



Job Aid – DCF Processing E&D and LTC Reviews

After January 1st, 2016

Objective

The goal of this job aid is to provide guidelines for DCF staff experienced in medical assistance to process applications for continuing coverage under Elderly and Disabled programs as well as requests for new coverage at review.

Overview

DCF will be processing E&D reviews beginning March 21, 2016. These will be Pre-Populated review forms.

This Job Aid provides processing instructions for DCF staff responsible for processing medical assistance reviews after the ERO transition. The Job Aid is not intended for staff who have not previously processed medical cases in KEES. It focuses on changes that have occurred since the transition of the Elderly and Disabled caseload in January or that are specific to the Clearinghouse. It also provides specific instructions for addressing reviews impacted by a variable discontinuance process. The Job Aid covers independent living as well and Long Term Care. Topics include task management, requesting information, communicating with third parties, verification and notices/forms.

Review/Discontinuance Status Update

The Review Batch continues to run for each month. The batch generates Super Passive, Passive, and Pre-Populated Reviews for all medical programs. Forms and Notices are automatically generated for both the customer and any appropriate Administrative Roles (e.g. Facilitators and Medical Reps) that are noted in KEES. Some programs (such as SSI) are called 'No Review' programs and are not impacted by the Review Cycle – examples are SSI and Foster Care programs. Super Passive and Passive Reviews do not require action. Pre-populated reviews do require action. The Review Cycle was typically executed around the 20th of each month, but future cycles will execute after the Come-Up month in KEES.

The Discontinuance Batch is designed to close programs that have not completed a review. The Program Block is closed for all cases where the review is incomplete but a notice is only sent for Program Blocks where the review isn't recorded. The Review Discontinuance Batch was originally scheduled to run monthly at the end of the month the review was due (similar to the Review Cycle pre-KEES). However, the Discontinuance Batch has been executed sporadically since July, 2015 and has been consistently delayed. The following table outlines when the Discontinuance Batch was executed. This is important, as processes to a work a review impacted by the schedule are different than when reviews are worked timely. Note a Defect Correction was executed in January to 'catch up' with cases that should have been discontinued in an earlier batch. Discontinuance has not been executed since 01-14-16. KDHE Leadership has delayed the execution of future Discontinuance Batch jobs until further notice. Example: Case was originally due for review in September, 2015. Review was not returned. Discontinuance batch ran for September in December. Case closed effective 12-31-15.



Monthly Discontinuance Batch Job	Date Batch Job Ran	Additional Defect Fix Correction
July	11/19/15	1/14/2016
August	8/15/2015	1/14/2016
September	12/17/2015	1/14/2016
October	1/14/2016	N/A
November	TBD	N/A
December	TBD	N/A
January	TBD	N/A

Because of this cycle, when a case is impacted by the delay in running the Discontinuance Batch, coverage continues in KEES. In the example above, the recipients on the case received coverage for October, November and December. Except for cases where a Medically Needy base period ends, coverage is also continued in the MMIS. If a case has both Medically Needy and an MSP, only the MSP is continued in the MMIS.

If a case was impacted by the delay in running the discontinuance batch and coverage has continued in either KEES or MMIS, timely and adequate notice is required when a negative action is taken.

Example: A LTC Review expired 02-29-16, but coverage continues in the MMIS and KEES. Review received 02-15-16 is processed on 03-28-16 and is over resources. Coverage is discontinued effective 04-30-16.

Process

Work is obtained through a report that will be distributed by DCF. Select the Eligibility tab then search on the case number. This will navigate to the Case Summary.

1) Research and Screen

Research the request for coverage to become familiar with the household and the type of coverage that has been received.

NOTE: The Registration team is starting a new process that changes how applications are registered when multiple applications are received. Registration staff no longer E-Link each application to the case. They will add a journal entry that identifies the E-app number of each application and will re-index images to the case. This will not be a common situation with reviews as it would only be applicable to reviews that came in on an application form. This could impact cases where an application has been received on a case with a pending review (e.g. MIPPA or FFM application).

a) Review the Review Form.

Review the request for coverage by perusing the request.

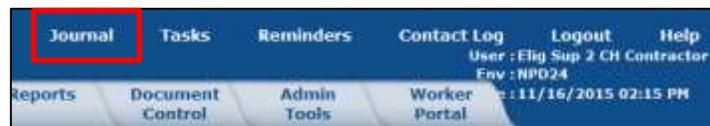
Most commonly, this will be the image of a Pre-Populated review form. However, in some cases other types of request may also exist:

- i) An E-Application (see Job Aid – Searching for an E-App using E-Tools - Attached)

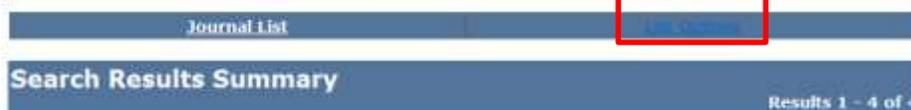
- ii) The PDF of an E-application through Images or the SSP Document Drawer (see Job Aid – Locating Application in ImageNow – attachment)
 - iii) The Journal for any verbal request for coverage
 - iv) The E-application for MIPPA or FFM applications
 - v) If there are multiple Applications/Requests for the case, review each document
- b) Read all journal entries from the prior 12 months.

Review any past history on the application and/or family. Don't forget to review journal entries on Companion Cases too.

- i) Click Journal on the Utility task bar.



- ii) From the Journal List, click on List Options.



- iii) Update the Date Range to include all journals from the past 12 months. Click Search.

