Policy Memo	
KDHE-DHCF POLICY NO: 2018-03-01	**From: Jeanine Schieferecke, Senior Manager**
Date: March 14, 2018	**KEESM/KFMAM Reference:**
RE: Policy Implementation Instructions for March 2018 Policy and KEES Changes	**Program(s): All Medical Programs**

This memo sets forth instructions for implementation of policy changes specific to the Medical Assistance programs as outlined below. All policy changes are applicable to KEES changes being made in March 2018.

Applicable to all Medical Programs:

- Review Types
- Reasonable Compatibility
- Zero Income
- View Correspondence
- Task Priority
- Document Upload Portal
- New Medicare ID number

Applicable to Family Medical Programs only:

- IBU Changes
- Both Below – Reasonable Compatibility Method
- Partial Approvals

Changes to the KEESM and KFMAM manuals will be effective April 1, 2018. Staff shall utilize this policy memo as guiding policy until the manuals are updated.

Unless otherwise indicated, the following implementation instructions are applicable to actions processed on or after March 18, 2018, which is the date of the KEES updates. For applications, reviews and other case actions currently in progress the income budgeting and verification changes are to be applied at the next EDBC run. However, if income verification is already in Tier 4 and a

request for information has been issued to the applicant/recipient it is not necessary to reevaluate under a previous Tier. For cases that are just reaching Tier 4 and verification request hasn't been sent, the case shall be reevaluated under the new guidance and adjusted accordingly. Note – this means for persons who do not have earned income reported, it will be necessary to add a $0 earned income record to these cases prior to running the Request Verification button.

Regarding the task priority changes, staff are responsible for adding the indicator to any application, review or change currently in flight as needed.

Regarding the changes to support non-parental caretakers, staff must review and update this page and update for any case action on or after March 18.

1. Changes Impacting All Medical Programs

The following changes have an impact on multiple medical programs, though not all changes impact all programs. In the sections below, the programs will be identified as applicable.

A. Review Types

There have been some changes to how the review batch is processed. These changes will improve the frequency of passive reviews and ensure that all programs receive a review. These changes will be effective with the first full Review processing batch following the KEES implementation – this will be the review batch that runs on or about April 15th for reviews that expire May 31, 2018.

1. Breast and Cervical Cancer (BCC)

All BCC programs will now receive a Targeted Review form. These have been hard-coded into the Review Batch to ensure that BCC consistently receives this type, regardless of other program activity that may occur on the case. KEES will generate the *KC1400 Notice of Review – Medical Assistance – BCC Program* and mail along with the Statement of Continuing Cancer Treatment form for completion by the physician. This change will allow staff to no longer manually monitor the BCC program to ensure that all reviews are mailed monthly.

When the household includes an individual receiving BCC along with others receiving medical assistance on other programs, the BCC woman must be established on a separate program block from the rest of the case. Setting up the programs on separate program blocks will ensure that individuals are correctly discontinued in situations where the review is not returned. For cases where the programs currently exist on the same program block, staff will take action to separate onto separate program blocks at the next case action.

Also, clarification is given regarding BCC coverage in relation to the Medical hierarchy. BCC coverage is not available to women who qualify under Caretaker Medical, SSI, or PW. Therefore, a separate program block isn't needed for these women

2. *Long Term Care (LTC) with Earnings*

All LTC programs which contain earned income will receive a Pre-Populated review form. This has been hard-coded into the Review Batch to ensure that these programs do not receive a Passive Review.

3. *Passive Reviews Changes*

Some changes have been made to the Review Type Determination Batch to improve the frequency of Passive Reviews.

Reasonable Compatibility – Currently, a Reasonable Compatibility check is completed prior to executing the review batch. This compares income to the TALX and KDOL files to determine if the income currently recorded in KEES is reasonably compatible. This is used to determine the review type. With this change, he RC batch has now been separated from the Reviews Determination Batch and will run prior to the actual review run. The new RC batch will run for all programs except LTC and SSI. All persons with a role of MEM or FRI on the program will be included. The results of this batch will then be used by the Reviews Determination batch to assign the most comprehensive review. An update to the RC page in KEES has also been made to show the 'Run Reason' (see item (2) below for more information on this new field). This will display as Batch if run by the RC batch. Staff may see this information on the RC page ahead of the actual review batch.

Tax Dependents – A Passive Review is now possible for cases that include a tax dependent residing outside of the home. These tax dependents shall be added as a case person and their income verified. The Household Status shall be set to '*Permanently Out of the Home'* or '*Temporarily Out of the Home'*, whichever is applicable. The '*Claiming Other Dependents Not On Application'* and '*Number of Other Dependents Not On Application*' fields on the Tax Household page are no longer required. These fields should always be left blank to allow the case to be processed as Passive when it meets all other criteria. Eligibility staff shall always review these fields when making updates to the Tax Household page to ensure these fields are blank.

B. Reasonable Compatibility

Changes have been made to both the policy associated with Reasonable Compatibility as well as the system functionality. The Reasonable Compatibility policies apply to MAGI,

Medically Needy, MediKan, MSP programs, and Protected Medical Groups with no Long Term Care.

1. *Reasonable Compatibility Policy*

Reasonable Compatibility is the income verification standard that is used to determine if wages reported by the consumer are generally consistent with information received through a recognized data exchange or other source. If information from the source is reasonably compatible with the customer's statement, additional information cannot be requested. Income amounts from both the customer and the source are converted to a monthly amount for the reasonable compatibility test; and the amounts are compared.

The applicant must provide sufficient information in order to determine the reported monthly income to complete the reasonable compatibility test. In situations where the consumer reports an hourly wage but fails to report the number of hours worked per week, staff shall assume 40 hours are worked per week to determine a self-attestation. When an hourly wage is provided along with range of hours is reported, staff shall use the average of hours reported to determine the self-attested income.

Reasonable compatibility applies to earned income and when zero/no earned income has been reported. See Section 1.D for additional information about changes to the zero earnings policy to support the use of the Reasonable Compatibility test.

Applicable data sources are TALX (The Work Number) and the wage records on KDOL-WAGES. The average of monthly income in these sources will be used in comparison to the reported income to determine if the income is reasonably compatible and therefore deemed to be verified.

There are two reasonable compatibility tests that are conducted; an individual test and a household-level test. Initially each individual in a budget unit (regardless of household status) has their income tested to determine if their income is reasonably compatible. For Elderly and Disabled programs, this is the only reasonable compatibility test completed. If income is not RC, then staff will proceed to Tier 3. However, for Family Medical programs, after the completion of the individual test, each individual in a budget unit (regardless of household status) will have a reasonable compatibility test conducted against their entire IBU.

a. Individual Reasonable Compatibility Test

Each individual's income is evaluated to determine if it is reasonably compatible. KEES evaluates reasonable compatibility in the order specified below. Reported earned income is considered reasonably compatible when one of the following reasons apply.

- No earnings were reported and both data sources do not return any earned income or
- The amount of earnings reported by the customer is greater than the amount received from one data source for the applicable time frame, or
- The amount of earnings reported by the customer is within 20% of the amount received from one data source for the applicable time frame.

Note: For individuals with no earned income reported, the record will be considered verified if there is a successful connection with the data source. There is no requirement that the data source return a '$0' record, as it is unrealistic for a person without income to have a hit with TALX or KDOL. If the record successfully matches with the data source it will search the data source for an earnings record. The record is considered unverified if the connection is unsuccessful.

For Elderly & Disabled programs, if not RC, proceed to Tier 3 verification. For Family Medical programs, KEES will automatically proceed to the Household Reasonable Compatibility test described below.

b. HOUSEHOLD REASONABLE COMPATIBILITY TEST – BOTH BELOW

For Family Medical programs only, after the individual income test is completed, each applicant's IBU will be evaluated for reasonable compatibility. The Household RC Test determines if both the amount reported by the consumer and the amount received from at least one data source are below Medicaid income limits for the applicant. This is known as '*Both Below'*; *BOTH* self-attestation and income from the data source are *BELOW* Medicaid. For this RC test, all income in an individual's IBU is used to determine if it is below the applicable income limit for that person. When the applicant is determined to be Reasonably Compatible due to Both Below – no income verification is required to complete their determination. They are eligible to receive Medicaid without asking the consumer to provide additional verification of income. See Section 2.B. for more information about the 'Both Below' reasonable compatibility determination.

2. REASONABLE COMPATIBILITY DETAIL PAGE

The Reasonable Compatibility Detail page in KEES has been updated to provide additional information to staff about the Reasonable Compatibility Test. When an RC test is completed, the results will now display the following additional information:

- KDOL-WAGES Quarter used
- TALX date range used
- Verification Source identifies the source of the Reasonable Compatibility verification (KDOL, TALX, etc.). When KDOL and TALX is called, a connection

made, and no data in the systems can be used, a new result of "*No Useable Data Found"* will be displayed.

