Medicaid Renewal Town Hall (9/7/23)

Questions and comments submitted prior to and during the call

A. Case Escalation

1. What is the best way then to escalate the case?

   For kynectors and insurance agents, please reference the Escalation Path on the KHBE website (most recent version sent 9/7/23 via email as well). Only agents and kynectors have access to this site. https://khbe.ky.gov/Agents-kynectors/Documents/Agent-kynector-Escalation-Path%209.8.23.pdf.

   A provider or community based organization without a kynector may escalate a dire need case for an individual who does not have current coverage to kynectdireneed@ky.gov. A *dire need* is defined as a case where the individual needs a prescription, has a medical appointment or requires other services that cannot be missed.

2. Do people other than kynectors have access to the incident tracker?
   Only agents and kynectors have access to this tool.

3. What should be done for those that do not have incident tracker?

   If the member is not already working with a kynector, we recommend referring to a kynector. A provider or community based organization without a kynector may escalate a dire need case for an individual who does not have current coverage to kynectdireneed@ky.gov. A *dire need* is defined as a case where the individual needs a prescription, has a medical appointment or requires other services that cannot be missed.

4. As a Kynector, today is the first day I have heard of the Incident tracker. I think it would be helpful for non-kynectors that assist with renewals to be able to escalate a case as well.

   The Incident Tracker has been widely discussed with kynectors through board meetings, committee meetings, newsletters, and direct emails. It is for any agent or kynector. For non-kynectors, if the person does not have coverage, a dire needs case can be escalated to kynectdireneed@ky.gov. A *dire need* is defined as a case where the individual needs a prescription, has a doctor's appointment or requires other services that cannot be missed.

5. Just as a refresher. What is the correct process for escalation?

   For kynectors and agents, always reference the Escalation Path on the KHBE website (most recent version sent 9/7/23 via email as well). If there is a change to the information kynectors and agents are notified by email and through other communication paths.

6. When submitting information through the tracker, do you follow up with the service provider? How long does it take for a response to be received?

The state does not generally follow up with the service provider but the kynector or agent is notified. Response depends on the complexity of the problem. Some are resolved within minutes, others may take several days if a system fix is needed.

7. What is the time frame in resolving an escalated case?

   Response depends on the complexity of the problem. Some are resolved within minutes, others may take several days if a system fix is needed.

8. Escalate to who and how? My team was told earlier this week DCBS is no longer processing cases via phone.

   DCBS workers do not process paperwork over the phone but can at the local office. Kynectors and agents should always reference the Escalation Path on the KHBE website (most recent version sent 9/7/23 via email as well). A provider or community based organization without a kynector may escalate a dire need case for an individual who does not have current coverage to kynectdireneed@ky.gov. A *dire need* is defined as a case where the individual needs a prescription, has a medical appointment or requires other services cannot be missed.

9. Kynectors are overwhelmed and the extra steps for escalating cases are additional work. What would it take for the Cabinet to pause renewals to give time to sort out these issues and hire more staff?

   The established process is meant to provide an easier way for kynectors to escalate cases. While we recognize it takes some time to enter information into the incident tracker, once submitted the issue is sent to the state for resolution and tracked. The kynector will be notified when it is resolved. New state staff are being hired and trained and processes are being improved to reduce wait times.

10. Should we send problems that we have resolved through the tracker in order for you to see that the problems are more large scale?

    No, but please submit incidents that are preventing enrollment.

B. Telephone Wait Times / Communication

1. A direct phone number for service providers to contact DCBS reps rather than using the 855 number would be helpful. I spent 2.5 hours on the 855 number last week, just to be hung up on.

   We regret the difficulties and wait times. Providing a direct phone number isn't feasible. DCBS workers need to take calls in order received. If the system is hanging up inappropriately, please note information for the call (time of day, number called) and forward to DMS so we can check for system issues.

2. I have to share this. I had to call into DCBS, the worker was very helpful. Due to client being in a shelter with four kids, the worker ask if she would like to apply for KTAP as well as getting her SNAP reinstated. She said I will transfer you to "your county's " KTAP worker, which was great. Once transferred, it gave us a wait time of 412 minutes. This is a problem. Thank you

   We regret the long wait times. We are reviewing changes in process for this particular situation to see what improvements might be possible.

