

Kansas Department of Social and Rehabilitation Services

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Program Training
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368-8137

MEMORANDUM

TO: IM/EPS Chiefs

DATE: October 27, 1998

FROM: Dennis Priest

SUBJECT: Implementation Instructions
for the HealthWave Program
and Related Changes to the
Medicaid Program Effective
January 1, 1999

This memo provides implementation instructions regarding the new HealthWave Program and changes to the Medicaid Program which both take effect January 1, 1999. In addition to these instructions, training on the changes will also be provided in late October and early November. A subsequent KPAM revision will be issued in December.

I. BACKGROUND

The HealthWave Program is being implemented as a result of passage of the Balanced Budget Act of 1997 and creation of separate program authority under Title XXI of the Social Security Act. The federal legislation provided for the establishment of an uninsured children's health insurance program for children whose family income does not exceed 200% of the federal poverty level. In Kansas, this program will operate as a separate program but allow for seamless coverage between the Medicaid and HealthWave programs. This has been accomplished through development and modifications to policy so that the eligibility rules for Medicaid and HealthWave are identical with the exception of rules governing uninsured status as noted in item 4 of the Policy Changes section.

The eligibility process has been centralized through a contractor, Maximus. Maximus has developed a central clearinghouse to serve as the main point of contact for persons applying for either Medicaid poverty level coverage for children or the new HealthWave program. Applications for strictly Medicaid poverty level coverage for children and HealthWave coverage will be processed and managed by Clearinghouse staff. Families accessing other benefits besides such medical coverage, including food stamps, child care, and other medical assistance, will be handled by the appropriate local SRS office. Further administrative details are covered later in this memo.

A new simplified application has been developed for this purpose and is to be used for both

the Medicaid children's poverty level program and the HealthWave program. A postage paid self addressed envelope is included with each application and provides for a central mail-in point to the Clearinghouse. Applications will then be either processed by the Clearinghouse or forwarded to the local SRS offices. They may also be mailed or hand-delivered to the local SRS offices. The IM-3100 application is also acceptable for accessing the HealthWave Program.

The HealthWave Program takes effect January 1 and changes to Medicaid policy which have been made as a result of this new program also take effect on that date. So that any children eligible for HealthWave can begin receiving benefits as of January 1, applications will be accepted beginning in November. No coverage however exists prior to January 1. Benefits will be provided through one of three managed care provider networks depending on where the family lives. HealthWave coverage does not begin until the child is enrolled in the appropriate network (see the Policy Changes section below).

II POLICY CHANGES

As noted above, eligibility policies for the new HealthWave program will be identical, with certain exceptions, to policies used in the Medicaid poverty level programs for children. As a result, changes have been made to Medicaid policies to help simplify or streamline eligibility for children accessing either program. Following is a description of changes made and policies adopted for Medicaid and HealthWave eligibility.

1. Mail-in Process - The requirement for face-to-face interviews for children and pregnant women has been eliminated. Applications for Medicaid (including MA and poverty level coverage) and HealthWave can now be either mailed or faxed and eligibility determined without an in-person interview. This also applies to any redetermination of eligibility.
2. Application Processing - Applications for either program are to be processed within 15 calendar days of receipt of a completed application and all necessary supporting documentation. This allows for expedited processing for children's health coverage. The current maximum 45 day processing time period remains in effect. In addition, the current expedited time frame for pregnant women remains in effect so any determination on a pregnant minor must be done within the 5/10 day period per KPAM 5335.

The following verification requirements are applicable:

- Proof of earned income - At least two months of wage stubs is recommended or a letter from the employer providing such information.
- Proof of unearned income - Benefit letter, copy of check, etc.
- Copy of health insurance cards or policy.
- If not a U.S. citizen, proof of immigration status.
- For Medicaid, proof of application for a Social Security number if number

known.

- For pregnant minors, proof of pregnancy.

All other information provided on the application does not require further verification unless questionable.

A new application/review form is required based on the current KPAM 1110 rules. In addition, based on the new continuous eligibility provisions described in item 5 below, a form shall also be required to add a new child (other than a newborn) to a currently eligible household or if a currently eligible child moves to the household of another caretaker. In both instances, if the child is eligible, a new continuous 12 month eligibility period is set for all eligible children in the household.

3. General Eligibility Requirements - Current requirements for residency, citizenship/alienage, cooperation, and act in own behalf are applicable.

A Social Security number (or proof of application) is required for children accessing the Medicaid program but not for HealthWave. However this information shall be requested at the time of application for either program as it will not be known which program the child will be eligible for until the case is fully processed. SSN information will also be requested for any adult household member but is not required in order to determine eligibility.

NOTE: An SSN or SS5 date must still be entered on the KAECSES SSDO screen for both Medicaid and HealthWave children.

Documentation of immigrant status will need to be provided in-person as it is unlawful for the immigrant to make photocopies of the documents to mail. Special Clearinghouse staff that will be based in the field for outreach purposes will be responsible to obtain such documentation for any Clearinghouse cases.

Cooperation concerning medical support is not a requirement for HealthWave but remains in effect for Medicaid. Children eligible for Medicaid must still be referred to Child Support Enforcement where one or both parents are absent and voluntary referrals can also be made for any HealthWave eligible children. The application only obtains the name of any absent parent. This information is sufficient for CSE referrals and local CSE staff will obtain the additional information.

Potential resource cooperation per KPAM 5222 shall only be applicable to children who are age 18. The labor dispute requirement of KPAM 5240 has been eliminated for Medicaid and shall not apply to HealthWave.

4. Eligibility Requirements Specific to HealthWave

- a. Effective Date of Coverage - In contrast to the Medicaid program where coverage generally begins as of the month of application, HealthWave coverage does not begin until the child is enrolled with one of the appropriate HealthWave managed care provider networks. This will more than likely result in coverage beginning either in the month following the month of application or the second following month depending upon when the case is processed. There is no prior medical eligibility in the HealthWave program so any coverage for months prior to the effective date of enrollment would have to be determined through the Medicaid program (see item III (1) below).

