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MEMORANDUM

To: EES Chiefs and Staff | **Date:** April 25, 2002

From: Dennis Priest | **RE:** Working Healthy Implementation Instructions

The purpose of this memo is to communicate implementation instructions for a new Medicaid coverage group, Working Healthy. This program serves persons with disabilities who also have earned income. Coverage under the Working Healthy program is effective July 1, 2002. All changes and instructions included in this memo are also effective July 1, 2002.

A. Background - The Ticket to Work and the Work Incentives Improvement Act of 1999 (TW-WIIA) provides Medicaid authority for the Working Healthy program. TW-WIIA established two new optional Medicaid coverage groups as an incentive for persons with disabilities to return to work without fear of losing health insurance coverage. The first optional group, the Basic Coverage Group, covers persons between the ages of 16 and 65 who meet Social Security's disability criteria and are working. It is being implemented at this time. The second optional group, the Medically Improved Group, provides coverage for persons who no longer meet disability criteria because of employment levels and remains an option for future expansion.

In addition to the new Medicaid coverage groups, TW-WIIA created other incentives for persons to return to work within the Social Security system. The primary change is the establishment of a phased-in voucher system, or the 'ticket' portion of TW-WIIA. Each person receiving Social Security Disability or SSI will be sent a ticket. Tickets are being implemented gradually on a state-by-state basis. Tickets are scheduled to be available to Kansans in the Fall of 2002. Social Security is in charge of the ticket program.

TW-WIIA provides for several additional changes within the Social Security system as well. For example, ticket users will not be subject to the current automatic disability review upon gaining employment and will be able to regain cash benefits easier if employment terminates. It also expands entitlement to free Medicare Part A to 8 years from the date disability benefits terminate. Additional information regarding the Social Security changes may be obtained from the local Social Security District Office.

Kansas was awarded a Medicaid Infrastructure Change Grant in October, 2000. The purpose of the grant is to design and develop the Medicaid groups under TW-WIIA. With the grant, an advisory group consisting of advocates, consumers, family members and state officials was formed to begin program planning. The input of this group formed the basic policies for the program. The group continues to meet and provide direction and input.

Among the goals the advisory group identified were to establish a program aimed at supporting consumers employed in a competitive and integrated setting and to ensure that they have a support system available to make an informed choice prior to returning to work. To provide an infrastructure to meet these goals, several new positions have been created within the Community Supports and Services division of Health Care Policy (HCP-CSS) called Benefits Specialists. These positions are explained below.

The group also recognized the importance of personal care services, especially those with physical disabilities. Many persons require assistance with daily activities, such as eating or dressing, in order to return to work. A new Medicaid service, Personal Care Services for Employment (PCSE), is being developed to provide these supports. PCSE would be available for all persons meeting disability criteria, including those over 65. An implementation date for this new service has not been determined. Additional details regarding this new service will be issued through Health Care Policy at the time of implementation.

B. **Benefits Specialists** - To provide support for consumers returning to work, new positions have been created both at the field level and within Central Office. The primary role of the Benefits Specialist will be to support individuals with disabilities in understanding the impact of employment. Most persons receiving SSDI or SSI benefits rely on a number of community and governmental support programs to provide for their basic needs. Understanding the impact returning to work will have on these benefits and supports is essential if the individual is to become or remain successfully employed. The Benefits Specialist will be certified in Benefits Planning, Assistance and Outreach. They will also receive intensive training about the Social Security system to better assist the consumer in understanding the complex rules of both the SSDI and SSI programs.

The Benefits Specialist will promote employment in a competitive and integrated setting, where both persons with disabilities and persons without disabilities work together on an equal level. Although employment in a sheltered workshop setting may provide wages enabling an individual to gain eligibility for the WH program, the Benefits Specialist will be available to assist the individual to move toward integrated employment. To ensure all consumers have access to the Benefits Specialist, a referral process has been developed, which is addressed in item J below.

Initially, a single Benefits Specialist Team Leader (BSTL), located in Central Office and 5 regional Benefits Specialists will be hired. In addition to supervisory responsibilities, the BSTL will be responsible for billing and tracking WH premium payments. The regional Benefits Specialists will be located in the Lawrence, Emporia, Hays, Chanute and Garden City areas. Benefits Specialists will be expected to service regions broader than the area office jurisdictions. A breakdown of the Benefits Specialists' coverage area is included with this material.

C. **Training, Education and Outreach** - The EES Program Training Unit is offering statewide, face to face training for eligibility staff in the months of April and May. For the general public, SRS has contracted with the Breakthrough Club in Wichita to provide education and outreach services across the state. In collaboration with the University of Kansas, Breakthrough Club will prepare and deliver presentations to potential eligibles and other interested parties. The sessions will be designed to explain the benefits of the program to potential participants, acquaint employers about this new resource, and

inform service providers (agencies and individuals who render employment or other services to potential WH participants) about the new program. In addition to presentations, Breakthrough Club will visit major community employers to update them about this new employee resource and discuss tax incentives to hiring persons who have a disability. Breakthrough Club in conjunction with KU will design all printed materials used in the outreach initiative.

D. **Coverage Information** - Working Healthy (WH) eligibles will not be assigned to Medicaid managed care. Coverages available for WH eligibles will be the same as the SSI and MS populations receive. Copayments for services will be applicable, except where otherwise exempt. Estate Recovery will apply to consumers age 55 and over. HIPPS referrals are required except where definite verification is received that indicates the employer does not offer healthcare coverage. Regular Medicare buy-in rules apply to this population and the normal two month delay will apply except where earlier buy-in is appropriate as explained in the KMSM (e.g. prior Kansas buy-in, QMB or LMB eligibility).

E. **Program Requirements -** To qualify for coverage under the WH group persons must meet the general eligibility criteria of act in own behalf, residency, supplying an SSN, citizenship and alienage (except for SOBRA coverage) and cooperation. Some clients must pay a premium for coverage and cooperation with the premium payment process is required (see item K). Persons cannot receive both HCBS and Working Healthy. The client much choose which category of coverage to receive. Spousal impoverishment provisions are not applicable to this population either. In addition, the following requirements apply:

(1) **Age** - Persons must be between the ages of 16 and 64. Coverage may not begin prior to the month of the individuals 16th birthday and may not extend past the month the individual turns 65. Even if an eligible WH consumer continues employment past the age of 64, coverage under WH terminates the month following the month he or she turns 65.

(2) **Disability -** Persons must meet Social Security Disability criteria. Referrals directly to DDS may be required according to current policy. The DDS referral forms, the DD-1104 and the DD-1105, have also been modified to better support the referral process, but there have been no changes in the current process.

(3) **Assistance Planning -** General rules under the MS program apply. If two persons in the same family group request WH coverage, a single plan is applicable. A spouse or parent(s) must be included in the WH assistance plan unless otherwise excluded (e.g. HCBS eligible, SSI recipient, etc). An ineligible spouse or parent is considered an excluded individual and a participation code of DI shall be used on the KAECSES SEPA screen. Likewise, the WH eligible spouse or parent is also included in the assistance plan of the family group members. Separate case numbers are needed when two or more MS assistance plans exist in the same family group. Consider the following examples:

(i) A disabled 55 year old and her 67 year old spouse apply for healthcare coverage. The 55 year old is employed and WH is considered. MS (spenddown) and QMB/LMB are considered for the senior spouse. Separate case numbers are required for the individual determinations. On both case numbers, the non-PI spouse has a participation code of DI. It is also important to note that any

applicable premium or other medical expenses incurred by the WH spouse are allowable toward meeting any spenddown for the non-Working Heathy spouse.

(ii) A 36 year old disabled mother applies for WH. Her husband receives SSI cash and currently receives a medical card. Their two children are both HealthWave recipients. The mother is the only individual in the MS assistance plan in this situation, as SI recipients (the husband) are not included nor are non-legally responsible family group members such as children. If approved, she continues to be included in the MP/HealthWave plan for the children as she is a legally responsible family group member. It is also worth noting that if the SI program is maintained by the Clearinghouse in this situation, it is appropriate to now add the SI program to the wife's MS case.

