Kansas
Department of Health and Environment
*Division of Health Care Finance*

| Policy Memo | |
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| **KDHE-DHCF POLICY NO: 2014-11-01** | **From: Jeanine Schieferecke, Senior Manager** |
| **Date: November 3, 2014** | **KEESM/KFMAM Reference: N/A** |
| **RE: Policy Implementation Instructions and Information for November 1, 2014** | **Program(s): All Medical Assistance Programs** **Section 2a end dated 4-30-16** |

This memo provides instruction for implementation of policy changes in both the Family and Elderly/Disabled areas of the program. These policy changes are effective upon receipt of this memo, unless otherwise indicated. These policies apply to all medical assistance programs unless otherwise noted.

## 1. Changes Impacting All Medical Programs

### A. Act In Own Behalf

With the elimination of the Mandatory Filing Unit, specific requirements of who can apply for Medicaid and CHIP have been modified. This change impacts all medical programs (family medical and elderly/disabled). Portions of this policy were included in the Affordable Care Act Implementation Instructions memo issued on April 4, 2014. This memo provides additional instructions not previously released.

#### 1. Applicants for Pregnant Woman Coverage

In order to accommodate the unique situations which sometimes exist for individuals requesting pregnant woman coverage, the following additional scenarios are allowable:

- The adult father of the pregnancy of an adult pregnant woman may apply on her behalf.
- The father of the pregnancy of a minor may apply on her behalf when residing with the minor and there is not a caretaker in the home. However, if the minor pregnant woman also lives in the home with her parents, then the parents must apply on her behalf.

- When a minor pregnant woman is residing with the minor father of the pregnancy, his caretaker may apply on behalf of the pregnant woman. This could be his parents, or another person who meets the caretaker definition in KEESM 2112 or KFMAM 2011.

## B. Appeals and Fair Hearings

The manner of requesting a fair hearing has been expanded and the following provisions are effective immediately.

An individual may request a fair hearing either orally or in writing. An oral request may be made in person or by telephone. A written request may be made in person, by mail, by fax, or by email.

Note: For fair hearing requests submitted after business hours via telephone, fax or email, the date of receipt shall be the next business day.

A request for fair hearing shall be any clear expression by the individual, or his or her authorized representative, that he or she wants the opportunity to present his or her case to a reviewing authority.

As indicated above, the request for fair hearing need not be in writing to be valid. However, if the request is not in writing, it must be documented by agency staff on the Request for Administrative Hearing form. The form shall include the date of the request and the action being appealed along with an explanation as to why the individual is appealing the agency action. The form shall also indicate if the individual wishes to continue benefits while the appeal decision is pending. The form does not need to be signed by the individual requesting the fair hearing but shall instead be signed and dated by the staff member taking the request.

When taking a verbal request for fair hearing, the staff member taking the request shall record the date and time the request is received including those that are received via voicemail. For requests received after business hours, the official date of receipt shall be the next business day. Both dates shall be recorded.

This documentation shall provide the basis for the fair hearing request and must be forwarded to the Office of Administrative Hearings (OAH). A copy of the completed form shall be retained in the case file.

## C. Reasonable Opportunity Period for Non-citizens

Verification of immigration status continues to be a requirement for non-citizen medical applicants/recipients. However, new federal rules require verification of immigration be obtained under a new computer match through the Federal Services HUB which is expected to be available with KEES implementation.

The following new rules apply to individuals declaring to be a qualifying non-citizen. Under the new rules, the agency may not request verification of qualifying non-citizen status from the applicant or recipient if that information is available to the agency. The agency shall make every effort to verify the status. Use of a Reasonable Opportunity (RO) Period is required for persons who declare a qualifying non-citizen status, but are unable to provide verification of the status. Until KEES is implemented, an interim process has been developed. Follow the temporary process described below until otherwise instructed.

An application shall not be delayed or denied because the agency was unable to verify the non-citizen status of an individual declaring to be a qualifying non-citizen. If otherwise eligible, the application shall be processed and approved granting a reasonable opportunity period. The reasonable opportunity period shall be three (3) calendar months commencing from the date of approval. If proof of qualifying non-citizen status is provided, the RO period ends and additional information is not necessary. Prior medical assistance may also be provided as part of an RO period. This special RO Period process remains in place until the new verification process with the HUB is established with KEES implementation. Coverage is provided until verification is received from the member or the agency is able to verify.

