



<b>Policy Memo</b>	
<b>KDHE-DHCF POLICY NO: 2014-05-01</b>	<b>From: Jeanine Schieferecke Senior Manager – Medicaid Eligibility</b>
<b>Date: May 13, 2014</b>	<b>KEESM Reference: N/A</b>
<b>RE: Reinstatement of Medical Assistance Program Review Processing</b>	<b>Program(s): All Medical Assistance Programs</b>

The purpose of this memo is to provide instructions for reinstating review processing for the medical assistance programs. These instructions apply to all medical reviews. This memo will provide guidance on the processing of those reviews both before and after the implementation of the new KEES eligibility system.

New review-related policies are described in Section D of this memo. The Review Reconsideration Period policy in Item 1 of that section is effective upon receipt of this memo. The new review types described in Item 2 of that section will be effective with the implementation of KEES.

**A. Background**

Last fall, KDHE suspended all medical assistance review processing. The purpose of the suspension was to temporarily relieve workload during the transition to the new policies under the Affordable Care Act and the planned implementation of the KEES system. Review dates and continuous eligibility dates were automatically adjusted in KAECSES to support the suspension. Several special jobs were run in KAECSES to support the suspension. Beneficiaries were notified of the new review dates through special notices.

In September 2013 family medical reviews occurring between 10/2013 and 03/2014 were extended an additional 6 months. In October, 2013 all elderly and disabled programs were extended an additional 8 months.

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The following charts illustrate the extension periods for the different medical programs.

## 1. Family Medical/MAGI Programs

Initial Review Extension Periods Family Medical Assistance Programs			
Original Review Month	Extended Review Month	Original Review Month	Extended Review Month
10/2013	04/2014	02/2014	08/2014
11/2013	05/2014	03/2014	09/2014
12/2013	06/2014		
01/2014	07/2014		

Because the dates for those reviews occurring between April, 2014 and September, 2014 were left in place, the extension resulted in doubling reviews for April 2014 through September 2014.

### Additional Extension for MAGI programs:

To ease the transition from the suspension, an additional extension was conducted in March, 2014 to extend April and May reviews and continuous eligibility dates. Reviews due April 2014 and May, 2014 were automatically extended to October 2014 and November 2014 respectively. This action effectively delayed doubled review processing until June 2014. But, a double review workload will occur for 6 months - June 2014 through November 2014.

Initial Review Extension Periods Family Medical Assistance Programs – March, 2014			
Original Review Month	Extended Review Month	Original Review Month	Extended Review Month
10/2013	04/2014	02/2014	08/2014
11/2013	05/2014	03/2014	09/2014
12/2013	06/2014	04/2014	10/2014
01/2014	07/2014	05/2014	11/2014

## 2. Elderly and Disabled/Non-MAGI Programs

Review Extension Periods Elderly & Disabled Medical Assistance Programs			
Original Review Month	Extended Review Month	Original Review Month	Extended Review Month
10/2013	06/2014	04/2014	12/2014
11/2013	07/2014	05/2014	01/2015
12/2013	08/2014	06/2014	02/2015
01/2014	09/2014	07/2014	03/2015
02/2014	10/2014	08/2014	04/2015
03/2014	11/2014	09/2014	05/2015

As indicated in the chart above, the elderly and disabled medical programs (MS and CI) that were scheduled for review beginning with the review month of October 2013 and through September 2014 had the existing review period automatically extended for 8 months.

- 3. Notification of Review Extension** – Depending on the type of medical program involved, each household subject to an automated review extension received one of the following system generated notices:

- X202 CI Review Extension
- X203 MS Review Extension
- X204 MA Review Extension
- X205 MP Review Extension
- X206 MK Review Extension

**B. Required Action During Suspension** – The following rules and processes apply to case action during the period of suspension.

- 1. Reacting to Changes** – An extended review does not provide guaranteed coverage through the end of the new extended review period. Staff shall continue to follow existing change processing provisions. The following examples illustrate.

Example 1: A Medically Needy (MN) + QMB recipient with an extended review period through 03/2015 reports on 05/07/2014 that he is moving out of state and no longer need services. Since this individual no longer meets residency requirements, the case is closed effective 05/31/2014 giving timely and adequate notice.

Example 2: An HCBS recipient with an extended review period through 01/2015 is determined on 06/11/2014 by the care coordinator to no longer be clinically eligibility for services. Since the individual is no longer eligible for HCBS coverage, the program is closed effective 06/30/2014 giving timely notice.

