
II Verifications/Checklist

Medical Programs



CBMS Project # 1404 (AKA CR2135)

CBMS Updates

- What this change will do
- What this change will not do
- CBMS Overview



This Change Will

- Implement the full functionality of the Awaiting Verification from Client field (AVC)
- Generate the verification checklist for required verifications based on data entry
- Grant the ability to pend for State Help Desk Ticket
- Deny for missing verifications including Citizenship and Identity



This Change Will

- Grant the ability to pend at the client level for “Good Faith”
- Grant the ability to authorize FM clients at the client level vs. case level
- Grant the ability to pend CHP+ clients at the client level vs. case level
- Automate the Recertification Notice for Family Medicaid guaranteed clients



This Change Will

- Resend verification checklists on all cases pending due to missing verifications and establish a new due date
 - Due to the outstanding cases that are pending for verifications, a data fix will be done to clear out all of the verifications and provide new dates for ALL medical cases that are pending verifications. This fix will be applied within a week after implementation of the project.



There will be a significant jump in client correspondence during this data fix. All clients will receive new verification checklists. Denial letters will go out after 15 business days for those that do not respond within 10 business days.

One-time data fix occurred February 6th, 2011 – February 13th, 2011

This Change Will Not

- Deny for failure to return the Recertification Notice
- Modify Special Action
- Modify the CBMS Exceeding Processing Guidelines (EPG) Reports
- Exempt Citizenship and Identity for Needy Newborns born prior to 3/1/2010



This Change Will Not

- Exempt Citizenship and Identity for Needy Newborns who are no longer in the home
- Recognize Identity Affidavits for applicants that provided this document prior to age 16
- Recognize applicants that were previously part of an exemption group



Questions?



CBMS Overview

- Verification Checklist
- Medical Verifications Button
- Good Faith
- Denials
- Family Medicaid and CHP+
- Adult Medical Programs
- Miscellaneous



Topics discussed in this training will follow the Sections within the **HCPF 2011 Desk Reference for Medical Programs: Verifications, Authorization, Good Faith, and Miscellaneous.**

For Terms discussed in this training, please refer to the Definition Section within your HCPF 2011 Desk Reference for Medical Programs.

Required Verifications Policy

- Family Medicaid & CHP+
 - U.S. citizenship and identity documents
 - Non-citizen documents
 - Earned income
 - Pregnancy verification for FM determination
 - Other health insurance



CHP+ does not require pregnancy verification or other health insurance. However, this is a required verification for FM and FM determination must be made prior to determination for CHP+.

Required Verifications Policy

- Adult Medical and Long-Term Care
 - U.S. citizenship and identity documents
 - Non-citizen documents
 - Earned income
 - Unearned income
 - Resources
 - Expenses verification
 - Pregnancy verification
 - Disability verification, if required
 - Other health insurance



Old Age Pension Health Care Program does not require U.S. citizenship and identity documents.

Breast and Cervical Cancer Program only requires U.S. citizenship and identity documents.

Required Self-Declarations Policy

- All Programs
 - Colorado residency (address)
 - SSN
 - Relationship status
 - Individual demographics (ethnicity, birth date, gender)
 - School information
 - Medical expenses
- Family Medicaid & CHP+
 - Unearned income



Verification Checklist Generation of Checklist

- Prior to this change, the eligibility worker was required to manually generate the Verification Checklist
- With this change, CBMS will generate the Verification Checklist upon completion of data entry
 - Verifications listed are based on verification Type and Source entered
 - Unacceptable verification Type/Source will be included on the Verification Checklist
 - Data Entry Complete field



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Please refer to **Section 1-Generating the Verification Checklist for required verifications** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples

Data enter all verifications that have been received from applicant/client within **Interactive Interview (II)**.

CBMS identifies which verification Types/Sources are acceptable per policy in order to determine eligibility for clients.

Any required verifications that do not have an acceptable verification Type and/or Source entered will be added to the Verification Checklist and applicable due dates will be set.

The Verification Checklist is automatically sent out by CBMS upon completion of data entry on a case.

If all information has been data entered within **II**, select **Y** in the **Data Entry Complete** field.

If all information has not been data entered within **II**, select **N** in the **Data Entry Complete** field.

If **N** is selected, the Verification Checklist **will not** be sent out to the client.

U.S. Citizenship/Identity Verification Policy

- All Medicaid and CHP+ clients who are **U.S. citizens** must provide original citizenship and identity documentation
- Exempted:
 - Presumptive Eligibility clients
 - Newborns of mothers receiving Medicaid or CHP+
 - Clients currently eligible for SSI, SSDI or Medicare
 - Foster care children



U.S. Citizenship/Identity Verification Policy

- Acceptable citizenship documents are broken down in tiered charts
 - Documents should be obtained from the highest level possible
- Identity documents are not tiered
- See complete list at [Colorado.gov/hcpf](https://colorado.gov/hcpf)



Non-Citizen Documentation Policy

- Non-citizenship documents must be issued by U.S. Citizenship and Immigration Services (U.S.C.I.S.)
- Documents need not be originals
- Must be verified through SAVE (Systematic Alien Verification for Entitlements)



Income, Resource and Expense Documentation Policy

- Income, resource and expense documentation, when applicable, should be provided for the month of application or the month prior to application if current month is not available
- All documents should be from the same month



