through the application process. Since this individual is not a case person, he/she shall be assigned an Administrative Role of “Facilitator.” These individuals will be listed with a “Facilitator” type in the RDB.

5. Additional Correspondence Recipient

In some instances, the applicant may authorize an additional individual to receive and share information on the case. The individual may not apply on behalf of the applicant but may receive copies of all correspondence. Since the individual is not a case person, he/she will be assigned an Administrative role of “Additional Correspondence Recipient”. These individuals will be listed in the RDB with a category type of Provider.

B. Mailing Forms to Administrative Roles

Individuals with an administrative role (responsible person, facilitator, or additional correspondence person) will automatically receive a copy of all notices mailed to the primary case individual. However, copies of forms will not be mailed to these individuals. A form is a correspondence that isn't based on an EDBC run such as a request for information, a MediKan approval, a Fair Hearing notice, or Spousal Impoverishment letter, a CHIP approval and some Long Term Care approvals. To ensure these individuals receive copies of the forms, a manual process has been developed.

A KEES report (Documents With Administrative Roles) will be generated every day. The daily report will identify all cases that have an administrative role where a form was mailed to the primary case individual the previous day. Address labels for the administrative role individual will also be produced. The report will be managed and worked by a dedicated group of staff in a central location.

The report will include the case number, case name, document name and number, and the date the original document was mailed. Each case will be accessed in KEES to locate the document listed on the report. The identified document will be manually reproduced by selecting the local print function in KEES. The printed document will then be manually folded and inserted into an envelope. The associated mailing label will be attached to the envelope, which will then be placed in the daily mail. The mail date of the reproduced form will be documented on the report for tracking purposes.

To ensure the integrity of the notification process, the report will be worked and the reproduced forms mailed the same day the report is produced/received. However, in some instances that may not be possible. All review forms are forms and will be mailed on the 15th of the month. Therefore, it could take an additional day or so to mail this large volume of reproduced forms identified on the daily report produced on the 16th. Eligibility staff need to be aware of this delayed mailing process when dealing with consumers and their administrative role individuals.

The following examples illustrate the delayed mailing process.

Example 1: A request for information is mailed to the applicant on 07/13/2015. There is a responsible person on the case. The daily report is produced the next day on 07/14/2015. Based on the report, a reproduced request for information form is mailed to the responsible person on 07/14/2015. The responsible person receives the correspondence a day or 2 later than the applicant received theirs.

KEES will set a task 10 days out from the initial mailing indicating that the requested information is due. However, the responsible person doesn't have the full 10 days to respond due to the delayed mailing. Therefore, staff need to take this delay into consideration when determining whether or not the requested information has been received timely. Staff shall allow an extra 3 days ($10 + 3 = 13$) from the task date before taking adverse action based on failure to provide.

Example 2: A pre-populated review form is mailed to the beneficiary on 09/15/2015. There is a responsible person on the case. The daily report is produced the next day on 09/16/2015. Due to the large volume of reproduced review forms to be mailed, the form is not mailed until 09/18/2015. The responsible person receives the review form 4 or 5 days later than the individual received theirs. The delay is not critical because the responsible person still has sufficient time to review, update and return the form.

Note that both the individual and the responsible person will each receive a review form. Only one form need be completed and returned. If both forms are returned, only one should be registered in KEES. The information reported on both forms will be used to redetermine eligibility.

C. Resource Data Bank (RDB) Process

The Resource Data Bank (RDB) is a central repository for a standardized listing of Administrative Roles. Entry and maintenance of each resource in the data bank will ensure a standardized name and address format for that resource and will allow data entry of each resource only one time in KEES. This standardization should prevent the use of multiple name and address variations for the same resource throughout KEES. The RDB is used by all medical eligibility entities, including the Clearinghouse, DCF-EES and DCF- PPS.

The following six types of individuals and Long Term Care providers are maintained in the RDB:

1. Representative (if not a case person)
 1. Facilitator (if not a case person)
 2. Institution
 3. HCBS Care Coordinator
 4. Placement Provider (PPS)
 5. PPS Payee

Note: A “Representative” is an individual who meets the requirements to act in one of the following Administrative Roles: Medical Representative, Guardian/Conservator/Legal Custodian, or Representative Payee for Social Security.