HealthWave applications processed by the first medical card run for a month will be enrolled for the first of the next month. Applications processed after that time will not be enrolled until the second following month. The enrollment process is automated and will be administered by Maximus.

For example, for a case that is approved on July 15 HealthWave, coverage will be effective August 1. No coverage will be available for July.

- b. Uninsured Status - To qualify for HealthWave, each child must not be presently covered under health insurance which provides basic comprehensive coverage. This includes health insurance which provides coverage for at least doctor visits and hospitalization regardless of extent of coverage or any co-payment, co-insurance or deductible requirements. Thus even a policy with a high deductible (such as \$5,000 or \$10,000) would exclude the child from participating in the program.

In addition, even though the yearly maximum benefit coverage has been reached, the policy would still render the child ineligible. However, if the lifetime maximum benefit level has been reached, the child could qualify for HealthWave. Health insurance providing only single types of coverage would be excluded from this definition. Examples of health insurance which would not disqualify a child include:

- Dental or vision only coverage.
- Prescription only coverage.
- Long term care insurance.

Coverage may be provided through a custodial or absent parent as well as other relatives of the child.

If health coverage is obtained while an application for HealthWave is still pending, the insurance would be considered for eligibility purposes. If this is obtained after HealthWave benefits have been approved, even if enrollment with a HealthWave managed care provider has not yet occurred, eligibility shall continue for the entire continuous eligibility period (see item 5 below) and then

terminated if health insurance is still in effect. The same is true if the insurance was present at the time the HealthWave benefits are approved but due to a waiting period, the coverage had not yet begun.

To support this eligibility requirement for HealthWave, three changes have been made to KAECSES. Beginning with the benefit month of 1/99, an insurance code of “Y” for yes, “N” for no, or “O” for other must be entered on the MERE screen. In addition, a new denial closure code of “HI” has been added. This new code is to be used when the reason for denial or closure is other insurance. Also, a new MP denial notice, the P216 HealthWave Denial - Health Insurance, is available on KAECSES. MP closure and change notices due to other insurance coverage will be added to the system in the coming months. See also conversion instructions for current ongoing MP cases in item V(2) below.

- c. Period of Ineligibility for Voluntarily Dropping Health Insurance Coverage - If the child had been covered under health insurance and such coverage was voluntarily terminated, there shall be ineligibility for HealthWave benefits for a period of 6 months beginning with the month the coverage is terminated. For example, if health insurance was terminated in January for a child, the child would not be eligible for HealthWave until the month of July.

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

- Loss of job from which health insurance was provided.
- Dropping of coverage by the parent’s employer.

Otherwise, coverage that is terminated would result in the period of ineligibility regardless of whether the coverage was affordable or provided only limited benefits (including high deductibles). Only termination of comprehensive coverage as defined in item 4b above shall result in a period of ineligibility.

For applicants, if a period of ineligibility has been established and that period will lapse prior to the effective date of HealthWave enrollment as defined in item 4a above, the application can be approved. For example, an application is filed on June 10 and it is determined that health insurance for a child was voluntarily terminated by the family in January. The period of ineligibility runs through June but the earliest effective date of HealthWave coverage is July 1. As this is outside of the ineligibility period, the application shall be processed and approved if otherwise eligible. Also, for system tracking purposes, staff must set their own alert on KAECSES.

NOTE: As noted later in this memo, both the Blue Cross - Blue Shield Caring Program of Kansas and the Caring Program of Kansas City (for children living

in Kansas) will terminate coverage of those enrolled children effective December 31, 1998. This will not result in a period of ineligibility and those children whose coverage is terminated can potentially qualify for HealthWave.

- d. State Employees - Based on provisions contained within Title XXI of the Social Security Act, children whose custodial parent is a state employee and who has access to the State group health insurance plan for the children shall not be eligible for HealthWave coverage regardless of whether the coverage has actually been taken. This is not applicable to 18 year olds unless the 18 year old or his or her spouse is a state employee. As noted in item 4b, it does not matter whether the family can afford the coverage, access to the insurance is what results in ineligibility. This eliminates HealthWave coverage for all children of Kansas State employees and would also eliminate coverage of children of employees of any of the surrounding states including Missouri, Nebraska, Oklahoma, and Colorado.

It is the custodial parent who must be the state employee and thus this prohibition is not applicable where only a stepparent, absent parent, or caretaker relative is the employee.

NOTE: A new KAECSES denial/closure code of SE and a new MP denial notice, P217, are to be used when HealthWave coverage is denied due to state employment.

- e. Ineligibility for Medicaid - The family does not have the choice between Medicaid and HealthWave benefits. If the child is eligible for Medicaid (including poverty level coverage or through the TAF, TransMed, MA, or MS programs), coverage must be provided under that program.

In regards to potential spenddown coverage in place of HealthWave, the combined application includes a question regarding existence of any unpaid medical bills and whether the family is interested in potential coverage for these bills. If they indicate interest in pursuing this, a determination of prior medical and/or current spenddown eligibility shall be made depending upon the amount of medical expenses provided and the date services were provided. If eligibility exists for the current spenddown period, Medicaid coverage shall be provided. See item III(1) for further information.

- f. Premium Requirement - A monthly family premium will be charged for HealthWave coverage beginning at 151% of federal poverty. If the total countable income is less than this amount, there is no premium charge. If income is equal to or greater than 151% of poverty but less than 176% of poverty, a \$10 monthly premium is charged. If income is greater than or equal to 176% of poverty, a \$15 monthly premium is charged. Only one premium per family is charged regardless of the number of HealthWave eligible children.