- Method that the income qualified as reasonably compatible – One of the following reasonable compatibility reasons will display to alert staff to the methods used to confirm both the individual and household level test:
    - No Income Reported
    - Self Attested > Data Source
    - Within 20% Tolerance
    - Both Below (Family Medical Only)
    - No Income Reported & Both Below (Family Medical Only)
    - Self Attested > Data Source & Both Below (Family Medical Only)
    - Within 20% Tolerance & Both Below (Family Medical Only)
- Run Reason - This new field identifies an EBDC run by a batch vs an EDBC run by a worker

3. *TALX DATA*

When KEES uses TALX data to complete the reasonable compatibility test, it will use the most recent 30 days of active earnings that exist within the acceptable timeframe for earned income verification. Active earnings are defined as income with an Employer Status of Active, Part Time, or Leave. For applications, the acceptable timeframe is defined as up to three months prior to the month of the application. For reviews and income changes, the acceptable timeframe is defined as three months prior to the month the RC test is run through the final processing date.

The RC test identifies the 30 days of TALX wage verification to use by selecting an 'Anchor Date'. When the Request Verifications is run, KEES will access the TALX data and find the date of the most recent paycheck. That check date becomes the anchor date. All paychecks within the 30 days prior to this date are selected and used for the determination. The checks are averaged and converted based on their TALX frequency and compared to the KEES Income amount to determine if the income is reasonably compatible. This 30-day date range is displayed on the Reasonable Compatibility Detail page.

Example 1: On 3/22/2018, eligibility staff are processing an application received on 1/18/2018. They request verifications on 3/22/2018. TALX could pull checks within the date range of 10/1/2017 through 3/22/2018 (the three months prior to the application month through the current date). TALX locates a check received on 3/16/2018. This becomes the anchor date, and KEES will pull all checks within the 30 days immediately prior to 3/16/2018. The date range used will be displayed on the Reasonable Compatibility Detail page.

Example 2: On 4/15/2018, KEES runs the RC batch for the May 2018 reviews. TALX could pull checks within the date range of 1/1/2018 through 4/15/2018 (the three months prior to the run date through the current date). TALX locates a check received on 4/6/2018. This becomes the anchor date, and KEES will pull all checks within the 30 days immediately prior to 4/6/2018. The date range used will be displayed on the Reasonable Compatibility Detail page.

4. KDOL –WAGES DATA

When KEES uses KDOL data to complete the reasonable compatibility test, it will use the more recent of the two prior quarters of wage data. For example, if checking verifications in March 2018, this is within the 1st quarter of 2018; the two prior quarters are 3rd and 4th quarters of 2017. If wages exist in the 4th quarter of 2017, these will be used for the reasonable compatibility test. If no wages exist in the 4th quarter, but wages exist in the 3rd quarter, these wages will be used. The quarter used will be displayed on the Reasonably Compatibility Detail page.

Because KEES will now use the two prior quarters, it is no longer necessary to use the Manual Reasonable Compatibility Tool for this purpose. This eliminates the need for Policy Directive 2017-04-01. At this time, the Manual Reasonable Compatibility Tool shall only be used if the KEES RC test fails to execute, or an issue occurs and the KEES Helpdesk instructs staff to use the Manual RC Tool.

5. RC TEST FOR INCOME CHANGES AND REVIEWS

A change has been made to the way in which KEES determines reasonable compatibility when an income change has been reported. This will be applicable when processing a review or an income change reported mid-year. When KEES determines the income records to compare to the data sources, it will now select only high-dated income records/income amounts. This allows staff to eliminate a workaround which had been used to ensure that the RC test was performed against the newly reported income, rather than income that existed in the system but was being end-dated because it no longer existed.

Example 3: An income change is reported on a March 2018 review received on 3/3/2018, which is updated on the case for the month following the month of report. The old income will be end-dated 3/31/2018 as this is the last month it shall be used in the determination. The new income record has a begin date of 4/1/2018. When requesting verifications and completing the RC test in the calendar month of March, the system will now select the new high-dated income record with a start date of 4/1/2018 as the income needing to be verified.

C. Verification Policies

Changes to the Reasonable Compatibility test also will result in changes to how the tiers are used when verifying wages and zero income. Additionally, clarification is being provided for some of the verification policies.

1. Approving Coverage with Unverified Income – MAGI Only

Due to the implementation of Both Below, applicants may be approved for a MAGI program when income remains unverified. When an applicant's IBU meets the Household RC Test for 'Both Below' and there is no other information, other than income, that is still pending, these individuals are eligible and should be approved for Medicaid. In these situations, it will not be necessary to verify the income prior to approval. This is further explained in Section 2.C Partial Approvals.

2. TALX - Tier 3 Changes

When wages are not Reasonably Compatible in Tier 2, staff shall proceed to verifying the income in Tier 3. Because KEES now calculates a converted monthly income from the most recent 30 days of earnings in TALX, it is no longer necessary for staff to manually access The Work Number website to obtain the paycheck information. Staff will now obtain the TALX Monthly Income Amount from the Reasonable Compatibility Test Detail page and use this for the determination. The existing income record which contains the self-attested income amount shall be updated to include this amount with a Verification Source code of '*Other*'.

3. Returning to a Previous Tier When Verifying Information

When a new self-attestation is received or when an administrative error is made, it is acceptable to return to a prior Tier to verify information. This would include returning to Tier 2 to attempt verification through Reasonable Compatibility or returning to Tier 3 if staff had inadvertently moved to Tier 4.

Even when a Reasonable Compatibility test has already been completed in Tier 2, staff may return to Tier 2 to repeat the reasonable compatibility test when clarifying information with a consumer verbally and the consumer provides new information. This policy is applicable when a new self-attestation is received.

Example 4: A Reasonable Compatibility test is conducted based on information provided by the applicant. Income is not reasonably compatible. While on the phone with the consumer explaining that a notice will be sent to request proof of income, the consumer indicates that their income has changed. A new self-attestation is obtained and the staff will repeat the RC test using the new information. If the income is still not reasonably compatible, staff will proceed to Tier 3.

Example 5: Eligibility staff requests proof of income from the consumer. After the information is received, another staff member identifies that there was available TALX data in Tier 3. Even though additional hard copy verification has been provided, staff shall return to Tier 3 and use the TALX data as this is higher in the Tier 3 hierarchy then using hard copy documentation.

4. PROOF OF END OF INCOME

The following policies outline how the Family Medical and E&D programs handle the report of the end of an income source.

For Family Medical Programs, proof of the end of income is only required in the following scenarios:

- Individual is a CHIP premium-payer and reports a reduction/elimination of income.
- TransMed or Extended Medical recipient reports a reduction/elimination of income.

In all other situations, a verbal indication of the end of the employment is acceptable. It is not necessary to get proof of the last date of employment.

For Elderly and Disabled Medical Programs, income changes trigger a redetermination of eligibility. Verification is required when processing a review or case change where the consumer has reported a source of income has ended. Verification is not requested of the consumer if information related to the end of unearned or earned income can be obtained through an appropriate interface. In situations where verification is requested of the consumer, failure to provide verification that unearned or earned income has ended as outlined below shall result in discontinuance.

- Unearned Income: For all Elderly and Disabled Medical programs, verification is required when an ongoing recipient reports a source of unearned income has ended.
- Earned Income: Verification is required as follows when a consumer reports a source of earned income has ended:
    - For Medically Needy (MDN), MediKan, Medicare Savings Programs (MSP – QMB, LMB, and ELMB), and Long Term Care (LTC), proof of the end of earned income is required when an ongoing recipient reports earned income has ended.
    - For Working Healthy recipients, communication with the Working Healthy Benefits Specialist is necessary as they are responsible to determine

when employment ended and whether a Temporary Unemployment Plan is needed.

In all other situations, a verbal indication of the end of the employment is acceptable. It is not necessary to get proof of the last date of employment.

5. *Prior Medical Simplification*

For Family Medical programs, a change is being made to the prior medical simplification policy due to updates made to the Reasonable Compatibility Detail screen in KEES. It is no longer necessary for a worker to research KDOL WAGES manually to complete the prior medical simplification following the new policy stated in KFMAM 6132.01. If the Reasonable Compatibility test returns a result of 'Both Below' as per section 1.B.1.b of this memo, and KDOL wages have been returned and are below the Medicaid income limits, this amount shall be used to determine Prior Medical eligibility. This is regardless of how many sources of employment have been reported. However, if only a TALX amount has been returned or if KDOL is not below the Medicaid income limits, actual income must be used to verify prior medical income as per KFMAM 6132.02.

6. *Collateral Contacts*

This memo clarifies policy regarding the use of collateral contacts. A collateral contact is a direct contact with a third party (e.g. employer, organization, agency, private party) to verify information from the applicant/recipient. A collateral contact may also be necessary when information is not provided, when information is missing or when information is not clear.

Usually a collateral contact is made over the phone, but can also occur in person or through email. When making a contact via email the communication must be secure. Staff must always ensure the emails sent outside of the state network are appropriately encrypted. Most collaterals will not provide information without receiving a release of information. A copy of the last page of a signed application may be faxed or securely emailed to the contact if needed. Or, staff may conduct a three way call by ringing the applicant/recipient and asking the individual to provide verbal consent to the collateral.

