



Policy Memo	
KDHE-DHCF POLICY NO: 2016-05-01	From: Jeanine Schieferecke, Senior Manager
Date: May 13, 2016	KEESM/KFMAM Reference:
RE: Medical Assistance Eligibility Changes	Program(s): All Medical Programs

This memo sets forth instructions for implementation of policy changes specific to the Medical Assistance programs. Many changes are related to functionality changes implemented in the KEES system effective May 1, 2016. Unless otherwise indicated, the following implementation instructions are applicable to actions processed on or after May 1, 2016. Topics addressed in this memo are described below.

Applicable to all Medical Programs:

- Self-employment Income Budgeting
- Poverty Level Changes
- Income Changes

Applicable to Family Medical Programs only:

- Continuous Eligibility and Review Periods
- CHIP Processing in KEES
- CHIP Premium Enforcement
- Third Party Liability
- Minor’s Income Limit
- CHIP for State Employees

Applicable to Elderly and Disabled Medical Programs only:

- Application Requirements for Long Term Care

This memo supersedes Policy Memo 2014-11-01, Section 2.A. CHIP Premium Enforcement and Penalties.

1. Changes Impacting All Medical Programs

A. Self-Employment Budgeting

The following instructions are applicable to both MAGI and non-MAGI programs and is effective with all actions taken on or after May 1, 2016.

When budgeting self-employment income from a tax return, the amount of self-employment tax that the individual paid must be deducted from the gross self-employment income. This results in the amount of countable self-employment income.

The 1040 tax form is used to determine the amount of self-employment tax paid. Line 27 identifies the amount of deductible self-employment tax. This amount shall be deducted from the amount of income taken from the applicable tax schedule as defined below.

- 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 more than one business exists, the worker shall only deduct the income from one of the self-employment businesses. When possible, the business selected should be one that has a net profit that is larger than the amount of self-employment tax. The full amount of self-employment tax must be allowed, therefore, it may be necessary to deduct the amount from multiple businesses to ensure the full amount is allowed. Add a note to the Income Detail Description field to indicate which business the SE tax was deducted from.

B. Poverty Level Changes

This memo implements the increases in the federal poverty level standards. The new levels take effect May 1, 2016. The change provides new standards for CHIP, Caretaker Medical, Medicaid Pregnant Women and Children, the Medicare Savings Programs and Working Healthy. It also impacts Presumptive Eligibility determinations for Pregnant Women, Children and Caretakers as well as the screening tool on the Customer Self Service Portal (CSSP). The Kansas Medical Assistance Standards (KEESM Appendix Item F-8) has been updated with the new standards.

1. **Medical Assistance Updates:** The poverty level standards have been updated in the KEES system and are effective for any determinations for the benefit month of May and later. No automatic updates were processed in the KEES system. In order to effect the

new change for any case, staff must accept and save the EDBC for the specific benefit month.

For new requests for coverage that fail eligibility due to excess income in a month prior to May, 2016 a second determination is completed for the benefit month of May if the poverty level is within 2% of the maximum income limit. For ongoing cases, the new level will be considered the next time eligibility is redetermined and no additional action is necessary at this time. This is accomplished by running EDBC. For Family Medical programs, changes are enacted according to information contained in other sections of the memo. For Non-MAGI programs, the change will be effective with the next case action.

2. **Presumptive Eligibility and CSSP:** The new income levels will be available in the on-line tools on May 1. For Presumptive Eligibility, the new levels will be used for any determination on or after this date. The information is being shared with the PE Qualified Entities but no additional action is necessary. The updates to the CSSP will also be available to any screening executed on or after this date.

C. Income Changes

The month in which we react to an income change is dependent upon whether or not there is also a request for coverage for a new individual.

1. Income Change Only

An income change unrelated to a request to add a new person is processed in the month after the month of report.

A. Family Medical

An income change does not trigger a redetermination of eligibility in most situations. The income is updated in KEES and left in a Pending status. Verification of the change of income is not required at the time of processing because there is no impact on eligibility.

The following Family Medical situations would require a redetermination of eligibility and therefore verification of the income change:

- a. Individual is a CHIP Premium-Payer and reports a reduction/elimination of income.
- b. TransMed recipient reports a reduction/elimination of income.
- c. Extended Medical recipient reports a reduction/elimination of income.

B. Elderly and Disabled

Except as noted below, verification is required for all income changes. Except as noted below, an income change shall trigger a redetermination of eligibility.

- a. Individual is a Working Healthy non Premium-Payer and reports a reduction of income. Verification is not needed at the time of change, but is required at the next desk review or recertification.
- b. Individual is a Working Healthy recipient and reports an increase in income. The income is updated in KEES and left in a pending status. Verification is not needed at the time of change, but is required at the next desk review or recertification.

Note: For Family Medical - It is not necessary to obtain verification of a loss of income but it would be necessary to verify a reduction of income such as a change from one job to another or a decrease in hours or salary from an ongoing job.

2. Income Change with Request for New Coverage

An income change reported at the time of a request to add a new individual is processed in the month of report. The new income must be verified and updated in the system prior to processing the request for the new individual. This allows the new income to be used in the determination for the new person, and is also applicable to the rest of the household members. This could result in a change in coverage or the reduction or removal of a premium obligation in the month of report when applicable.

3. Processing the Income Change in KEES

Per the KEES User Manual, when ending an income record, the End Date should be the last day of the month the income should be counted for eligibility. When modifying an existing income record, a new Income Amount Detail record is added with the Begin Date of the first day of the first month the income should be counted for eligibility. Therefore, this date will vary depending on whether processing an income change only, or an income change along with adding a household member. Consider the following examples:

Example 1: Three children are receiving PLN. The Primary Applicant calls on 4/18/2016 to report that she has lost her job. The income record is end dated 4/30/2016. No verification is required.

Example 2: Three children are receiving PLN. The Primary applicant calls on 4/18/2016 to report that she has lost her job – AND – requests coverage for herself. The income record is end dated 3/31/2016. No verification is required.

Example 3: An individual who is receiving Working Healthy calls on 4/18/2016 to report that he has gotten married and his hours at work have been reduced. He is now requesting coverage for his spouse who has Social Security and Medicare. The income change is verified and the new income amount detail record is added with a begin date of 4/1/2016. Since this would most likely result in an increase in premium for the WH client (due to spouse's income) even though his earnings have decreased, staff would need to approve new spouse but override WH budget to keep the premium the same and not increase it until desk review or recertification.

Example 4: An elderly ELMB consumer calls on 4/18/2016 to report he is no longer working his part-time job. The income record is end dated 4/30/016. No verification is required.

2. Changes Impacting Family Medical Programs Only

A. Continuous Eligibility (CE) and Review Periods

Once eligibility is established under a Family Medical aid code, all individuals are continuously eligible. The length of the continuous eligibility period will vary depending upon the category of assistance/aid code. KEES has been updated to include specific CE periods for each Medical Aid Code. The correct CE date will be set automatically by KEES and does not require staff intervention to set the correct continuous eligibility period. There is, however, one situation where KEES does not set the correct CE period and this is explained in section 2.A.2 below.

In order for KEES to set the correct continuous eligibility dates, it is critical that eligibility months are processed in sequential order, starting with the first prior medical month when prior medical is requested. Processing months out of order will cause incorrect CE dates, review periods and other inaccurate outcomes.