Pregnancy Documentation Policy

- Pregnancy verification required unless observable
- Verification from licensed medical professional (Certified Medical Assistant or higher)
- Verification need only include name and due date signed by professional



Verification Checklist

Viewing the Checklist

- Process will remain the same with this change
 - The Verification Checklist can be viewed by selecting the Verification Checklist button within the Display Eligibility Summary window



Please refer to **Section 1-Viewing the Verification Checklist** and **Adding Notes to the Verification Checklist** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Display Eligibility Summary

Case #: Case Name:

Program Group	Payment Month	Eligibility Status	Benefit Amount	Adverse Action Amount	Household Size	Eligibility Begin Date	Application Date
Family Medical Assiste	2010/11	PENDING	\$ 00	\$ 00	2	00/00/0000	11/02/2010
Childrens Health Plan f	2010/11	PENDING	\$ 00	\$ 00	2	00/00/0000	11/02/2010
Family Medical Assiste	2010/12	PENDING	\$ 00	\$ 00	2	00/00/0000	11/02/2010
Childrens Health Plan f	2010/12	PENDING	\$ 00	\$ 00	2	00/00/0000	11/02/2010
Family Medical Assiste	2011/01	PENDING	\$ 00	\$ 00	2	00/00/0000	11/02/2010
Childrens Health Plan f	2011/01	PENDING	\$ 00	\$ 00	2	00/00/0000	11/02/2010

CBMS

 Message Code : 1311

Description : Verifications must be viewed before Wrap Up can be initiated.

OK

Reason... **Verification Checklist...** Initiate Wrap up... Individual Details...

Click on the **Verification Checklist** button to view the checklist.

Case Number: [] Name: [] Programs []
 Status: Pending Status Date: 12/01/2010 Pending Alerts: 12 WP [Y/N]: N

Summary | Detail | Good Faith

Program Group: ALL

Name	Item Description	Due Date	Program Group	Aid Code	Pay Month	Notes
	Identification	01/14/2011	Family Medical Assist	1931	2010/12	N
	Income from employment	01/18/2011	Childrens Health Plan	CHP+	2011/01	Y
	Income from employment	01/18/2011	Family Medical Assist	1931	2011/01	N
	Pregnancy	01/14/2011	Family Medical Assist	1931	2010/12	N
	U.S. Citizenship	01/14/2011	Family Medical Assist	1931	2010/12	N

System Notes: []
 User Notes: Please send a copy of paycheck stubs for Coox Bxxxxx for employment at Wxxxxxx, Inc. for the month of Dec2010

Medical Verifications | Online Print

The Verification Due Date is set from the Notice Date. This date is printed on the Verification Checklist as the date verifications are due by. This date varies per program group.

The Notice Date = the day after EDBC is run. The Verification Due Date timeframe begins the day after the notice date.

This date is displayed as **Due Date** on the **Verification Checklist** window.

Enter detailed information for each client within the **User Notes** section. Include what verifications are missing, month, etc. Do not include information within this section that does not pertain to the missing verification listed on the checklist.

NAME	NEED PROOF OF	PROGRAM GROUP	DUE DATE
	Income from employment	Childrens Health Plan Plus	01/18/2011
	NOTES:		
<div style="border: 1px solid orange; padding: 5px;"> Please send a copy of paycheck stubs for Cxxx Bxxxxx for employment at Wxxxxxx, Inc. for the month of Dec 2010 </div>			
	Identification	Family Medical Assistance	01/14/2011
	NOTES:		

Information entered into the **User Notes** section is added word for word to the Verification Checklist notice sent to the client.

Questions?



Verification Checklist

Additional Information and Exceptions List

- Suppression
- Changes to User Notes section only
- Changes to a Verification Type or Source
- Pending for Additional Verifications
- Disabled Online Print
- State Help Desk Ticket
- Clients on a Guaranteed Program
- Good Faith
- CHP+ Pending Verifications Past RRR Due Date



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Verification Checklist Suppression

- Prior to this change, the Verification Checklist was resent to the client each time EDBC was run on the case and there were missing verifications
 - Suppressed by using the Online Print function
- With this change, the Verification Checklist will be suppressed if EDBC is run on the case while it is pending for missing verifications and there are no changes to the verification types, sources or notes



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist-Suppression of Checklist** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Verification Checklist

Changes to User Notes Section Only

- Process will remain the same with this change
 - The verification due dates do not change if the only change is an update to the User Notes section
 - CBMS generates an additional verification checklist to the client with the new information and the original due date remains the same



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist-Changes to Notes Section Only** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Verification Checklist

Changes to a Verification Type or Source

- Prior to this change, verification due dates were extended if the client provided another invalid verification Type or Source
- With this change, the verification due dates will not change if a missing verification contains an invalid verification Type or Source and is updated with another invalid verification Type or Source



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist-Changes to a Verification Type or Source for a Missing Verification** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Questions?



Verification Checklist Pending for Additional Verifications

- Prior to this change, Verification Due Dates were set for each household member and for each missing verification
 - Verification Due Dates were based on the day the verification was updated
- With this change, a new Verification Checklist is generated with a new due date if additional missing verification is identified
 - New Verification Checklist includes previous missing verifications with their due dates as well as the new missing verification with the new verification due date



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist-Pending for Additional Verifications after the Initial Verification Checklist** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Verification Checklist Disabled Online Print

- Prior to this change, the Verification Checklist could be removed from batch by using the Online Print function
- With this change, the Online Print function is disabled for all Medical Programs
 - Function is not disabled if there are missing verifications for both Medical and Financial programs



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist-Disabled Print and Financial Programs** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Financial Program = Food Assistance (FA), Colorado Works (CW) and Adult Financial (AF).