Resource ID:

Journal Type:

Case Number:

Contact Type:

Date Range: From To

Source:

Keyword Search:

- c) Review any previous case history
 - i) Status of each program block
 - ii) Who is included in each program block?
 - iii) Ghost Worker ID assigned to each program block
 - iv) Who has active coverage, what type of coverage is it, and what is each recipient's RMT?
 - ii) What month the review is due?



- v) If the program block was previously discontinued, determine if the new request was received within the Reactivation (RA) timeframe.

- d) Note the status of the program block. Has it been impacted by a discontinuance batch? If so, note additional information in the Overview and special instructions for cases impacted by the discontinuance outlined in Section 9 and 12 see special instructions.

- e) Note the month/year the review was due. If the review is past due, coverage may or may not have been sent to MMIS. Check MMIS prior to processing any review that is past the expected expiration date to determine what coverage is in the MMIS.

- f) Screen for Specialty Coverage – New Requests
DCF will not process new requests for specialty coverage, but can process reviews for some of these programs (as noted in Item h).
If there is a NEW request for coverage for one of the following programs, DO NOT WORK the request.
 - Working Healthy or WORK
 - MediKan Reintegration
 - SOBRA
 - Inmate
 - Refugee
 - Pre-Release
 - Breast and Cervical Cancer
 - SOAR
 - TBI

- g) Screen for HCBS/PACE/MFP - If the consumer is requesting to add or change HCBS, PACE, or MFP at review, **DCF does not process**. DCF may process reviews for some of these programs as noted in item (h).

- h) Reviews for Specialty Coverage:
DCF does not process reviews for the programs listed above, except DCF may process a review for a case with existing coverage:
 - Working Healthy or Working Healthy/WORK
 - HCBS
 - MFP

2) View the images

- a) Review the image of the review form and any supporting documents.

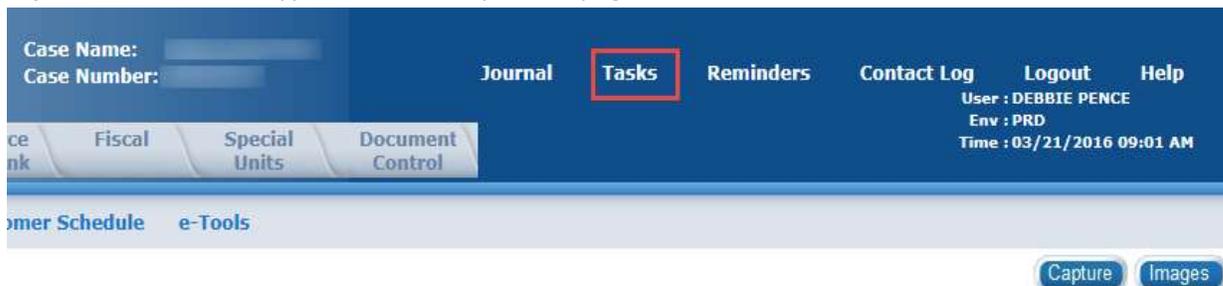
Quick Search <input type="text" value="Search"/>				
Case Number <input type="text" value="starts with"/>				
Created	Drawer	Received Date	Case Number	Document Type
1/4/2016	KEES Case	12/31/2015	2000000	CH Review

- b) Ensure the review form has been signed.
- c) Refer to *KC1600 – E&D Pre-Populated Review Form Eligibility Processing Job Aid* to determine what is an acceptable answer for each question. Document is attached
- d) Make note of any new requests for coverage or household changes being reported.
- e) If there is a new request for institutional coverage, request an MS-2126 from the facility. The facility must fax the form to the Clearinghouse: 1-844-264-6285. Also, request a CARE score from KDADS.
- f) Screen for PMDT

For reviews that require a PMDT referral, follow the new process for sending a referral to PMDT. See PMDT Communications Job Aid - attachment.

3) Are you able to work the review

- a) **If yes** - Click on Tasks hyperlink at the top of the page.



- b) The Task Management page displays. Claim all task on the case related to the review. DCF is responsible for completing other tasks associated with the case as part of processing the review.

Task Management				
Case	Tasks:			
Task	Queue	Received Date	Status	Actions
Review	E and D Eligibility	03/08/2016	New	<input type="button" value="Claim"/> <input type="button" value="Void"/>
Change	E and D Eligibility	03/08/2016	New	<input type="button" value="Claim"/> <input type="button" value="Void"/>



NOTE: if a task is claimed that cannot be processed by DCF, Release the task. Do no Void any tasks.

- c) **If No** – Contact your DCF point of contact.
- 4) If you find a task that is associated to a Family Medical request, process the E&D portion and then send an email to FamilyMedicalSpecialtyApps@maximus.com with the subject line: Family Medical Application. DCF will resolve the E&D task and leave the FM task pending.
- 5) **Update RMT** – If the RMT needs updated, update the RMT.

Example: If an E&D recipient requests LTC at review, an RMT of LTC will need added if not already added by registration. The begin date for the new RMT would be the date the RMT should be used in determining eligibility.

- 6) **Update Prior Medical Months for New Applicants** - If there is a new request for medical assistance and prior medical coverage, continue using the steps below. If the only requests for coverage are for people who were receiving coverage when the review came due, skip to **Step 7**.

- a) If Prior Medical coverage is requested, and the person requesting it did not receive coverage in that month, the prior medical months will need to be added to the program block.
- b) Click on View Details in the program block you want to update. The Medical Program Detail page will display. Click Edit.