(4) **Resource Test** - A $15,000 resource test applies to the WH program. This increased level is applicable to all size plans. Because the KAECSES system has not been modified to support this elevated level, it may be necessary to manipulate the system if resources exceeding the $2000/$3000 current thresholds are present.

An additional exemption is also being implemented for the WH program only. All retirement funds are exempt for WH. Included in the exemption are IRA's, Keogh accounts, 401(k) plans and private pension funds, such as KPERS. This exemption shall also apply in the determination of extended coverage through the temporary unemployment provisions described below.

Note that when considering other Medicaid groups for a person moving from WH, any accumulated resources in excess of the limits for the new program must be considered and may render the person ineligible. For example, a person with an $8000 savings account is eligible for WH. The individual quits work, so eligibility under regular MS, QMB/LMB is considered. The person is no longer eligible because the $8000 savings account is over the resource limit for these groups.

For family groups with more than one MS assistance plans, such as in example (i) of item (3) above, resources of both spouses or parents are countable in all assistance plans. This includes exempt retirement funds. While exempt for the WH program, a retirement plan of the WH spouse is countable on the non-Working Healthy spouse's plan. In addition, excess resources of the WH spouse may render the non-Working Healthy spouse ineligible.

(5) **Earned Income Requirement/Income Budgeting** - Persons must have earned income in order to qualify for WH. In general, earned income is defined as providing a service in return for compensation. For purposes of WH, such compensation, or payment, must be subject to withholding under the Federal Insurance Contributions Act (FICA) or the Self-Employment Contributions Act (SECA). Both FICA and SECA provide for collection of Social Security and Medicare tax, which is required to be paid on virtually all earned income. FICA withholding is applicable when there is an employer-employee relationship. The employer is required to pay one half of the total tax due and the employee is required to pay the remaining one half. The employer must withhold FICA from the employee's paycheck. Common line item deductions may be described as 'FICA', 'Social Security' or 'Medicare' withholding on an individuals paycheck. SECA withholding is applicable in self employment

situations. The business owner is required to pay the full amount of Medicare and Social Security tax. These payments are generally made quarterly by the taxpayer, but may be made monthly or annually when filing federal income tax.

For WH, an individual must present evidence of FICA withholding or self-payment through the SECA system. Income for which these payments are not made is NOT considered earned income for purposes of WH unless there is evidence of employment but FICA/SECA is not withheld because the individual is exempt from these payment under federal law. Some examples of employment situations which would usually be considered earned income for WH yet are specifically exempt from FICA include:

(i) Ministers and other clergymen and women. FICA is generally not withheld from paychecks for these persons. Most ministers are required to file a tax return and some pay self-employment tax. If the individual has taken a vow of poverty within the religious order, no SE tax is applicable.

(ii) Students enrolled in and performing services for that same school, college or university.

(iii) Certain non-resident aliens are also exempt from FICA withholding. However, because these persons do not qualify for Medicaid due to the citizenship/alienage requirements, this would only impact SOBRA cases.

(iv) Some government workers, such as the police and fire departments, do not pay into the Social Security system because they pay into a separate retirement fund. These persons do continue to pay Medicare tax however, which would be sufficient evidence in this case.

For self-employed persons, persons are required to present evidence of paying SECA tax at least once during the past year for the business or enterprise currently in operation in order to meet WH criteria. Although IRS laws may not require that the business owner self-pay prior to actually filing an income tax return, the individual has the option to pay on a monthly basis. For persons claiming new self-employment, in order to document that the individual is involved in a legitimate business venture, the person must demonstrate SECA payment and is expected to take advantage of the option to pay incrementally.

It is recognized that additional instances may exist where an individual has not made payment through either system, yet appears to have earned income. Any questionable situation should be submitted the Medical Assistance Eligibility Manager in EES Central Office for review.

The definition of earned income for WH purposes may differ from the standard definition of earned income for budgeting purposes. In other words, a person may indeed have earned income, as defined in KEESM 6300, yet not qualify for WH because of the more restrictive definition. Example of an earned income which would not qualify for WH include blood plasma sales. In addition, persons out on temporary sick pay, although budgeted as earned income, do not meet the earned income criteria

for WH unless the Temporary Unemployment provisions, explained in item I are applicable.

It is also important to note that even though the program has been designed to serve those persons employed in a competitive and integrated environment, federal Medicaid rules strictly prohibit applying a definition of work this restrictive. Therefore, employment in any environment, including sheltered workshops, can meet the employment criteria for WH provided FICA withholding exists.

Current income budgeting provisions are applicable to WH. Income shall be converted or averaged as established in KEESM. Actual income is used for prior medical.

(F) **Premium Requirement** - Some clients eligible for WH must pay a monthly premium for coverage. Premium obligation is determined on a sliding scale and is based on the amount of countable income and the size of the assistance plan. Countable income is determined after all disregards have been applied. Non-covered medical expenses are not allowed against the countable income unless they are countable as an IRWE/BWE (see item L). A graduated premium scale has been developed, with premiums starting at 100% of poverty level. Plans with income below this amount do not pay a premium. Incomes falling between the specified ranges pay the premium amount indicated. The premium amount is updated annually. The current WH premium table is listed below:

One Person Assistance Plan	
Monthly Net Income (countable) Range	Monthly Premium
$ 00 - 739	$ 0.00
$ 739.01 - 924	$ 55.00
$ 924.01 - 1108	$ 69.00
$1108.01 - 1293	$ 83.00
$1293.01 - 1477	$ 97.00
$1477.01 - 1662	$110.00
$1662.01 - 1847	$124.00
$1847.01 - 2032	$138.00
$2032.01 - 2217	$152.00

Two or Three Person Assistance Plan	
Monthly Net Income (countable) Range	Monthly Premium
$ 00 - 995	$ 0.00
$ 995.01 - 1243	$ 74.00
$ 1243.01 - 1493	$ 93.00
$ 1493.01 - 1742	$112.00
$ 1742.01 - 1990	$130.00
$ 1990.01 - 2238	$149.00
$ 2238.01 - 2487	$168.00
$ 2487.01 - 2736	$186.00
$ 2736.01 - 2985	$205.00
Three person Only:	
$ 2985.01 - 3756	$ 205.00

The net countable income, after all disregards are applied, is used to determine the monthly premium amount. For example, Joe is a single person on WH and has the following monthly income:

Social Security Disability	$854.00
Earned income	+ $665.00
Earned income disregard	- $ 65.00 ($665.00 - $65.00 = $600.00)
Earned income disregard	- $ 300.00 ($600 / 2 = $300.00)
Standard disregard	- $ 20.00
Countable Income	$1134.00

When Joe's income is compared to the table for a single person assistance plan above, his countable income of $1134.00 falls into the range, $1108.01 - $1293, giving Joe a monthly premium of $83.00.

(1) **Premium Process -** The EES Specialist is responsible for determining the premium amount and any subsequent enforcement action. The BSTL will have primary responsibility for premium billing and monitoring, as well as establishment of any repayment agreement. SRS Central Receivables will have collection responsibilities.

Premium obligations are entered on the KAECSES MSID screen. A special report is produced each month to communicate premium information to the BSTL. The report will be produced early in the month and will list all persons with premium obligations. Billing statements will be generated based on the information on the report. For new approvals, cases must be authorized by the last working day of the month to be included on the report for the next month. Cases authorized after this date will be listed on the report produced the following month. This report is scheduled to be available to EES staff on SAR in the future. All billing statements will be mailed by the 10th of the month. Statement will be mailed to the mailing address listed on KAECSES or to the clients address if there is no separate mailing address listed. New approvals may also have multiple months of premiums reflected on the report, especially if prior medical has been approved. Statements will be mailed with a postage-paid envelope for payments. Consumers are strongly encouraged to pay premiums through the mail, but payments must be accepted at local SRS offices as well. If a payment is received at the local office, the payment shall be receipted and forwarded to Central Receivables. All premium payments are due on the last day of the month billed. Central Receivables will provide a monthly accounting of all premiums paid to the BSTL by the 5th of the following month. Unpaid premiums for the prior period will be added to the current premium amount and the total obligation billed on the next statement.