To ensure standardization, items 1-4 of the RDB are maintained centrally by staff at the KanCare Clearinghouse. Although all eligibility staff will have the ability to choose resources from the RDB, only the RDB Maintainers can add, update and discontinue resources. PPS is responsible for items 5 and 6, but will also use items 1-4 for those types of requests.

The following apply for eligibility staff to request RDB actions:

1. Medical RDB Request

Staff must search the RDB to determine if the medical resource already exists. If the medical resource is not found in the RDB and a new one must be added, or the resource is found but needs to be updated, a request is sent to the KanCare Clearinghouse. A Word template titled “Medical RDB Request” has been created for this purpose. Staff completing the form must distinguish between a resource that is to be added and one that will be updated.

Complete the form, noting the required fields and send as an email attachment to: KSRDBMedicalRepandFa@Policy-Studies.com.

Note: If the primary or secondary phone number is not provided, a phone number of (999) 999-9999 must be entered.

2. Clearinghouse Response

The KanCare Clearinghouse will process the request and update the Response section of the template as indicated below. If the add or update involves a LTC provider, KDHE-DHCF Policy staff will be consulted before completing any request.. Sending staff may expect a response to the request within 24 hours for Representatives and Facilitators, and 72 hours for Institutional and HCBS. The response will be returned to either the sender's email or to an alternate email as specified by the sender.

- If a new medical resource has been added, the Resource ID will be provided.
- If a new medical resource was not added because it already existed in the RDB, the Resource ID will be provided.
- If a new medical resource could not be added, an explanation will be provided.

Once the response of a successful add is received, the user may then add the Administrative Role or create the LTC Data Detail record by searching the RDB using the Resource ID provided on the request template.

3. Updating an Existing Resource in the RDB

If the resource is found after completing a search in the RDB, but needs to be updated, the user must complete the "Medical RDB Request" template by marking the "Change Resource" section. The user must specify the Resource ID. The following changes may then be reported. The KanCare Clearinghouse will process the request and update the "Response" section of the template as indicated below. The response will be returned to either the sender or to the email address provided with the updated template attached.

a. Change in Address

A change of address will typically be requested when the user knows a Representative or Facilitator has moved or reports a new mailing address. Institutional Care and HCBS rarely report a change of

address. The new mailing address must be provided. All cases linked to this resource will be automatically updated with the new address.

b. Change in Phone Number

A change in phone number is applicable to all types of medical resources. If an existing phone number has changed, enter the old phone number and the new number, including the phone type. If the existing phone number did not change (or there previously was no number), enter only the new phone number and the phone type. All cases linked to this resource will be automatically updated with the new phone number, provided the number would normally display.

c. Change in the Resource Name

A change in the resource name is applicable to all types of medical resources. If a Medical Representative or Facilitator has changed names, enter the new name. If an Institutional Care resource has changed names, complete this section only if all other information (e.g. type of facility, address, phone number, email, fax) for the facility remains the same. All cases linked to this resource will be automatically updated with the new name.

d. End Institutional Care Resource

If an institutional facility has closed or is under new ownership and there has been a change in both name and other information (e.g. type of facility, address, phone number, email, fax), this section must be completed, including the following information:

- The approximate date the facility changed ownership.
- Complete the “Add Resource” section to provide the new facility information.
- Add a comment that the facility is under new ownership.

The LTC Data Detail page must be updated with the new resource. It will continue to display the old facility name until the worker manually changes it by selecting the new facility name from the RDB.

e. End Institutional Care or HCBS Care Coordinator - Additional Cases

Additional cases could also be impacted when a resource is ended. The LTC Data Details screen will also need to be updated on those cases. To identify these cases, a report will be produced listing all impacted cases. Staff will need to connect the case to the new resource when this occurs.

f. Additional Changes

For any other resource changes that are needed, besides those listed above, should be described in the “Additional Comments” section of the request template.

g. Clearinghouse Response

The KanCare Clearinghouse will process the request and update the “Response” section of the template to indicate that either the change was made, or that it wasn’t (including the reason). The response will be returned to either the sender or to the email address provided with the updated template attached.