Staff are given considerable flexibility when using collateral contacts. Although the use of collateral contacts is not required for every situation, it is a valuable verification tool that can be used to shorten case processing time and improve accuracy. The practice is encouraged. In general, contacts are made for very specific information that can be quickly obtained. However, staff must also use professional judgement when making collateral contacts. If additional information is disclosed while conducting the call, the staff person must decide if it may be relevant to the determination and be prepared to ask additional questions. Careful and complete documentation is always required.

a. TIER 3 VERIFICATION

A collateral contact is a Tier 3 verification source. Meaning other sources, including data sources, are used before a collateral contact is made. Information gained through the collateral contact is used for the determination as reported by the contact. If the information differs from that reported by the consumer, it replaces the consumer attestation.

For example, an applicant reports she makes $11/hour and works about 30 hours per month. The employer is contacted and reports the applicant actually works about 40 hours a month. Because the case is now in Tier 3 for income verification, the case is budgeted using 40 hours a month.

b. NEW INFORMATION OBTAINED THROUGH A CONTACT

Although new policy allows reentry to a previous tier in certain situations, this would rarely happen as a result of a collateral contact. However, if the agency becomes aware of new information while making a collateral contact, it may be necessary to run the new information through the tiers. Some flexibility exists if the collateral has obvious knowledge about the new information. Careful and complete documentation is required.

For example, an applicant reports a pension of $350/month. While making a collateral contact to verify the income, it is reported the payment is reduced by a 'life insurance payment'. There is no report of a life insurance policy on the application and it must be verified. The life insurance policy will require verification through the tiers. However, a worker should exercise prudent person judgement and ask the third party for additional details regarding the life insurance policy. If the necessary information is provided by the third party this could be used for the determination.

c. GENERAL CONSUMER CONTACT

Do not confuse a collateral contact with general consumer contact. Consumer contact may occur any time throughout the life cycle of an application or a case. Some contact reasons, such as to verify who is applying for assistance or to confirm an illegible address do not require a tier reference, but are necessary in order to determine how to process the application. However, when actual consumer contact is necessary to complete verification of an element, this falls to Tier 4. For example, a phone call is made to a consumer to confirm the date income ends for a family medical case.

d. NECESSARY INFORMATION

An item is considered verified via collateral contact if the staff person receives sufficient information to satisfy the verification requirement. This means enough

information must be obtained to properly record the information in KEES. The level of detail depends on the specific element. Any element verified via collateral contact should always be logged as a Tier 3 verification in the journal.

• For earned income, at attempt to verify the information in the same manner as reported by the consumer is attempted first. For example, if the client attested to 50 hours a month and $10.00/hour, this is presented to the employer. If the employer is not able to confirm this, the worker could represent the attestation as a weekly amount (about 12 hours a week in the example above). If the client did not provide a usable attestation on the application, the worker would usually ask for the consumer's representative wages for a typical pay period. These would be recorded in the KEES system with a verification type of 'Collateral Contact'

• For unearned income, staff shall ask for the gross amount per month and the frequency paid. If payments are received on a frequency other than monthly, obtain the information for the last payment if it is representative of the normal benefit. This information is recorded in KEES.

• For health insurance premium expenses, it is important to verify the type of coverage, who is covered as well as the amount/frequency of the premium.

• For other medical expenses, it is not recommended that staff attempt verification of a medical expense without some information from the consumer. It would be necessary to obtain information regarding the type of services, the date of service, insurance payments, etc. However, a collateral contact is very effective when verifying a specific element. For example, the amount of a bill that is still due and owing or the amount of a bill that is actually the responsibility of the client. Again, enough information to record the expense in KEES is required.

• For resources, hard copy verification is required of most resources when establishing initial eligibility. However, a collateral contact can be a very effective method to clarify certain elements. For example, clarifying ownership/title of personal or real property, dates of transfers or critical transactions or even to confirm a low balance on an account. Again, sufficient information to properly record the resource in KEES must be obtained.

7. Real Time Interface History Response

With the addition of Reasonable Compatibility updates, clarification is being added to the Real Time Interface Responses for KDOL and TALX. When a call to KDOL WAGES or TALX has failed, meaning no connection has been made, KEES will now display the following message when KDOL or TALX has failed to connect: ***Error: Request Failed***

When an eligibility worker sees this message, this indicates the connection to the interface was not completed. Workers should submit an incident ticket to the KEES Helpdesk so the connection issues can be researched. If one interface was able to connect and make a positive RC determination, then no further RC action is needed. If the RC determination resulted in a "NO" then a manual check of the failed interface may be needed, in order to complete a manual RC test. If both interfaces failed to connect, a manual RC test will need to be completed followed by the remaining Tiered verification methods if not Reasonably Compatible.

D. Zero Earnings

As noted above in Section 1.B.1., changes are being implemented to the policies for processing medical assistance requests when there is no or zero earnings. The following policies are applicable to all medical programs, and where specific rules differ depending on the program, these are noted.

Verification of earned income is required for all individuals, whether or not earnings have been reported. KEES has been modified to allow us to check earned income data sources for all individuals. This allows us to verify reported earnings, but also lets us check those same data sources to ensure that no unreported wages are found. This policy is applicable to all individuals who do not report earnings, report non-wage income only, such as self-employment or unearned income, or fail to answer questions about their income. Earned income sources are also checked for children. Even though most children will not have earnings found, this income test is a necessary element of the 'Both Below' Reasonable Compatibility test.

1. KEES Evaluation of Zero Earnings

There are two different methods by which KEES evaluates zero income. This is through the use of a 'No Income Reported' income verification record or a $0 earned income record. Either record type results in the individual being checked on KDOL-Wages and TALX and the completion of a Reasonable Compatibility determination.

. No Income Reported

KEES automatically establishes the 'No Income Reported' verification code through the e-app process based on how income questions are answered on the application. When the response to the income question is left unanswered (blank), a 'No Income

Reported' record is created in KEES if there is not a current income record in KEES (End Dated or High Dated) for the individual. The '*No Income Reported*' is generated through any e-application (SSP, FFM, Worker Portal). The 'No Income Reported' verification record is viewable on the Verification List page. It cannot be manually created by staff.

Note: Because KEES automatically creates this verification code based on information reported by the consumer, it is critical that income records are created appropriately as part of the data entry process.

a. $0 EARNED INCOME RECORD

In situations where an individual, including a child, has NOT reported earnings and KEES has not created a 'No Income Reported' record, staff must create a $0 earned income record. This will provide staff with the necessary verification item in order to Request Verifications and complete the Reasonable Compatibility Test. When creating the $0 earned income record, it is not necessary to select an employer record.

c. MANAGING RECORDS

Persons with either a $0 Earned Income record or a No Income Reported record require specific case management processes to ensure verification and budgeting are correct. If these processes are followed, KEES outcomes should be correct and minimal intervention will be needed.

- Both $0 Earned Income and No Income Reported individuals will have a Reasonable Compatibility test completed to confirm that no earnings are found. The Verifications List page will display a pending 'No Income Reported' Verification type, or a pending 'Income' Verification type. This means that an eligibility worker must ensure theses Verifications are dealt with properly in order to make an accurate determination. These verification types will be selected and verifications checked using the Request Verifications button.

- When an individual has a 'No Income Reported' record, and later income is reported for this individual, before the No Income Reported has been verified, staff must create an income record for the individual based on reported information. This provides the necessary verification in order to Request Verifications and complete the Reasonable Compatibility Test. Even though the Income record was created, the 'No Income Reported' verification will not disappear. Staff will need to mark this verification status as 'Not Applicable' using the Edit functionality on the Verifications List screen in KEES.

- After requesting verifications, the results will display on the Reasonable Compatibility Detail page.

2. *REQUEST VERIFICATIONS – NO INCOME FOUND*

When both TALX and KDOL interface checks are successful and neither identify the existence of wages, this is considered as verifying the $0 income or No Income Reported record. The income is marked as Reasonably Compatible with the reason of 'No Income Reported' and the record marked Verified. For the $0 income record, both the income record itself and the verification type will be marked as Verified. For the No Income Reported situations there is no actual income record, so only the verification type is marked as Verified.

3. *REQUEST VERIFICATIONS – INCOME FOUND*

If TALX or KDOL interfaces return any income amount greater than $0, the income is considered to NOT be reasonably compatible for no income. For family medical programs, the Household RC test is conducted to evaluate if any applicant is 'Both Below' as defined above in Section 1.B.1.

For E&D Medical Programs, the income is not reasonably compatible and staff will evaluate the income found using the chart below.

For Family Medical Programs, before evaluating the income found, staff will first determine if the income requires verification. If all applicants are Reasonably Compatible in the Household Both Below test, then verification or research of the income found is not necessary. If one or more applicants is not RC with Both Below, then staff will evaluate the income found using the chart below.

Note: In situations where TALX and KDOL data is returned, the TALX section should be followed.