1. Continuous Eligibility Periods

Continuous Eligibility Periods are set individually at the time of approval. Individuals on the program may receive a different CE period from other household members depending on their eligibility outcome. The following is a summary of continuous eligibility periods:

- a. Medicaid children and Caretakers are continuously eligible for 12 months.
- b. CHIP children are continuously eligible for 12 months from the first full month of CHIP eligibility.
- c. Deemed Medicaid newborns are continuously eligible for 13 months.
- d. Deemed CHIP newborns are continuously eligible through the end of their mother's CE period.

- e. Pregnant women are continuously eligible through the 2nd postpartum month.
- f. 18 year olds are continuously eligible through the month of their 19th birthday.

When an individual falls into multiple categories, the longer of the two CE periods will apply with the exception of a non-pregnant 18 year old child. The CE period is always set for the month of their 19th birthday. An 18 year old caretaker would set the longer of the two CE periods.

See the Appendix Item: CE Dates Chart for details about the CE date set by KEES for each aid code.

While, CE periods are set individually, reviews are set at the case level. At the time of initial approval, the review period will be set to the shortest CE period on the case. When changes to the CE dates are made, the review period shall be adjusted to match the shortest CE period. Staff shall ensure that the review period is updated by KEES and adjust it manually when necessary.

Examples of Initial CE and Review Periods

Example 5: Application received in April 2016, applying for two children. Both children are approved for Medicaid. Child 2 is age 18 and turns 19 in December 2016. Child 1 is CE through March 2017. Child 2 is CE through December 2016. The review period is set for December 2016.

Example 6: Application received in April 2016, applying for two children. Application processed on May 12th. Child 1 is approved for Medicaid and Child 2 is approved for CHIP. Child 1 is CE through March 2017. Child 2 is CE through May 2017. The review period is set for March 2017.

KEES has been modified to display the CE and Review dates when running EDBC. The Medicaid EDBC Summary page will display these dates at the time they are being set. If EDBC is run and it does not change or set the Review Date or CE date the field will be blank.

2. **Pregnant 18 year olds**

When processing a new application for an 18 year old who is reporting a pregnancy, KEES does not set the CE period correctly. KEES sets the CE for 12 months. In this situation, the CE should be set for either the second postpartum month or the month of the 19th birthday, whichever is longer.

Staff must manually adjust the CE period. This is not done through an eligibility override. Instead, the CE is adjusted on the Medical Program Detail page. See KEES User Manual Section *Family Medical > Updating Individual Continuous Eligibility and Review Dates* for more information.

3. Adding Household Members to an Existing Program

All applicants, including individuals added to an open case shall be continuously eligible for the periods defined above in section 1. The review period already established on the case is maintained. In most situations, the person being added will have a CE date that is beyond the existing established review period.

Other policies regarding the application process when adding an individual to an existing program have not changed. A formal review is not required. Income currently being budgeted for individuals already included in the plan shall be used to determine eligibility along with the income of the new individual being added and any new IBU members added to the plan due to the addition of the individual.

4. Requirement to Comply with a Review Period

It is no longer a requirement to cooperate with any review required prior to the end of the continuous eligibility period. If a review is due for a household, only members whose continuous eligibility periods are aligned with the review are required to be reviewed. If the review is not returned, only those at the end of their continuous eligibility periods will be discontinued, when the discontinuance batch is run.

If the review is returned, eligibility is redetermined for all household members. Individuals who are still within a CE period that extends beyond the review period may have coverage changed and/or CE period extended. After processing the review, the review date is then reset for the next shortest CE date and the case will be reviewed again at that time. See section C below regarding coverage changes in an existing CE period

5. CE Protecting Aid Codes

Each time the EDBC is run on a program, the eligibility and continuous eligibility dates are examined for each individual. Except as outlined below, individuals shall not switch between medical aid codes during their continuous eligibility period. KEES rules have been updated to appropriately control when a change of coverage during an existing CE period is allowed. When a coverage change is allowed, it will also impact the existing CE period. KEES will reset the period as appropriate.

A. Extending Continuous Eligibility

The following situations will allow a change in coverage and the CE period will be extended if the new eligibility sets a longer CE period than what has been previously established. In some situations, the CE period will remain the same.

- a. TransMed (TMD) to Caretaker Medical (CTM)
- b. Extended Medical (EXT) to Caretaker Medical (CTM)
- c. Poverty Level Pregnant Woman (PLN/PW) to Caretaker Medical Pregnant Woman (CTM/PW) or Caretaker Medical Parent (CTM/PA)
- d. Poverty Level Medicaid Newborn (PLN/NB) to Poverty Level Medicaid Deemed Newborn (PLN/DN)
- e. CHIP Pregnant Woman (PLT/PW) to Poverty Level Pregnant Woman (PLN/PW) or Caretaker Pregnant Woman (CTM/PW)
- f. Changes within the aid code, such as changes within PLT, PLN, or CTM. The identifier can change, such as PLT/C5 can change to PLT/PW.

B. Not Extending Continuous Eligibility

Not all situations will cause an extension of the CE period. In the following situations, the coverage changes, but the CE period is not extended. In these situations, the CE period may remain the same, be shortened or eliminated. When the CE period is shortened, staff must manually adjust the review period to match the new CE period.

- a. CHIP Newborn (PLT/C3) to CHIP Deemed Newborn (PLT/DN) - This situation will cause the CE period to be shortened, because a Deemed CHIP newborn's CE is set to match the end of their mother's CE period.
- b. PLT to PLN when processing an income change or a household change - Note: See Section 2A.3 for information about adjusting a premium in this situation.
- c. PLT to PLN when a prior medical request is received/processed after CHIP eligibility was established and Medicaid eligibility is overlaying the previously established CHIP coverage. See section 9 below.
- d. Any MAGI category to any non-Continuously Eligible Aid Code which is higher in the hierarchy from the original MAGI category. Examples of this would include a child on Poverty Level 19 or Poverty Level CHIP who becomes eligible for HCBS, SI, or is placed into Foster Care. In this situation, the CE period is actually broken, as the individual is moving to a non-CE category.

Consider the following examples to help explain these policies.

Example 7: Mom and Child are open and receiving coverage from 1/2016 through 12/2016. Mom has TransMed coverage and child is open as a PLN child. They both are CE through 12/2016 and their review is set for 12/2016 as well. In 7/2016, the mom reports that she has lost her job and they now have \$0 income. When processing the

income change (in the month after the month of report) mom's coverage is changed from TMD to CTM/PA and she is given a new 12 month CE period: 8/2016 through 7/2017. The child's coverage does not change (PLN to CTM is not an allowed aid code change.) The review due remains set for 12/2016.

Example 8: A woman is approved for PLN/PW coverage with a due date of 2/2016. Therefore, her CE period and review are both set for 4/2016. In 2/2016, she reports her baby is born in 2/2016 and also reports that she is no longer working. Because this is an income change reported at the time of adding a person, the income change is processed in the month of report. The income record is end-dated 1/31/2016. EDBC is run in 2/2016 to add the baby. Baby is approved for CTM/CH on the basis of the income being within CTM income limits and given a CE of 2/2017, and mom's coverage switches to CTM/PW as well. Her CE remains 4/2016. The review remains due 4/2016. No further action is taken until the review is processed.