Maximus administers the premium payment system and is responsible for all necessary billing and tracking of payments as well as providing reports. The family will be billed monthly but premium collection shall not be enforced until the time of the yearly review. At that time any premiums due and owing must be paid in full or the HealthWave eligible children cannot receive further assistance. Such children can also not re-qualify for the program at a later date until any delinquent premiums are paid provided the children continue to live in the family unit upon which the premium was assigned. This includes HealthWave children who based on the yearly review would be eligible for premium free coverage in the next review period. However, as Medicaid eligibility is not affected by non-payment of premiums, any Medicaid eligible child in the family would still qualify even if there are premiums due and owing from a period in which they were HealthWave eligible.

Maximus will provide monthly accountings of premium payments for each family to the appropriate local SRS offices for HealthWave cases maintained in the field. At the time of review, payments for a family must be up to date as of the last monthly statement available for eligibility to continue. Delinquent payments must be made even if the family is no longer subject to any further premium requirement.

If a review occurs on a case prior to the end of the 12 month continuous eligibility period as noted in item 5 below, any premiums not paid at that point must be brought current before eligibility is allowed to continue. Payments are to be made by mail but if brought to the local office, shall be accepted. See the attached Coordination Procedures guidelines.

Premium amounts must be entered on the KAECSES system and the premium amount set based on the poverty level percentage shown on the PLID screen. The "Family Premium" is a new worker entry field which has been added to the Poverty Level Group Detail (PLGD) screen. The \$10 or \$15 premium amount is entered on PLGD after benefits are authorized and the poverty level percent for the household is displayed on the Poverty Level Income Determination (PLID) screen.

If a change occurs during the 12 month continuous eligibility period which decreases the amount of countable income, a review should be conducted at that point and the premium amount lowered or eliminated as necessary.

5. Continuous Eligibility - For children determined eligible for the HealthWave program and for poverty level, TAF, TransMed and MA CM Medicaid coverage, eligibility shall continue for 12 months, regardless of changes in financial eligibility. This does not apply to children in the MS, CI, RE, SI, AS, FC or MA programs. Continuous eligibility begins with the month of application or 1st month of eligibility for Medicaid. This excludes months in the prior eligibility period if the child is eligible for Medicaid in the current period. However, if eligibility is established for

Medicaid in any month of the prior period and the child will not be eligible for the current period, the prior month shall establish continuous eligibility for Medicaid from that point.

For the HealthWave program, continuous eligibility begins with the 1st month of managed care enrollment as described in item 4a above. For example, an application is filed on April 20 for a child and she is determined Medicaid poverty level eligible beginning that month. Her continuous eligibility period would run from April 1 to March 30 of the following year. If this child was HealthWave eligible instead and was not enrolled in the managed care plan until June 1, her continuous period would go from June 1 to May 31 of the following year.

In families where there are both Medicaid and HealthWave eligible children, for case management purposes, the continuous periods are to be initially linked at the point the application is processed. This will involve extending the Medicaid continuous period an additional month or more (from 12 to 13 or more) to match the HealthWave period. For example, a family applies for 2 children on January 8 and the case is processed by January 20. One child is Medicaid eligible and the other is HealthWave eligible. The HealthWave child will be enrolled with a managed care provider as of February 1 so that child's continuous eligibility period will run from February 1 to January 31. Although the Medicaid child's continuous period begins January 1 that child's period will be lengthened to end January 31 instead of the end of December so that the two periods match. Thus the Medicaid child receives 13 months of eligibility in these instances.

Once the continuous eligibility period expires, the family's eligibility is reviewed and if eligible, a new 12 month continuous eligibility period set.

The continuous eligibility period for a child shall be shortened to end prior to the 12th month if one of the following circumstances occurs:

- the child turns 19;
- the child is no longer a resident of Kansas;
- the child dies;
- the child enters a long term care institutional arrangement or becomes eligible for HCBS;
- the child enters jail or other penal facility;
- the child no longer lives with a qualifying caretaker;
- the child becomes eligible for SSI, foster care or adoption support;
- the family fails to complete a requested review;
- the family voluntarily requests a case be closed;
- loss of contact with the family;
- the child is later found to have not been initially eligible for benefits.

In any of the above situations, continuous eligibility ends with the month the change occurred or becomes known. It cannot be reinstated if there is a break in coverage of

one or more months and the children would have to re-qualify. No other changes in circumstances affects the continuous eligibility period. However, changes which benefit the family such as moving from a premium payment status to a non-premium payment status shall be acted upon during the 12 month period.

As noted above, continuous eligibility for medical benefits applies to children who are or become TAF or MA CM recipients. Should the adults on these types of cases lose eligibility for assistance, medical coverage must still be protected for the children under this provision. For example, a TAF application is taken on March 3 for a family and cash and medical benefits are approved effective that month. A continuous eligibility period for the children's medical coverage has now been established for March 1 to February 28. The family fails to turn in the monthly report form due in July and the TAF case is closed July 31. Medical coverage for the children must still be provided through February and thus a separate MP program should be established at the time the TAF case is processed to allow coverage to continue in such instances.

If a family approved for either TAF or MA CM loses such eligibility and qualifies for TransMed or extended medical coverage, a new 12 month continuous eligibility period is to be established at that time beginning with the first month of TransMed or extended medical eligibility.

A new continuous eligibility period shall also be established at the time a review form is requested if the family retains eligibility for medical benefits following that review. This includes adding a child to the plan (other than a newborn) and when a review occurs under another program (e.g., a food stamp review). If the family becomes ineligible for medical coverage as a result of the review, the continuous eligibility period already established for the children shall remain in effect with a review conducted again at the end of that period.

For example, a continuous eligibility period is currently established for two children for the months of February to January. Another child enters the home in May and an application/review form is completed to add the child to the existing plan. If the children retain eligibility and the new child's coverage begins effective May 1 (Medicaid eligible), a new continuous period is established for the period May 1 to April 30. If adding the new child results in ineligibility for the family, benefits are denied to the new child and other two children stay within the current February to January continuous period. A review would then come due in January to do another full family determination at that point.

