Policy Memo	
KDHE-DHCF POLICY NO: 2014-01-01	**From: Jeanine Schieferecke, Senior Manager**
Date: April 4, 2014	**KEESM/KFMAM Reference: N/A**
RE: Medical Assistance Program Instructions Related to the Affordable Care Act	**Program(s): All Medical Assistance Programs**

This memo provides instruction for implementation of major policy changes in both the Family and Elderly/Disabled areas of the program, some of which are required by the Affordable Care Act. Policies are applicable to all eligibility actions taken on or after the receipt of this memo, unless specifically indicated otherwise. There is not a specific benefit month tied to these changes.

Note that processes to support some policies have been delayed. Training material and other supporting documents released previously may not be accurate unless specifically noted in this memo. Section 4 includes a specific list of approved Job Aids and other documents to be used prior to KEES implementation.

1. Changes Impacting All Medical Programs

1.1 ACA – Changes

1.1.1 MAGI vs. Non-MAGI

Modified Adjusted Gross Income (MAGI) is a term that describes the budgeting methodology used to determine eligibility for all family medical programs. The term MAGI is also used to reference the group of medical programs that follow this methodology. MAGI determinations are significantly different from the way family medical programs are determined today. Information about these policy changes will be presented throughout this memo. MAGI budgeting is directly tied to federal income tax rules.

Non-MAGI methodology refers to all medical programs that do NOT follow the MAGI methodology.

MAGI medical categories include:

- Parents and Caretaker Relatives

- Pregnant Women
- Children under age 19
- Medically Needy for pregnant women or children under age 19

Non-MAGI medical categories include:

- SSI
- Foster Care and Adoption Support
- Elderly and Disabled (including Blind)
- Long Term Care
- Protected Medical Groups
- Medically Needy for Elderly and Disabled
- Medicare Savings Programs

1.2 DIVISION OF WORK

A major change to workload responsibilities occurred last fall when all Family Medical (MAGI) processing was assumed by the Clearinghouse (see Application Implementation Instructions memo issued on September 4, 2013). Although additional workload changes have been announced and are still planned, those are being delayed for implementation with KEES. Processes that are delayed include MAGI screening by DCF (aka The Big Four), Foster Care Aged Out and Self-Service Portal Application registration by the Clearinghouse. Instructions will be issued if any portion of these processes must be implemented prior to KEES go-live.

1.3 WHO CAN APPLY?

With the elimination of the Mandatory Filing Unit and new policy whereby a tax household is used to determine the budgeting unit, specific requirements of who can apply have been modified. Requirements for a child to be residing in the home of an approved caretaker according to KFMAM 2110 still apply.

1.3.1 TAX PAYER/DEPENDENT

An individual may apply for medical assistance for any individual that they claim or intend to claim as a tax dependent.
Example: Monica files an application for herself, her child Jessica, and an unrelated child, Julie. Julie is Monica's ex-boyfriend's child whom she is taking care of. Monica files taxes and claims both Jessica and Julie as tax dependents. Because Monica reports on her application that she claims Julie as a tax dependent, she is permitted to apply on her behalf. If Monica does not claim Julie as a tax dependent then the existing policies of KFMAM 2011 and KEESM 2112 still apply. Staff must request a completed ES-3108 – Appointment of Authorized Agent for Minor form.

1.3.2 PARENTS OF A MUTUAL CHILD

An adult can apply on behalf of another adult with whom they have a mutual child. This was previously allowable as part of the Mandatory Filing Unit rules which are eliminated with the implementation of the new MAGI budgeting rules.
It is our intention to continue to allow this relationship the authority to apply on each other's behalf, regardless of their tax filing status.

1.4 CITIZENSHIP AND IDENTITY – VERIFICATION & REASONABLE OPPORTUNITY PERIODS

Verification of citizenship and identify continues to be a requirement for most medical applicants/recipients and there are no changes regarding who is subject to these requirements with this change. However, new federal rules require primary citizenship and identity verification be obtained under a new computer match through SSA. The new SSA match will be available through the Federal Services HUB and is expected to be available with KEES implementation. Under the new rules, coverage is not to be delayed or denied for individuals whose citizenship cannot be verified through the new HUB process. Specific use of the Reasonable Opportunity (RO) Period is required for persons who attest citizenship but cannot be verified through the new process. Until KEES is implemented, an interim process has been developed. Follow the temporary process described below until otherwise instructed.

Effective with receipt of this memo, applicants who declare to be a US citizen are provided an RO Period in order to obtain citizenship and identify verification. If verification isn't available through other sources (including other data sources, the existing case file or verification supplied by the applicant), an RO period is established for all applicants who declare citizenship status. Once the RO period is established, documentation is then requested from the applicant.

If proof of citizenship and identity is received, the RO period ends and additional information is not necessary. Prior medical assistance may also be provided as part of a RO period.

This special RO Period process remains in place until the new SSA match is available from the HUB with KEES implementation. New instructions will be released at that time.

1.4.1 LENGTH OF REASONABLE OPPORTUNITY PERIOD

The length of the RO period is three months from the date of approval of the application. Under the interim process, the RO period is extended if the HUB is not operational. Coverage is provided until verification is received from a data source or until the HUB is operational, whatever is later.

An initial RO period of three months from the date of approval is established. A request for citizenship information is sent to the individual with a due date of three

months. However, negative action cannot be taken against the individual if the information in not received unless the HUB is operational.

Example: If the RO period is approved on April 23rd, the due date in the approval notice will be July 23rd. The case is evaluated on July 23rd. Even if the consumer has not responded to the request for information, if the HUB interface is not operational as of July 23, the RO is extended for an additional 3 months, to October 23rd.

1.4.2 KAECSES NOTICES

Changes have been made to the existing notices that are used to request citizenship and identity and to approve a reasonable opportunity period.

V070 – This notice is used to request proof of citizenship and identity when other information is also needed to process the application (e.g. verification of income). If the only information needed is citizenship and identity, do not send this notice. The application is pended for other information. If the other information comes in and citizenship verification is still needed, then establish an RO period and send the V071.

V071 – This notice is an approval notice to be used when the only information missing is citizenship/identity and an RO period has been established. It informs the recipient of the requirements of the RO period. This notice serves a dual purpose by notifying of the medical assistance approval and informing the individual of the information needed in order for their coverage to continue under the RO Period.

V073 – This notice has been eliminated.

1.5 SELF-EMPLOYMENT INCOME

1.5.1 SELF-EMPLOYMENT INCOME BUDGETING

IRS tax rules are used to budget self-employment income. In addition, the option of a standard 25% deduction is eliminated.