3. The appointment maker on the system is there for us to make appointments, especially for SNAP interviews. I have had so many clients who do not get that call from DCBS. I learned that there was an issue with the appointment scheduler. It would have been great if we had been notified about this issue. I set appointment for a client 4 times and no call. Elderly or older clients do not understand and do want to give up. Communication is key for everyone

   We are trying to open up the lines of communication and provide information more timely. Please escalate any cases experiencing difficulties.

C. Documents Not Recognized

1. We are also seeing cases where documents are not reviewed timely or all documents are not reviewed and the case is denied incorrectly. What is our recourse?

   If a member is denied incorrectly, the member should appeal, reach out to DCBS, or a kynector or agent could escalate the case for review. If documents are not reviewed by the renewal date, the member should be automatically extended. Please continue to send examples and escalate cases that are not extended.

2. Why are the RFI requests so vague? My clients don't understand when they get a request for a document they have already submitted, they are confused, when the RFI should say, your documentation was not sufficient and this is the reason why.

   This is an issue that is being addressed. DCBS eligibility workers are instructed to add to the RFI what specific information is needed, i.e. bank statement for account XXXX, or why returned documentation was not acceptable. We will continually reinforce this guidance.

3. I have been noticing that in the document center is now showing requests for years ago and recent request also since Tuesday.

   This was a defect and has been resolved.

4. Who do we contact to give the examples of cases being denied after documentation is submitted?

   If the issue is that documents have been submitted but not reviewed and the member was terminated, the case should be escalated.

5. If you're denied Medicaid because you "didn't submit documents on time" when you're documents are actually pending, you do not get APTC eligibility.

   Financial Assistance (both Medicaid/APTC will be denied) but can be put back on retroactive if appropriate. If documents are pending for Medicaid renewal, the member should be extended until they are reviewed.

6. This is happening a lot more. Documents are not getting verified in the 30 day period.

   If documents are pending review, members should be automatically extended until they are reviewed. Please escalate any cases if this is an issue.

7. There are times that I upload documents as soon as I do an application for someone. I tell clients to bring in certain information because I know it may be asked for. They will then receive an RFI a week or 2 later stating they need to turn in information. But the information was already uploaded. That really confuses clients also. Clients will also get

text messages stating they still have documents needed, but everything has already been uploaded.

Examples would assist us in researching if there is a systemic issue. There are cases where the notice was already generated when the member submitted the response. Cases reviewed to date are complex and have had multiple notices impacting various members of the household. We understand this can be confusing.

8. The 30 day review period seems to be taking more like 40 days. Also the documentation is not being reviewed and cases are denied.

   If documents are pending review, members should be automatically extended until they are reviewed. Please escalate any cases if this is an issue.

9. We have to upload information many times. We have confirmation it was received, but they continually say they never received it.

   Examples would assist us in researching if there is a systemic issue. Please escalate cases through the incident tracker or the dire needs process if the member has been terminated.

D. Other Issues & Questions

1. Are service authorizations also extended for LTC? Yes.
2. Why do clients who have Medicare and are applying for the MSP receiving letters saying they are denied QHP? This is VERY confusing to them. They should only receive a letter of approval/denial if applying for MSP.

   A change order has been submitted to remove the language.

3. A lot of people who should be going through reconsideration are being told to re-apply.

   Prior to the PHE, members would have to reapply if terminated. The reconsideration period is a flexibility during unwinding. We are providing education around this issue.

4. I have a client who has Medicaid secondary to her Medicare. She has QMB and the state should be paying her Part A and Part B premium. They have been paying her Part B premium, but not Part A. She now owes over $1,900 for this. We called DCBS and the rep (Bruce) kept telling me Part A is always free, they never get charged for Part A. He got his manager, which didn't help. He was saying the same thing. They need better training.

   We know this is an issue and are currently working to resolve it. The resolution will apply retroactively and communicated to impacted individuals.

