Kansas
Department of Health and Environment
Division of Health Care Finance

Policy Memo	
KDHE-DHCF POLICY NO: 2019-01-01	**From: Erin Kelley, Senior Manager**
Date: Jan 25, 2019 **April 22, 2019 - Revised**	**Medical KEESM Reference: 1430 and 9300** **KFMAM Reference: 1420 and 7300**
RE: Implementation of Notice Requirements and Review Processing Edits	**Program(s): All Medical Programs**

This memo sets forth instructions for implementation of policy changes related to the KEES release scheduled for January 27, 2019. All changes are effective with the KEES release. The Medical KEESM and KFMAM will be updated as part of a future revision and the guidelines established in this memo shall be used until the update occurs. These changes are applicable to all medical assistance programs.

1. NOTICE REQUIREMENTS

The following changes are implemented with the KEES release. Both will impact any correspondence generated from KEES after January 27, 2019. Notices and forms issued prior to the release will not be impacted. There is no expectation that staff must regenerate a document solely to produce a correspondence that includes the changes.

A. LANGUAGE ASSISTANCE SERVICES

Section 1557 of the Affordable Care Act requires State Medicaid programs to provide additional information regarding language assistance services for persons with limited English proficiency. The law requires each Medicaid program identify the top 15 languages spoken by LEP individuals in the state. Then, the state must develop taglines in those languages to inform consumers of the availability of interpreter/translator services. Kansas is implementing these requirements with this release.

In Kansas the top 15 languages are: Spanish, Vietnamese, Chinese, German, Korean, Laotian, Arabic, Tagalog, Burmese, French, Japanese, Russian, Hmong, Persian/Farsi and Swahili.

1. *15 Language TagLine Document*

As required by the federal rule, KDHE has created a single document containing the required taglines. The document informs the consumer that language assistance services are available free of charge. The document Language Assistance Services is added to the Appendix – Miscellaneous section with this revision.

Note: In order to preserve the integrity of the document, including correct justification and alphabet/characters, the document is only to be reproduced as a PDF.

2. *Correspondence*

All communication to applicants, recipients and representatives must include all taglines. Any correspondence that is generated from KEES will include an additional page with the correct phrases. This includes all approvals, denials, change notices and requests for information. It will also be included with all forms, including review forms that are directed to applicants, recipients and representatives.

Because all consumer-directed correspondence from KEES will include the form, there was no need to add the material to the Standard Cut and Paste. However, if staff ever send a document directly to a consumer, the form *Language Assistance Services*, must be included in the mailing.

Note the application forms will not be updated to include the document until a later date. The document is posted on the KanCare Application page.

3. *Communication exempt from TagLines*

Communication sent to third parties do not need to include the tagline document. These are items that are not sent to a consumer or their representative. Examples include nursing facility forms, the ES-3160, the MS-2126, Appeal Summaries sent to Administrative Hearings, policy clearances and similar communication. Communication coming from KEES that is directed to these entities, such as facility forms will not include the extra page.

B. Rights and Responsibilities

With the implementation of expedited fair hearing option earlier this month, the statement of Rights and Responsibilities has now been updated to include information regarding the

new process. All documents and communication issued on or after January 27, 2019 that require a statement of Rights and Responsibilities must include the new language.

1. *NOTICES AND FORMS*

All KEES notices and forms that currently include a statement of rights and responsibilities will be updated with the new language. This will occur automatically as part of the KEES update. Updates will also be made to the Pre-populated review forms- the KC1200 and KC1600.

2. *OTHER CORRESPONDENCE*

The Medical Rights and Responsibilities (the KC5720) has also been updated with the new language and is available on the Standard Copy and Paste. A Spanish version is also available. The new statement must be used for all correspondence produced after the KEES update.

Medical applications, both online and paper, as well as correspondence generated from the MMIS will be updated at a later date. However, information regarding the fair hearing process, including expedited fair hearings, is available on the KanCare website and through a link on the Consumer Self Service Portal.