When an income tax return has been filed by an individual that includes the applicable self-employment income, the countable amount of self-employment income is taken directly from the form. The following outlines the line on the tax form used for each type of business:

- Schedule C: Line 31 – Net Profit (or loss)
- Schedule C-EZ: Line 3 – Net Profit
- Schedule F: Line 34 – Net Profit (or loss)

- Schedule E Rental Income: Line 26 – Total Rental Real Estate and Royalty Income (or loss)
- Schedule E Partnership or S-Corp: Line 32 – Total Partnership and S-Corp Income (or loss)

When a loss is reported on the tax form, it is to be treated as $0.00 income for the eligibility determination. A loss from a business cannot be deducted from another source of income, even if the other source is another form of self-employment.

If the self-employment income is not part of the individuals last income tax return filed, an SE Worksheet is required (see instructions below).

At the time of review, the applicant is not required to submit proof of self-employment income unless they are reporting a change in the amount that has been counted to determine eligibility.

1.5.1.1 BUDGETING SELF-EMPLOYMENT INCOME FROM THE SE WORKSHEET

The Self-employment budget worksheet, KC5150, obtains all income and expenses in the last 12 months. Staff will total all of the income, subtract all of the expenses and enter this net amount into the SEEI screen in KAECSES. A medical divisor of 12 is used.

In a situation where the worksheet is being used because it is a new business, or there has been a substantial change in the business, the medical divisor will be adjusted based on how many months of income is being included in the determination.

Example: Applicant reports a fundamental change in their business which occurs starting in April. After reviewing both the tax return and the SE worksheet, the worker determines that the tax return can't be used because it is not representative of the current business. Staff will use the income and expenses from the SE worksheet beginning in April to the current month. Income prior to the fundamental change in the business isn't used.

1.5.2 VERIFICATION OF SELF-EMPLOYMENT INCOME

Hard copy verification is required for all self-employment. This will be in the form of a tax return or a new form – KC5150 Self-Employment Worksheet. Sometimes both items are required. **Ledgers and other business records are no longer accepted as verification of self-employment income.**

Tax Return - When the applicant indicates they have filed taxes, a copy of their tax return is required. This must include all supporting schedules and attachments. Use the most current tax return that has been filed. If it is after

April 15th and the applicant has not filed their tax return, the prior year's return may be used if they have filed an extension with the IRS. Verification of the extension is not required.

KC5150 - Self-employment Worksheet - When a tax return has not been filed or is not representative of the existing self-employment income the self-employment worksheet is required. The worksheet will request documentation of income and expenses for the 12 months prior to the month of application. This form can be found in Section 4 of this memo. This form is not available through KAECSES and is generated off-system by staff and mailed locally.

Upon opening the SE Worksheet, a pop-up box will display. The application date is entered in this field. The SE Worksheet then updates the form automatically with the 12 months prior to the application month. Note: The Spanish version of this form does not include this automation. Staff shall enter the 12 months prior to the application month in Spanish. The SE Worksheet is a four-page form, though staff will decide which pages of the form are sent to the applicant. Page one includes several fields that staff must complete prior to mailing. These fields include the following:

- Date – Enter the date the form is being mailed
- Primary Applicant Name
- Date information is due
- Name of Self-employed person
- Type of Business
- Name of Business
- Date Business Started
- Phone Number to call for Assistance
- Hours available for Assistance

Pages two, three, and four each request expense information for different business types. Only the page(s) applicable to the reported business type need to be sent to the applicant.

Note: In cases where the consumer indicates their tax return is not representative of the existing self-employment income, both the tax return and the self-employment worksheet are required so staff may evaluate this.

The Self-employment worksheet is used in the following circumstances:

- The tax return is no longer representative of the self-employment income. The reason for the discrepancy must also be clearly documented by the applicant and is only allowed when there is a definitive change in the amount of business.
- It is a new business and a tax return has not yet been filed.

- It is an existing business, but the applicant has not (or will not) file a tax return.
- A change in the amount of self-employment income is reported.

1.6 RESIDENCE

Rules for establishing Kansas residency for purposes of medical coverage are changed with the ACA. Individuals must no longer specifically express an intent to stay in Kansas in order to establish residency. Instead, the applicant will choose the state of their residence as either the state they are living in with the intent to reside (including without a permanent address,) or the state they entered with a job commitment or for seeking employment (even if not currently employed.)

This change specifically impacts individuals requesting SOBRA coverage while living in Kansas on a Student VISA. Historically, these individuals were denied as not being residents of Kansas because the VISA identified that they did NOT have intent to stay in Kansas. These individuals are no longer ineligible based on residency.

1.7 NOTIFICATION OF OPTION TO APPLY AT THE HEALTH INSURANCE MARKETPLACE

Policy Memo 2013-09-02 Initial Implementation of ACA Requirements instructed staff to send KAECSES notice V-504 when a request for coverage was denied for specific denial reasons. The purpose of the V-504 notice is to refer the applicant to the Health Insurance Marketplace to inquire about other options for health coverage.

This memo clarifies that the V-504 notice is sent on ALL denials, not just those outlined specifically in the earlier memo. Staff are to begin following this process with the release of this memo. This process will continue until the automated referrals to the FFM are available.

2. CHANGES IMPACTING FAMILY MEDICAL PROGRAMS ONLY

2.1 MAGI INCOME CONVERSIONS – NEW INCOME STANDARDS

When determining eligibility for medical assistance under existing rules, income deductions are used to obtain a gross income amount that is compared to a monthly income standard. MAGI methodology eliminates most income disregards and expense deductions to align eligibility for Medicaid and CHIP with the Federal income tax credit programs. All programs that are part of the Single Streamlined Application process (described in KDHE Policy Memo 2013-09-0) use the same method of counting income. In addition, a 5% income disregard is applicable to the highest standard of eligibility for an individual. The 5% disregard is built into the standards implemented with this change.

The following specific income deductions have been eliminated from the Family Medical programs:

- MP program - $200 work expense
- MACM program – 40% earned income disregard
- MACM - $90 work expense
- MACM – Child care expense

2.1.1 INCOME STANDARDS FOR CARETAKER MEDICAL

The Caretaker Medical program no longer uses shelter groups and the shared/non-shared living arrangement as part of the income budgeting method. All individuals use the same income standard regardless of their county of residence or whether or not they share their home with others.

The new income standard for Caretaker Medical is 38% of the Federal Poverty Level (FPL). This is currently $648 for a household of four. See KEESM Appendix item F-8 Kansas Medical Assistance Standards for details of this new income standard.

2.1.2 INCOME STANDARDS FOR POVERTY LEVEL MEDICAL

New income standards were implemented for the poverty level programs effective January 1, 2014. Note: the CHIP limit effective January 1, 2014 was 250% FPL. Effective April 1, 2014 the CHIP upper limit changed to 247%. For more information, see KEESM Appendix item F-8 Kansas Medical Assistance Standards.