TALX returns wage information	Evaluate the TALX check dates returned on the Reasonable Compatibility Detail page. If the latest check date is older than 30 days, this is indicative that there has been a change in income. No further research is needed. Mark the record as verified. If the latest TALX check date is within the last 30 days, the existing income record shall be updated with the TALX Monthly Income Amount from the Reasonable Compatibility Test Detail page. This amount is used for the determination. For programs *NOT* using MAGI Income Budgeting: Reasonable Compatibility is not applicable. Actual income verification is used.

No TALX, KDOL 2nd previous quarter only	No further research needed. Mark the record as verified.
No TALX, KDOL 1st previous quarter	Complete the following steps: • Evaluate the application for an explanation or indication of a recent job loss. If explanation found, no further research needed. Mark the record as verified. • Review KDOL manually to look for an indication of a job loss, which is often shown by a dramatic drop in wage amount in one quarter. Using prudent person, staff can determine that further research is not needed. Mark the record as verified. Thorough documentation of the decision is required. • If no explanation found, contact with the consumer is required. • Proceed to Tier 4 to contact the consumer and inquire about the employment found. A verbal indication of the end of the employment is acceptable. It is not necessary to get proof of the last date of employment. A verbal statement of the last day or estimated last day is acceptable, as indicated above in Section 1.C.4. • When the individual indicates that the employment is ongoing, obtain a verbal self-attestation and return to Tier 2 to re-attempt reasonable compatibility. If not reasonably compatible, continue to Tier 3 to attempt verification by locating images in the medical or non-medical case file. If unable to verify in Tier 3, proceed to Tier 4 and request verification.

4. Request Verifications – Interface Checks Unsuccessful

In situations where the interface checks with TALX and KDOL are not successful, additional steps are required to verify the zero earnings. Reasons for an unsuccessful interface check can vary, but may include the following: SSN not provided, invalid SSN, KEES error, or Interface not accessible.

Note: In situations where the SSN has not been provided, it may be possible to obtain the SSN from the consumer in order to perform the interface checks in Tier 2. An SSN is not required for individuals not requesting assistance. Therefore, if asking a household member to provide their SSN in order to check interfaces and ease the application process, the following phrase must be used in the request.

"Household members who are not applying for medical assistance do not have to give their SSNs. But if you give your SSN, the process may go faster. We use SSNs to check income and other information to see who qualifies for medical assistance."

The following chart outlines the steps required depending upon whether or not an SSN has been provided and if the consumer has self-attested to no income or another source of income. The situation is handled differently when the consumer has left income questions on their application blank.

SSN	Next Steps
SSN not provided	Evaluate the case to determine if the individual has self-attested to not having earnings. It is considered self-attestation if the consumer has answered NO to the question 'Does this person have income', wrote $0 in income sections, or otherwise has indicated they do NOT have earned income. If self-attested to no earnings - accept the self-attestation. No further research needed. Mark the record as verified. If no self-attestation and the individual is under age 16, assume $0 income is correct and mark the record as verified If no self-attestation and the individual is age 16 or over, verbally obtain answers to income questions. • If self-attest to $0, then accept self-attestation and mark the No Income Reported as verified. • If indicate that income does exist – move to Tier 4 and request proof. If unable to reach consumer verbally, send verification notice using 'Unanswered Income Questions' notice fragment. Ask for answers to income questions and proof if income exists.
SSN provided	Check KDOL and TALX manually. If both KDOL and TALX confirm no income, then the income is considered Reasonably Compatible. Mark the record as verified. If TALX shows an Active, Leave, or Part Time Pending income record in the timeframe that is defined in Section 1.B.3, the income is NOT verified. Proceed to Tier 3 and create and/or update the income record using the wage verification from the most recent 30 days which has been found in TALX. If TALX does not return income, but KDOL returns income in the

SSN	Next Steps
	quarter prior to the current quarter, the income is NOT verified. ***Note:*** Income returned from the 2nd prior quarter is not considered. If this is the most recent quarter returned, no further research is needed. Mark the record as Verified. Proceed to Tier 4 to contact the consumer and inquire about the employment found. A verbal indication of the end of the employment is acceptable. It is not necessary to get proof of the last date of employment. A verbal statement of the last day or estimated last day is acceptable. When the individual indicates that the employment is ongoing, obtain a verbal self-attestation and return to Tier 2 to re-attempt reasonable compatibility. If not reasonably compatible, continue to Tier 3 to attempt verification by locating images in the medical or non-medical case file. If unable to verify in Tier 3, proceed to Tier 4 and request verification. ***Note****:* When checking KDOL/TALX manually, the information found shall be imaged to the case.

The changes made to verifying the report of no earnings against earned income sources does not change the existing policies which exist for Family Medical and E&D programs in regards to checking other income sources.

For Family Medical programs, EATSS is only checked for income when the individual reports SSA income or there is an indication of disability or previous SSA income. EATSS may be used to verify SSN for applicants only when verification of the SSN through the Federal Hub fails, and 'Good Cause' shall be selected as the Verification code. See Policy Directive 2016-09-01 for additional details. BARI is only checked for income when the KDOLUI interface has found unemployment activity for an individual. This is identified by a KDOLUI 'Verified' response on the Real Time Interfaces page.

Note: Additional information about KEES Verifications can be found in the KEES User Manual.

For Elderly & Disabled Medical programs, EATSS is checked for income for all applicants. EATSS is also checked for the spouse if the spouse is age 62 or older or if there is an indication of disability or previous SSA income. EATSS may be used to verify SSN for applicants only when verification of the SSN through the Federal Hub fails, and 'Good Cause' shall be selected as the Verification code. BARI is only checked for income when the KDOLUI interface has found unemployment activity for an individual. This is identified by a KDOLUI 'Verified' response on the Real Time Interfaces page.

E. CUSTOMER VIEW CORRESPONDENCE

Additional information is available through the Customer Self Service portal after the March release. Consumers who have an SSP account linked to an active Medical or Non-medical case will have the following added functionality:

- Receive an e-mail to their personal e-mail address when an electronic notification is available in their SSP Message Center,
- Receive electronic notifications sent from KEES to their personal SSP Message center,
- Ability to access and view their KEES Correspondence (NOAs and Forms) on the SSP as attachments to their SSP messages.

Note that other self-service activity, such as checking benefits and coverage levels, completing reviews and reporting changes will be available with a future release.

1. SSP ACCOUNT

Only persons with existing SSP accounts or newly applying individuals will have access to these features. In order to have access to the new features, the SSP user must have their SSP account 'linked' to their case. Staff can see accounts linked to the case by viewing the 'All SSP Users Linked to this Case' section at the bottom of the Case Summary page.

It is absolutely critical that ALL STAFF pay extremely close attention to individuals listed on this section. If you see an account linked, it means the holder of the account has access to case information on the SSP; most notably for this release will be the NOA's and forms sent on the case. If an account is incorrectly linked to a case, the information is at risk for a HIPPA violation.

a. APPROPRIATELY LINKED ACCOUNTS

All staff are responsible for ensuring an SSP account is appropriately linked to a case. Review of the SSP Users block on the Case Summary page should become a routine step when evaluating any case situation. Except for those rare, specific instances involving an Administrative Role noted below, only persons who are case participants can hold an account. Staff shall evaluate each account holder to determine if they are appropriately linked.

An account is considered appropriately linked if the SSP User listed is an adult on the case who is still considered part of the household. The adult is part of the household if s/he is designated either In the Home or Temporarily Out of the Home or is the Community Spouse of an LTC recipient. Staff shall compare the personal information of the account holder to the persons on the case to determine if the SSP User is actually part of the case. Prudent person is used to make the determination, but guidelines include:

- The SSN of the account holder matches with an allowable adult

- The Full Name matches with an allowable adult
- A partial name matches and the birthdate is the same of an allowable adult

Other account information that convinces the staff person the account holder is an active adult on the case.

Staff should error on the side of caution when making these decisions. Unless the staff person is convinced the account is appropriately linked, action to delink the account is necessary. This should be initiated without delay to reduce the risk of a violation.

b. ADMINISTRATIVE ROLES

Special concern is noted for account holders who are not case persons – such as Medical Representatives or Facilitators. In rare situations, it is possible to allow an admin role to be a linked SSP User. However, staff must take extreme caution when making this determination.

Persons are only allowed to be a linked SSP User if they are properly appointed by the applicant/recipient and an appropriate authorization must be on file for the individual to act on behalf of the consumer. This means all of the necessary paperwork to secure the appointment must be received, easily verifiable and clearly stated. Only persons with a role allowing them to act for the beneficiary will be allowed - Medical Representatives, Guardians and other similar roles. Facilitators are not considered appropriate account holders at this time. Staff are not expected to do extensive research to verify a questionable situation. Unless convinced, request the account be delinked.

Please note that KDHE intends to allow additional roles to access the SSP in the future. This policy is in place for the initial implementation.

c. CURRENT ACTIVE ACCOUNTS

All SSP accounts that are linked to an active case will have the ability to view case information through the SSP beginning March 18. There are currently thousands of active SSP User Accounts for medical programs. Although most accounts are linked to an appropriate case, action must be taken to delink those accounts that are incorrectly linked.

