Policy Memo	
KDHE-DHCF POLICY NO: 2023-08-02	**From: Erin Kelley, Senior Manager**
Date: Aug 4, 2023	**MKEESM/KFMAM Reference(s):**
RE: PHE Unwinding Flexibilities	**Program(s): All Medical Programs**

This memo provides instructions for implementation of additional flexibilities approved by CMS for the purposes of minimizing termination of coverage for procedural reasons during the Kansas "Unwinding Period" for medical programs. The effective date for the changes below is August 1, 2023. For information related to the Unwinding Period and the resumption of reviews following the end of the COVID-19 Public Health Emergency Continuous Coverage requirement, see PM 2023-03-02 V3

Applicable to all medical programs:

- MCO Assistance with Renewal Forms
- Telephonic Designation of a Medical Representative or Facilitator
- Suspension of the Requirement to Apply for Other Benefits

I. Changes Impacting All Medical Programs

A. MCO Assistance with Review Forms

Per existing requirements under the Social Security Act, Managed Care Organizations (MCO's) cannot assist consumers in completing or signing application or review forms.

In order to assist consumers and mitigate procedural terminations, this flexibility will allow MCO's to voluntarily assist their enrollees in completing the review process, including filling out certain parts of the review form. MCO's must limit their assistance to completing the fields with information provided by the consumer. They may not assist with the fields pertaining to MCO selection or the signature page. They are also prohibited from acting as a consumer's authorized representative.

Below outlines what the MCOs are allowed to do under this waiver.

- Managed care plans may offer their assistance in completing renewal forms but only provide such assistance if the enrollee chooses to accept the plan's assistance. Consistent with the Medicaid managed care marketing regulations, managed care plans are prohibited from engaging in all forms of marketing and potential conflicts of interest and must protect managed care enrollees' confidentiality related to providing assistance with renewals.
- When assisting enrollees with completing renewal forms, managed care plans will limit their assistance to completing fields with information provided by the enrollee relating to eligibility criteria which the enrollee must meet to retain coverage. Plans cannot assist enrollees with completing any fields associated with managed care plan selection and plans may not sign the renewal form on the enrollee's behalf.
- Any assistance provided to enrollees in completing their eligibility renewal forms is purely an administrative activity offered by the managed care plan; managed care plans are prohibited from acting as an enrollee's authorized representative.
- Managed care plans will not take actions that could influence the enrollee to select the managed care plan that is providing the assistance or not enroll in another managed care plan.
- Managed care plans will not perform activities that must be provided by an enrollment broker, including choice counseling. Enrollment brokers must be independent and free from conflict of interest from all managed care plans in the state.

B. TELEPHONIC DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

Per existing policy, an individual may grant authority to a person helping them with the application or review process. In order to appoint someone as an administrative role, a signed, written authorization is required, either via an approved form or on the application/review form itself.

This flexibility allows an applicant/recipient or authorized individual (i.e., DPOA, Guardian or Conservator) to designate an authorized representative via telephone without the requirement to submit the signed authorization form, for purposes of signing and submitting an application or review form and only at the request of the consumer or other authorized individual. A telephonic signature from the consumer must be recorded for the case file.

This flexibility is intended for use at the agency's discretion for the purpose of removing barriers to completing the review process for consumers during Unwinding. It may be

used within the parameters specified above in several ways, depending on the types of barriers identified. Some examples of how this could be implemented are listed below:

Example 1: The agency receives a review form signed by an unauthorized individual. Typically, the review/signature would be treated as invalid and additional information would be requested from the consumer in order to validate and process the review. Under this flexibility, staff could obtain authorization from the consumer directly over the phone to validate the signer as a limited authorized representative without taking additional steps (i.e., sending the review form back to the consumer, requesting the authorization form, or going through the telephonic review process with the consumer).

Example 2: A consumer calls the agency and states that they are unable to sign and submit their review. Staff may offer the option for them to designate another individual for the purpose of signing and submitting the review.

NOTE: Due to the limited nature of this authority, the administrative role will be journaled only and not added to the program block in KEES. This means that the authorized representative (for signature purposes only) will not receive notices, unless validly appointed as an approved administrative role per standard policy and procedure. The MCO still cannot be an authorized representative in this limited role.

C. Suspension of the Requirement to Apply for Other Benefits

Standard eligibility policy requires applicants/recipients to pursue benefits for which they are entitled, such as disability or VA benefits, unless they can show good cause for not doing so. This requirement mostly pertains to the Elderly and Disabled (including Long Term Care) programs (see MKEESM 2124). For the duration of the unwinding period, this requirement is hereby waived for applicants/recipients. Instead, eligibility staff shall note the potential resource/income in the case journal and address the requirement to pursue that resource/income at the next scheduled review.

NOTE: This waiver pertains specifically to income and resource benefits and does not apply to the disability determination requirement as noted in MKEESM 2662 and subsections.

II. Questions

For questions or concerns related to this document, please contact the KDHE Medical Policy Staff at KDHE.MedicaidEligibilityPolicy@ks.gov.

Erin Kelley	Senior Manager
Amanda Corneliusen	Family Medical Program Manager
Jessica Pearson	Elderly & Disabled Program Manager

Sara Reese	Elderly & Disabled Program Manager
Jennifer Sanders	Family Medical Program Manager

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