



<b>Policy Memo</b>	
<b>KDHE-DHCF POLICY NO: 2019-11-02</b>	<b>From: Erin Kelley, Senior Manager</b>
<b>Date: Nov 26,2019</b>	<b>KFMAM Reference: 1407.01, 1409, 1409.01, 1409.02, 2413</b>
<b>RE: Policy Implementation Instructions for Removal of Crowd Out and Expedited Pregnant Women Coverage Policy</b>	<b>Program(s): Family Medical</b>

This memo sets forth instructions for policy changes being implemented in December 2019. Unless otherwise indicated, the following implementation instructions are applicable to all eligibility actions taken on or after December 1, 2019. Revisions to the KFMAM manual will coincide with the release of this memo. Additional information related to the implementation of these changes is available through training material released to eligibility staff.

The memo supersedes PM2001-05-01 [Policy Memo: Crowd Out](#).

## **1. CHANGES IMPACTING FAMILY MEDICAL PROGRAMS**

The following changes are applicable to Family Medical programs.

### **A. REMOVAL OF CROWD OUT**

The policy detailing the provisions of ineligibility of three months for children with an FPL 219 – 235% and voluntarily terminated their other health insurance, also known as Crowd Out, is being removed. This change is applicable to all cases processed on or after December 1, 2019.

#### **1. BACKGROUND**

Currently, if a family's income is between 219 – 235% of FPL and the child(ren) had been covered under other comprehensive health insurance and such coverage was voluntarily terminated, there would be an ineligibility of CHIP benefits for a period of three months. This ineligibility period would begin with the month the coverage was terminated. Any family meeting a good cause status for termination of other health insurance were exempt from the ineligibility period.

## **2. NEW POLICY**

As of December 1<sup>st</sup>, 2019 the previous ineligibility period for voluntarily dropping other comprehensive health insurance will no longer be enforced. The removal of the ineligibility period will be regardless of good cause status. This means it is no longer necessary for eligibility staff to contact the household in order to determine if a good cause reason is present.

- a. For requests for coverage received or processed after December 1<sup>st</sup> the new policy will be in effect and no penalty period is established.
- b. Assuming a case is otherwise eligible, any case under an active period of ineligibility due a crowd out penalty shall be eligible for coverage effective December 1<sup>st</sup>, 2019. If a consumer requests a redetermination during their crowd out penalty period and the request for coverage is within 45 days of receipt, a new application will not be needed.

**Example:** Application for CH was received 11/1/2019 and was denied due to Crowd out on 11/10/2019. Crowd Out penalty is applied for the months of 11/2019, 12/2019 and 1/2020. Consumer calls in on 12/5/2019 and requests a redetermination. Since the application was not over 45 days old when the redetermination was requested, a new application is not needed, and coverage can be approved. Normal CHIP start date rules will apply.

To monitor possible misuse of the removal of Crowd Out the state will produce a quarterly report that compares the number of individuals under the age of 19 that were denied due to other insurance and then approved for CHIP within a three (3) month time frame. This report will monitor the percentage of such applicants and if the substitution exceeds ten (10) percent, the state will work with CMS to identify an alternative strategy to reduce the substitution.

## **B. REMOVAL OF EXPEDITED PREGNANT WOMEN BENEFITS**

Current policy outlining when Expedited Pregnant Women benefits are to be issued prior to full verification having been received, is being removed. This change is applicable to all cases processed on or after December 1, 2019.

### **1. BACKGROUND**

The Expedited policy indicates a pregnant woman who applies for medical assistance shall be initially assessed for expedited medical eligibility. This expedited criterion includes meeting the financial requirements based on the self-attestation of income, along with meeting all other non-financial requirements. If this determination is done within ten (10) days of receipt of the request, expedited benefits can be initially approved while a request for any needed verification is sent.

The formal determination of eligibility would then be completed based on normal processing timelines. If the pregnant woman was found to be ineligible at the time of formal determination, the expedited benefits would end allowing timely notice.

### **2. NEW POLICY**

As of December 1<sup>st</sup>, eligibility staff will no longer determine or approve expedited benefits for pregnant women. Pregnant Women requests for coverage shall be required to have all verifications provided, prior to finalizing the determination and are subject to the 45-day processing timeliness standard. However, these requests will still need to be reviewed within ten (10) days of receipt to determine if any additional information is required. If immediate services are needed for a consumer, services can still be accessed by Presumptive Eligibility (PE) Entity if they meet the requirements. Staff will not be sending referrals to the PE Entities.

The priority for pregnant women tasks in registration will not change. Registration staff will still need to ensure these are identified accordingly.

This policy update does not negate the Partial Determination process that was added in the PM2019-01-01 [Implementation of Notice Requirements and Review Processing Edits Memo, for Administrative Reviews requirements](#). If a determination can be made for the pregnant women's month of application but staff are unable to complete a prior medical request or another household members request for coverage, the Partial Determination Process outlined in the memo will need to be followed.

## 2. QUESTIONS

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

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