2. REVIEW PROCESSING CHANGES

A new edit is added to KEES to improve review processing. The new validation edit will require action when attempting to authorize coverage (i.e. Run EDBC) for any benefit month following the end of a review period. KEES will not allow EDBC to execute unless a RE Run Reason is used. The edit 'Error- The Review Needs To Be Completed' will appear when EDBC is executed without a RE Run Reason for a month following the end of the review period for the program block. More information regarding the edit and validation message can be found on the EDBC Warnings page of the KEES User Manual. The implementation of the edit requires policy clarifications as stated in this section.

Note: This does not mean that staff should always use the RE Run Reason anytime the edit is encountered. Staff must follow the instructions in this memo to ensure correct case processing.

A. BACKGROUND

Last month, the KDHE Policy Memo 2018-12-02 was released that implemented several review related changes aimed at improving the review process. This document included a full implementation schedule of the automated discontinuance batch and No Review tasks. The guidance also addressed several critical reviews related problems, most notably

programs with expired review periods that continue to receive coverage. A schedule has been put in place to complete a review on each of these cases and, where applicable, reset the review period. This is a step that will ensure the federal requirements regarding 12 months are met.

However, this was only part of the solution. Once fixed, these cases must be maintained appropriately to ensure future reviews are executed correctly. As part of the recent research, a multitude of user errors when processing cases with an expired review period, specifically failing to appropriately reset the review period by using the RE Run Reason, were discovered as a key contributor to the current review issues. If used correctly as a prompt of a potential problem, the new edit will provide users a valuable tool to produce high quality case work.

B. EXPIRED REVIEW PERIODS

First, it is important to stress that it is never appropriate to continue coverage beyond an expired review period unless the program block is eligible for extended months as noted in Section 2 of Policy Memo 2018-12-01. Extended months are only allowed for programs that returned a review, but the agency has not yet processed the determination. Action is always needed to process a review in order to extend coverage for those members of the household subject to the review. KEES will complete the necessary action for program blocks with a review type of Passive, Super-Passive or No-Review. For those with a Pre-Populated or Targeted review, both the consumer as well as the agency must take action before the review is complete. Once the review action has been completed, the RE Run Reason in KEES must be used to reset the review period.

1. *REVIEW EXTENDED WITHOUT COMPLETING REVIEW*

In some cases, a new review period is appropriate for some members of the household, even when required action to complete the review hasn't occurred. Individuals are eligible for continued overage beyond the review period in the following instances:

- Children, caretakers and Pregnant Women with a CE period later than the review month through the end of the CE period.
- SSI recipients (including those deemed to be receiving SSI)

2. *ACTION ON CASES WITH EXPIRED REVIEW*

KDHE Policy Memo 2017-02-02 provides direction when taking action on cases with an expired review period – specifically when adding a new person. Although this guidance remains in effect, additional detail is being provided and is applicable to all situations when taking action on an expired review period.

Effective with the KEES release, case action can only occur for months within an active review period. A review must be completed in order to take any action on a month

following the last day of the review period. For example, action is requested on 02-25-19 for a case with a review expiration date of 08-31-18. No action can be taken for benefit months after August 2018 until the review is completed. Unless a review is pending processing, a review form must be requested from the consumer in the vast majority of situations. This rule does not apply to a discontinuance- the review does not have to be completed to discontinue a case. When discontinuing, a new review form is not needed. For example, the consumer calls to request case closure because he is moving out of state. A review form is not needed for this action.

Prior to implementation of the new Review Edit, there was not a warning to users when encountering these situations. The new edit will provide such a warning. Although running with the RE Run Reason will enable processing, it is not always appropriate. The following rules are applicable whenever staff encounter a program block with an expired review, regardless of receipt of the warning message.

1. Before taking any action on a case, confirm the review date. If the review date is in the past, additional research is needed before proceeding with any requested action. A current review is required for the vast majority of case actions. This includes adding a person, processing an income change or a level of care change.