Medical Programs

Worker: Clearinghouse Worker	Primary Applicant/Recipient: Jennifer One
Worker ID: KH0206Q1A3	Language: English
Program Status: Active	Phone Number: (785)785-7857
	Application Date: 07/01/2013

Review Due Month: 06/2014 Review

Name	Requested Medical Type	Review Month	Relationship To Primary Applicant	Role	Role Reason	Status	Status Reason
▶ Jennifer One	Medical	06/2014	Primary Applicant	MEM		Active	

View Details

- c) Click the Edit button to the right of the name of the person who is requesting the prior medical coverage in the Program Persons block.

Program Persons

Name	CE	Requested Medicaid Type	Relationship To Primary Applicant	Role	Role Reason	Status	Status Reason
Jennifer One		Medical	Primary Applicant	MEM		Active	

Edit



- d) Enter the first prior medical month into the Retro Months block. Using the Requested Medical Type drop down, select the correct medical type then click the **Add** button. Repeat until all retro months are added.

Retro Months	
Month	Requested Medical Type
06/2013	MAGI
05/2013	MAGI

- e) Once all necessary prior medical months have been added, click **Save and Return**. Repeat Steps above for all individuals who need prior medical.

Click **Save and Return** on the Medical Program Detail page. The Case Summary will display.

7) Check for Verifications

- a) Request verifications using the Request Verifications button, if necessary.

NOTE: Refer to new Job Aids for additional information regarding using KEES for Verification – Verification Page Training Materials and Request Verifications documents - attachments

- b) Access verifications through other systems:

- i) Log into KAECSSES.
- ii) Check BASI if the consumer is reporting earnings.
- iii) Check BARI if the consumer is reporting UI.
- iv) Check EATSS to verify if the consumer is receiving SSA Disability or SSI.

(1) If the applicant does not have a current TPQY, BENDEX, or SDX record on EATSS, skip to step 8 (e) – Send a TPQY.

(2) If the applicant does have a current record:

- (a) Check Payment Status for SSA and SSI. If receiving benefits, note the amount(s) being received.
- (b) Verify if the consumer is receiving Medicare Part A, Part B or both. If so, determine if they have been bought in.
- (c) Skip to **Step 8 (ii)** - Check the Medicare Information page.



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CAN: 999999999 A WIRE THIRD PARTY QUERY PAGE #1
SSN: 999999999 NAME: JONES JOE DOB: 01011900 SEX: F
-----TPQY/SSA INFORMATION-----
SSN: 000000000 NAME: JONES JOE S DOB: 01011900 SEX: F
CAN: 999999999 PYMT STATUS: CURRENT.PAYMENT..... EFF DATE: $GROSS$
DOD: 000000 DUAL ENTITLEMENT NO: 000000000 ... 1215 ..755.00
INIT ENT: 0203 LUMP SUM AMT:$ ....0.00 1214 ..755.00
SSN VERIFIED: Y LUMP SUM DATE: 0000 1213 ..743.00
NET MO BEN:$ ..755.00 DISABILITY BEGAN: 090102 1212 ..732.00
-----
MEDICARE ENTITLED PREMIUM STOP STATUS BUY-IN START STOP
PART A HOSP 0205 $ ..0.00 0000 YES-AUTO.ENTITLEMENT .... 0000 0000
PART B SUPP 0205 $ 104.90 0000 YES-ENROLLED..... KS.. 0205 0000
-----
SSN: 999999999 NAME: JONES JOE S DOB: 01011900 SEX: F
PYMT STATUS: TERMINATED..... 1619B: . INIT ELIG: 1203
NET BENEFITS DATE FED AMT STATE AMT
CURRENT--> 010116 TYPE PAYMENT $ ....0.00 $ ....0.00
HISTORY 010110 NO.PAYMENT.MADE..... $ ....0.00 $ ....0.00
060109 NO.PAYMENT.MADE..... $ ....0.00 $ ....0.00
QOFC: ..... BENDEX: ..... SDX: ..... F7=TPQY: 20160121
  
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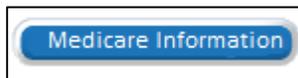
v) **Send a TPQY** (in order to verify SSA/SSI income)

(1) Press F4 to request an update in KAECSES.

NOTE: Updates sent prior to 3:30pm should be available the following day.

8) Check the **Medicare Information** page to see if page has been updated by the TBQ interface.

i) Click Medicare Information on the bottom right of the Medicare Expense Detail screen.



ii) The Medicare Information page displays. The information displayed on the page should match the information shown in EATSS. If the Medicare Information page is out of date or is blank, update the Medicare Expense page. Any change to the Medicare Expense page will request a new TBQ. You must save the change on the Medicare Expense page in order for the request to be sent..

NOTE: TBQ requests may take up to **TWO** days to get a response.

Medicare Information				
Medicare Name	SSN	DOB	Medicare Claim Number	
Medicare Information Part A header				
Part A Entitlement Date	Part A Entitlement End Date			
Part A Entitlement Status	Part A 3rd Party Premium Payer	Payer Start Date:	Payer End Date:	
Medicare Information Part B header				
Part B Entitlement Date	Part B Entitlement End Date			
Part B Entitlement Status	Part B 3rd Party Premium Payer	Payer Start Date:	Payer End Date:	
Medicare Information Part D header				
Part D Start Date:	Part D End Date:	Part D Opt-Out Indicator:	Retiree Drug Subsidy Start Date:	RDS Term, Date:
Other Medicare Information Header				
End Stage Renal Disease Start Date	End Stage Renal Disease End Date			
Verified				



9) Determine if New Spenddown Likely to Be Met

Do not automatically establish a new 6 month base period at the end of a Medically Needy review. Several factors must be considered. If the Review:

- a) Is not a Medically Needy (aka spenddown) review, skip to **Step 10**.
- b) Is a Medically Needy (spenddown) review, check the MMIS and determine if a new spenddown is likely to be met and the review is being worked timely. See *Job Aid – Does Consumer Anticipate Meeting a Spenddown* for more information.
 - i) If the review falls within a base period, continue the spenddown until mid-review. A task is generated when the base period ends.
 - ii) If the consumer is likely to meet a spenddown, skip to **Step 10**.
 - iii) If the consumer is not likely to meet a new spenddown and you are working the review after the last day of the base

Example: Base Period ended 01-31-16 and you are processing the review 03-25-16:

- (1) The consumer is NOT eligible for MSP, coverage will not usually have been sent to the MMIS, however coverage has continued in KEES. This means you will need to set up a new 6 month base period in KEES in order to establish some coverage in the MMIS. Complete the following steps in order to discontinue coverage correctly:
 - Create a new base period beginning with the first month after the previous base.
 - Run EDBC for the month after the last month of the existing base period.
 - Discontinue giving timely and adequate notice.
- (2) The consumer has been eligible for MSP, coverage will generally be in the MMIS for the months since the base ended. You will not establish a new 6 month base. Add a new RMT of MSP. To do this, navigate to Case Summary, click the View Details button in the appropriate program block, Edit the Program Detail, then edit the person for whom the RMT is being added. In the RMT section, click the Add button. Select MSP as the RMT and enter a begin date of the first unpaid month that is being processed.
- (3) The consumer had MDN only and you are adding new MSP eligibility, then follow normal MSP processing. See KEES User manual MSP Processing.

Example: On-going QMB and Medically Needy through 01/31/2016. Processing review on 03/15/2016. The consumer is no longer eligible for Medically Needy but QMB continues. QMB exists in MMIS through 04/30/2016. Adding RMT of MSP with Begin Month of 05/2016. Run EDBC starting 05/01/2016.

Example: On-going Medically Needy through 01/31/2016. Processing review on 03/15/2016. The consumer is no longer eligible for MDN but eligible ELMB. Add RMT of MSP with Begin Month of 02/2016. Run EDBC starting 02/01/2016 through system come-up month.

NOTE: *If you are unsure whether the consumer will be eligible for MSP or not, you can leave the case as is until EDBC is run. Once EDBC is run, you can review the MSP budget for correctness. If MSP eligible, add a new RMT. If not eligible, add a Customer Option of Medically Needy so KEES won't set up another spenddown.*



10) Update the Non-Financial & Financial data collection screens- When new, differing, or updated information is received it is necessary to update data collection screens. Accept or Reject all information with **NEW** beside it as appropriate.

NOTE: In some instances, multiple applications have been e-linked to the case. This will require data acceptance of each. A change has been made to the Registration process that reduces the need to complete Data Acceptance on multiple applications, but also impacts the methods that Eligibility staff use to review the multiple applications that have been received on the case. The registration staff will add a journal entry that identifies the e-App number of each additional application and will re-index images to the case.

Because the E-app is not going to be linked, Eligibility staff will have to search for the E-app by number, in order to review the information provided by the consumer on that application. See Job Aid - Searching for an e-App using e-Tools for instructions on how to locate an e-App – attached.

Comparing the E-apps is not an easy task – because it is not simple to view e-apps side by side. Staff will have to be diligent when comparing the application to identify differences between the various requests for coverage, which could be coming from different sources like MIPPA, FFM, SSP, or Paper applications.

NOTE: DO NOT open multiple KEES sessions to review the applications. This causes other problems in KEES and is not a solution for comparing applications.

When comparing multiple applications that have a PDF, such as the paper or SSP applications open these images and review side-by-side. For applications that do not have a PDF – such as MIPPA or FFM – staff will need to open each of the E-Apps in KEES, expand the sections and take screen shots in order to compare the applications side-by-side.

a) Navigate to the Non-Financial data collection screens

- i) Verify each member in the home has a valid address on file.

NOTE: To ensure information goes to the MMIS, the address must include the county code. To do this, verify the zip code is in the Zip+4 format.

- ii) Check the Administrative Roles on the case to ensure the Medical Rep and/or Facilitators are correct. Updating using existing RDB processes. Registration staff at the Clearinghouse will add these as part of their normal process.
- iii) Ensure all information on the Individual Demographics screen is current.
- iv) Ensure the Citizenship/Identity record is set up correctly and, if not exempt, citizenship and identity has been verified.



U.S. Citizenship Verification	
Document Type on File:*	Federal Data HUB
Medical Citizenship Verified:*	Pending
Identity Verification	
Document Type:	Federal Data HUB
Medical Identity Verified:*	Pending