Group	Federal Poverty Limit (FPL)
Medicaid children ages 6 – 18	0 - 113%
Medicaid children ages 1 – 5	0 - 149%
Medicaid children under age 1 and Pregnant Women	0 - 171%
CHIP children ages 6 – 18	114 – 166%
CHIP children ages 1 – 5	150 – 166%
CHIP children ages 0 – 18 $20 premium	167 - 191%
CHIP children ages 0 – 18 $30 premium	192 - 218%
CHIP children ages 0 – 18 $50 premium	219 - 247%

2.2 MAGI BUDGETING UNITS

A MAGI Budget Unit is defined as a person or group of people that must be included in a single applicant's eligibility determination. The budget unit is based on the expected tax

household. For family medical programs, the policies for assistance planning and the Mandatory Filing Unit (MFU) have been eliminated and are replaced with the concept of the Budget Unit.

There is one Budget Unit for each member applying for coverage. Tax household members may be included in the Budget Unit of other household members, but each individual has a unique Budget Unit that is used to determine their individual eligibility.

Much of the MAGI determination is based on an applicant's **planned** tax household. What we need to know is if the applicant intends to file taxes and who they intend to claim on the tax return. The budget unit is not based on how an individual actually files their taxes, but on how they plan to file them. The questions on the application should be answered based on how the individual would file taxes if they filed today.

We are required to collect certain new tax information. In the application process, each individual is required to respond to the following set of questions which are used to determine the budgeting unit:

- Does this person plan to file a Federal income tax return?
- Will this person file jointly with a spouse?
    - If yes, name of spouse
- Does this person have any tax dependents on their tax return?
    - If yes, list name(s) of dependents
- Is this person claimed as a dependent on someone else's tax return?
    - If yes, list the name of the tax filer
    - How is this person related to the tax filer?

The above information is used to determine:

- Who can apply
- Who is considered in each individual budgeting unit
- Whose income is considered in each individual budget

Refer to the MAGI – Building Individual Budget Units document to access the decision flowchart that is used to determine budgeting units. The attachment titled MAGI Individual Budget Units (IBU) Examples further explains this policy.

2.2.1 FILERS

For individuals who plan to file taxes and are not claimed as a tax dependent by someone else, their household includes themselves, their spouse if living together and all individuals claimed as dependents on their tax return.

2.2.2 NON-FILERS

If the applicant does not intend to file a tax return and is not being claimed as a tax dependent, the household we would consider is:

For adults: Applicant + Spouse + all children (natural, adopted, and/or step) living in the home
For applicants under 19: Applicant + Parents (natural, adopted, and/or step) + Siblings (natural, adopted, and step) who are under 19 living in the home.

2.2.3 INDIVIDUALS CLAIMED AS A DEPENDENT

When an individual is claimed as a dependent by another, there are a series of questions we must ask in order to determine if the individual's IBU is based on the tax household or on the Non-Filer rules. These questions are referred to as 'exceptions' on the MAGI IBU Examples document. These questions are:

- Is the individual being claimed as a dependent by someone other than their spouse or parent (biological, adopted, or step?)
- Is the individual under age 19 and being claimed as a tax dependent by only one parent, but living with both parents (biological or adopted?)
- Is the individual under age 19 and being claimed as a tax dependent by a parent (biological or adopted) not in the home?

A 'yes' answer to any of these questions indicates that the individual's IBU is determined based on the Non-Filer rules.

2.2.4 ADULTS CLAIMED AS A DEPENDENT BY ANOTHER INDIVIDUAL

When an adult is claimed as a tax dependent by another individual, additional information is needed in order to correctly determine the MAGI budget. This other tax filer may be living within the same household or elsewhere.

In most situations, the tax household information of the tax filer will be required. This will include detailed information about each member of the tax filer's tax household and income for those individuals as well.

The information may be obtained verbally, however Form KC4520 has been created to assist with this process. This form can be found as an attachment in Section 4 of this memo. This is a non-KEES and non-KAECSES form, so is generated off-system by staff and mailed locally. The KC4520 includes several fields that staff must complete prior to mailing. These fields include the following:

- Case Number
- Primary Applicant name
- Due date – enter 10 days from mailing date

- Name of the individual that is being claimed as a tax dependent
- Name of the tax filer claiming above dependent, if unknown. If the name is unknown, include the relationship of this individual.
- Relationship of tax filer to the case name.

If the information is not received within 10 days the request for assistance is denied.

Note: Tax household members not living in the home are only added to KAECSES when they have income that must be counted for the individual budget unit.

2.3 VERIFICATION

Verification of information needed to determine eligibility is based on a tiered verification approach. The tiered system is used for all verification needs and is not limited only to income. At this time, the tiered verification system applies only to the MAGI populations.

2.3.1 TIERED VERIFICATION

Tiers provide a formal policy and hierarchy that is to be used when verification is needed.
There are four tiers of verification. A hierarchical relationship exists among the tiers meaning that Tier 1 should always be used when available; Tier 2 should be used when Tier 1 is not available and so on.

Federal law requires that we use information available to us through interfaces or other means prior to contacting the applicant. For example, if wage verification can be obtained through an interface, it is not permissible to request verification from the applicant.

A description of each tier follows:

- **Tier 1: Payer Interfaces –** Payer interfaces include Social Security Income and Unemployment Compensation.
- **Tier 2: Automatic Interfaces** – The term 'automatic' is somewhat confusing in this context. When KEES is implemented, these interfaces will be automatic. At this time, Tier 2 interfaces are still manually checked by staff. Tier 2 interfaces include wage verification from either The Work Number or KS Department of Labor (KDOL) wages. All resources used to verify citizenship and identity are also included in Tier 2, such as Kansas VRV or KSWebIZ.
- **Tier 3: Research -** Staff research the case file, review the information found in the Tier 1 and Tier 2 interfaces, and access other sources to determine what information is still required.
- **Tier 4: Request for Information** – As a last resort, when the information cannot be verified through any other means, contact with the applicant is made.

On occasion, the information may be obtained verbally through phone contact. But primarily this would include sending a request for information.

Note: Refer to the Job Aid on Tiered Verification as an additional resource.

2.3.2 INCOME VERIFICATION

Unless otherwise noted, all income must be verified.

2.3.2.1 UNEARNED INCOME

Unearned income is verified through payer interfaces, documentation provided by the applicant, or in some cases self-attestation.

Tier One payer interfaces are used to verify SSA income and Unemployment Compensation. Because this verification is directly from the source, the amount verified through the interface is to be used regardless of what has been reported by the applicant.

For unearned income types not verifiable through Tier one, the following policies apply:

- For MAGI, self-attestation is accepted as verification of all unearned income except for the following types:
    - Annuity income
    - Trust income
    - Contract Sales
    - Insurance Payments
    - Oil Royalties & Mineral Rights
    - Railroad Retirement

2.3.2.2 EARNED INCOME

Earned income is verified through Tier 2 interfaces, wage verification, The Work Number data, DCF (TANF and FA) income records, or collateral contacts.