6. Financial Requirements - There is no assets test for either the Medicaid poverty level eligibles or HealthWave program and current income exemptions in KPAM 5540 and 5550 and subsections also apply. In addition, current income definitions and guidelines as specified in KPAM 5510, 5520 and 5530 and subsections continue in effect as well as the use of conversion/ averaging budgeting methods described in

KPAM 5560 and subsections.

Two changes have been made which will be applicable to both Medicaid and HealthWave determinations. The first concerns assistance planning. A “family unit” concept is being implemented which is similar to the filing unit concept used in the TAF program. For purposes of determining MA, poverty level, and HealthWave eligibility, the family unit shall consist of the child, his or her natural or adoptive siblings in the home (including step-siblings), the legally responsible family members for these children, and the spouses of such legally responsible persons. As is current policy, emancipated minors, minors determined able to act in their own behalf, and 18 year old children shall have separate assistance plans and thus, separate cases. A separate plan shall also be established for any child (and his or her siblings) in the family who is not living with a legally responsible person (such as grandchildren, nieces and nephews, etc.). Children who are ineligible but are otherwise part of the family unit shall continue to be considered in the determination excepts for SSI recipients and pregnant minors who meet pregnant woman poverty level guidelines.

Examples of family units include:

- A mother, father, and mutual children.
- A mother, stepfather, and non-mutual child.
- A mother, father, mutual child, and the mutual child’s baby.
- A husband and wife and each of their non-mutual children.

Boyfriend/girlfriends are included in the family unit if there is a mutual child (not including an unborn),

This new policy eliminates the policy in effect prior to January where the family could apply for only certain children in the family. All children in the family unit must be included. In addition, the change will also result in consideration of income from other adult members in the household including stepparents and boyfriends/girlfriends depending on the situation.

The family unit size will then determine the poverty level percentage for all children in the unit. For example, in a family consisting of a mother, father, and 2 children (ages 4 and 10), a 4 person poverty level standard will be applied. If the family’s countable income is at 125% of poverty, both children will qualify with the 4 year old receiving Medicaid (as this falls within the 133% standard for children ages 1 to 6) and the 10 year old receiving HealthWave (as this exceeds the 100% Medicaid standards for children 6 and older). The poverty level percentage is system calculated and displayed in a new field on the KAECSES PLID screen.

Any child who is pregnant will continue to have a separate determination based on current policies regarding eligibility for pregnant women. This determination will only include the pregnant minor, the parents of the minor if living together, the

unborn child, and the father of unborn child if present. If the pregnant minor is ineligible for poverty level coverage, she shall then be added to the family unit for the regular Medicaid/HealthWave child determination. This is done by removing the PW indicator and coding the unborn OU on SEPA and then reauthorizing MP on PLID.

The second change concerns determination of countable income. A standard earned income disregard of \$200/month per wage earner shall be deducted from gross earnings. This replaces the current \$90 work expense and child care deductions. In addition a new standard 25% disregard is being implemented in the cash, medical, and food stamp programs to determine countable self-employment income. In place of income producing cost deductions, gross self-employment income shall be reduced by 25% to obtain adjusted gross income. If the family disagrees with the countable amount obtained through this process, they shall be allowed to have countable income determined based on actual income producing costs as currently permitted in KPAM 5531.3.

NOTE: To implement the new 25% deduction, staff can use one of two options in KAECSES: A first option would be to calculate the 25% of self employment income manually off the system and then enter the result as an expense on the Self Employment Work screen (SEEW). A second option would be to calculate 75% of gross self employment off the system and enter this amount directly on the Self Employment Earned Income screen (SEEI). The system will then deduct the \$200 earnings disregard to determine net countable income on PLID.

III. OTHER POLICY ISSUES

1. Spenddown/Prior Medical Determinations - As mentioned earlier, HealthWave coverage becomes effective with the first month of managed care enrollment which will delay coverage to at least the month following the month the family applies for the children and possibly the second month. In addition, HealthWave coverage is not available if a child is otherwise eligible for Medicaid. As some families may have existing medical expenses for some or all of the children that they want coverage for, prior and current Medicaid eligibility may need to be determined.

Prior medical eligibility provisions currently in effect are applicable to any family seeking such coverage even though they may be only be HealthWave eligible in the month of application or are not currently eligible for either Medicaid or HealthWave. Eligibility can be established either through a poverty level or spenddown determination for the prior 3 months. If spenddown is used, an MA or MS application would need to be registered on KAECSES.

For a child that would be otherwise eligible HealthWave, if there are expenses in the month of application as well as potentially past due and owing expenses which could be used to meet a current spenddown, the family can also be given the opportunity to

qualify under the spenddown program (including both MA and MS). A full 6 month determination would be applicable. If the family can meet the spenddown and it is to their benefit to do so, Medicaid eligibility would be initially established on the case.

As noted above, the new combined application asks about the existence of unpaid medical bills. If the family responds that they are interested in seeking coverage of these bills, a separate Medical Expense Supplement (IM-3105.5) has been developed to obtain this information as well as information concerning resources which is needed for a spenddown determination. The family will need to be contacted to discern if there is a potential for spenddown coverage and the degree to which it will benefit the children. A final HealthWave determination would not be made until the spenddown decision is made.

If spenddown coverage is not established, HealthWave coverage shall then be initiated. If spenddown coverage is established for the current period, only one 6-month base should be established with a review set at the end of that period to redetermine HealthWave eligibility and establish the 12 month continuous eligibility period. If spenddown can be met for more than 1 base period due to using older unpaid bills or current non-covered expenses, spenddown coverage is to be extended for as long as the family or child can meet the spenddown requirement.

2. Newborn Coverage - The continuous newborn eligibility provisions of KPAM 5334(2) are still applicable. Thus a child born to a Medicaid eligible mother will be automatically eligible for Medicaid until the age of 1. If the child is born during a continuous eligibility period for his or her other siblings, the child shall be added to the case without requiring an application/review form. At the end of the continuous eligibility period, if the children all continue to be eligible the newborn shall then be included in the new 12 month continuous eligibility period which would now take precedence over the newborn provisions. If however, this review results in ineligibility for the children or would move the children into premium payment status, the newborn shall continue to receive Medicaid coverage up through the month the child reaches age 1 and then closed off if not otherwise eligible or added to the existing HealthWave case if the siblings continued to be eligible.