- v) Ensure each member has a current Household Status.
 - vi) Add/Update the following records if applicable: Relationship, Non-Citizenship, Pregnancy, Residency, Other Program Assistance (OPA), Non-Compliance, Customer Options, and Employment.
 - vii) If Institutional Care is being requested, add a LTC Data record. If already receiving LTC, ensure the LTC Data record is set up correctly.
 - viii) Validate information on the Medical Condition page. Update if necessary.
- b) **Navigate to the Financial data collection screens-** Verify all records on file are current. Add/End records if needed. If the source of the income remains the same, add a new amount record to the existing income record. Set the begin date to when the new income should begin being budgeted. Adding a new amount record will automatically end date the existing amount record.
- i) **Earned/Unearned income** - Add/Update income using the correct budgeting method.
 - (1) For self-employment and unearned income, use the appropriate TIER verification process.
 - (2) For LTC and Working Healthy, verify income based on old school budgeting.
 - (3) Wages are subject to MAGI budgeting for E&D Medical programs that are not related to LTC or Working Healthy. Workers will need to use the Reasonable Compatibility Tool on the KEES Repository to compare the consumer's self-attestation of wages with what was reported on BASI. If wages are Reasonably Compatible (RC), the amount of wages which should be budgeted is shown on the Reasonable Compatibility Tool. If not RC, verify income using the appropriate TIER Verification processes. The RC Tool must be imaged to the case.
 - ii) **Resources** - Update based on resources reported by the consumer. Follow existing verification policies for individuals without application history.
 - (1) Existing exempt resources (including those determined exempt at the time of initial approval such as irrevocable burial plans) may NOT need re-verified at review unless a change is reported which would affect the exempt status of the resource.



- (2) Existing non-exempt resources must be re-verified unless previously verified within the timeframes listed below:
 - Liquid Resources: Verified within the last 3 months
 - Personal Property: Verified within the last 12 months
 - Real Property: Verified within the last 12 months
 - (3) If a new resource is reported at review, it must be verified if either non-exempt or if verification is needed to determine its exempt status.
 - (4) If the countable value of an existing non-exempt resource has changed or an exempt resource has become non-exempt, a new record must be added and the existing record end dated. The begin date on the new record is the month in which the new value/non-exempt status should be used in determining eligibility. The end date on the old record would be the last day of the previous month.
 - (5) If applicant reports an annuity, obtain new KC3167/KC 3167. If application reports a trust obtain information necessary to complete a trust clearance. Send information to Jeanine Schieferecke (jschieferecke@kdheks.gov)
- iii) **Expense page** – Review the Expenses currently being allowed against the share of cost to ensure they are appropriate. If a change in the amount of an existing expense is reported or if a new expense is reported, the expense must be verified before it can be allowed. However, coverage is not denied for failure to provide proof of an expense. Update the Expense page if applicable.
- iv) **Medicare Expense** – Pay close attention to the following:
- (1) If the consumer has a spenddown and is not anticipated to meet another spenddown, ensure the Medicare Information page is correct. MSP will not determine correctly if this page does not reflect the correct Medicare information. If needed, make a change to the Medicare Expense page to request a new TBQ.
 - (2) If the consumer has Medicare premiums which can be allowed against a spenddown or LTC liability, ensure the page is updated appropriately based on findings from Medicare research conducted earlier. If the consumer does not have a spenddown or LTC Liability, a Medicare Expense record is not needed; however, if one exists, it can be updated.
- v) **Other Health Insurance** – Add/Update records if applicable.

11) Verify Missing Information

- a) Navigate to the Verifications List page.
- b) The Verifications List page will display showing **Pending** as the Status and **Medical** as the Program.

Status: [*] Pending	Program Type: [*] Medical	From:	To:	View
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- c) Review the remaining verifications. If any of the verifications listed are in Pending status in error, navigate to the appropriate page and update the status of the verification.
- d) If the information is not verified, check the box next to the record and then click the **Request Verifications** button to check the interfaces.

Type	Program Type
<input checked="" type="checkbox"/> Liquid Resource	Medical
Verify	Request Verification



- e) If the information cannot be verified using an interface, send a V008 to request the missing information. Use the Verification Fragments from the Standard Text for Copy and Paste in the KEES Repository when requesting information.
 - i) ALL information requested from the consumer should be sent to the Clearinghouse, not to DCF. This information will be conveyed in the V008 as part of the Verification Fragments.
 - ii) When requesting information it is important that we give the consumer enough time to return requested information. With DCF assisting in processing E&D reviews and information being sent to the Clearinghouse it is imperative that more time is allowed before case action is taken. Therefore when placing a task on hold, the due date should be set *3 days after the 10 day due date*. *This allows for additional time for the documentation to be received, imaged, and linked to the case.*

Example: NOA was sent requesting bank statements on 3/1/2016. Due date on NOA will read 10 days from 3/1/2016 which is 3/11/2016. This is the correct date. However, the due date on the task will need to be set to 3/14/2016.

- iii) It is acceptable to call the consumer in attempt to resolve any issues at hand. If unable to reach the consumer on the first attempt, DCF staff need to follow their current process and leave a voicemail stating they will call back in five minutes. If unable to reach the consumer on the second attempt, leave a voicemail informing the consumer that information is needed and to call the Clearinghouse. If the consumer is reached, they need to be made aware that they are to call the Clearinghouse for all future case activity

NOTE: The KEES Journal must accurately reflect all of the information that is required of the consumer so the Call Center at the Clearinghouse can relay this information when they call.



(1) A sample script may say: *I am assisting the KanCare Clearinghouse with processing your review. We need to speak with you before we can continue. Please contact the Clearinghouse at 1-800-792-4884 during the hours of 8am to 7pm.*

iv) Clearinghouse information is as follows:

KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601-9738
Phone 1-800-792-4884
TTY 1-800-792-4292
Fax 1-844-264-6285

f) Once all information on file has been verified, proceed to **Step 12**. If information is not received, determine if the applicant/recipient(s) will be denied due to failure to provide the information. Remember expenses which are not verified do not result in denial. Instead, the expense is not allowed. If a denial due to failure to provide is appropriate, set any pending verifications to Refused and create a non-compliance record. Set the begin date to the 1st of the first month which should be denied due to failure to provide.