2. Determine if a review has been received and has not been processed. Research both the KEES system (Review/IR record, E-Application) as well as Image Now for any forms that were not appropriately registered. If the review has been received, process the review before taking any further action.

   If, after completing the review, all persons continue to be eligible, a new review period is established. The new review period is established according to policy memo 2017-02-01 (9)(C)- based on the first available unpaid month at the time the review is processed. The RE Run Reason must be used to establish the new review period. The new review expiration date is 12 months from the first month of the determination unless there are other individual members on the case with a CE date expiring in the future. For those situations, the review date will align with the closest upcoming CE date.

   If some individuals do not continue to be eligible at the time of processing normal procedures will apply.

3. If there is not a review on file and the program is a ‘No Review’ type, a new review determination is not needed, and a new review period must be established. Again, the new review period is based on the first available unpaid month at the time the review is processed. The RE Run Reason must be used to establish the new review period.

4. Determine if the case will be pulled for the Review adjustment batch process for

skipped reviews in the near future. As indicated in Policy Memo 2018-12-02, most cases with a review past due in late 2018 will be assigned a new review expiration date. The process to assign a new review month is completed at the end of the month prior to the targeted month. If a case is within this skipped review processing window it can be held until the batch cycle has ran. When the Review adjustment batch runs, the review date will be adjusted by the batch and action can be taken when processing the review. Consult the KC-7008, Skipped Review Chart, for specific action dates. Note this option is usually reserved for situations where changes are not left pending receipt of a review. Where action is still pending, it is recommended staff generate a manual review.

5. If a review has not been submitted, a new pre-populated form is sent to the consumer to provide an opportunity to complete the review. The review is manually generated, and the consumer given at least 12 days to submit the form.

    a. If the review is returned, normal processing standards will apply.

    b. If the review form is not received by the required date, any household member with active coverage pertaining to the review must be discontinued. In addition, any other changes cannot be processed, such as adding a new person or adjusting patient liability.

6. When processing a late review on a case with an active/ongoing program that includes an add-a-person request, always process the earliest pending month first and then run all necessary EDBC's in order. It may be necessary to run with the RE Run Reason for multiple months to reset the review date appropriately. Additionally, for MAGI programs, before EDBC is run, CE should be updated to match the last paid month. For example, a new request for coverage is made in 12/18 on an open program with a review due in 09/18. It is processed in 04/19. CE should be updated if applicable to 04/19. Once completed process the first month of potential coverage (in this case 12/18) first and then run subsequent EDBC's in order.

    When processing a late review that includes a significant change, always run EDBC for the unpaid month first (using the RE Run Reason). This will establish a correct review period. Then, if action is required for an earlier month (e.g. LOC change or premium adjustment), those actions can be taken. It is important that staff pay close attention to the notices produced for these prior month actions.

C. RE RUN REASON

Again, it is important to stress that use of the RE Run Reason is not always the appropriate action anytime the edit is received on a case. As with most case action, staff must evaluate the details of the case and decide the best action to take. The RE Run

Reason should only be used when establishing a new review period or when specifically instructed to do so by KEES HelpDesk or KDHE Policy.

D. Manually Adjusting the Review Period

While researching the KEES review process, it was discovered that manually adjusting the review period in KEES has contributed to the volume of skipped review issues because doing so can corrupt the database housing the review information. To minimize the risk, staff are now advised to avoid adjusting the review period unless instructed to do so by the KEES HelpDesk or KDHE Policy.

Medically Needy cases have been approved for manual review adjustment. It is always preferable to set the review period consistent with the end of a Medically Needy base period. This will continue to be an allowable reason to adjust a review date manually. Staff should always make the adjustment AFTER completing any applicable review and running with the RE Run Reason.