For newborns not meeting the provisions of KPAM 5334(2), including children born to HealthWave recipient mothers or children who have HealthWave eligible siblings, the child shall be added to the existing HealthWave case for the remainder of the current 12 month continuous eligibility period. No application/review form is required to do so. At the end of the continuous eligibility period the entire case shall be reviewed and if the child is ineligible, he or she shall have coverage terminated.

In all instances, no verification is needed to add the newborn at the time of birth and name and date of birth information should be obtained through contact with the family. When the case is reviewed, a Social Security number should be obtained along with any insurance coverage status. The birth must be reported within the

month of birth or the 3 following months to add the child retroactively.

It should be noted that the birth of a child may result in a combining two previously separate MP assistance groups. For example, in a household consisting of a pregnant mother, her child, a boyfriend (the father of the unborn child), and his child, there would initially be three separate plans, one with the pregnant mother, one with her child, and one with the boyfriend's child. Once the mutual child is born, the plans would need to be combined as the family unit would now consist of all 3 children. If the family was on a single case number, eligibility would be reworked to combine the children. The mother would continue on in a separate plan for the postpartum period. If the family was on 2 separate cases, one case would need to be closed out with those persons added to the existing case and eligibility reworked. The current review period for the case remaining open would continue to be applicable. In all instances, adding a newborn child can impact eligibility. However the already eligible siblings can be advantaged by any changes but not disadvantaged.

3. Pregnant Women - As noted earlier, there are no changes in regards to determining eligibility for pregnant women. Only the woman, the unborn and the unborn's father are included in this determination and a separate assistance plan established. If the pregnant woman is a minor, her parents, if in the home, would also be included in the determination. As also mentioned, if an application is filed for a child who is also pregnant, a Medicaid poverty level determination (PW) is required first. If the child is ineligible based on this determination, she would then have a poverty level or HealthWave child determination completed.

For children who are determined eligible under the pregnant women category, the continuous eligibility provisions for pregnant women as referenced in KPAM 5334(1) are applicable. Thus after the birth of the newborn child, she continues eligible through the postpartum period. At the end of this period, she would be treated as a new child entering the home and a review required at that point for the family unit. If eligible, she would be added to her siblings Medicaid or HealthWave plan and a new 12 month continuous eligibility period set. If not eligible, no further assistance to her would be provided and the remaining children would continue eligible for the remainder of their current continuous eligible period.

For pregnant women 18 years of age and older, the current provisions of KPAM 5334(1) are also applicable. The newborn child will either be added to the Medicaid or HealthWave plan as noted in item (2) above and the pregnant woman would continue to be covered through the postpartum period. If the woman is 18, she may then qualify in her own right as a Medicaid poverty level or HealthWave child through the month she turns 19.

4. 18 Year Olds - Current provisions regarding 18 year olds in the poverty level programs remain in effect and shall also be applied to HealthWave. These persons can apply and receive benefits in their own behalf and shall have a separate determination from the rest of the family. For an ongoing recipient child who turns

18, action to set up a separate plan for the individual does not have to be established until the time of the next scheduled review. A KAECSES age alert will be generated when an MP child turns 18 but staff will be required to set their own alert when a child turns 19.

5. Reviews - As noted in previous items, reviews will be established based upon the continuous eligibility periods set for the children. This will normally occur every 12 months except in setting up the case initially where there are both Medicaid and HealthWave eligible children. In addition, review periods can be shortened to link with review periods for other programs attached to the case. A case shall be reviewed earlier than 12 months when a new child enters the household (except newborns) or when an eligible child moves to another household. If a review occurs prior to the end of a current continuous eligibility period and a child or children on the plan are disadvantaged as a result of the redetermination of eligibility (such as moving from a Medicaid category to HealthWave or going from non-premium payment status to premium payment status), the child(ren) are to finish out the current continuous eligibility period in the advantaged category before switching.
6. Other Changes in Circumstances - For the most part, changes in circumstances need to be acted upon as they occur especially changes in household composition (children entering or leaving home), residency, etc. All changes must still be reported within 10 calendar days of the change. Changes which result in a child moving from HealthWave to Medicaid eligibility should take effect with the month following the month the change is reported. Further instructions will be issued regarding changes or actions taken which could result in retroactively establishing Medicaid eligibility for a period of time in which a HealthWave record already exists.

Because of continuous eligibility provisions however, changes in income and in the age of the children (excluding children turning 18 or 19) do not have to be acted upon until the time of the next review unless they are beneficial to the family. If income increases, the changes are to be incorporated at the time of next review. If income decreases, the same is true unless such a decrease would move the family into a non-premium payment status. In these instances, the change must be incorporated beginning with the month following the month the change occurred.

Children who turn age 1 or age 6 may end up transitioning from a Medicaid to a HealthWave category. However, such a change should not be made until the next review and the current monthly MP mass change process which redetermines eligibility based on age changes will be eliminated after the run in October.

If two currently eligible families combine, the family will need to choose which of their cases continue and who will be the PI. The other case would then be closed and those members added to the case still in effect. The review period for that case would remain in effect and the combined family would then be fully reviewed at the end of that period.

IV. KAECSES/SYSTEM CHANGES

Both Medicaid poverty level (children and pregnant women) and HealthWave eligibility will be determined and processed using the MP program on KAECSES. Benefit records will also be established for both on MP. This includes children receiving TAF and MA CM. Because continuous eligibility is only supported in the MP programming, children on TAF and MA CM should also have an MP plan established. For TAF, this can occur on the same case. However, for MA CM, a separate case for MP benefits must be established because of system limitations. This is also applicable when a TAF family becomes eligible for TransMed or 4 month extended medical benefits. The MP program on the TAF case must be closed and a separate case number established to reopen MP.