2.3.2.2.1 Reasonable Compatibility

Reasonable Compatibility is the income verification standard that is used to determine if wages reported by the consumer are generally consistent with information received through a recognized data exchange or other source. If information from the source is reasonably compatible with the customer's statement, additional information cannot be requested. Income amounts from both the customer and the source are converted to a monthly amount for the reasonable compatibility test; and the amounts are compared.

Reported information is considered reasonably compatible if:

- The amount reported by the customer is greater than the amount received from the data source for the applicable time frame, or
- The amount reported by the customer is within 20% of the amount received from the data source for the applicable time frame.

Applicable data sources are The Work Number and the wage records on KDOL (BASI). The worker reviews information available from these resources. The average of monthly income in these sources will be used and compared to the reported income to determine if it can be accepted as verification. The Reasonable Compatibility Tool is used to make this comparison. Refer to Job Aid – Reasonable Compatibility Tool and the Reasonable Compatibility Tool for further instructions on this process.

The reasonable compatibility test only applies to earned income and Tier 2 verification. The applicant must have provided enough information to determine the reported monthly income in order to do the reasonable compatibility test.

If the income cannot be verified using the Reasonable Compatibility test, verification may be obtained through the following sources: These sources shall be reviewed in the order presented and should always be used prior to requesting verification from the applicant.

- Hard-copy Wage Verification – Staff shall review the case file to determine if hard copy verification has been submitted. This could be in the form of copies of paystubs or a statement from an employer. The date of paystubs or employer statement must be within the three months prior to the month of application.
- The Work Number – While The Work Number data was not successful in establishing reasonable compatibility, the income details may be able to verify some of the income reported.
- DCF income records – Income records used to establish TANF or Food Assistance may be used to verify wages for a medical applicant. If the most recent DCF application date is within 3 months prior to the month the medical application was received, the DCF records can be used as verification. At this time, users will access the EAIN screen in KAECSES.
- Employer Contact – In rare or unusual circumstances, staff may contact the applicant's employer directly. Note: This is not a required level of verification. Staff may proceed to Tier 4 without contacting the employer.

If the income cannot be verified using the above methods, staff proceed to Tier 4 and the applicant shall be contacted to provide verification of the last 30 days earnings. While income from the last 30 days is requested, submitted verification shall be used as long as the date of verification is within the three months prior to the month of application.

2.3.2.3 NO INCOME REPORTED

This policy was implemented effective March 14, 2014. When an applicant has answered all income questions and reports no income, the request for coverage is processed using zero income without further research. When there is no income reported, there is nothing to verify, and therefore, staff should not view the income interfaces.

Staff shall continue to evaluate the request for coverage and identify discrepancies in the information provided. When a discrepancy is found, staff shall make contact with the applicant to attempt to resolve the discrepancy. In order to do further inquiry with the applicant, staff must be able to clearly define and document what specific discrepancy was found.

Additional quality measures will be put in place to monitor decisions made under this policy after the initial eligibility determination has occurred.

Refer to Training – Households with no Reported Income in Section 4 of this memo for additional information.

2.4 INCOME BUDGETING

At this time, the following budgeting policies are applicable to MAGI programs.

2.4.1 MAGI INCOME TYPES – COUNTABLE/EXEMPT

For MAGI programs, only income that is taxable is counted, with the exception of Social Security income. Therefore, there are new types of income added to the Exempt Income list. The following types of income are **exempt** for MAGI programs:

- Child Support – Current, Arrears, and Voluntary Payments
- Worker's Compensation – whether or not the individual is returning to work
- Disability Income – whether or not the individual is returning to work
- Strike Pay
- Blood/Plasma
- Educational Income – including that which is used for living expenses

- Government Payments (such as cash assistance, tax refunds, HUD payments, etc)
- Insurance Legal Settlements
- Interest on Burial Fund
- Life Insurance Dividends
- Cash Gifts
- Loans which must be repaid
- Deemed Sponsor Income
- Military Allotments (Subsistence for Food and Housing)
- Monies withheld to Recover Overpayment
- Vendor Payments/Diverted Income
- Allocated Income
- Reimbursements or Refunds
- Income of an SSI Recipient
- Veterans – All types with the exception of Pension are exempt
- WIA - Incentive or Training Allowance
- Work Employment Program Payments
- VR Training

Refer to attachment – MAGI Income Types – Countable/Exempt for a complete listing.

2.4.2 MAGI – COUNTABLE/EXEMPT INCOME RULES BY AGE

Some individuals will have their entire income exempted, regardless of the income type. This is based on three things: the individual's age, whether or not they are being claimed as a tax dependent and whether or not they are required to file Federal income taxes.

The income of individuals who are not required to file taxes is exempt if they are age 18 or younger, or age 19 or 20 and claimed as a tax dependent. Children are required to file taxes if they have earned income that exceeds $5950 per year or unearned interest income that exceeds $950 per year.

All other individuals' income is countable, with the exception of the income types above in section 2.4.1.

Please refer to the attached MAGI Countable/Exempt Income Rules by Age for further information.

2.4.3 PROSPECTIVE BUDGETING

Income is prospectively budgeted based on what the household expects to receive beginning in the month of application. Prospective income is that which the

household reasonably expects to receive going forward from the month of application.

When the income is irregular (e.g. change in employment, loss of job, loss of unemployment) the income is budgeted by projecting the income expected to continue in the future. *Whatever happens last is what is used.*

Example 1: The applicant reports a job loss and unemployment has started in the month of application. The wages are not included but a prospected amount of unemployment compensation is used.

Example 2: The applicant reports being hired for a new job. Their current income is $0 and they are expected to start the new job in 6 weeks. At this point in time the income is $0. The job has not actually started and therefore, it cannot be used in the determination.

Example 3: The applicant applies on the 5th of the month and calls on the 15th to report they started working. Their application has not yet been processed. At this point in time because the individual has begun working, their wages are prospectively budgeted.

Example 4: The applicant applies on the 25th of the month and reports just losing their job. They've received paychecks all month and will get their last check in the first week of the following month. At this point in time they are not employed, the income is $0.

2.4.4 BUDGETING CURRENT MONTHS

When budgeting income for the current eligibility month, there are four methods used. These are:

- Using the Payer Source
- Reasonable Compatibility
- Full Month budgeting method
- Partial Month budgeting method

2.4.4.1 PAYER SOURCE

When using income which has been verified through an interface in Tier 1, the amount of income is used despite what the client reports.

2.4.4.2 REASONABLE COMPATIBILITY

Reasonable compatibility, as defined above in section 2.3.2.2.1 is used as verification of earnings when determined reasonable.