E. Adding Persons With Expiring Reviews

When a request for coverage is received for a new person on a case with current active coverage, special processes must be followed if the review is scheduled to expire in the upcoming months. These processes are only applicable for situations where the absence of a completed review prevents running all EDBC's necessary to fully process the new person. For example, on February 25 the PA mother on a current case calls to request coverage for her nephew, who has just come to live with her. The request was received while the case is active, so a phone request for coverage is accepted. The review date for the program expires 03-31 and a pre-populated review was generated but has not been returned. Although the child can be added to the program, processing the new child in KEES cannot be fully completed because the worker is unable to obtain a high-dated EDBC – April is now the come-up month and the new review edit is preventing the eligibility determination for April until the review is received. The case is left in an incomplete status unless additional action is taken.

It is important to clarify that it is appropriate to process the request up to the point that the case is 'stuck'. In the situation above, the nephew is added, and coverage approved for February and March, but additional action will be required at a later date. In some situations, especially when new information is needed, it is also acceptable to wait until a review is received (or not received) before moving forward with processing. The guidance provided below is used to determine how to proceed in these situations. In any event, the case action must be thoroughly documented as additional case action will likely be necessary.

1. *Administrative Reviews*

For situations involving a high priority request for coverage and the new person needs an immediate determination, an Administrative Review can be conducted. An Administrative Review is a review conducted by eligibility staff using information available through interfaces and in the case file to determine ongoing eligibility. Cases receiving an administrative review are processed manually by eligibility staff and are conducted without the use of a review form.

a. GENERAL REQUIREMENTS

The following are high-priority requests that are considered appropriate for an Administrative Review:

1. Pregnant Women
2. Newborns
3. Urgent Medical Need requests on a case by case basis, as determined by Policy.

Administrative Reviews can only be completed if a Pre-Populated review form was sent to the consumer and a request for coverage is made prior to the return of the review form. Administrative Reviews are also only appropriate for cases with an expiring review described above; that is, the review is current and the come-up month available in KEES is a month following the review date. Any situation other than the specified list will not be eligible for an Administrative Review and will follow the Alternative Process described below. Those cases will be placed on hold until the review is received, or the discontinuance batch for the month is executed.

When processing an Administrative Review, a review must be recorded in KEES by editing the corresponding Pre-Populated Review record. The date the case is processed is used as the received date for the Review/IR record. The Review/IR Record must also be completed to show the Document Status as Received and that the review has been signed, as these are required fields.

b. PROCESS

When an Administrative Review is appropriate, staff must first determine if all necessary information is available to process the review. A statement regarding the current situation is obtained from the client. This is usually done at the time the request for coverage is received (over the phone) but can also be completed later. All required review-related verification must also be obtained, following the Tier process.

1. Income: Income must be Reasonably Compatible or otherwise verified. This means once an income statement is received, an RC test must be completed or, income otherwise verified following the Tier process (available in the case file). The RC test completed by the Reviews Batch can be used if the newly added individual does not bring new income into the case and there has been no reported change in income. Note that cases with self-employment will

rarely be eligible for an Administrative Review unless recent verification is on file that is consistent with client statement.

2. Household Composition: Unless information is received to the contrary, assume all members currently receiving coverage wish to continue.

3. Tax Filing Status: Confirm tax filing status/tax unit. Information regarding the tax filing status of the new member must be obtained (unless already known as part of the current case).

4. Other Factors: If there is any other indication of a change in the case, the information must be considered and a judgement regarding the Administrative Review documented.

5. Resources: If resources exceed 85% of the allowable limit, verification is required. Other resource factors that disqualify a person from a Passive Review (ex: trust) are applicable and will also prevent the Administrative Review.

6. Expenses: Current verification of any expenses must be available in the case file. Or, if the consumer is eligible without allowing expenses, it is allowable to remove the expense until verification is received.

If an Administrative Review is completed, staff are required to contact the consumer to inform them of the completed determination and that the Pre-Populated Review form doesn't need to be returned. The worker saving EDBC results on the case is responsible for contacting the consumer. If the Pre-Populated Review form is later returned and changes are reported, these are treated under current change process rules.