5. Do DBCS workers know that they are supposed to ask applicants if they are offered coverage from their employer? This is important. Sometimes when individuals are referred to me to assist with enrolling in a QHP, through conversation I find out they may be eligible for EPI. This is a game changer when it comes to APTC and eligibility.

   Yes, DCBS workers are trained to ask if employer sponsored insurance is available and should be asking at every application and renewal. If you are finding that they are not asking then it is something that can be addressed. If anyone believes they have received incorrect information from, or experiencing issues with, DCBS they can always

email DFS.Medicaid@ky.gov. Issues we receive are reviewed and appropriate action taken to correct the issue and addressed with field staff.

6. I feel like it would be less work for CHFS overall if those workers determining eligibility would just call the applicant instead of letting the case terminate.

   Outreach is being conducted numerous times during the renewal period from both the state and MCOs. MCOs are now able to assist members with completing documents for renewal. If this is related to DCBS workers processing documents that are determined insufficient, there is not a current DCBS policy for the worker to contact the member directly. This is primarily due to workforce capacity. We will continue to evaluate policies to improve current processes.

7. For adults, the income limit is 138% FPL and for KCHIP it is 213%, correct?

   It is 218% FPL for KCHIP.

E. Questions/Situations Shared when Registering for Town Hall

1. Can a special workgroup be established to help providers to resolve issues that impact our clients?

   Service providers may work with kynectors for support when there are issues so they can be escalated through the Escalation Path. A provider or community based organization without a kynector may escalate a dire need case for an individual who does not have current coverage to kynectdireneed@ky.gov. A *dire need* is defined as a case where the individual needs a prescription, has a medical appointment or requires other services that cannot be missed.

   Unfortunately there are no additional resources to provide a special workgroup.

2. How can I assist someone with 2 hour wait times to reach a DCBS worker ? This is very frustrating

   We regret the long wait times and are working to increase staff who can process determinations. In the meantime, kynectors and insurance agents have access to an Escalation Path. A provider or community based organization without a kynector may escalate a dire need case for an individual who does not have current coverage to kynectdireneed@ky.gov. A *dire need* is defined as a case where the individual needs a prescription, has a medical appointment or requires other services that cannot be missed.

3. How can you fix newborn coverage that does not go back to the date of birth? Is there a contact person to use to help fix this.

   For a QHP, please call the Professional Services Line and ask them to have the coverage backdated to the date of birth. For Medicaid, please email DFS.Medicaid@ky.gov.

4. I have worked myraid events and no Medicaid member is aware of the end of the PHE. What do you think should be done ?

   We are open to suggestions but to date there has been extensive advertising through radio stations, newspapers, billboards, vehicle wraps, direct member communication, as

well as getting the word out through various stakeholders including community organizations and providers.

5. If someone with HCBS waiver is terminated with docs pending, can you assure they won't lose waiver services?

   If documents are pending review, the member should be extended. Cases terminating for this reason should be escalated.

6. Is there any way to expedite reviewing documents for clients seeking SUD treatment?

   If this involves a renewal, the member should not be terminated while documents are pending. Please escalate any cases where a member has been terminated pending document review. If the person does not have coverage, the case can be escalated to kynectdireneed@ky.gov for Dire Need Incidents. A *dire need* is defined as a case where the individual needs a prescription, has a doctor's appointment or requires other services that cannot be missed.

7. Is there anything that I can advise my clients to make your jobs easier?

   When submitting a document, please submit the most clear and complete document available. Sometimes, many different kinds of documents do not have all the needed information (pages of wage stubs but missing weeks, multiple tax forms, zero income statements that do not have all information etc.).

8. Issues with Tax credits showing on QHP.

   View QHP History on the Enrollment Management Module will show what APTC is applied to each month. If there is an error, please call the Professional Services Line and ask them to have the APTC applied or updated for any missing months. You may also report this through the incident tracker.

