



<b>Policy Memo</b>	
<b>KDHE-DHCF POLICY NO:</b> 2017-08-02	<b>From:</b> Jeanine Schieferecke
<b>Date:</b> September 1, 2017	<b>Medical KEESM Reference:</b> 1300, 1710, 2145, 9121.1 <b>KFMAM Reference:</b> 1300, 7140, 1601, 2045, 3100, 3200, 5100, 7140
<b>RE: Implementation of KEES Phase 3 – Memo #2</b>	<b>Program(s):</b> All Medical Assistance

The purpose of this memo is to provide detailed implementation instructions regarding the implementation of Phase 3 of the Kansas Eligibility Enforcement System.

**I. BACKGROUND**

This is the second memo issued to address the impact of KEES Phase 3 on the medical assistance programs. The first memo, 2017-08-01, was issued in early August and provided basic information regarding the change. This memo provides specific case processing guidance. Additional instructions may be found in training materials, job aids, and other documents.

**II. MANAGING MEDICAL PROGRAMS IN A SHARED ELIGIBILITY SYSTEM**

As introduced in KDHE Policy Memo 2017-08-01, managing the medical programs in a shared eligibility system provides unique challenges. This section addresses how we will use data available in KEES; react to changes, address discrepant information, and specific process changes related to working with shared data.

**A. CONSUMER RESPONSIBILITY**

The use of interfaces and other data sources in the eligibility process are basic requirements of the medical programs. Phase 3 adds another important source, DCF information, to the list of acceptable sources. Using other data sources prior to contacting the consumer is not only an efficient model for the program it is also a federal requirement. That being true, this does not absolve the consumer of their responsibility to report changes. With the implementation of Phase 3, and the use of DCF information, additional confusion for both staff and consumers could result. Therefore, it is important to reiterate the consumer’s responsibility regarding their case.

Medical KEESM 1212 and KFMAM 1211 establish responsibilities of the applicant/recipient for the medical assistance programs. Included within these provisions is the responsibility to report changes. Consumers are reminded of the specific reporting requirements through notices issued through KEES. These requirements are not changing with this implementation.

However, the availability and use of DCF information may cause confusion for some consumers. Information that consumers previously had to tell both agencies may now become immediately available to the sister agency after notifying just one agency. This could result in an unrealistic expectation on the part of the consumer that all information will automatically be shared across programs.

In general, the information coming from DCF through the integrated eligibility system is treated like other information coming from interfaces or other third party sources in that we will use it to the extent possible. But, the availability of the information does not absolve the consumer of their responsibility to report information.

## **B. KNOWN TO THE AGENCY**

Federal regulations require the agency responsible for medical assistance eligibility to act upon information it receives or obtains. The agency must then determine if the new information affects the eligibility of an individual or the benefits to which he or she is entitled. These concepts are not new. However, with the merging of the medical and non-medical programs into one eligibility system it is necessary to clearly define the specific parameters required when new information is received. The concept 'known to the agency' is being implemented with this revision. Staff may be familiar with this term already, as it has been used by non-medical programs to convey similar rules. However, policy requirements tied to the phrase differ between the agencies and should not be confused.

This term is often used to define a set point in time in which the agency becomes aware of specific information in order to act upon that information for purposes of making an eligibility decision. It is necessary to define both what is meant by the term 'agency' and when information is actually considered 'known'.

### **1. DEFINITION OF 'AGENCY'**

For this purpose, the agency is the State Medicaid Agency, KDHE-DHCF, as well as contractors or other state agency units authorized to support the medical assistance eligibility determination process or determine medical assistance eligibility. Currently, this means the KanCare Clearinghouse, KDHE Outstationed Workers, and DCF PPS workers making Adoption or Foster Care determinations. It does not include other DCF staff making non-medical determinations. The definition also includes automated systems that support medical eligibility determination. Information that becomes available through automated processes, or through another program, is also included.

## 2. DATE INFORMATION BECOMES 'KNOWN':

It is also necessary to specify the date information is considered known to KDHE. This date establishes the date by which information must be acted upon.

- a. Information reported directly to KDHE by a consumer or third party, by any channel, is considered known on the date it is reported. Consider the following examples:
  - The date of the phone call for a verbal report of information
  - The date of receipt of written correspondence
  - The date a Nursing Home reports a change in living arrangement
  - The date a new application is received, whether for a new household or an existing household reporting a change or a new member
  
- b. Information that becomes known through another state agency through a specific business process is known to the agency on the date the information was reported to KDHE. Consider the following examples:
  - The date DCF creates a task notifying KDHE of a new medical condition
  - The date DCF notifies KDHE of a change in health insurance premium amount
  
- c. Information obtained through a KEES interface is known to the agency on the date the information is added to KEES. For example:
  - The date a TBQ adds new Medicare entitlement to the Medicare Information page
  - The date an SDX task is created from a Social Security interface telling KDHE that SSI has ended
  
- d. Information originally obtained through another program through any channel that was not directly reported to KDHE is known to the agency based on the type of information received. Note this includes information that DCF receives from third parties as well.
  - Information received through a shared data field and is immediately used for case processing, is considered known to KDHE on the date the information is added to KEES.
  
  - Information received through a shared field and is not immediately used for case processing, is considered known to KDHE on the earlier of the following two dates: date the information is used for processing or the date it is viewed by a person considered part of the 'agency'.

- For non-shared data fields, the information is NOT known to KDHE until it is viewed by a person considered part of the 'agency'. If while following normal business processes, eligibility staff encounter non-shared records or additional information pertaining to a non-medical case, that is the date that it now becomes known to the agency.

### **3. ACTING ON INFORMATION KNOWN TO THE AGENCY**

There is no change to the existing policies which define how and when to act on changes reported by the consumer on their medical program or when information is received by a KDHE interface. This section is intended to address situations where the reported information is received in a manner other than direct report by the consumer to the medical program.

Changes are being made to the policies to accommodate Phase 3. KEES uses the data currently available to the system to issue benefits. In most instances, this involves the execution of an EDBC, where the eligibility rules will use the information to issue a result. KEES can also use the data for general updates that do not require an EDBC. Medical staff have become accustomed to a system where they, or their coworkers, had complete control over the data used for that determination. This is no longer the case. As previously explained, the information used by EDBC may have originated from a DCF process.

KDHE shall act on information according to when it is available and the method it became available. Information made available to KDHE from DCF via a shared field is known to the agency when it is acted upon or viewed by a person considered part of the agency.

- a. When information is updated in a shared field that does not require EDBC, the information is considered known to KDHE immediately and is acted upon accordingly. KDHE Policy memo 2015-06-04, Section 11(C)(2) addressed 'Super Triggers' that send information to the MMIS immediately. Specific elements include: Person Data (Name, Gender, SSN, DOB), Other Name, Address, Telephone Number and Other Health Insurance. Staff processing such changes need to be aware that the source of the change does not matter. If it comes from KDHE or DCF it is to be acted upon within 10 days of report.
- b. When information is updated in a shared field, but EDBC is required, it is acted upon with the next scheduled batch or the next time the information is viewed by an agency staff person. For staff purposes, this means that when information is populated by DCF but there is no process in place to notify KDHE of the change, the information is not considered known to the

agency until an automated action occurs or an agency staff person views the information. The most common automated action will be the reviews batch, but other automated processes may also result in changed coverage.

- c. When information is updated by EDBC in a non-shared field, the information is acted upon when it is viewed by a member of the agency. As indicated in II.A above, it is still the consumer's responsibility to report all changes to both the medical and non-medical programs.
- d. In some situations, KDHE will produce reports to identify changes in critical information so that additional eligibility action can be taken. This will help to protect the integrity of the data and identify situations where the consumer may have failed to notify the medical program of critical information that could impact the eligibility determination when an automated batch is executed. See section VI.C for a list of reports currently planned.

## **C. USING DCF CASE INFORMATION**

DCF case information can be used in one of three ways: as a verification source, to clarify conflicting or missing information on the medical case, or as a red flag that will require additional research.

### **1. VERIFICATION SOURCE**

Information contained in the DCF case record can be used to satisfy verification requirements for the medical program. Effective with implementation of Phase 3, staff shall review the images on the DCF case to determine if additional information exists that can be used to assist in verifying information on the medical case. The check of DCF images is routinely done prior to issuing any pending request for information if there is a possibility the information exists in the DCF record.

For example, a medical request for coverage is received and income must be verified. The worker checks the DCF record for appropriate images prior to pending. In general, if there is a non-medical program case number when checking Person View, staff must consider checking for recent images on that case number just as they would do on the medical case number. The current status of the DCF case is not relevant. It may also be necessary to check the DCF journal to clarify any information regarding the image.

All programs do not require the same types of information to be verified, or verify information with the same types of documents. So information may not always be available but the images should be accessed prior to requiring the consumer submit proof.