Example 3: A Working Healthy (WH) recipient with an extended review period through 05/2015 reports on 04/30/2014 that he has a change in income from his job. The change in earnings would increase his monthly premium from \$55 to \$69. However, by policy, his premium may not be increased until the next scheduled review. If the change had resulted in a decrease in premium, action would have been effective 05/2014 (the month after the month the change was reported).

Example 4: A poverty level pregnant woman with a due date of 06/27/2014 had her review extended through 04/2015. On 07/01/2014 she reports that she had her baby on 06/30/2014. The new mother would be eligible for two months of post-partum coverage through 08/31/2014. She would have no poverty level eligibility beginning 09/01/2014. The newborn would be continuously eligible through 06/30/2015. Assuming no other changes, the child's coverage would end at the expiration of the continuous eligibility period.

Example 5: A poverty level child with an extended review period through 12/31/2014 turns 19 on 08/23/2014. Since this individual has aged out of the program, eligibility ends effective 08/31/2014. Any continued coverage would have to be determined under another program.

2. **Full Review Not Required** – There are instances where a full review of the case is not necessary in order to update eligibility. An example for family medical would be the birth of a child to a current recipient. As a deemed newborn, the child could be added to the active case. An example for elderly and disabled medical would be a current Medically Needy (MN) recipient who becomes dual eligible. As a new Medicare eligible, it would be appropriate to determine eligibility for MSP (QMB, LMB, ELMB) without completing a full review.

A full, formal review is not required to complete these actions. The recipient need not complete a new application or review form nor would the review extension initiated earlier affect this process in any manner.

3. **Working Healthy Desk Review** – The 6 month Working Healthy (WH) desk review shall be reinstated only on cases that have been re-determined eligible for assistance with a new 12 month review period. The desk review does not apply to cases where the extended review date is not yet due. Staff must still react to reported changes by applying existing policy during the extended review period as indicated in section 1. above.

Example 1: A Working Healthy (WH) case is reviewed in 06/2014 and re-determined eligible effective 07/2014 through 06/2015. Assuming the case remains open, a 6 month desk review would be completed in 12/2014.

Example 2: A Working Healthy (WH) case with the automatic 8 month extended review due date of 12/2014. In 06/2014, the worker notices that there are only 6 months remaining in the current review period and conducts the 6 month desk review. Since a new review period has not been established after the expiration of the current extended review period, the WH desk review is not appropriate.

### **C. Reinstatement of Review Processing –**

As indicated above, annual reviews have been reinstated and processing must resume. The following instructions provide the detail for processing medical assistance reviews prior to KEES implementation and includes general information regarding processing once KEES is live.

1. **Prior to KEES Implementation** – All review processing prior to KEES implementation will continue to occur using existing systems, specifically KAECSES and the PSI Platform.
  - a. **Family Medical/MAGI Processes** – Processing of the family medical program reviews began with reviews due in April 2014 (ie: for benefits expiring on 04/30/2014). The Clearinghouse will employ three different types of reviews – passive, administrative and paper. The type of review selected for each medical program is based on several factors, including program type, household income, household composition, and availability of TIAR (Tax Information and Relationship) data. The use of macros to facilitate review processing will continue. Modifications to the complete full review processing will continue to occur.
    - i. **Paper Reviews** – Cases which are not completed through either the passive or administrative review process are reviewed via the use of a paper review form. The KC-1100 application form is mailed to the beneficiary for completion and return. The form is not pre-populated. These reviews shall be processed with existing review policy and procedures. Paper reviews include MA and MP cases. Paper Reviews are completed on all MA-WT and MA-EM programs as well as any case with self-employment income.

These reviews can be identified by the presence of a mailing label with the beneficiary's name and address that is attached prior to mailing.

If the beneficiary fails to complete and return the review form, coverage will automatically end at the expiration of the review period. KAECSES will close the case and send a closure notice for failure to complete the review process.

- ii. **Passive Reviews** – Passive reviews are reviews that are completed with very little involvement of eligibility staff as processing relies on the use of macros to retrieve interface information and recalculate eligibility. If eligible, coverage is provided for an additional 12 months. Passive reviews are completed on MP programs that meet one of the following:
- All household member have only parental or child relationships
  - All income on the case belongs to a child and there is no step-parent indicated on the case,
  - The PI is a non-parental caretaker of the child(ren). Note: Income is below 113% of FPL on MP cases. Note: Effective with June 2014 reviews, this FPL was increased for some cases to 149%. For July 2014 reviews, all cases will be evaluated based on income below 149% of FPL.