As indicated in the KEES Dispatch a HelpDesk ticket must be created to delink an SSP account from a case. To reduce the risk of inappropriate release of information, a mass delinking effort is planned. This will delink all cases where the personal information listed on the SSP account does not match at least one active adult listed on the case. This effort is currently

under development and staff will be notified when the mass delinking is executed.

Following this one time mass delinking effort, staff are responsible for noting when an SSP account must be delinked from a case. All staff are responsible for recognizing these situations and making the request for the delinking action. Changes can happen any time; examples include an adult who leaves the home, the appointment of a new medical representative or a similar change.

d. CREATING NEW ACCOUNTS/LINKING

Currently, only new applications coming from the SSP will be linked to a case. It is not possible to link an SSP account to another case or set an existing case up with a new SSP User ID. That functionality will come in a future release. So, once an SSP account is delinked that account cannot be relinked to that case. The functionality that will allow re-linking and new linking is expected to be available in the future.

e. NEW REGISTRATION PROCESS

Current registration business processes create a high risk for inappropriate linking of a case. When a new application is received through the Self-Service Portal, the SSP account tied to that app is automatically linked to that KEES case. This means an application could have been submitted by an individual without proper authority to have confidential information of the applicant.

A new process is put in place to reduce the risk of a confidentiality violation. Registration staff will now be responsible for viewing the account information on the Case Summary page. If it does not match an existing adult on the case who has a status of '*In the Home'* or '*temporarily out of the Home'*, registration staff shall generate a delinking request (see Section e below). This same process will be followed for Medical Representatives and other Administrative Roles. If the appropriate documentation is not readily available, the account is to be delinked. All Facilitators will be removed at this time. These other administrative roles are expected to have enhanced access with a future KEES release and processes will be updated at that time.

Even though this step is being included within the registration process, eligibility staff are equally responsible for ensuring an SSP account is linked to an appropriate case. Eligibility staff must be especially cautious for cases that go through No-Touch registration as these will not be screened by registration. Also at high-risk are case maintenance actions, especially those

where individuals are moving in and out of the home. Staff must journal any action taken to remove a User ID from a case.

f. HELP DESK TICKETS/IMPACT ON CASE PROCESSING

As indicated above, a HelpDesk Ticket must be created in order to delink an SSP account from the case. Normally, the creation of a HelpDesk ticket would require a case be placed in 'On Hold' status and processing would cease until the issue was resolved. However, for these delinking actions it is not necessary to hold up case processing while a HelpDesk ticket unless the action results in the generation of a notice or other correspondence. This means a case can proceed through normal processing but must be placed in 'On Hold' once a notice is required. A notice should not be generated with an inappropriate SSP account linked to the case.

Staff should always make a journal entry when an account delink is requested. Use the following language:

A ticket was submitted to KEES HelpDesk for the de-linking of (Insert SSP account holder's initials).

KDHE Policy is currently working the KEES HelpDesk to develop a special process to indicate 'high priority' tickets, such as delinking requests, and this will be communicated through the Dispatch or similar method.

2. *VIEWING CORRESPONDENCE*

The most notable feature of the SSP enhancement is the ability for a consumer to view NOA's and Forms online through the Self Service Portal. Any notice or form that is sent on or after March 18 will be available to view on the SSP. Correspondence sent before that date will not be available on the SSP.

Documents will be visible once the Distributed Document status has changed from "Pending Print Central" to "Printed Centrally" or is sent to "Printed Locally".

3. *PERSONAL E-MAIL MESSAGES*

Consumers who provide a valid email address at the time they set up their online SSP account will begin receiving communications through this method in addition to the copy mailed to their physical/mailing address. When a valid-email address has been provided, the consumer receives an e-mail message that notifies them they have information waiting for them online in their SSP Message Center. The e-mail does not provide any case-specific information. Consumers must login to their Medical or Non-Medical SSP account to view the messages in their SSP Message Center.

Emails are sent when the status of KEES Correspondence (NOAs or Forms) in Distributed Documents has changed from “Pending Print Central” to “Printed Centrally” or the initial change to “Printed Locally”. This will be for every KEES Correspondence (NOAs or Forms) that is sent.

In addition, a daily batch identifies consumers with an unread SSP message and sends them a follow-up email to alert them of the unread message awaiting their review in the SSP Message Center. Below is a table, which lists the e-mail messages that a consumer will receive.

Agency	Subject	Message Body	When Message Occurs
KDHE	Medical Consumer Self-Service Portal – New Message	New information is available online. Click here to login to the Medical Consumer Self-Service Portal to view your message center inbox for more details.	NOA or Form sent to consumer in KEES, either ‘Printed Centrally’ or ‘Printed Locally’.
Both (DCF & KDHE)	Kansas Self-Service Portal – New Message	New information is available online in your Self Service Portal account. Click here to login to the Medical Consumer Self-Service Portal to view your message center inbox for more details, or Click here to login to the DCF Self-Service Portal to view your message center inbox for more details.	The SSP Messaging Batch runs and identifies a message which remains unread. This batch identifies only messages from the prior day that remain unread.

a. Updating an Email Address

The email address in KEES for the Primary Applicant is the email used to communicate with the consumer. If a consumer needs to update the email address they can report the new email address to the KanCare Clearinghouse and it can be updated on the Primary Applicant’s Individual Demographics page. If the change is being reported to the Call Center or

other Clearinghouse staff via a phone call, staff should advise the consumer to log in to their SSP Account and update their SSP account email address as well. The email address for their SSP account will not be automatically updated by changing it in KEES.

4. SSP Message Center

The online SSP Message Center is a secure site where electronic notifications are stored, accessed, and viewed. Consumers must login to their SSP account to view their SSP messages via the SSP Message Center. The SSP messaging functionality is used to alert Consumers of when it is time to take action on their case, actions that have been taken on their case, or when KEES Correspondences (NOAs and Forms) are sent. The SSP Message Center is shared between both the Medical and Non-medical SSPs, therefore a consumer will see both Medical and Non-Medical messages in their SSP Message Center. The messages will remain in the Message Center inbox for 14 months from the date received.

The following Table includes the Medical messages designed to be sent to the consumers' SSP Message Center and the triggers for each message. Consumers will also receive messages from DCF about Non-medical reviews and change reporting.

Agency	Subject	Message Body	When Message Occurs
KDHE	Application Details	Thank you for submitting your application. Click on the attachment to review a copy of your application.	Medical SSP application submitted.
KDHE	Correspondence Sent	You are receiving this message because a notice has been sent to you about your Medical assistance. For more details, click the attachment to view this notice.	NOA or Form sent to consumer in KEES, either 'Printed Centrally' or 'Printed Locally'.

F. Task Priority

With the implementation of CR 756- Track Task Priority Changes, KDHE Central Office and the KanCare Clearinghouse staff will now be able ensure accurate reporting on the

timeliness metrics of the Clearinghouse Contractor. The updates made will also allow for better, more efficient and timely distribution of high priority work.

1. *Priority Date*

A new data element has been added to the system, which allows for tracking the updates made to the Priority Status of a Task, e-Application and Review. This new 'Priority Date' data element is not a user enterable field and is defaulted to blank until a Priority is added or removed, at which point it is auto populated based on the date the 'Priority' field is adjusted. The field is also automatically populated by the system during system task creation, if applicable. The history of the changes to the priority status are stored in KEES but are not visible to the user, they will only see the status and the date of the most recent change.

In addition to 'Priority Date' a 'Priority' field was also added to the e-Application Summary and Medical Review and IR/12 month Detail Pages. These fields allow staff to adjust the priority of e-Applications and Reviews. This is used for Reporting purposes and does not auto update the Priority of Tasks.

When an application is identified as needing a priority status, staff must update both the associated task and the e-application records to the new priority. When a review is identified as needing a priority status, staff must update the associated task, Review and IR/12 month record, and if the review was submitted via an application form, the e-application record must also be updated.

2. *Pages Impacted*

The 'Priority Date' field was added to the following KEES pages:

- Task Inventory Search Results Page
- Task Details Page
- e-Application Summary Page
- Review and IR/12 month Detail Page

These changes are being made retroactively to all Tasks, medical e-Application Summary and Medical Review and IR/12 month Detail Pages. If a task was previously marked with a priority then the task creation date will display in the 'Priority Date' field.

The following changes will take effect with this implementation.

a. Contact Log Workflow

Previously when an 'Add Pregnant Woman' task was generated from the Contact Log it generated without a priority status. With this implementation, the 'Add Pregnant Woman' task that is generated from the Contact Log Workflow will now generate with the priority status of 'Expedited' so the

worker will no longer be required to manually set the priority.

G. New Medicare ID Number

The majority of consumers currently have three different numbers assigned to them by Federal Government Agencies for different purposes, a unique Social Security Number (SSN), a Health Insurance Claim Number (HICN) when they begin receiving Medicare coverage, and a Claim Account Number (CAN) when they begin receiving benefits from Social Security. If a consumer receives Social Security benefits from more than one Social Security account, they may be assigned more than one CAN, one for each account from which they receive payments.

