



Policy Memo	
KDHE-DHCF POLICY NO: 2018-12-02	From: Jeanine Schieferecke, Senior Manager
Date: December 31, 2018	KEESM Reference: KEESM Reference: 1322.4, 1322.4(1), 1322.4(4), 1414.1(2), 2664.5(1), 8172.3, 8270.3, 9310.3(2), 9310.4, 11121.1 KFMAM Reference: 1330, 2445, 6112.02, 6130, 7330.03, 7410.01
RE: Review Processing Instructions	Program(s): All Medical Programs

The purpose of this memo is to provide implementation instructions to eligibility staff related to the KEES review process. New review discontinuance policies, addition of new information in the Tier structure, as well as verification policies are implemented with this change.

This policy is effective with the issuance of the memo.

A. BACKGROUND

Historically, all review determinations were completed manually by eligibility staff based on a receipt of a paper review form mailed to the consumer for completion and return. When a consumer failed to timely return the review form, continued eligibility could not be determined, and coverage was automatically discontinued effective the last day of the current review period for failure to complete the review process. Timely returned forms were processed according to established policies and processes. Eligibility did not continue past the end of the current review period even if processing of the review extended beyond that date.

Some Family Medical assistance programs were passively reviewed by determining eligibility without a review form based on information already reported to and/or known by the agency. With the implementation of the KEES eligibility system, this automated passive review process was expanded to include some Elderly and Disabled medical programs. A paper pre-populated review form is still required for all medical programs subject to review that fail to meet the specified criteria for some level of passive review. Failure to complete and return the signed pre-populated review form according to policy should result in discontinuance of coverage.

Discontinuance of coverage for failure to return the signed pre-populated review form should be an automated process. However, that automated discontinuance process was not fully engaged for all programs or aid codes with the implementation of KEES. In addition, KEES by design does not suspend coverage pending a review determination. Eligibility continues until action is taken to either approve the review or discontinue coverage for failure to meet program requirements. This has allowed coverage to continue unreviewed in many instances, well past the end of the current review period.

See KDHE-DHCF Policy Memo No. 2017-02-01. The review processing provisions contained in that memo remain in effect unless specifically superseded by the policy and procedures contained in this memo.

B. REVIEWS RECEIVED TIMELY

When a review form is received and registered, both the Medical KEESM and KFMAM currently indicate coverage is discontinued at the end of the review period unless formal action is taken to renew coverage. The policy was based on the assumption the automated review discontinuance process would run consistently and would also discontinue coverage when a review form was received but unprocessed before the end of the existing review period. As indicated above, this is not the case. Although designed in KEES, the automated batch to discontinue coverage has not been consistently completed and coverage has been allowed to continue past the review expiration date for the majority of cases with returned and unreturned reviews since KEES implementation.

This memo formally implements policy to continue coverage past the review expiration date when a review has been received and not yet processed. A review that has been registered - that is recorded in KEES by either imaging a barcoded review form or updating the review IR record - before the review discontinuance batch, will continue to receive coverage until subsequent intervening action (either automated or manual) is taken on the case.

1. PROCESSING STANDARDS

The review form is mailed to the household on or about the 15th of the month prior to the last month of the review period. To be considered timely filed, the signed review form must be returned by the 15th of the last month of the review period. This gives the household at least 30 days to return the required form.

Example: A review that expires 12-31-18 is mailed by 11-15-18 and must be returned by 12-15-18 to be considered timely.

If the review form is timely filed by the household and all review requirements have been met, the review shall be promptly processed to ensure correct and timely coverage is

provided. The timely processing standard is dependent upon the date the signed review form is received by the agency.

A KEES process improvement is planned for implementation in January to align the 10 day closure deadline with the KEES Come-Up Month for the following month. For the purposes of this specific memo closure date and KEES Come-Up Month will be the same date as of January 2019. An updated KDHE Processing Deadlines Code Card chart will be available with the issuance of that plan.

The following processing standards apply. See attachment: Review Processing Standards Timeline.

- i. A review form received before the 1st day of the last month of the review period shall be processed by the closure processing deadline in the last month of the review period.
- ii. A review form received on or after the 1st day (but no later than the 15th) of the last month of the review period, has a processing goal of the closure processing deadline in the month after the last month of the review period. If unable to process by the closure date, the review will need to be completed by 30 days from the received date. Whenever possible, though not required, every effort shall be made to process the review by the closure processing deadline in the last month of the review period.
- iii. If the review is received between the 16th and the last day of the review period, the form is not timely filed and is treated as a late review and shall be processed within 30 days from the date of receipt.
- iv. A review received after the last day of the review period during the Review Reconsideration period shall be processed within 30 days from the date of receipt.
- v. A review received after the end of the Review Reconsideration period shall be treated as a new application and processed within the 45/90 day standards.

EXAMPLE 1: Review for the household is due 12/18. Form is received by the agency on 11/22/2018, which is before the 1st day of the last month of the review period. The review needs to be processed by 12/19/2018.

EXAMPLE 2: Review for the household is due 11/18. Form is received 11/2/2018, which is after the 1st day of the last month of the review period, but before the 15th. The review needs to be processed by 11/19/2018.

EXAMPLE 3: Review for the household is due 11/18. Form is received 11/17/2018, which is after the 15th day of the last month of the review period. Due to the review not being timely filed, the request should be processed before 10 Day Closure, if possible. However, it must be processed within 30 days from the date of receipt, 12/17/2018.