**Step 1 – Special macro is run.** A special subsystems macro is run on cases identified for passive review. The case is then updated based on the information found in the subsystems.

**Step 2 – Income screening is completed.** Cases are put on a list based on the results of an income screening. Cases where the income exceeds 219% of FPL fail the passive review requirements and then fall to the administrative review category. If additional problems are found, those problems are resolved before the case moves to the next step.

**Step 3 – Case processed in KAECSES.** Cases are processed automatically in the KAECSES system. The cases are rolled to the current month and approved with a new 12 month review period without additional intervention from eligibility staff. If an issue is identified, the case is put on a list for correction. Once corrected, the case will be rolled to the current month.

**Step 4 – Notification is sent.** Notification of the review completion is sent to the beneficiary, including direction to contact the Clearinghouse to report any changes. If the beneficiary does not report changes, coverage will continue based on the information in the system. The notices are sent outside of KAECSES and will only be viewable in images. Changes are processed according to current policy for passive reviews.

Note: Passive review cases can be identified by case logs within the platform. In addition, subsystem macros will not be in the usual format. Follow the macro zone job aid for any change that needs to be completed on a passive review case.

- iii. **Administrative Reviews** – This memo implements this new review type. Administrative reviews are reviews conducted by eligibility staff using information available through interfaces and in the case file to determine ongoing eligibility. Cases receiving an administrative review are processed manually by eligibility staff. The review is conducted without the use of a review form. Administrative reviews are completed on MP and MA-CM cases that do not meet Passive or Paper review criteria

The following steps occur when conducting an Administrative Review

**Step 1 – RERE Macro.** A special macro to register cases identified for an administrative review is conducted. This is done to avoid an automated closure based on no review.

**Step 2- Subsystem macro is run.** A regular subsystem macro will be run on cases Identified for administrative review.

**Step 3 – Macro results are reviewed.** The results of the subsystem macro will be reviewed by staff. Changes will be based on additional directions given to these staff.

**Step 4 – Information is requested.** When the administrative review cannot be completed with information available, an informational request is sent to the beneficiary.

**Step 5 – Review is completed.** Coverage continues after completion of the administrative review. This review type functions just like a standard review, except no paper review form is required.

**Step 6 – Notification is sent.** Regular approval or closure notices are sent to the beneficiaries out of the KAECSES system. No additional interaction with the beneficiaries is required.

Note: Eligibility staff assigned the task of processing administrative reviews are given a report of cases to process. Staff not assigned this task should email supervisors when a case has a review registered but no paper review is on file.

**a. Family Medical/MAGI Review Period**

Beginning with reviews for the month of June 2014, the new review date for family medical programs is based on whether or not the case has already received a review extension. Cases that were extended six months will only receive an additional six months of coverage when the review is processed. Cases that did not get extended and were originally scheduled for a June review continue to have a 12 month review period set. April and May 2014 reviews were given a 12 month review period. Reports are provided to the staff to identify the cases which require a 6-month or a 12-month review.

Review dates are set according to the following table.

Review Extension Periods – New Review Through Months Family Medical Assistance Programs					
Original Review Month	Extended Review Month	New Review Month	Original Review Month	Extended Review Month	New Review Month
10/2013	04/2014	04/2015	04/2014	10/2014	10/2015
11/2013	05/2014	05/2015	05/2014	11/2014	11/2015
12/2013	06/2014	12/2014	06/2014	06/2014	06/2015
01/2014	07/2014	01/2015	07/2014	07/2014	07/2015
02/2014	08/2014	02/2015	08/2014	08/2014	08/2015
03/2014	09/2014	03/2015	09/2014	09/2014	09/2015

## **b. Elderly and Disabled/Non-MAGI Medical Processes**

Review processing of these medical programs will resume as in place prior to the suspension of reviews. The following steps reflect a June 2014 review (ie: for benefits expiring on 06/30/2014), but are illustrative of how each successive review month will be processed prior to KEES implementation.

The KC-1500 shall be used for these reviews. A supply of forms and outbound envelopes has been sent to each office. The stuffers will not be included. When a non-medical program (FA, TANF, CC) is also being reviewed, the ES-3100r shall be used for the non-medical programs. In those instances the two forms may be mailed together.

**Step 1 – Review mailing labels are printed.** The review mailing labels are created each month on the first working day after the 15<sup>th</sup> of the month which is 2 months prior to the review month. This date is approximately 75 days before the last day of the review period. Note that the SW0183L-R01 (CR110 Review Due/Overdue) report will also be created and available in SAR at the same time.