If a case has missing verifications that are related to both a Medical and Financial program, the Online Print function is **not** disabled. If the function is utilized, the Medical Programs' information will be suppressed from the Verification Checklist.

The Verification Checklist will be sent that evening and will include both Medical and Financial missing verifications.

Disabling the Online Print function for Medical Programs will ensure that the Verification Checklist is sent out and can be tracked for appeals, audits, etc.

Verification Checklist State Help Desk Ticket

- Prior to this change, the Verification Checklist was sent to the client if the case was pending for both a State Help Desk Ticket and missing verifications
- With this change, if a Medical Program is pending for a State Help Desk Ticket, the Verification Checklist will not be sent out



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist- State Help Desk Ticket and the Verification Checklist** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Pending due to a State Help Desk Ticket overrides pending for missing verifications.

If the case is pending correctly due to missing verifications, the Verification Checklist must be generated prior to pending the case for State Help Desk Ticket in order for the Verification Checklist to be sent to the client.

If there were previous missing verifications, those will remain on the Verification Checklist that was initially sent prior to pending for a State Help Desk Ticket.

Questions?



Guaranteed Programs Policy

- Clients on a Guaranteed Program will be exempted from missing verifications and continue to pass until the end of their guaranteed period
- Includes clients on the following programs:
 - Eligible Needy Newborns & CHP+ Newborns
 - 4-month Extended
 - Transitional Medicaid
 - Qualified or Expanded Pregnancy



Guaranteed Programs Policy

- Clients will receive a Recertification Notice at the end of their guaranteed period in order for their eligibility to be reassessed
- Reassessment required due to change in circumstances following guaranteed period
 - All household members must comply just like at RRR
 - Non-compliance will result in discontinuation for all household members affected by the missing verification



Example 1:

Mom, Dad, and child reassessed after 12 months of TM. They do not return the needed income verification. Mom, Dad, and child are discontinued.

Example 2:

Mom and Needy Newborn reassessed after Mom's 60 days post-partum. Mom does not return income verification. Mom is discontinued, Needy Newborn stays on guaranteed program.

Verification Checklist Clients on a Guaranteed Program

- Prior to this change, missing verifications impacted guaranteed members causing them to Pend
- With this change, failure to provide missing verifications will not impact clients on a Guaranteed Program
 - Missing verifications that are needed to determine eligibility for another household member are included on the Verification Checklist



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist-Verification Checklist and Clients on a Guaranteed Program** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

The Verification Checklist provides a statement indicating that the information for the client who is on a Guaranteed Program is required for other household members and that their eligibility is not impacted.

If the client who is on a Guaranteed Program is the only member in the case requesting assistance and they are missing verifications, the **Verification Checklist** window does not list any missing verifications and the Verification Checklist is not sent.

Good Faith Policy

- Applicants/clients that are not able to provide documents within the reasonable opportunity period but are trying to secure documentation should be granted additional time to secure documents
 - At eligibility site discretion
 - Verbal declaration of need is sufficient unless questionable
 - Time period based on a case-by-case basis
 - Granted according to the reasonable amount of time needed to secure documentation



Verification Checklist Good Faith

- Prior to this change, there was no way to indicate that a Good Faith extension was granted for an individual for missing verifications
 - All missing verifications are included on the Verification Checklist
- With this change, the Verification Checklist will include all missing verifications even those that have been granted a Good Faith extension
 - A statement will be included on the Verification Checklist indicating that a Good Faith extension has been applied



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist-Good Faith and the Verification Checklist** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

A Good Faith extension is applied at the individual level not at the verification level. For example, A client is missing citizenship and income but the client only requests Good Faith for citizenship. The client can only be selected from the drop down list to apply good faith and good faith can not be applied to the citizenship only.

If an individual requests additional time to provide a missing verification and is granted a Good Faith extension, this extension will be applied to all missing verifications that have a Verification Due Date that is after the Good Faith extension Begin Date. For example, client is missing verification of earned income and pregnancy, both have due dates after the Good Faith extension begin date. The Good Faith extension will be granted and the client will remain pending. If the earned income and pregnancy verification due date was prior to the Good Faith begin date, the client would have been denied for missing verification.

If the Verification Checklist is printed after the Good Faith extension has been granted, a note stating “Good Faith extension granted” is included next to the missing verification on the Verification Checklist.

The established Verification Due Date remains the same as when the Verification Checklist was initially sent.