2. TIMELY PROCESSING OF CONTINUING REVIEWS

When a review has been registered – meaning a barcoded review form is imaged or the report record has been updated to “received” and has been marked as “signed” before the closure processing deadline in the last month of the review period, eligibility at current levels will continue automatically until the review process is completed.

a. INCORRECT DISCONTINUANCE

If the review is timely received, but not registered - meaning the report record is not updated to “received” and marked “signed” before the closure processing deadline, coverage will be automatically discontinued by the Review Discontinuance batch. This is considered an incorrect discontinuance and coverage will need to be reinstated.

The discontinuance shall be rescinded, and if the review cannot be processed that day, previous coverage is reinstated while the review is pending. Although rare, all efforts should be made to process the review the same day as action to reinstate coverage is taken. Special processing is required to ensure KEES data records are not compromised as a result of this action. Steps are listed below:

- i. Rescind everyone on the program block.
- ii. If the review is being processed on the same day as the reinstatement, no special processing is required, but EDBC will need to be run with the “RE” Run Reason. The Review Date and applicable CE periods will be reset appropriately. Notices to the consumer, as well as any long-term care entity must be sent per policy and an ES-3161 will need to be sent for HCBS recipients. The LOC must be reset as indicated in Step C (3)(b) below.
- iii. If the review cannot be worked the same day, the previous coverage levels will need to be reinstated and the EDBC run with the “RE” Run Reason.
 - a. Even though this action is resetting the Review Date before the review is processed, it is correct. Since the new eligibility period hasn’t actually been established, staff may need to manually adjust the cases CE dates once the full review is completed. But by using the “RE” Run Reason now, before the review is formally processed, it will prevent complex data issues in the future.

- iv. Staff must ensure the correct notice is issued and indicates the case has been temporarily reinstated until the review process has been completed. A new snippet will be added to the Standard Copy and Paste for the temporary reinstatement. A notice to any LTC provider must also be generated or an ES-3161 will need to be sent if necessary. The LOC will need to be reset as indicated in Step C(3)(b) below.
- v. When the review is fully processed, either with a failure to provide or a completed determination, staff will need to assess the case CE dates, as they may also need to be reset with this action. If the determination results in consumers loss of coverage, the negative change will need to be processed allowing for timely notice. Manual adjustment of the case Review Date is not needed.
- vi. If processing a redetermination request for a review, the program block will need to be rescinded with the existing case CE Dates. If found to be eligible for coverage, the Review Date will need to be updated to the last month of coverage and EDBC ran with the "RE" Run Reason.

If an untimely review is received during the review reconsideration period, the discontinuance shall be rescinded but previous coverage shall not be reinstated, pending the completion of the review. An untimely filed review negates the opportunity to receive continued benefits pending completion of the review process.

b. PROCESSING REQUIREMENTS/EXTENDED MONTHS

For reviews with a due date on or after 12/01/2018, if a timely received review is not timely processed by the agency, the current level of coverage for the household may continue past the end of the review period for one or more months [extended month(s)]. The date the timely review is received by the agency will determine if those months are subject to correction.

- i. If the review is received before the 1st day of the last month of the review period, it is anticipated that the review will be completed prior to the closure processing deadline in the last month of the review period. Therefore, there should be no extended months of coverage. However, if the review is not timely processed, resulting in extended months of coverage, those months are subject to correction, if necessary. Understated eligibility shall be restored, and an agency error claim shall be created for any overstated eligibility for those months.
- ii. If the review is received on or after the 1st day of the last month of the review period, correction (if any) is required beginning with the second extended month. The first extended month is only subject to correction when the new benefit level is greater than the previous coverage. In that instance, the extended month shall be corrected

to reflect the new benefit level for that month. If the new benefit level is less than the previous coverage, no correction of the extended month is required. Correction is required for all months beginning with the second extended month.

Note: If the review is not timely processed and the ultimate action taken on the case is adverse, timely and adequate notice of the action is required. Corrections will need to be made in the first month timely notice can be provided, and an entry added to the Overpayment Spreadsheet. If the action taken on review is not adverse (i.e.: level of coverage increases or remains the same), only adequate notice is required.

C. AUTOMATED DISCONTINUANCE

Since KEES implementation, a modified version of the automated review discontinuance process has been in place. The modified process resulted in only a subset of cases being closed through the automated process. Beginning with reviews expiring for the month of December 2018 reinstatement of the automated review discontinuance batch will be implemented. The batch run will fully implement original medical policy and will discontinue program coverage where a registered signed pre-populated review form has not been timely returned or has been timely returned but not yet imaged or had the report record updated in KEES. Unlike the current discontinuance process that runs for a subset of all reviews, this batch will run for all medical populations – including Elderly and Disabled, LTC participants and Family Medical cases that are subject to review requirements. This means that populations that previously required manual action to terminate will now be automatically discontinued.

To avoid this review discontinuance batch run, the signed pre-populated review form must be received and registered before the discontinuance batch date of the last month in the current review period.

1. NOT IMPACTED BY DISCONTINUANCE

Some persons/programs will not be impacted by the discontinuance batch. Coverage will continue uninterrupted. However special processes will be required for some cases as indicated in item (3) below.

- Targeted Working Healthy 6 Month Reviews
- SSI Recipients (Excluding Presumptive Eligibility Tier 1)
- Children, Caretakers and Pregnant Women with CE dates that are later than the review month

2. IMPLEMENTATION

The process will impact reviews due on or after December 2018. It will not include reviews due earlier. Manual action will still be required on cases where the review period has expired, and a review has not been returned.