Example 9: A child was approved for PLT on 2/11/2016 with a \$30 premium. CE and review date are set for 2/2017. An income change is reported in 5/2016 which brings the child into the Medicaid income limits. Income changes are processed in the month after the month of report, so the change is processed in 6/2016. KEES will remove the premium and change the child to PLN from 6/2016 through 2/2017. The CE and review period are not reset in this situation.

Example 10: A child was approved for PLT on 4/12/2016 with a \$50 premium. CE and review date are set for 4/2017. In 6/2016 a request is received to add a sibling to the case and an income change is reported. The income brings everyone into the Medicaid income limits. EDBC is run in 6/2016 to process the request for the new individual. KEES will recognize the income change for the PLT member as well and will allow coverage to change to PLN in 6/2016. This means that the premium will also be adjusted to \$0 effective 6/2016. The new child is approved for PLN 6/2016 through 5/2017. The existing member is approved for PLN 6/2016 through 4/2017.

6. Pregnancy Reported for an Active Recipient

When a pregnancy is reported for an individual already receiving Medicaid, she is continuously eligible through the end of the postpartum period. When processing the change in KEES, the continuous eligibility date will be automatically adjusted to equal the most beneficial CE period. The aid code may also change to include the PW identifier.

Example 11: A minor is receiving PLT/C2 through July 2016. She reports that she is pregnant with a due date of December 2016. After processing the change, her aid code changes to PLT/PW, but her CE date remains the same. Continuous eligibility dates are not extended to the end of the postpartum period for CHIP individuals. However, if

an income change was also reported, or by adding the unborn to her IBU she became PLN eligible, her aid code would change to PLN/PW and then her CE date would be extended to February 2017 to match the end of the postpartum period.

Example 12: A woman is currently receiving CTM/PA through 10/2016 when she reports that she is pregnant with a due date of July 2016. After processing the change, her aid code changes to CTM/PW and her CE date will not change. Her CE date for her pregnancy would only go through 9/2016 and since that is shorter than the already existing CE period then no change occurs.

Note: when adding a pregnancy to an active recipient and there is no change in the aid code or a change that could impact other household members, it is only necessary to run EDBC in the current calendar month. This will update the continuous eligibility date for the pregnant woman. If another change is reported, such as an income change, it will be necessary to run eligibility through the come-up month.

7. Medicaid Deemed Newborns

A child born to a woman who is eligible for and receiving Medicaid coverage under one of the following categories is automatically eligible for Medicaid coverage and is continuously eligible through the month of their first birthday.

- a. Refugee Medical
- b. Aged Out Foster Care (including SOBRA)
- c. Foster Care
- d. Adoption Support Medical
- e. SSI Medical
- f. Breast and Cervical Cancer
- g. Protected Medical Groups
- h. Working Healthy
- i. Caretaker Medical (including SOBRA)
- j. Transitional Medical
- k. Extended Medical
- l. Poverty Level T19 (including SOBRA)

KEES will identify the correct aid code for the child and establish a CE date that is 13 months from the month of birth. The child's aid code will not always reflect a deemed newborn category. This is appropriate and no other action is needed.

8. CHIP Deemed Newborns

A child born to a woman who is eligible for and receiving CHIP coverage is automatically eligible for CHIP starting with the date of birth and is continuously eligible

through the month of the mother's continuous eligibility period as long as the birth is reported within three calendar months following the month the baby is born.

When running EDBC for the household at the time the baby is added, KEES will redetermine eligibility for the PLT/PW. If there have been changes in the case circumstances the CHIP mother may be changed to Medicaid, which would change the expected eligibility for the newborn as well.

If the mother remains CHIP eligible, then a special process is required to ensure that the baby is also provided with CHIP coverage. Follow the process outlined in KEES User Manual section Family Medical > CHIP Medical > CHIP Deemed Newborns.

9. Processing Prior Medical months

When eligibility for Medicaid does NOT exist in the application month, but eligibility does exist in one of the prior medical months, the continuous eligibility period is established from the first eligible prior medical month. When processing a new application with a prior medical request, KEES will establish the correct continuous eligibility dates.

When Medicaid is approved for one of the prior medical months, KEES will initially set the CE date for the individual for 12 months from the first prior medical month where Medicaid eligibility exists. Then, when running EDBC for the application month, if also Medicaid eligible, the CE date will be extended to be 12 month from the application month.

When processing a prior medical request that was received after initial eligibility is established, a special process is required if the initial eligibility was CHIP and the CHIP start date caused any of the prior months to be fully denied. See KEES User Manual section *Family Medical > CHIP Medical > Prior Medical Requested After CHIP Approval* for instructions.

B. CHIP Processing in KEES

Several changes have been made in KEES in order to support CHIP Processing. These changes include:

- MMIS/Prem. Bill Override (field has been eliminated)
- CHIP Start Date (field added)
- Prem Bill Start Date (field added)
- New Role Reason added – Future CHIP Start Date
- New Rescind Reason added – CHIP Start in Future

1. **CHIP Eligibility Start Date**

With this implementation, KEES will automatically determine the CHIP eligibility start date. The user will now be able to see the CHIP start date on the EDBC summary page. This eliminates the need for staff to override EDBC when processing an application or a request to add a person in order to manually set the start date of eligibility. No change is being made to the policy for the CHIP start date; eligibility begins on the date the application is processed. The CHIP eligibility start date will be sent to the MMIS on the nightly file.

Note: This also eliminates the need to create a CHIP Customer Options record to prevent approving CHIP in error for months prior to the date the application is processed.

2. **Premium Start Date**

KEES will now automatically start the CHIP premium in the first full month of CHIP eligibility. The 'Prem Bill Start Date' will include this date and can be found on the EDBC Summary. The premium start date information is sent to the Premium Billing and Collection system on the nightly file along with the monthly premium obligation records.

3. **Processing a CHIP approval**

A CHIP child will receive the Role Reason of 'Future CHIP Start Date' when KEES has determined that their CHIP Start Date is outside of the application month. This is how KEES determines that they are not eligible in the month of application, but are eligible for CHIP to begin at a future date. Example: If processing a March application on 4/14/2016, KEES sees that their CHIP Start date (4/14/16) is outside of the application month of March. So, March is denied with the role reason of 'Future Chip Start Date'.

This new Role Reason will behave differently depending upon the family composition. Specific instructions have been outlined in the KEES User manual for processing a new application when all children are CHIP eligible, when the application is blended, or when adding a CHIP child to an already open program. See KEES User Manual section *Family Medical > CHIP Medical > CHIP Approval* for complete instructions.

4. **Processing a Blended Application approval**

When processing a Blended application, that contains both Medicaid approved and CHIP approved individuals, the process to approve coverage is outlined below. This process is also applicable to situations where a CHIP child is being added to an already open program.

When processing the application month, the CHIP child will become an Active FRI because they are used in the determination of the other Medicaid household members. This acts as a denial for this individual without actually denying them in KEES. They receive a Role Reason of 'Future CHIP Start Date'. Eligibility can then be run in the current calendar month and the CHIP eligibility will be approved and the CHIP Start Date set appropriately by KEES.

There will be several NOAs generated from this action. The Medicaid approval letter also contains language that indicates coverage was denied for the individuals that are being approved for CHIP. This is acceptable language and the NOA is usable.

5. Processing a CHIP or Blended Review or Late Review

When processing a review and the individual is now CHIP eligible in the new review period, the CHIP start date is set based on the type of coverage the individual had in the prior review period. For individuals who were CHIP in the prior review period and remain CHIP, KEES will set the CHIP start date to the first of the month of the new review period, filling the gap in coverage.