## 1. Eligible Non-Citizens

The following table lists all immigration statuses that could qualify an individual as an eligible non-citizen. Some of these statuses require a five year wait following the date they gain their qualifying status. For individuals who must meet the 5 year bar, the date of entry is required in order to establish if they are a qualified non-citizen.

| Must meet 5 Year Bar | Eligible without wait |
|---|---|
| Lawful Permanent Residents | Asylees and Refugees |
| Paroled into the U.S. for at least one year | Cuban/Haitian entrants |
| Conditional entrant granted before 1980 | Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa |
| Battered non-citizens, spouses, children, or parents | Granted withholding of deportation |
| | Member of a federally recognized Indian tribe or American Indian born in Canada |

## 2. Verification Process

In order to qualify for a reasonable opportunity period, the applicant must declare they meet one of the above qualifying non-citizen statuses. This declaration can come from a variety of sources, such as the application form, phone contact with the applicant, or documentation in the case file.

a. **Research by the agency** - Staff shall review the application, case file and imaged documents to determine if the applicant has previously declared they meet one of the above qualifying non-citizen statuses.

b. **Contact with the applicant or recipient** – If there is not enough information to determine if the applicant is a qualifying non-citizen, a phone contact is made. During this phone contact, request the individual's immigration ID number, date of entry, and status. Questions should also be asked to try to determine if the individual meets one of the eligible non-citizen statuses listed above. If the immigration ID number or other necessary information is obtained verbally, a SAVE verification is processed with the information.

c. **Systematic Alien Verification for Entitlements (SAVE)** – Using information provided by the applicant, the agency shall then verify legal non-citizen status through the primary and secondary SAVE processes described in KEESM 2146.4 and KFMAM 2047.04.

## 3. Determination of Reasonable Opportunity Period

Following the research outlined above, a reasonable opportunity period is provided to individuals declaring to be a qualified non-citizen who are otherwise eligible.

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 for an additional three months if the HUB is still not operational. Coverage is provided until verification is received from the applicant, another data source, such as the SAVE process, or until the HUB is operational.

## 4. KAECSES Notices

A new KAECSES notice, V076, has been created to request verification of the qualifying non-citizen status and to approve a reasonable opportunity period. This notice shall be sent in addition to the appropriate notice of approval.

## 5. Examples

Please review the following examples.

**Example 1:** Application is received for an individual who answers 'No' to the question asking if they are a U.S. citizen. They report on their application that they have a Lawful Permanent Resident (LPR) card, but have not answered other immigration questions on the application. Staff are unable to check SAVE because the ID number isn't known. Eligibility staff attempt contact to obtain the immigration ID number and date of entry but are unable to reach the individual. The application is pended to request additional information about the immigration status and copies of the documents. A reasonable

opportunity period is not provided because the date of entry must be known in order to determine if an LPR is a qualifying non-citizen.

**Example 2:** Application is received for an individual who answers 'No' to the question asking if they are a U.S. citizen. They report on their application that they are a LPR. The eligibility staff locates a caselog entry from a prior determination which indicates the applicant had reported a date of entry of 8/16/2008. Neither the immigration number nor a copy of the LPR card is on file. Eligibility staff attempt contact to obtain the immigration ID number but are unable to reach the individual. Since the individual has declared they are a qualifying non-citizen based on their status and the date of entry they are approved for a reasonable opportunity period.

**Example 3:** Application is received for an individual indicating they are a refugee. No immigration documentation has been provided. Since the individual has declared they are a qualifying non-citizen based on their indication that they are a refugee, they are approved for a reasonable opportunity period.

## D. Self-Employment Clarification

Policy Memo 2014-01-01: Medical Assistance Program Instructions Related to the Affordable Care Act implemented new policies for budgeting self-employment income. This policy serves as clarification on how to budget self-employment income when the individual is also receiving a wage from their business, has income from rental properties, and new information about counting Capital Gains income.

### 1. Wages from a Business

Individual business owners may pay themselves a wage from the business income. These wages are to be treated as a separate form of income from the self-employment and they are both countable. The self-employment income is budgeted using the appropriate line for the specified schedule. This line on the tax return will have already incorporated the expense of wages paid out.