9. The space allowed here is too small to ask my question about the changes on incontinence supplies for adults on HCB.

   Please direct this question to Amanda Ritchey at amanda.ritchey@ky.gov or 502-564-6890, who is in the Department for Medicaid Services, Division of Health Care Policy.

10. We are seeing an influx of waiver participants that are given an end date for their Medicaid eligibility.

    Waiver participants are subject to annual renewal. If needed, waiver members have up to an additional two months to respond to a notice.

11. What can be done to escalate Dire Needs cases with DCBS staff? What can be done about 2+ hour wait times when calling DCBS?

    Please email kynectdireneed@ky.gov for Dire Need Incidents. This process is generally for when someone does not have coverage. A *dire need* is defined as a case where the individual needs a prescription, has a doctor's appointment or requires other services that cannot be missed. We regret the long wait times. We recommend utilizing kynectors and the Escalation Path for issues.

12. What is being done to build better communication flow in the relationship between navigators, kynectors and DCBS workers?

    It is our hope that reinstating monthly meetings will help open the lines of communication.

13. What is the best path for someone to address their issues? Wait time on the phone is very long & some are not computer savvy.

    We recommend they go to a local DCBS office, kynector or insurance agent, or call a kynector or insurance agent to assist. Kynectors and agents can escalate cases through the incident tracker. A provider or community based organization without a kynector may escalate a dire need case for an individual who does not have current coverage to kynectdireneed@ky.gov. A *dire need* is defined as a case where the individual needs a prescription, has a medical appointment or requires other services that cannot be missed.

14. What is the plan to help people who are struggling with us.

    We do not understand the question. Perhaps a response to another question addresses the issue.

15. What is the turn-around time for Medicare cases waiting to get approve by DCBS for Medicaid?

    DCBS does not approve Medicare—this can only be done by the Social Security Administration.

16. Will you consider pausing Medicaid renewals until the system is fixed so that people who are eligible are not terminated?

    We have implemented several strategies and continue to monitor to make future changes if warranted.

F. **Key Issues & Questions Submitted by Priscilla Easterling**

This is a list of six key issues that have repeatedly come up among assister groups from across the state. Each issue has several clarification questions underneath that will help us better understand what the policy is and how the process should work.

1. Individuals with active SSI receive renewal packets and RFIs.

Policy: When individuals with active SSI have to renew their Medicaid, they are first run through the passive renewal process. For some individuals, the system fails to verify SSI income from SSA. This generates a renewal packet for individuals with active SSI who are categorically eligible for Medicaid.

Process Issues: Members who are eligible for Medicaid by way of receiving SSI are sent renewal packets and RFIs for income and resources. Since Kentucky is a 1634 state, SSA makes the Medicaid determination for SSI recipients automatically. Since SSI recipients are automatically eligible for Medicaid as determined by SSA, members with active SSI should not have to submit additional information to DMS to maintain their Medicaid coverage.

Questions:

- Is this the correct understanding of the policy and procedure?

Individuals with active SSI only do not go through a renewal. If the file we receive from the Social Security Administration (SSA) indicates that SSI eligibility has ended, a notice will be sent indicating their Medicaid coverage is ending. The notice instructs the individual to file an application to determine if they still be eligible. Please note that SSI members who are in long term care or a 1915(c) waiver do go through a renewal. Members with RSDI and SSDI also go through a renewal and are subject to income verification.

- Why is the system unable to verify SSI income? Or why is it failing to verify SSI income?
  If the individual is only active SSI, they do not go through a renewal and their income does not have to be verified. During the first few months of renewals, there were a few SSI cases where the system generated a renewal packet in error. There may also be confusion with cases involving an SSI member who is also in long term care or a 1915(c) waiver, or the member may be RSDI or SSDI. These members would be sent a renewal packet.
- Shouldn't the lack of notification from SSA telling DMS of a termination of SSI benefits be sufficient to passively renew individuals with Medicaid by way of their SSI eligibility without requesting additional information?
  Correct. An active SSI only member is terminated if the state receives a file from SSA indicating their SSI is terminated.

2. **When SSI is discontinued and individuals subsequently lose their Medicaid benefits, some members are not evaluated for coverage under other Medicaid categories prior to the termination of Medicaid**.