For example, Jill's WH case is approved with a premium on 09-22-02 for the months of August, 2002, September, 2002 and October, 2002. The monthly premium amount of $55.00 for 08-02, 09-02 and 10-02 will appear on the BSTL billing report generated at the beginning of October. A bill of $165.00 will be sent to Jill on 10-10-02. Jill pays her premium, in full, on 10-22-02. On or about November 1, a new premium report is generated and Jill's name appears on the report with a premium of $55.00 for the month of November. The special accounting list shows the BSTL that Jill did indeed pay her full obligation for the initial billing. A new bill of $55.00 is now sent to Jill on November 10. If Jill had paid only $100.00 of the obligation, the remaining $65.00 would have been included with the November billing.

(2) **Impact on New Applicants** -Some consumers who apply for Medicaid may not wish to pay a monthly premium for coverage. A consumer has the option to refuse Medicaid if a premium is required. Because of this, WH coverage cannot be authorized for a client subject to a premium until the client has agreed to pay the premium. The client shall be given an estimated premium based on the above chart and given the option of WH coverage or, if otherwise eligible, the potential of spenddown, QMB or LMB only coverage. In some instances, HCBS may also be an option for the client. If a client is unsure about the options, refer the client to the local Benefits Specialist for additional consultation.

To ensure the client has been informed, a new form, the ES-3165 'Working Healthy and Premium Information' has been developed. The form provides summary information about the WH program and allows the consumer to self-determine an estimated premium. This form may be given to the potential premium payer at intake or sent after an estimated premium has been computed. This form is also available on KAECSES as notice N810, Working Healthy Premium, and will be available for use on or about May 15, 2002. The client may sign the form indicating his or her knowledge of the premium obligation. However, submitting the form is not a requirement. A verbal acknowledgment of the premium and agreement to pay the premium, either with EES, the Benefits Specialist or other agency personnel, is acceptable. A note or other written communication is also acceptable. Verbal agreements must be documented in the case file. Obtaining a signed form is preferred, but not required. No prior agreement is required for cases without a premium obligation.

If prior medical is requested, eligibility can be determined for one, two or three months of the period. An agreement to pay the premium for these months must also be obtained prior to authorizing. Because actual income is used in determining eligibility for the prior medical period, premium obligations may fluctuate during this time and the client may elect to only accept coverage in specified months of this period. Coverage must be determined under other programs (QMB, LMB, etc) for all other months.

A similar statement may need to be obtained at review or the 6 month desk review if a client moves from non-premium status to premium-status. A new notice is not required at review for clients experiencing a change in their premium level. It is the client's responsibility to request closure of WH coverage because of the premium obligation.

For either the prior period or the current period, if the client does not respond to the request regarding the premium obligation, coverage may be established under other Medicaid coverage groups.

(3) **Impact on Eligibility** - Although premiums are due monthly, if the premium is not paid timely, enforcement action is only taken at the regular redetermination/review and at the special 6 month desk review. Persons with overdue premiums at the time of either of these recertifications shall not be eligible for ongoing WH coverage past the last day of the specified period. It is necessary to verify the current status of a client's premium account prior to recertifying coverage. Contact with the BSTL is required to determine current account status. Because of the timing of the premium reports, information regarding the account status will not be available until the 10th of the month. All contacts with the BSTL for this information should be made after this date.

If premiums are current at this point, coverage can be reauthorized if all other eligibility requirements are met. If premiums are not current, eligibility under WH ceases. However, if the client provides proof that the premium obligation has been paid prior to the last day of the month of the period, eligibility may be reinstated without additional action.

It is essential to note that ineligibility for failure to pay premiums may only impact eligibility under the WH group. Eligibility under other programs, such as spenddown, HCBS or QMB, must be considered when WH coverage terminates.

To facilitate communication regarding premiums, a special GroupWise mailbox will be established specifically for these issues. Inquiries regarding current premium status, as well as questions or comments regarding individual payments can be addressed to the mailbox. The mailbox address is not yet available and will be communicated when it is operational. **Please note that the mailbox is only for client specific premium payment issues, it is not to be used to submit policy questions, requests for information, etc.**

(4) **Repayment Plan** - Clients wishing to regain eligibility because of non-payment of premiums may do so by negotiating a premium repayment plan with the BSTL. The purpose of the repayment plan is to allow the consumer the opportunity to retain WH coverage while paying off the past premium debt incrementally. Repayment plans must account for the entire back due obligation. The plan will call for the client to make equal payments over the period of 6 months. In other words, the past due obligation is divided by 6 with the quotient becoming the monthly repayment obligation. The consumer must stay current on all payments, both the repayment agreement as well as any current premium obligation. Failure to make a single payment shall result in ineligibility for WH. The client cannot access WH in the future until the past due premium obligation is paid in full.

If a consumer has a past due premium obligation and is interested in establishing a repayment plan, a referral to the BSTL shall be made. Coverage shall not be reinstated until confirmation that a signed agreement has been received. The BSTL will notify EES when the agreement is received and finalized. When the repayment agreement is returned, only the current premium obligation (if any) is entered on the KAECSES system. The BSTL will track payment of the remaining portion. The BSTL will notify EES if premium payment during the period is delinquent.

For an example, consider Jill above. After starting out so diligent, Jill quickly fell behind in her premium payments. At her 6 month desk review in January, the EES worker discovered Jill owed $125.00 in premiums. Her case was closed effective 01-31-03 for failure to pay premiums and she has $6000 in an IRA so is not eligible for other Medicaid. On Feb. 15th she contacted her worker asking about getting her WH coverage back. A referral was sent to the BSTL through the mailbox indicating Jill wanted to negotiate a repayment agreement. On 02-28, the EES receives information that Jill has an approved repayment plan. Coverage is reinstated effective 02-02 and income is reconsidered because of the 6 month desk review. Because Jill has new IRWE expenses, she no longer has a premium. The system is updated. Jill makes her payment for Feb on time. However, on April 4th, the EES worker receives a note from the BSTL that Jill has missed her March payment in her repayment plan. Jill still has her IRA, so her case is closed effective 04-30-02. Jill is not eligible for WH coverage in the future until her premium obligation is paid in full.

(5) **6 Month Desk Review** - A special desk review shall be completed every 6 months for WH clients. The purpose of the review is to determine changes in premium

obligation. All WH clients must complete the desk review, regardless of premium status.

The six month review shall generally be completed at the beginning of the 6th month of eligibility to redetermine premium obligation effective the 7th month. However, when the regular review is due prior to the 6th month, the 6 month review is waived. If the client is found to be eligible at review, a new 6 month desk review is set. Any prior medical months do not apply toward the establishment of the 6 month period.

For example, Becky applied for WH on 09-12-02. She requested prior medical for August only, as she just moved in from Missouri on 08-06-02. Her case is approved on 10-14-02 effective 08-01-02. A six month desk review must be completed in 02-03 (the 6th month of standard eligibility without regard to the prior period) before benefits for March are authorized. Any increase in Becky's premium is effective 03-03.

Income must be verified at the point of the six month review. In the case of self-employment where a tax return was used to establish countable income, an indication from the client that the representative amount is still valid is sufficient without additional verification. Failure to cooperate with the 6 month review shall result in ineligibility for WH.

There is no KAECSES support for the 6 month desk review. It is up to the EES Specialist to set a worker alert at the time of initial case processing to ensure the special desk review is completed. It is recommended the alert be set between the 20th day of the 5th month and the 1st day of the 6th month. In Becky's example above, the WOAL would have been set between 01-20-03 and 02-01-03. A request for income verification is to be sent explaining the potential change in premium. A special notice, the N811 has been created for this purpose. For persons currently paying a premium, a check must be made with the BSTL to determine if overdue premiums currently exist. This request cannot be sent prior to the 10th of the month because the information will not be available until that day. Ten day notice must be given for any increase in premium or other change. Ten clear day notice must be given for any closures. Special notices have been created to communicate the results of the special 6 month desk review.

(6) **Changes in Premium Amount** - Changes which increase the amount of countable income are not acted upon until the next scheduled review or 6 month desk review. However, changes which decrease the amount of the premium are to be considered and any adjustment in eligibility or the amount of premium made the month following the change is reported. Examples of changes which could impact the amount of the premium are changes in income, household size, and BWE/IRWE deductions. A notice shall be sent informing the client of any change in premium.

