

## Project 1404 Overview

The following will provide a high level overview of the changes being implemented into CBMS within Project 1404 (AKA 2135).

### 1. Verification Checklist:

- The verification checklist will be sent automatically from CBMS to the client without requiring the user to trigger it to be sent.
- The “online print” functionality will be disabled for medical programs to ensure that the letter is always sent from CBMS for auditing purposes. The letter will still be available in the printed correspondence queue to review.
- The verification due date will be corrected to provide 10 business days to the client as of the date the letter is sent. Currently CBMS sets the due date to the date the verification is updated, regardless if the letter is sent out many days later.
- In addition, the system will allow an additional 5 business days before triggering the case to be denied for missing verifications. This will help technicians in keeping track of cases and making sure they are closed timely.
- The verification checklist cover letter will identify whenever there is a client on a guaranteed program so they know that we need their verifications for other family members but their coverage will still continue if the information is not returned.

### 2. Data Entry Complete for LIS (Low Income Subsidy):

- For the LIS program, the logic to pend the LIS HPLG when the Reason for Requesting Assistance is invalid will be removed. They will now use Data Entry Complete along with all other medical programs.

### 3. Awaiting Verifications from Client (AVC):

- In addition to using the verification checklist to pend for verifications, the awaiting verifications (AVC) functionality will also be programmed for all medical programs. This functionality will allow for users to be able to pend a case without having to enter all data within the case.
- This is also used to report to the courts the cases pending due to the client versus pending due to the technicians.
- A generic letter is sent to the client with AVC. This project is adding a Notes box to give the technician the ability to add additional notes for the client.

### 4. Good Faith:

- Functionality will be built to allow to give a “Good Faith” period to clients that need additional time to obtain their verifications. This Good Faith will be a new tab within the Verification Checklist window.
- Only those individuals pending for verifications will show up on the new tab.
- A letter will be sent to clients that are provided a Good Faith period. In addition, the verification checklist will indicate whenever a client has been given Good Faith.
- Effective begin and end date fields will be provided to allow the technician to determine when the Good Faith should be closed. If the client’s verification due date is in the past, the client will be denied for missing verifications.

## **5. Exception for AM/LTC when Denying:**

- The timeframe for all other verifications is 10 business days and must be satisfied prior to pending for DRA. For the AM and LTC medical programs, clients are provided 70 calendar days to provide verification of citizenship and/or identity if they have been determined eligible.

## **6. Exceptions for AM-OAP:**

- OAP-HCP programs are exempt from DRA-8 requirements. Therefore, clients that are determined past due for DRA-8 verifications in the OAP-A or OAP-B programs will be allowed to roll into OAP-HCP A or OAP-HCP B, rather than being denied for AM.

## **7. Authorization at the individual level for FM**

- If an individual is determined to be eligible for Family Med, CBMS will allow for their eligibility to be authorized regardless if there are other individuals pending for verifications. For example, if a child is eligible but sibling is pending for citizenship and identity, the child that is eligible will be able to receive benefits immediately rather than wait for the sibling.
- The only exception to this is whenever there is a financial responsibility. For example, if mom is pending income, all her children will also pend due to financial responsibility.

## **8. For CHP+ Only**

- Individuals who are not eligible for FM will be allowed to continue to be determine for CHP+ eligibility even if there is another individual that is pending for FM. Currently CBMS will hold up all individuals within FM whenever there is at least one person pending.
- Logic within CBMS will be fixed so that the enrollment fee for CHP+ is not calculated until everyone is either approved or denied. This will prevent an incorrect enrollment fee to be sent out.

## **9. FM Guaranteed Programs**

- A reassessment letter for guaranteed FM clients will be sent out 60 days prior to the end of their guarantee period. Technicians will need to manually track the result of the reassessment letter and deny or approve appropriately.

## **10. Special Action**

- Special action will be modified to add the other HLPG as of the month following the date the RRR was initiated. Currently CBMS adds the other program as of the month following the RRR period which may leave a gap in coverage.

## **11. Data Fix**

- 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.

## **12. Miscellaneous screen changes**

- The Data Entry complete Y/N field will now be a required field for medical programs.
- A field is being added to the Collect Case Summary Detail window to capture a help desk ticket number for cases that are pending due to help desk.