2.4.4.3 FULL MONTH BUDGETING METHOD

If at least 30 days of income verification is provided, a prospective amount shall be determined and used in place of reported income.

2.4.4.4 PARTIAL MONTH BUDGETING METHOD

If less than 30 days of income is provided (or you don't know if it represents a full month) determine a prospective amount. Then use whichever is greater, the amount reported by the applicant or the prospective monthly amount.

Note: When using DCF income records it is unknown whether or not a full 30 days of income was provided. Therefore, the Partial Month budgeting method is used.

2.4.5 PRIOR MEDICAL BUDGETING

The eligibility determination for the prior medical period is based on whether or not there has been a change reported by the applicant that occurs in the prior period. The applicant is asked a series of questions on the application form if they are requesting prior medical assistance. These questions assist the eligibility staff in determining how the prior period should be budgeted. The questions are as follows:

- Have there been any changes in the household during the last three months? (People moving in or out)
- Have there been any changes in the household income during the last three months?

Applicants are asked to explain the changes that have occurred.

Note: The online application does not ask these follow-up questions when a request for prior medical has been made. Staff must contact the applicant to ask the above follow-up questions for all online applications that include a request for prior medical.

2.4.5.1 PRIOR MEDICAL MONTHS - INCOME CHANGES

2.4.5.1.1 No Change

If a change of income has not occurred, the amount that has been verified and budgeted for the current month is used as the amount of income received in each of the prior months. No further verification is required.

2.4.5.1.2 Change reported

If a change of income has been reported, then eligibility staff will ask the applicant to provide proof of their actual income received in the three prior months. The actual verified income will be budgeted for each month of

the prior period. Note: If information for the prior medical months can be obtained through interfaces such as unemployment income or wages through The Work Number, then verification is not requested from the applicant.

If the information provided by the applicant is incomplete, but eligibility staff are able to determine the actual income received in each month, verification shall be considered complete. An example is the use of the year-to-date information on pay stubs to determine the amount of missing checks.

2.4.5.1.3 Change Reported – Staff Determine no actual change occurred

Depending on the type of change reported by the applicant, staff may actually be able to determine that no change that would impact eligibility has occurred. These situations will be treated as if the applicant has not reported a change. The reported change must be in the rate of pay (ie: received a raise or pay cut) or the regularly scheduled hours of work (ie: weekly hours were increased or decreased). Missing a few days of work due to sickness or working some occasional extra hours or overtime does not trigger this change policy. The change must fundamentally alter the expected income to be received.

2.4.5.1.4 Fails to Answer Change Question

If the applicant fails to answer the questions concerning change in the prior months on the application, it cannot be assumed there was no change. Best practice would be to call the applicant, if possible, to solicit a response. If unable to reach the applicant by phone, it will be necessary to send a request for information in writing which asks the applicant to answer the change questions and to provide proof of actual income received in the three prior months, if appropriate.

2.4.5.2 HOUSEHOLD CHANGES

When a household change is reported by the applicant, eligibility staff must evaluate what type of change occurred and what the impact is on the determination. If the change involves a person moving in or out who has income – then staff will use the income changes guidelines above, as applicable. Other household changes which do not impact income will just be updated in the system so the correct budgeting unit is used when determining eligibility.

Verification of household changes is not required, unless necessary to determine custody of a child.

2.5 CHIP

2.5.1 CROWD-OUT

There continues to be ineligibility for CHIP for members of the CHIP expansion group that have voluntarily dropped health insurance. When CHIP was originally expanded, the group included any individual with an FPL of 201% or higher. Due to the change in the FPL standards for Medicaid and CHIP, this percentage has changed. The Crowd-out policy now applies to individuals with FPL of 219 – 247%.

Individuals, who voluntarily drop insurance and do not meet one of the exceptions, will be ineligible for CHIP for a period of 3 months following the month that insurance ended.

This provision is not applicable to coverage dropped by a non-custodial parent (such as a stepparent or absent parent) or by a caretaker relative. It is also not applicable to coverage which was terminated for the following reasons:

- Loss of job from which health insurance was provided
- Loss of insurance related to the changes in the Affordable Care Act
- Death of the policy holder
- Divorce of a parent
- Dropping of coverage by the policy holder's employer
- Dropping of coverage due to financial hardship
  - Financial hardship exists when the monthly family health insurance premium exceeds 9.5% of the household gross monthly income or 5% of the household income if the policy is child-only. Verification of the cost is required to establish a financial hardship exemption.
- Child with special health care needs

2.5.2 PREMIUM AMOUNTS

Due to the change in the Federal Poverty Levels used for the Medicaid and CHIP programs, the levels at which a premium is required has changed. A monthly family premium is charged to CHIP families with a Federal Poverty Level of 167% or higher. Effective January 1, 2014 the premium obligations are as follows:

FPL Percentage	Premium Amount
167 – 191%	$20
192 – 218%	$30
219 – 250%	$50

Note: Effective April 1, 2014, the upper limit changed from 250% to 247%. All other premium ranges and amounts are still applicable.

2.6 FOSTER CARE AGED OUT

The existing Foster Care Aged Out program is being expanded. Youth who aged out of foster care are now eligible through the month of their 26th birthday. This is an expansion of the existing program that provides coverage for former foster care youth up to age 21.

To be eligible under the new Foster Care Aged Out program the young adult must meet the following guidelines:

a) Be in foster care and receiving Medicaid:
    1. The month of the youth's 18th birthday or
    2. The month the individual aged out of foster care (for young adults leaving foster care after reaching age 18.)
b) Foster Care youth not receiving Medicaid on the above dates solely because of living arrangement (such as incarceration or residing in detention facilities) are considered eligible for Medicaid for purposes of this group and may qualify for coverage under the new Foster Care Aged Out program.
c) Foster care coverage is available for youth who were under the authority of SRS/DCF, JJA, KDOC or the Tribes.
d) Be under the responsibility of Kansas while in foster care. Youth or young adults under the responsibility of another state or in foster care in another state are not eligible for coverage under this group.
e) Be a current resident of Kansas. Young adults who do not meet Kansas residency requirements are not eligible under this group regardless of former foster care status.
f) Meet citizenship and alienage requirements of KFMAM 2040. In addition, appropriate documentation of citizenship and identity or non-citizen status is required.
g) No income or resource test is applicable.
h) Case are subject to a 12 month review. Administrative reviews will be completed on all FC AO cases. If additional information is needed to complete the redetermination, a request for information is sent to the beneficiary. An application/review form is not required.
i) Verification of foster care status in the month of the individual's 18th birthday or later date. This can be obtained from KAECSES benefit history.
j) Youth in this coverage group are potentially eligible for coverage of institutional stays (including PRTF.) No patient liability will be established. Youth in this group are eligible for HCBS up to age 21 and will need to be transitioned to the MS program if HCBS is to be continued or established.
k) When a young adult is eligible for more than one coverage group, the FC-AO program takes priority except in the following situations:
    1. SSI recipients – Persons receiving SSI (or considered to be receiving SSI) shall be enrolled in SSI-related medical.
    2. MS or CI for LTC/HCBS as indicated above in item "j".