Policy: When individuals lose their SSI, these cases are evaluated in one of two ways: either reviewed and issued ex parte coverage for 60 days or terminated. During the ex parte period, the state sends a notification that the member must contact the agency to complete an application to see if they are otherwise eligible for Medicaid. For members who are not eligible for the ex parte period, they are terminated and advised to submit a new Medicaid application.

Process Issues: The current policy falls short of the state's obligation to review for eligibility under other categories before Medicaid is terminated. The state should make every effort to collect any missing information and review for other eligibility prior to terminating Medicaid. Additionally, when members receive notices terminating their SSIR Medicaid coverage, they experience technical difficulties applying for Medicaid under a different category before their existing coverage is terminated. After receiving a termination notice advising members to submit a new application, members who try to apply for Medicaid before their coverage ends are blocked by the kynect system for already being enrolled in Medicaid.

This creates a gap in coverage, as members must wait until their categorical Medicaid coverage ends before they can apply for Medicaid under other categories, including MAGI or expanded Medicaid. While DMS will approve coverage retroactively to cover the gaps in coverage, members during that time are effectively uninsured until they can submit a new application and it is processed. This can unnecessarily create a massive risk and burden for members with significant health needs in the meantime.

Questions:

- Is this the correct understanding of the policy and procedure?
  Yes. When a member has categorical eligibility, the state is unable to determine eligibility under a different category as it does not have sufficient information. For example, the state does not know household size, such as other family members, or income. There is no requirement for the state to attempt a determination for another category or send a prepopulated form for these individuals. However, we are currently reviewing options to make the process easier on SSI terminated individuals. There are some states that give additional time or send a prepopulated form with the limited information on file.
- Before members are terminated from SSIR Medicaid coverage, can they submit a new application or respond to an RFI for whatever missing information the state needs to make a full determination of eligibility for all categories of Medicaid?
  SSI terminated members may file a Medicaid application through a DCBS worker approximately 45 days prior to the termination date. Currently, there is an issue with the SSP that prohibits an SSI member from submitting an application prior to the termination date. There is a change order in progress to update the SSP to align with the DCBS worker process.
- What makes someone ineligible for the 60 days of ex parte coverage following the loss of SSI?
  Based on federal rules, there are only five reasons someone is granted the ex parte coverage: excess income (N01), living arrangement such as going into a nursing facility (E01), excess resources (N04), refusal of treatment for drug addiction (N10), and refusal of treatment for alcoholism (N11). Individuals who lose SSI for reasons other than the ones listed above are not eligible for ex parte.
- What case information is shared from SSA to DMS in these cases?
  The only information shared in the SSA file is that the member is no longer eligible, along with a limited reason code.

3. **Members are being automatically terminated from Medicaid after submitting documents before documents are reviewed and a determination is made**.

Policy: When members have an active renewal packet or an RFI due, members have until the end of that due date to submit documentation. If members submit their documents by the end of the day on the due date, their case should remain open, and Medicaid will remain active until such time as a DCBS worker reviews their documents

and makes a determination of eligibility. Medicaid coverage is only terminated automatically if no documents are submitted.

Process Issues: There have been numerous reports of people responding to RFIs by submitting requested documentation on or by the due date listed on the RFI, and still receiving termination notices. These notices seem to be automatically generated and sent to members with the reason being listed as “failure to submit documents” despite these documents being submitted by the due date. When reaching out to DCBS following these termination notices, workers admitted that these submitted documents had not yet been reviewed by DCBS workers and that a final determination had not been made.

Additionally, members and assisters can see in kynect that the documents were uploaded before or on the due date, but the system has sent termination notices regardless of the submission of documents. In many of cases, the termination was generated on the due date, rather than the day after the due date. This indicates that this process may be happening automatically. While there is evidence that this is an issue for people who upload documents to kynect, this issue has also been reported by members who took their paperwork to the DCBS office in person. This issue is additionally complicated by members receiving duplicate RFIs and renewal packets despite already submitting the requested documents to the state.

