



Policy Memo

KDHE-DHCF POLICY NO: PM2025-07-02	From: Erin Kelley, Senior Manager
Date: June 27, 2025	Medical KEESM/KFMAM Reference(s):
RE: PHE & Unwinding Flexibilities	Program(s): All Medical Programs

This memo sets forth instructions related to CMS waivers and state-approved processing flexibilities implemented during the COVID-19 Public Health Emergency (PHE) and PHE Unwinding period. Some processes will continue on a permanent basis, some will change, and some will be retired. This memo supersedes and/or replaces the information found in PM2023-03-02 v.3, PM2024-05-02, PM2023-08-02, and PM2024-06-01 and is effective July 1, 2025. The policy manuals will be updated with the next scheduled revision.

Applicable to all medical programs:

- Status of CMS Waivers
- Employer Statements Flexibility

Applicable to Family Medical Programs only:

- Unknown Tax Filing Status Flexibility
- Partial Approvals

Applicable to Elderly and Disabled Medical Programs only:

- Untimely AVS Results
- SSI Terminations – Extended Time to Return Application

I. CHANGES IMPACTING ALL MEDICAL PROGRAMS

A. STATUS OF CMS WAIVERS

During the PHE and PHE Unwinding periods, several waivers were authorized by CMS and implemented for the purpose of reducing burden on consumers and minimizing procedural terminations

due to failure to provide information at review as well as keeping consumer contact information up to date. These waiver authorities were previously extended by CMS through June 30, 2025, see PM2024-05-01. The below outlines the status of each waiver and how/if it will continue to be in effect.

1. WAIVERS CONTINUING

a) MCO ASSISTANCE WITH RENEWALS

Per PM2023-08-02 and PM2024-05-02, Managed Care Organizations (MCO's) have been permitted to assist consumers with completing the review process, including filling out certain parts of the review form. This assistance is limited to completing the fields with information provided by the consumer. They are not permitted to assist with the fields pertaining to MCO selection or the signature page, and they are prohibited from acting as the consumer's medical representative or facilitator.

While the original flexibility was considered temporary, CMS has since determined that this level of assistance is permissible on an ongoing basis at state discretion. For that reason, Kansas will continue this practice and/or the ability to exercise this option as needed. MCO's are still prohibited from completing sections related to plan choice, acting as an authorized representative, and signing on behalf of the beneficiary.

For a full list regarding how MCO's may and may not assist the consumer, see PM2023-08-02, section I.A.

b) IN-STATE ADDRESS CHANGES FROM USPS OR MCO

Per PM2023-03-02, v.3 and PM2024-05-02, during the PHE and Unwinding periods, Kansas adopted CMS waivers to allow the acceptance of in-state address changes received from USPS (via returned mail) and MCO's without conducting additional outreach to the consumer. Since then, CMS has issued a new eligibility rule making this practice required. This rule designates USPS and MCO's as reliable sources for in-state address changes, meaning that if the state receives an updated in-state address from a reliable source, it must accept the information, update the consumer's address, and notify the consumer of the change.

2. WAIVERS EXPIRING

a) REVIEW RECONSIDERATION PERIOD – REINSTATEMENT

Currently, Kansas is operating under a CMS waiver that allows reinstatement of eligibility back to the termination date for those who are discontinued at review for failure to return a review or requested information and who submit the review or information during the 90-day review reconsideration period. Reinstatement was also allowed per state review policies dating back to 2014.

As of June 30, 2025, reinstatement in these situations is no longer automatically allowable. When a review or requested information is received during the review reconsideration period, it is processed as an application, and coverage is effective according to application rules. Prior medical may be used to fill any gap months if the criteria is met.

For the full policy related to review reconsideration period changes, see PM2025-07-01.

b) TELEPHONIC DESIGNATION OF AN AUTHORIZED REPRESENTATIVE

Per PM2023-08-02 section I.B., during the PHE Unwinding period, Kansas adopted a waiver flexibility to allow applicants/recipients to appoint an authorized representative (i.e., medical representative or facilitator) over the phone without obtaining it in writing.

As of July 1, 2025, this flexibility is no longer allowable. Authorized representatives must be designated in writing via the approved form or the application/review form. Signatures must continue to be accepted in all modalities, including by telephone through the telephonic signature process.