The following guidelines are used for specific elements:

**a. Income:**

- **Earned Income:** The image is considered usable verification if it was received within 3 months prior to the month of the medical application.
- **Unearned Income:** The image is considered usable if the dates meet current medical policy.

**b. Resources:**

- **Liquid Resources:** The image is usable if received in the month of application or in the month prior to the application month. For prior medical requests, an image dated within the prior medical period is also acceptable.
- **Real Property:** The images are usable if received in the past twelve months for exempt property or within the last three months for non-exempt property.
- **Exempt resources reported on a DCF case:** When an exempt burial plot, vehicle or primary home is discovered on a DCF case, it is added to the KDHE case and is considered verified through the next scheduled review. If the consumer does report any change to the exempt information, it is considered fully verified at that point.

**c. Expenses:**

- **Health Insurance Premiums:** The images must be for the applicable calendar year.
- **DCF images cannot be used to verify other expenses.**

**d. Non-Financial:**

- **Non-date Specific Verification:** For situations where the date is not material, the images can be within any time frame. Examples include birth verification, DPOA, child custody records, divorce records

If information is discovered in the DCF record, staff must document the original source of the document and copy the image into the Medical record with the appropriate Document Type. See the KEES User Manual for instructions on how to copy an image from the non-medical case to the medical case. When copying the image, use the date the image is located as the received date on the medical case. Even though the consumer actually provided the document to DCF on an earlier date, it was not known to the agency prior to this time.

Regarding business process related to this policy, if information is not found in the initial review of the DCF record and information is requested from the consumer, it

is not necessary to conduct another search of the DCF file. If the documents have not been submitted by the due date, the request should be denied for failure to provide. The consumer is responsible for returning the information that has been requested for the medical program.

Using DCF images is further explained in Section V.A below. (Tier 3 policy change)

## **2. CLARIFICATION OF CONFLICTING OR MISSING INFORMATION**

If information present on the medical case is missing or conflicts with other case information, it is acceptable to review a non-medical case in attempts to clarify the information. For example, if a consumer reported a bank account on their medical application, but the details of the account were illegible, it would be acceptable to review the DCF information to clarify the bank name, account number, etc.

## **3. RED FLAGS**

A red flag is a discrepancy on the case that requires further research. Because person-level information, such as income and resources is viewable from any case number, there are situations where staff will encounter information that does not exist on the medical program. Some of these discrepancies will require additional research in order to determine if the information is necessary for an accurate medical determination.

When identifying a red flag, it is not necessary to access the Detail pages to determine if exact information matches. Required action is dependent upon staff viewing only the List pages. A red flag is present when specific data differs between the cases or when information is inconsistent.

### **a. Types:**

The following unreported information is considered a potential red flag that requires additional research:

#### **i. Earned Income records**

- DCF case is Active/Pending
  - High-dated earned income record on the non-medical case that is not reported on the medical case
- DCF case is Denied/Discontinued
  - High-dated earned income record on the non-medical case with a begin date that falls within the medical application month and the three prior months

Note: It is not considered a red flag if the employer name is different or missing from one of the earnings records. If one earnings record is reported to medical and one reported to non-medical, this is not a red flag.

## ii. **Unearned Income records**

- If the income is not time-limited, any high-dated unearned income record that is not reported on the medical case
  - Example: Non-Medical has an unearned income record for retirement/pension and the consumer has not reported a retirement/pension income source on their medical case
  - Example: Non-Medical has two unearned income records for retirement/pension and the consumer reports ONE on the medical case
- If the income is time-limited, any high-dated unearned income records that are not reported on the medical case are considered a red flag unless the duration has already been addressed, such as short-term disability.

## iii. **Zero Income Cases**

There has been no change to the existing policy for how we verify zero income. When zero income has been reported, staff shall not be accessing income interfaces for these individuals. Since income has not been reported, there is no income to verify and it is therefore not necessary to access the income interfaces as part of the screening process.

However, with the implementation of Phase 3 and the ability to view income which has been reported to the non-medical programs, it will increase the instances of identifying potential red flags. While processing a zero income case, it is necessary to access the Income List page to ensure that all previously reported income records have been end-dated. While accessing this page, if income reported on the non-medical case as indicated above in section i. and ii. is found, they are considered red flags and shall be researched.

## iv. **Resources**

As resources are only applicable to the Elderly & Disabled medical programs, a red flag related to a resource would also only be applicable when determining eligibility for an E&D program.

- DCF case is Active/Pending –
  - High-dated non-exempt resource record on the non-medical case that is not reported on the medical case
- DCF case is Denied/Discontinued –
  - High-dated non-exempt resource record on the non-medical case with a begin date that is within 12 months prior to the month of application that is not reported on the medical case
- DCF case with any status –
  - High-dated exempt resources: burial plot, primary home, or vehicle that is not reported for medical is not considered a red flag. Instead, it is added to the case as a known resource. See Item C.3.1.b above

**v. Expenses**

With the exception of health insurance, a discrepancy in the expense record is not considered a red flag. An expense will not be considered for the medical program until it is reported to KDHE and verified by the consumer.

For health insurance, if the consumer failed to answer the health insurance questions on the application and a health insurance record exists for the non-medical program, this would be a red flag and requires follow-up.

**b. Differences in reported amounts**

When evaluating the existence of a red flag based upon a different amount reported, the program rules vary depending on the type of medical program.

- For E&D Medical: For all above categories, when the consumer consistently reports the type of income or resource, no further evaluation of the non-medical record is completed. It would not be necessary or appropriate to evaluate the non-medical record to determine if the same amount was reported on the non-medical program. We will use our verification methods to determine what is countable. However, if staff become aware of a different amount being used for the non-medical case it may require clarification as per item (d) below.
- For Family Medical: For an unearned income type that uses self-attestation as verification, it would be necessary to evaluate the non-medical record to determine the amount which has been reported to DCF. If there is a different reported amount on the DCF record, it should be evaluated to determine if the difference will have an impact on the medical program. Staff shall use their judgement in determining when this difference is significant enough to require clarification or additional verification of the income. For earned income, consistent with the guidelines used for E&D programs, we are not concerned about a difference in reported amount. We will use our verification methods to determine what is countable.

**c. Process**

When a red flag is identified, it is necessary to conduct additional research into the reason for the discrepancy. Staff must first attempt to resolve the red flag with internal research, including interfaces and other systems. For example, unreported Social Security can be verified through EATSS, unreported unemployment can be verified through BARI, and the existence or termination from employment may be verified through The Work Number. However, if research is not successful, it is necessary to contact the consumer. An initial phone call is required and, if not successful, a notice of action requesting clarification is required. The Standard Text for Copy and

Paste spreadsheet has been updated with additional fragments to assist in requesting clarification and verification of the discrepancies found.

With the exception of exempt resources specifically noted in item C.3.b.iv above, the information found on the DCF case is not used on the medical program prior to clarifying/verifying. The existence of a record on a non-medical program does not always mean the KDHE case is incorrect. Different program rules may actually substantiate the current situation. However, if information requested from the consumer in order to clarify the red flag is not received, it would be appropriate to deny or discontinuance assistance for failing to provide information.

**d. Other Red Flags**

Staff may come across cases where information, when considered as a whole, is inconsistent. These situations are also considered red flags and require follow up and resolution. Examples include a case where DCF has a Medicare supplement listed, but medical doesn't have record of Medicare entitlement or a case where a child reports living with a grandparent, but the DCF case indicates the grandparent is out of state.

It is important to call out case maintenance actions in particular. If an unreported change is discovered when completing case maintenance actions, staff must use their judgement as to whether research and follow-up is needed. It is acceptable for medical staff to conduct research and follow-up with the consumer in situations where the unreported change may make a difference in the benefits the consumer is receiving. For example, a change in income may not make a difference for a continuously eligible child. For Elderly & Disabled medical programs, a change in income may not make a difference in the benefits for a person receiving assistance as a 1619B or Adult Disabled Child, but it would make a difference for a person receiving a spenddown or LTC.

Although it is important to maintain boundaries within the context of day to day casework, it is also important that staff recognize the flexibility to apply common sense to these situations. These are considered on a case by case basis and thorough case journaling is always required. In addition, staff are encouraged to discuss these situations with supervisory staff regarding the need to explore the situations further.

**4. JOURNALING**

Using DCF case information requires special journaling. It is necessary to identify when verification was found or clarified on the DCF case. Also, when a red flag is identified and further case research is needed, the case documentation must

include details to support case actions. The journal shall include the specific discrepancies identified and the research that occurred to resolve the discrepancy. Consider the following as examples of special situations that would require journals.

**a. Verification Source**

- Need verification for income from McDonalds. Paystubs found in the Non-Medical images with received dates within the appropriate timeframe. Copied paystubs to Medical case and used in eligibility determination.