The new program began January 1, 2014. This is the earliest possible effective date of coverage. Three month prior medical is available, but cannot be dated earlier than January 1.

Until KEES is implemented, applications are processed on the Foster Care program in KAECSES using procedures currently in place for the original FC-AO program. Designated DCF-PPS staff are responsible for these determinations. Responsibility will transition to the Clearinghouse at a later date.

The existing application form, PPS 7230 is obsoleted with this memo. Individuals apply for medical assistance using the KC1100 Family Medical Assistance application. The KC1100 application includes a question that asks if the individual was in foster care at the time of their 18th birthday. All individuals answering 'Yes' to this question shall be screened for potential eligibility for Foster Care Aged-out.

When a potential former FC youth is identified on an application received at the Clearinghouse, the application is imaged and a copy sent to the designated PPS Central Office contact. The applications will be distributed to the appropriate DCF service locations for processing. The original application date (when received in the Clearinghouse) is used.

DCF-PPS will maintain the case until KEES is implemented. Additional transitional instructions will be provided at that time.

2.7 EXTENDED MEDICAL

Now that child support income is exempt, eligibility for the Extended Medical program is based solely on an increase in spousal support. No other policies for the Extended Medical program have changed.

3. CHANGES IMPACTING ELDERLY AND DISABLED MEDICAL PROGRAMS ONLY

3.1 LONG TERM CARE (LTC)

The following provisions apply to the long term care programs (institutional care, HCBS, MFP, and PACE).

3.1.1 PACE START DATE

The current start date for Program of All-Inclusive Care for the Elderly (PACE) coverage is dependent on the date the PACE entity notifies the Kansas Department for Children and Families (DCF) that the applicant has enrolled in the program. Depending on when the notification is received, PACE coverage begins either the first day of the next month, or the first day of the month after.

Although eligibility staff have been given direction as to the optimum time in which to complete processing of the application/request for coverage, the start date of

coverage always begins according to when notification of enrollment was received, regardless of when the case is actually processed. This process has resulted in some unintended outcomes, including the commencement of PACE services before actual coverage is ever approved.

To mitigate the risk to both customer and provider an alternate process has been developed.

3.1.1.1 PACE START DATE

While eligibility staff are urged to process a PACE application/request as soon as possible to ensure needed services may begin without undue delay, the start date shall no longer be tied to the date enrollment notification is received from the PACE entity. Beginning immediately, the start date for PACE coverage shall be the first day of the month following the month of approval.

The PACE entity shall continue to be responsible for notifying eligibility staff of the enrollment date. Once notification is received, assuming the applicant is otherwise eligible; coverage shall be approved beginning with the first day of the month following the month of approval..

Example 1: The PACE entity notifies DCF on 1/23/2014 that the applicant has been enrolled in the program. The application is processed and approved for coverage on 2/21/2014 with a start date of 3/01/2014 (first day of the month following the month processed/approved). If the application had been processed and approved on 1/30/2014, the coverage start date would be 2/01/2014 (the first day of the month following the date processed/approved).

Example 2: The PACE entity notifies DCF on 1/07/2014 that the applicant has been enrolled in the program. The application is processed and approved on 1/10/2014 with a start date of 2/1/2014 (the first day of the month following the month processed/approved). Even though notification and approval both occur in the same month, coverage doesn't begin until the next month.

Example 3: The PACE entity notifies DCF of enrollment on 1/15/2014 and immediately begins providing services. The application is processed and approved on 1/29/2014 with a start date of 2/1/2014 (first day of the month after the month processed/approved). Even though the PACE entity has already begun providing services, there is no coverage for those services provided prior to 2/1/2014.

Example 4: The PACE entity notifies DCF on 2/04/2014 that the applicant has been enrolled in the program. The PACE entity begins providing services effective 3/01/2014 assuming coverage will be approved commencing with that date. However, an application is never received, or an application is received,

but coverage is denied for excess resources. Since eligibility was never approved, there is no coverage for any of the PACE services provided.

3.1.1.2 EXCEPTIONS

There is no PACE coverage for months prior to the month following the month the application is processed and approved However, in rare instances, eligibility staff may contact the Kansas Department for Aging and Disability Services (KDADS) PACE Program Manager for authorization to begin coverage prior to the month following the month the application is approved. If an exception is granted, PACE coverage is effective the month authorized by the Program Manager.

No exception shall be processed by eligibility staff until authorized by the Program Manager.

Documentation of the decision to authorize an earlier start date must be included in the case file. Issuance of assistance without prior approval shall result in an overpayment subject to recovery.

Example 1: The individual files an application on 2/03/2014 and PACE notifies DCF of enrollment on 2/06/2014. DCF processes and approves coverage on 3/27/2014. PACE coverage should commence effective 4/01/2014 (the first day of the month following the month processed/approved); however the worker decides that the application was not processed timely and approves coverage effective 3/01/2014. Since retroactive coverage cannot be granted without an exception approved by the PACE Program Manager, approval for 03/2014 is inappropriate and considered an overpayment.

Example 2: DCF received a PACE application on 2/28/2014 and is ready to process on 3/04/2014. If the worker processes the application, eligibility will be effective 4/01/2014. However, the worker is aware that the applicant is in immediate need of services, and before fully processing the application, sends an exception request to the PACE Program Manager to begin coverage effective 3/01/2014. The PACE Program Manager grants the exception and the worker processes/approves coverage effective 03/01/2014.

Example 3: When an application is processed, the worker simply fails to follow correct policy and approves coverage one month too soon. Realizing the mistake the next day, the worker sends an exception request to the PACE Program Manager to cover the mistaken month. The Program Manager denies the request. The incorrect approval month is considered an overpayment.

Note: An exception request sent after the case has already been processed and approved shall be denied. There is no retroactive coverage without prior

approval. In addition, this exception process is not intended to compensate for processing errors. The exception process is only to be used to address situations similar to the situation illustrated in example 2 above.

3.2 MEDIKAN

The MediKan medical assistance program has been de-linked from the General Assistance (GA) cash assistance program.

3.2.1 BACKGROUND

General Assistance (GA) is a cash assistance program serving needy adults and married couples without minor children in the home who "have insufficient income or resources to provide a reasonable subsistence compatible with decency and health." The program is authorized by state statute and funded by allocations authorized by the state legislature. There is no federal fund participation (FFP) in the GA program. It is funded 100% by the state.

MediKan is the medical assistance counterpart to the GA cash assistance program. An individual who is eligible for GA is automatically eligible for MediKan. There are no other eligibility criteria for MediKan. Like GA, MediKan is also funded by the state legislature with 100% state funds.