(G) **Relationship with Other Programs** - Persons initially making application for Medicaid may qualify for more than one medical program. In addition, WH coverage and policies may also impact the food stamp program.

(1) **Medical** - For the elderly and disabled populations, a hierarchy has been established

to ensure that persons are put in the most appropriate group. Generally, the person is to be put in the most advantageous category available. Factors such as frequency of reviews and amount of spenddown or other obligation are to be considered. Note that LTC programs, NF and HCBS, are considered separate groups and are not included. QMB/LMB eligibility shall be considered whenever applicable, with any program. Expanded/Partial LMB should also be discussed with clients who are not eligible for full Medicaid. This hierarchy also applies to those individuals who are not employed.

(i) **SI** - SSI recipients and those deemed SSI recipients, such as a 1619(b) eligible. This would also include those in a temporary suspended status for a financial reason (such a 3 or 5 paycheck month) for up to one month and those in a temporary suspended status for a non-financial reasons (such as a pending payee) as long as efforts are being taken with Social Security to resolve the situation.

(ii) **MS - Protected Groups** - such as Pickles, Adult Disabled Children, etc.

(iii) **MS - Without Spenddown** - If a person is eligible without a spenddown, s/he should be placed in regular MS. This is to the persons advantage because those open under WH are subject to the 6 month desk review. The exception to this would be if excess resources for spenddown coverage exist.

(iv) **MS - Working Healthy Without a Premium** - If the client would have a spenddown, it is advantageous to be included in the WH group.

(v) **MS- Spenddown OR Working Healthy With A Premium -** Client's choice. In these situations, the client must be given the option of which program to choose. The individual can be placed into a spenddown without first consulting the client, but cannot be placed into WH and assigned a premium unless he has agreed to pay a monthly premium.

(2) **Food Stamps** - The following issues must be considered for WH eligibles who are also food stamp applicant/recipients:

(i) **Premiums** - Any monthly premium obligation is allowable as a medical expense for the food stamp program. The premium amount shall be entered on the KAECSES EXNS screen.

(ii) **Income** - BWE/IRWE disregards are not automatically applicable when determining countable income for food stamps. However, certain expenses which are disregarded may be allowable food stamp medical deductions.

(iii) **Resources** - The resource limit for the food stamp program is not changing. Special coding has been created to accommodate the exemption of 401(k) plans for the FS program and the retirement fund exemption for the WH program.

(H) **Changes** - Current change reporting requirements are still in effect and all applicable changes must continue to be reported in 10 days. Except for changes in countable income

which would increase the premium obligation, all changes must be considered for possible adjustments in eligibility.

Budgeting changes occur as cases transition from and to WH. When changes occur that result in the client becoming eligible under a higher priority group as described above, eligibility must be adjusted to place the client in the new group. In addition, the following rules apply:

(1) **<u>Independent Living to Working Healthy</u>** - For cases moving to WH from independent living the month of the change is based on the status of the spenddown (met vs. unmet).

If the spenddown has been met, the change is effective with the first month of the new base period. The current base period remains intact and no premium obligation is assessed. A worker alert must be set at the end of the current base to process the change to WH.

If the spenddown is not met, the change is effective with the first month of WH. The current base period is shortened to end the month prior to the first month of WH. The new spenddown amount resulting from the shortened base must be communicated to the client, and may now be met.

For example, Jane currently has a spenddown of $1200 for the period of 05/02 - 10/02. She has submitted $300 of allowable expenses and now has a remaining spenddown of $900.00. She is employed and WH coverage begins July 1, 2002. The current base is shortened and is now 05/02 -06/02 with a spenddown of $400.00. Because Jane has already submitted $300.00 toward her spenddown, she only has $100.00 left. WH coverage begins in July, and because Jane's income is below $739.00/month, she has no premium.

For QMB/LMB only cases, the change is effective the first month of WH eligibility. WH coverage can coexist with QMB and regular LMB, so the WQ or WL PICK code may be appropriate in these situations.

(2) **<u>HCBS to Working Healthy</u>** - WH coverage begins the month following the month HCBS services end. Because the client's Medicaid card is active until the end of the month, it is not necessary to convert to WH in the month services terminate. The HCBS obligation remains in place for the month, and LOTC must be updated to reflect termination of HCBS services (IL/NA segment is effective the day following the date services end).

(3) **<u>NF to Working Healthy</u>** - WH budgeting begins the month the NF arrangement ends. All countable income is used in the WH determination and a premium may be due. Because of the change in budgeting, the patient liability is reduced to $0 for the month the arrangement ends. A retro patient liability change form is always needed in these instances. LOTC is updated to reflect NF payment termination (IL/NA segment is effective the day following the date services end).

In spousal impoverishment situations, the change would be effective the month

following the month the living arrangement ends. There is no need to send a retro patient liability request in these situations because the patient liability remains in place for the final month of the NF arrangement.

The following rules apply when a current WH recipient experiences a change in living arrangement or loses eligibility under WH:

(1) **Working Healthy to Independent Living** - The change to independent living begins the month following the month WH eligibility terminates. SEPA/PICK codes must be removed or changed to reflect current eligibility. The new 6 month base begins the month following the month WH eligibility ends.

(2) **Working Healthy to HCBS** - The change is effective the month the HCBS arrangement begins. SEPA/PICK codes are to be updated for the first HCBS month and LOTC coded appropriately for the given waiver. Any premium due in the month of change continues to be due and owing but is allowed to reduce the client obligation. If there is no client obligation, the premium obligation is negated for the month of change and a request for a retroactive premium adjustment made.

For example, Jack is a current WH recipient with a $55.00 premium. On 10-05-02, an ES-3160 is received indicating Jack now receives HCBS - PD services beginning 10-01-02. He has countable income of $816.00, leaving a client obligation of $100.00. Since the premium continues to be obligated in the month HCBS begins, the obligation is reduced by $55.00 leaving $45.00 to pay. For the month of November the obligation is $100.00.

Consider the example if the notification would have been received on 10-05-02 and HCBS effective 09-29-02. The same procedure would be followed as indicated above for September. However, the premium is only allowable against the obligation in the month of change. Because the case is now in October and the premium obligation for October has already been sent to the BSTL, a retroactive premium adjustment must be made to refund/eliminate the October premium only.

Also consider the situation if Jack has a spouse, Diane. Once HCBS begins, Jack allocates $500 income to Diane for September, reducing the obligation to $0.00 immediately. In this situation, the retroactive premium request must be sent for 09-02 requesting a premium refund because there is no HCBS obligation to reduce.

(3) **Working Healthy to NF** - If the consumer enters the NF for a temporary stay not to exceed the month of entrance and the following month, WH eligibility remains in place. The premium obligation continues, unless a decrease in income is reported which would result in a decreased premium, and no patient obligation is determined. It is also appropriate to use the TC Living Arrangement Code in these situations.

If the consumer enters the NF for a permanent stay, WH eligibility ends the month following the month of entrance, except for spousal impoverishment situations. The client remains obligated for any premium due in this month, but there is no patient liability established. LOTC must be completed under current guidelines with a $0.00 patient liability. NF budgeting begins the following month.

For spousal impoverishment, NF budgeting begins the month the arrangement begins. Any premium due in the month of entrance in these situations is allowable against the patient liability. If there is no patient liability the premium may be eliminated through the retroactive premium change process.

(I) **Temporary Unemployment** - Coverage under the WH program shall terminate when employment/earned income terminates. Eligibility ends in the month of the change or the following month, providing for timely and adequate notice requirements. Coverage may be extended for up to 6 months for persons who are temporarily unemployed, but intend to return to work, as described below.

Persons with disabilities sometimes have temporary periods where it is not possible to continue to work. Many times these temporary periods are due to episodic conditions related to the disability. When this occurs the individual is dependent upon medical care to become healthy enough to return to work. Providing for continued medical coverage during this time of recuperation provides much needed care to allow the individual to return to work.