It is then necessary to obtain verification of the individual's wages. Verification of the wages shall follow the Tiered Verification policy. Reasonable Compatibility shall be used when possible. If unable to use Reasonable Compatibility, one of the following is used as verification:

a. Line 7 of the 1040 tax return, if the individual indicates that the wages on line 7 are only representative of those that have been paid out from the business and not a combination from other jobs held.
b. Wage statements
c. If no other verification is available, self-declaration of the wages, if consistent with other information, is used.

### 2. Capital Gains Income

For individuals who report self-employment income and provide a tax return as verification, any amount from Capital Gains or Other Gains is countable. The amount of gains reported on form 1040 on Line 13 or Line 14 shall be prorated over the year. This will mean dividing the total by 12 to determine the monthly countable amount.

### 3. Rental Income

KDHE-DHCF Policy No. 2014-01-01indicates that when an income tax return has been filed by an individual that is reporting rental income, the countable amount of self-employment income is taken from the Schedule E, Line 26 – Total Rental Real Estate and Royalty Income (or loss). This memo provides clarification that Line 26 shall always be used, even when the individual owns multiple properties.

### 4. Verification of Self-Employment Income at Review

Verification of self-employment income is required at every application and review. At the time of review, verification shall be requested, in the form of a tax return or the KC-5150 Self-employment worksheet. In addition, if the consumer indicates the tax return is not representative of their current self-employment income, both the tax return and the KC-5150 Self-employment worksheet are also required.

## 2. Changes Impacting Family Medical Programs Only

### A. CHIP Premium Enforcement and Penalties

Currently, requirements regarding payment of CHIP premiums are enforced at application and review. Once terminated for non-payment, individuals remain closed until their account balance is paid in full. However, Federal law no longer permits an open-ended period of ineligibility. Instead, a three month penalty period is established. Overdue premium balances will no longer cause ineligibility for CHIP once the penalty period has been served.

This policy is effective for all applications and reviews processed on or after the date of this memo. It applies to ALL cases with premium balances. However, the penalty period will not be applied retroactively to a previous period of ineligibility related to premiums.

This policy does NOT apply to requests to add a child to an open program/case.

### 1. Overdue Premiums and Delinquency Threshold

Premium payments are due by the end of the month for which they are billed. Any payment that has not been paid on time is considered *overdue*. The Delinquency Indicator in the Premium Billing & Collections (PB&C) system is used to identify accounts meeting the definition of delinquent: more than one month of overdue premiums.

For purposes of implementing this policy, a penalty period is applied when any amount of premiums are *overdue*.

## 2. Denials and Closures for Overdue premiums

A denial or closure for overdue premiums shall only be applied to individuals who are otherwise eligible for CHIP, with the exception of a Crowd-out penalty. If the individual is ineligible for CHIP for multiple reasons, the other denial/closure reasons take priority over the application of a premium penalty.

For example, if an individual has existing health insurance or access to state employee health insurance, they shall be denied or closed for that reason. They are not considered otherwise eligible for CHIP, so the overdue premiums are not relevant to their denial or closure. However, when an individual is ineligible for CHIP due to Crowd-out, they shall also be denied for their overdue premiums and the penalties applied concurrently. See the examples in section 2.A.6 for additional detail.

Prior to denial or closure for an overdue premium obligation, a notice is sent to the applicant informing them of the requirement to pay. The applicant is given a minimum of ten days to pay the account in full.

In situations where the applicant has both an overdue premium amount and a current premium amount, the notice shall include the full account balance. For example, when processing an October review, the consumer is found to have $80 in overdue premiums along with $20 for the month of October. The October premium will not be overdue until November 1st. In the notice to the consumer, they are told of the full account balance, or $100.

Failure to pay the overdue amount results in a denial of eligibility and a penalty period is established. The amount of payment required will vary depending upon when the case is processed. Based on the above situation, there are several potential outcomes.

**Example 1**: The consumer pays the full balance of $100. The case is approved for CHIP coverage.

**Example 2**: The consumer pays only the overdue amount of $80. The case is processed in October. The case is approved for CHIP coverage. Because the premium of $20 for benefit month October is not overdue yet, this amount is not required to approve coverage.

**Example 3**: The consumer pays only the overdue amount of $80. The case is processed in November. The case is closed and a penalty period is established. Because the premium of $20 is now overdue, the full payment of $100 would be

required in order to approve coverage.

In situations where the applicant has an overdue premium amount and additional information is also needed to determine eligibility, such as income verification, all information should be requested in the initial pending notice. In addition to the notice language requesting the income verification or other necessary information, the following wording shall be added to the pending notice to request premium payment.

