

Kansas Department of Social and Rehabilitation Services
Rochelle Chronister, Secretary

Economic and Employment Support Commission
Candy Shively, Commissioner 296-3349
Ben Coates, Deputy Commissioner 296-3349

M E M O

To: EES Chiefs
Date: September 10, 1999
From: Candy Shively
RE: Implementation Instructions for 10/1/99 KEESM Policy Changes

This memo provides implementation instructions for the following policy changes incorporated in the new Kansas Economic and Employment Support Manual (KEESM):

1. Self-employment budgeting changes.
2. Changes to assistance planning rules in the Medicaid poverty level, HealthWave, and MA programs.
3. Work-related requirement changes including TAF participation rate and two parent family rules changes.
4. Vehicle Purchase policy changes.
5. Child Care policy changes including out of home relative and IE EM child care.
6. Revised IM-3160 Form.
7. Other policy issues.
8. Updates to current Policy Memos.

[Back to Top](#)

In addition, two tools are attached to help acquaint staff to the new manual. An index has been included providing an alphabetical list of subject headings and commonly used terms and forms with the appropriate new manual reference for each. Upon implementation of the KEESM on the Internet, each reference in the index will be hyper-linked to the manual. Also, a cross reference guide is included which links the previous KPAM, KFSM, and KEPM manual references and subjects with the new KEESM sections. This will help staff in locating subject matter placement they knew from the previous manuals with where it can be found in the new manual.

It is suggested that at a minimum, each EES unit keep one copy of the KPAM, KFSM, and KEPM for future reference purposes for 3 years.

SELF-EMPLOYMENT (KEESM [7132](#))

1. **General Information - As noted in [SCL - 1021](#) self-employed persons will now be allowed to claim actual income producing costs if they disagree with the standard 25% deduction. In addition to this change, self-**

employment budgeting rules have been revised to rely more on usage of yearly tax return information to develop a 12 month average in place of the previous 2 or more months averaging policy. Both changes become effective for any application processed on or after October 1, 1999 and, for ongoing cases, no later than the next scheduled review.

When tax return information is not available, is not reflective of current earnings, or does not reflect a full year of earnings, either an estimate or an average can be established based on at least 3 months of representative earnings. Current forms contained in the Appendix section of KEESM can be used for this purpose including the Daily Business Log Sheet, Cost of Goods Sold Worksheet, and the Self-Employment Worksheet.

- 2. Self-Employment Training Packet - A training packet will be available in late September and will be sent under separate cover. The material will highlight all self-employment policies including what information is applicable for budgeting purposes from the individual's tax return and schedules and other policies and procedures connected with self-employment cases.**

[Back to Top](#)

ASSISTANCE PLANNING FOR MEDICAID POVERTY LEVEL, HEALTHWAVE AND MA PROGRAMS (KEESM [4311](#))

- 1. General Information - As noted in [SCL - 1021](#) the new policies take effect on any application processed on or after October 1, 1999. The new policies would also apply to any prior medical determination connected with those applications. Stepparents are to be excluded from the determination where only a stepchild is involved. In all other instances, the filing unit shall be determined based on the children for whom assistance is being requested. If the application is being denied due to inclusion of family members that can now be excluded, and staff are aware of potential eligibility if the filing unit is changed, staff are encouraged to contact the family and make such changes before the action to deny is taken.**

The HealthWave application is being modified to better instruct families on who can be excluded as well as highlight where there is a stepparent or grandparent and minor mother situation. However, because of the number of current HealthWave applications that have been distributed, it may be some time before the newer revision takes hold. As a result, stepparent households will need to continue to be identified through the current application under Section 4 in the "Relationship to Children space and review of the mother/father information on the children listed in Section 2. The same would apply to identifying grandparent and minor mother

households by identifying children in Section 2 whose mother or father is also a child listed in this section.

2. **Inclusion of Ineligible Children - Because of the policy change and the opportunity for the family to include or exclude children, the determination of eligibility shall continue to be based on those children for whom assistance is requested. If one or more of those children are ineligible due to failure to meet eligibility criteria such as citizenship, or being uninsured (for HealthWave), they shall continue to be included in the filing unit (coded as DI or IN) for determining the other children's eligibility. This would not apply if the child:**

[**Back to Top**](#)

- **does not meet age criteria**
- **has entered an institution or jail**
- **is eligible for HCBS or for SSI, foster care or adoption support assistance.**

In addition, if the family has failed to cooperate in providing information necessary to determine his or her eligibility, the child would no longer be included in the filing unit.