NAME	NEED PROOF OF	PROGRAM GROUP	DUE DATE
	Income from employment	Childrens Health Plan Plus	01/13/2011
	NOTES: Good Faith extension granted from 12/28/2010.		
	Income from employment	Family Medical Assistance	01/13/2011
	NOTES: Good Faith extension granted from 12/28/2010.		
	NOTES:		

Verification Checklist

CHP+ Pending Verifications/RRR Due Date

- Prior to this change, if the case was denied after the RRR Due Date, the eligibility would end as of the RRR Due Date regardless of when the denial occurred
- With this change, CHP+ clients will receive coverage until the end of the month of the denial



Please refer to **Section 1-Additional Information and Exceptions for the Verification Checklist-CHP+ Pending Verifications Past RRR Due Date** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Verification Checklist Review

- If Data Entry Complete = N will the Verification Checklist be sent to the client?
 - No
- Will you be able to Online Print the Verification Checklist for a combo FM and FA case?
 - Yes, but the Medical verifications will be suppressed and a separate checklist will be sent through batch that evening
- What groups are exempt from providing Citizenship and Identity verification?
 - Presumptive Eligibility clients
 - Newborns of mothers receiving Medicaid or CHP+
 - Clients currently eligible for SSI, SSDI or Medicare
 - Foster care children



Questions?



Medical Verifications

Awaiting Verifications Window

- Prior to this change, the Medical Verifications button and Awaiting Verification from Client field were available and active for Adult Programs only
- With this change, all Medical Programs can use this field to Pend a case for missing verifications at Intake and RRR modes only
 - Generates Medical Verifications Notice



Please refer to **Section 2: Medical Verifications Button** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

The **Awaiting Medical Verifications from Client** field located on the **Awaiting Verifications from Client** window can only be utilized at Intake or RRR modes.

This field pends at the case level vs. individual level

This window can be accessed by selecting the **Medical Verifications** button within **Perform Interactive Interview Wrap Up** window.

Do not use for Financial Programs because they are not programmed to this field and will not pend for missing verification.

If you are only missing CIT and/or ID verifications for a AM or LTC application, do not use this field to request missing verification as it will not generate the correct Verification Due Date. You can use this field to request CIT and/or ID verifications for FM and CHP+ as it will generate the correct Verification Due Date.

Best practice is to complete all data entry within Interactive Interview (II) and generate the Verification Checklist rather than use the **Awaiting Medical Verifications from Client** field to request missing verification.

Case

Number: Name: Programs

Status: Pending Status Date: 01/05/2011 Pending Alerts: 2 WP [Y/N]: N

The values on this window will only impact Medical Programs.

Medical Program Group	Awaiting Verif from Client	Verification Due Date	App Denial Due Date
Childrens Health Plan Plus	N	00/00/0000	00/00/0000
Family Medical Assistance	N	00/00/0000	00/00/0000

Medical Program Group: Childrens Health Plan Plus Awaiting Verifications from Client [Y/N]: N

Verification Due Date: 00/00/0000 Application Denial Due Date: 00/00/0000

Notes:

Select the appropriate Medical Program from the list.

On the **Awaiting Medical Verifications from Client** field change N to Y.

When changing Family Medical Assistance from N to Y, CHP+ automatically updates to match FM.

When the **Awaiting Medical Verifications from Client** field is changed from N to Y the **Verification Due Date** and **Application Denial Due Date** will become system populated and the **Notes** section will become available.

The **Verification Due Date** is system generated and is set to 10 business days after the day that the **Awaiting Verifications from the Client** field is changed to Y. This applies to all Medical Programs with the exception of LIS which provides 15 calendar days.

The **Application Denial Due Date** is system generated and is set to 15 business days after the day that the **Awaiting Verifications from the Client** field is changed to Y. This applies to all Medical Programs with the exception of LIS which provides 20 calendar days.

If action has not been taken on a case when the **Application Denial Due Date** has been reached, CBMS will automatically run EDBC on the case and deny for missing verification.

Case

Number: Name:

Status: Status Date: Pending Alerts: WP [Y/N]:

The values on this window will only impact Medical Programs.

Medical Program Group	Awaiting Verif from Client	Verification Due Date	App Denial Due Date
Childrens Health Plan Plus	Y	<input type="text"/>	<input type="text"/>
Family Medical Assistance	Y	<input type="text"/>	<input type="text"/>

Medical Program Group: Awaiting Verifications from Client [Y/N]:

Verification Due Date: Application Denial Due Date:

Notes:

Enter detailed information for each client within the **Notes** section. Include what verifications they are missing, month, etc.

Changes made to the **Notes** section will generate another notice to the client.

The case will pend and the Medical Verifications Notice will be sent out regardless if the **Data Entry Complete** field is either Y or N.

Display Eligibility Summary

Case #: Case Name:

Program Group	Payment Month	Eligibility Status	Benefit Amount	Adverse Action Amount	Household Size	Eligibility Begin Date	Application Date
Long Term Care	2010/12	PENDING	\$.00	\$.00	1	12/18/2009	12/10/2009
Long Term Care	2011/01	PENDING	\$.00	\$.00	1	12/18/2009	12/10/2009

Display Reasons

Reason

awaiting verifications from Client = Y

Eligibility approval for Long Term Care

Reason...

Awaiting Medical Verifications from Client field will not pend case at the individual level.

STATE OF COLORADO



To :

From :

Date :

We did not receive all requested verification documents for your Medical application dated . Please provide all requested documents to us by , so that your eligibility determination can be made. If requested documents are not received by then your application will be denied.

Please provide verification of income (copy of paystubs) for Axxxxx Pxxxxx for his employment at Txxxxx for the month of December 2010.

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Information entered into the **Notes** section is added word for word to the notice sent to the client.

Case

Number: Name:

Status: Status Date: Pending Alerts: WP [Y/N]:

The values on this window will only impact Medical Programs.