Questions:

- Is this the correct understanding of the policy and procedure?
  Yes. Members should not be terminated if there is a response pending but not completed or processed on or before their renewal date. This only applies to individuals going through renewals. We continue to review cases but have not identified a systemic issue.
- Do members have until the due date listed on their RFI or renewal packet to submit it to the state?
  Yes, if tied to a renewal. If documents are mailed and received after the date or submitted late on the renewal date, the system may not pick up the pending response. These cases should be escalated when identified.
- When documents are submitted on kynect, does the system skip terminating these cases automatically? Is it programmed to continue cases where documents have been submitted but a determination has not been made?
  The system should be automatically extending anyone with a pending document.
- Does a worker have to do anything manually to continue coverage until documents are reviewed?
  No. The system should be automatically extending anyone with a pending document.

- Once documents have been uploaded into kynect, does the system require a manual acknowledgment by Cabinet staff for coverage to continue until documents are reviewed? Or does the uploading and acknowledgment in the system mean the documents will be reviewed, and thus no other selecting of a button is required for the system to know that the document review is still pending (and so coverage will continue until they are reviewed)?
  For renewals, the documents uploaded and acknowledged in the system should automatically extend the case if pending on after the renewal date.
- When documents are submitted in person at a DCBS office, do members need to get these documents stamped and scanned in the office before they leave?
  Current process is for the document to be scanned the returned with a date stamp. Some offices have drop boxes. However, we encourage members to take their documents into the office to be scanned and date stamped. Please report concerns with specific examples if the process is not being followed.
- When documents are mailed in, what is the process for these documents to get to a worker for review?
  When received in the mailroom, they are uploaded, indexed and a task is generated for field staff.

4. **Medicaid members are being transitioned into QHP eligibility without receiving an RFI for income before terminating Medicaid.**

Policy: When members go through the passive renewal process, the system checks data sources to verify income information to determine Medicaid eligibility. Members deemed ineligible for Medicaid based on income from these data sources are then automatically evaluated for QHP eligibility. If they are eligible based on income, then they are transitioned to QHP eligibility with or without APTC and sent a notice telling them that they are no longer eligible for Medicaid but that they are now eligible for a QHP, and the amount of APTC they are eligible for, if applicable.

Process Issues: Members are not being sent an RFI for income verification before being terminated from Medicaid. Existing members are not being notified of the opportunity to submit updated information about their "point in time" or "anticipated annual income" prior to the termination of Medicaid coverage. The system may be using verified, but possibly outdated income to incorrectly determine members ineligible for Medicaid coverage and eligible for QHP coverage. Tax returns, unemployment income, and self-employment are all income types that can vary significantly from year to year and can quickly become outdated or incomplete.

It is appropriate to use the passive renewal process to determine a member eligible for Medicaid, but it is not appropriate to use the passive renewal process to determine a member ineligible for Medicaid and eligible for QHP coverage at the same time - these should be two separate steps. If members fail the passive renewal process,

they should receive an RFI for income prior to being evaluated for QHP coverage. This gives members additional time to send in updated income documentation for the state to make a final determination on their eligibility. Only after members have responded to an RFI for Medicaid, should the system evaluate and transition members to QHP coverage.

Questions:

- Is this the correct understanding of the policy and procedure?
  We transition to QHP during passive renewal if they are eligible for APTC. However, when the member receives the notice they are instructed to contact DCBS if the information is incorrect. If they are not eligible for APTC they will receive a renewal packet.
- Are all members being sent an RFI for income before Medicaid is terminated?
  If they are eligible for APTC, the member receives a notice indicating that eligibility but instructing the member to respond if the information is incorrect. If they are not eligible for APTC, the member receives a renewal packet.
- If not, what are the exceptions to this policy?
  See above.
- Before receiving a NOE for QHP eligibility, are any members sent an RFI for income before being transitioned from Medicaid to marketplace eligibility?
  See above.