Persons who report employment termination and indicate an intent to return to work, can continue coverage under the WH group for up to 6 months. Unemployment can be for any reason (job quit, temporary disability, termination, etc) but the client must provide the reason for unemployment. Persons receiving temporary disability pay from an employer do not continue to be eligible for WH, unless the conditions of the unemployment plan are met. Coverage continues at the current level. However, keep in mind that adjustments in premium may also be necessary at this time, as income may have decreased. A special notice, the N812, has been developed to notify the client that coverage will continue temporarily.

For coverage to continue the person must cooperate with the establishment of an employment plan with the local Benefits Specialist.

Upon approval, an ES-3161 must be sent to the Benefits Specialist regarding the need for the employment plan due to temporary unemployment. If at any time the individual does not cooperate with the Benefits Specialist regarding the establishment of the plan or the requirements within the plan (such as job search), coverage shall be terminated. The Benefits Specialist is responsible for notifying EES if the client fails to cooperate with the plan. Any 6 month desk reviews or regular annual reviews shall be completed during the temporary unemployment period.

The six month period begins the month following the first month of unemployment. If the person continues to be unemployed by the end of the six month period, coverage terminates on the final day of the 6 month period.

(J) **Communication and Referral -** Communication with the Benefits Specialists is essential to the success of the program. Several situations have been identified that require communication between the Benefits Specialist and the EES Specialist. These include:

- Notification of each WH approval

- Notification of changes in eligibility (e.g. premium change, etc.)
- Notification of termination of WH coverage
- Referral for consultation for someone considering employment
- Referral for Employment Plan establishment (Temporary Unemployment)
- Referral for consultation for someone employed considering the impact of premium obligation

Several methods have been identified to provide for adequate communication:

(1) **ADAD** - A copy of every notice of action shall be shared with the local Benefits Specialist. This is accomplished by adding the name and address of the local Benefit Specialist to the ADAD KAECSES screen. Because this action will generate an automated copies of each notice, it is not necessary to screen print and mail all notices. This will accomplish items 1 -3 above.

(2) **ES 3160/3161 Forms** - For other communications or referrals, the existing ES-3160 and ES-3161 have been revised to include WH referral information and options. Some examples of instances where the ES-3160 or 3161 would be sent include general referrals to a Benefits Specialist, to communicate changes when a notice of action is not issued and to request an Employment Plan when the Temporary Unemployment provisions apply.

To allow for the addition of WH information all Level of Care/ CARE information has been removed from these forms. A new ES-3164 has been created specifically for the purpose of requesting LOC information from KDOA.

(3) **Multiple Referrals** - For consumers unsure of the benefits available to them, multiple referrals may be necessary. When this occurs, it is appropriate to send referrals to all sources, with an indication that the referral was sent to multiple parties. For example, a new applicant who is undecided between WH or HCBS should be referred to both the Benefits Specialist and the CIL. The same ES-3160 may be used for both referrals, with a copy sent to the second referral.

(K) **KAECSES Instructions/Modifications** - To accommodate WH, modifications are being made to the KAECSES system. Special procedures have also been developed to correctly determine and display WH coverage. All system modifications are effective with the benefit month of July, 2002. It is expected that the changes to the system will be made in May, 2002.

SEPA/PICK - WH is to be established under the MS program. A new program subtype of WH is being created for use with the MS program only. A WH subtype must be used in order to establish WH coverage, it is not an optional code. In addition to the new program subtype, three new special medical indicators, or PICK codes, will also be available. The appropriate code must be entered on the KAECSES PICK screen for a complete determination. The new PICK codes are:

WH - Working Healthy only coverage

WQ - Working Healthy plus QMB. The majority of clients eligible for QMB and WH will be authorized by placing a 'Y' on the appropriate field on MSID. However, it is necessary to utilize the WQ code in the first quarter of the year if the SSA COLA disregard for the first quarter of the year provides QMB coverage.

WL - Working Healthy plus LMB. This code is to be used for WH plus regular LMB eligibles. Note that person eligible for WH are not eligible for Expanded LMB or Partial LMB.

As with all PICK codes, these codes are month-specific and override any other eligibility determination, except where the benefit is in suspended status. This is especially important if changes in coverage occur. If a PICK code remains on the system after eligibility has formally terminated, the coverage associated with the code will continue to be issued, regardless of other action. Although edits are being put into place for WH to prevent some errors, it is good practice to double check the MEBH screen following any case action to ensure the intended result has been accomplished.

MSRD - The system will not be modified to accommodate the elevated resource test. KAECSES will continue to edit only for the standard $2000/$3000 limits and will fail cases which exceed this limitation, with the exception of QMB where cases will fail if resources exceed $4000/$6000. Cases which fail WH due to excess resources must be evaluated to determine if countable resources are in excess of the $15,000 limit. It will be necessary to change the resource code for the excess amount of resources to exempt in order to allow the case to pass the resource edit. A new code, WX, has been created for use in these situations. The WX code will exempt resources for the MS/CI programs but count the resources for other programs. Documentation in the case file is necessary where this manipulation occurs.

MSID - The MSID screen is also being modified to support online entry of the WH premium. A new 'WH premium' field will display on MSID for all MS cases but will only be enterable for certain WH situations. The field will be open only if a WH subtype exists. It is the responsibility of the EES Specialist to determine the amount of the premium and enter the appropriate amount in this field, as there is no automated premium determination available.

The premium obligation is based on the amount of net countable income, which is displayed under the 'Total Net Income' field on MSID. A premium table has been added to the HELP screen associated with MSID, which can be accessed by selecting PF10 from the MSID screen. The premium obligation can be determined by locating the appropriate income range on the chart for the current assistance plan size. The corresponding premium amount for the income range is the premium for the WH plan. Once the premium is found, a user can return to MSID by selecting PF10.

Premium information does not copy forward. If multiple months are processed it is necessary to reenter the premium amount each month. Premiums do roll forward with monthly rollover, however.

SPEN - Changes have not been made to the SPEN screen, but it is important to note that the CC override is not to be used for WH eligibles. The Subtype/PICK code combination

has been designed for WH and deviations from the prescribed code combinations could result in unintended eligibility to be authorized or incorrect information being sent the MMIS.

Retirement Fund Exemption - To accommodate the new exemption for retirement funds, a new code of 'WR', WH retirement funds, will be available. When this code is used, the asset will be exempt for all MS/CI programs, including WH determinations but countable for other programs. Staff should be careful to change this code for subsequent determinations under other medical programs.

Beginning 05-01-02, 401(k) plans are exempt resources for food stamps. A special resource code, KF, was created for implementation of this policy which exempts 401(k) plans for FS and counts the value for other programs. To ensure resources are budgeted properly, the following coding shall be used for 401(k) plans:

KF - Used for FS only and FS in combination with MS programs other than WH. This code will count the value for the MS program and exempt it for FS.

WR - Used for WH only programs. This codes exempts the 401(k) for the WH program.

XA - Used for FS/WH program combinations. This code exempts the 401(k) for both determinations.

ERROR MESSAGES - Several new error messages have been developed to support Working Healthy:

(1) **Invalid Prog Subtype/pick Combo** - A new severe error that will appear if a WH program subtype exists and a PICK code other than WH, WQ or WL is entered.

The existing error message displaying on SSDO has been modified to accommodate Working Healthy. In the month an individual reaches age 65, an OA subtype will no longer be required for WH cases. However, if a case without a WH program subtype is found, the following message will appear in the month of the 65th birthday: **Age > 65, Use OA Subtype-No Elig for MS-WH** .

(2) **Premium Amt Must Be Numeric -** displays on MSID when a non-numeric value is entered in the 'WH Premium' field.

(3) **Check PICK - Premium Not Allowed** - displays on MSID when there is no PICK code entered

(4) **No WH Eligible - Net Income >300% FPL'** - displays on MSID when countable income exceeds 300% of the poverty level

(5) **Enter Premium - WH Net Income > 100% FPL** - displays on MSID when premium field is blank and income exceeds 100% FPL

(6) **No Premium - WH Net Income < = 100% FPL** - displays on MSID when a premium amount > 0 is entered and income is less than 100% FPL.

PRAP - A new program alert has been created for WH cases with an overdue premium. The code OD (Overdue WH premiums) shall be set when overdue premium exist.