Medical Program Group	Awaiting Verf from Client	Verification Due Date	App Denial Due Date
Childrens Health Plan Plus	Y	<input type="text"/>	<input type="text"/>
Family Medical Assistance	N	00/00/0000	00/00/0000

Medical Program Group:

Verification Due Date: Application Denial Due Date:

Notes:

If Medical Verifications are received by the **Verifications Due Date**:

Select the appropriate Medical Program from the list.

On the **Awaiting Medical Verifications from Client** field change Y to N.

When **Awaiting Medical Verifications from Client** field is changed from Y to N the **Verifications Due Date**, **Application Denial Due Date** and **Notes** section will become blank.

Close this window and return to the Navigate CBMS window and initiate the queue to update case with verifications received.

If the **Awaiting Medical Verifications from Client** field is not changed from Y to N after verifications are received and entered within II, CBMS will automatically reset this field to N.

Medical Verifications Review

- In what modes can the Medical Verifications button be used?
 - Intake and RRR
- When missing verifications are received do you need to update the Awaiting Verifications from Client field?
 - Yes, update this field to reflect N
- Should you use the Medical Verifications button to request DRA verifications for AM or LTC?
 - No, use the II Verification Checklist when requesting this verification to ensure correct verification due dates



Questions?



Good Faith

Good Faith Extension

- Prior to this change, there was no way of granting a Good Faith extension for missing verification
- With this change, CBMS provides the ability to grant a Good Faith extension and prevent clients from being denied for missing verifications during the Good Faith period



Please refer to **Section 3: Granting a Good Faith Extension, Good Faith and FM/CHP+ and Good Faith and CHP+ in Ongoing Mode** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

A Good Faith extension is applied at the individual level by selecting the Good Faith tab within the Display Verification Checklist window, selecting the individual that is missing verifications and has requested an extension and creating the record. A Good Faith Extension cannot be granted to individuals who are not missing verifications.

When a client's record for a Good Faith extension is saved, CBMS sends a notice informing them of the additional time to provide verifications.

Once the Good Faith record is created, the individual will remain pending even if the Verification Due Date has passed.

Whenever a Good Faith extension is granted to an individual, the system determines if that individual's missing verifications are needed to determine eligibility for another member in the household.

If their missing verifications are needed for another member in the household, CBMS will pend all dependent individuals until the missing verifications are received.

For CHP+ only, Good Faith is not granted when the case is in ongoing mode.

A Good Faith extension cannot be granted if the Verification Due Date has passed and the client has been denied.

Display Verification Checklist

Case

Number: Name: Programs

Status: Pending Status Date: 01/05/2011 Pending Alerts: 8 WP [Y/N]: N

Summary Detail **Good Faith**

Name	Begin Date	End Date
	1/13/2011	

Name: Begin Date: 01/13/2011 End Date:

Notes: Client called to request additional time to provide verification. Granted a Good Faith record

Please refer to **Section 3: Ending a Good Faith Extension and Additional Information and Exceptions for Good Faith** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples

A Good Faith extension can be ended in three different ways:

- Clearing the missing verifications within CBMS
- End Dating Good Faith record
- Denying the individual for another valid reason

STATE OF COLORADO



To :

From :

Date :

We did not receive all requested verification documents for _____ for Adult Medical Assistance. You have been granted an extension to give you more time to provide the documents. Please provide all the documents as soon as possible and keep your county worker informed of your progress in getting them. Thank You.

Good Faith Review

- What are the 3 ways within CBMS that a Good Faith Extension can be ended?
 - Clearing the missing verifications within CBMS
 - End Dating Good Faith record
 - Denying the individual for another valid reason
- Can a Good Faith extension be granted if the verification due date has passed?
 - No
- Is a Good Faith extension time limited?
 - No, time period is determined by the eligibility worker based on the client's situation



Questions?



Verification Timeframes Policy

- FM, CHP+, AM, MSP and LTC
 - 14 calendar days (CBMS allows 10+5 business days)
- AM and LTC special verification period for DRA verifications
 - 70 calendar days (CBMS allows 70+1 calendar days)
- 8.100.3.H.9
- LIS
 - 15 calendar days (CBMS allows 15+5 calendar days)
- 20 CFR part 418 , §418.3115 (c)



Standard Verification = Income, Resource, etc.

Standard Verification due dates are set for 10 business days from notice date (Max Denial Due Date =15 business days).

LIS standard verification due dates are set for 15 calendar days from notice date (Max Denial Due Date =20 calendar days).

DRA Verifications = Citizenship and/or Identification.

DRA Verification due dates are set for 10 business days from notice date for FM and CHP+ and 70 calendar days from notice date for AM and LTC (MSP and LIS exempt from DRA) (Max Denial Due Date = 70 calendar days + 1 business day).

Denials

Denial Due Dates

- Prior to this change, CBMS was unable to deny or close a case/individual for missing verifications
- With this change, all Medical programs will deny or close a case/individual due to missing verifications if they are not received and entered within CBMS prior to the denial due date



Please refer to **Section 4-Verification Denial Due Date (II Verifications)** and **Application Denial Due Date (Medical Verifications)** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

The Medicaid programs (FM, AM, LTC, MSP, LIS) deny in all modes (Intake, RRR and Ongoing).

If missing verifications are received, they must be entered prior to the Denial Due Date to prevent CBMS from running and authorizing the denial for missing verifications.

If the case is denied or closed incorrectly, rescind the case and process accordingly with the received verifications.