3. SPECIAL PROCESSES

a. NO REVIEW CASES THAT FAIL PROCESSING

As part of the review process, KEES will select all cases with the applicable review due month for potential processing. This includes cases identified as 'No Review' such as PPS and SSI. These cases are then sent through the batch EDBC process like other programs due for review that month. In most instances, the process will result in a new review period and coverage fully authorized. No action is required on these programs.

However, if a No Review case fails this process, a Read Only EDBC results. Even though benefits will continue with a Read Only EDBC, a new review period will not be reset. This is a problem and action must be taken to ensure these cases are fully processed.

When a No Review case fails review EDBC, a task is generated – No Review Failed Eligibility-Not Saved. This tells staff that something is likely wrong with the information in KEES and that action to correct the case must be taken. In some instances, the individual is no longer eligible. But in most cases, there are some data quality issues that must be corrected. In either event, manual action is required by staff.

The task is generated with the initial review batch – on or about the 15th of the month prior to the expiration of the review period. Staff should use the Job Aid – Troubleshooting EDBC when processing these cases. It may also be helpful to consult one of the Skipped Cases-COLA Job Aids (depending on the reason) if more instruction is needed.

Example – for reviews that expire in January, the task is generated on or about December 15. Staff must process these tasks and ensure the review period is reset by the Negative Action deadline of the last month of the review period (January 17, 2019 in the example above).

b. LEVEL OF CARE (LOC) END DATE

New functionality is implemented with the discontinuance batch to automatically end date the KEES Level of Care record for any individual closed by the discontinuance batch. This will only impact cases with an open-ended LOC record. The record will be updated with an end date according to the following rules:

- i. For an LTC Type of HCBS, the HCBS Terminated field will be updated to 'Yes' and the Termination Effective Date will be set at the last day of the month of the review period. A Termination Reason of 'Review Discontinuance' will be listed.
- ii. For Temporary Care records, the Discharge Date will be set as the last day of the

month of the review period.

- iii. For Institutional Care records, the Discharge Information field will be 'Yes'. The Discharged To field will be 'Other' with a reason of 'Review Discontinuance'. The effective date will be the first day of the next review period.
- iv. For MFP records, the MFP Terminated field will be changed to 'Yes'. The Date (for MFP Terminated) will be the last day of the month of the review period. A Termination Reason of 'Review Discontinuance' will be used.
- v. If Temporary Care record exists, the Temporary Care Discharge Date will be the last day of the review period.
- vi. For PACE records, the Involuntary Disenrollment field will be 'Yes'. The Effective Date (for Involuntary Disenrollment) will be the last day of the month of the review period.

Once sent on the KEES file, the record in MMIS will also be updated and this will help prevent erroneous LTC segments in the future.

For staff, this will mean they need to pay special attention to the LTC Data Details record for any person impacted by the discontinuance batch who also received LTC in the past and wants to continue to receive LTC services. It is not always necessary to create a new LTC Data Details record when an untimely review or new application is received for an individual meeting this criteria. In many cases, the termination or discharge date may be removed from the LTC Data Details record if eligibility will be re-established without a gap in coverage and there has been no change in living arrangement. A new LTC Data Details record will need to be created if eligibility will be re-established with a gap in coverage or a change in living arrangement has occurred.

Consider the following examples.

1. Review Received within Review Reconsideration Period – A consumer receiving institutional care fails to timely submit their review and eligibility is discontinued January 31st. On March 5th, the consumer submits their review to the KanCare Clearinghouse. Upon processing the review, eligibility is reinstated without a gap in coverage. The Discharge Date on the Institutional Care LTC Data Details record is removed.
2. Application Received after the Review Reconsideration Period – A consumer receiving HCBS fails to timely submit their review and eligibility is discontinued March 31st. A new application is submitted on August 12th which includes a request for prior medical assistance. The consumer has been admitted to the nursing facility. A new LTC Data Details record is needed because the consumer has had a change in living arrangement and there will be a gap in eligibility.

c. SSI-MSP CASES

While SSI programs are not subject to formal review, any companion MSP program must complete the formal review process. Although the SSI program is set as a 'No Review', the MSP is not. The majority of MSP-SSI reviews are Super-Passive or Passive, but a portion of these cases do receive a Pre-Populated review form. This can happen for a number of reasons but is usually because a data quality issue in KEES did not allow the full EDBC to pass, resulting in a Pre-Populated review form.

If the consumer returns the completed form, staff should process as normal review. However, because the consumer is an SSI recipient, verification requirements are different and a request for information is seldom required. While processing, staff should spend time evaluating the case to resolve any data quality issues that might prevent automated EDBC's in the future.

If the consumer does not return the review form, the MSP would close. To prevent unnecessary closures due to data quality issues, staff are to review all SSI/MSP cases where a Pre-Populated review was sent but not returned. If possible, an administrative review is completed on the case to determine if MSP can be reauthorized. It is not necessary to secure an application form for this purpose but the "RE" run reason must be used when running EDBC. Again, it is important to spend time reviewing the case to determine if there are any data quality issues preventing EDBC from executing.

Regardless of the outcome, a notice must be sent to the consumer informing of ongoing eligibility. A notice is not produced as a result of a Read-Only EDBC, so the worker is responsible for ensuring the notice is sent following the completion of the review.

A report of all SSI-MSP cases requiring an Admin Review will be generated immediately following the Review Discontinuance batch each month. These cases must be administratively reviewed before the first day of the next month.