The information below introduces a new identification number that will be assigned to consumers who have Medicare.

1. Medicare Beneficiary Identifier

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 mandated the removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards to address current risk of beneficiary identity theft. The HICN is a Medicare beneficiary's identification number and is used for processing claims and for determining eligibility for services across multiple entities (e.g., Social Security Administration (SSA), Railroad Retirement Board (RRB), States, Medicare providers, and health plans). The Centers for Medicare and Medicaid Services (CMS) has created a new identification number, the Medicare Beneficiary Identifier (MBI), to be used in place of the current Health Insurance Claim Number (HICN) for consumers.

The Medicare Beneficiary Identifier (MBI) is a unique, randomly generated, non-intelligent identifier that consists of eleven characters, both alphabetic and numeric, that will be used instead of the HICN on provider transactions. Key positions 2, 5, 8, and 9 within the MBI will always be alphabetic. In order to limit the possibility of letters being interpreted as numbers, alphabetic characters will be upper case only and will exclude S, L, O, I, B, and Z. An example of the MBI is 1EG4-TE5-MK73.

The MBI will be used in all transactions with CMS and medical providers but Social Security will still use the HICN for their transactions.

This legislation requires that all new, current, and deceased Medicare beneficiaries be assigned a new number. New Medicare cards with a new MBI will be mailed to current Medicare beneficiaries by April 2019. Anyone becoming eligible for Medicare coverage after April 1, 2018 will be assigned an MBI and their Medicare card will display that

number. These newly eligible Medicare consumers will never be informed of their HICN. It will be unknown to them and only used internally by Social Security.

2. GENERATING THE MBI

CMS began generating MBIs in January 2018 for all current (60 million) and deceased (90 million) Medicare beneficiaries. A one-time TBQ file will be run by KEES to request the new MBI for all current, pending, and recently deceased consumers. Consumers with a date of death more than two years prior to the date the file is created will not be included on the TBQ file. Once received on the TBQ Response file, the MBI will populate on the Medicare Information page in KEES and be sent to the MMIS.

3. CARD ISSUANCE

Phased issuance of newly redesigned Medicare cards will begin in April 2018. New cards will be mailed to current Medicare beneficiaries based on geographic location. Kansas beneficiaries will begin receiving their cards after June 2018. It is expected that all Medicare cards displaying the MBI will be issued by April 16, 2019.

Because a phased approach will be used when issuing new Medicare cards to consumers, not all consumers will know their MBI at the same time. It is important that eligibility and call center staff refrain from discussing the MBI with the consumer if the consumer has not been notified of their new MBI number by CMS.

4. TRANSITION PERIOD

A transition period will exist where providers can submit claims using either the MBI or the HICN. The transition period will run from April 2018 through December 31, 2019. CMS will accept and use either the HICN or MBI for claims processing during the transition period, whichever is submitted on the claim. Beginning in January 2020, only the MBI will be used on data exchanges and for claims processing.

5. SYSTEM CHANGES

The following updates have been made to the Worker Portal, Customer Self-Service Portal (CSSP), and specific pages within KEES to ensure accurate processing of both the HICN and the MBI. These changes will be implemented after March 18, 2018.

- Worker Portal and CSSP: The name of the field that captures the Medicare number has been changed. This field was previously titled Medicare Claim Number but will now be titled Medicare Identification Number.

- Medicare Expense Detail page: The MBI or HICN that is entered in the Worker Portal or the CSSP will be mapped to the newly titled Medicare Identification Number field on the Medicare Expense page.
- Medicare Information page: Both the HICN and the MBI will display on this page. A field titled Medicare Identification Number was added and will populate the MBI value pulled from the interface data. The HICN field remains which is populated with HICN data from the interface and used for some processing as noted in section 1.G.1 above.

The following outlines specific changes to KEES interfaces.

- EATSS Interface: The Claim Account Number (CAN) data element transmitted over the EATSS interface is no longer tied to the Medicare Claim Number field on the Medicare Expense page. Instead, the CAN data element will be populated from the Claim Number that is entered for Social Security income records on the Income page.
- MMIS Interface: The MMIS Interface will send the new MBI and the HICN to the MMIS. Both the MBI and the HICN will display in the MMIS. Buy-in accretion and deletion files use the HICN while MCOs use the MBI when processing claims.
- TBQ Interface: The new MBI will be included on the TBQ Interface. When a TBQ update is requested and Medicare data is received, both the HICN and the MBI will appear on the Medicare Information page.

6. *IMPACT TO ELIGIBILITY STAFF*

Changes in KEES related to the MBI affect eligibility staff in the following ways:

a. INCOME PAGE

EATSS records will still be accessed using the consumer's SSN or CAN number. However, EATSS will not allow manual inquiries on CAN numbers that are not entered on the Income page. The CAN number sent on the EATSS interface is now pulled from the Claim Number field on Social Security income records, it is important that each Social Security income record include the CAN number for which the benefit is received. This means that individuals who receive separate payments from Social Security from multiple CAN numbers must have separate income records with the applicable CAN number documented in the Claim Number field.

While updates in KEES related to the MBI will not be effective until March 18th, eligibility staff may begin entering CAN numbers on the Income Details page immediately as part of normal processing.

b. Medicare Expense Page

There have been no changes to the process of requesting a TBQ update. When completing the Medicare Expense Detail page, eligibility staff shall enter the consumer's MBI instead of their HICN in the Medicare Identification Number field. The MBI may be obtained from the beneficiary's Medicare card, letter of notification of eligibility for Medicare, premium notice, utilization notice (Explanation of Medicare Benefits), or the TBQ interface.

c. Medicare Data Exists Task

In KEES, a 'Medicare Data Exists' task is created when new Medicare data is received from the TBQ interface. Since KEES will be receiving the MBI for every Medicare consumer, when the one-time file is being processed, the 'Medicare Data Exists' task is being suppressed as eligibility staff do not need to take any action.

It is anticipated that there may be some consumers identified with this one-time file process for which the Medicare data is new and not in KEES. A report is being generated that will identify consumers that did not previously have Medicare data in KEES. When processing the report, eligibility staff must consider Medicare Savings Program (MSP) eligibility for each active or pending individual with newly identified Medicare eligibility.
.

2. Changes Impacting Family Medical Programs Only

The following changes have an impact on Family Medical programs only.

A. Individual Budgeting Units (IBUs) and Parental Control

Historically, incorrect IBUs have been created by KEES in situations involving adults who are not filing taxes, tax filer or tax dependent not residing in the home, households with SSI or LTC recipients, and households with a non-parental caretaker. With this implementation, along with some updates made at Phase 3 implementation, KEES Workarounds 298, 431, and 444 have been eliminated. Unless otherwise specified, these changes are effective with eligibility actions taken on or after the implementation of KEES changes in March 2018.

1. *IBU UPDATES*

KEES will now correctly capture all individuals who are in a budget unit. For the majority of these updates, workers will not need to update processing steps to achieve the correct IBU. However, for Non-Parental Caretakers, Tax filers and/or Dependents outside the home, and the new Family Size Only (FSO) role additional steps may be needed to ensure IBU accuracy.

Following the implementation of these changes, there are no known IBU issues with KEES. Therefore, any IBU not correctly being created shall be reported to the KEES Helpdesk.

The following examples demonstrate situations that KEES will now determine correctly.

Example 6: Primary applicant, age 20, is Pregnant and applying for herself only. She has 2 minor siblings in the home. No taxes are being filed. KEES will now correctly determine the IBU of 2: Primary Applicant and Unborn.

Example 7: Primary applicant, age 45, living with her two children, ages 20 and 17. The Primary Applicant is applying for herself only. No one is filing a tax return. KEES will now correctly determine the IBU of 2: Primary Applicant and CH (17).

Example 8: Primary applicant, spouse, two children, and one niece. Applying for the two children only. The PA and Spouse are filing jointly claiming and claiming both of their children as well as their niece as tax dependents. KEES will now correctly determine the IBU of 5: PA, SP, CH1, CH2, and Niece.

Example 9: Primary applicant, spouse, two children and the parents of the primary applicant. Applying for the two children only. PA and Spouse are filing jointly and claiming both children and the PA's parents as tax dependents. KEES will now correctly determine the IBU of 6: PA, SP, CH1, CH2, Parent1, and Parent 2.

Example 10: Primary applicant, spouse, primary applicant's child, and spouse's child. Applying only for PA's CH. PA and SP will file jointly and will claim both children as dependents. KEES will now correctly determine the IBU of 4: PA, PA's CH, SP, and SP's CH.

Example 11: Primary applicant, spouse, Primary applicant's child, SP, and spouse's two children. Applying only for the Primary applicant's child. PA and spouse will file separately and will each claim their own children as tax dependents. KEES will now correctly determine the IBU of 3: PA, SP, and PA's CH. *Note: KEES previously looked at this as an exception (child being claimed by one parent, but living with both parents (biological or adopted)) by adding step-parents into the logic even though it should not have been included.*

2. *Non-Parental Caretaker*

A child must be living in the home of a caretaker, and an individual must meet the definition of a caretaker in order to receive Caretaker Medical coverage. A person must have care and control of the child and meet one of the criteria outlined in KFMAM 2110.