If the individual had Medicaid in the prior review period, then KEES will set the new CHIP eligibility period based on the date the review is processed. In these situations, it will be necessary to follow a workaround to update KEES with the correct CHIP start date. See KEES User Manual section *Reviews > Processing Reviews that Include a CHIP Child* for complete instructions.

Example 13: Processing a late review – CHIP coverage ends 3/31 for failing to return the review. The review is returned in April and processed on May 10th. Run EDBC for April. Because the child was CHIP in the month prior to the month that we are determining eligibility, KEES will set the CHIP start date to 4/1/2016.

Example 14: Processing a late review – Medicaid coverage ends 3/31 for failing to return the review. The review is returned in April and processed on May 10th. Run EDBC for April. Because the child was Medicaid in the month prior to the month that we are determining eligibility, KEES will set the CHIP start date to 5/10/2016. This would be incorrect, because the consumer returned their review within the three months following the end of their review period, we must fill the gap in coverage. Follow instructions outlined in KEES User Manual section *Family Medical > CHIP Medical > Processing Medicaid to CHIP* (Late Review Section).

There will be several NOAs generated from this action: a CHIP denial letter and a CHIP approval letter. The denial letter shall be deleted and only the approval sent.

6. Processing CHIP Newborns

When approving a Deemed CHIP Newborn or when an application is filed for a newborn within 31 days of the date of birth and the newborn is determined eligible for CHIP, coverage will backdate to the date of birth. Per policy, coverage is back-dated to the date of birth in these situations even when the consumer does not specifically request assistance with prior medical bills.

Changes have been made to KEES to correctly set this start date – instructions are as follows:

- EDBC is run in the application month for the newborn.
- If the application date is within 30 days of the date of birth, KEES will display a warning message that says:
 - CHIP Start Date is before the Application Date. Add a MAGI Requested Medical Type Retro Month record and run EDBC.
- The purpose of this message is to alert the worker that they need to go back and add a retro month for the month of the baby's birth and determine eligibility in that month.
- When EDBC is run in the month of birth, KEES will correctly set the CHIP Start date to the baby's date of birth.
- Eligibility is then run in sequential month for all other prior months, application month through the come-up month.

If a premium obligation is required for a CHIP newborn, the premium will begin the first full month of CHIP eligibility. Because CHIP coverage is provided retroactively in these situations, you may find that the premium start date is prior to the date that eligibility is approved. This is appropriate and no action shall be taken by the staff to modify the premium start date.

7. NOAs and Forms

Because CHIP will no longer require the EDBC to be overridden, this will now allow NOAs to be automatically produced. Staff will need to thoroughly review the NOA produced by KEES to ensure that it has all necessary information and is accurate. Because we have not had CHIP NOAs produced by KEES before, due diligence will be required to report incidents when the NOA contains inaccurate information. When submitting the incident, include the phrase 'CHIP NOA' in the Short Description so these can be correctly prioritized.

Some issues have already been identified with the KEES produced NOAs. The following situations will require a special process.

- a. Prior Medical requested at the time of application and approved Medicaid in prior medical and the month of application. A notice is not generated for the

application month. Staff must use the V008 form with the General Notice of Approval template.

- b. Approved a CHIP application and then consumer later requests prior medical and Medicaid is approved in the prior medical month. When reprocessing the month of application to change to Medicaid, a notice is not generated. Staff must use the V008 form with the General Notice of Approval template.

C. CHIP Premium Enforcement

Payment of CHIP premiums is a requirement for CHIP eligibility. Failure to pay premiums results in the establishment of a penalty period where CHIP coverage cannot be received. When processing a new request for CHIP, whether a new application or adding a person to an existing program, if the account meets the definition of delinquent, CHIP coverage is denied and a three-month penalty is applied. If CHIP is already open, and a consumer becomes delinquent, the case will be discontinued and a three-month penalty is applied.

Effective May 1, 2016, a new policy is in place regarding CHIP premium enforcement. When an ongoing CHIP recipient fails to pay their premium obligation for two invoices, the account becomes delinquent, coverage is discontinued and a penalty is established.

Penalties continue to be applicable to a new request for coverage as well. Once a consumer has served their penalty for an overdue amount and related delinquency period, that same amount and time period cannot be used again to terminate or deny coverage.

Hewlett Packard Enterprise (HPE) is responsible for Premium Billing and Collection services for CHIP and Working Healthy. They operated the Premium Billing and Collection (PB&C) system which interfaces with KEES to manage premium services. Many changes have been made to both KEES and the interfaces with the HPE Premium Billing and Collection System in order to implement these new policies.

1. Premium Billing and Penalty Process

Premiums are due on the last day of the month in which they are billed. On the evening of the first business day of each month, the PB&C will identify the accounts that are delinquent. An account meets the definition of *delinquent* when there are two invoices that have not been paid and not previously used in a penalty. These invoices do not have to be consecutive and may occur from two different eligibility periods. The PB&C system is responsible for determining when an account is delinquent and transmitting that information to KEES so it may be used in the eligibility determination.

HPE sends a Delinquent Balance File to KEES on a daily basis. Every account that meets the definition of delinquent is present on this file and will remain on this file until

the point that is considered to no longer be delinquent. An account remains delinquent until the payment is made for the delinquent amount, the penalty is served, or the penalty is shortened.

2. Denials and Discontinuance for Delinquent Premiums

A denial or discontinuance for delinquent premiums shall only be applied to individuals who are otherwise eligible for CHIP, with the exception of a Crowd-out penalty. For example, if an individual has existing health insurance, they shall be denied or closed for that reason. They are not considered otherwise eligible for CHIP, so the delinquency is not relevant to their denial or discontinuance. However, when an individual is ineligible for CHIP due to Crowd-out, they shall also be denied for their delinquent premiums and the penalties applied concurrently. In this situation, it is not necessary to use Workaround 68 for Crowd-out. KEES will deny for delinquent premiums and establish the correct premium penalty. Staff must then add a specific journal entry which indicates the crowd-out penalty period and that it is applicable at the same time the premium penalty is being applied. The NOA must be appended with a phrase to reference the Crowd-out penalty, which can be found on the Standard Text for Copy and Paste spreadsheet in the KEES repository.

a. Denials

A denial for premium delinquency is not applicable to all situations where the consumer has a past due balance, but only to situations where they meet the actual definition of delinquency, meaning at least two invoices are unpaid. The decision to deny for Premium Delinquency is based on the KEES Delinquency Indicator of a 'Y'. Only cases which meet the delinquency definition will have this indicator. It is not necessary for staff to access the Premium Billing and Collection system to determine the past due amount. The amount that must be paid to prevent a denial is the amount contained in the Delinquent Amount field in KEES.

Prior to denial for a premium delinquency, staff must send a notice 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. This is only applicable when processing an application (including a verbal request to add a person to an existing program). When an ongoing CHIP recipient becomes delinquent, a 10-day request to pay notice is not sent. See section b below.

In situations where the applicant is delinquent and additional information is also needed to determine eligibility, such as income verification, all information should be requested in the initial pending notice. The Standard Text for Copy and Paste spreadsheet has been updated to include the following fragment which shall be used to request payment.