4. NOTICES

Discontinuance notices will be issued in the following manner:

d. CONSUMER/ADMIN ROLES

The KEES batch run will auto-generate a discontinuance notice to the Consumer and all appropriate Administrative Roles.

e. LONG TERM CARE ENTITIES

The discontinuance batch run will not auto-generate discontinuance notices for nursing homes, MCOs for HCBS recipients, or PACE entities. Notices must be manually sent to

such entities. A special report will be run each month identifying long term care individuals discontinued for failing to return a signed review. There will be a separate report for each nursing facility, for each MCO for HCBS, and for each PACE entity.

KDHE will produce a special list each month following the discontinuance batch. A separate report listing the names and relevant information impacted by the process will be produced for each facility/MCO. Staff must mail these reports, along with an appropriate cover letter, to each entity shortly after the review discontinuance batch is run. This process is similar to the one used for COLA mass change.

It is critical that the long term care provider listed on the LTC Data Details page is correct. This will ensure that the correct entity is being notified of the discontinuance.

5. JOURNAL

The automated discontinuance batch run will not auto-generate a journal entry to the case. Eligibility staff are not required to manually create a journal entry for this event.

6. PROCESSING PRIORITIES

Since coverage continues while a review is pending, it is imperative that the following programs receive priority processing. If possible, the review should be processed prior to the MMIS monthly run date for that month.

a. MEDICALLY NEEDED (MN) SPENDDOWN

The review for a Medically Needy (MDN) Spenddown program normally coincides with the end of a base period. When a pre-populated review form is received and timely processed, eligibility for the next base period will properly transmit to MMIS. However, when a pending review extends past the date of the monthly MMIS file run, continued eligibility (without a base period) is transmitted to MMIS for the month after the month the current review period ends.

The transmission of a Medically Needy (MDN) record to MMIS without a base period creates multiple problems that eventually require KEES Help Desk intervention to resolve. To avoid this issue, Medically Needy (MDN) reviews should be given processing priority.

Note: As a reminder, continued Medically Needy (MDN) coverage should not be approved where the recipient has not met previous spenddowns, is not meeting the current spenddown, and/or is unlikely to meet a future spenddown. For further guidance

see Medical KEESM 1414.1 (2) and KDHE-DHCF Policy Memo No. 2017-03-01 (Section 4).

b. PROGRAMS WITH A SHARE OF COST

Medical assistance programs with a share of cost should also be given priority attention. These include, long term care cases (nursing home, HCBS, and PACE) with a liability/obligation, Working Healthy (WKH) and CHIP with a premium. To ensure the share of cost is correct beginning with the first month of the new review period for timely filed signed pre-populated review forms, the review must be processed prior to the MMIS monthly run date for that month.

i. INSTITUTIONAL

The monthly patient liability amount may change. In general, a change reported at review should be effective the first month of the new review period. However, if the review is not processed by the MMIS file run, the old (incorrect) patient liability will continue into the next month. An overstated patient liability may be changed (corrected) for/in retro months. See Medical KEESM 8172.3. An understated patient liability based on an untimely processed review is considered overstated eligibility and is subject to recovery as an agency error. See Medical KEESM 11121.1.

ii. HOME AND COMMUNITY BASED SERVICES (HCBS)

The monthly client obligation amount may change. In general, a change reported at review should be effective the first month of the new review period. However, if the review is not processed by the MMIS file run, the old (incorrect) client obligation will continue into the next month. An overstated client obligation may be changed (corrected) for/in retro months. See Medical KEESM 8270.3. An understated client obligation based on an untimely processed review is considered overstated eligibility and is subject to recovery as an agency error claim. See Medical KEESM 11121.1.

iii. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

The monthly participant obligation amount may change. In general, a change reported at review should be effective the first month of the new review period. However, if the review is not processed by the MMIS file run, the old (incorrect) participant obligation will continue into the next month. An overstated client obligation may be changed (corrected) for/in retro months. See Medical KEESM 8172.3 (Institutional) and 8270.3 (HCBS). An

understated participant obligation based on an untimely processed review is considered overstated eligibility and is subject to recovery as an agency error claim. See Medical KEESM 11121.1.

iv. WORKING HEALTHY (WKH)

The monthly premium amount may change. This includes situations where the recipient does not report a change at review, but an earlier reported change has resulted in an increased premium amount that is being delayed until completion of the review. See Medical KEESM 2664.5 (1).

v. CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

The monthly premium amount may change. Similar to the Working Healthy (WKH) program above, an earlier reported change which results in an increase in premium is delayed until completion of the review. See KFMAM 2445. This means that even if no change is reported at review, there may still be a change in the premium amount at review due to the earlier reported change.

c. MEDIKAN

MediKan eligibility is limited to a fixed 12-month coverage period. This means, in all probability, MediKan eligibility by policy should cease effective with the last month of the current review period. Failure to process a timely filed signed pre-populated review before the MMIS monthly run date will result in incorrect extended coverage for the program. MediKan coverage past the 12th month is overstated eligibility subject to recovery as an agency error claim. See Medical KEESM 11121.1.

d. REVIEW RECONSIDERATION

If the signed pre-populated review form is received after coverage has been discontinued due to failure to return a signed review, the normal rescind vs. reapply processes apply. This includes situations where the review was timely filed, but not imaged or report record updated, prior to the review discontinuance batch run.

i. RESCIND

If the signed prepopulated review form (or a new application) is received by the end of the third month following the month of discontinuance, the discontinuance shall be rescinded and the review form (or application)

registered for review. Normal review processing applies. See Medical KEESM 9310.3(2) and KFMAM 7330.03.