**Step 2 – Review mailing labels are delivered to regional DCF offices.** The printed review mailing labels are mailed to the regional DCF offices shortly after printing. One set of 3 labels will be created for each case due for review even if multiple programs (such as MS and FA) are being reviewed in the same month.

**Step 3 – Review packets are assembled.** The review form(s), cover letter and envelope are affixed with the review labels and assembled for mailing.

**Step 4 – Review packets are mailed.** The assembled review packets are mailed to the beneficiaries approximately 10 days before the end on the month prior to the last month of the review period. For June 2014, this should occur on or about May 20, 2014. The cover letter included in the review packet should request the review form be completed and returned to the regional DCF office by the 5<sup>th</sup> of the last day of the review period. For June 2014 reviews, that date should be June 5, 2014.

**Step 5 – Review forms are returned.** The review form must be returned by the 15<sup>th</sup> of the last month of the review period to be considered timely.

**Step 6 – Review forms are registered.** Review forms received by the last day of the current review period are registered as a review. If the review is not received and registered by the no review closure date, the case will automatically send a closure notice

See section D Below concerning the new medical assistance review reconsideration policy for reviews received after the last day of the current review period.

**Step 7 – Review processing tasks are created.** A task is created for the Blue or Orange team to process the review. DCF staff shall follow the local office protocol in accepting and processing the task.

**Step 8 – Reviews are processed.** The task is claimed by the Blue or Orange team and the review is processed. A notice of action is sent to the beneficiary detailing the action taken on the case. A new 12 month review period would generally be established for the medical assistance program. However, a shorter review period may be set in order to align with the end of a Medically Needy (MN) base period.

2. **After KEES Implementation** – The review process will change with implementation of the KEES system. The review process in KEES begins approximately 45 days before the end of the review period with a special batch job to determine the appropriate review type. Subsequent actions will run interfaces, complete a passive or super-passive review and produce a pre populated review form. All medical programs will be impacted by the special review batch that will occur on or about the 15<sup>th</sup> of each month. For example, if KEES is live on June 5<sup>th</sup>, the first review batch will be run on or about June 15<sup>th</sup> for July reviews. There are no automated review processes for reviews prior to that first review batch.

#### **D. New Policies**

The following policies are being implemented to support review processing. The review reconsideration period is effective with receipt of this memo. Specific policies regarding review types will be implemented with KEES. Additional information regarding KEES implementation of both policies will be provided at a later date.

1. **Review Reconsideration Period** – An individual subject to review that fails the review process shall be provided a special three (3) month reconsideration period to provide any required form(s), documents(s) or other information necessary to complete the review process and renew coverage. The standard review reconsideration period ends on the last day of the third month following the initial review period. This period may be extended in specific instances to allow additional time to provide requested information. The reconsideration period applies regardless of the reason the review failed, including failure to return the review form, failure to provide requested information, and failure to meet program requirements. This new policy is effective immediately and applies to all medical assistance programs subject to review.

Examples demonstrating application of the new policy are included in Attachment A to this memo.

- a. **Review Form** – Under this new policy, when a form is required, it must be returned by the 15<sup>th</sup> of the last month of the current review period to be considered timely. The form must still be returned (and registered) by the last day of the last month of the current review period to prevent the case from auto closing. However, as long as the review is returned by the last day of the review reconsideration period it is still considered a review for processing purposes.

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

**b. Requested Information** – Requested information must still be returned within 10 days from the date of request in order to prevent adverse action. However, if the requested information is provided after adverse action is taken, but during the review reconsideration period, the adverse action may be rescinded and the review reinstated for processing. This is true regardless of the length of time that has passed from the initial request.

If the requested information is timely provided (almost always within 10 days from the date of request), but outside of the three (3) month review reinstatement window, the review may still be reinstated for processing. This will most commonly occur when the review form is received at the very end of the three (3) month reinstatement period and there are less than 10 days remaining in the reinstatement period, or where the agency has failed to request the information in a timely manner which causes the response time to fall outside of the reinstatement period.

In addition, in the situation described above, the 45 day reinstatement period applies where the requested information is not timely provided. If the information is ultimately provided within 45 days from the date the review form was received, the review may be reinstated for processing. However, see subsection (d) below concerning the potential effect on the coverage start date for the CHIP and QMB programs.

**c. New Information** – If the review has been processed resulting in discontinuance of eligibility due to failure to meet program requirements, the review may be reinstated if additional information is provided within the three (3) month review reinstatement period. The review would then be reprocessed based on the new information. If eligible, coverage shall be reinstated beginning with the first month of the new review period.