For example, a family consists of a mother and 3 children. She requests assistance for all 3 and thus the determination would be based on a family of four. If one of the children did not meet citizenship requirements, he or she would still be included in the determination. However, if one of the children received SSI, the determination would exclude that child and look at only a family of three.

3. **Establishment of Separate Cases - As also indicated in the there are no mutual children (or only a mutual unborn child) and both the mother and father have non-mutual children for whom they want assistance.**
1. **both the mother and father have non-mutual children for whom they want assistance and a mutual child who is qualifying for pregnant woman coverage.**
 2. **there are mutual children but assistance is not requested for them and the mother and father both have non-mutual children for whom assistance is requested.**

[**Back to Top**](#)

All of these instances will require that the mother and her children and the father and his children be put on separate cases as the KAECSES system would otherwise combine them in single determination if left on the same

case. In addition, in the instance of the pregnant minor, the minor could be included on either case. There may be other instances not mentioned where the system may inappropriately group family members together and thus requiring separate case establishment to prevent the grouping. Staff will need to review the filing unit grouping processed by the system to make sure it adheres to the new policy.

Although separate cases may be required in certain situations, it is not necessary to obtain two applications. One application can be accepted for the family as all information necessary to determine eligibility for each case can be incorporated on one form. By the same token, it is recommended that the same PI for both cases in KAECSES be used as long as the individuals are all part of the same family group. This would include all stepparent families but only those boy/girlfriend families where there is a mutual child in the household (including a mutual unborn) as there is no legal relationship to tie the boyfriend and girlfriend together without a mutual child.

Where separate cases have been established and then a request is made to add a mutual child or a mutual newborn (as noted in item 6 below), the cases are to be combined at the point the child is added.

- 4. TAF - MP Combinations - The procedure for adding an MP program to a TAF case in order to protect continuous eligibility for the children remains in effect. Because of differing rules now between the programs on consideration of stepparents, it is recommended that the non-pregnant parents on the TAF case be coded OU on the MP case to prevent any erroneous income determination should the TAF case be closed. This can apply to all non-pregnant parent situations, not just stepparent households.**

[Back to Top](#)

- 5. Adding Children to an Existing Plan - Per KEESM 9773, a review is required when a new child enters a household (other than a newborn, except as noted in item 6 below). As families now have the ability to include or exclude children for filing unit and eligibility purposes, this requirement is applicable only when the family requests assistance for that child. In these instances, if the family cooperates in providing all necessary information, the child shall be added in the appropriate month and a new continuous eligibility period established per current policy. If they fail to cooperate or follow through with information necessary to add the child, such action will no longer affect the continuous eligibility of the other children already on the plan. This is in contrast to the current wording of KEESM 2644(2)(i) and 2780(7) and the manual material will be modified in the next revision. A pen and ink correction for these sections and KEESM 9773 is noted at the end of this memo.**

If the child is not added to the plan, he or she would not be included in the filing unit as noted in item 2 above.

It should be noted that per KEESM 2770, if there is a current premium requirement for the children already on the case at the time of the review and delinquent premium payments exist, the premiums must be brought current

before eligibility is allowed to continue for these children. If the family does not follow through or cooperate with the review to add the new child, this requirement would not be enforced. However, if they do cooperate, any delinquent premiums must be brought up to date for eligibility to continue. This also affects the new child since if he or she will also be part of the premium requirement (T7 eligible) the child would not be added on the case until the delinquent premiums are paid. If the new child is Medicaid eligible, he or she would be added to the case but the other children would not be eligible until the delinquent premiums are paid. This can only be determined at the point the new eligibility determination is completed and timely and adequate notice is required to terminate assistance for the currently eligible children. When the family requests assistance for the new child, the notice sent with the application form should indicate if premiums are due for the family and the amount of the delinquency along with a statement that the premiums need to be paid as part of the determination process.

[Back to Top](#)

For example, a family consists of a mother, father, and 2 mutual children. Income is at 190% of poverty and a \$15 monthly premium requirement exists. Another mutual child enters the home on October 3 and a request is made to add him to the case. An application form is sent out and the family provides all information on October 15. At the time of the request, the family owed premiums for the months of July, August, and September. The new child puts the family at 177% of poverty so a premium is still required. The delinquency is not paid as of October 19. Action to close the current recipient children would be taken and is effective October 31. Assistance would also be denied to the new child.

If in this example information to add the child was not provided until October 25, eligibility for the current recipient children would continue through November and action to close the case taken effective November 30.

It should be noted that if adding the new child results in elimination of the premium requirement for the other children, payment of delinquent premiums is not required to continue assistance.