**b. Red Flag Income – Applicable on E&D and FM programs**

- Red Flag discovered on Income List. Other agency shows a high-dated earnings record for the PA that was not reported on the medical application. Called consumer. Consumer indicates that they are still working and provides a self-attestation of 40 hours at \$14.75. Informed consumer that they would receive a notice if additional verification was needed. Income determined RC so no further verification was needed.
- Red Flag discovered on Income List. Other agency shows two high-dated earnings records. Medical application only reported one. Contact made to the consumer to request current employment status at Fullerton's. Left voicemail. Sent notice for information. Due 12-12-17.
- Red Flag discovered on Income List. Other agency shows two high-dated retirement/pension records. Application only reported one. Contact made to the consumer. Left voicemail. Further verification requested.
- Red Flag discovered on Income List. Both agencies report unearned VA Pension income. Checked Income Detail and compared the reported amounts. Amount reported to non-medical is \$75 higher than what was reported to medical. Evaluated difference and determined that this additional income does not impact the outcome of the case. Children remain PLN regardless of which income was used. Red Flag resolved.
- Red Flag discovered on Income List. Consumer reported zero income on medical. Went to Income List to end-date previous income record and other agency shows a high-dated earnings record. Contact made to the consumer. Consumer indicated that the job just ended prior to her applying for medical. Earnings do not continue. Red Flag resolved.

**c. Red Flag - Resource Records - Only applicable on E&D programs with a resource test.**

- Red Flag discovered on Resource List. Other agency shows two records for Bank Account/Cash for the PA. Only one Bank Account/Cash for the PA on the medical application. After further research it was discovered that one of the non-medical records is actually Cash. Further information is not needed. Red Flag resolved.

**d. Red Flag - Expenses- Application on E&D and FM cases.**

- Red flag discovered on Expense List. Other agency shows a high-dated Health insurance record. Consumer did not answer health insurance questions on the application. Attempted call to applicant, phone is out of service. Pended for information regarding this health insurance. Due date 05-15-18.

**e. Other**

- Unreported vehicle discovered on Resource List page. Other agency shows a vehicle and none was reported on the medical. Since this is the only car for the household, it is exempt. Added to the medical case. Will address at next review.

**D. EXCESSIVE CASE RESEARCH**

Although the inclusion of non-medical programs into KEES provides additional information that can be useful, it is also necessary to establish boundaries regarding the use of the information. As a reminder, staff processing medical cases are only able to use the information contained within the DCF case record that is necessary for the purpose of the medical application. Given this, policy has established boundaries and limitations regarding allowable research into the DCF case. Unless specifically outlined by policy or in a specific business process, it is not acceptable to conduct additional research or investigation into the DCF case unless there is a specific indication of a potential issue. It is never acceptable to compare the information provided to the two agencies side by side unless specifically instructed to do so.

If a discrepancy is identified on the medical program, it is acceptable to do additional research on the non-medical program to look for corroborating information that will resolve the discrepancy. It is not acceptable, however, to compare the medical and non-medical programs in order to identify all potential discrepant information.

**E. RESOLVING CONFLICTING INFORMATION**

Although a number of detailed processes have been implemented between KDHE and DCF to ensure the most accurate information is used for both agencies, it is expected that staff will encounter situations where the DCF record and the KDHE record are in conflict and an

immediate resolution is not available. When this happens, a special process is used to resolve the issue and determine the best method to handle the situation. This should be a rare occurrence, only used when the consumer is insisting one thing to DCF and another thing to KDHE. In most situations, we just update the record with what the consumer is reporting.

A multi-level approach will be used when attempting to resolve conflicting information. If conflicting information is reported, staff shall follow the process outlined below to seek resolution.

- (1) Eligibility staff will first review the Journal and images associated with the DCF case to determine if information exists that can be used to clarify and resolve the discrepant information reported.
- (2) If the Journal and images associated with the DCF case do not resolve the conflicting information, staff shall then contact the consumer by phone in attempt to resolve any conflicting information reported.
- (3) If the consumer cannot be reached, staff shall then reach out to DCF via email. Staff will be provided with specific instructions for how to reach the DCF staff in each region.
- (4) If DCF is unable to assist in resolving conflicting information, staff shall then consult their supervisor for assistance.

If a situation arises in which eligibility staff are unable to resolve conflicting information after following the process outlined above, an email will be sent to the KDHE Policy Team mailbox to request guidance.

Consider the following example:

Example 1:

A couple applies for a non-medical program with the DCF office and indicates they are not married. Later, they submit a new application for the medical program and indicates they are common-law married. Medical staff update the marital status and relationship status. This information is now available for both programs so the relationship change will impact the non-medical program. A change is processed on the non-medical program and their cash benefits change. The consumer disputes the relationship change to DCF. Before DCF can modify the shared relationship and marital status, they will follow the above process to attempt to resolve the conflict. DCF looks in the files of both cases, searching for any information that could resolve/confirm the discrepancy. They can't locate where the client reported the common-law marriage. DCF contacts the consumer. They insist they are not married. DCF wants to update the status back to Unrelated. DCF reaches out to the KDHE worker about status. KDHE worker identifies in the file where the consumer reported the common-law marriage. Because the consumer is still insisting to DCF that they are not married and are insisting to KDHE that they are common-law married, the KDHE and DCF workers will contact their supervisors for assistance. An email is sent to the Policy Email Box asking for guidance on how to resolve the discrepancy. The medical and non-medical policy

staff will agree on which data is used. This will be communicated to the medical and non-medical staff.

## **F. MEDICAL AND NON-MEDICAL SCENARIOS**

Consider the following examples as further explanation of how we react to information which becomes known to the agency through shared information with non-medical programs.

### **Example 2:**

Consumer contacts the DCF office on 9/15 to report they have obtained a job. No contact has been made to the medical program staff. DCF adds an earnings record for the consumer onto the non-medical case number. This information is not known to the agency and cannot be acted upon to redetermine eligibility. On November 21<sup>st</sup>, the medical staff are taking an unrelated action on the medical case. While viewing the income records on the medical case number, they can see that the individual has a non-medical earnings record. On this date, this information now becomes known to the agency. The new income must be reviewed to determine if it is a red flag. In addition, depending on the medical program type, an overpayment may need to be considered if the increase of income would have made a difference in the program eligibility.

### **Example 3:**

Consumer contacts the DCF office on 9/15 to report an address change. DCF updates the address for the consumer on 9/17 which automatically updates the address on all cases for which that person is active. This information is therefore known to KDHE as of 9/17 as well. Notices mailed to the consumer following the date the address is updated in KEES will be mailed to the new shared address.

### **Example 4:**

Consumer reports to the DCF office on 9/15 that they've gotten married and their spouse has moved into the home. This information has not been provided to the medical program staff. DCF adds the spouse to their non-medical case number and updates the shared marital status and relationship status in KEES. The new marital status is now known to KDHE as well. However, because the spouse is not reported to the medical staff, he has not been added to the case and it is NOT known to the agency. On 11/15, the review batch is run and the case is passively reviewed. Because the consumer has still not reported the spouse in the home, he will not be included in the passive review determination. The consumer would be expected to respond to the passive review letter to report the change once they've realized that we don't have that information. When the staff react to the Passive Review Response, depending on the medical program type, an overpayment may need to be considered if the change in relationship status would have made a difference in the program eligibility.

### III. ELIGIBILITY DETERMINATION USING SHARED DATA

When a consumer is active or contributing on both a Medical and Non-Medical program at the same time, some of the information is considered to be 'shared data'. This means that when a change is made on one program, it is automatically updated for all programs that the individual is associated with in KEES. In other situations, the data itself might not be shared, but special processes are required to manage the verification types, program types, etc. The following sections outline the special processes required for the primary eligibility pages in KEES.

#### A. ADDRESS

Addresses are universal across programs and agencies, meaning KEES only allows one address for each individual in the system. KDHE will not have a unique address from that used by DCF. Updating an address on the medical case will automatically update the address on non-medical cases and vice-versa. Address updates are made for each individual on the case.

##### 1. CONVERSION:

When a consumer had both an active medical and non-medical case, the conversion process used the last record updated. This means medical addresses may have been updated because of this. Manual clean-up of address records may be necessary following this conversion and notification will be provided if additional work is necessary.

##### 2. PROCESSING ISSUES:

When processing an address change, it is important to confirm that the address being added is the most current. Always check the date of the last update to ensure a former address isn't being reentered.

Because address updates are made for each individual there is the potential for some members of the case to be missed if the DCF program includes different case persons. DCF processes may not always result in an update for all household members. If DCF updates an address for their case, it will update the address for all of the same KDHE members. However, people not included on the DCF case will be missed. This could mean the missing individuals are no longer part of the household. A special report will be issued to assist staff in resolving these situations.