Notices - In addition to those listed previously in this memo, several new notices have been developed to support the Working Healthy program. A complete list is not available at this printing, but will be issued through SRS Help Desk when available.

L. Related Policy Changes Applicable to All MS Plans - In addition to Working Healthy, two new policies are also being implemented in July. These are applicable to all MS plans, not specifically WH households.

(1) BWE/IRWE - Blind Work Expenses and Impairment Related Work Expenses- Two additional earned income deductions are now available to persons determined disabled under Social Security standards or those age 65 and over. BWE and IRWE are the costs of certain equipment, items and services that a person with a disability needs to work. These allowances are available to persons in independent living as well as HCBS or in long term care. It is important to note that Social Security also disregards certain BWE and IRWE expenses. Although our Medicaid policies are similar, they are not the same and should not be confused. In addition, these expenses are only applicable to the MS population, and not other Medicaid groups or food stamps, TAF or child care. For food stamps, certain items may be allowable medical expense deductions.

Allowable expenses are directly associated with the clients ability to maintain employment, and are very specifically defined below. Expenses outside of those defined are not allowable. Expenses must be the responsibility of the impaired individual and cannot be paid by, or subject to payment of by another source. For medical expenses, only the bills, or the portion of bills, that are not covered by Medicare, Medicaid or other third party insurance are allowable.

Approved expenses are deducted from gross earned income. The deduction is made prior to the other earned income disregards (i.e. the first $65.00 and one-half the remainder) and prior to the standard $20.00 deduction. The total IRWE/BWE disregard may never exceed the total amount of earned income.

There are two specific policies, one for the blind and one for all other persons meeting the MS program criteria. This distinction is intentional, as the federal basis for this policy requires more liberal allowances for the blind. For persons age 65 and over, a formal disability determination through Social Security is not necessary. However, it may be necessary to request information regarding the persons impairment in order to determine the necessity of the reported expense.

For the blind, the following expenses are allowable:

- Guide dog expenses including the cost of obtaining and maintaining the animal such as food, licenses and vet bills;
- Transportation to and from work;
- Federal, state and local income taxes, Social Security tax;

- Attendant care services;
- Visual aides and translation services;
- Drugs and other medical expenses or equipment NOT covered by Medicaid or other insurance;
- Costs of training to use special equipment.

For other meeting disability criteria or those age 65 and over, the following expenses are allowable:

- Attendant care performed in the work setting or helping prepare for work;
- Specialized Transportation to and from work; (Examples include structurally modified vehicles to accommodate the individuals disability (both the operating costs and the cost to modify), the costs of a driver or taxi cab if the individual requires assistance and cannot manage to get off or on public transportation or public transportation has not been modified for the persons disability (e.g., wheelchair accessible). Transportation is not allowable for person's who can drive an unmodified car or utilize public transportation without assistance;
- Drugs and other medical expenses or equipment not covered by Medicaid or other insurance;
- Service dog expenses including the costs of obtaining and maintaining the animal such as food, licenses and vet bills;
- Non-medical equipment and services, such as tools and one-handed typewriters, related to the impairment.

For persons reporting an allowable expense, a standard deduction is given. For the blind, the standard deduction of $300/month is given. For all others, the standard deduction is $100.00/month. In order to use the standardized deduction, the expense need not be verified. However, the client must be prepared to substantiate the need for the expense and to verify the expense if requested. If expenses exceed the standardized deduction, actual expenses may be allowed. For this determination, expenses are to be verified and averaged.

Because of the higher disregard for persons who are blind, it is necessary to determine if the individual is blind. As part of the disability determination process, SSA captures blindness information and carries an indicator in their system. Necessary modifications to the EATSS system are being explored to carry the information on the SDX, TPQY and/or BENDEX. If information is needed regarding the status, contact with SSA may be necessary. An SSA-1610 can be used for this purpose. It is further recommended that once it is substantiated through Social Security that blindness criteria have been met, the Individual Medical Subtype (on the KAECSES MERE screen) shall be updated to correctly display a code of 'AB'.

Because the application does not capture BWE or IRWE expenses, it will become necessary to routinely request the client supply this information when follow up requests or contact is made with the client. Failure to submit information or verification regarding the presence of an allowable shall not result in a case denial or closure solely because the information was not provided. When this occurs, action must be taken to process the case without these expenses.

KAECSES Procedures - To accommodate the new income disregards, earnings of a person on the MS program with an allowable BWE or IRWE must be entered on the self-employment screens. Utilizing the SEEI screen will enable the worker to account for the exact amount of the BWE or IRWE and also give the appropriate disregard. The income shall **NOT** be entered on the EAIN screen.

When an allowable expense is reported and/or verified, the SEEI screen is used by placing an appropriate code on the screen. For BWE/IRWE situations, two new codes have been established:

IW - For use when Impairment Related Expenses are budgeted
BW- For use when Blind Work Expenses are budgeted

The SEEW screen is then accessed. The full, countable income must be placed on the SEEW screen because it establishes a monthly amount of income, the income must be converted or averaged first. An expense of $100, $300 or an actual amount of expense is then entered. The worksheet must continue to be screen printed prior to processing. Depressing the Enter key will compute the amount of countable income and place it on the SEEI screen.

Conversion - To notify current recipients of this potential new expense, all consumers with earned income open under the MS program will be sent information about the new allowance. This includes those in nursing facilities or on an HCBS waiver. The notices will be mailed in mid-May and will be generated from labels produced centrally. The client must inform the Specialist if expenses exist which meet the defined criteria.

When an individual reports an expense, conversion processing shall begin with a determination regarding any reported expense. If the client reports one an allowable expense, consistent with his/her employment and/or disability, the standard deduction shall be allowed. For system processing, the worker must first access the SEEI screen and enter a BW or IW income type code. When the enter key is selected, the Self-Employment Worksheet (SEEW) is displayed. The total amount of countable income for the month (following conversion, averaging, etc) must be entered (code I, for income). The amount of the expense must also be entered on the worksheet (code E, for expense). Remember to print this screen before selecting the enter key. Total countable income is now displayed on SEEI.

Earned income may also be present on the EAIN screen. If so, staff must remove the income from the medical budget screen (or code the income XM-exempt for medical) in order to avoid counting the income twice for medical. If earned income is budgeted on a corresponding food stamp program, no changes are necessary to the EAIN screen.

For persons self-employed, the SEEW screen must be adjusted, as indicated above. If food stamps are also being considered for the household, it is necessary to complete two SEEW screens (one prospective and one medical) and to screen print both for retention in the case file.

(2) **Earnings of a Disabled Student Under The Age 22** - The income of a student under the age of 22 meeting the disability criteria is exempt beginning July 1, 2002. To be considered disabled, the Social Security disability criteria must be met. This new exemption extends the current policy which exempts earnings of persons under the age 18.

To be considered a student for purposes of this policy the individual must meet one of the following criteria:

(a) In college or university at least 8 hours a week
(b) In grades 7-12 at least 12 hours a week
(c) In a training course in preparation for employment at least 12 hours a week. An example would be a vocational, trade or technical school.

The exemption terminates the month following the month the client reaches age 22. Because no automated alerts are generated at the 22nd birthday, it is recommended that a Worker Alert be set in the month of the 22nd birthday to evaluate the client's income. For persons in WH, premium changes are not considered until the applicable review, as discussed previously in this memo.

For conversion purposes, all open MS cases with participating persons under the age of 22 with earnings have been identified. This report will be included with the Working Healthy implementation report generated in mid-May.

M. Conversion - Specific conversion instructions are addressed in an attachment to this memo. Please refer to this attachment for specific information regarding conversion issues.