> *You have unpaid premiums from past coverage in the amount of $XXX. If you do not pay the amount in full, it may keep your children from getting coverage. To ask questions about your premium balance or to make a payment over the phone, call 1-866-688-5009.*

Failure to pay the full account balance will result in a denial of eligibility provided that payment of overdue premiums was the only information required to determine CHIP eligibility for an individual. Consider the following examples:

> **Example 1**: An application is received for a child in July and prior medical is requested for April, May and June. The consumer reports a change in income during the prior medical months so actual wage verification is required. In the current month, the child is eligible for CHIP but has an overdue balance of $80 from three years ago. The application is pended to give the consumer time to provide proof of the prior medical income and to pay the overdue balance in full. Payment is not received. In August, prior medical is denied due to failure to provide the requested information; however, the only information relevant to the CHIP determination for the month of application was payment of the overdue premiums. Since the premiums remain unpaid, the application month is denied due to overdue premiums. A penalty period of August thru October is established.
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> **Example 2**: An application is received for a child in July. There are overdue premiums from 6 years ago. The worker also determines the consumer's income is not reasonably compatible. A request is sent for proof of income and payment of overdue premiums. The deadline passes with no response from the consumer. Since CHIP eligibility cannot be determined, a penalty is not established. Instead, the application is denied for failure to provide requested information.

### 3. Penalty Period

Individuals closed or denied for overdue premiums must serve a three-month penalty period, at a maximum. For a denial, the three-month penalty period begins with the month the application is processed. For a closure, the three-month penalty period begins with the first month of ineligibility. For closures at review, the first month of ineligibility is viewed as

what would have been the first month of the new review period. Closures or Denials for other reasons do not initiate the start of the three-month premium penalty period.

> **Example 1**: An October 2014 review is received in December 2014. A notice is sent requesting payment of overdue premiums. On 1/5/2015, eligibility staff determine they are ineligible based on failure to pay the overdue premiums. The case is closed again effective 10/31/2014. A penalty period of November – January is established. Since February can be worked at the time the case is processed, February would be approved for CHIP without regard to the overdue premiums.

## 4. Reinstatement following Closure or Denial

Once coverage has ended or been denied due to overdue premiums, coverage can only be reinstated when the following conditions occur:

a. **Prior to the 3-month penalty period** – The penalty is negated if payment is made for the full amount of overdue premiums and a request for reinstatement is received. Coverage is reinstated with no gaps in coverage. Use of the Retro 21 indicator may be required depending upon when staff process the reinstatement.

   - **Example 1**: On October 9, 2014, action is taken to close a case effective October 31, 2014 for overdue premiums in the amount of $90. On October 23, 2014, the consumer makes a payment for $90 and contacts the Clearinghouse to request coverage be reinstated. Eligibility staff reinstate coverage effective November 1, 2014.

b. **During the 3-month penalty period** – If all overdue premiums are paid and a new request for coverage is received, the penalty period may be shortened. This is a new determination and is not a reinstatement of prior coverage. Generally, CHIP will begin the first processing day following CHIP approval. However, when CHIP exists in the MMIS for the calendar month prior to the new month of CHIP, then coverage is backdated and fills the gap in coverage.

   - **Example 1**: On October 9, 2014, eligibility staff are processing an October review. Action is taken to close the case effective October 31, 2014 for overdue premiums in the amount of $90. The individual had been receiving CHIP coverage. On November 12, 2014, the consumer makes a payment for $90 and contacts the Clearinghouse to request coverage be reinstated. Eligibility staff process this request on November 19, 2014. Because CHIP

eligibility exists in the prior month (October), then coverage is automatically back-dated to November 1, 2014.

- **Example 2**: On October 9, 2014, eligibility staff are processing an October review. Action is taken to close the case effective October 31, 2014 for overdue premiums in the amount of $90. The individual had been receiving Medicaid coverage. On November 12, 2014, the consumer makes a payment for $90 and contacts the Clearinghouse to request coverage be reinstated. Eligibility staff process this request on November 19, 2014. Because there is no CHIP eligibility in the prior month (October), then coverage begins the next day after approval, or November 20, 2014.

c. **After the 3-month penalty period** – Only a new request for coverage is required to provide eligibility once an individual has served their penalty period. Payment of the overdue premiums is not a requirement. This is a new determination and is not a reinstatement of prior coverage. The individuals must requalify for medical assistance. However, if the medical program remains open for other household members, the child(ren) shall be added back to the case using the policies in KFMAM 2460.