In situations where the household includes a non-parental caretaker, such as a grandparent, other relative, or guardian, this individual must be identified in KEES as having care and control of the child. This identification is made on the Relationship Detail page by selecting the care and control box, choosing 'medical' in the care and control programs, choosing 'legal authority provided by court document' in the care and control status.

Updates made to KEES will allow non-parental caretakers and their spouses to be correctly assessed for coverage on the basis of being a caretaker. Additionally, the utilization of the care and control check box within the relationship detail has been enhanced which also allows an individual to be considered a caretaker even if situations where the child is not applying. These updates also allow Medical and Non-Medical programs to choose separate Care and Control individuals based on their unique policies. Eligibility staff shall not establish, or update any Non-Medical Care and Control Relationships.

Upon implementation of these updates, a data fix will be applied to KEES. This fix will add the program of "Medical" to applicable relationships utilizing Care and Control. This fix captures most situations however it will be the responsibility of the eligibility worker to ensure that when this box is checked, Medical is chosen if applicable to Medical. *Note: If the Care and Control box is checked, only has Non-Medical chosen, and does not apply to Medical, no updates should be made and Non-Medical should remain chosen*.

Example 12: Primary Applicant, Spouse, and grandchild. Requesting coverage for all individuals. KEES will now correctly approve coverage for both the Primary Applicant and the Spouse on the basis of being a caretaker (assuming other requirements such as income are met).

Example 13: Primary Applicant, age 20 and sibling, age 17. Requesting coverage for the Primary Applicant only. KEES will now correctly approve coverage for the Primary Applicant on the basis of being a caretaker (assuming other requirements such as income are met). The sibling does not need to be applying for benefits for this to occur.

Example 14: Primary Applicant, unrelated child for which the Primary Applicant is a Legal Guardian, and the parent of the child are in the home. The Primary Applicant is requesting coverage for all individuals. The Primary Applicant is identified as having Care and Control on the Relationships page. KEES will now correctly approve

coverage for the Primary Applicant on the basis of being a caretaker (assuming other requirements such as income are met) even though the Child's parent is in the home. The parent would then be denied on the basis of not being the Caretaker.

Example 15: Primary Applicant, and child are in the home. The Primary Applicant is requesting coverage for all individuals. The Primary Applicant is identified as having Care and Control on the Relationships page by Non-Medical. Medial programs do not need to establish Care and Control for a "Parent". Therefore, this record should be left unchanged as Non-Medical would have set this based on their policy, which does not affect Medical cases.

3. *Tax Filers and Tax Dependents outside the home*

KEES will now correctly include tax filers and tax dependents who live permanently out of the home in the applicable IBU when appropriate. Previously these individuals had to be coded as '*Temporarily Out of the Home'* in order to be included in the IBU. When processing reviews and case maintenance actions, it will be necessary to evaluate the household status of individuals and update them to 'Permanently Out of the Home' when appropriate. This will not have an impact on continuous eligibility.

Other system pages will also need to be completed such as Individual Demographics, CIT/ID (record only), Relationships, and Income (if any). All policies regarding verifications still apply to these individuals.

The "Claiming Other Dependents Not on Application" and "Number of Other Dependents Not on Application" boxes will no longer be used. When completing any case action, staff shall review these fields and ensure they are left blank. See also Section 1.A.3. A report will be provided so a cleanup effort can occur to remove any data from these fields.

4. *Family Size Only (FSO)*

Limitations in KEES prevented SSI and LTC recipients from properly being added to a household budget. For MAGI households that also include an SSI recipient, KEES will now correctly include them in the individual's budget unit. This is done by giving these individuals a role of Family Size Only (FSO). This Role is similar to the roles currently used by KEES (MEM and FRI). KEES will now automatically move these individuals to the FSO role when EDBC is run. Workers will no longer need to follow previous workarounds associated to adding SSI recipients to budgets. Workers should see this Role in EDBC results in the individual budgets and on the Program Block when the individual is not receiving benefits on that program. If they are receiving benefits under that program block, they will show up as MEM.

For MAGI households that include an LTC recipient, KEES will also move these individuals to the FSO roles when EDBC is run. Staff must continue to establish a

separate program block for the LTC individual. However, the income of an LTC recipient IS countable for the MAGI household if the person is included in the MAGI household.

Even though the MAGI IBU has been corrected, a gap still exists with the budget – the income of the SSI/LTC recipient is not always properly counted for the MAGI IBU. Specifically, income noted as 'non-exempt' for a MAGI budget is being counted for an SSI recipient. No income is being counted for the LTC recipient. This means that special processes may need to be used if the MAGI IBU includes SSI or LTC recipients with income.

The income of the SSI person included in the MAGI IBU is exempt for the MAGI budget. The income of the LTC individual is countable for the MAGI case if the individual is included in the MAGI IBU. If a person is receiving both SSI and LTC, the SSI policy applies. Allocated income from an LTC individual to a community spouse or dependent family member is not countable to the MAGI household. Special instructions for processing these cases are included in the attached *KDHE Instructions – MAGI Budgets with SSI or LTC individuals*. Staff shall follow processes outlined in these instructions until changes are implemented in the KEES system.

Example 16: Primary Applicant, Child 1, and Child 2 who is an SSI recipient. Applying for both children. KEES will now correctly add the SSI recipient (CH2) to CH1's IBU as an FSO role, and result in a family size of 3. However, the income of the SSI recipient maybe counted. CH2 will still receive a role of MEM on their own budget and on the program.

Example 17: Primary Applicant, Child 1, and Child 2. Applying for both children. Primary Applicant is already open on HCBS. KEES will now correctly add the PA to both children's IBU as an FSO role, making the household size of 3. However, the income of the parent will not be included. Staff must follow the processes outlined in the job aid to determine if there is countable income for the IBU, recalculate the countable income for the IBU and determine if special action is needed to provide correct eligibility according to the Instructions.

5. TIAR (KC4520) FORM

Workers will now be able to generate and send the TIAR Form through KEES. This will eliminate any off system processes currently being used. The form will be generated and created through Document Control. The TIAR Form number in KEES is V777. There are several places (mandatory and optional) on the form that workers will need to enter manually to ensure accurate information is returned. Once generated, there will be some system populated information on the form, such as due date.

B. Both Below – Reasonable Compatibility Method

As introduced earlier in the memo, we have implemented a Household Reasonable Compatibility Test known as 'Both Below'. This RC test has been implemented for Family Medical programs only (CHIP and TransMed are not included) only Federal regulations require a two-part RC test that looks at the reasonable compatibility of individual income, but then evaluates the household income and compares it against the Medicaid income limit for each applicant. The intention of this secondary test is to prevent a delay in providing medical assistance to any applicant whose income is clearly within the Medicaid income limit. It allows us to approve medical assistance for some applicants without requiring additional pending for information.

Income is Reasonably Compatible with the reason of Both Below when both the self-attestation of income and the amount received from at least one data source are below the Medicaid income limit for the applicable individual. The applicable individual shall be approved without requiring additional income verification.

Note that the Both Below RC verification is an additional method of verification available for a determination. Other RC methods may also be used. The primary RC verification methods of '*20% tolerance*' and '*Self Attested > Data Source*' will be considered primary to a Both Below determination.

In order to determine whether an individual qualifies under the Medicaid income limit, KEES must evaluate the income of all IBU members for each individual. Changes have been made to how KEES performs the RC test for MAGI programs to support the Both Below determination. KEES will identify the members of the IBU, pull the income of those individuals and compute the self-attested income and the interface income for the IBU. If both are below the Medicaid income limit for the individual, the income is verified for that individual. KEES will consider multiple methods of reaching an RC verified record with each RV button run. As indicated previously, the Reasonable Compatibility Detail Page is being updated to display the RC method. If income was verified as RC through multiple methods, all will be displayed on the RC Detail page.

When considering a Both Below determination, both the IBU and income may be in pending status. For example: If a particular individual has their household status pending, they will be assumed to be in the home when the IBU is determined for the Both Below test. The RC test for Both Below is performed with both pending and verified income records, as an individual may qualify as being 'Both Below' even when one of more household members have pending income records.

Staff must pay particular attention to cases where multiple individuals are determined and the interplay of multiple IBU's, different income verification codes and partial approvals. This is especially evident when taking negative action on only some members of the

household. It is allowable to for staff to deny eligibility for some family members based on self-attested household income. However, in order to accomplish a proper denial, the income of the IBU members must be verified. A verified income record could impact other determinations. Consider a household of mother and two children where the younger child is approved for Both Below. This leaves a determination for both the mother and older child. Staff review the case and can determine the mother is over income for CTM based on self-attestation of income. However, in order to properly deny her coverage request, the income must be marked verified. This action will also verify income for the older child, meaning that child could accidently be approved. This is not proper casework. Although denial based on self-attestation is allowable, staff must exercise caution when taking action. First, it is only allowable if it taken for all remaining undermined members of the case. In addition, staff shall use discretion when evaluating the level of income reported when taking action. If the level of income reported is close to the limit, it is acceptable to ask for verification. These decisions, as well as the reason for the decision, are always recorded in the journal.