The following highlights the first phase of modifications made to the MP program as a result of the policy changes and issues previously described and instructions for working the system as it relates to these issues.

1. Expanded KAECSES Design: MP programming has been modified to include three new HealthWave (Title XXI) coverage groups for children ages 1 to 19 with countable family income less than or equal to 200% of the federal poverty level. The children covered by the current MP program will continue with regular Medicaid (Title XIX) eligibility. The three new HealthWave coverage groups are listed below.

Individual Medical Subtype on MERE, MEBH, CAP2	Age	Poverty Level
PW	Pregnant woman all ages/Medicaid	150%
N2	Children thru the month of first birthday/Medicaid	150%
N3	Age 1 thru month of 6 th birthday/Medicaid	133%
N4	Age 6 thru month of 19 th birthday/Medicaid	100%
T5	Age 1 thru month of 6 th birthday/HealthWave	133% to 150%
T6	Age 6 thru month of 19 th birthday/HealthWave	100% to 150%
T7	Up to age 19/HealthWave	150% to 200%

Note: The poverty level % displayed on the PLID screen is to be used as a guide to determine premium requirement and amounts, as KAECSES will determine eligibility

and medical subtype based on actual dollar amount of countable household income.

2. Screen Changes

LERP: The system set continuous eligibility indicator field will now apply to all Medicaid poverty level and HealthWave eligible children. This indicator will be set automatically when eligibility is determined on the PLID screen. It can be overridden from Y to N by the worker, if needed. A NEXT screen field has also been added allowing the ability to next to other screens from LERP.

MERE: The insurance code field on MERE is now mandatory for each individual coded IN for MP on SEPA. The allowable codes are “Y” for yes (has comprehensive coverage as defined in item II(4b) above), “N” for no, or “O” for other insurance (insurance that is not comprehensive). Eligibility cannot be authorized on the PLID screen for a HealthWave child when a “Y” appears in the INSURANCE CODE field.

The new individual medical subtypes for MP will appear on MERE, CAP2 and MEBH for all eligible children and pregnant women. This new subtype will be system set after eligibility has been determined on the PLID screen. The system set subtype can be overridden by workers when necessary.

PLID: Up to three groupings can be displayed on PLID. In rare situations when there are more than three groups another case number must be opened. Other changes to the PLID screen include the new POVERTY LEVEL % field showing the income percentage for each group and a DENIAL/CLOSURE REASON field, which can be used to deny the MP program due to excess income. Closures for excess income must be done on MPED. When MP is authorized on PLID, it is important to note the amount in the POVERTY LEVEL % field calculated by the system, as this determines whether a premium amount must be entered on the PLGD screen which is displayed next when enter is pressed.

PLGD: Two new fields have been added to PLGD. Both the CONT. ELIG. THRU DATE and the new FAMILY PREMIUM fields are worker entered informational fields. These new fields will be used to enter family premium amounts and to help track continuous eligibility.

3. Notices: To implement HealthWave several new notices have been added to KAECSES and a number of existing notices have been changed as indicated below.

New System Notices:

P106 HealthWave Only-Approval
 P107 HealthWave and Medicaid-Approval
 P108 HealthWave Only Approval-Partial Denial
 P110 HealthWave and Medicaid-Review Complete
 P216 HealthWave Denial-Health Insurance

P217 HealthWave Denial-State Employee

Denial Notices Changed:

P200 MP/HW-Failure to Provide Information
 P201 MP/HW-Failure to Cooperate
 P202 MP/HW-Residency Requirement Not Met
 P203 MP/HW-Loss of Contact
 P205 MP/HW-Income Exceeds Maximum
 P208 MP/HW Denial-Other Reasons
 P209 MP/HW Application Withdrawn
 P211 MP/HW-Citizenship/Alien Status
 P290 MP/HW & FS Denial/Failed to Provide Info.
 P291 MP/HW & FS Denial/Failure to Cooperate
 P292 MP/HW & FS Denial/Residency Req. Not Met
 P293 MP/HW & FS Denial Loss of Contact
 P298 MP/HW & FS Denial/Other Reasons
 P299 MP/HW & FS Denial/Applications Withdrawn

Change and closure notices will be added in the near future and separate notification will be sent regarding these.

4. KAECSES Code Changes: To implement HealthWave, a number of new codes have been added to the system as indicated below. Code card revisions are currently being printed with distribution to field staff planned for early November.
 - a. New Individual Medical Subtype codes have been added to identify each individual on MP as either Medicaid or HealthWave Unlike other medical subtypes which are entered by the worker on the MERE screen and then displayed for information on CAP2 and MEBH, the new MP subtypes which are listed in the table in item 1 above are set by the system when eligibility is determined on the PLID screen.

As previously mentioned, these system set subtypes may be overridden by the worker when necessary to prevent an individual from being disadvantaged during an established 12 month continuous eligibility period. An example of when the subtype should be overridden by the worker is when a new individual with income is added to the case changing the household from Medicaid to HealthWave with a premium requirement. This situation can be identified when the POVERTY LEVEL % on PLID shows 150% to 200% and one or more of the medical subtypes listed on MEBH has changed from Medicaid to HealthWave. When this happens it is necessary to next back to the MERE screen and override the system set subtype to the medical subtype on MEBH for the benefit month prior to the change. This override would be effective until the end of the previously determined continuous eligibility period.

Since KAECSES resets the medical subtype every time enter is pressed on PLID, it

is important not to access the PLID screen after overriding the subtype on MERE. When accessing PLID is required, staff may PF9 out or repeat the process for overriding the system set subtype described above. A routine check of the MEBH screen each time the MP case is processed will help prevent problems and errors related to medical subtypes.

- b. Three new denial/closure reason codes have been added to identify HealthWave denials and closures when the household is ineligible due to uninsured status or premium payment policies.