3.2.2 DE-LINKING OF MEDIKAN FROM GENERAL ASSISTANCE (GA)

As indicated above, GA relies exclusively on state funding to operate. However, the program has not been funded since 07/01/2011. While GA remains an assistance program under state statute, it cannot function without funding. Even though the GA program is not funded, the MediKan medical assistance program has continued to be funded by the state legislature.

It has been very problematic to determine MediKan eligibility based on the criteria of an unfunded GA program. To remedy the problem, the MediKan program has been de-linked from the GA program. MediKan is now a stand-alone medical assistance program. No longer dependent on the GA eligibility rules, MediKan has adopted the following rules.

The new MediKan rules rely heavily on the basic existing GA rules with notable exceptions detailed below.

3.2.2.1 APPLICATION PROCESS

The MediKan application process follows:

Request – An application or request for cash assistance shall not be considered an application for MediKan medical assistance. A specific application or request for medical assistance must be made by the applicant.

Interview – An interview is not required for a MediKan application. As with any of the medical assistance programs, the applicant may request an interview, but it is not required as part of the application process.

3.2.2.2 NON-FINANCIAL CRITERIA

A MediKan applicant/recipient shall meet all the existing general non-financial requirements of citizenship, residency, social security number, and cooperation associated with all medical assistance programs.

3.2.2.3 VEHICLE REGISTRATION

Vehicle registration in the state of Kansas was a key eligibility requirement under the GA program. That rule has been eliminated for the MediKan program. Failure to register or license a vehicle does not make the applicant/recipient a non-resident for eligibility purposes. If otherwise eligible (including meeting residency requirements), MediKan coverage may be approved.

Note: For resource purposes, vehicles are either exempt or countable following the existing medical assistance resource counting rules.

3.2.2.4 NOT ELIGIBLE FOR MEDICAID OR SSA

A MediKan applicant/recipient may not otherwise be eligible for or receiving Medicaid assistance or Social Security Administration (SSA) cash assistance. Nor may the applicant/recipient voluntarily render him/herself ineligible for either program. As a state funded program, MediKan coverage is secondary to other federally funded resources.

3.2.2.5 APPLICATION FOR SSA

An applicant for MediKan shall be required to apply for Social Security Administration (SSA) disability benefits, including Supplemental Security Income (SSI). An applicant/recipient shall also continue to cooperate with SSA throughout the application process. Failure to apply or cooperate shall render the individual ineligible for assistance.

3.2.2.6 AGE

The MediKan program is limited to adults age 18 to 64. Children under 18 and adults 65 or older are not eligible under this program.

3.2.2.7 ASSISTANCE PLANNING

The MediKan mandatory filing unit shall consist of the applicant and the applicant's spouse, if living together. Both spouses must meet all MediKan criteria in order to qualify even if only one spouse is requesting assistance. The

following additional provisions also apply:

SSI Recipient – If one spouse is an SSI recipient, the other spouse shall be budgeted as a household of one with none of the SSI spouse's income or resources counted. Assuming all other eligibility criteria are met, the non-SSI spouse may be approved for MediKan coverage.

Long Term Care – If one spouse is in a long term care arrangement, the other spouse shall be budgeted as a household of one with none of the long term care spouse's income or resources counted (unless spousal impoverishment resource and income provisions apply). Assuming all other eligibility criteria are met, the non-long term care spouse may be approved for MediKan coverage.

No Minor Child(ren) – There is no MediKan eligibility for an adult with a minor child in the home, even if no assistance is requested for the child. An adult with a minor child in the home may still potentially qualify for family medical assistance or for medical assistance based on age (65 or over) or disability (if determined to meet PMDD Tier I criteria – discussed below).

3.2.2.8 DISABILITY

A qualifying MediKan applicant/recipient must meet disability criteria based on a Presumptive Medical Disability Determination (PMDD). The applicant/recipient must be claiming a disability lasting at least 12 months or resulting in death.

Tier I Determination – An individual with a Tier I determination is potentially eligible for Medicaid coverage. There is no MediKan eligibility for a Tier I individual. Nor is there MediKan eligibility for an individual who already meets SSA disability criteria (even if in SSA/SSI non-pay status) or is 65 or older – those individuals are potentially Medicaid eligible.

Tier II Determination – An individual with a Tier II determination is potentially eligible for MediKan coverage. For a married couple living together, both spouses must have a Tier II determination to qualify for MediKan. If one spouse is Tier II and the other spouse is Tier I (or already meets SSA disability criteria, or is 65 or older, or receives SSI), the Tier II spouse may qualify for MediKan while the other spouse may be Medicaid eligible.

Neither – An individual with neither a Tier I nor a Tier II determination is not eligible for medical assistance based on a disability (unless they already meet SSA disability criteria).

3.2.2.9 RESOURCE LIMIT

The MediKan resource limit is $2,000 for a single individual and $3,000 for a married couple living together. The general medical assistance resource counting rules apply.

3.2.2.10 INCOME LIMIT

The MediKan income limit is $250 for a single individual and $325 for a married couple living together. There are no income disregards. The gross countable income of the individual or couple is applied against the income limit. The general medical assistance income counting rules apply.

3.2.2.11 TIME LIMIT

MediKan is limited to a fixed 12 month coverage period beginning with the first eligible month. There is no MediKan eligibility after the expiration of the 12 month fixed period. If only one spouse has exhausted his/her coverage period, neither spouse may be eligible while living together.

Individuals who previously received less than 12 months of MediKan coverage who re-apply may be approved (if otherwise eligible) for the remaining months of coverage in a fixed period as described above. There is no hardship provision allowing coverage to extend beyond the 12 month limit.

3.2.2.12 REINTEGRATION PROGRAM

The MediKan Reintegration Program provides presumptive time-limited MediKan coverage to residents being discharged from state psychiatric hospitals (Larned State Hospital, Osawatomie State Hospital, and Rainbow Health Care Center). The following provisions apply to this program:

PMDD Referral – An approved discharge plan for each individual shall include a referral to PMDT for a disability determination, including the ES-3903 Questionnaire, the ES-3904 HIPAA Compliance form, and the ES-3901 Referral form. The plan must also document that the individual has been referred to Social Security to make an application for SSI and SSDI.

Eligibility – Eligibility shall be based on the income, resources and living arrangement following discharge from the facility as reported on the application. If the individual is in need and not obviously ineligible for some other reason, eligibility shall be approved.

Since a complete eligibility determination has not been completed, coverage under this program is limited to the month of discharge and the two following months. A full determination should be completed before the expiration of that

period. In rare situations (i.e. the PMDT disability determination is still pending), the time limitation may be extended for good cause.