- **Example 1**: On October 9, 2014, eligibility staff are processing an October review. Action is taken to close the case effective October 31, 2014 for overdue premiums in the amount of $90. A new application is submitted on February 4, 2015. No payments have been received. Eligibility staff process this request on February 17, 2015 and determine the individuals are eligible for CHIP. Coverage begins on February 18, 2015. A new review period and continuous eligibility period is established. The overdue premiums are not a factor in the CHIP determination because the individuals have served the penalty.

- **Example 2**: On October 9, 2014, eligibility staff are processing an October review. The household is blended with one child eligible for Medicaid and one child eligible for CHIP. Action is taken to close the CHIP individual effective October 31, 2014 for overdue premiums in the amount of $90. A new request for coverage is received for the CHIP child on February 4, 2015. No payments have been received. Eligibility staff process this request on February 17, 2015 using the Adding a Child to a Plan provisions. The CHIP child's coverage begins on February 18, 2015 and continues through the already established review period and continuous eligibility period of October 2015. The overdue

premiums are not a factor in the CHIP determination because the individual has served the penalty.

The application period and the review reinstatement periods shall be applied when determining whether or not a new application is required. A new application is not required if the payment and request for coverage is received within the 45-day application period. For a review, a new application is not required if the payment and request for coverage is received within the three-month review reconsideration period.

## 5. Evaluating the Completion of a Penalty Period

Once a consumer has served their penalty for an overdue premium and related time period, that same amount and time period cannot be used again to terminate or deny coverage.

When payments are made to overdue premiums they are applied to the oldest unpaid months. Because of this, it will be difficult to determine when a consumer has already served a penalty by looking at the PB&C. Staff should always review the notice sent at the time the penalty was put into place to determine if a penalty has already been served. See section 2.A.6 below for additional information about the notice.

## 6. KAECSES Notices

Notices used when closing or denying an individual for overdue premiums are required to include two key facts: the amount of overdue premiums and the time period that the premiums are from. For the first penalty period applied to a case, the time period in reference should be the last month a premium was billed and prior (e.g. 11/2009 and prior). Following penalties must include a range of months that the premiums apply to. Notices are as follows:

- P223 – Denial for overdue premiums
- P451 – Closure for overdue premiums, entire case closed

If the outcome of the case results in both an approval and a denial, it is not appropriate to use the Approval/Partial Denial notices. Denials related to overdue premiums must always be sent using the separate P223. In addition, when one individual is being closed but the case remains open, KAECSES will not allow the closure notice, P451 to be sent. Staff will instead copy the language from the P451 notice and use the V008 General Correspondence notice.

## 7. Collection of Past Due Premiums

Although the penalty period for a past due premium may have expired, the past due obligation is not forgiven. The obligation remains on the consumer’s account. Collection activities will continue to be made against the consumer until the balance is paid.

### 8. EXAMPLES

Consider the following examples:

**Example 1**: An application is received for a child in July. The child is eligible for CHIP but has an overdue balance of $80 from three years ago. Three years ago, the coverage ended for failing to complete the review. The application is first pended to give the consumer time to pay the balance in full. Payment is not received. The application is denied in August for failing to pay overdue premiums. The premium penalty period is August, September, and October.

**Example 2**: A child is receiving CHIP and at the time of review is closed for failing to pay overdue premiums. Coverage ended May 31, 2014. The review reconsideration period is June, July, and August. The consumer makes payment in full, notifies the eligibility staff and requests coverage again on August 6, 2014. A new application is not required because the individual is still within their review reconsideration period, but retroactive CHIP coverage is not provided. If eligibility is authorized the same day, August 6, 2014, then coverage for CHIP would begin again on August 7, 2014.

**Example 3:** An application is received in July. Two children are within CHIP income range, but have existing comprehensive health insurance as well as an overdue premium balance. The application is denied for having existing health insurance. The premium balance is not included as a reason for denial because the children aren't considered to be otherwise eligible for CHIP. The three month premium penalty would not be applied at this time. If a subsequent application is filed after health insurance has been lost (e.g., a parent was laid off) and the overdue premiums have not been paid, a three month premium penalty may be appropriate at that time since it was not applied earlier.