**d. Coverage Start Date** – If the review is processed during the reconsideration period, the effective date of coverage will be the first day of the new review period. For the vast majority of persons impacted by the new reconsideration period, coverage will “fill the gap”. This includes persons eligible for QMB and CHIP (including premium obligations

For cases where the review process continues beyond the review reconsideration period, there may be a break in assistance for the CHIP and QMB programs. CHIP coverage begins the day after action is taken to approve coverage (pre-KEES) or the day of approval (with KEES). QMB will begin the first day of the month after the month of approval if all of the following conditions are met:

- The review form is received within the review reconsideration period (if required); and
- The requested information is not received timely; and
- The requested information is received outside of the review reconsideration period, but within the 45 day reactivation period (as described in subsection (b) above)

This limited exception applies only to the CHIP and QMB programs, and only under the specific circumstances listed above. It does not apply to any other medical assistance program.

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

**f. Review and Continuous Eligibility (CE) Periods** – The review period for all medical programs and the continuous eligibility (CE) period for the family medical programs shall be 12 months for all reviews processed under the new review reconsideration policy. The first month of the review period is either the month after the last month of the previous review period for all medical programs, or the first month of coverage for the CHIP and QMB programs subject to the exception described in subsection (d) above.

**g. Passive Reviews** – Individuals subject to a Super Passive or Passive Review don't have the same need for a 3 month review reconsideration period. Individuals approved for ongoing medical benefits following a Passive Review have already been processed without any interruption of benefits. Therefore changes reported in response to the Passive Review continue to be processed as a change in the month following the month of report. Coverage changes will not occur retroactively.

However, when an individual is closed at the time of a Passive Review or based on other action related to the Passive Review, a reconsideration period is applicable. Eligibility shall be determined using the guidelines outlined above .

**2. Review types** – The following review types will be utilized in the new KEES eligibility system. The criteria used to determine the review type for each medical assistance program will be available in the Review Type Matrix – tem T-13 in the KEESM Appendix) will be released at Go-Live. The review types described in this section will be effective with the implementation of KEES. A description of each review type follows.

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

**b. Passive** – A passive review is the same as a super passive review described above, except eligibility notification to the beneficiary includes the information used to complete the review along with instruction to contact the agency if the information is not correct. The passive review notification forms are the KC-1300 (Family Medical) and the KC-1700 (Elderly and Disabled Medical).

**c. Pre-Populated** – If it is determined that a super passive or passive review is not appropriate, the beneficiary will be required to complete a formal non-passive review. In those instances, a notice of expiration of the review period shall be sent to the household along with a system generated pre-populated review form for completion and return. Failure to return the review form along with requested information shall result in discontinuance of coverage. The pre-populated review forms are the KC-1200 (Family Medical) and the KC-1600 (Elderly and Disabled Medical). When a review is required and another review type is not identified, a Pre-

Populated form will sent.

- d. **Targeted** – A targeted review is one for a specific or limited purpose. The two programs subject to a targeted review are Breast and Cervical Cancer (BCC) and Working Healthy (WH). BCC completes a 12 month review using the KC-1400 (Medical Assistance – BCC) form. WH completes a 6 month income review using the system generated N812 (Working Healthy Desk Review) form.
- e. **Internal** - The Tuberculosis (TB) program is subject to an internal review. Eligibility continues as long as the Tuberculosis Control and Prevention staff at KDHE deems coverage is necessary.
- f. **No Review** – No review is necessary for the AIDS Drug Assistance Program (ADAP), Foster Care (FC), Adoption Support (AS), and State Supplemental Payment Program (SSPP) programs. Nor is a review required for pregnant women and children determined eligible under Presumptive Eligibility (PE).

**Multiple Review Types:** Where multiple medical programs for one household are being reviewed at the same time resulting in more than one type of review, the most restrictive type will be used to review all the programs. The most restrictive is non-passive (pre-populated), followed by passive, then super passive.

Example: A Medically Needy (MN) and QMB review are due for the same individual in the same month. Based on established criteria applied to the specific case, the Medically Needy (MN) program requires a non-passive (pre-populated) review, but QMB requires a passive review. The more restrictive non-passive review would be completed for both programs.

The KDHE Clearinghouse and DCF will use the processes outlined in the earlier section of this memo until KEES is operational.

## E. Conclusion

If you have any questions or concerns about the information in this memo, please contact:

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