

State Interaction – Elderly and Disabled Medical

Update 07-03-17

TYPE OF ACTION		MAXIMUS	STATE
Approvals	MediKan – Tier 2 Favorable determination following Tier 1	X	
	Medicaid approvals <ul style="list-style-type: none"> • Prior Medical • Medically Needy/Spenddown (includes reinstating following a 2nd base period closure) • SI • MSP-QMB, LMB, ELMB • Working Healthy • Long Term Care –Nursing Facility, HCBS, PACE • PMD Tier 1 Medicaid approval • Favorable determination following Tier 2 • Protected Medical Groups (PMGs) 		X
Denials	Failure to provide information	X	
	MediKan	X	
	Medicaid Denials for all programs listed above under Medicaid Approvals		X
	General Eligibility Denials <ul style="list-style-type: none"> • Kansas resident • Citizen/Immigration status • Not categorically eligible for our programs <ul style="list-style-type: none"> ○ Does not meet disability criteria • Unable to act on their own behalf or on the behalf of the consumer 		X
Discontinuances	Discontinuance when another aid code continues <ul style="list-style-type: none"> • Example: Closing a Spenddown and leaving MSP open 	X	
	Moved out of state	X	
	Failure to Provide information	X	
	Client Request	X	
	Death	X	
	Lost categorical eligibility <ul style="list-style-type: none"> • No longer meets disability criteria • Receive an unfavorable SSA/SSI determination 	X	
	Over Income		X
	Over Resources		X
Reviews	Review discontinuance for failure to provide review	x	
	Review application withdrawn/client request closure	x	

	Discontinuance at review for excess income, resources		X
	Closure due to death	X	
	Review discontinuance failure to provide information	X	
	Review discontinuance failure to meet categorical criteria		X
	Review approval – no change in aid code (includes instances where a liability, spenddown or premium changes)	X	
	Review approval – changes within the aid code, but the test category remains the same. SSI: change between DS, BL, OA; MDN: change between OA, BL, DS; 300: change between OA, DS, BL; WH: change between BL, DS	X	
	Review approval – change from one MSP to another MSP	X	
	Review approval – change from one PMG to another PMG		X
	Review approval – change in program (example client was spenddown and now approving PMG)		X
	Review discontinuance of one program (such as spenddown or PMG, but MSP remains open)	X	
	Review approval, but changes from one type of LTC to another	X	
	Complete review discontinuance for failure to meet spenddown		X
Other	Application withdrawal, including withdrawal for prior medical request	X	
	Income and Expense changes that result in a change in the share of cost	X	
	Moving from categories within the SSI program (disabled to elderly), moving within the MSP program (QMB to LMB, ELMB) or within the Medically needy program (disabled to elderly).	X	
	Reinstatement of WH following payment of past due premiums	X	
	6-month WH review that does not result in a change of eligibility (can do a change in share of cost)	X	
	Establishing 2 nd base period within the 12 month review period	X	
	Allowing expenses against a Spenddown until the point when the Spenddown is MET.	X	
	Resource Assessments Only	X	
	LTC change that results in a category change - such as 300 to MN or MN to 300		X
	Change from one type of Long Term Care to another (example - PACE to HCBS, HCBS to NF).	X	

	Change in LOC/LAC that doesn't result in an eligibility category change (example - SSI) or temp stay	X	
	Living Arrangement change that results in termination of benefits, with no new coverage (example – leaving HCBS with no eligibility for MN)		X
	Reauthorizing coverage that was discontinued in error	X	
	Medicaid recipient being approved for another Medicaid program (MSP to spenddown, Spenddown requests LTC, etc.)		X
	2 nd base period in a 12 month review period – when ending Spenddown at the end of the first 6 months for not meeting and setting up another program, like MSP.		X
	Transfer of Property penalties		X
	Changes to a consumer's name, address, phone number, or other identifying information that does not impact eligibility	X	
HCBS	<i>Remember – Initial HCBS determinations are sent to the Intake Managers.</i>		X

NOTE: For situations not specifically outlined in this chart, the case should be routed to KDHE for processing.

State Interaction – Family Medical

TYPE OF ACTION		MAXIMUS	STATE
Approvals	CHIP approval	X	
	Newborn deemed eligible	X	
	Medicaid or Blended approval <ul style="list-style-type: none"> • CTM/TransMed/Extended Medical • Prior Medical • Pregnant Women • Poverty Level -19 • Medically Needy/Spenddown • SI • Individual added to an open KanCare Medicaid program 		X
Denials	CHIP Discontinuance <ul style="list-style-type: none"> • Excess Income • Health Insurance • Crowd-Out penalty • Premium Balance 	X	
	CTM Discontinuance for excess income <ul style="list-style-type: none"> • Only when children are being approved for CHIP coverage or income exceeds for CHIP 	X	
	General Eligibility Denial <ul style="list-style-type: none"> • Only on the individual level, i.e. if one individual on the case is being denied for not meeting citizenship criteria, but the other family members are being approved for CHIP, the Contractor can complete this full determination. 	X	
	Failure to provide information	X	
	Medicaid Denials <ul style="list-style-type: none"> • Prior Medical • Pregnant Women • CTM denials for Excess Income (Except when kids are approved for KanCare-CHIP) 		X
General Eligibility Denials-at the Case Level <ul style="list-style-type: none"> • Kansas resident • Citizen/Immigration status • Age • Not categorically eligible for our programs (unless the individual is reporting Disability or elderly at which time ES would route to E and D for a Medical determination) • Already receiving assistance 		X	

TYPE OF ACTION		MAXIMUS	STATE
Discontinuances	Moved out of state	X	
	Failure to Provide information	X	
	Client Request	X	
	Death	X	
		X	
	Lost categorical eligibility <ul style="list-style-type: none"> No longer meet caretaker requirement (children left home) Age (reached age 19 and not pregnant or a caretaker) No longer pregnant and not a caretaker 	X	
	PE – Failure to submit an application	X	
	PE – CHIP Approved	X	
	Over Income <ul style="list-style-type: none"> Includes determinations at the end of post-partum when over income for CTM 		X
	PE – Medicaid Approved		X
Reviews	Review discontinuance for failure to provide review	x	
	Review application withdrawn/client request closure	x	
	Discontinuance at review for excess income		x
	Closure due to death	x	
	Review discontinuance failure to provide information	x	
	Review discontinuance failure to meet categorical criteria		x
	Review approval – no change in aid code (includes instances where a premium changes)	x	
	Review approval – changes within the aid code, but the test category remains the same. SSI: change between DS, BL, OA; PLN: changes between PN, NB, C2, C3, C4; CTM: Changes between PW and PA; PLT: Changes between PW, DN, NB, C1, C2, C3, C4, C5	X	
	Review approval – change from one MSP to another MSP	X	
	Review approval – Change from CTM to TMD or EXT		x
	Review approval – change in program (example client was CHIP and goes to Medicaid)		x
	Review discontinuance of one program (such as spenddown or CTM, but MSP remains open)	x	
	Complete review discontinuance for failure to meet spenddown		x
	CHIP Review Approval	x	
	CHIP Review Closure	X	

Other	Application withdrawal, including withdrawal for prior medical request	X	
	Change in coverage that does <u>not</u> extend the CE period (PLN PW to CTM PW)	X	
	Reauthorizing coverage that was discontinued in error	X	
	Adding pregnancy coverage to a Medicaid Recipient	X	
	Change in coverage that extends the CE period (PLN PW to CTM PW)		X
	Changes to a consumer's name, address, phone number, or other identifying information that does not impact eligibility	X	

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