A review is also required when a currently eligible child moves to a new home. Failure of the new caretaker to cooperate in that process will still terminate the continuous eligibility period for that child per KEESM 2644(2)(i) and 2780 (7). However, per KEESM 2770, if the caretaker does cooperate and there are delinquent premiums on that child from the previous family unit, those premiums do not have to be paid to add the child to the new plan.

[Back to Top](#)

- 6. Newborn Children - Although families now have the choice to include or exclude children, the policy for automatically adding newborns who qualify for continuous newborn coverage under KEESM 2644 (3) or for HealthWave per KEESM 2793 without a new determination or review remain in effect. In mixed households where**

one sibling is Medicaid and one is HealthWave (or the mother of the newborn is HealthWave) and the mother does not qualify for Medicaid as a pregnant woman, the provisions of KEESM 2793 are also applicable and the newborn shall be added to the existing HealthWave plan.

An application is required to add a newborn when the mother was not eligible for Medicaid as a pregnant woman and the mother or siblings of the newborn were not HealthWave recipients. A new family determination would then be applicable as the newborn must be added to the existing filing unit. If the child is ineligible, no assistance would be provided and the other siblings receiving assistance would not be impacted. This would include instances in which the child is denied due to failure to cooperate in providing information to determine the child's eligibility. If eligible, the child would be established in the appropriate category (Medicaid or HealthWave) and a new continuous eligibility period established for all of the children. However, the category of assistance for the siblings already on the case must be protected through the original continuous eligibility period for them and then switched after that.

For example, a family consists of a pregnant mother, her child from a previous marriage, and her new husband. Her child qualified for Medicaid but she was not eligible for pregnancy coverage due to her husband's income. The child is born on October 10 and the family files an application for him on the 12th. Adding the husband's income to the determination results in both the newborn and sibling being eligible for HealthWave. The newborn is added for HealthWave effective November 1, 1999 resulting in a new continuous eligibility period for both children from 11/1/99 through 10/31/00. The current continuous eligibility period for the sibling ran from 8/1/99 through 7/31/00 and so the sibling's coding on MERE would need to be changed back to Medicaid (N3 or N4) through July. In this instance the new continuous eligibility period would be established on the case for both children. Since the sibling's Medicaid eligibility must be protected through July, an alert will need to be set to convert the sibling's MERE coding to match that of the newborn's effective with August.

Similar situations will arise in boyfriend/girlfriend arrangements where there are nonmutual children and a mutual newborn.

[Back to Top](#)

- 7. Retroactive Coverage Determination for Certain Families - For families who applied for Poverty Level/HealthWave coverage on or after July 1, 1999 and who were denied based on the previous filing unit policy and for families whose case was closed on or after July 1, 1999 due to that same policy, eligibility is to be redetermined under the new policy back to the point of the original application (including any prior medical period) or closure if the family reapplies for assistance. For example, if a family consisting of a mother, her child, and the child's stepparent applied for poverty level coverage for her child on July 20 and were subsequently denied due to consideration of the stepparent's income, eligibility would be redetermined back to July (as well as April if prior medical is requested in either**

the previous or new application) based on excluding the stepparent's income if they reapply as noted below.

A special mailing will be sent at the end of September to all families identified as having been denied or closed since July 1 because of excess income informing them of the new rules and the ability to reapply for assistance. A new application form will be sent with the mailing and these families will be given through November 30, 1999 to reapply and have retroactive as well as current coverage determined. Those applying after this date will not be eligible for this retroactive determination process. The application will be specially marked so that those families who file based on this mailing can be readily identified. Further information on this mailing will be provided separately.

Information provided in the initial application or the review form when assistance was denied or closed shall be relied upon to the greatest extent possible to make the retroactive determination. This includes the income information provided. Should eligibility be approved for any of the prior months, continuous eligibility would then be provided which would supercede any income changes that have occurred since that time. Changes in household composition (children or adults leaving or entering the home since the initial application or closure) shall be taken into account on a month by month basis.

[Back to Top](#)

Determinations shall follow these guidelines:

- **Eligibility shall be determined back to the original application date (and if requested, back to the 3 months prior to the application month) for those children who the family now requests assistance. The determination shall be based on the family income that was reported at the time of the denial or closure and which would be considered based on the new policy. If not eligible in the original application month, the determination is to be carried forward up through the new application month until a first month of eligibility is established.**
- **Coverage is to be provided based on the program the family would have initially qualified for had the new assistance planning rules been in place. In most instances this should be Medicaid. However, if it is HealthWave no coverage will be provided in the retroactive period and will only take effect with the earliest enrollment date based on the current application.**
- **Continuous eligibility shall also be determined from the first month that benefits are provided. Thus if the family is retroactively eligible for Medicaid, the continuous eligibility date would begin in the month that Medicaid is first approved (excluding the prior medical months). However, if the family only qualifies for HealthWave, continuous eligibility as well as coverage would begin with the earliest current**

enrollment month. If eligibility for both Medicaid and HealthWave exists in the family, continuous eligibility would be based on the first enrollment month for HealthWave.

