Policy Memo	
KDHE-DHCF POLICY NO: 2024-10-01	**From: Erin Kelley, Senior Manager**
Date: October 30, 2024	**MKEESM Reference(s): 9340** **KFMAM Reference(s): 7420**
RE: Review Processing Timeframes	**Program(s): All Medical Programs**

This memo provides updates to the existing timeliness standards for the processing of review forms received by the KanCare Clearinghouse as mandated by the Centers for Medicare and Medicaid Services (CMS) in their final rule issued in April 2024. This update is effective November 1, 2024. Previous policies are superseded where noted. Policy manuals will be updated with the next scheduled revision.

I. Changes Impacting All Medical Programs

A. Background – Timely Review Processing

Pre-populated reviews have specific timeframes in place to be considered processed timely by the agency. Per the existing policy outlined in PM2018-12-02, the timely processing standards are currently defined as listed below:

1. When a review form is received before the 1st day of the review due month (i.e., last month in the review period), the processing deadline is the closure processing deadline for the last month in the review period.
2. For reviews received on or after the 1st day of the review month but prior to the 15th, the processing goal is the closure processing deadline for the last month in the review period or 30 days from the received date.
3. A review received past the 15th of the review month is considered a late review and has a processing timeframe of 30 days from the date of receipt.

Effective with the release of this document, the above standards are considered retired, and new timeliness standards for reviews are being issued.

B. Updated Review Processing Timeliness Standards

The CMS Final Rule issued April 2024 has defined new requirements for timeliness standards for states to complete renewals. The updated timeframes are described below:

1. If a consumer returns their review form at least 30 calendar days before the end of their review period (i.e., the last day of the review month), the state must process the review before the end of the review period.

2. If the consumer returns their review with less than 30 days remaining before the end of the review period, the state must process the review no later than the last day of the following month.

A review received after the 15th of the review due month is no longer defined as a late review. A review is considered received timely if it is received by the last day of the review period.

The latter deadline (#2) includes reviews received after the discontinuance batch has run but before the last day of the review period. The deadline for these to be processed timely would be the last day of the month following the end of the review period (as shown in Example 2 below).

Example 1: An individual has a review period ending 06/30, and a pre-populated review is sent. The review form is received on 05/31. Because it was received more than 30 days prior to the end of the review period (06/30), the deadline for timely processing is the end of the review month (06/30).

Example 2: An individual has a review period ending 06/30, and a pre-populated review is sent. The review form is received 06/12. Because it was received with less than 30 days left the in the review period, the deadline for timely processing is the last day of the following month (07/31).

C. Extended Months

Timely notice and consumer timeliness standards for reviews remain unchanged by this policy. If the review is received prior to the review discontinuance batch (around the 15th of the month), coverage will remain in place until a final determination and notice can be made by the agency which could result in extended months of coverage. Reasons for this could be the following:

- The consumer is determined ineligible at review.
- The consumer is determined eligible for an adverse change or lower program in the hierarchy.
- Additional information is needed to process the review.
- A determination must be made under a non-MAGI category (E&D or LTC)

At least 10 days timely notice must be allowed prior to closure or adverse change. While this may cause existing coverage to continue/extend beyond the timeframes described above, processing would be considered timely as the extended month(s) is due to meeting timely notice requirements.

Example 1: A review due 04/30 is received 04/12. Processing is initiated timely, on 05/25. The individual is determined ineligible for all medical programs. As there are less than 10 days (timely notice) remaining in the month and coverage for the following month has already become paid/active, coverage is discontinued with an effective date of 06/30. As processing was completed timely, and the extra month of coverage was a result of meeting timely notice requirements, the review is considered timely processed.

Example 2: A review due 04/30 is received on 04/12. Processing is initiated timely, on 05/25.

Information is needed to complete processing and is requested with the appropriate due date (12 days at this time). Information is returned within the timeframe, but by the time processing is completed, coverage is active through 06/30. As processing was completed timely, and the extra month of coverage was a result of additional information needed, the review is considered timely processed.

NOTE: Timely notice applies to adverse changes. For positive changes, only adequate notice is required, and the change can be made retroactively as appropriate.

D. Other Considerations

1. Non-MAGI Determinations

When the review form is received, and processing initiated timely, additional processing may be needed when an individual must be determined based on age or disability for non-MAGI programs. In these situations, the additional time needed would not impact review timeliness standards if non-MAGI application processing deadlines were met (90 days from the receipt date).

2. Unimpacted Policies

Unimpacted by this change are timeframes related to ex parte/passive renewals and passive review responses and setting CE dates at review. For current policies and timeframes regarding passive reviews and passive review responses, see PM2024-06-02. For policy related to setting CE periods at review, see PD2021-01-01.

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
Jennifer Sanders	Family Medical Program Manager
Jessica Pearson	Elderly & Disabled Program Manager
Danielle Burns	Elderly & Disabled Program Manager

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