



Policy Memo	
KDHE-DHCF POLICY NO: PM2025-04-01	From: Erin Kelley, Senior Manager
Date: April 1, 2025	KFMAM Reference(s): 7410 MKEESM Reference(s): 9330
RE: Review Requirements & Extended 60-Day Timeframe for Submission of Review	Program(s): All Medical Programs

This memo sets forth instructions for implementation of a new policy requirement related to the reviews process, Medical Review Type Determination Batch, and consumer responsibility for timely submission of a pre-populated review form. This policy becomes effective with the Medical Review Type Determination Batch running in April 2025 for reviews due June of 2025 and supersedes PM2017-02-01 Section 3A and PM2018-12-02 section B1. The policy manuals will be updated with the next scheduled revision.

I. CHANGES IMPACTING ALL MEDICAL PROGRAMS

A. STANDARD REVIEW REQUIREMENTS (REVISITED)

During the Unwinding period for the COVID-19 Public Health Emergency (PHE), the Centers for Medicare and Medicaid Services (CMS) issued clarifying guidance regarding the federal requirements how states conduct and manage reviews. Those requirements were previously documented in PM2023-03-02 v.3 PHE Unwinding – COVID-19; however, as these requirements remain the standard, they are documented here again:

The federal requirements for conducting medical reviews include the following:

- Attempting to complete a review using information found in data-sources or interfaces prior to requiring information from the consumer (referred to as passive review, or ex parte renewal)
- Sending a pre-populated review form when unable to renew via passive or ex parte review
- Providing beneficiaries with at least 30 days to return their review form
- Allowing the review form to be received through all available channels or modalities (i.e., mail, the Consumer Self-Service Portal, phone, or in-person)
- Allowing the consumer to submit a review through all modalities for three (3) months following discontinuance for failure to return a review without requiring them to fill out a new application (a.k.a., Reconsideration Period)

- Determining eligibility on all bases (meaning for any applicable program) prior to determining an individual ineligible
- When discontinuing coverage due to ineligibility or failure to return the review, providing timely notice (at least 10 days prior to the last day of coverage) and appeal rights

Kansas has made adjustments over the past few years to ensure alignment with these requirements. See PM2024-06-01 for other review-related policies.

B. TIMEFRAME TO RETURN A REVIEW - BACKGROUND

Per federal/CMS regulations, states must provide no fewer than 30 days for consumers to return a pre-populated review form prior to taking adverse action. For this reason, Kansas has historically sent out review forms to consumers qualifying for a pre-populated review by the 15th (i.e., within the first two weeks) of the month preceding the review month, in order to provide consumers with at least 30 days to return the review as well as timely notice prior to discontinuing for failure to return the review. This process is managed through automated batches that run each month. The Medical Review Type Determination Batch runs at that time to assess the type of review an individual will receive, and individuals who do not meet passive review criteria are sent a pre-populated review form with a 30-day due date. The Review Discontinuance Batch runs on or around the 15th of each review month to close coverage for individuals who have failed to return a review form, allowing timely notice.

While 30 days is the minimum standard per federal regulations, states are encouraged to provide a longer period of time for both MAGI and non-MAGI consumers in order to give them enough time to complete and return the renewal form and requested information. The additional time may only be granted prior to the end of the review period and may not extend the review period beyond 12 months, due to the requirement that individuals must be reviewed once every 12 months for MAGI and no less than every 12 months for non-MAGI programs.

B. NEW POLICY – EXTENDED TIMEFRAME TO SUBMIT A REVIEW FORM

In an effort to benefit consumers and reduce the potential loss of coverage at review for a procedural reason (i.e., failure to return the review form or information required to complete a review), Kansas has elected to extend the amount of time provided for consumers to return their review forms from 30 days to 60 days. Effective with the system implementation, the Medical Review Type Determination Batch will run on or around the 15th of the month *two* months prior to the end of the review period.

Example: For a review due in April, the Medical Reviews Batch will run on or around the 15th of February, one month earlier than before (or two months before the review is due), providing at least 60 days to return the review form prior to being closed by the Review Discontinuance Batch with timely notice.

1. KEES UPDATE - FUTURE BENEFIT MONTH

When staff run EDBC to screen or complete an eligibility determination at review, a dropdown displays for staff to select the correct month for the determination. Historically, the only future

benefit month staff could select from the dropdown was the “come-up” month, or the next unpaid month. For this reason, if staff were processing an early received review (such as an application form returned up to three months prior to the end of the review due month), the correct benefit month was not always available to select from the dropdown.

With the extended timeframe in place for a consumer to submit a review, we expect to see more early received reviews, making it necessary for staff to run EDBC up to three months in the future. With the system implementation, staff will be able to view and run EDBC for the correct future benefit month for the next review period, even when the review is received up to two months early.

Example: For a review due in April, the Medical Reviews Type Determination Batch runs around the 15th of February, sending out review forms and SSP notifications to members with a pre-populated review type. The consumer submits their review form on 02/20. Staff initiate processing on 02/28 and are able to finish processing without any additional verification. When running EDBC, they will be able to select the future benefit month of May from the dropdown with an RE run reason, allowing benefits to be computed and authorized for the next review period.