Administrative Reinstatement – An individual may have medical assistance coverage administratively reinstated without an application if discharged from the facility within a previously established 12 month medical assistance eligibility period. The individual must still meet all eligibility requirements for the program in order to be reinstated.

Coverage Months – Coverage months under the MediKan Reintegration Program do not count against the 12 month lifetime MediKan coverage period. Nor does Reintegration approval start the fixed coverage period for regular MediKan. As long as the individual meets all eligibility criteria, there is no limit to the number of times (or cumulative number of months) that Reintegration may be approved.

3.2.3 TRANSITION RULES

The transition from the old MediKan time limit policy (12 months of lifetime coverage need not be continuous) to the new policy (coverage is established for a fixed period) follows:

3.2.3.1 NEW APPLICANT

If the new applicant has no months of previous countable MediKan coverage, eligibility shall be established for a set 12 month period commencing with the first month of eligibility. If the applicant has less than 12 months of previous countable MediKan coverage, eligibility shall be established for a set period equal to the remaining number of months not yet used. If the applicant has already used his/her 12 months of MediKan coverage, eligibility under that program shall be denied.

Example 1: Application for MediKan is received on 11/03/2013 from an individual with no previous countable MediKan months. If approved, a set 12 month coverage period shall be established effective 11/2013 through 10/2014.

Example 2: Application for MediKan is received on 12/15/2013. The applicant has already received a total of 6 months of previous countable coverage. If approved, a set 6 month coverage period shall be established effective 12/2013 through 06/2014. There is no MediKan coverage after that period and the program shall be closed.

Example 3: Application for MediKan is received on 12/11/2013. The individual has already received a total of 12 months of previous countable coverage. There is no MediKan eligibility and the application shall be denied.

Note: If an individual under an existing fixed coverage period loses eligibility (i.e. moves out of state, excess income, excess resources, etc.) and then later reapplies within the coverage period, eligibility may be re-established for the remaining months of the fixed coverage period, if otherwise eligible. There is no coverage under this program if they reapply after the fixed coverage period ends.

3.2.3.2 CURRENT RECIPIENT

A current MediKan recipient who has not yet received a full 12 months of countable coverage shall continue to be eligible until a full 12 months has been received or until the program closes earlier for another reason. If the individual has not received the 12 full months upon closure and later reapplies for MediKan, coverage shall be approved (if otherwise eligible) for a fixed period equal to the remaining months as indicated above.

Example 1: Current MediKan recipient with no previous coverage months under a 12 month has a review period of 06/2013 through 05/2014. Assuming the program is not closed for some other reason, once the 12 month coverage limit is reached, the program shall be closed. The individual has no further eligibility under the program.

Example 2: Current MediKan recipient with 3 previous coverage months was approved for 9 months of additional coverage effective 07/2013 through 03/2014. The recipient later moves out of state and the program is closed effective 12/31/2013. The individual later moves back to Kansas in 04/2014 and reapplies for MediKan the same month. If otherwise eligible, a fixed 3 month coverage period shall be approved effective 04/2014 through 06/2014. At the end of that period, MediKan coverage ends and the program shall be closed. The individual has no further eligibility under the program.

Note: Countable MediKan coverage months for purposes of this program are those months received since and including 01/2002.

3.2.4 MEDIKAN PROCESSES

KAECSES does not support an automated eligibility determination for the MediKan program based on the new eligibility rules. A MediKan eligibility determination shall be completed off-system using an electronic worksheet (MediKan Eligibility Worksheet – Item W-14 in the KEESM Appendix).

3.2.4.1 APPLICATION FILED

A paper application may be filed at either a local Department for Children and Families (DCF) office or at the Division of Health Care Finance (DHCF) Clearinghouse. A paper application may also be received by one of the DHCF Out-stationed Workers. An application may also be filed on-line through the Self-

Service Portal (SSP) and, in some instances, received as a file transfer from the Federally Facilitated Marketplace (FFM).

All applications will be screened to determine the proper routing for processing – to DCF or DHCF. MediKan eligibility determinations shall be the responsibility of DCF staff.

3.2.4.2 PRESUMPTIVE MEDICAL DISABILITY TEAM (PMDT) REFERRAL

An applicant who declares a qualifying disability (lasts at least 12 months or will result in death) must be referred to the PMDT for a disability determination following the current manual process. There is no automation in KEES to support the referral process.

3.2.4.3 PMDT RESPONSE RECEIVED

The PMDT will respond back with the disability determination. A Tier I determination means the applicant meets Medicaid level disability. A Tier II determination equals MediKan level disability. An applicant meeting neither Tier I nor Tier II is not considered disabled for the medical assistance programs.

3.2.4.4 MEDIKAN WORKSHEET COMPLETED

As indicated above, MediKan eligibility shall be completed off-system. A new worksheet (MediKan Eligibility Worksheet, Item W-14 in the KEESM Appendix) has been developed specifically for this purpose. The worker must fully and accurately complete the worksheet to comprehensively document the MediKan eligibility or ineligibility determination decision.. The completed worksheet must be signed and dated by the worker with a copy retained in the case file for documentation purposes.

3.2.4.5 PROCESSING IN KAECSES

KAECSES has not been updated to determine eligibility for the stand-alone MediKan program. Eligibility is still determined under the GA program. The outcome from the MediKan Eligibility Worksheet will determine how the program is entered into KAECSES.

If the applicant is MediKan eligible based on the worksheet, the program will be processed as normal in KAECSES, except that no income information shall be entered. All other information must be entered.

If the applicant is not MediKan eligible for any reason based on the worksheet, KAECSES may be updated with minimal information and an appropriate denial code entered directly on the GAED screen.

The existing MediKan notices may continue to be used to notify the applicant of the eligibility outcome.

Note: There is no automated MediKan months tracking mechanism in KAECSES. Eligibility staff shall be required to check the benefit history and manually calculate the number of months received before processing a new coverage request. A report has also been created which will alert staff once a recipient has reached the 12 month limit.

4. JOB AIDS AND OTHER TOOLS

The following is a list of attachments that have been referenced in this policy memo.

- Kansas Medical Assistance Standards – KEESM Appendix F-8, effective 1/14
- Kansas Medical Assistance Standards – KEESM Appendix F-8, effective 4/14
- MAGI Building Individual Budget Units Flowchart
- MAGI Individual Budget Unit (IBU) Examples
- KC4520 Requesting Tax Household for non-Household members
- KC4520S Requesting Tax Household for non-Household members, Spanish
- Job Aid – Reasonable Compatibility Tool
- Reasonable Compatibility Tool
- MAGI Income Types – Countable/Exempt
- MAGI Countable/Exempt Income Rules by Age
- Job Aid – Tiered Verification
- Medikan Eligibility Worksheet – KEESM Appendix W-14
- KC5150 Self-employment worksheet
- KC5150S Self-employment worksheet, Spanish
- Training – Households with No Income Reported