A standard format has been developed for entering the address of a homeless individual. Staff are not to use the word 'homeless' in the address line. Use the following format:

Name of the Individual  
General Delivery  
City, State, & Zip

### **3. OUT OF STATE ADDRESSES:**

Out of state addresses require a special process for both agencies. When a consumer reports an out of state address, the first agency to receive the report shall update the address on the Address Detail page and then notify the agency of the change by creating a task through the Contact Log. In some situations, a medical consumer is still eligible to receive medical assistance while they reside in another state. Examples include when a child is going to college in another state or someone who is admitted to a medical facility in another state. Per KDHE policy, the consumer's address must remain as the Kansas residential address so they can continue to receive medical coverage. However, per DCF policy, these individuals are no longer eligible for non-medical assistance. The agency that first becomes aware of the out of state address shall update the checkbox 'This person is living out of state' on the Address Detail page. The address shall remain as the Kansas address.

In addition, when an individual moves out of state and retains eligibility for medical assistance in Kansas, a Kansas county code must be entered in KEES. Although the address is updated to the new out of state address, the county listed is the Kansas county code of the persons last know Kansas address. This is NOT the county of the new out of state address.

Note: The process for creating a task for DCF was outlined in KDHE Policy Memo 2017-08-01 and can also be found in the Agency Cross Communication Guide.

## **B. INDIVIDUAL DEMOGRAPHICS DATA**

The data on the individual demographics page is considered person-level data. It belongs to the consumer, and updates to the information on a medical case number will also update the information for non-medical cases. Special considerations are needed when dealing with this shared information.

### **1. MARITAL STATUS**

It will be important for staff to follow the policies regarding marriage status as outlined in KDHE Policy Memo 2015-11-01. In most situations, marital status is updated as reported by the consumer without any further verification. Consider the following examples:

Example 5:

An applicant reports they are married to Spouse A. On a previous application received a few months earlier, the applicant reported being married to Spouse B. The applicant may be contacted in this situation to clarify their marriage situation with verification ultimately requested if warranted.

Example 6:

A common-law married individual previously denied for assistance due to excess income from the spouse reapplies for assistance a few months later. On the new application, the individual reports they continue to cohabit, but are not married. The new application will be processed with the partners still considered to be a married couple.

However, because there is conflicting information, the consumer must be given the opportunity to provide verification of the change in relationship. Sufficient verification would include either a divorce document or proof that they were legally incapable of being common-law married at the time they reported the relationship to the agency.

Example 7:

A 21 year old applicant reports being common-law married to their 17 year old spouse. Since an individual must be at least 18 years old to be common-law married in Kansas, the applicant's attestation is questioned. Further contact with the applicant is warranted to clarify marriage status. Verification of the marriage would be required.

Example 8:

An unmarried adult is receiving assistance based on having a disability. At review, the recipient reports being married. Since the marriage was not previously reported, an overpayment may have occurred. Contact with the recipient to verify the date of marriage is warranted to correctly determine eligibility for past months. Self-attestation by the applicant would satisfy this requirement.

## **2. DECEASED DATE**

KDHE shall continue to process dates of death according to current processes. However if DCF updates a date of death, it will impact the medical case with the next EDBC run. A report will be generated to identify newly updated dates of death on cases not processed by KDHE.

## **3. EMANCIPATION DATE**

Adding an emancipation date for an individual who is truly not emancipated will negatively impact non-medical programs. However, medical programs currently use the emancipation date for two workaround processes. These processes have been modified to ensure that an incorrect emancipation date will not have impacts on the non-medical programs.

The two workarounds/processes are WA 314 for 18-year old applicants and PPS WA when approving Foster Care for a minor mother. For both of these processes, after running EDBC and completing the eligibility determination for the medical program, staff shall remove the Emancipation date. In any other situation where

there is an emancipation date already present on the Individual Demographics screen, medical staff shall not make changes to the date as it has already been verified by DCF staff.

#### **4. RACE OF AMERICAN INDIAN OR ALASKAN NATIVE**

The race code of American Indian and Alaskan Native has significant impacts on medical programs. Incorrectly changing this code can have implications on premiums and the managed care population. If it is later determined that a consumer has been incorrectly assigned a race code of American Indian/Alaskan Native, only medical staff shall modify this race code.

### **C. CITIZENSHIP AND IDENTITY**

Identity is a required verification for both medical and non-medical programs. While there are separate verification codes, there is only one document type allowed for Identity. Because medical programs have stricter verification rules for identity, the document type will be driven by what is needed for the medical program.

If KDHE has already verified the identity of an individual for a medical program, DCF shall not modify the document type used for this verification.

In situations where KDHE has provided an individual with a Reasonable Opportunity period because they have been unable to verify their identity, as this is not a verified document, DCF staff will remove this document and use one that is acceptable for non-medical programs. A report will be used to ensure that all individuals that are removed from Reasonable Opportunity status are still correctly identified when they reach the end of their Reasonable Opportunity period.

### **D. RELATIONSHIP**

Updating a relationship on the medical case will automatically update the relationship on non-medical cases as well. The reverse is also true. However, relationships on KEES will only display when both individuals in the relationship are case persons. Because of this, it is possible that a relationship will be updated by one agency but the other agency will be unaware.

#### **1. IMPORTANCE OF CLIENT REPORT**

This is another situation where the responsibility of the consumer becomes crucial. If the individual has not been reported as a household member for the medical case, we will not be able to take action when a relationship changes.

Example 9:

A Food Assistance case includes Mom, her boyfriend and their child. The Medical case includes a mom and her child receiving CTM. Mom and Boyfriend get married and report that to Food Assistance. This change won't appear on the on the medical case because the boyfriend/husband is not a case person. We won't

know that he is in the home or the marriage occurred until the consumer reports it to us.

## **2. PATERNITY**

In regards to the paternity of a child, KDHE accepts self-attestation of the relationship while DCF will verify paternity of children. If DCF determines paternity for a child that differs from what was previously self-attested, KDHE will accept that information, will not change the verification to self-attestation and will not change the relationship. Paternity information will be available on the non-custodial parent page. The date of the relationship change will be the date that paternity is established. Prior months are not adjusted, as the determination was made based on what was known and reported by the consumer at the time of application. No change is made to the original determination unless the consumer reports the paternity change to the agency and requests a redetermination. The child's continuous eligibility period will remain intact; and changes to coverage will follow normal continuous eligibility rules.

Example 10:

The Medical case includes Mom, her boyfriend and their child. Boyfriend is reported as the child's father. Therefore, he is included as an IBU member and his income is used in the child's determination. The family later applies for Food Assistance and a paternity test is done. It is found that the boyfriend is NOT the child's father. DCF will update the Non-custodial page with the paternity information and change the relationship to Unrelated. The date of the relationship change will be the date paternity is established. This new relationship will now be in KEES, but isn't relevant to the determination until the next time eligibility is determined.

If the consumer wishes for us to redetermine eligibility excluding the boyfriend's income, the client will have to report the results of the paternity test so that we can take action. Otherwise, it will be addressed with the next review.

## **E. NON-COMPLIANCE**

With the implementation of Phase 3, the following Non-Compliance values will be shared by both KDHE and DCF.

- Failure to Provide—Proof of Income
- Failure to Provide—Name and/or Identity
- Failure to Provide—Non-citizenship documents
- Failure to Provide—Proof of Trust
- Failure to Provide—Social Security Number
- Failure to Provide—Residence

In order to prevent different impacts to medical and non-medical cases, a checkbox will be utilized to indicate which program the Non-Compliance record pertains to. This creates the potential for multiple Non-Compliance records to be present with the same value on a case.

Additional changes were made to the Non-Compliance Detail page that impact medical assistance processing. These changes are outlined below.

The following values were added to the Types dropdown:

- a. CSS non-coop was added for Medical programs allowing for discontinuance or denial for non-cooperation with Child Support Services. However, current policy does not require cooperation with CSS, so this value will not be used. CSS Non-Cooperation is used for non-medical processing only.
- b. Generic was added but will not be used for Medical programs.
- c. Medical Subrogation will be used to process medical assistance denials and discontinuances for failure to cooperate with Medical Subrogation.

Furthermore, when the following Types are selected, the available Reason field values have changed:

- d. Failure to Provide: Medical Prudent Person and HIPPS reasons were added. Medical Prudent Person will not be used at this time. Guidance will be provided if this reason is to be used in the future.
- e. Failure to Pursue Potential Resources: A reason of Medical was added.
- f. Potential Employment: Violation was added as a reason and Potential Employment was removed however, this type will not be used for Medical.

A data fix will be completed at Phase 3 implementation that will associate all existing Non-Compliance records to the Medical program.

## **F. MEDICAL CONDITION**

Information recorded on the Medical Condition record displays at the person level and will be shared between both KDHE and DCF. Within this page, the Presumptive category is used by KDHE only while the Active and Declared categories are used by both agencies. This creates the potential for multiple Medical Conditions to be listed on a case.

There has been no change to the categories or types of medical conditions KDHE staff use when determining eligibility for Elderly and Disabled medical programs. Non-Medical programs use different criteria and verification methods to determine whether a consumer is eligible for assistance with an Active Medical Condition. When selecting the Active category, KDHE staff will not use the Other Food Assistance Disability or Incapacity – Verifiable and at Least 30 Days types as these are specific to non-medical programs and will not affect medical processing or eligibility determination if present. KDHE eligibility staff shall follow normal verification processes when determining eligibility for medical assistance for a consumer who has reported a disability.