B. EMPLOYER STATEMENTS FLEXIBILITY

During the PHE for Family Medical programs and continuing through the Unwinding period for all programs, the state adopted a temporary process simplification to waive the requirement to obtain an employer statement of a job ending.

As of July 1, 2025, this flexibility is no longer allowed, and standard policies apply for requesting the employer statement. Per standard policy found in PM2018-03-01, for Family Medical programs, an employer statement is only required when the consumer reports the loss of a job that will result in either a switch from Transitional Medical (TMD) to Caretaker Medical (CTM) or the reduction/elimination of a CHIP premium. This would typically be reported as an income-change. For E&D and LTC programs, standard policy for both reported changes and at review is to require verification of the income change unless it can be verified through the standard tiered verification process (except for Working Healthy recipients).

II. FAMILY MEDICAL PROGRAMS ONLY

A. UNKNOWN TAX FILING STATUS FLEXIBILITY

Under standard MAGI policy, obtaining tax household information is a requirement of eligibility for all applicants as it impacts how their income is budgeted and counted. During the Unwinding period, the requirement was waived for situations where tax household information reported on the application or review was missing or unclear, and it was allowable to default to non-filer household status for those individuals.

As of July 1, 2025, this flexibility is modified to align with standard policies and CMS requirements. In situations where the consumer has reported a tax filing status on the application or review form, but it is lacking or unclear, staff must reach out to the consumer and confirm this information for budgeting purposes. (See PM2023-03-02, v.3 for reference.) The information is required as a condition of eligibility.

If there is no response to the question pertaining to whether the individual plans to file a tax return and the following tax filing fields are also blank, it is still acceptable to assume the household is not filing taxes and utilize non-filer rules. Additionally, if a consumer reports that they are unable to identify or establish their tax filing status or that of their household members, non-filer status may also be used.

B. PARTIAL APPROVALS

A partial approval refers to when a determination is made for one or some members while pending for additional information needed for others, or when only prior medical information was missing. This is generally an operational flexibility to accelerate benefits for those for whom we have sufficient information. Because it causes some system or processing complexity, it is generally not utilized unless there is a unique need.

During the PHE and Unwinding periods, staff were directed to use the partial approval process indiscriminately when the only information missing was for a prior medical determination. (See PM2023-03-02, v.3 and PM2020-04-01 for reference.)

Going forward, it is no longer required to complete a partial determination in instances where the only information missing is for the prior medical determination. This strategy remains an operational flexibility to be utilized as the organization determines useful.

III. ELDERLY & DISABLED MEDICAL PROGRAMS ONLY

A. UNTIMELY AVS RESULTS

As noted in PM2023-03-02 v3, during the PHE Unwinding Period, KDHE opted to continue use of the CMS waiver authority to assume there were no changes in resource values for Elderly and Disabled (E&D) and Long Term Care (LTC) eligibility determinations when the AVS response was either not received within the 10-day reasonable timeframe, or not received at all. This waiver continued to better streamline review processing by mirroring ex-parte resource policies.

As of July 1, 2025, this flexibility is no longer allowed, and standard AVS resource verification policies apply.

B. SSI TERMINATION – EXTENDED TIME TO RETURN APPLICATION

Due to the continuous enrollment requirement during the COVID-19 PHE, beneficiaries were required to maintain the full Medicaid benefits for the duration of the PHE. These included recipients of the SI Medical Program, even if they lost their SSI recipient status with Social Security (SSA).

At the start of the PHE Unwinding Period, KDHE Eligibility Policy issued guidance for this population referencing the SSI termination policies outlined in PM2018-10-01. This guidance required that an application be sent to individuals who lost their SSI recipient status with SSA. Additionally, the PHE Unwinding guidance temporarily extended the timeframe for individuals to return the application from twelve (12) days to thirty (30) days.

Recently, questions have arisen regarding the duration and end date of this policy, highlighting the need for formal clarification for eligibility staff.

Although the requirement to allow thirty (30) days for returning an application was effectively retired at the end of the PHE Unwinding Period, the use of this flexibility – implemented administratively at state option – may have continued beyond that date. Since allowing thirty (30) days is a more permissive, not more restrictive, policy, this memo affirms that any individual granted the extended timeframe after the conclusion of the PHE Unwinding Period and through July 1, 2025, shall not be found in error.

Effective July 1, 2025, standard pending timeframes outlined in MKEESM 1414 must be followed.

IV. QUESTIONS

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

Amanda Corneliusen	Senior 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.