Denials

Denial Due Dates

- Prior to this change, CBMS was unable to deny or close a case/individual for missing verifications according to the rules of each Medical HLPG
- With this change, each Medical program will deny or close a case/individual due to missing verifications according to their rules



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Please refer to **Section 4-CHP+ Denying at Intake and RRR Modes only and Maximum Denial Due Date for FM and CHP+ and Maximum Denial Due Date for Adult Programs** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

The CHP+ program denies in Intake and RRR mode only.

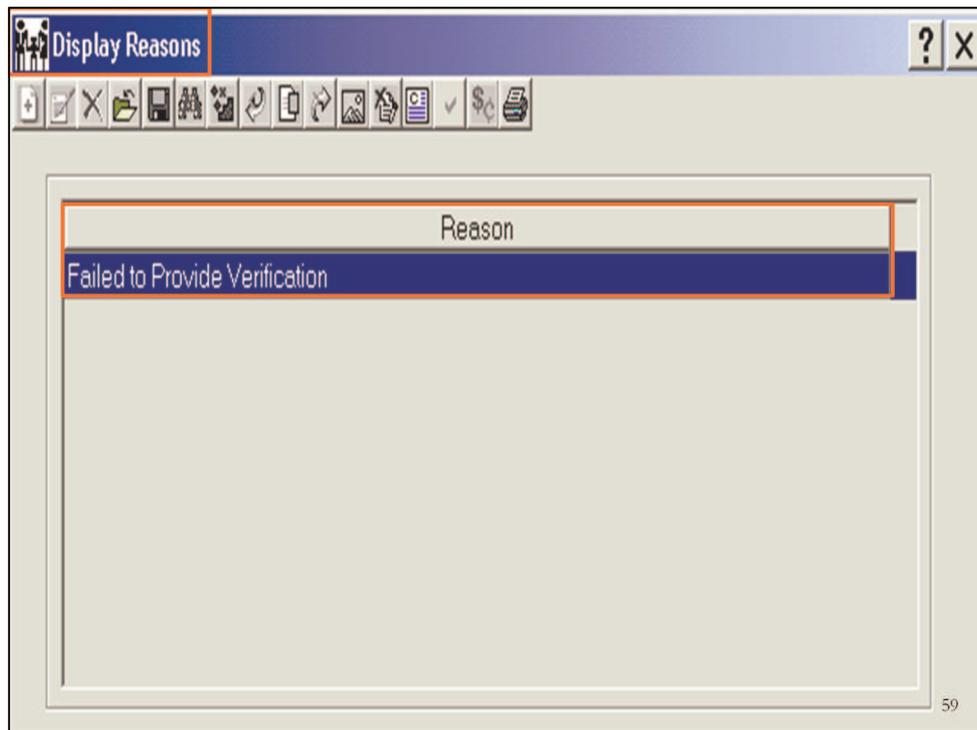
If there is a mixed household of FM and CHP+, the FM program denies for missing verifications in ongoing mode but CHP+ does not deny.

Based on the data entry and the circumstance of each application, a case or individual may have multiple denial due dates.

If there are multiple denial due dates, the Maximum Denial Due Date is set to the date furthest in the future and all prior are ignored.

The maximum denial due date is calculated by comparing all the denial due dates including the **Application Denial Due Date (Medical Verifications)** and the **Verification Denial Due Date (II verifications)**.

Until the Maximum Denial Due Date is reached, the case or individual remains pending.



Please refer to **Section 4-Exception of Maximum Denial Due Date for Adult Medical Programs** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

A client must be determined to be potentially eligible (income, resource, etc.). If a standard verification is requested at the same time or after the DRA verifications were requested, the Standard Verification Denial Due Date overrides the DRA Verification Denial Due Date. The Standard Verification Denial Due Date is considered the Maximum Denial Due Date. If a standard verification is requested after the DRA verifications were requested but the DRA Denial Due Date is prior to the Standard Verification Denial Due Date, the DRA Denial Due Date is considered the Maximum Denial Due Date.

STATE OF COLORADO



Date and time of eligibility determination :

At the date and time shown above, your eligibility for one or more programs was determined. The details of that eligibility determination are as follows:

The Long Term Care redetermination dated has been denied for because we did not get all the information we needed to redetermine your eligibility.

You may reapply at any time.

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Denials Review

- When there are multiple verification due dates, what due date is used to Deny?
 - Maximum Verification Due Date
- What is the Verification Due Date set to for FM?
 - 10 business days from notice date
- What is the verification time frame for Citizenship and Identity verifications for AM and LTC?
 - 70 Calendar Days



Questions?