When a consumer reports to DCF that they have a new medical condition, their medical condition has changed or they no longer have a medical condition, this information will be updated in KEES and then communicated to KDHE for purposes of re-evaluating eligibility. DCF will create a task for KDHE using the contact log. Note: The process for creating a task for DCF was outlined in KDHE Policy Memo 2017-08-01 and can also be found in the Agency Cross Communication Guide.

Consider the following examples:

Example 11:

A consumer applies for Medical Assistance on 9/15 and reports a disability. The consumer has a pending application with Social Security so a referral to PMD is needed. A Declared Medical Condition is added. On November 10<sup>th</sup>, PMD finds the consumer eligible as a Tier 2. The consumer then applies for Food Assistance with DCF on December 2<sup>nd</sup> and reports a disability. An Active Medical Condition (using one of the codes specific to DCF) is added by the DCF worker. In this situation, DCF will not set a task for KDHE because the Medical Condition added is specific to the Non-Medical determination.

Example 12:

A consumer applies for Food Assistance and Medical Assistance through the SSP on 9/20 and reports a disability. A PMD referral is needed. The PMD Team returns a disability finding of Tier 1 eligible. When processing the eligibility determination, the Medical eligibility worker finds a Medical Condition of Active Other Food Assistance Disability. No changes are made to that Medical Condition as it is applicable to the Non-Medical program only. The Medical eligibility worker adds a Medical Condition of Presumptive Tier 1 and continues normal processing. In this situation, DCF will not set a task for KDHE because the Medical Condition added is specific to the Non-Medical determination.

Example 13:

A consumer is a recipient of Medical Assistance with a Presumptive Tier 1 Medical Condition. They also have an open Food Assistance case with DCF. On 9/15, DCF learns the consumer has been approved for SSI benefits with the first payment received in September. The DCF worker adds a Medical Condition of Active – SSI Disabled with a Begin Date of 9/1/2017. The DCF worker also sets a task for KDHE using the Contact Log. The date the task is set for KDHE is the date the change in Medical Condition becomes known to the agency.

## **G. EXPENSES**

The Expense page in KEES is shared. This means all records will be visible to both agencies. Some expense types will be used by KDHE only (for spenddowns and LTC), some will be used by DCF only (for Food Assistance), others are shared between both agencies, and some expense types should not be used by either DCF or KDHE as they could result in incorrect eligibility determinations for the other agency. All staff must be cognizant of

information recorded on the Expense page as changes may affect a Food Assistance program to which a consumer is associated.

Medical staff must continue to verify expenses (for a spenddown or LTC) even if an expense record exists that is being used for Non-Medical programs and no change in the amount was reported. Prior to pending for verification of expenses, staff must check images to ensure that information has not already been submitted on the DCF case. If verification is found confirming the amount of the reported expense, the document must be copied to the KDHE case as outlined above in Section II.C.1. Otherwise, verification must be requested from the consumer.

With the implementation of Phase 3, the following expense types will only be used by the program specified.

<p><b>Medical only Expenses</b></p>	<ul style="list-style-type: none"> <li>• Blind Work Expense</li> <li>• Impairment Related Work Expense</li> <li>• Medical Expenses:             <ul style="list-style-type: none"> <li>○ Allocation of Income</li> <li>○ Non-Participating HH Member</li> <li>○ Non-covered Medical Expense</li> <li>○ Override Allocation of Income</li> <li>○ Past Due Owing</li> <li>○ Medical Expense (Medical Only)</li> </ul> </li> </ul>
<p><b>Non-Medical only Expenses</b></p>	<ul style="list-style-type: none"> <li>• Actual Utilities             <ul style="list-style-type: none"> <li>○ Electricity – Not Used to heat or cool</li> <li>○ Water/Sewage/Garbage</li> </ul> </li> <li>• Child Support – Court Ordered</li> <li>• Cost of Home – Temp Absence</li> <li>• Dependent Care</li> <li>• Home Repairs – Natural Disasters – Fires/Floods</li> <li>• Medical Expense:             <ul style="list-style-type: none"> <li>○ Working Healthy Premium</li> <li>○ HCBS Obligation</li> <li>○ Medical Expense (FA Only)</li> </ul> </li> <li>• Utility Allowance</li> </ul>
<p><b>Shared Expenses</b></p>	<ul style="list-style-type: none"> <li>• Health Insurance Premiums:             <ul style="list-style-type: none"> <li>○ BC/BS</li> <li>○ Health Insurance Premiums</li> <li>○ LTC Insurance Policy</li> <li>○ Medicare Supplement Policy</li> <li>○ Other</li> </ul> </li> <li>• Shelter:             <ul style="list-style-type: none"> <li>○ Association/Mandatory Fees</li> <li>○ Home Insurance</li> <li>○ Home Taxes</li> <li>○ Lot Rent</li> <li>○ Mortgage</li> <li>○ Rent</li> <li>○ Second Mortgage</li> </ul> </li> </ul>

<b>Never Used (Medical or Non-Medical)</b>	<ul style="list-style-type: none"> <li>• Medical Expenses: <ul style="list-style-type: none"> <li>○ Durable Medical Equipment/Supplies</li> <li>○ Medical Transportation</li> <li>○ Prescriptions</li> <li>○ Private Pay LTC Expense</li> <li>○ Payment Plan</li> </ul> </li> </ul>
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### 3. SHELTER EXPENSES

When completing data acceptance, Medical staff will reject any 'New' shelter expenses regardless of whether an open or pending non-medical program exists, unless the case is LTC with spousal impoverishment. If spousal impoverishment provisions apply, Medical staff will accept or reject 'New' shelter expenses based on whether an expense record for the shelter expense already exists or not.

If a record for the shelter expense already exists the 'New' shelter expense will be rejected. If a change in the amount of the expense is reported, a new amount is added to the existing expense record. The end date for the existing amount is the last day of the month prior to the new amount being used to determine the income allocation in a Medical eligibility determination.

Medical staff must continue to verify reported shelter expenses as outlined above. If verification is not located in the DCF images and is requested from the consumer but not received, the expense cannot be allowed.

### 4. MEDICAL EXPENSES

The following Medical Expense types will no longer be used by KDHE nor will they be used by DCF:

- Durable Medical Equipment/Supplies
- Medical Transportation
- Prescriptions
- Private Pay LTC Expense
- Payment Plan

If one of the above shared medical expense types is reported, when completing data acceptance, Medical staff shall reject the expense. Once verified, expenses for durable medical equipment/supplies, medical transportation, and non-covered Medicare Part D co-pays and Part D exceptions would be bene billed for a spenddown. For LTC, these expenses are entered in KEES as Medical Expense (Medical Only). The description field will be utilized to provide information about the type of expense. Non-Medical staff will follow the same protocol.

Past due and owing facility charges which are being allowed to reduce a liability would be entered in KEES as Past Due Owing. Otherwise, if not past due and

owing, facility charges are entered in KEES as Medical Expense (Medical Only) and the description field utilized to provide information about the type of expense.

Payment Plan will not be used by Medical or Non-Medical programs. Guidance will be provided if this specific expense type is to be used in the future.

The presence of a DCF Medical Expense (which includes Medical Expense (FA Only), Working Healthy Premium, and HCBS Obligation) is not to be considered a red flag. Nor is a Medical Expense previously allowed by DCF to be considered toward a Medical determination without having been reported to KDHE and verified. It is the responsibility of the consumer to report all Medical Expenses to KDHE.

## **5. HEALTH INSURANCE PREMIUMS**

Health Insurance premiums will be shared between both agencies. This means there will be one expense record entered that is counted toward both Medical and Non-Medical programs. When a consumer reports to DCF that they have a change to their health insurance, including a new premium amount, discontinuance of a premium, adding or changing the amount of their premium, addition or change to the contributor on the health insurance premiums, this information shall be updated in KEES and communicated to KDHE. In reference to a change in contributor, this is when there is a change to the person who is responsible for paying the expense. DCF will create a task for KDHE using the contact log. Note: The process for creating a task for DCF was outlined in KDHE Policy Memo 2017-08-01 and can also be found in the Agency Communication Guide.

If a consumer submits an application for medical assistance and does not complete the questions pertaining to other health insurance, medical staff shall continue to assume the consumer does not have other health insurance. The exception would be if medical staff find a high-dated health insurance premium expense that was allowed for Food Assistance. Then, the consumer must be contacted to clarify if they still have the health insurance.

When a health insurance premium has been allowed for Food Assistance, and a change in the health insurance premium is reported, a special process will be used. To maintain the history of expenses allowed toward a Non-Medical case, Medical staff must add a new expense amount on the existing health insurance premium expense record beginning in the come-up month. Then, a new Medical Expense (Medical Only) expense will be created to allow the difference between what was allowed for the Non-Medical determination and what must be allowed for the Medical determination. This will allow the expense to be included in the Medical determination without affecting Non-Medical benefits that have already been paid.