For example, a family consists of a mom, her 2 children from a previous marriage, and her husband. Both the mom and her husband work. They originally filed an application on August 5 but were denied because of their combined income. A new application is filed on October 5. By excluding the husband's income, the children are now eligible for Medicaid beginning in August (and potentially May if prior medical is requested). Coverage would be established for the prior months and a continuous eligibility period set beginning with August (8/99 - 7/00).

If in the same example the children only qualified for HealthWave, coverage would not begin until November 1999 based on the new application and continuous eligibility would be set from that point (11/99 - 10/00).

[Back to Top](#)

- **For KAECSES purposes in order to process the retroactive determination, it is recommended that the MP program be re-opened using the REPT function for previously denied applications as they have been previously registered on KAECSES. Closures will be treated as new applications.**

Denials - Use of REPT will allow any prior medical request made on the initial application to be processed, as well as provide for current case processing. It is acceptable to use the new application date to avoid untimely applications if all appropriate coverage determinations can be made. When REPT is used, the benefit proration date can be no more than 6 months back from the new application date. This would only affect those instances in which the original application was filed in July and a request made for prior medical back to April.

For instance, a family reapplies on 10-05-99 following a denial of an 08-10-99 application. They do not request medical coverage prior to 08-99. In this case, the MP program should be reverted to open, changing the application date to 10-05-99 and the proration date to 08-01-99. All benefits can be provided using the current application date. However, if an application is received on 11-05-99 following a denial of an application that was dated 07-10-99 and prior medical was or is now requested, the previous application date will need to be used. The case should again be REPT'd upon receipt, but

neither the application nor the proration date should be changed; they will remain 07-10-99 and 04-01-99 respectively.

Closures - In situations involving closed cases, any necessary backdating can be done using the current application date and an appropriate proration date to provide benefits through the retroactive period. However the proration date cannot be prior to the effective date of the previous MP closure.

[Back to Top](#)

A new untimely code has been created for these retroactive situations. The MF = (Medical Filing Unit Change 10-01-99) will be available for use beginning in the month of September.

NOTE: Situations may exist where it will be adequate to simply register the new application and enter an earlier proration date. However, this should only be done if all the benefit months can be included. Any use of the copy back function could be problematic. It is difficult to deny prior months when using copy back, and the range of use is limited to three months. Therefore, use of the copy back function to provide these retroactive benefits should only be done if instructed by Help Desk.

The system allows for an MP review period of up to 18 months. This should permit the appropriate review through date to be set on the majority of cases. However, in situations where the applicant requested prior medical on the initial application, an early review through date may need to be set and a desk review worked to provide for the full coverage period. When this occurs, the review should initially be set through the current month and the desk review registered using the current application.

For example, a previously denied application from 07-10-99 exists for a family who reapplies on 11-25-99. Prior medical was requested on the previous application. On 12-15-99 it is processed for 04-99. One child is HW eligible and a younger brother is Medicaid eligible. Because coverage for the HW child won't begin until 01-01-00 for the older child, the continuous eligibility period/review period for the family ends 12-00. The review through field will not accept this date, so a desk review must be registered. The current month is 12-99, so this is entered as the review through date. The continuous eligibility date entered is 12-00. The case is processed through 12-99. A review is then registered (using the date of the current application), the case processed and the real review through date of 12-00 is entered.

As stated earlier, once an individual's medical subtype is established it should remain the same through the retroactive period and until the end of the continuous eligibility period. Care must be taken to ensure that once eligibility is established income is not changed during the retroactive months. If a change does occur (such as a birthday) it is important that MEBH be checked

and, if necessary, MERE is updated to display the correct medical subtype. Keep in mind that any determination involving 04-99 will be made using previous poverty level standards. If a family fails to qualify in 04-99, the case should be processed for 05-99 as well. Contact the SRS HelpDesk via GroupWise if KAECSES problems are encountered while processing the retroactive period.

Special notice situations will be created for use with this group as well. These notices will be made available for use following mailing of the applications.

[Back to Top](#)

[NEXT Part II](#)