Note: If there are new individual(s) being applied for at review, rescind should always be used **before** reapplying the new individual(s).

ii. REAPPLY

If the pre-populated review form (or new application) is received after the third month following the month of discontinuance, the discontinuance is not rescinded. The review form or application is treated like a new application and registered as such. Normal application processing applies. See Medical KEESM 9310.4 and KFMAM 7410.01

D. SKIPPED REVIEWS

When the reviews batch is executed, KEES takes into consideration several different factors. These include elements that are visible to end users (such as the review date) as well as data that is only maintained on tables not viewable by users. When encountering unexpected information during the review batch, it was discovered reviews were being skipped – meaning no review was ever generated. This has allowed many cases to continue without a completed review past the review expiration period. Although recognized as a problem soon after KEES go-live, the extent of the problem is much more severe than originally estimated.

The KEES team has developed special processes to reduce the likelihood of skipped reviews. However, it is necessary, to comply with federal rules, that all cases be placed back into regular processing schedules. A special project is being implemented to ensure all cases are reviewed and placed back into a regular schedule.

1. PROCESS

The skipped review special process will run for approximately 20 months. During the process, the review period will be automatically reset, based on the schedule below for each identified case. The case will then be run through the regular review batch and be subject to the same rules as other cases. This includes the RC test, SSA matching income, self-employment income, etc. If it meets the criteria for a Passive or Super-Passive review, such a review type will result. Otherwise, a Pre-Populated review will generate.

There are no special processing rules for cases that are subject to review as part of the skipped review process.

2. SCHEDULE

The current Skipped Review Schedule is attached to the memo. Schedule is subject to change.

E. OUTSTANDING UNPROCESSED REVIEWS

No special processes are required for reviews that have been received but have not been processed. However, the new timeliness standards described above apply to these reviews as well.

F. VERIFICATION AT REVIEW

To ensure timely verification of data is provided at review time, new guidelines are applicable when processing a pre-populated review or a change on a passive review.

1. RC TEST

The review batch will automatically complete a Reasonable Compatibility test as part of the process and the results are visible on the appropriate KEES pages.

When processing a pre-pop or a passive review, the RC test completed as part of the review is valid until the end of the third month following the month the test was executed. A new RC test is required for any review with an older RC test.

EXAMPLE: Pre-pop review is processed, and RC test ran on 12/04/2018. The RC test will remain valid until 3/31/2019.

2. CREATING NEW INCOME RECORDS

New income records for zero income will not automatically be created by the batch at this time. It is also not necessary to update an existing \$0 income record with new start and end dates. However, if the consumer attests to a new income amount at the time of review, a new income record will need to be created an RC test completed.

G. REASONABLE COMPATIBILITY EXCEPTIONS

1. TALX TIER 3 AMOUNT

The amount of income received through the TALX interface shall continue to be used as currently specified. This amount is currently taken from the Reasonable Compatibility

Detail page in KEES and used in the budget. Although staff shall continue to use the TALX Tier 3 amount to create an initial income record, there are instances where it is necessary to reconsider the budgeted amount and adjust the income used in the determination. An income record is still created from TALX information, but a different methodology is used to determine the appropriate amount to budget. Use of this approach is limited to the situations described in this section.

2. TALX DATA

When income is found for a consumer through the TALX interface and the employer does not provide a complete/accurate income record - specifically, the employer indicates the income is received 'hourly' - the interface does not have a way to determine the exact frequency of pay for the wage (e.g. biweekly, monthly, etc.) and may not accurately budget the income. When this occurs, policy has indicated the total of all payments received during the 30-day period starting with the Anchor Date are used in the budget. Staff can see this amount displayed on the Reasonable Compatibility Detail page. For most, this approach will result in countable income very consistent with an amount derived from a record that includes a correct payment frequency. But, for a person paid biweekly, the income could be inflated, resulting in incorrect eligibility. The special process below has been created to provide an alternative to ensure income is budgeted correctly per KFMAM 6112.02.

For persons paid biweekly with a payment frequency of 'hourly', the determination will total all payments received in a 30-day period from the Anchor Date. An average is not computed because there is no indication on the file the consumer is paid biweekly. For many individuals paid biweekly, this could include three pay checks.

Cathy Example: Cathy, a pregnant woman applicant, is paid \$1000 biweekly, but the TALX record indicates she is paid hourly. Worker requests verification on 08-07-18, Pay checks returned are dated 07/06/18, 07/20/18, and 08/03/18. The interface uses the 08/03/18 pay check as the Anchor date, resulting in the TALX date range being 08/03/18 to 07/04/18. The total of the paychecks is computed, \$3000, and this is displayed on the Reasonable Compatibility Detail page for Cathy.

This conflicts with KFMAM 6112.02 that indicates biweekly income is converted to a monthly amount using a multiplier of 2.15. Meaning an RC amount of \$2150 would have been used for the RC page if the employer correctly entered the TALX record.

3. TALX ADJUSTED DETERMINATION – HOURLY RATE RECONSIDERATION

It is important to recognize this situation will occur only in rare instances. However, an exception to TALX budgeting is being implemented for limited cases where eligibility may be impacted as a result.

When budgeting the full 30 days of income results in denial of benefits or when the consumer requests a redetermination of coverage, staff shall conduct a detailed review of the TALX results. This is done manually by reviewing the full TALX record as well as the information provided by the consumer.