**Example 14:**

A consumer has active Food Assistance. She submits an application for Medical on 9/14/2017 (Prior Medical not requested). On the application, she reports both Medicare and Dental Insurance. The premium for the dental insurance is \$38/mo. The Expense List page shows a high dated expense in the amount of \$36/mo. for Health Insurance Premiums – Other. Verification is received and the application is being processed on 9/30/2017. A new amount of \$38 is added to the existing Health Insurance Premiums – Other expense record with a begin date of 11/1/2017 (the come-up month). The end date on the old amount of \$36 is set to 10/31/2017. A Medical Expense (Medical Only) record is created for \$2 (the difference) with a begin date 9/1/2017 and an end date of 10/31/2017. This allows the full \$38 premium to be allowed beginning 09/2017 but retains the history of expenses for the non-medical case.

**6. IMPACT ON FAMILY MEDICAL**

Because expenses are shared between both agencies, it is important that Family Medical staff react to reported expenses. Action taken by Family Medical staff will be dependent on whether the case requires a non-MAGI determination.

Expenses reported on a case that requires a MAGI-only determination shall be rejected. It is the responsibility of the last person authorizing the case to ensure all reported expenses have been rejected appropriately.

Expenses reported on cases that require a non-MAGI determination shall be left in “new” status. Once the case is routed to the appropriate non-MAGI team, the E&D/LTC worker will complete data acceptance as normal. If it is learned that a non-MAGI determination is not needed, the individual making the final eligibility determination is responsible to reject all reported expenses.

**7. MEDICARE EXPENSES**

The Medicare Expense page is primarily owned by Medical programs. If there is an Active Medical program and the Medicare Expense page is populated, Non-Medical programs will not make changes to the existing record. Non-Medical programs will only add or change information to this page if there is not currently an open Medical program.

**8. EXAMPLES**

**Example 15:**

A couple applies 9/15 and requests LTC (no prior medical) for the wife as she is in the nursing facility. Spousal impoverishment applies as the husband resides in the home. The couple has an open Food Assistance case with a rent expense of \$550 listed on the Expense page in KEES. An increased rent expense of \$585 is reported on the medical application. The Medical worker requests verification, which is received 10/5. The Medical worker processes the case 10/9 and adjusts

the existing rent expense to reflect the \$550 rent expense ending 8/31 and the increased rent expense beginning 9/1, as that is the earliest date income allocation can begin. Medical staff are not required to notify Non-Medical programs of a change in shelter expenses.

**Example 16:**

A consumer applies for LTC on 9/15 as she currently resides in a nursing facility and has run out of funds to continue private paying. The consumer is widowed and only requests assistance for herself. LTC is denied in the month of application as the consumer's resources exceed the allowable resource limit. The nursing facility provides verification of the amount owed for the month of application as the consumer does not have the funds available to private pay for that month. Instead of allowing this expense as Medical Expenses – Private Pay LTC Expense, the medical worker allows the expense as Past Due Owing as it meets the past due and owing criteria.

**Example 17:**

A consumer applies for medical assistance on 9/15 and requests prior medical. They report a health insurance premium expense of \$156 monthly and provide verification that the expense began in January. When completing data acceptance, the medical worker finds that an existing health insurance premium expense of \$148 is being applied toward the consumer's Food Assistance case. The worker checks ImageNow on the non-medical case and verifies the expense reported is the same expense being allowed by DCF, but the monthly premium amount has increased. The medical worker adds a new expense amount on the existing health insurance premium expense record beginning in the come-up month. Then, a Medical Only expense of \$8 is allowed for the first prior medical month through the end of the month prior to come-up. The Health Insurance Premium expense added during data entry is rejected.

**Example 18:**

A consumer applies for medical assistance on 9/15 and requests coverage for herself and her 13 year old granddaughter. Grandmother reports a health insurance premium and receives Social Security retirement benefits of \$1,100 monthly. She is not eligible for CTM due to excess income. Granddaughter was approved for PLN. Grandmother's health insurance premium expense is left in "new" status because a Non-MAGI determination is needed. Grandmother is approved for a Medically Needy spenddown with LMB.

## **9. EXISTING RECORDS**

Just prior to implementation, a KEES data fix will be executed that will remove expenses, end date expenses, or change the expense type of expenses shared by both agencies.

- Shelter expenses listed on medical cases that do not involve spousal impoverishment will be removed.
- Health Insurance Premium expenses on denied or discontinued medical cases will be end dated.
- Records with a value of \$0 will be end dated effective July 31, 2016
- Existing Medical Expenses with a type of Durable Medical Equipment/Supplies, Medical Transportation, Private Pay LTC Expense, or Prescriptions will be converted to Medical Expense (Medical Only).

Medical expense types used only by KDHE will not be changed. These fixes will not be executed for pending applications/requests. Staff MUST manage these expenses according to the rules listed above when processing these cases.

## **IV. SYSTEMATIC CHANGES IN ELIGIBILITY PROCESSING**

### **A. DATA ACCEPTANCE**

When processing a new application, staff must disposition all new data reported by accepting or rejecting individual records. This process is extremely important to the overall application process, as downstream automated actions are often initiated by the data staff choose to accept or reject. With the implementation of Phase 3, acceptance or rejection of these elements will now impact non-medical programs as well as medical programs.

It is extremely critical that staff be extra diligent when choosing to accept new data into the system – especially when it involves a shared data element. Although it is generally expected that information will change based upon the consumers situations, the staff person who is making a determination to ‘accept’ or ‘reject’ any given element is responsible for ensure the validity of the change. Applicants may make mistakes when completing an application, such as ‘fat fingering’ a birthdate or transposing digits on a Social Security Number, but staff must ensure these discrepancies are noted and business processes are followed when electing how to disposition the element. For that reason, a change has been put into KEES to help facilitate a careful review. The ‘Check All/Accept All’ option has been eliminated as an option from the Individual Demographics Page. When processing an application for an existing individual, staff are expected to select the ‘Reject All’ option and determine which, if any, elements need to be accepted.

In addition, the Data Acceptance Processing Guide has been updated and is attached. All staff processing cases are expected to review this guide and follow necessary steps.

### **B. REINSTATEMENT OF CHILD SUPPORT SERVICES (CSS) REFERRALS**

While, the requirement to cooperate with Child Support Services has not been implemented for medical programs, this requirement does exist for non-medical programs. When an individual is active on both non-medical programs and the Caretaker Medical program, a task

may be received on the medical case if the individual fails to cooperate with CSS. Because cooperation is not a requirement for medical programs at this time, these tasks should be voided and no action is needed.

### **C. SDX TASKS**

Logic behind the SDX Tasks received has been refined to better support integrated system functionality for both Medical and Non-Medical programs. As a result, SDX Tasks will now be created only when certain criteria exist. In addition, other SDX tasks have been executed while others will no longer be received.

The following SDX tasks have been modified:

- SDX SSI Income Start – This task will only be created for Active members who do not have a high-dated SSI income record.
- SDX SSI Income Ended – This task will only be created for Active members who have an active SSI income record that is high-dated.
- BENDEX SSA Income Start – This task will only be created for Active members or FRIs who do not have a current SSA income record.

In addition, the BENDEX SSA Income Change task will be executed when the income amount on the interface record is less than the income amount on the existing income record in KEES. The SDX SSI Income Change task will no longer be received for Medical programs.

### **D. SOCIAL SECURITY NUMBER VERIFICATION**

The 'HUB-SSA' and 'SSA-SVES' verification statuses for a consumer's Social Security number can no longer be manually selected from the SSN Status field dropdown on the Individual Demographic page. For SSN with a pending status running verifications is the only way to populate the verified HUB-SSA status value and SSA interfaces are the only way to populate the verified SSA-SVES status value.

For FFM applications, if a consumer provides their SSN, the SSN will populate their Individual Demographic page with an SSN Status set to "SSN Provided". Staff were previously able to manually select the 'HUB-SSA' verifications status to indicate that the SSN was verified. Staff will now select "Good Cause" for this situation. This will allow Medical Rules to recognize that the SSN is in a verified status. Good Cause is appropriate for other situations where the SSN has been verified by the HUB-SSA interface but value is not available to select manually.

### **E. NON-CITIZENSHIP PAGE**

This section of the implementation memo will cover the changes made to the Non-Citizenship page in KEES for Phase 3. With the inclusion of these changes, User Manuals, training guides and other supporting materials will also be updated.

## **1. USCIS DOCUMENT & SECTION CODE DROPDOWN**

The USCIS Document dropdown and Section Code dropdown on the Non-Citizenship Status Detail Page are shared dropdowns amongst KDHE and DCF. System enhancements were made to sync-up the values of the USCIS Document dropdown and Section Code dropdown on the Non-Citizenship Status Detail Page with the INS/Citizenship rules so that the system will run properly for medical and non-medical programs. USCIS Document and Section Codes have been updated.