You have unpaid premiums from past coverage in the amount of \$XXX
(The amount is populated from the amount found in the Delinquent
Amount field on the Case Summary page in KEES.) 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 delinquent amount will result in a denial of eligibility provided that payment of premiums was the only information required to determine CHIP eligibility for an individual. KEES will deny eligibility using the Role Reason of 'Premium Delinquency'. A three-month penalty period is established beginning with the month the application is processed. Consider the following examples:

Example 15: 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 a delinquent 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 delinquent 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 premiums. When running EDBC for the application month of July, CHIP is denied due to Premium Delinquency and a penalty period of August thru October is established.

Example 16: An application is received for a child in July. There are delinquent 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 delinquent 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.

Example 17: Medicaid is approved for one child for January through December. In March, the consumer requests to add a child and reports a change in income. The worker determines the income is Reasonably Compatible and that the child would fall within the CHIP income range. However, the CHIP Delinquency indicator is a Y, because there are delinquent premiums from a premium CHIP eligibility period. A notice is sent giving the consumer 10 days to make payment. The premiums are not paid, and the request is processed on April 28th. When running EDBC for the application month of March, CHIP is denied due to Premium Delinquency and a penalty period of April thru June is established.

b. **Discontinuances**

As stated above, when a consumer fails to pay their premium obligation and becomes delinquent by having two unpaid invoices, CHIP coverage is discontinued. In most situations, this discontinuance occurs automatically by a batch job that runs on the 5th of the month that the delinquency is identified.

A NOA is generated which informs the consumer of the discontinuance and the requirement to pay the delinquent balance in order to have coverage reinstated. The NOA will inform the consumer of the amount delinquent, plus the amount of the current premium obligation which will become overdue after the end of the month. This NOA is generated automatically by KEES.

A three-month penalty period is established beginning with the first month of ineligibility.

Example 18: CHIP coverage was approved for January 2015 through January 2016. A premium obligation of \$30 began in February 2016. The consumer paid regularly and then failed to pay July and August. On September 1st, they will be determined to be delinquent, as there are two unpaid invoices. KEES will take action to discontinue eligibility effective September 30, 2016.

While most discontinuances will occur during an eligibility period, it is possible that this discontinuance will also be aligned with the review period. See Section 4C below.

3. Impacts of Payments on the Penalty Status

a. **Payment made BEFORE the Penalty Begins**

If a payment is made of the delinquent amount BEFORE the penalty starts, the account is no longer considered delinquent and the penalty is NEGATED. CHIP eligibility would be reinstated without a new request for coverage.

b. **Payment made DURING the Penalty Period**

If payment of the delinquent amount is made at some point DURING the penalty period, the penalty is SHORTENED.

A new request for coverage is required and a new determination is made. If the request is received during the Reactivation Period, a verbal request is allowed. After that time, a new application is required. This would include a verbal request for coverage when allowed by policy.

The Reactivation Period for a discontinuance is the calendar month following the month of closure. The Reactivation Period for a denial is 45 days from the application date or 10 days from the date of determination, whichever is later.

This is considered a new determination and is not a reinstatement of prior coverage in all situations - whether processing a verbal request or a formal application. If approved for CHIP again, coverage is not backdated; it begins the day of approval. A new continuous eligibility period would be established.

c. **No Payment made**

If no payment is made during the penalty period, the penalty is considered to be SERVED on the first day of the month following the end of the premium penalty. Once a consumer has served their penalty for an overdue amount and related delinquency period, that same amount and time period cannot be used again to terminate or deny coverage. A new application (including a verbal request when allowed by policy) is required and a new determination is made. Payment of the overdue premiums is not a requirement. This is a new determination and is not a reinstatement of prior coverage. If approved for CHIP again, coverage is not backdated; it begins the day of approval. A new continuous eligibility period would be established.

4. **Collection of Past Due Premiums**

Although the penalty period for a past due premium may have been served, and another penalty will not occur for that same premium balance, 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.

HPE applies a special payment methodology to the accounts in such a way that will prevent the case from going into a delinquent status, solely on the basis of how the payments are applied. These methods are outlined below:

Oldest invoice to newest invoice: When the case is actively receiving CHIP, in an ACTIVE penalty or NEGATED penalty, payments are applied to the oldest invoice first.

Newest invoice to Oldest Invoice: When the case has already SERVED or has a SHORTENED penalty, the payments are applied from the newest invoice to oldest invoice.

When a consumer has a SERVED or SHORTENED penalty, the delinquent months and delinquent amount will not be used to re-penalize the consumer. HPE will not count

these months when determining the delinquency. Therefore, payments will be applied to any new obligations which occur AFTER the original penalty period to prevent the consumer from going into a new penalty. Any extra payments will be applied to the older obligations.

5. Premium and Penalty Information in KEES

Several changes have been made in KEES in order to support the new methods of premium enforcement. These include:

- a. Medical Program Detail Page
 - o Delinquency Fields for CHIP
 - o Delinquency Fields for Working Healthy
 - o CHIP Penalty Periods
 - o CHIP Penalty Statuses
 - o Premium Penalties History Screen page
 - o Premium Period Detail page
- b. Delinquent Premiums Processing Batch
- c. Update Penalty Period for Non-Delinquent Premiums Batch

6. KEES Premium Billing and Penalty Process

The following outlines how the process works in KEES, beginning with assigning the premium obligation and continuing throughout the entire penalty period.

- a. **Premium Obligation Established**

The premium obligation is established at the time of running EDBC. KEES determines the amount of the premium obligation and the date the premium obligation shall begin. This information is displayed on the EDBC Summary Page in addition to the CHIP Start Date and Prem Start Date fields. After EDBC has been Accepted and Saved, the amount will display on the Medical Program Detail page.
- b. **Premium Invoice Mailed**

The premium amount is sent to HPE via a nightly interface file. HPE will send a premium invoice for the amount to the consumer. HPE sends invoices twice each month, on the 1st and the 15th, though a consumer will only receive one monthly invoice. If the obligation is sent to HPE between the 1st and 14th of the month, the consumer's invoice will be mailed out on the 15th. For records sent between the 15th and the end of the month, the invoice is mailed on the 1st.

Note: If the 1st or 15th falls on a weekend, the mailing occurs on the next business day.

c. **Premiums Become Delinquent**

When two invoices have been unpaid, HPE determines that the premiums are delinquent. Since premiums are due by the last day of the month, a case will only be determined delinquent on the 1st business day of the month. HPE sends the case to KEES on the daily Delinquent Balance File. The Delinquent Balance File will identify whether the premiums are associated to a CHIP or a Working Healthy program, the amount that is delinquent, and the months that are delinquent.

There are two sets of Delinquency fields on the Medical Program Detail Page; one for CHIP and one for Working Healthy. CHIP is the only program for which a premium penalty is applicable. This implementation has no impact on Working Healthy premium enforcement policies. KEES will update the fields accordingly, based on the information sent on the Delinquent Balance File.

- Delinquent CHIP/Working Healthy Premiums (Y/N indicator)
- Delinquent Amount
- Date

Note: the Delinquent Amount will not include the amount of the current month's premium obligation because it is not past due. However, this field will get updated with the current month's obligation at the time that it becomes past due.

d. **CHIP Coverage is Discontinued**

A new batch, the Delinquent Premiums Processing batch, will identify individuals that are active CHIP members and have been flagged to have delinquent premiums.