**Example 4:** An application is received in August. Two children are within CHIP income range, but their parents dropped their health insurance effective June 30, 2014 because they didn't like the company. They also have an overdue balance of $40 from several years prior. The application is denied in August for crowd-out as well as having an unpaid premium obligation. The crowd-out penalty period is July, August, and September. The premium penalty period is August, September, and October.

## B. CHIP ELIGIBILITY FOR NEWBORNS

Effective with the release of this memo, when an application is filed for a newborn within 30 days of the date of birth and the newborn is determined eligible for CHIP, coverage will backdate to the date of birth. This essentially closes any gaps in coverage for the newborn that would exist from the date of their application to their date of birth. This eliminates the need to determine a Medically Needy spenddown for many of these newborns to pay for the birth expenses. A spenddown must still be offered prior to CHIP approval if the newborn's request for coverage is received more than 30 days after the date of birth.

In order to approve coverage with the correct start date, the eligibility worker must enter a 'Y' in the RETRO 21 ELIG field on the PLGD screen in KAECSES. This indicator must be entered in each benefit month from the month of birth through the current calendar month. This is what will set the correct start date of eligibility for the child in the MMIS.

Note: This policy change is not related to CHIP Deemed Newborns, but rather newly eligible CHIP babies. A deemed CHIP newborn is one who is given coverage solely on the basis of the mother receiving CHIP coverage in the month of birth. A deemed newborn is provided coverage back to the date of birth as long as coverage is requested within three months following the month of birth.

## C. Cooperation with Child Support Services (CSS)

Federal guidance no longer requires strict enforcement on of cooperation with obtaining child support. Beginning with the benefit month of August 2014, penalties for failing to cooperate with Child Support Services (CSS) are being temporarily suspended. This is applicable to all eligibility actions. Penalty periods are still applicable to any month prior to August 2014. Therefore, if a request for prior medical coverage is received, an individual is not eligible for any prior medical month prior to August 2014 if a penalty was in place. Enforcement of CSS penalties will be reinstated at some time following the implementation of KEES.

When processing a new application or review for caretaker medical coverage, staff are no longer required to check the KAECSES-CSE system to determine if the individual is in cooperation status with CSS, unless addressing a prior medical request as stated above. A referral to CSS is still required for all individuals approved for Caretaker Medical when there are one or more absent parents.

If eligibility staff are notified that a caretaker medical recipient is not cooperating with CSS, a penalty is not applied. A caselog entry is required indicating that notification of non-cooperation was received, but "'action to enforce a penalty was not required, per policy" when processing the notification.

For individuals already serving a penalty, the penalty will remain in place until <u>one</u> of the following occurs:

- A new request for coverage is received
- Notification is received from CSS that the individual is now cooperating.

## D. MAGI – Determining the Individual Budget Unit (IBU)

At the time MAGI determinations were implemented, instructions were provided in Policy Memo #2013-12-01: MAGI Redeterminations. This memo outlines the interim process for completing a MAGI determination prior to the implementation of KEES. At that time, staff were instructed to use the 'MAGI In The Cloud' tool to determine the correct Individual Budgeting Unit. This instruction serves as additional clarification that the 'MAGI In The Cloud' tool is not

a requirement for a correct MAGI determination. Staff who have demonstrated knowledge of the MAGI IBU policies are permitted to determine the correct IBU without the use of the tool. Each individual's IBU must be documented in the case log when the 'MAGI In The Cloud' tool is not used.

In addition, the following rules are being provided as clarifications for determining the correct IBU.

a. Individuals under age 19 who are filing taxes and not being claimed as a tax dependent by anyone else are to be determined using the non-filer rules.

b. For individuals whose IBU is based on the tax household, the spouse of the tax payer is included in the IBU if they are filing jointly. When the spouse is not filing jointly with the tax payer, they are only included in the IBU when the spouse and tax payer are living together.

c. The spouse of the individual requesting medical assistance is always included in the IBU when the spouse and individual live together.

d. When an unmarried couple indicates they will file jointly, staff must first make contact to clarify their tax filing intention. If after contact, the couple still attests to filing jointly, then the non-filer rules shall be used for all household members.

The MAGI – Building Individual Budget Units flowchart has been updated to provide additional clarification. This chart is included as an attachment to this memo.