NOTE: Consider the self-attestation (SA) of the income and resources for E&D Programs that use MAGI budgeting methods – if the applicant is over the income or resource limit based on SA, do not request hard copy verification.

12) Run EDBC

- a) Navigate to **Run EDBC**. If determining ongoing eligibility or ending a spenddown, see **Step 9**.
- b) Run EDBC months sequentially.

NOTE: If processing Medicare Savings Programs follow the process in the KEES User Manual in KEES User Manual>Processing Medicare Savings Programs.

- c) If LTC, ensure all long term care information is available.
 - i) If working a case with previous history (especially with existing base periods, check MMIS before running EDBC.
- d) Click the check box next to the Medical program block. Choose the status of RE in the Run Reason dropdown. Click Run EDBC.

NOTE: If establishing a new spenddown, it may be necessary to also run with a Timely Notice exception and a reason of Waiver on File.

The image shows a software interface element titled "Run Reason". It features a dropdown menu with "RE" selected. Below the dropdown are two buttons: "Run EDBC" and "Cancel".

- e) Click the **Medical** link with a Run Status of **Not Accepted**.

Begin Month	End Month	Program	Type	Run Status	Auth Amount	Date Run	EDBC Source
07/2013	06/2014	Medical	Regular	Accepted - Saved	Details	05/16/2014	Online EDBC Rules
06/2014	06/2014	Medical	Regular	Not Accepted	Details	05/21/2014	Online EDBC Rules
07/2014		Medical	Regular	Accepted - Saved	Details	05/20/2014	Batch EDBC Rules

- f) Review the EDBC results.
If the EDBC results provided do not reflect the correct determination, review the Non-Financial and Financial records on the case, correct any errors, and complete any additional troubleshooting steps.
- g) If the EDBC results are accurate, accept the EDBC results, and click **Save and Continue** on the EDBC List page.



NOTE: *If a review is received early and a positive change can be made prior to the new review month, add any new information on the appropriate data collection pages with a begin date of the first day of the month the change should take place. Run EDBC for the appropriate month to adjust the eligibility determination.*

- h) Ensure the EDBC DOES NOT result in putting the beneficiary placed in an Ineligible Status. See the item below from a recent KEES Dispatch:

Negative Change in Paid Months/Ineligible Status in KEES

Cases should only be Discontinued in the Come-Up Month. If the MMIS Monthly File has run, the coverage is in MMIS and the case cannot be closed until the following month.

Example: *September 2015 eligibility has been sent to MMIS. You can now only discontinue coverage by running 10/2015 EDBC to end benefits 09/30/2015.*

Unless the user is selecting a Timely Notice Exception of Yes and a Reason value—KEES will not allow the user to Discontinue or give worse coverage in a Paid Month. The EDBC is a Read Only. A Read Only EDBC is just that—it is for view only. It is used to determine if an overpayment has been made.

If the user does use the Timely Notice Exception and discontinue a month already sent to MMIS, KEES will give a Program/Person Status of Ineligible. We do not remove coverage from MMIS.

The exception to this is when a user is closing an LTC case where there is no other coverage being approved. Running Paid Months is required to send the IL/NA to MMIS. This will not end medical eligibility.

Person is 'Ineligible' on EDBC



Never Accept and Save a 'Failing' EDBC that shows any person as 'Ineligible'. Back out of the EDBC and reassess what month you are attempting to run EDBC in. You should not be 'Denying' benefits in a month that has already been paid.

Medicaid EDBC Summary

Begin Month	End Month	Run Date	Run Status
08/2015		08/03/2015	Accepted - Saved

EDBC Information	
Type:	Regular
EDBC Run Reason: RE	

Program Configuration	
System Determination	
EDBC Source: Online EDBC Rules	
Program Status:	Denied
Program Status Reason: FTP Income	
Note: Overridden rows are in bold.	

Name	DOB	Role	Role Reason	Status	Status Reason
		MEM		Ineligible	FTP Income
		FRI	Ineligible Non Citizen	Ineligible	FTP Income
		FRI	Child of FTP Income	Ineligible	FTP Income
		FRI	Child of FTP Income	Ineligible	FTP Income

If you have a person with an Ineligible Status in KEES, contact the Help Desk.

- i) **Special Medically Needy/Spenddown Processing Instructions:** Due to the discontinuance batch not being run and eligibility continuing past the review month, there is a special process that will need to be followed when determining eligibility for spenddowns. (also see Step 9)
 - i) If a new spenddown is being established, select the first month of the new base period as the benefit month. Click Select. EDBC must be run for the first month of the new base period in order to set the correct base period.



If the discontinuance batch did not run and eligibility was sent to MMIS for months after the old review due ended, the worker is required to check MMIS the day after processing the Medically Needy review in order to determine whether the case must go to the HelpDesk for further processing. If MMIS shows the new base period but does not show current eligibility, the case must be sent to HelpDesk.

- ii) If a new spenddown is not being established (because they do not anticipate meeting a spenddown or because they have received other coverage, such as QMB, that is already in MMIS), then the benefit month selected depends on whether coverage has been sent to MMIS for months after the review period ended or not.

NOTE: For a case that is just Medically Needy (not Medically Needy and MSP) – A new spenddown base will need to be established if processing after the last day of the old base period. This will allow you to discontinue the case in the current come up month and avoid the Ineligible status noted above in item i.



If there are:

- (1) No paid months in KEES beyond the Review Due month, select what should have been the first month of the new base period from the Benefit Month dropdown. This means the program block was discontinued and rescinded.
- (2) One or more paid months beyond the Review Due month, select the first unpaid month from the Benefit Month dropdown.