On the 5th of the month, Batch EDBC will run to discontinue CHIP individuals at the end of the month with the reason of 'Premium Delinquency'. A NOA is generated and mailed to the consumer which informs them of the discontinuance due to premium delinquency, the amount of past due premiums, the months those premiums are for, and the date range of their premium penalty. The notice also informs the consumer that they may shorten their penalty period if they pay the premiums owed, and directs them to HPE to make a payment.

Note: The action to discontinue the individual will generally occur automatically. However, if there is a pending person in the program block, or some other error occurs that prevents KEES from discontinuing coverage, a

task will be generated. The task, CHIP Medical Program Delinquent Premium, must then be processed by the worker to manually discontinue CHIP coverage. This action must be taken by the KEES Closure Processing Deadline in order to allow for timely notice of the discontinuance.

e. **Penalty Period is Established**

KEES updates the Medical Program Detail page with the penalty information and sets the penalty status as ACTIVE.

- Penalty Start and Penalty End
 - Will display the start and end date of the three-month penalty period.
- Delinquent Month Start and End
 - The delinquent months represent the benefit months for which the premiums were not paid. This may just be a two-month period or could represent several historical periods that have been unpaid. When several delinquent month segments are applicable they will display as multiple rows in the Delinquent Month Start and End fields.
- Status
 - The Status of the Penalty Period. There are four penalty statuses, which will all be updated automatically by KEES depending upon the individual case situation. They are defined below:
 - Active: Individuals are not eligible for CHIP when there is an active penalty period. When a penalty is first applied to a case it starts in Active status. It will stay in this status until it moves into one of the following statuses.
 - Negated: A penalty is cancelled before it actually begins. This occurs when the delinquent premiums are paid before the penalty start date.
 - Shortened: A penalty is shortened if the consumer pays their delinquent premiums or becomes Medicaid eligible sometime DURING the penalty period.
 - Served: A penalty is considered served once the penalty period has ended and no other status changes have occurred.

The above fields will display the most current penalty information. An additional screen has been added which is accessed by clicking the 'View Penalty History' button. The Premium Penalties History screen will display all penalty records that are applicable to the case.

f. **Payments Applied**

Payments are made to HPE and applied to the account in the PB&C. The Delinquent Balance file will update KEES daily with any changes to the delinquency or delinquent amount.

(i) **Partial Payment** – The delinquent amount will be reduced by the amount of the payment. The account remains delinquent until the amount of two invoices is paid.

(ii) **Full Payment** – KEES will update the Delinquency Indicator to 'N' and indicate a \$0 delinquent amount. Depending upon when this payment is made, the status will either move to NEGATED or SHORTENED. The Status Date will be updated to the applicable date when the status changed.

g. **Eligibility Reinstated**

If payment of the delinquent balance is made prior to the start of the penalty period, the premium penalty is NEGATED and eligibility is reinstated without a new application or request for coverage.

A task, Reinstate CHIP coverage, will be created in KEES. Staff processing this task will run EDBC for the reinstated month through the come-up month and the CHIP start date will automatically backdate to ensure there is no gap in coverage.

Note: It is the expectation that these tasks are processed within 10 days to provide the consumer with timely reinstatement of coverage. However, KEES will set the CHIP Start Date to the first day following the discontinuance as long as the task is processed within 3 months of the closure. This policy is only applicable to situations where the penalty is NEGATED because the consumer paid the delinquent amount prior to the start of the penalty period.

h. **Penalty Served**

A Penalty Status of SERVED will only occur if payment is not made to shorten the penalty and the three month penalty period has expired.

KEES notifies HPE when a penalty has been served. HPE removes the case from the Delinquent Balance File and flags those delinquent months and amounts so that they are never again counted towards a future Delinquency. The Delinquency indicator is now updated again to 'N' and CHIP eligibility can be approved.

Only the delinquent premiums are associated with the penalty period. A premium which was not past due at the time the penalty was assessed but which has become past due at some point later, is not associated with the penalty period. This month may be applied to a premium penalty at some point in the future when a total of two invoices are unpaid.

Example 19: CHIP coverage was approved for January 2016 through December 2016 with a \$50 premium obligation. The consumer fails to pay his May or June premiums. On July 1st, the account is flagged as delinquent because there are two invoices that have not been paid. On July 5th, the case is discontinued and a penalty period established for August through October. On November 1st, the penalty status switches to Served and KEES notifies HPE the penalty has been served. HPE flags the months of May and June as having been associated with a penalty period.

At this point, only July is considered past due. Because there is only one past due month, the case is removed from the Delinquent Balance File, so the Delinquency Indicator is changed to 'N'.

In November, the consumer reapplies. The application is processed on 11/10/16. CHIP starts that day, and a new premium obligation of \$30 begins 12/1/2016. On January 1st, the December premium becomes past due. Now the July and the December premium are unpaid, and so the account meets the definition of Delinquent again. On 1/1/2017, the Delinquent Indicator is set to 'Y'. On 1/5/2017, a new penalty period is established (for July and December past due premiums).

i. **New Request for Coverage**

A new request for coverage is required to establish coverage following a SHORTENED or SERVED penalty. A verbal request is allowed when received in the first month following the discontinuance. After that, a formal application is required.

New applications received in the last calendar month of an Active penalty period can be used to determine eligibility following the penalty period.

Applications received within an Active penalty period must still be processed in the application month, and prior medical if requested, to determine if Medicaid eligibility exists. The CHIP premium penalty is not a condition of eligibility for Medicaid and therefore would not impact a Medicaid approval.

When processing an application during an Active penalty period and the income is within the CHIP income limits, the consumer must be given 10 days

to pay their delinquent premiums before completing the determination. See section 3.B.1. above.

In situations where the penalty period is still active, and CHIP is being determined for the period following the premium penalty, KEES will not allow a CHIP approval while the account remains flagged as Delinquent. The application must be put on hold until the 1st day of the month after the penalty period ends. At this time, EDBC can be run and CHIP approved.

If at the time of processing, the status has moved to SERVED, the application can be used to determine eligibility following the penalty period, even if the application was received in a month prior to the last month of the penalty period.

7. Adding a Child to a case when there is a premium penalty

If there is a request to add a child to a CHIP program where a penalty is already established and has begun – the child should be denied CHIP and will have the same premium penalty as the existing family members. We will not require that child to have a different penalty period. Penalties are at the case level – not the child level.

However, if the request is processed in the last month of CHIP eligibility before the actual penalty begin date, rather than denying the child for past due premiums, the child is approved for CHIP in that final month and then discontinued with the rest of the children and given the same premium penalty.

This would require that we append the approval NOA for the child to also include the discontinuance information. The append phrase can be found on the Standard Text for Copy and Paste spreadsheet in the KEES repository.

Example 20: Two children were approved for CHIP in March 2016 through March 2017. \$20 premium obligation began on April 1. They failed to pay their premium obligation for April and May. In June, the case is marked as delinquent and on the 5th, the system processes a discontinuance for those children effective July 1, 2016. Their premium penalty is established for July, August, and September. On June 10th, a request is received to add a child to the case. This request is processed on June 20th and the child is within CHIP income guidelines. The child should be approved for June 20th through the 30th, and then the premium penalty is applied. When sending the child's NOA, it must include information about the approval dates as well as the discontinuance due to premium penalty.

8. Delinquency at the time of Review

A penalty may be established and coverage discontinued at the same time that a review is due for the family.