Staff must thoroughly document all case action in the journal.

c. ADD PERSON – ALTERNATE METHOD

If an Administrative Review is not appropriate or cannot be completed, the person may be added to the case, but future action will always be required. This process is required for any high priority cases listed above where an Administrative Review cannot be completed or any other case where the person is being added and it is determined inadequate to wait for the review.

For these situations, process the new request for coverage up until the month a RE Run Reason is required. At that point, the case is then put on hold pending return of the review form. The case may be sent to the state for processing the new individual at that point. If approved, KDHE staff will follow the instructions for partial tasks found in the State Interaction Job Aid. KDHE will send back a partial task to the contractor. This task may be returned as one of the following:

1. **Partial Application** – created when KDHE determines no corrections are necessary and completes an Application – State task with a status of KDHE – Partial.

2. **Partial – Review** – created when KDHE determines no corrections are necessary and completes a Review – State task with a status of KDHE – Partial.

3. **Partial – Change** – created when KDHE determines no corrections are necessary and completes a Change – State task with a status of KDHE – Partial.

4. **Partial – Manua**l – manually created by KDHE when returning a task that was manually created without corrections.

   The Eligibility worker will claim the partial task and place it on hold. The due date is then set to be the date the discontinuance batch is scheduled to run for the last month of the review period.

   If the review is returned prior to this date, the review is then processed, and the task is resolved. No special action is required, but staff should pay attention to the notices to ensure they are appropriate.

   If the review is not returned before the batch runs, special action is required. First, because there are members in a 'pending' status, the review discontinuance batch will not run on these cases - they will be skipped. So, the case must be manually discontinued in accordance with timely notice. The worker will discontinue the members up for review using the Negative Action reason of "Failure to Return Review." Use the RE Run Reason to reset the review date according to the newly added member. It is imperative that the correct discontinuance reason is used in order for the system to function properly. Then, coverage is allowed to continue for the newly added person.

   Note: Pregnant Women partial tasks will need to follow the process described in the Pregnancy Reported job aid to ensure correct identifying indicators are left in place.

   With this process most review people will receive an extra month of coverage due to the fact the action cannot be taken until after timely/adequate notice deadline.

d. ADD PERSON – PEND FOR REVIEW

A third method for handling the situation is to allow the request to pend until the review is received, or not received. This process is used most often when

adding a person onto an Elderly and Disabled medical program or when the request is received before the discontinuance batch runs. When this process is used, a task is set for the date the discontinuance batch is scheduled to run for the last day of the review month. Action is then taken based on receipt of the review.

If the review batch ran and discontinued the household members associated with the review, the worker will then process the additional add person request as applicable and run it through all needed months to ensure a high dated EDBC.

e. EXAMPLES

Example 1: Household of PA and two children. Review for the two children is due 2/19. PA called in on 2/6/19 requesting PW coverage for herself. The eligibility worker picks up the PW task on 2/8/19. The review form has not been returned at this point and the come-up month now must be ran for 3/19 in order for the PW to be high dated. This means the RE Run Reason will be required when 3/19 is ran.

The worker reviews the information provided in the request and all information is captured to process the review for the two children. The SA is found to be RC and the case is able to be sent to KDHE for authorization.

Example 2: Household of PA and two children. Review for the two children is due 2/19. PA called in on 2/8/19 requesting to Add Child, no UMN reported. The eligibility worker picks up the task on 2/9/2019 to process the Add Child request and notices the review for the other two CH has not been returned and the come-up month for 3/19 is now available in the system, which means the RE Run Reason will be required when 3/19 is ran.

As the request is not a UMN the case will need to be put on hold for the Discontinuance Batch run date. When the task comes due the worker will process the Add CH request at that time. If the review was received the worker will also process the review for the CH's and use the RE Run reason for the month of 3/19. If it was not received, the CH's due for review will be discontinued for "Failure to Return Review."