Example: A base period ends 12/31/15, discontinuance batch did not run. Processing a review today and must set a new base period of 1/2016 through 6/2016 and discontinue with timely notice.

j) For Long Term Care cases:

When a case was impacted by the discontinuance batch, coverage should have continued at the previous benefit level (including Level of Care and patient liability/client obligation/participant obligation). You should verify current MMIS eligibility prior to processing a long term care review.

13) Important Info About EDBC:

- a) If the application is for spenddown, run all of the months of eligibility and check the “budget” hyperlink for each EDBC. The Base Period and spenddown amount needs to be correct for each EDBC.
 - i) Do NOT Accept and Save an EDBC if the Base Period isn’t correct or overlaps one that has already been created. KEES will not know which base period to send. That’s why it’s good to check what the MMIS has so you can match the base periods up with KEES.
 - ii) Be sure to NOT skip any months when you run the EDBC or KEES begins a new base period. If you’re checking the budget for each EDBC it should be obvious to see the different base period for that EDBC.
 - iii) Be sure that the last base period that is created covers the current month. Since these applications may be many months old, be sure you have a base period that covers the current and future month (if you’re working the application late in the month). Otherwise eligibility will be sent to the MMIS but no base period will be sent because there isn’t one created to send.
- b) For LTC Cases – Be sure to check each EDBC that is run for Long Term Care cases.
 - i) With the fix that went in so KEES now creates the “TC” code, if a case hasn’t been touched since conversion there could be problems if you just accept the EDBC – as it may have TC codes. That’s because the LTC Data Details page may have the “Length of Stay” as “30 days or less” which creates the TC.
 - ii) Change the Length of Stay to “More than 30 days” and the correct LTC code should then display on the EDBC. If the TC code is present, the Patient Liability may be wrong also as it will be using the Independent Living PIL in the budget.
 - iii) Check the “budget” hyperlink to ensure ALL the details are correct before Accepting and Saving the EDBC.
- c) If the EDBC has LTC Details the Aid Code MUST be 300% or else Medically Needy eligibility will be sent to the MMIS. In these situations, you must override the EDBC results to set the 300 Aid Code. If the Medical Aid code reflects SSI or PMG, no override is necessary.



- d) Users should pay attention if they receive a 'Read Only' EDBC they should not Save and Accept it. This will not send any benefits over to MMIS. (This usually means EDBC is being run for an already paid month without an exception.)
- e) The process for completing a Temporary Stay in KEES has changed. Staff will need to follow the instructions in the KEES User Manual when processing all requests for coverage when a temporary stay is involved.

14) Send the NOA

- a) If the EDBC results were accepted and saved, a Notice of Action (NOA) will automatically be generated. Click on the name of the NOA to review the contents.

Select	Date	Worker	Document	Recipient	Type	Program	Benefit Month	Status	Receive Date	Posted Date
<input type="checkbox"/>	05/12/2014	user user	NOA - MC Approval	Jennifer One		Medical	07/01/2013	Accept - Pending Print Central		

- b) Review the notice, making sure that the determination that was authorized is reflected.

KanCare Clearinghouse
PO Box 3599
Topeka, KS 66601-9738

Jennifer One
1234 SW TOPEKA BLVD

TOPEKA, KS 66604



Notice Date: 05/12/2014
Case Name: Jennifer One
Case Number: 20001081
Program: Medical

We have approved your application for Medical Assistance beginning 07/01/2013 for the following individuals:
One, Jennifer

People eligible for coverage will get a medical ID card. We will send a medical card to new members. If

- c) Make sure the review dates are correct, as well as the names of who was approved and who was denied, and the amount of the patient liability, spenddown or other cost sharing information. Verify the notice meets all applicable criteria for an acceptable NOA. If all the information on the notice is correct, click **Save and Print Centrally**. If the NOA is not correct, append the NOA or send a manual form as appropriate.

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Print
Save and Print Locally
Save and Print Centrally



If processing a review for Institutional Care, a Form will need to be sent to the nursing facility to inform them of the changes. This will need to be completed if the review was approved or denied.

- d) If processing a review for HCBS, an ES-3161 will need to be e-mailed securely to the MCO using the appropriate email address. While DCF staff will be sending these emails from their own email accounts, it is important to note that MCO's will not be continuing contact with them. All contact from MCO's will be directed to the HCBS e-mail box at the Clearinghouse.

15) Shorten Rev Due Month – If the case is impacted by a delayed discontinuance batch, and coverage has continued, there are situations where EDBC will have to be run (with the RE run reason) for the come-up month. In these situations, the Review Due month must be corrected. Because EDBC was run for the come-up month, the 12 month review period was set based on the come-up month being the first of the 12 months. Per policy, the Review Due month needs to be based on what should have been the first month of the new review period. The worker must manually correct the Rev Due month.

Example: LTC & MSP Rev Due 12/2015. The case was touched and staff realized no review had been received and coverage ended 2/29/2016 due to no review when the discontinuance batch ran. The consumer had 3 months following closure to submit his review as part of the review reconsideration period. He turned in the review on 3/5. The review is processed on 3/6. Coverage for 01/2016 – 02/2016 was already paid, so EDBC was run with the RE run reason for 03/2016. This caused a Rev Due of 02/2017 to be set in error. The Rev Due will need to be manually shortened to 12/2016.

- a) To shorten the Review Due Month, click **View Details** on the appropriate program block.
- b) Click **Edit** on the Medical Program Detail page.

16) Update the Review Due Month accordingly. Click Save and Return.

Update IR/12 Month Review Reporting Page- When completing and authorizing a review, the Review/IR Record **must** be updated to reflect the current document and report status of the review.