## **2. SAVE STATUS FIELDS**

The Primary, Secondary, and Tertiary SAVE tables in rules have been updated to appropriately handle the determination of non-citizenship status. System enhancements were implemented with Phase 3 that allow the rules to correctly determine qualified non-citizen status. It is critical that staff correctly enter information into the SAVE status fields in order to achieve the appropriate determination of non-citizen eligibility. The dropdown value of “Institute Additional Verification” was added to the Initial Save Status, Secondary SAVE Status and Tertiary SAVE Status dropdowns. When selected, this value will direct the rules to use the information captured in the next sequential SAVE Status field.

I.e. If “Institute Additional Verification” is selected for the Initial SAVE Status field then the rules will look to Secondary SAVE Status field to determine the non-citizenship status.

## **3. VERIFY LAWFUL PRESENCE (VLP) INTERFACE**

No changes were made to the functionality of the Federal Data HUB VLP interface for Phase 3. The VLP interface will still be initiated in the same manner that it was for Phase 2. This is based on the USCIS Document type that is selected. If the USCIS Document type selected is not a designated VLP initiator then the HUB request will not be sent and staff will be required to use SAVE for verification. The VLP interface results will still be viewed on the INS Document Verification Request Detail page. It is important that all pertinent USCIS document information is entered on the Non-Citizenship Detail record to ensure accurate results from the VLP interface.

## **F. QMB START DATE EXCEPTIONS**

While there have been no changes to the policy surrounding QMB start date exceptions, system enhancements were made to KEES that will allow cases where a QMB start date exception is applicable to be processed without the use of an override. With the implementation of Phase 3, the Other Program Assistance (OPA) page will be used to process QMB start date exceptions. Logic within KEES was designed to check whether the consumer had QMB in the month prior to eligibility being determined. If the consumer did not

receive QMB in the previous month, rules will then check the OPA page. The Other Program Assistance (OPA) page will be used to process QMB start date exceptions when the following criteria exist.

Note: A TBQ update may be necessary in all situations described below as the Medicare Information page must be populated to determine eligibility for all Medicare Savings Programs.

#### **1. QMB IN ANOTHER STATE**

The OPA page will be used to process QMB for individuals moving to Kansas who were receiving QMB coverage in another state. Medical staff will use this page to document the state the consumer moved from and that they were receiving QMB in that state in the month prior to eligibility beginning in Kansas. The begin and end dates are used to indicate the record was valid for the prior month. Medical staff shall enter a begin date of the first day of the month and an end date of the last day of the month prior to eligibility beginning in Kansas.

#### **2. MEDICARE OPEN ENROLLMENT**

Individuals who apply for QMB during the general open enrollment period and whose Medicare Part A coverage is delayed until July 1, are eligible for a QMB start date exception. QMB coverage for these individuals would begin with the month of July. The OPA page may be used to process a QMB start date exception in this situation if QMB coverage is not processed during the month of June. In the event QMB is not processed during the month of June, the OPA page will be completed to reflect a beginning and end date of June 1<sup>st</sup> through June 30<sup>th</sup> to allow eligibility in July to be authorized. The state of Kansas will be documented as the state QMB was received in the month of June.

#### **3. MEDICARE BEGINS**

Individuals who become eligible for Medicare while currently receiving medical assistance under another program are eligible for QMB to begin with the month Medicare begins. The OPA page may be used to process a QMB start date exception in this situation if QMB coverage is not processed in the month prior to Medicare beginning. In these situations, the OPA page will be completed to reflect a beginning and end date of the first and last day of the month prior to Medicare beginning. To allow the system to determine QMB eligibility, the state of Kansas will be documented as the state QMB was received in the month prior to Medicare beginning.

#### **4. REVIEW RECONSIDERATION**

Individuals are eligible for QMB to be reinstated without a break in assistance if approved during the review reconsideration period. The OPA page will not be used for this process because QMB coverage will exist in KEES.

## 5. EXAMPLES

### Example 19:

A consumer applies 9/15 and requests help paying their Medicare premiums. They moved to Kansas from Nebraska in August. Upon checking EATSS, the worker finds the consumer's Medicare premiums are still being paid by Nebraska. A QMB start date exception applies as the consumer is eligible for QMB to begin in the month of application, without a break in assistance. The worker documents that the consumer was receiving QMB in the state of Nebraska on the Other Program Assistance page with a begin date of August 1<sup>st</sup> and an end date of August 31<sup>st</sup>.

### Example 20:

A consumer is currently receiving Medically Needy with a spenddown and will begin receiving Medicare in October. A task is received in September indicating that Medicare data exists for the consumer. A Medical worker claims the task on October 19<sup>th</sup>. A QMB start date exception applies because the consumer was receiving assistance at the time Medicare began. This means the consumer is eligible for QMB to begin in October even though action was taken in that month. The worker adds an Other Program Assistance record to document the consumer was receiving QMB in Kansas in September.

## G. VERIFICATION

Several enhancements are being made to the Verification List page that will impact how medical cases are processed. These include:

- New Program Type values of "Non-Medical" and "All" added to the Program Type dropdown.
- Medical and Non-Medical Verification records are now displayed.
- Generate Form Button will now dynamically display when "Medical" or "Non-Medical" is selected from the Program Type dropdown.
- Generate Form Button will now generate either the Non-Medical Verification Request List Form V000 or the Medical Verification Request List Form V001, depending on the individual's Worker ID.
- Workers can designate specific Verifications to include in the Verification Request List Forms.

### 1. VERIFICATION LIST PAGE SEARCH

Although staff now have the ability to view verification records for both medical and non-medical, KEES will set a default display based on the Worker ID. So, for a Medical worker the Verification List page is set to display all pending Medical Verification records and vice versa for Non-Medical workers. However, staff will need to click the Search button to refresh the page to display only the pending Verification records.

Workers are still able to restrict the types of Verifications displayed using the filter functionality. For example if a worker would like to see only Medical Verification records that have been “Refused” they would select “Refused” from the Status dropdown and “Medical” from the Program Type dropdown and then click the Search button. The page would re-display and only Verification records that have a Status of “Refused” and Program Type of “Medical” and “Both” will display.

## **2. GENERATE FORM BUTTON**

Although staff have not been instructed to use this functionality, please make note of the following regarding the Generate Form Button. It will now dynamically display on the page when “Medical” or “Non-Medical” are selected from the Program Type dropdown. If “All” is selected the Generate Form button becomes hidden.

The Generate Form Button will now generate either the Non-Medical Verification Request List Form V000 or the Medical Verification Request List Form V001 depending on the individual’s Worker ID. In addition workers can now select specific Verifications to include on the Form, by checking the checkboxes next to the Verification Record.

NOTE: It is important that workers be aware of how they have the Verifications List page filtered when using the Generate Form functionality. The Verifications that populate the Form are the Verifications that are displayed on the page when the Generate Form button is clicked. Remember to always click the search button after updating the filters and prior to clicking the Generate Form button to ensure that the correct Verification records are being included in the form.

## **V. POLICY CHANGES IMPLEMENTED WITH PHASE 3**

The following information outlines specific medical policy changes that are being implemented with Phase 3 KEES.

### **A. TIER 3 VERIFICATION**

With Phase 3 implementation, there is a change to how DCF records are used when verifying information in Tier 3. For information that is not shared data, such as income and resources, the information on the KEES records is not used for the medical program. Methods of verification and budgeting differ between medical and non-medical programs, so the record itself is no longer used on the medical case.

Rather than using the DCF system records, Tier 3 verification will now include viewing the DCF images as explained above in Section II.C.1.

## **B. MAGI – INDIVIDUAL BUDGETING UNITS FOR 18 YEAR OLDS**

There has been a change to how we determine the IBU of an 18 year old. The IBU will vary depending upon whether or not the 18 year old is living in the home of their parents or residing alone.

For 18 year olds living with their parents, the parental income will always be included, whether or not the parents or 18 year old are filing taxes. In order to accomplish this, it may be necessary to use a work-around when establishing the tax record. See section C.1 below.

The MAGI Building Individual Budgeting Units has been updated to reflect this change and is included as an attachment to this memo.

## **C. MAGI – COUNTABLE INCOME FOR CHILDREN AND TAX DEPENDENTS**

Changes have been made to the rules used to determine when a child or tax dependent's income is included in the total household income. This impacts whether or not the child or tax dependent's income counts for themselves in their own IBU and for others who they are IBU members of.

### **1. KEES CHANGES**

Changes have been made to KEES in order for the income of a child and/or tax dependent to be correctly calculated. The following sections outline the changes made to KEES and the importance of inputting accurate data in KEES to achieve a correct outcome.

#### **a. Income**

This change eliminates the special process required of staff, whereby staff had to choose whether or not a child's income was entered into KEES. All income, whether exempt or countable, of all household members will be entered into KEES.