Consider the following examples:

Example 18: Application received for Mom and one child, age 3. Requesting assistance for the child only. Mom self-attests to $1000/monthly earnings. No income is reported for the 9 year old.

Income Records: Mom has an earned income record of $1000/month

Verification Types: On the Verification List page, the worker will select 'Income' for Mom and 'No Income Reported' for the 3 year old.

Interface Results:

- Mom: Nothing is returned from TALX. KDOL-Wages indicates a monthly amount of $1300.
- 3 year old: Nothing is returned from TALX or KDOL.

Reasonable Compatibility Determinations:

- Mom:
  - Individual RC test – *NOT* Reasonably Compatible. The SA of $1000 was compared to the KDOL-Wages result of $1300. The SA was not greater than or within 20% of the interface.
  - Household Both Below test – *NOT* Both Below. Mom has an IBU of 2, and both the $1000 and $1300 are greater than the CTM income limit of $515.
- 3 year old:

- Individual RC test - *YES* Reasonably Compatible for No Income Reported. No income was returned from both TALX and KDOL-Wages, confirming that the 3 year old does not have earnings.
- Household Both Below test - *YES* Both Below. The 3 year old has an IBU of 2 and the $1000 and $1300 are both below the Medicaid income limit of $1800.

Eligibility Determinations: Contract staff run EDBC (even with Mom's income still pending) and it indicates PLN eligibility for the 3 year old. PLN eligibility exists because of the Both Below reasonable compatibility test. The case is transferred to KDHE to complete the Medicaid determination. When the Both Below RC test is used, coverage may be approved even when there is an IBU member with a pending income record. Because of this result the contract worker may refer this case to KDHE to complete PLN approval for 3 year old.

Example 19: Application received for Mom, Dad, and 2 children, ages 8 and 17. All individuals are requesting medical assistance. Mom self-attests to $1000/monthly earnings. The 17 year self-attests to $250/monthly earnings. No income is reported for the Dad or the 8 year old.

Income Records: Mom has an earned income record of $1000/month. 17 year old has an earned income record of $250/month.

Verification Types: On the Verification List page, the worker will select 'Income' for Mom and the 17 year old, while choosing 'No Income Reported' for the Dad and 8 year old.

Interface Results:

- Mom: Nothing is returned from TALX. KDOL-Wages indicates a monthly amount of $1300.
- Dad: Nothing is returned from TALX or KDOL-Wages.
- 17 year old: Nothing is returned from TALX. KDOL-Wages indicates a monthly amount of $400.
- 8 year old: Nothing is returned from TALX or KDOL.

Reasonable Compatibility Determinations:

- Mom:
  - Individual RC test – *NOT* Reasonably Compatible. The SA of $1000 was compared to the KDOL-Wages result of $1300. The SA was not greater than or within 20% of the interface.
  - Household Both Below test – *NOT* Both Below. Mom has an IBU of 4, and both the $1000 and $1300 are greater than the CTM income limit

of $779. *Note: the 17-year old's income is not included because it is below the filing threshold and the parent is in the home.*

- Dad:
  - Individual RC Test – *YES* Reasonably Compatible for No Income Reported. No income was returned from both TALX and KDOL-Wages, confirming that Dad does not have earnings.
  - Household Both Below test - *NOT* Both Below. Dad has an IBU of 4, and both the $1000 and $1300 are greater than the CTM income limit of $779.
- 17 year old:
  - Individual RC test – *NOT* Reasonably Compatible. The SA of $250 was compared to the KDOL-Wages result of $400. The SA was not greater than or within 20% of the interface.
  - Household Both Below test – *YES* Both Below. The 17 year old has an IBU of 4 and the $1000 and $1300 are both below the Medicaid income limit of $2727.
- 8 year old:
  - Individual RC test - *YES* Reasonably Compatible for No Income Reported. No income was returned from both TALX and KDOL-Wages, confirming that the 8 year old does not have earnings.
  - Household Both Below test - *YES* Both Below. The 8 year old has an IBU of 4 and the $1000 and $1300 are both below the Medicaid income limit of $2727.

Eligibility Determinations: Mom and Dad are both ineligible due to excess income. Because both children were approved, the only remaining members are the parents. Therefore, self-attestation is used to deny for excess income and it is not necessary to pend for additional information. The staff person makes this determination before running EDBC and updates Mom's income record to verified, in order to obtain the correct determination. The contract worker will journal the decision. Both children are eligible for PLN coverage. The case is transferred to KDHE staff for the final determination.

1. *Both Below Eligibility Process*

Implementation of Both Below has a significant impact on the process staff use to determine eligibility. After running verifications and conducting the Reasonable Compatibility test, staff will then identify what additional information is needed to complete the eligibility determination. If everything has been verified, with the exception for income, then staff will run EDBC to determine if an applicant is eligible based on Both Below.

When EDBC is run, staff must evaluate the results to determine if an individual can be approved. If all applicants are eligible based on Both Below, then the case shall be routed to KDHE to complete the Medicaid determination. It is acceptable to approve coverage with the pending income verification record.

Example 20: Primary Applicant is applying for two children. The Primary Applicant's income is not reasonably compatible, but no other information is required. Eligibility staff will run EDBC to determine if either of the children is eligible to be approved based on their Both Below status.

Example 21: Primary Applicant is applying for three children. Child 3 is also open on another medical program with another relative. After requesting verifications via KEES and completing the RC test for all individuals, staff will pursue additional information about the whereabouts of Child 3 before running EDBC. It is necessary to correctly determine household members before determining eligibility based on the Both Below status.

The Partial Approvals section below further explains how to complete a determination when some individuals are eligible using Both Below and additional information is still needed to complete the determination for other applicants.

C. Partial Approvals

In situations where one or more individuals' meets the Both Below Reasonable Compatibility test and others still need income verification, eligibility shall not be delayed for any individual for whom additional information is *not* needed.

1. Process For Other Household Members

KEES enhancements have been put in place to support both the approval of household member who qualify under Both Below as well as the continued tracking of persons in the household who do not and, therefore, may require additional verification.

When EDBC is run for the program and income verification is the only item needed a new EDBC Role Reason of Income Verifications Needed will be assigned to any applicant who is not eligible under Both Below. This will identify those individuals who still require a determination. Staff should pay close attention to the outcome of this run. It is possible that corrections or mistakes could be identified after viewing this outcome. For example, if all remaining applicants are obviously over income as a result of the EDBC run, staff can return to the Verification List page and record the parental income as verified. However, this can only be done if all applicants dependent upon that income are ineligible based on self-attestation. See Section 2(B) above regarding Both Below.

The approval NOA generated includes a fragment that indicates that not all individuals were approved for assistance and that a separate notice will be sent requesting information. When KDHE staff approve the Medicaid coverage, they will also generate the request for information notice to pend for the additional information. The task shall be returned to MAXIMUS staff using the KDHE-Partial status code. See the *KEES User Manual* for additional information regarding the Partial Approval task process.

2. GROSS MISREPRESENTATION

Because some individuals are approved based only on self-attested income which will later be verified for another determination, there is a potential that when verifying income in Tier 3 or Tier 4, the outcome would have been different. In most situations, the determination shall not be changed when the income verification is received and would have resulted in a different determination. However, if staff identify that a consumer grossly misrepresented their income on the application, a correction may be needed. This is only an issue if the EDBC indicates a different outcome after running EDBC with the new income.

Upon identifying the discrepancy, the worker must make a prudent person evaluation of the situation. Multiple factors are considered when deciding if a gross misrepresentation occurred. Examples include the time between the original attestation and the new verification, the amount of the difference and the type of budgeting (e.g. partial month). Consultation with supervisory/lead staff is encouraged if the staff person is not confident with their decision. Journaling is required.

If a gross misrepresentation has occurred, the original determination shall be adjusted according to timely and adequate notice requirements. The continuous eligibility for the individual will be discontinued on the basis of 'originally ineligible.' The individual will receive a new determination with the income verification submitted. Note that eligibility will never be negatively adjusted without timely and adequate notice.

The case shall able be referred to Program Integrity staff (Overpayment Spreadsheet) for further review. Consider the following example.

Example 22: Primary Applicant applies for herself and two children. One of the children is approved due to Both Below. After completing the partial approval, staff pend to request additional income verification. Mom provides proof of her income as requested. It is found that her income is actually $1000 per week, rather than $1000 per month as originally stated on the application. Because this is a gross misrepresentation of the income, staff determine that it would be appropriate to review the earlier approval to determine if it was appropriate.

3. QUESTIONS

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

Erin Petitjean, Elderly and Disabled Program Manager- Erin.Petitjean@ks.gov
Vacant, Family Medical Program Manager
Jeanine Schieferecke, Senior Manager – Jeanine.Schieferecke@ks.gov

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