Example 21: CHIP coverage was approved for June 2015 through May 2016 with a \$50 premium obligation. The consumer has not paid the March or April 2016 premium payments. On May 1st, they will be determined to be delinquent, as there are two unpaid invoices. KEES will take action to discontinue eligibility effective May 31, 2016, which is also the last day of their review period. At the time that their discontinuance for premiums occurs, the consumer will have also been mailed their review form and may return it for processing. The premium penalty will be assessed for the three months following the review period.

If a Pre-Populated review form is received during the penalty period, the review can be used to redetermine eligibility in place of a new application. If a change is reported that results in Medicaid eligibility, the penalty period will be shortened and the payment is not a requirement for Medicaid coverage. However, if the consumer remains CHIP eligible, all policies related to the penalty are applicable. Payment of the delinquent amount must be paid or the penalty must be served.

When processing the review form, if the consumer:

- a. Remains within CHIP income limits and the penalty status is negated then CHIP coverage is backdated to the first month of the RR period.
- b. Remains within CHIP income limits and the penalty status is shortened then daily enrollment applies and the CHIP Start Date is the day that the review is processed.
- c. Remains within CHIP income limits and payment is not received, CHIP eligibility does not exist until after the penalty period has been served. The action taken is dependent upon when the review was received. If the review was received in the last month of the penalty period the case is put on hold so it may be processed following the end of the penalty (See section 4.A.9.) If the review was received in a month earlier, then the review is denied for Premium Delinquency.
- d. Is now within Medicaid (including M-CHIP) income limits, Medicaid can be approved because payment of delinquent premiums is not a requirement for Medicaid coverage. The penalty period will be shortened to end with the day prior to the first month for which Medicaid is approved.

If the passive review response or a Pre-Populated review form is received after the RR period has expired, it would be processed as a new application and not as a review.

On passive review responses, the CSR would gather information about the change being reported as well as notify the consumer of the premium penalty and advise the consumer that delinquent premiums may need paid in order to avoid having to submit a new application. A passive review response will only be accepted if it is received prior to the end of coverage or within the first month following discontinuance for premium delinquency.

A discontinuance for a Premium Delinquency may also occur at the time of review when a consumer has been receiving Medicaid, is now eligible for CHIP and has a delinquent balance from a previous CHIP eligibility period. When processing the review, CHIP eligibility will be denied for Premium Delinquency if the Delinquency Indicator is a 'Y' and However, KEES establishes the penalty period as if it was a denied request (beginning with the month the action is taken) rather than beginning with the first month of ineligibility following the old review period. When this occurs, staff must manually edit the premium penalty start and end date to match the correct penalty period. The NOA will also not produce the correct information. Staff should copy the NOA generated by KEES and paste into a V008 form, so the premium penalty months can be adjusted.

Example 22: Consumer received Medicaid through March 2016, when they were discontinued for failing to return their review. They return their review in April 2016 and it is processed in May 2016. When running EDBC for April, KEES will deny for Premium Delinquency, but will set the premium penalty period for May – July. In this situation, because coverage has been discontinued, not denied, the correct penalty period is April – June. The eligibility worker must edit the premium penalty data as follows on the Penalty Period Detail page:

Penalty Start Date: 4/1/2016

Penalty End Date: 6/30/2016

There is no need to override EDBC in this situation. The only adjustment needed is to the penalty period.

9. **Adjusting a Premium**

When processing a change in eligibility, the premium shall be adjusted according to the following policies:

- a. A premium reduction or removal is processed in the month after the month of report of the change when it is unrelated to a request for coverage for a household member

- b. A premium reduction or removal is processed in the month of report when also processing a request for coverage for a household member.
- c. A premium shall not be increased for an individual during their continuous eligibility period, unless adding CHIP coverage for a new household member who requires a premium obligation.

Premiums will be adjusted automatically in KEES when processing other changes, but staff shall be diligent to ensure that KEES is following this logic. There are situations where KEES will not make the premium change in the correct month according to the guidelines above, and will require staff override the Prem Bill Start Date to ensure the premium is adjusted correctly.

When processing an overpayment of CHIP coverage, or when a consumer reports they have been charged a premium in error, after reviewing the eligibility decision, a request for review shall be submitted to the Premium Billing mailbox:

PremiumBilling@kdheks.gov

The email shall include the following information:

- Case Name
- Case Number
- Month (s) that needs adjusted
- New premium amount for each month if more than one
- Reason for the Premium Change

In addition, if a premium change occurs in a past month that has an overridden EDBC the reduction will not be sent to HP. When this occurs please send the following information directly to Patty Rice at the KEES Help Desk: price@kdheks.gov

- Case Name
- Case Number
- Month (s) that needs adjusted
- New premium amount for each month if more than one

10. American Indian/Alaskan Natives (AI/AN) – Premium Policies

Families that include participating AI/AN children are not subject to premium requirements. Therefore they should not be billed a premium, nor be subject to a premium penalty.

If a premium has been charged in error to an AI/AN child, the premium(s) need to be adjusted to \$0 in order to prevent any negative action due to Premium Delinquency. Submit an email to the Premium Billing Mailbox as instructed above in Section 2.C.9.

11. Adding Historical Premium Penalties to KEES

Premium penalties were originally implemented for CHIP effective November 1, 2014. For penalties that have been applied since that time, it is necessary to add records to KEES so the rules correctly determines eligibility and does not re-penalize a consumer for a penalty that has already been served. The following explains how these historical records have been added to KEES.

- a. Penalties that occurred prior to March 1, 2016 are not being added to KEES. Rather, these penalties are considered served at the point that this is implemented in KEES and therefore are flagged by HPE in the Premium Billing system as being served. Because they are served penalties, the months associated with them will not be counted towards a delinquency and the consumer will not be re-penalized for the delinquency.
- b. Penalties that began March 1, 2016 or later have been created in KEES so that the system can appropriately update the penalty statuses and apply the correct premium policies. If when processing a case, the journal or other case activity indicates that the consumer was in a penalty period post March 1, then they need to manually add.

At any time, if staff identify a case where a penalty has begun after March 1, 2016 and a penalty record has not already been added to KEES, a special process is required. See KEES User Manual section *Family Medical > CHIP Medical > Manually Updating a Penalty Period* for instructions on creating a manual penalty record.

In addition, if staff identify a case where a penalty has been served, but KEES is denying eligibility and establishing a penalty for the same delinquent period, this case must be manually corrected. See KEES User Manual section *Family Medical > CHIP Medical > Manually Updating a Penalty Period* for instructions on how to correct this and send an email to the Premium Billing Mailbox as instructed above in Section 2.C.9.

D. Third Party Liability (TPL)

The TPL – Other Health Insurance (OHI) Detail page has been updated with changes that will allow rules to correctly determine CHIP eligibility as it relates to the existence of other health insurance.

1. Comprehensive

The eligibility rules in KEES have been updated to define Comprehensive insurance as a policy that includes both ‘Doctor’ and ‘Hospital’ coverage. Both components can be found on one health insurance record or the combination of two separate records. KEES will now correctly deny coverage when comprehensive insurance exists and WA

124 'Dental, Vision, and Other Insurance Results in MAGI CHIP Denial' is no longer applicable.