These new codes are:

FP = Failure to pay premium for HealthWave
 HI = Other health insurance available for HealthWave
 SE = State employee

- 5. System Implementation Issues and Procedures: Several implementation issues have been identified during testing of KAECSES software changes which are noted below. Some of these situations may require a procedural work around for correct processing during the initial implementation phase of HealthWave. Future system enhancements are planned which will eliminate the need for several of the procedures listed.
 - a. MP Mass Change - Due to the new continuous eligibility provisions, the MP program will no longer be included in the monthly mass change with rollover beginning on 11/20/98. For any open MP cases with SSA income, the SSA amount will automatically be changed due to the COLA increase for 1/99 without recalculating MP eligibility. Eligibility will be recalculated with the new SSA amount the next time the worker accesses the PLID screen for a benefit month of 1/99 or greater, or when the federal poverty level increases are processed on KAECSES for 4/99 or 5/99, whichever occurs first.
 - b. MP Age Alert - The current MP age alert is for age 18. Based on current policy no action will be required on open MP cases at the time a child turns 18 until the next review is due. At the time of the next review following the 18th birthday the 18 year old is to be split off to a separate case of their own. When an MP recipient turns 19, the case will be deauthorized with rollover and the worker will need to close the case.
 - c. Insurance Codes on MERE - Beginning 11/2/98, the INSURANCE CODE field on MERE becomes a mandatory field for the MP program. Staff should be gathering this information, as this will be required to authorize MP the next time the MP case is processed. To assist staff in the completion of the INSURANCE CODE field, a special report will be provided listing all active TPL segments from the MMIS for individuals coded as IN on open MP cases. This printout will be sent to the field on or about October 28.

- d. Conflicting Individual Medical Subtypes on MERE - Problems occur when two programs which require a medical subtype are opened on the same case number. This includes the following program combinations: MA & MP, TransMed & MP, and Extended Medical & MP. Because of this separate case numbers will be required when MA and MP are opened for the same time period. MP for children on TAF cash will be closed when the case changes to TransMed.
- e. Uninsured Status Requirement - Even though the system will fail eligibility for HealthWave children who are coded “Y” in the INSURANCE CODE field on MERE, uninsured status is not listed on the MPED screen as an eligibility requirement for the individual. So when an MP child fails eligibility and the reason is not listed on PLID as excess income and there is no failure listed on MPED, the worker should check MERE to see if there is a “Y” in the INSURANCE CODE field which causes ineligibility.
- f. MP Review Dates - To accommodate differences in the initial continuous eligibility periods for HealthWave and Medicaid children on the same case, it is now possible to set MP review periods for longer than 12 months. (Refer to continuous eligibility policy information in item II-5 above.) Even though the REVIEW THRU DATE can be set for up to 14 months. on PLID, once set it cannot be extended to a longer period. For this reason it is advisable to set a 13 or 14 month review period when it appears that there may be both HealthWave and Medicaid children on the same case. Then if MEBH shows that all of the MP individuals are eligible for Medicaid, the review period can be shortened to 12 months.
- g. Poverty Level Percentage Calculation on PLID - In rare situations an MP case could appear eligible with 200% displayed in the new POVERTY LEVEL % field on PLID, but show an “N” for not eligible in the SUBGROUP ELIGIBLE field. This is a problem when the countable household income is within \$1 of the poverty level dollar amount for the number in the group. The problem is caused by the way the federal poverty level percentage is calculated. When this rare situation occurs the “Y” or “N” code in the SUBGROUP ELIGIBLE field will correctly show eligibility or ineligibility for the MP group.

The same problem could occur in regards to Individual Medical Subtypes set by the system when the countable income is within \$1 of the poverty level amount which separates one subtype from another. The POVERTY LEVEL % on PLID may indicate income at 150%, while the individual subtype on MERE shows T7 rather than T6. When this happens the subtype on MERE will be the correct indicator.
- h. Pregnant Minors - For pregnant minors who have countable income above 150% of the poverty level, it will be necessary to go back to SEPA, remove the PW

indicator, code the unborn out, and reprocess the case to determine eligibility for the pregnant minor as a HealthWave child. This is required because the system will always determine Medicaid eligibility in a separate pregnant woman grouping for anyone coded as a PW.

- i. System Problems - Please report system problems to SRS Help Desk at 785-296-4357 or on GroupWise. It is best to report system problems before making changes to the case, or at least document the problem by making screen prints of appropriate items before making any corrections to the case.

V. **FURTHER IMPLEMENTATION INSTRUCTIONS**

1. Applications - Applications for HealthWave coverage can be filed as of November 1, 1998. This will allow for the managed care enrollment process to be completed in time to provide medical benefits to the first group of applicants effective January 1, 1999. Applications that are processed by December 23, 1998 will have access to HealthWave benefits for January. Applications processed after that time will not be enrolled for coverage until February or a later month.

As noted earlier, HealthWave coverage does not begin until the child is enrolled with one of the managed care providers for the program. The enrollment process will be automated and a mandatory assignment given. Cases processed up to the first medical card run of a month will be enrolled by the first of the following month.

Per system instructions provided in Section IV, the new policy rules and HealthWave processes will be effective in KAECSES beginning with the benefit month of January. Thus applications for poverty level medical coverage which are processed on or after November 1, will need to have eligibility determined for January as well as November and December benefits. Benefit months necessary to catch the case up to rollover for January 1999 will need to be processed and staff will need to also copy details into January so that eligibility can be determined for that month. For TAF applications, an MP program needs to be added as the TAF case is processed for protection of continuous eligibility.

2. Treatment of Ongoing MP Cases - Current MP cases will need to be converted to the new eligibility policies as expeditiously as possible. Although the policy changes take effect in January, staff have until the poverty level increase mass change, which is expected to take place at the time of rollover in March 1999, to make any necessary changes. This could include taking such actions as adding additional eligible children to the case, counting additional income from family members not previously considered, redetermining financial eligibility, and transitioning some or all of the children to HealthWave.