5. **Members are being told to reapply for Medicaid rather than to submit requested documents during the 90-day reconsideration period.**

Policy: After members are terminated from Medicaid for failure to respond to a notice, they have a 90-day reconsideration period to submit the requested documents. If members submit their documents within the 90-day period following this loss of Medicaid, DMS can review these documents, make a determination of eligibility, and if applicable, reinstate the coverage back to the day of loss, without members having to submit a new application.

Process Issues: When members call DCBS to update their cases and submit information, the call center or DCBS workers are telling people to submit new applications for Medicaid rather than helping to update their cases. Some members also report being told that their cases were closed and that they must submit a new application to re-enroll in Medicaid. As of the end of August 2023, only members with a renewal date of May 31st are at the end of their 90-day period. All other members are still well within their 90-day period, so they should be encouraged to take advantage of this policy to ease re-enrollment into Medicaid.

Questions:

- Is this the correct understanding of the policy and procedure?

Yes. However, normal eligibility processing would require a reapplication and is causing confusion. We are providing education to the DCBS workers to ensure alignment. In addition, the system is undergoing changes to align and simplify the process.

- Are there any exceptions to this policy?
  No.
- Are there any reasons why some members would have their cases closed and need to submit a new application instead of updating their case or submitting requested documents?
  This process is for those terminated for lack of response.
- Is the reconsideration process limited to only some cases?
  See above.

6. **Members experience barriers to completing ID proofing and verification.**

Policy: For members to access their online kynect account, they must successfully pass ID proofing to set up a KOG account. If members fail the ID proofing when setting up a KOG account, they are referred to Experian. If Experian is unable to verify their identity, then they are sent to DCBS or DMS call centers. From there, members are either referred to a local DCBS office or a kynector to manually verify an individual's identity.

Process Issues: There is a lack of clear information on the SSP on why members need to call Experian. When members fail ID proofing with Experian, they are instructed to call DCBS and often get bounced around among different phone lines before they are connected to someone who can help. This defeats the purpose of the SSP because it requires members to call and sit on hold to speak to someone before getting directed to someone who can help. When members go to a DCBS office in person, they are told that workers do not have access to the SSP and cannot verify their identity to create or access their kynect account. Members are then referred to the kynect technical support call center or a kynector to manually verify their identity. This creates delay after delay for members to submit their documentation.

Questions:

- Is this the correct understanding of the policy and procedure?
  This is correct although we aware there are issues with the current process and are working to make improvements. We welcome a collaborative effort in this area.
- Is there a process in place for individuals who attempt to go to their local DCBS office to verify their identity before ever attempting the state hotline or website?
  DCBS should accept the documents to upload for processing.

- When DCBS has verified information in worker portal, why are they unable to share that information with the SSP? (A member was told by a DCBS worker that they already verified the member's license in the worker portal, but the worker cannot access the SSP and thus can't verify their identity. This worker also reported that this is a daily conversation they have with members because members are told by the call center that DCBS can help in person, but they can't.)
  The system is undergoing changes to allow DCBS workers to share the information in the SSP.
- For members who have already been enrolled in Medicaid or other state programs, are there any workarounds to automatically verify their identity through verified state data sources instead of the standard Experian process based on credit history?
  There are no current workarounds for KOG. We are considering improvements to the process and plan to engage stakeholders in the discussion.
- Why would some members need to verify their identity more than once?
  Currently someone may have to verify their identity to create a KOG account and may also need to verify for the specific program requirements. The same verification cannot be used for both. However, we are reviewing this for future changes.

7. Additional clarification questions:

- During the last stakeholder meeting, a list of "additional flexibilities" was shared: Which of these flexibilities have been implemented and which ones are still being implemented? What is the timeline for implementation?
  The most current status of the flexibilities is provided in a separate document. This is also being uploaded to the unwinding website.
- What does extending the 90-day reconsideration period mean? How does it work? Is it extended on a case-by-case basis?
  See responses to Q5 above. Anyone terminated due to lack of response has 90 days to provide the requested documentation or verification. If determined eligible, the member will be reinstated back to the termination date. This is a change from pre-PHE eligibility and enrollment processing when reapplication was required and is causing some confusion. We are providing additional education and training to improve the process.