15. Reviews

An Automated Review process is included in the KEES system. Review functionality will provide for processing throughout the review cycle: Identifying reviews coming due, identifying the type of review according to newly established Review-Type guidelines and issuing the review. The review process will also generate proper notices and, for Passive and Super-Passive reviews, run and update EDBC. There is also a discontinuance batch process that will discontinue cases that fail to return required reviews. The majority of these processes are part of a general review batch that occurs on or about the 15th of each month for reviews expiring the following month. Subsequent processing is dependent upon the results of the review batch.

The first full review cycle in KEES will initiate on July 15, for reviews that expire on August 31. Detailed information regarding the full review process in KEES will be included in a later memo. However, it is critical that staff work the Post – Conversion Processing Report to prepare for the initial Review cycle in KEES. This essentially requires staff ensure all cases identified for review have gone through the steps outlined. This mass effort will need to occur each month until EDBC has been executed on all converted cases. To assist management, a report listing all upcoming reviews will be available through the KEES Report Distribution. This report - *Reviews Coming Due*’ will be available on the first day of each quarter and will provide a full list of reviews due over the next three months.

This memo provides instruction for reviews that expire on or before 07-31-15 (July reviews). These instructions apply to reviews expiring in months prior to July, 2015 as well.

1. All reviews for July, 2015 and earlier months were generated prior to KEES implementation. Passive and Administrative reviews at the Clearinghouse were completed to the extent possible. Paper reviews from all locations were mailed.
2. If the review was processed and fully approved in KAECSES prior to conversion, there should be no additional work necessary on the case to continue coverage. Exception: Cases appearing on the Exception Report noted in Item 10(B) above.

3. If the review was processed and was not fully approved, the case is subject to a review reactivation/reconsideration. If additional information is received and requires reprocessing according to the Review Reconsideration, update the Review and I/R record in KEES. Closed programs must be reactivated using the Rescind option in KEES. The case is then processed according to policy outlined in KDHE Policy Memo 2015-06-04. If the case does not qualify for a Review Reconsideration, treat the application as a new request for coverage.
4. If the review was received and not fully processed, it is a pending review and must be worked to ensure coverage is fully determined back to the date of discontinuance (with consideration for the item above regarding reactivation/reconsideration periods).
5. Although an automatic Review Discontinuance process to close pre-populated reviews that are not returned and recorded timely is part of the overall KEES Review Design, it will not be run for the month of July, 2015 (see item 10(B) above regarding Discontinuance Batch). This means that reviews that are not returned for the month of July, 2015 will automatically continue to receive August coverage unless specific closure action is taken to discontinue coverage. The Review Discontinuance process is planned to run for the first time in August, 2015. Cases that did not return a review will be terminated at that time unless action is taken prior to that date.

An effort to manually close cases that did not return the review for August coverage (coverage would end July 31) is still under consideration. If such action is required, instructions and a report will be issued to staff. This will impact reviews processed in KEES for coverage ending July 21, 2015.

Note – Reviews denied effective July 31, 2015 in KAECSES (for August coverage) will likely have coverage continue in August due to the conversion process. These will appear on the Inconsistent Coverage report and manual action will be required in KEES immediately after go live to ensure eligibility is correctly recorded for August.

If staff are taking any action on the case on or after July 10, 2015 and a required review has not been received, it is appropriate to execute a manual discontinuance. Proper notice is required if this occurs.

16. Attachments

- Processing Deadlines Code Cards
- SSP Application Job Aid
- Worker Portal Job Aids
- Master Code Table
- Clearinghouse Job Aid: KEES Aged Out Foster Care
- F-8: Kansas Medical Assistance Standards
- All Communication Guide
- Medical RDB Request

Questions

For questions or concerns related to this document, please contact one of the Medical program staff below.

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