2. CHANGES REPORTED AT REVIEW

Due to this change, consumers will receive their review forms a month earlier than in previous years. This will potentially increase the probability of a reported change occurring prior to the review due month. Since income changes are effective the month following the month of report, there may be situations where an income decrease or other changes reported on the review form need to be reacted to as reported changes ahead of the new review period. If the updated information provided on the review form results in a positive change of benefits, EDBC will need to be run without the “RE” run reason in the month after the change was reported and through the come-up month. The “RE” run reason will then need to be selected in the proper month. Examples of this could include a decrease in CHIP or Working Healthy premiums, a positive change from one program to another (i.e., CHIP to PLN or MSP/LMB to MSP/QMB), or a decrease in an individual’s Spenddown amount or Long Term Care (LTC) share of cost.

Example 1: A review due in April is received in March, and processing is initiated in that same month. A new attestation of income is provided on the review form that will decrease the premium for a CHIP child. Though the new eligibility period will not begin until May, the month following the reported change is April. The income will need to be updated on the case and EDBC run for April forward in order to effectuate the positive change. The “RE” run reason would then be selected for May.

Example 2: A review due in April is received early and processing is initiated in March. The consumer reports loss of employment on the review form that will decrease the spenddown amount for a Medically Needy recipient. Though the new eligibility period will not begin until May, the month following the reported change is April. The income should be updated on the case and EDBC run for April forward in order to effectuate the positive change. The “RE” run reason would then be selected for May.

Example 3: A review due in June for a Long Term Care (LTC) nursing facility recipient is received in April. The consumer reports certain annuity payments have ended on the review form that will decrease their patient liability. Verification of this change is received to confirm the loss of income. Though the new eligibility period will not begin until July, the month following the reported change is May. The expense should be updated on the case and EDBC run for May forward in order to effectuate the positive change. The “RE” run reason would then be selected for July.

Example 4: A review due in September for a Working Healthy (WKH) recipient is received in July. The consumer reports a new work-related expense that will decrease the monthly WKH premium amount from \$124 to \$0. While, the new eligibility period will not begin until October, this is a positive change that will result in a decreased premium obligation the month following the month of report. The expense is added to the case and EDBC run for August forward in order to effectuate the change. The “RE” run reason would then be selected for October.

NOTE: In these examples, the RE run reason should not be used until coverage is run for the first month of the new review period which will begin the new coverage/CE period.

3. USING AN APPLICATION FORM AS A REVIEW

The Self-Service Portal (SSP) will allow the consumer to elect to fill out an online review form through a link that will become available once the Medical Review Type Determination Batch runs. The SSP application link is currently suppressed while the SSP review link is active; however, in a future update, the SSP application link will also be made available to allow consumers the option. Similarly, a paper application form may be received through the mail, fax, or in person during the review period, and these must be addressed accordingly.

Per PM2017-02-01, an application form shall be used to process a review when it is 1) received within two months prior to the review due month, 2) received any month after the review due month through the current month when the discontinuance batch has not been run, 3) the come-up month is available, and 4) all household members are listed on the application.

With the implementation of the longer timeframe to submit a review and the updates made to future come-up month availability, we would no longer expect the benefit month for the next review period to be unavailable. Staff will now be able to select a come-up month up to three months in the future. Additionally, it is clarified here that an application received within the review timeframe should be acted upon as a review for any individual listed on the form for whom a review is due, regardless of whether *all* household members are listed. For household members not included on the application, we would allow them to continue through the automated reviews process (as in, return their review form or be passively reviewed) or obtain their information over the phone as best practice. As usual, any changes reported on the application form must be updated on the case and any discrepancies resolved prior to completing the determination.

NOTE: For E&D/LTC recipients, additional verification of separation or divorce may be required as noted in MKEESM 4312. Additionally, if an FFM application is submitted for ED/LTC programs, a supplemental application is required to process the FFM as a review form.

4. SKIPPED REVIEWS AND MANUALLY SENT REVIEW FORMS

There are times when a review will be skipped by the Medical Reviews batch due to various reasons, resulting in the consumer not receiving the appropriate review form. When this occurs, the review process must be handled through manual processes. If possible, an administrative review may be completed for individuals who meet passive review criteria outlined in MKEESM 9310.2 and KFMAM 7330.01. If sufficient information is not available through data-sources to renew the individual, or if the individual appears ineligible based on available information sources, a pre-populated review form must be manually generated and sent through KEES to the consumer.

NOTE: If the reporting record was not generated by the medical reviews type determination

batch, a KEES Help Desk ticket is needed for the record to be created.

When this occurs, the review form mailed will have the incorrect due date on the cover letter. A separate letter (V008) must be mailed out with the review form indicating the correct due date. (See Standard Copy and Paste (SCP) labeled "Skipped Review – Review Form Sent Manually). The due date provided in the letter should continue to reflect the standard minimum 30-day due date. The consumer must continue to receive coverage until they have had the full 30 days to provide the review form; if it is not received by the due date, coverage will be discontinued with timely notice only for the individual(s) for whom a pre-populated form was required.

II. QUESTIONS

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

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