## E. MAGI – Countable/Exempt Income Rules by Age

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. The minimum income requirement that establishes whether or not the individual is required to file taxes is set by the Internal Revenue Service (IRS) and is subject to periodic changes. Effective with the release of this memo, the minimum income requirement for these individuals is as follows: Earned income that exceeds $6100 per year or unearned interest income that exceeds $1000 per year.

## F. Verification and Budgeting the Income of a Minor

This policy serves as clarification of how to budget the income of an individual age18 or younger, or age 19 or 20 and claimed as a tax dependent. It also addresses when verification is required.

Verification of the income of a minor is not required when the self-attestation of income, prospected over 12 months is less than 80% of the income threshold used to determine whether or not the income is countable.

The current threshold of earned income is$6100 per year. 80% of this is $4880. Therefore, when the prospected annual income from a self-attestation is $4880 or less, then the income is deemed as exempt and is not required to be verified.

When the prospected income is greater than $4880, then verification of the income is required. Verification shall follow the standard Tiered Verification policy. Once the income has been verified it will be determined countable or exempt based on whether or not it exceeds the income limit of $6100.

> **Example 1:** Individual age 18 reports earning $500 per month. This is prospected to an annual amount of $6000. This is above the 80% threshold of $4880; therefore the income must be verified. Eligibility staff locate income information in The Work Number and the income passes the Reasonable Compatibility test. It is, therefore, considered verified. The income amount is below the minimum income requirement of $6100 and it is, therefore, exempt.
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> **Example 2:** Individual age 18 reports earning $350 per month. This is prospected to an annual amount of $4200. This is below the 80% threshold of $4880. Therefore, the income does not require verification and is deemed to be exempt.

## G. TRANSMED COVERAGE

There are changes to the way eligibility for TransMed is established based on MAGI budgeting units. The following policies are effective with the release of this memo.

To qualify for TransMed, an individual must meet each of the following requirements:

- The individual meets the definition of a caretaker in KFMAM 2110.
- The individual received Caretaker Medical coverage in the month prior to the month being determined.
- The individual has an increase in earned income since the last determination
- The income of the individual's IBU exceeds Caretaker Medical income limits.

When these requirements have been met, 12 months of TransMed are approved for the individual. Other household members do not automatically receive TransMed coverage based on the individual's approval. Other requirements must be met for other household members to also receive TransMed.

### 1. ESTABLISHING TRANSMED FOR OTHER HOUSEHOLD MEMBERS

Household members (including children) of an individual approved for TransMed may also receive TransMed coverage when the following requirements are met:

- The individual is not eligible for any other MAGI program.
- The individual's IBU includes the TransMed approved individual.

Household members approved for TransMed at the time of the initial TransMed determination shall be approved for 12 months. However, when adding a household member to an already established TransMed program, continuous eligibility is only provided through the end of the existing TransMed review period. Prior medical coverage may be provided for the three prior months to a household member as long as they were a member of the IBU and resided in the home in the three prior months.

## 2. Reacting to Changes During TransMed

Individuals approved for TransMed are continuously eligible according to KFMAM 2310, with one exception. When a reduction of income is reported, the eligibility shall be assessed to determine if the income is again within the limits of Caretaker Medical. If the income meets eligibility requirements for Caretaker Medical, the coverage shall be changed for the remainder of the existing review period.

Individuals leaving the TransMed household do not automatically lose their eligibility for TransMed. Non-pregnant adults must continue to live in the home and qualify as a caretaker for eligibility to continue. Coverage shall continue according to KFMAM 2310 and 2340.

## 3. Processing in KAECSES

If MACM and MAWT coexist for the same household, two case numbers will be required to assign the correct eligibility.

## 4. Examples

Consider the following examples.

**Example 1:** Review being processed for a household which includes a Mother and one 10-yr old child. They have both been receiving Caretaker Medical coverage. The mother reports that she has started working and is earning $1200 monthly.

| Individual | IBU size | Income counted | Outcome |
|---|---|---|---|
| Mom | 2 | $1200 | TransMed |
| Child (10) | 2 | $1200 | Poverty Level Medicaid |

In KAECSES this will be processed with two programs: MAWT and MP. Both individuals are approved for a 12-month period.

**Example 2:** Using the same example above, except the wages received by the mother are $2000 monthly and she has obtained health insurance for her child through her new employment.

| Individual | IBU size | Income counted | Outcome |
|---|---|---|---|
| Mom | 2 | $2000 | TransMed |
| Child (10) | 2 | $2000 | TransMed |

The income is within the CHIP income range, but the child is ineligible for CHIP due to having existing comprehensive health insurance. Because no other eligibility exists for the child, the child is placed on the TransMed program.