IMPORTANT: Failure to update this page will result in coverage ending even if new coverage has been determined and saved in EDBC

- a) Navigate to the Eligibility tab
- b) Select Reporting in local navigation.
- c) Click Edit to the right of the review record.

Type	Submit Month	Document Status	Report Status	Program	Date Received
Pre-Populated Medical Review	07/2014	Received	Reviewed- Ready to Run EDBC	Medical	

- d) When the Review and IR/12 Month Reporting Detail page displays, check the Document Status. If it still shows Sent, the Document Status must be updated to Received to avoid the case being closed in error. Update the Report Status to

Report Type: Pre-Populated Medical Review	Submit Month: 07/2014	Document Status:* Received	Report Status:* Complete- EDBC Accepted
Customer Report - Pre-Populated Medical Review		This Report	
1. Is the review application signed? *			Yes

e) Click **Save and Return**



IMPORTANT: Failure to update the Review record with a **COMPLETE** status will result in coverage closing in error even if all other review registration steps have been completed. In addition, if the Report Status is set to Complete but the Document Status is left in Sent status, coverage will close in error.

With the discontinuance batch, all program blocks with an unprocessed review are discontinued. However, a discontinuance notice was sent to anyone who has a Document Status of Sent and a Report Status of Incomplete.

17) Future Dated Tasks

Set any future dated tasks need to be set (e.g. removing Medicare Premium due to Buy-In). See the Job Aid for Future Dated tasks – attachment

18) Journal

Complete a Journal Entry according to the Review Journal Templates – see attachment.

a) Click the **Journal** link in the Utility Navigation bar.



b) Ensure **Free Form** is selected under the Add Entry: designation at the bottom right of the Journal List window and click **Go**.



c) Complete a journal entry documenting the reasoning and decisions made on the case. See attached Journal Template for guidelines of what an appropriate journal entry contains.

19) Complete the Task

a) Once all case actions have been completed, the Process Review task will need to be completed. Click the **Tasks** link in utility navigation.

- b) When the Task Management window opens, click on the name of the Process Review task. The Task Details window will open.
- c) If the final determination on the case has been completed and coverage was authorized, click the **Complete** button on the Task Details window without updating the status. Do not click the Void button.



The screenshot shows the Task Details window with the following fields and buttons:

- Buttons: Images, **Complete** (highlighted), Release, Save and Continue, Cancel
- Status: Assigned
- Status Reason: * KDHE-Being Worked (dropdown)
- Priority: None (dropdown)
- Created Date: 05/13/2014
- Created Time: 8:01 PM
- Due Date: * 05/18/2014 (calendar icon)
- Review Due: (calendar icon)
- Received Date: 05/02/2014
- Region: (empty)
- Location: (empty)
- Worker Assigned: user user

- d) If the task was pended for requested information, update the Status Reason to reflect **KDHE – On Hold** and list the appropriate Due Date. See Step 11(e)(ii) for more details about the Due Date when placing tasks on hold for requested information. Click **Save and Continue** and close the Task Management window.



The screenshot shows the Task Details window with the following fields and buttons:

- Buttons: Claim, **Save and Continue** (highlighted), Cancel
- Status: New
- Status Reason: * KDHE-On Hold (dropdown)
- Priority: None (dropdown)
- Created Date: 06/13/2015
- Created Time: 11:18 AM
- Due Date: * 06/17/2015 (calendar icon)
- Review Due: (calendar icon)
- Received Date: (empty)
- Region: (empty)
- Location: (empty)
- Worker Assigned: (empty)

20) Check MMIS

- a) It is required that workers check MMIS the day after processing a review to determine if accurate coverage is reflected. If expected eligibility is not in place, follow instructions in the KEES user manual to determine the next steps.
- i) For more information about checking MMIS when processing spenddowns at review, see **Step 11(i)**



Applications Pending Social Security Decision

Reassigning Worker ID

For tracking purposes any pending Social Security determination should be assigned to the worker ID **KH0206Q103**. To do so the following steps will be needed to reassign the worker ID: (Make a note of the program block number before you begin)

- Select **Admin Tools** from Global Navigation
- Select **Workload Assignment** from Local Navigation
- In the **From** box enter **case number** in the box next to case number.
- Hit enter
- In the Reassign Quantity box select the **program block** needing to be reassigned under program.
- In the To box click **select** under Worker ID
- The Select Worker screen will appear. Enter KH0206Q103 in the **Worker ID field**.

Select Worker

The screenshot shows the 'Select Worker' form with fields for Last Name, First Name, Classification Title, and Worker ID. The Worker ID field is highlighted with a red box and contains the value 'KH0206Q103'.

- Click **Search**
- When search results appear ensure the correct worker ID is selected.

Search Results Summary

Name	Worker ID	Classification Title
GHOST WORKER, PHDT	KH0206Q103	Other

- Click **Select**
- The Workload Reassignment Detail Screen will now appear again. In the To box click the box next to the worker ID to place a check mark next to it.
- Select **Reassign**.

Workload Reassignment Detail

The screenshot shows the 'Workload Reassignment Detail' screen. The 'From' section includes fields for Worker ID, Case Number, and From Any Eligible Position. The 'Reassign Quantity' section includes Number of Cases, Entire Workload, Program, and Language. The 'To' section includes Worker ID, Auto Assign to Eligible Positions, Effective Date, and Effective Date. The 'Reassignment Option' section includes Automatically Reassign When Attended and Print New Worker Letter. The 'Reassign' button is visible at the bottom right.