N. Closing - The Working Healthy program is being collaboratively administered between the Health Care Policy and Integrated Service Delivery divisions. This material has primarily been developed by the Working Healthy Implementation Team. This team, comprised of field and Central Office staff, included the following representatives:

EES Central Office - Cheryl Woods, Lauri Corcoran, Kristi Scheve, Susan Craig, Mark Wunder, Kent Waltmire, Dennis Priest, Jeanine Schieferecke
Health Care Policy - Mary Ellen O'Brien Wright, Sharon Johnson, Marianne Deagle, Howard Moses, Gail Giordono
Rehabilitation Services - Mary Hirst
DDS - Connie Wold, Alyce Maher
EES Field Staff - Doug Ptacek, Hays; Joyce Shipley, Kansas City; Linda Haag, Ottawa; Brenda Mulberry, Chanute
Rehabilitation Services Field Staff - Rosemary Taylor, Lawrence
Kansas University School of Education - Jean Hall

A tremendous amount of coordination and effort will be necessary to ensure the success of the Working Healthy program. Your efforts and continued involvement in achieving such success is very much appreciated. If you have any questions about this material please contact Jeanine Schieferecke at (785) 296-8866. For questions or problems regarding automated systems, contact SRS HelpDesk at (785) 296-4357.

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WORKING HEALTHY CONVERSION

All current MS independent living and HCBS cases with earned income between the ages of 16 and 64 must be reviewed for potential eligibility under Working Healthy. In some instances, conversion will be automatic and will not require additional contact with the client prior to case action. New IRWE and BWE disregards shall also be considered at the time of conversion, if these expenses are available. The case must also be evaluated to determine if the specific earned income requirement of WH (evidence of FICA withholding, etc.) has been met. Additional information may be needed to make this determination.

To assist with the process, a printout, 'SRS Working Healthy Conversion Report' will be provided listing all current cases meeting this criteria in your Area. The printout only lists those cases in which the individual between the ages of 16-64 is receiving medical assistance and has earned income. It does not list those cases where the only person with earned income is an ineligible spouse or parent. The printout is sorted by worker. The printouts will be issued to your office on or about May 15. A draft copy of the printout is included with this material.

Most fields on the printout are self explanatory. A few do require additional explanation:

HH - (Household Size) - Provides the current size of the MS assistance plan. The size only displays if it is larger than 1 person. The field is blank ( ) for a unit of one.

SUB - (Program Subtype) - Provides the program subtype for the MS program. If there is no medical subtype listed, an 'IL' (Independent Living) is listed.

ELIG - (Eligibility Indicator) - Provides the basis of eligibility as appears on MEBH. For example LL = Expanded LMB, CC = Cost of Care Override, SD = Spenddown, PK= Pickle, etc.

LOC - (Level of Care) - Provides the current level of care on LOTC. The field is blank ( ) if no LOC is included on the case.

PLAMT - (Patient Liability Amount) - Provides the current patient liability/client obligation as listed on LOTC. A 0 (zero) displays if the amount is $0 on LOTC. A dot (.) displays if no amount is listed on LOTC.

SDAMT - (Spenddown Amount) - Provides the amount of the spenddown prior to any MEEX deductions. If the SUB = HC or AC, there is no amount in the field and a dot (.) displays.

FPL - (Federal Poverty Level) - Provides an approximate % of FPL based on income currently on the system. Information in this field should be used as a guide only. Countable income may change with the new IRWE/BWE disregards.

When taking action to convert cases, the following procedures should be followed:

1. **NF Cases** - although not eligible for WH, nursing facility residents have also been included on the printout. This information is informational only to give staff a reference for potential contacts regarding the program. It was also produced for the Benefits Specialist to track possible inquiries. No action is required on NF cases. These cases are identified by an AC 'SUB' (subtype) column of the printout. If a resident or family member expresses interest in WH a referral to the Benefits Specialist is appropriate.

2. **HCBS Cases** - HCBS recipients are not eligible for WH but may wish to convert. To ensure all HCBS clients are aware of the new program, information regarding the program shall be sent to those meeting the earned income requirement. EES is responsible for identifying those persons potentially eligible for WH. This information is to be shared with the HCBS case manager/Independent Living Counselor, who is responsible for communicating the information to the client. An ES-3161 shall be sent to the case manager/ILC for this purpose. As a courtesy, an estimated premium amount shall be included in the referral, if possible. These cases are identified by an HC in the 'SUB' (subtype) column on the printout. The 'LOC' (Level of Care) column provides the actual waiver the person is served under.

   The CM/ILC shall send an ES-3161 if the client elects to terminate HCBS. Immediate action to convert to WH may be taken provided the client has agreed to any applicable premium.

3. **Case Without Spenddown** - For cases without a spenddown, no action is necessary at this time because they are not converted to WH. This includes those eligible under the Pickle provisions or other protected groups or those with incomes below the protected income level. Protected persons are identified by a DC, PK, DW or EW in the 'ELIG' column. Persons with low incomes are potentially identified by an IL (independent living) in the 'SUB' column, a code of RG (regular) in the 'ELIG' column and a $0 (zero) in the 'SDAMT (spenddown amount) column. However, these persons could also have a met spenddown, so they must be evaluated to determine the proper course of action.

4. **Case With Met Spenddown -** For cases in an existing 6 month base with a met spenddown, no action to convert is necessary until the end of the 6 month base period. At that time the case must be evaluated as described below in item (5) to determine possible action. To ensure WH coverage is considered at the end of the 6 month period, setting a Worker Alert reading 'Check WH at end of base' is recommended. These cases are potentially identified by an IL in the 'SUB' column, an RG in the 'ELIG' column and a $0 (zero) in the 'SDAMT' column. As indicated above, these may also be cases without a spenddown, so each must be evaluated individually.

5. **Cases With Unmet Spenddown or QMB Only Without a Premium** - Cases which meet the criteria for WH and will not have a premium are to be automatically converted to coverage effective 07-01-02. Cases with countable income up to 100% FPL do not have a premium. These will generally be identified on the printout in one of the following ways:

      -QO or LO in the 'SUB' column, an SD in the 'ELIG' column and a dot (.) in the 'FPL' column; or

      -IL in the 'SUB' column, SD in the 'ELIG' column and a dot(.) in the 'FPL' column.

   It is important to keep in mind that other cases, without the combination of codes on the printout, may also meet this criteria.

6. **Cases with Unmet Spenddown, or LMB Only With a Premium** - Because WH eligibility with a premium cannot be fully authorized until the consumer has agreed to pay the monthly premium, contact with the consumer must be made prior to taking any case

action. Cases with potential premiums are primarily those appearing on the printout with an SD, LL, LS, or RG in the 'ELIG' column and an FPL greater than 0. Other cases may also meet the criteria but are listed on the printout with a different combination of codes. It is important to evaluate each case prior to taking any action.

Once potential premium cases have been identified, a special notice must be sent to the consumer which provides information on the WH program and the obligation associated with a premium. The notice, N810 - Working Healthy Premium, will be available to staff following the release of the final printout in May. Clients are asked to contact their case worker if they want to choose WH. They are given the option of signing and returning the notice, but a phone contact is sufficient to document the client's choice. If no further contact is received from the client regarding the program, the case shall remain open in the current status. A client who does not elect WH may choose WH at any point in the future provided all criteria are met at the time of the choice.

Other cases listed on the printout must be evaluated to ensure all clients are notified of their eligibility, or potential eligibility, for WH.

Conversion Process - Follow the actions listed below to complete the conversion of a current MS case to WH.

For current one month bases (e.g., QMB only, LMB only), for benefit month 07/02:

- SEPA: enter a program subtype of WH
- MERE: ensure individual medical subtype is correct (AB or AD)
- SEEI/EAIN: if BWE/IRWE are now allowable, earned income must be removed from the EAIN screen as it is now computed on the SEEI screen (exception: current self employment income)
- PICK: enter the appropriate PICK code (WH, WQ, WL)
- MSID: enter the appropriate premium amount, authorize QMB (if Medicare A)
- SPEN: authorize case
- if the client also has food stamps, allow premium amount and authorize FSAD
- send notices, check MEBH
- WOAL: set alert for 6 month desk review unless review will occur prior to 12/02

For cases with existing 6 month bases (spenddown), follow the steps above. However, the existing base period must be shortened prior to changing for WH. In benefit month 06/02:

- MSID: enter MSID to reflect change on MEBH
- SPEN: shorten base to end 06/02, redetermine spenddown for new base period send notice for new spenddown prior to making changes for WH. In 07/02, a new base period must be entered onto SPEN when it is first accessed.