**Example 3:** Continuation of Example 2. Four months after the review is processed, the mother gets married and her spouse moves into the home. He is requesting medical assistance. The couple reports they will file jointly and claim her child as a tax dependent. He has $1200 monthly earned income.

| Individual | IBU size | Income counted | Outcome |
|---|---|---|---|
| Spouse | 3 | $3200 | TransMed |

The spouse is eligible for TransMed because he is not eligible for any other MAGI program and his IBU includes the individual initially eligible for TransMed. However, he is only added to the program for the remainder of the existing review period.

**Example 4:** Review being processed for a household which includes a Mother, Father, and their 3-yr old child. The mother and father are not married. Both the adults file taxes, but the father claims their child as his dependent. They have all been receiving Caretaker Medical coverage. At review, the father reports that he has started working and is earning $3200 monthly.

| Individual | IBU size | Income counted | Outcome |
|---|---|---|---|
| Mother | 1 | $0 | Caretaker Medical |
| Father (boyfriend) | 2 | $3200 | TransMed |
| Child (3) | 3 | $3200 | CHIP |

**Example 5:** Review being processed for a household which includes a Mother, Father, and their 17-yr old child. The parents are married and filing jointly, claiming their child as their tax dependent. They have all been receiving Caretaker Medical coverage. At review, the mother reports that she has started working and is earning $300 monthly. The teenager has also started working and is earning $600 monthly.

| Individual | IBU size | Income counted | Outcome |
|---|---|---|---|
| Mother | 3 | $900 | TransMed |
| Father | 3 | $900 | TransMed |
| Child (17) | 3 | $900 | Poverty Level Medicaid |

The mother is eligible for TransMed because she had an increase in earned income since her last determination and her IBU exceeds the income guidelines for Caretaker Medical. It does not matter that the amount of her earned income alone would not exceed the income guidelines, as it is the IBU income that is counted for the determination. The father is eligible for TransMed because his IBU income exceeds Caretaker Medical and the individual initially eligible for TransMed is a member of his IBU. The child is eligible for Poverty Level Medicaid.

## H. Non-Filer At Review

Effective with MAGI reviews processed on or after receipt of this memo, cases without current tax filing information on record with the agency are processed using non-filer rules.

The following rules apply only to Passive or Administrative reviews where an ex parte process is in use for a review and no client contact is required to process the review.

1. For cases without a previous declaration or response regarding tax filing status, the non-filer rules are used to process the review.

2. For cases with tax information on file, the newest available information is used to process the review unless the information conflicts with other, current information. If conflicting information exists, the non-filer rules are used.

3. If client contact is needed to verify any other eligibility factor (e.g. income) tax filing status information must be requested as part of the review process. This information may be requested verbally if phone contact is made, or by mailing the KC4510 – Tax Information and Relationship (TIAR) form. If the consumer fails to return the completed TIAR form, but all other information is available to determine eligibility, the non-filer rules are used to process the review.

4. If use of the non-filer rules results in ineligibility, the determination is not considered final. The consumer must be contacted to obtain the tax filing information. The KC-4510 TIAR form is mailed to the consumer. If the consumer fails to provide the tax filing status, the review shall be denied for failing to provide information.

5. If the process results in a CHIP premium, the review is completed, but the household must be notified that the use of tax household information may cause a change in eligibility. This is accomplished by adding the following statement to the CHIP review approval notice:

   '*You did not tell us about your tax filing status. We approved you for coverage as someone who does not file taxes. If you do file taxes, please contact us so that we may adjust your case. It may affect the coverage you receive*.'

   For those applicants who contact the agency after receiving the above notification, the case shall be redetermined to see if there is any change in the premium obligation based on the tax filing information provided. If the premium is reduced or eliminated, the change will be applied to the month following the month the information is reported. No other changes to eligibility will be made, including an increase in premiums.

6. In order to support future processes, tax information is still requested via the TIAR form according to current protocol.

Note: This policy would not be applicable to situations where the consumer fails to provide the form, KC4520 – Requesting Tax Household for non-household Members. For those cases, the filing status is already known (they are filing a tax return). This policy of assuming the consumer is a non-filer is only allowed when we don't have a declaration or response about the filing status.

## 3. CONCLUSION

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff listed below.

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