- i. If the consumer reports a biweekly payment and the interface indicates an 'hourly' payment in the Employee Pay Frequency section, a new determination using the adjusted TALX amount is necessary.
- ii. The income record is end dated and a new one created using the adjusted TALX amount. The adjusted record is determined by recording all TALX records within 30 days of the Anchor date into the Average Calculator in KEES. Record with a frequency of 'Every Two Weeks'.
- iii. The TALX Tier 3 income record can be removed if a determination was not issued using the amount (meaning the client was never notified of the decision). However, if a determination was made with the existing income record, it must be end dated and a new income amount detail record created with the new Adjusted amount.
- iv. Redetermine eligibility using the Adjusted amount. If the redetermination results in the consumer not being eligible, EDBC would need to be ran in the come up month. Running EDBC in the previous paid months will result in an ineligible status in KEES.
- v. Worker submits a KEES Help Desk ticket regarding incident. The incident ticket needs to contain the KEES monthly amount and the worker determined monthly amount. Additionally it will also need to state that KEES using the "hourly" rate is causing the incorrect determination.

Cathy Example Continued: Cathy failed RC, but a review of the Reasonably Compatible Detail page in KEES indicates a TALX record of \$3000. Following protocol, the worker uses this amount to create an income record. When EDBC is executed, Cathy fails. Because Cathy is paid biweekly, the worker examines the TALX record and discovers the employer indicated a payment frequency of 'Hourly'. The worker has determined that a TALX Adjustment is needed.

Using the date range on the Reasonable Compatibility page, the worker determines the Anchor Date is 08/03/18. There are three paychecks that fall within the 30 day period prior to the Anchor Date – and these are recorded in the Average Calculator and a new income record is created. Because the previous record was not used for any determination, the prior record of \$3000 created from TALX Tier 3 is removed.

A new income record of \$2150 is now used for Cathy's determination. EDBC is executed and she is eligible for PLN/PW coverage. The worker narrates that a special TALX Income Adjustment was applicable due to the denial and submits an incident ticket to the KEES Help Desk.

Bobby Example: Bobby's mother filed an application for her 4 year old son last month. She received a denial notice last week telling her he was denied coverage for CHIP because of insurance his father provides. She was disappointed so she called to find out more. During the call she finds out that \$2400/month was used for the determination. She indicates this is more than she makes and requests a re-determination.

The worker reviews and discovers that a TALX Tier 3 record of \$2400 was used. This is consistent with the Reasonable Compatible Detail page. He also notes the Anchor Date and that Bobby's mother is paid biweekly. He determines further evaluation of TALX is required and discovers a pay frequency of hourly. Three checks are noted within 30 days of the Anchor Date - \$500, \$700 and \$1200. The worker confirms a TALX Adjustment is necessary.

Because a determination has already been made using the TALX Tier 3 income amount, this income amount detail record is end dated and the paychecks are recorded on the Average Calculator. A new income amount detail record is created for the corrected income amount, and \$1720/month is now used in the budget. This puts Bobby into the Medicaid range and eligible. A notice is issued, the worker logs a TALX adjustment was used and submits an incident ticket to the KEES Help Desk.

4. INCONSISTENT INFORMATION

The purpose of this section is to describe instances where the workers are permitted to do further research on the differences between reported income and resulting reasonable compatibility verification findings. We do not want to ultimately delay the processing of a case; however, it may be necessary in some situations. This is not a change to current processing procedures and does not require staff to compare every RC detail record.

a. INTERFACE DISCREPANCY

There have been instances of KDOL and TALX records displaying vastly different amounts when running reasonable compatibility verifications in KEES. In the situation where a KDOL record comes back as RC with the self-attestation and there is a TALX record with a significantly different income amount or a more recent date, that would make a difference in the program, workers can research the discrepancy to determine which record should be used. If it is found that the income identified in KDOL or TALX would not impact the ultimate program determination of the case, no additional research is needed.

At this time a phone call placed to the consumer is considered adequate research and will need to be completed, to determine which record is the most current representation

of the household's income. If a worker is unable to contact the consumer, pending will be necessary to resolve the discrepancy.

Per previous policy, all calls will need to be logged via the contact log if they are placed to the consumer. A notation in the journal will also be needed if staff did additional research into the verification details and used the resulting findings in their determination.

EXAMPLE 1: An application is received 9/15 for a household of four, which includes the PA and three children (ages 6, 7, and 8) requesting coverage for the three children. The reported self-attestation of the PA's income is \$2300 per month.

When the verification is ran in KEES it pulls back a reported amount from KDOL in the 3rd quarter of \$1900 per month. Since the KDOL amount is within the 20% range, the self-attestation of \$2300 is marked as RC and would make the children potentially PLN eligible. The worker also notices on the RC results that TALX however is showing paychecks dated 10/5 and 10/19 each of \$1800, making the monthly income \$3600. This amount would not be RC with the self-attestation and would put the children CHIP eligible.

A phone call is then placed to the PA to clarify the differences in the two income amounts. When this is made it is found that the PA has since received a promotion at work and the TALX records will need to be used for the household's determination.

EXAMPLE 2: A review is received 9/15 for a household of four, which includes the PA and three children requesting coverage for the entire HH. The reported self-attestation of the PA's income is \$2300 per month.