Family Medicaid Authorized at the Individual Level

- Prior to this change, CBMS would Pend all individuals within a case if there were any missing verifications even if the verifications did not impact other household members eligibility
- With this change, FM will be able to deny for missing verifications at an individual level rather than a case level allowing the authorization of benefits for household members that are not missing verifications



Please refer to **Section 5-Pending and authorizing Family Medicaid on the individual level** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Display Eligibility Summary

Case #: Case Name:

Program Group	Payment Month	Eligibility Status	Benefit Amount	Adverse Action Amount	Household Size	Eligibility Begin Date	Application Date
Family Medical Assists	2010/12	PASS	\$.00	\$.00	4	12/01/2010	12/27/2010
Childrens Health Plan	2010/12	PENDING	\$.00	\$.00	4	00/00/0000	12/27/2010
Family Medical Assists	2011/01	PASS	\$.00	\$.00	4	12/01/2010	12/27/2010
Childrens Health Plan	2011/01	PENDING	\$.00	\$.00	4	00/00/0000	12/27/2010
Family Medical Assists	2011/02	PASS	\$.00	\$.00	4	12/01/2010	12/27/2010
Childrens Health Plan	2011/02	PENDING	\$.00	\$.00	4	00/00/0000	12/27/2010

Reason... Verification Checklist... Initiate Wrap up... **Individual Details...**

Display Individual Eligibility Summary

Case #: Case Name:

Payment Month: 12/2010

Colorado Works | Food Stamps | **Family Medical** | CIP | CHP+ | Adult Financial | Adult Medical | Medicare

Individual	Participation Status	Eligibility Result	Begin Date	Program	Limited to EMS	Fi S
	Include	PASS	12/01/2010	1931	<input type="checkbox"/>	
	Include	PASS	12/01/2010	1931	<input type="checkbox"/>	
	Include	PASS	12/01/2010	1931	<input type="checkbox"/>	
	Ineligible -Inc/	PENDING	00/00/0000	1931	<input type="checkbox"/>	

Display Reasons

Reason

- missing verif. See checklist
- client identification record=blank
- new DRA-8 logic applied

Override

Family Medicaid

Recertification of FM Guaranteed Programs

- Prior to this change, eligibility workers were required to manually send out a Recertification Notice to clients on a Family Medicaid guaranteed program in order to reassess their eligibility
- With this change, CBMS will automatically send out a Recertification Notice to the client 60 days prior to end of their guaranteed period
 - No longer need to track the guaranteed period and manually send out the Recertification Notice



Please refer to **Section 5-Reassessing Clients on a Family Medicaid Guaranteed Program** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples.

Upon authorization you will see the Recertification Notice within the correspondence queue. It will remain in the queue and will be sent to the client 60 days prior to the end of their guaranteed period.

Clients on the Transitional Medicaid Guaranteed Program must have 12 month of coverage in Transitional Medicaid in order for the system to automatically send the Recertification Notice 60 days prior to the end of their 12th month guaranteed period.

If the Recertification Notice is not returned, the case will not automatically close for failure to return. This will be implemented in a future change. It is at the discretion of the eligibility site to develop a procedure to track and close these cases. In the interim, please process cases according to your current business process.

STATE OF COLORADO



RECERTIFICATION NOTICE

It is time to see if your family is still eligible for the medical benefits you receive. The information you give will be used to determine if your family is still eligible for these programs.

Please return the following information to me by 03/18/2011 to continue benefits for your family. If you do not return this information by 03/18/2011, your family's benefits may end.

I am reporting the following change(s) (Check the boxes for your changes):

Pregnancy:

Pregnant Woman's Name: _____ Due Date: _____

*Please send a pregnancy statement signed by a medical professional including the expected due date.

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CHP+

Determining Eligibility at the Individual Level

- Prior to this change, whenever one client was pending FM, CBMS would Pend the entire CHP+ household within FM regardless if they were not eligible for FM
- With this change, CBMS identifies which individuals are not eligible for FM and allows them to process through CHP+ regardless if other household members are pending within FM



Please refer to **Section 5-CHP+ determining eligibility at the individual level and CHP+ Generation of Enrollment Fee** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples

At intake and RRR, when one family member is pending for FM for missing verifications and there are other potentially eligible members for CHP+, the system will continue processing eligibility for CHP+.

CBMS will not allow eligible CHP+ members to be authorized at the individual level and begin receiving benefits until eligibility is determined for all household members. This is due to having to wait until eligibility is determined for all members to calculate the enrollment fee.

At intake and RRR, when one family member is pending in CHP+ for missing verifications and there are other potentially eligible members for CHP+, the system will not calculate the enrollment fee until the pending family members eligibility is determined.

Family Medicaid and CHP+ Review

- If one household member is pending for missing verifications, can you authorize benefits for other household members?
 - Yes, only if the missing verifications does not impact those member's eligibility
- If one household member is pending for FM and another member is potentially eligible for CHP+, will CBMS continue processing for CHP+?
 - Yes
- A Recertification Notice is sent out 60 days prior to the end of the guaranteed period for FM guaranteed clients? True or False
 - True



Questions?



Adult Medical Programs

Exception for AM-OAP and DRA Verifications

- Prior to this change, AM-OAP Medicaid clients would Pend indefinitely for missing CIT/ID verifications
- With this change, AM-OAP Medicaid clients will Pend for missing CIT/ID verifications until the Denial Due Date. If the client does not provide missing CIT/ID verifications, they will not be denied. CBMS will approve client for AM-OAP Health Care Program as CIT/ID verifications are not required.



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Please refer to **Section 6-Exception for Adult Medical OAP and DRA verifications** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/or examples

If a client passes for AF-OAP, we are required to pass the client for a category of AM-OAP. Eligibility for Medicaid or the Health Care Program (HCP) is based on the client's demographics that are data entered.

If the client is not potentially eligible for AM-OAP Medicaid based on demographics entered, the client will not pend for missing CIT/ID verifications. They will be approved for AM-OAP HCP.