Benefits Specialist County List

07-01-02

County	Specialist Location
Allen	Chanute
Anderson	Chanute
Atchison	Lawrence
Barber	Garden City
Barton	Garden City
Bourbon	Chanute
Brown	Lawrence
Butler	Emporia
Chase	Emporia
Chautauqua	Chanute
Cherokee	Chanute
Cheyenne	Hays
Clark	Garden City
Clay	Lawrence
Cloud	Lawrence
Coffey	Chanute
Comanche	Garden City
Cowley	Chanute
Crawford	Chanute
Decatur	Hays
Dickinson	Lawrence
Doniphan	Lawrence
Douglas	Lawrence
Edwards	Garden City
Elk	Chanute
Ellis	Hays
Ellsworth	Hays
Finney	Garden City
Ford	Garden City
Franklin	Chanute
Geary	Lawrence
Gove	Hays
Graham	Hays
Grant	Garden City
Gray	Garden City
Greeley	Garden City
Greenwood	Chanute
Hamilton	Garden City
Harper	Emporia
Harvey	Emporia
Haskell	Garden City
Hodgeman	Garden City
Jackson	Lawrence
Jefferson	Lawrence
Jewell	Hays
Johnson	Lawrence
Kearney	Garden City
Kingman	Emporia
Kiowa	Garden City
Labette	Chanute
Lane	Garden City
Leavenworth	Lawrence
Lincoln	Hays
Linn	Chanute
Logan	Hays
Lyon	Emporia
Marion	Emporia
Marshall	Lawrence
McPherson	Emporia
Meade	Garden City
Miami	Chanute
Mitchell	Hays
Montgomery	Chanute
Morris	Emporia
Morton	Garden City
Nemaha	Lawrence
Neosho	Chanute
Ness	Garden City
Norton	Hays
Osage	Emporia
Osborne	Hays
Ottawa	Lawrence
Pawnee	Garden City
Phillips	Hays
Pottawatomie	Lawrence
Pratt	Garden City
Rawlins	Hays
Reno	Emporia
Republic	Lawrence
Rice	Emporia
Riley	Lawrence
Rooks	Hays
Rush	Garden City
Russell	Hays
Saline	Lawrence
Scott	Garden City
Sedgwick	Emporia
Seward	Garden City
Shawnee	Lawrence
Sheridan	Hays
Sherman	Hays
Smith	Hays
Stafford	Garden City
Stanton	Garden City
Stevens	Garden City
Sumner	Emporia
Thomas	Hays
Trego	Hays
Wabaunsee	Lawrence
Wallace	Hays
Washington	Lawrence
Wichita	Garden City
Wilson	Chanute
Woodson	Chanute
Wyandotte	Lawrence

SRS WORKING HEALTHY CONVERSION REPORT RUNDATE: APRIL 19, 2002

OPEN MS RECIPIENTS AS OF APRIL 2002 MONTHLY EXTRACT UPDATE
WHO WERE AGE 16 -64 AND HAD EARNINGS BUDGETED ON KAECSES
NOTE: HH SIZE DISPLAYS ONLY IF EXCEEDS 1 PERSON
NOTE: FPL PERCENT DISPLAYS ONLY IF EXCEEDS 100%

WORKER=211-2-07

CNTY	CASENO	REVIEW	HH	NAME		SSN	AGE	SUB	ELIG	LOC	PLAMT	SDAMT	FPL
WL	1234567	03/03		ANGEL	ANDY	999999999	17	HC	CC	SE	0	.	.
WL	1345678	02/03		BEAUTY	BLACK	888888888	40	IL	SD		.	1899	107
WL	1456789	02/03		BROWN	BOBBY	777777777	46	IL	SD		0	4214	157
WL	1567890	08/02		CANE	CANDY	666666666	53	IL	RG		.	1412	.
WL	1678910	09/02		GINGER	BREAD	555555555	49	IL	SD		.	1630	101
WL	1789012	11/02		GRAHAM	CRACKER	444444444	45	QO	SD		.	1200	.
WL	1890123	09/02		HILL	BILLY	333333333	45	HC	CC	DD	102	.	111
WL	1901234	11/02		MARX	MOE	222222222	29	IL	RG		.	1895	107
WL	1012345	11/02		NASIUM	GYM	111111111	51	IL	SD		.	502	.
WL	1123456	11/02	02	PILL	BILL	000000001	49	LO	LL		.	707	119
WL	1134567	11/02		RABBIT	ROGER	999999998	44	HC	CC	DD	0	.	.
WL	1145678	12/02		WORKER	WENDY	888888889	24	HC	CC	DD	459	.	159

STATE OF KANSAS
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
ECONOMIC & EMPLOYMENT SUPPORT

ES-3165
07-02

Working Healthy and Premium Information

PLEASE READ - INFORMATION ABOUT THE WORKING HEALTHY PROGRAM and PREMIUMS

This letter has important information about the Working Healthy program. Working Healthy is a Medicaid program. To qualify for this program, a person must:

- Have a disability determined by Social Security;
- Be no younger than 16 or no older than 64;
- Be employed in a competitive work setting;
- Have total income of less than 300% of the Federal Poverty Level;
- Not be receiving Home and Community Based Services;
- Not be living in a nursing facility; and
- Have resources that are less than $15,000.

There is a monthly premium charge for Working Healthy medical coverage when net income is between 100% and 300% of the federal poverty level. Below is a chart listing the income breakdowns for the monthly premium charges.

PREMIUM CHART FOR WORKING HEALTHY PROGRAM (05/02)

SINGLE PERSON PLAN FOR MOST SINGLE ADULTS		TWO/THREE PERSON PLAN FOR MOST MARRIED COUPLES OR CHILDREN	
MO NET INCOME	**MO PREMIUM**	**MO NET INCOME**	**MO PREMIUM**
00.00 - 739	0.00	00.00 - 995	0.00
739.01 - 924	55.00	995.01 - 1243	74.00
924.01 - 1108	69.00	1243.01 - 1493	93.00
1108.01 - 1293	83.00	1493.01 - 1742	112.00
1293.01 - 1477	97.00	1742.01 - 1990	130.00
1477.01 - 1622	110.00	1990.01 - 2238	149.00
1662.01 - 1847	124.00	2238.01 - 2487	168.00
1847.01 - 2032	138.00	2487.01 - 2736	186.00

2032.01 - 2217	152.00	2736.01 - 2985	205.00
>2217	NOT ELIGIBLE	2 Person >2985	NOT ELIGIBLE
		2985.01 - 3756	205.00
		3 Person >3756	NOT ELIGIBLE

You can figure your net income using the following steps:

- Add all of your gross earnings (amount before taxes)and divide by two.
- Take this dollar amount of earnings and add it to your monthly unearned income, such as, Social Security or Veterans benefits.
- Take that total amount and look at the chart to see if your family's income would have a Working Healthy premium charge.

Single persons without a spouse should use the single plan column. If you are living with a spouse, his or her income must also count toward the total net income. Follow the same steps to determine his or her income, add it to your net income, but now use the two/three person column to determine the monthly premium amount. The two/three person column also applies when an application is filed for a 16 or 17 year old child living with his or her parent(s).

Once you know your monthly net income and this income amount shows you probably will have a monthly premium, you can now decide whether or not to continue the application process for Working Healthy.

If you decide to continue the Working Healthy application process, contact your local SRS office, or sign below and return to the local SRS office. If you have not already filled out an application, you need to fill out an application and return it to your local SRS office.

_____________________________________ ______________________________

Signature Date

A feature of Working Healthy is you can receive Medicaid for a past month. Coverage can begin as early as three months before the month you file an application. This feature is called Prior Medical. Any monthly premium charges begin with the first month of coverage which may include the past three months before you file the application. To help with your decision whether or not to ask for coverage for the past three months, it is helpful to look at unpaid medical bills you have for the past three months. When your cost for medical expenses is greater than what your total premium charge is for those same months, it is wise to explore the option of Working Healthy coverage for those past three months.

If you are interested in the past medical feature, contact the local SRS office or sign below and return to the local SRS office.

____

Signature Date

We are sure you will have additional questions or want more information about the program.

Please call ____ at _________________
__

between the hours of ___________________________.