When the verification is run in KEES it pulls back a reported amount from KDOL in the 3rd quarter of \$1900 per month. Since the KDOL amount is within the 20% range, the self-attestation of \$2300 is marked as RC. This income would make the children potentially eligible but deny the PA for being over income. The worker notices that while TALX also verified it is showing only one paycheck being received in October for \$650. As this is significantly lower than the reported SA and could potentially make the PA Care Taker eligible, a phone call is placed to clarify the discrepancy.

When contact with the consumer is made the worker finds the PA is no longer employed and a new self-attestation of \$0 income is used for the household's determination.

H. CHANGES TO TIER 1

1. Background

The four-tiered verification process for earned income applies to all medical assistance programs, except for Long Term Care (LTC) and Working Healthy (WKH) – those programs use actual income. This process requires the use of the reasonable compatibility (RC) verifications in KEES to determine the amount of countable earned income, even when verification of earnings had already been provided.

This means eligibility staff are required by policy to disregard paystubs provided at the time of application, unless the four-tiered verification process defaults to level 3, where staff review images that are submitted with the application – information that the agency potentially already has in the form of paystubs (or pay statements) prior to engagement of the tiered process. The result is that, in some instances, additional unnecessary steps are added to the verification process.

2. Policy Change

Effective with the issuance of this memo, the strict tiered verification process for MAGI earned income is being narrowly modified to allow use of hard copy verification for earnings that has been provided at the time of application or request for assistance.

For all programs, earned income shall be verified under the tiered process as specified in Medical KEESM 1322.4 and KFMAM 1330, *unless* paystubs (or other comparable documentation has been provided by the employee or employer) necessary to determine the amount of countable earnings are available at the time the application or request for assistance is received. This will normally occur where the consumer voluntarily provides paystubs at the time the application or request for assistance is filed.

a. VERIFICATION REQUEST

It is important to clarify the new policy does not allow a request for pay checks prior to attempting verification through other electronic sources or other information known to the agency. Specific requests for verification to the client are only made as a part of Tier 4.

b. SUFFICIENT VERIFICATION

When paystubs are voluntarily provided or available at the time of application or request, eligibility staff must determine if the information provided is sufficient (without further verification) to establish the amount of earnings to budget on the case. Sufficiency for purposes of this provision is defined as follows:

- i. All paystubs received in the 30 days immediately preceding the date of application or request for assistance;
- ii. Paystubs which allow calculation via year-to-date totals of gross earnings received in the 30 days immediately preceding the date of application or requesting assistance;

- iii. A written statement from the employer attesting to the employee's gross earnings received in the 30 days immediately preceding the date of application or request for assistance, including the date(s) and frequency of payment; or
- iv. Any other document or documents from either the employee or employer which verified the total amount of gross earnings received by the employee in the 30 days immediately preceding the date of application or request for assistance.

If the information voluntarily provided is sufficient to verify the earned income, no further verification is required. The information provided shall be used to determine the amount of earnings. Further use of the tiered verification process is not required, including reasonable compatibility. If the information voluntarily provided is insufficient to verify the earned income, the remaining tiered verification process steps (including reasonable compatibility) in Medical KEESM 1322.4(1) and KFMAM 1330 must be followed.

Note: While some income provided may be insufficient for the purposes of the new Tier 1 process, it may possibly still be used in Tier 3 with partial month budgeting.

C. PRIOR MEDICAL

This new policy does not change the process for verifying earnings in the prior medical assistance period as described in Medical KEESM 1322.4(4) and KFMAM 6130. If no change is reported for the prior period, the verified earnings in the current period shall be budgeted in the prior period. If a change is reported, verification of actual earnings for the prior month(s) shall be required.

3. Transition

This policy is effective with the issuance of this memo and applies to all applications received on or after the effective date. The policy also applies to all pending applications, reviews and changes processed on or after the effective date of this memo.

4. KEES

If the documentation provided at the time of application, review or request for assistance is determined to be sufficient, Reasonable Compatibility will not be ran on the self-attestation of that specific earned income record. The workers will need to record the information provided in the Average Calculator in KEES to arrive at the monthly income. This amount will be marked as "Verified" via "Document" source type and used for the EDBC determination.

If it is found that the provided documentation is not sufficient at the time of processing, workers will need to move to the next step in the tier verification process.

Example 1: Application is received 11/1/2018 requesting MAGI coverage for one child. Paystubs with the dates of 10/26/18 for \$1000.00 and 10/12/2018 of \$1200.00 for the PA were submitted with the application. Since the paystubs are within the immediate 30 days

of the application date they are determined sufficient to be used for the income records. The two paystubs are entered the Average Calculator and the monthly amount of \$2365.00 is calculated. The new Tier 1 verification process was used, and the income record is marked as “Verified” via “Document” source type.

Example 2: Review form is received on 11/15/2018 requesting MAGI coverage for two children. An employer statement dated 9/22/2018 is provided with the review stating the PA made \$2500.00 for the month of 8/2018. Worker has determined the employer statement is not sufficient due to the income being verified was not in the 30 days immediately preceding the date of the review and cannot be used in the determination. Worker will proceed with tier 2 verification of income.