If a potential AM-OAP Medicaid client does not provide missing CIT/ID verifications and is authorized for AM-OAP HCP and EDBC is run again in an ongoing mode, the system will not pend and set a new Verification Due Date if CIT/ID are still missing. The missing CIT/ID verifications will be ignored allowing the case to pass again for AM-OAP HCP.

If the client later provides the missing CIT/ID verifications, CBMS will not allow the client to be retroactively approved for AM-OAP Medicaid.

The client will remain on AM-OAP HCP until their OAP eligibility is redetermined at the AF-OAP RRR month (AM does not set an RRR for AM-OAP categories).

If the CIT/ID verification provided is acceptable, the client will be approved for AM-OAP Medicaid effective the first of the month following the AF-OAP RRR month.

Adult Medical Review

- Is Citizenship and Identity verification required for AM-OAP HCP?
 - No, because AM-OAP HCP is not Medicaid
- If Citizenship and Identity verifications are not received for a potential AM-OAP Medicaid client, will AM be denied?
 - No, the client will be approved for AM-OAP HCP
- If the client is approved for AM-OAP HCP because they did not provide CIT/ID verifications, will they be approved for Medicaid once they provide the missing verification?
 - Yes, effective the first of the month following the AF-OAP RRR month



Questions?



Pending for State Help Desk Ticket

- Process will remain the same with this change
 - All medical programs will pend at the case level if it is indicated that there is a pending State Help Desk Ticket
 - New State Help Desk Ticket Number field



Please refer to **Section 7- Pending for State Help Desk Ticket** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/ or examples.

Pend your case for this reason only after you have run EDBC on the case, identified a system issue, submitted a **State** Help Desk Ticket and have received a **State** Help Desk Ticket number.

The **State Help Desk Ticket Number** field is a manual data entry field and may be used for reporting purposes for State Help Desk Tickets only.

Do not enter County help desk ticket numbers within this field.

Collect Case Summary Detail

Case
 Number: Name:
 Status: Status Date: Pending Alerts: WP [Y/N]:

Case Information **Programs Requested** Case Payee

Program Group	Emergency Request	Effective Begin Date
Childrens Health Plan Plus		08/19/2010
Family Medical Assistance		01/03/2010

Application Override Date:
 Override Reason:
 Application Date:
 Program Status:
 Status Date:
 Help Desk Ticket (HDT) Number:

Complete the fields indicated above to pend your case for a State Help Desk Ticket.

Enter detailed Case Comments indicated that your case is Pending for a State Help Desk Ticket. Include program pending, summary of issue, expected result and State Help Desk Ticket number.

Once the State Help Desk Ticket has been resolved, clear the fields indicated above and click on Save. Since there is no history saved on this window, please enter Case Comments when ticket has been resolved. Include program pending, State Help Desk Ticket number and resolution received from the State Help Desk.

Display Eligibility Summary

Case #: Case Name:

Program Group	Payment Month	Eligibility Status	Benefit Amount	Adverse Action Amount	Household Size	Eligibility Begin Date	Application Date
Childrens Health Plan	2011/02	PENDING	\$.00	\$.00	0	00/00/0000	01/01/2011
Childrens Health Plan	2011/01	PENDING	\$.00	\$.00	0	00/00/0000	01/01/2011
Family Medical Assiste	2011/02	PENDING	\$.00	\$.00	2	00/00/0000	12/18/2007
Family Medical Assiste	2011/01	PENDING	\$.00	\$.00	2	00/00/0000	12/18/2007
Family Medical Assiste	2010/12	PENDING	\$.00	\$.00	2	00/00/0000	12/18/2007

Display Reasons

Reason

pending help desk ticket

Reason...

Data Entry Complete

- Prior to this change, the Data Entry Complete field was enabled for all Medical Programs with the exception of LIS to Pend for case incomplete
- With this change, the Data Entry Complete field has been made a mandatory field for all medical programs including LIS



Please refer to **Section 7-Update to Data Entry Complete Field** in your HCPF 2011 Desk Reference for Medical Programs for detailed direction and/ or examples.

Perform Interactive Interview Wrap Up

Case

Number: Name:

Status: Status Date: Pending Alerts: WP [Y/N]:

Signatures **Data Entry Info**

Program Group	Data Entry Complete [Y/N]	Effective Begin Date
Childrens Health Plan Plus	Y	08/19/2010
Family Medical Assistance	Y	01/03/2010

Effective Begin Date: Program Group:

State Help Desk Ticket and Data Entry Complete Review

- How do you Pend a case that has an active State Help Desk Ticket?
 - Complete the Application Override Date, Override Reason and HDT number fields within the Collect Case Summary Detail Window
- Should you Pend for County help desk tickets within this window?
 - No
- Is Data Entry Complete a mandatory field for all Medical Programs?
 - Yes



Questions?



Reminders

- Add detailed case comments each time there is an update made to your cases
- Review and resolve all Alerts timely
- Follow the field definition guide and all data entry documents located on the Department of Human Services Web Portal or by using Shift + F1 within CBMS
- Read all CBMS Communications
 - If you are not signed up for communications, contact PC.HELPDESK@state.co.us



Where to Get More Information

- HCPF Website - Colorado.gov/hcpf
- Medicaid Eligibility Email Address - Medicaid.eligibility@hcpf.state.co.us
- CHP+ Eligibility Email Address - CHP+.eligibility@hcpf.state.co.us



Questions?



Thank You!