To prevent having to change all MP cases at the same time, the MP program has been removed from the January 1999 COLA mass change run which would have otherwise

deauthorized all MP cases where MERE insurance coding did not exist. In addition, as noted in the System Change section, the MP program will no longer be subject to monthly mass change.

Staff then have approximately 5 months to convert current MP cases. This can occur for some cases at the point of review where the review period comes due during this timeframe. However, other cases will need to be worked as identified. Staff should use the active caseload listings to identify MP cases for conversion. This listing will also provide information on other program involvements tied to the case.

As noted earlier, insurance coding on MERE will be mandatory for MP and insurance information on the family will need to be reviewed when the case is converted to code the screen properly. A printout will be available to help identify these cases as mentioned in item IV(5) above.

In regards to continuous eligibility, the 12 month period shall not be established until the case is converted. Thus if a current MP case is not converted until February 1999 and the children remain eligible (for either Medicaid or HealthWave), the continuous eligibility period would run from February through the end of January 2000 for Medicaid only or likely March through February for HealthWave.

If conversion results in some or all of the children becoming ineligible for both Medicaid and HealthWave, there is no continuous eligibility period for those children even though they received benefits for January, February, and/or March and they would be closed off the case allowing for timely and adequate notice. In these instances, none of these months would be viewed as an overpayment.

As part of the conversion process, an MP program shall also be added to all TAF cases at the time of the next review (other than TransMed or 4 month extended medical cases). When adding MP, the benefit proration date shall be the first month of the new TAF review period and the 12 month continuous eligibility period shall be set to match this review period. Should the TAF case close prior to review, there is no continuous eligibility for the children until a formal MP determination has been made. This shall occur at the time of the TAF closure and if eligible, a continuous eligibility period established from that point. If there is no eligibility, no further coverage would be provided. Once an MP program has been added to the TAF case, if the family becomes ineligible for TAF, the MP continuous period for the children would be retained and medical benefits redetermined at the end of that period.

If an MP case with food stamps is converted prior to the next scheduled food stamp review date, at the time of the food stamp review, MP eligibility is to be redetermined. If eligibility remains unchanged, a new 12 month continuous eligibility shall be established to parallel the new food stamp review period.

3. Treatment of Ongoing MA Cases - Current MA cases will also need to be converted to the new eligibility policies especially family unit and earned income disregard changes.

MA cases will be subject to the January 1999 COLA Mass Change process so those cases which deauthorize as a result of mass change should be converted at that point. In addition, MA cases that deauthorize because of other program involvement (such as food stamps) should also be converted as they are reauthorized.

It is expected that a number of MA cases may include older siblings of currently eligible MP children (see item 4 below). If the siblings are eligible for Medicaid poverty level coverage, the current MA base shall be shortened to the end of December and poverty level eligibility established effective January 1.

If the siblings are not Medicaid eligible but meet HealthWave guidelines, the case should be converted to HealthWave effective January 1 unless the family has already met the current spenddown or had no spenddown in the current base. In these instances, HealthWave coverage would be established effective with the end of the base period unless the family would otherwise continue to meet spenddown for future bases. See the guidelines of item III(1) above.

For all other MA cases, conversion should occur by the end of the current base period for future base period determinations. Both Medicaid poverty level and HealthWave eligibility should be determined and if the children meet these guidelines, establish such eligibility effective with the month following the last month of the current base.

The active caseload listing can again be used to help identify these cases.

4. Other Conversion Issues - Besides converting current MP cases coming due for review in the time period November through March and those cases which deauthorize during this same time period, other issues to note as cases are converted include:

- Current MP cases where there are siblings who are ineligible due to age and/or income. With new policy rules and HealthWave coverage, these children are likely to be eligible. A new application is not needed to add the siblings to the current case for January or a later benefit month. If eligible, the continuous eligibility period would begin effective with the month of conversion. An MP review would not be registered on the system and the current MP review date would be retained. When the case is then later reviewed, if the family retains eligibility, a new 12 month continuous eligibility period would be set to match the new review period. If the family or some of the children become ineligible, the continuous eligibility period set when the sibling was added would remain in effect for those becoming ineligible.
- Current MP cases where an adult is coded as OU. These cases will likely need to be reworked in terms of financial eligibility due to the new assistance planning policy. As stepparents and boyfriends/girlfriends are now likely to be included as part of the family unit, their income will need to be obtained to

determine eligibility. Some of these cases may fail eligibility and need to be reviewed as timely as possible.

- Ongoing MS cases for children that do not involve long term care. Some of these cases may involve fairly significant spenddowns and based on the new policies contained in this memo, may be eligible for Medicaid poverty level or HealthWave coverage. These cases can be considered at the time of the next scheduled review or as identified.
 - Children whose current MP eligibility is ending either effective November 30 or December 31. These children may be eligible for either Medicaid or HealthWave effective January 1 based on the new rules. As such, staff should process eligibility for the month of January for these children and if eligible, reestablish their eligibility effective January 1. A new application would not be required in such instances unless this determination is part of a regularly scheduled review for those months.
5. Failure to Cooperate Regarding Information Necessary for Conversion - If information is not provided that is necessary to convert a current MP or MA case to new policies, the case or individual shall be closed allowing timely and adequate notice.
 6. Cases that Close in November and December - Current MP or MA cases that are to close by the end of November or December based on current rules are to be sent a HealthWave application at the time of closure and allowed to apply for benefits. These applications will likely be returned initially to the Clearinghouse for processing but may be returned to the local SRS office.
 7. Termination of Blue Cross-Blue Shield Caring Program - As referenced earlier, both the Blue Cross-Blue Shield Caring Program of Kansas and Caring Program of Kansas City will be terminated for Kansas residents effective the end of December. Because HealthWave income levels exceed those standards used in the Caring Program, there is no current need to continue the program. Approximately 4,000 - 5,000 children total will be impacted by this change. A special mailing of the HealthWave application to current Caring Program recipients will occur in November. Most if not all of these children are expected to qualify for either Medicaid or HealthWave.

Please let us know if you have any further questions.

DP:KR:jmm

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