I. QUESTIONS

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

Jeanine Schieferecke, Senior Manager – Jeanine.Schieferecke@ks.gov

Erin Kelley, Elderly and Disabled Program Manager - Erin.Kelley@ks.gov

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Questions regarding any KEES issues are directed to the KEES Help Desk at KEES.HelpDesk@ks.gov

	Review Batch Run	Program Type	Review Dates	Review and Reporting Page Requirements
1	Dec-18	PPS	All PPS Past Due Reviews	
2	Jan-19	PMDT, Landon and Assigned Worker ID's	All Past Due Reviews	
		LTC, E&D	November, October and September 2018	Document Status: Sent Report Status: Incomplete
3	Feb-19	LTC, E&D	Dec-18	Document Status: Sent Report Status: Not Applicable, Passive Document Status: Sent or Received Report Status: Complete – EDBC Accepted and IR Submit month is greater than 1 year from current month Document Status: Received Report Status: Not Applicable and most recent review type was “Targeted”
			November, October, September 2018	Document Status: Sent or Blank Report Status: Not Applicable, Passive or Blank Document Status: Sent or Received Report Status: Complete – EDBC Accepted and IR Submit month is greater than 1 year from current month Document Status: Received Report Status: Not Applicable and most recent review type was “Targeted”

	Review Batch Run	Program Type	Review Dates	Review and Reporting Page Requirements
3	Feb-18	Family Medical	Dec-18	Document Status: Sent Report Status: Not Applicable, Passive
			Nov-18	Document Status: Sent or Blank Report Status: Not Applicable, Passive or Blank
4	Mar-19	LTC, E&D	August, May, April, March 2018	Document Status: Sent or Blank Report Status: Not Applicable, Passive or Blank Document Status: Sent or Received Report Status: Complete – EDBC Accepted and IR Submit month is greater than 1 year from current month Document Status: Received Report Status: Not Applicable and most recent review type was “Targeted”
			June, July 2018	Document Status: Sent or Blank Report Status: Incomplete, Not Applicable, Passive or Blank Document Status: Sent or Received Report Status: Complete – EDBC Accepted and IR Submit month is greater than 1 year from current month
		Family Medical	October and September 2018	Document Status: Sent or Blank Report Status: Not Applicable, Passive or Blank Document Status: Sent or Received Report Status: Complete – EDBC Accepted and IR Submit month is greater than 1 year from current month

	Review Batch Run	Program Type	Review Dates	Review and Reporting Page Requirements
5	Apr-19	LTC, E&D	February 2018, September, August, June 2017	<p>Document Status: Sent or Blank</p> <p>Report Status: Not Applicable, Passive or Blank</p> <p>Document Status: Sent or Received</p> <p>Report Status: Complete – EDBC Accepted and IR Submit month is greater than 1 year from current month</p>
			January 2018, December, November, October, July, May 2017	<p>Document Status: Sent or Blank</p> <p>Report Status: Not Applicable, Passive or Blank</p> <p>Document Status: Sent or Received</p> <p>Report Status: Complete – EDBC Accepted and IR Submit month is greater than 1 year from current month</p> <p>Document Status: Received</p> <p>Report Status: Not Applicable and most recent review type was “Targeted”</p>
		Family Medical	Aug-18	<p>Document Status: Sent or Blank</p> <p>Report Status: Not Applicable, Passive or Blank</p> <p>Document Status: Sent or Received</p> <p>Report Status: Complete – EDBC Accepted and IR Submit month is greater than 1 year from current month</p>

	Review Batch Run	Program Type	Review Dates	Review and Reporting Page Requirements
6	May-19	LTC, E&D	Apr-17	See LTC, E&D requirements for Review Dates of February 2018
			March, February, January 2017	See LTC, E&D requirements for Review Dates of January 2018
		Family Medical	Jul-18	See FM requirements for Review Dates of August 2018
7	Jun-19	LTC, E&D	Dec-16	See LTC, E&D requirements for Review Dates of January 2018
		Family Medical	Jun-18	See FM requirements for Review Dates of August 2018
8	Jul-19	LTC, E&D	Nov-16	See LTC, E&D requirements for Review Dates of January 2018
		Family Medical	May-18	See FM requirements for Review Dates of August 2018
9	Aug-19	LTC, E&D	Oct-16	See LTC, E&D requirements for Review Dates of February 2018
		Family Medical	Apr-18	See FM requirements for Review Dates of August 2018
10	Sep-19	LTC, E&D	September, August 2016	See LTC, E&D requirements for Review Dates of February 2018
11	Oct-19	LTC, E&D	Jul-16	See LTC, E&D requirements for Review Dates of January 2018
12	Nov-19	LTC, E&D	All Remaining LTC/E&D Review Due	See LTC, E&D requirements for Review Dates of January 2018
13	Dec-19	Family Medical	All Remaining 2018 Review Dues	See FM requirements for Review Dates of August 2018
14	Jan-20	Family Medical	December, November 2017	See FM requirements for Review Dates of August 2018
15	Feb-20	Family Medical	October, September, August 2017	See FM requirements for Review Dates of August 2018

	Review Batch Run	Program Type	Review Dates	Review and Reporting Page Requirements
16	March -20	Family Medical	July, June 2017	See FM requirements for Review Dates of August 2018
17	Apr-20	Family Medical	May, April, March 2017	See FM requirements for Review Dates of August 2018
18	May-20	Family Medical	All Remaining 2017 and December 2016	See FM requirements for Review Dates of August 2018
19	Jun-20	Family Medical	November, October, September, August 2016	See FM requirements for Review Dates of August 2018
20	Jul-20	Family Medical	July, June, May, April, March 2016	See FM requirements for Review Dates of August 2018
21	Aug-20	Family Medical	All Remaining Family Medical Review Due	See FM requirements for Review Dates of August 2018

Pre-Populated Review Processing Standards