2. Accessibility

CHIP eligibility does not exist for individuals who have Comprehensive health insurance. Comprehensive health insurance that is not reasonably accessible to a child because of the distance involved in traveling to participating providers shall not be considered. A new question has been added to the OHI detail page that allows the user to indicate when the insurance is not accessible. KEES will not deny eligibility to a CHIP individual for the reason of Comprehensive Insurance if the insurance has been marked as not accessible. Additional information about how to determine if an insurance policy is considered accessible can be found in KFMAM 2411.

E. Minor's Income limit

The income threshold that determines when a minor is required to file taxes has changed. With cases processed on or after the receipt of this memo, for the benefit month of May 2016, the following new thresholds are applicable.

- Earned income - \$6300 annually (the 80% verification test amount is now \$5040)
- Unearned Interest Income - \$1050 annually

Note: KEES is still incorrectly calculating the children's income. The earned income threshold is being applied to all countable income instead of just their earned income. So, if their combination of income, earnings, Social Security, etc., exceeds the threshold then KEES is counting all of their income. See the KEES User Manual section *Family Medical > Financial Data Collection > Income > Child's Countable Income*.

F. CHIP for State Employees

Effective January 1, 2016 CHIP coverage is available to children of individuals who have access to the State Employee Health Plan (SEHP) and is implemented per order of Executive Leadership. This change applies to children of state employees as well as employees of non-state groups that participate in the SEHP program. Prior to this change, children of such employees were excluded from enrollment in the CHIP program because they had access to coverage under SEHP. This change eliminates that exclusion. This change only impacts children who merely have access to SEHP; it does not change policy for children who are enrolled in the SEHP. Children who are enrolled in SEHP continue to be ineligible for CHIP coverage.

In the past, children in many families of state employees were able to access SEHP because of a subsidy available through the HealthyKids program. Families eligible for the HealthyKids program were subject to reduced premiums because their incomes were

below the CHIP income level. Although the HealthyKids program still exists, benefits with the program have been reduced, and some families may wish to switch to CHIP coverage. Note that children of individuals employed by non-state groups are not eligible for the HealthyKids programs. Families with questions regarding the HealthyKids program should contact their agency's HR department. Children in families who continue to participate in the HealthyKids program are enrolled in SEHP and, therefore, are not eligible to participate in CHIP.

1. **Effective Date:** This policy does not change the date-specific enrollment policies that already exist with the CHIP program or are provided in other sections of this memo. Children should not have concurrent CHIP and SEHP coverage. The earliest effective date of CHIP coverage for any child impacted by this change is the day following the last day of SEHP coverage.
2. **Crowd-Out:** Children in families with incomes over 219% FPL are subject to a waiting period if comprehensive coverage is terminated without good cause. To implement this policy, children in families within this income range who drop SEHP coverage in order to access CHIP coverage will not be subject to a Crowd-Out penalty through September 30, 2016. This means coverage must be terminated on or before September 30, 2016. Verification of SEHP termination, including the effective date, must be provided in order to waive the waiting period.

Following the initial implementation period, Crowd-Out will apply to children in families over the named income limit. Except, families who do not re-enroll in SEHP at open enrollment will not be subject to Crowd-Out penalty if they are CHIP eligible effective January 1. Families who drop coverage during the year will be subject to a crowd-out penalty unless good cause applies.

Example: Sally Sue is receiving SEHP coverage through the mother's employer – KDOT. During open enrollment in October, 2016 mother elects to receive coverage only for herself in the upcoming year. She does not reenroll Sally Sue, so her coverage under SEHP will terminate 12-31-16. Mother applies for CHIP and includes proof from her HR department that Sally Sue's coverage ends 12-31-16. The ES determines Sally Sue's income is 225% FPL, which is in the crowd out range. Because the change was part of an open enrollment election, there is no Crowd-Out penalty and Sally Sue is eligible for CHIP effective 01-01-2017.

3. **KEES impact:** The enhanced Third Party Liability – Other Health Insurance Detail page (described in Section D) shall be used to record individuals who have access to SEHP. Although access is no longer a CHIP eligibility factor, the information shall be captured for future use. If a person reports access to SEHP, is a child of a state employee or is a child of an employee of an entity participating as a non-state group

SEHP group, record the information in the 'Access to Employer Sponsored Health Insurance' box on this page. Note: if the information is recorded as 'Access to State Health Insurance' this will cause CHIP eligibility to be denied in error.

Note that staff are only required to complete this field if the information becomes available as part of the normal application process. An application shall not be pended nor shall it be necessary to do extensive research to record this information. Verification is not required.

3. Changes Impacting Elderly and Disabled Medical Programs Only

A. Application Requirements for Long Term Care

Policy is being clarified regarding application requirements for current recipients requesting a change in coverage or program (i.e. aid code).

1. **For children under age 18:** Except for instances where a child is losing SSI recipient status, a new application is not required for recipient children who are requesting long term care services. The eligibility worker must ensure information in the case file is up to date. It may be necessary to obtain current information from the family, but a new application is not required.

Example 1: A child covered under the Medicaid poverty level program enters a PRTF. The previous application reported Child Support income, but the income was not verified because child support income is not countable for MAGI. The eligibility worker must obtain and verify the current Child Support benefit as part of the LTC determination, but an application isn't required.

Example 2: A child receiving both Child Support and SSI enters a long term PRTF stay. His SSI cash payments are terminated as a result. A new application is necessary in this situation.

2. **For Adults (includes 18 year olds):** For SSI recipients covered under a MAGI program, the supplement (KC-1105) is required when LTC coverage is requested. For SSI recipients covered under non-MAGI programs, when SSI recipient status is lost, a KC-1500 is required. In most situations, it will have been several years since an application has been filed. A new KC-1500 is not required for all other current recipients who request coverage under a different category or LTC services. However, it is necessary to ensure specific program elements are addressed:

- a. **Resources** – Resources must be verified to be below the applicable resource limit. Verification of the current level must have been obtained within the past 12 months. This is especially important when the individual was covered

under an Aid Code with a higher resources standard, such as an MSP or Working Healthy. If MSP was determined from a MIPPA application and a review has not been done, all countable resources will need to be verified.

- b. **Income** – Any previously exempt income which is countable under the new category must be verified. Verified income that is currently countable is used, although budgeting changes may be necessary.
- c. **Screening/LOC requirements** – Applicable screening requirements must be met. This is primarily the CARE assessment, but may be on a 3160 form if requesting HCBS. See KEESM 8114.
- d. **Spousal Impoverishment** – If there is a community spouse, spousal impoverishment provisions apply.
- e. **Transfer of Property or Income** - Prior to approving LTC payment, the case must be reviewed for a potential Transfer of Property or Income (TOP). All potential issues must be addressed prior to approving LTC payment. Generally, this will involve a review of the case to determine if the client has attested to the TOP questions on a previous application or if there is a previous indication of a potential transfer. If an application has been submitted within the past 12 months indicating there have been no transfer issues and there is no indication of a transfer which would result in a penalty, the TOP provisions are met. When a current client response to the question is not available, it must be obtained from the client. The statement does not have to be made in writing. Previously identified or known transfer issues must also be addressed prior to approving LTC payment.

Note: This does not change the policy that is in place that allows individuals to request medical assistance over the phone when they are a member of an already open case. Neither an application form nor signature is required to add additional household members to an existing medical program unless the individual requesting coverage is without coverage due to failing to complete a required review. The request for coverage does not have to be for the same type of medical assistance program.

4. Questions

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

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