Example 3: Household of PA and two children. Review for the two children is due 2/19. PA called in on 2/6/19 requesting PW coverage for herself. The eligibility worker picks up the PW task on 2/8/19. The review form has not been returned at this point and the come-up month now must be ran for 3/19 in order for the PW to be high dated. This means the RE Run Reason will be required when 3/19 is ran.

When working the PW task the worker determines the request cannot be expedited due to SA not being reasonably compatible. NOA is sent requesting the hard copy of income and the task is put on hold. When the income is returned the review form still has not been received and the discontinuance batch has been ran. The PW determination is completed for the PA, but the worker would need to discontinue the CH's for "Failure to Return the Review." The PW request is unable to be used as an Administrative Review as the income stated in the PW request was not RC and does not meet the requirements.

Example 4: Household of PA and two children. Review for the two children is due 2/19. PA called in on 2/6/19 requesting to add a Deemed Newborn. The eligibility worker picks up the NB task on 2/8/19. The review form has not been returned at this point and the come-up month now must be ran for 3/19 in order for the NB to be high dated. This means the RE Run Reason will be required when 3/19 is ran.

As the worker processes the newborn request it is determined that the current HH income was not provided, but all other information was provided to process the review. The worker contacts the PA via phone and gathers the missing household income which is found to be RC. This allows the review to be completed at the same time as the Newborn request.

Example 5: Household of PA and two children. Review for the two children is due 2/19. PA called in on 2/6/19 requesting to add a Deemed Newborn as of 12/18. The eligibility worker picks up the NB task on 2/8/19. The review form has not been returned at this point and the come-up month now must be ran for 3/19 in order for the NB to be high dated. This means the RE Run Reason will be required when 3/19 is ran.

As the worker processes the newborn request it is determined the current HH income was not provided and the worker is unable to reach the PA on the phone. The NB is added to the case in the months of 12/18 – 2/19 and an NOA is sent to the PA requesting current income. The NB task will be placed on hold with the due date of the discontinuance batch run date. When that date is reached, it is found the review form was returned. The worker at that time process the review for the other two CH's.

F. New Requests During the Review Reconsideration Period

It has been identified that situations where a review is received during the Review Reconsideration Period, following discontinuance for Failure to Return Review, and there is a request to add an additional household member in a future month will cause issues for

the system if the review is rescinded at the same time as the reapply for the new household member.

In these situations, there are two paths depending on which month the review was received.

1. If the review is returned in the month it was due, before the first month following discontinuance/first month of the Review Reconsideration Period, the review must be rescinded first and then the added person can be reapplied. For example, 4/2019 review is discontinued as of 5/2019. The review is returned in 4/2019 with an add person request. The individuals being reviewed must be rescinded first and then the add person must be reapplied.

2. If the review is returned any time during the Review Reconsideration Period, all individuals must be reapplied. For example, 4/2019 review is discontinued as of 5/2019. The review is returned in 6/2019 with an add person request. All individuals must be reapplied. In this scenario the discontinued program persons will need to be reapplied instead of rescinded, and the application date will need to be entered as the first day of the month following the discontinance. The additional household member that was not previously receiving coverage will need to be reapplied with the actual application date. This will allow KEES to continue processing the case without a gap in coverage and all review rules applying. EDBC will not have the RE Run Reason available to select as the rescind function was not utilized and staff will need to manually update the Review/IR Record in KEES. Additionally, the notice will need to be amended to inform the consumer that this has served as their review.

Further processing direction will be included in the KEES User Manual.

G. EXCEPTIONS

On rare occasions, action will be necessary on a case with an expired review period and a review is not necessary. The new edit will prevent some actions unless a review is received and processed. Cases with fair hearing orders are an example. When situations that require such action are encountered, do not run with the RE Run Reason strictly to enable processing. Instead, these cases must be referred to KDHE Policy Mailbox for guidance. Staff shall follow current protocol for submitting case questions to the mailbox.

3. CONCLUSION

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

Vacant, Elderly and Disabled Program Manager -
Jerri Camargo, Family Medical Program Manager - Jerri.Camargo@ks.gov

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