#### **b. Income Threshold**

KEES will now correctly calculate individuals whose income is below the MAGI Income Threshold. The MAGI Income Threshold is used to determine when income shall be counted for certain children and tax dependents. The MAGI Income Threshold is defined as earned income that is less than \$6300 annually or \$525.00 per month or Interest/Dividends income that is less than \$1050 annually or \$87.50 per month. Individuals whose income is above the MAGI Income Threshold are expected to file a Federal tax return. However, whether or not they actually file a tax return has no impact on how their income is counted for medical assistance purposes.

### **c. Tax Records**

It is critical that staff accurately complete the tax household page in KEES for a correct eligibility determination. A tax record should be created for all individuals who are tax filers. In addition, for everyone age 18 and older who is not filing taxes, a non-filing record must be created.

When there are tax household members who are residing out of the home, they must still be added as case persons so their income can also be included in the determination when appropriate. As described in KDHE Policy Memo 2014-01-01, the KC4520 form is used to obtain information about the additional tax household members.

The following outline special processes which are required for special tax household situations.

#### **18-year olds**

When an 18 year old is living with their parents, the parental income must always be used in their determination. In situations where the parents are not filing taxes, but the 18 year old IS filing taxes, no tax records can be entered into KEES in order for the rules to correctly count the parental income. Even though the 18 year old has reported filing taxes, a tax record is NOT created for them.

#### **Tax Dependents who live apart from the Tax Household –**

When a tax dependent is living apart from the other members of their tax household, these individual must be added as case persons to the case. They must also be given a Household Status of 'Temporarily out of the home' in order for the IBU to calculate correctly.

## **2. COUNTABLE INCOME POLICY CHANGE**

KEES will determine when it is appropriate to include or exclude the income for the individual's IBU or IBUs of other household members. The rules are different depending on whether it is a Filer tax household or a Non-filer tax household.

### **a. Non-Filer Budgeting Units**

For Non-Filer Budgeting Units, the income of a child (under age 19) will be excluded when their income is below the MAGI Income Threshold and their parent or step-parent is in the IBU. When these requirements are not met, all taxable income of the child is included in their own IBU and any IBU that they are a member of.

#### **b. Filer Budgeting Units**

For Filer Budgeting Units, also known as Tax Household Budgeting Units, the income of a tax dependent will be excluded when their income is below the MAGI Income Threshold and they are a tax dependent of the Primary Tax Payer. When these requirements are not met, all taxable income of the tax dependent is included in their own IBU and any IBU that they are a member of.

### **3. IMPLEMENTATION DATE**

This policy is implemented for eligibility actions taken on or after Phase 3 Go Live. However, instructions to redetermine eligibility for cases impacted by this policy are in progress. Therefore, no attempt to 'fix' any cases previously denied or approved is to be attempted at this time. Special instructions will be issued regarding the process to correct selected cases in the future.

### **4. EXAMPLES**

Example 21:

Application received from Nancy who is applying for herself and her daughter, Kelly, age 16. Nancy has SSA income of \$975 and Kelly works a part-time job, earning \$125 per month. Nancy does not plan to file taxes. No one else claims Kelly as a tax dependent. Kelly's income is below the Income Threshold. Because this is a non-filer household and Kelly is under age 19, with income below the Income Threshold, and her mother is in her IBU, her income is excluded from her own IBU and the IBU of her mother.

Example 22:

Application received from Mandy, age 22. She is pregnant and applying for herself. Her father, Marty claims her as a tax dependent. Marty makes \$2,500 a month. Mandy is a college student and makes \$400 a month working as a waiter. Mandy's income is below the Income Threshold. Because this is a tax filer household, Mandy is a tax dependent of her father, and her income is below the Income Threshold, her income is excluded from her IBU.

- Mandy's IBU = 2 (Mandy and Marty – Filer Household)
  - Total IBU income = \$2500/month

Example 23:

Application received from Sadie (55 years old) who is applying for herself, her daughter, Stephanie (age 17), and her granddaughter, Sarah age 2. Sadie is filing taxes and claiming both Stephanie and Sarah as tax dependents. Sadie makes \$3,000 a month from her job. Stephanie makes \$500 a month from her job. Sadie and Stephanie both plan to file taxes, but Stephanie's income is below the Income Threshold. In this situation, we have two tax filing households and one non-filing household, so the rules in KEES will handle each IBU differently.

- Sadie's IBU = 3 (Sadie, Stephanie and Sarah – Filer Household)

- Total IBU income = \$3,000/month
- Stephanie is a tax dependent of the Primary Tax Payer and her income is below the Income Threshold. Therefore, her income is excluded from this IBU.
- Stephanie's IBU = 3. (Stephanie, Sadie and Sarah – Filer Household)
  - Total IBU Income = \$3,000/month
    - Stephanie is a tax dependent of the Primary Tax Payer and her income is below the Income Threshold. Therefore, her income is excluded from this IBU.
- Sarah's IBU = 2. (Sarah and Stephanie – Non-filer Household)
  - Total IBU Income = \$500
  - Stephanie is under the age of 19 and her income is below the Income Threshold. However, her parent is not in this IBU. Therefore, Stephanie's income is *included* for this IBU.

Example 24:

Application received from Michelle, age 26. She is pregnant and applying for herself. Michelle is a tax dependent of her parents. Michelle's Mom earns \$1200 a month and her dad earns \$3000 a month. Michelle earns \$400 a month from her job. Her parents also claim her younger sister, Tiffany. Michelle is planning on filing taxes, but is not required to file. Because this is a tax filer household, Michelle is a tax dependent of her parents, and her income is below the Income Threshold, her income is excluded from her IBU.

- Michelle's IBU = 5 (Michelle, the unborn child, her parents and Tiffany – Filer Household)
  - Total IBU income = \$4200/month

Example 25:

Application received from Mary who is applying for her nephew, Matthew, age 18. Mary plans to claim Matthew as a tax dependent. Mary earns \$2,500/month from her job. Matthew earns \$100 a month from his job and \$450 a month in SSA-Survivor's benefits. Even though Matthew is being claimed as a tax dependent, he meets an IBU exception because the person claiming him is not his parent, so this is a non-filer IBU. Therefore, because he is under age 19 and his parent is not included in this IBU, his income is countable.

- Matthew's IBU = 1 (Matthew – Non-filer Household)
  - Total IBU income = \$550/month; both his wages and his SSA income are included.

Example 26:

Application received from Joseph, age 18. Joseph lives alone, and is filing taxes. No one else is claiming him as a tax dependent. He has wages of \$450 per month. This is a tax filer household, but because Joseph is not claimed as a tax

dependent of anyone, the special exclusionary rules do not apply to him. His income is countable, even though it is below the Income Threshold.

## **5. VERIFICATION OF INCOME FOR MINORS AND TAX DEPENDENTS**

Due to the changes in the above policy related to counting the income of a minor, this also requires a change in the policy for verifying minors' income.

All income must be verified. With the implementation of KEES Phase 3, it is necessary to verify the income of all IBU members. Tiered verification policies apply, including the Reasonable Compatibility Test in Tier 2, looking in other resources in Tier 3 and then pending for information in Tier 4. If verification of the income has not been provided, it would be appropriate to deny for failure to provide information.

Example 27:

Application received for a Mother, Father, and two children. The mother, father, and one of the children all have earnings. The KEES Reasonable Compatibility test is completed for all three individuals. The mother and father's income is found to be reasonably compatible, but the child's income was not. We move to Tier 3 to look in The Work Number and in the case file for verification. No verification is found. In Tier 4, a notice is sent to the consumer to request proof of the child's income. If the income is not provided, the application will be denied for failure to provide information.

## **VI. GENERAL KEES ITEMS**

### **A. MASTER PERSON INDEX**

Additional information regarding the Master Person Index is not available at this time. However, staff will be instructed when new instructions are available.

### **B. REPORTS/REPORTING FUNCTIONALITY**

No functional changes were made to the Medical reports for Phase 3, therefore reports will continue to run as before. However, some of the original report designs did not limit a Phase 2 report to only display Medical data, which means that Non-Medical data may now be shown. Because of this "tighter" parameters should be used when running reports.

A few of the Medical Reports were updated to add an additional Surrogate Key column, which will identify a consumer who has a pre-assigned Client ID with another Interface partner such as MMIS or EBT. This will allow the consumer to keep their pre-assigned Client ID with the other interface and maintain a KEES Client ID.

Security for Phase 3 remains the same. Access to the report task tab links are limited by security profile. Some Non-Medical reports may now be shown in the Data Views, Portal,

Shared Management or Workflow report task tab links, which will be accessible to either agency.

Several new reports, or changes to existing reports, will be produced to account for shared data issues. Specific instructions and parameters will be included with issuance of the reports. The following are a sample of the type of reports that will be produced:

1. Dates of Death on Active programs
2. Reasonable Opportunity Period
3. New Relationships
4. Updated Health Insurance records
5. Conflicting addresses on a case

## **VII. CONCLUSION**

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

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