Division of Family Support

OPERATION MANUAL
Volume IVA

OMTL-495

Medicaid (MA) and State Supplementation

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MS 1010 ADULT MA DEFINITIONS (1)

[The following are terms used for the Adult Medicaid program:]

ACTUARIALLY SOUND: A term used by the Office of the Actuary of the Social Security Administration (SSA) to determine if the average years of expected life remaining for an individual coincide with the life of a financial instrument, such as an annuity, promissory note, loan, mortgage, or land contract. If the individual is not reasonably expected to live longer than the guaranteed period of the financial instrument, it is not considered to be actuarially sound as the individual will not receive fair market value (FMV) based on the projected return.

ANTICIPATED INCOME: Money expected to be received in the future.

ASSESSED VALUE: The value of a piece of property or an asset shown on record in the county property valuation office.

[BEHAVIOR HEALTH SERVICES: Medical services related to the treatment of mental disorders and substance abuse.

BENEFICIARY IDENTIFICATION CODE (BIC): These codes are letters or letter-number combinations which are usually at the end of SSA claim numbers, but are at the beginning of claims numbers for Railroad Retirement beneficiaries.

BURIAL FUND: Monies deposited in a financial institution with a contractual agreement which designates that the funds deposited are for burial purposes and payable upon death only.

BURIAL INSURANCE: Insurance whose terms specifically state the proceeds can be used only to pay burial expenses of the insured.

BURIAL RESERVES: Method of which funds are set aside for the individual's burial expenses. Burial reserves can be a combination of multiple funding sources. These can be life insurance policies designated for burial, burial funds, prearranged funeral contracts, and any other identifiable fund or resource designated as set aside for the individual's burial expense.

BURIAL RESERVE EXCLUSION: An allowable $1,500 exclusion from liquid resources when a client indicates these resources are to be used for burial purposes.

BURIAL SPACES: Cemetery plots, crypts, mausoleums, urns, vaults, caskets, headstones, opening and closing of the grave or other repository which is used for the remains of a deceased person. Each household member is allowed one burial container and location, one headstone, and opening of/closing of grave or other repository.

BUY-IN: A Medicaid (MA) program which pays the Medicare Supplementary Medical Insurance (SMI) premium for eligible individuals.

CASH SURRENDER VALUE (CSV) OF LIFE INSURANCE: The dollar amount the individual would receive for cashing in a life insurance policy. This amount represents the cash value less any outstanding loan on the policy.]

COINSURANCE: A percentage of the cost of covered health-related services after the deductible has been met. Both Medicare recipients and individuals with private health insurance may incur this expense. Example: An individual has a medical bill that private health insurance paid 80% of the total. They are responsible for payment of the remaining 20%.

COMMUNITY SPOUSE: An individual who resides at home, in the community, and is legally married (or considered legally married by a state that recognizes common-law marriage) to an institutionalized spouse receiving LTC services such as Home and Community Based Services (HCBS), Supports for Community Living (SCL), etc. The individual is considered the community spouse, even if separated from the institutionalized spouse, unless incarcerated. The institutionalized spouse is considered as single when divorced from a spouse. A spouse living at home with an individual in a Personal Care Home (PCH) or Family Care Home (FCH) is not considered a community spouse.

Note: Kentucky does not recognize common-law marriage.

COMMUNITY SPOUSE INCOME ALLOWANCE: An amount deducted from the income of the institutionalized spouse in the post eligibility determination for maintenance of the community spouse who has insufficient income to meet his/her needs. The deduction is equal to the difference between the gross income of the community spouse and the designated community spouse income allowance standard. The deduction is allowed only if the institutionalized spouse actually makes the income available to or for the benefit of the community spouse.

COMMUNITY SPOUSE RESOURCE ALLOWANCE: A designated amount deducted from the combined countable resources of the institutionalized spouse and community spouse prior to determining resource eligibility of the institutionalized spouse.

CONTINUING INCOME: Money received and expected to recur on a regular ongoing basis.

COST OF CARE: Monthly rate for a MA recipient plus end-of-month ancillary services charges for the institutionalized recipient.

[COST OF LIVING ADJUSTMENT (COLA): Annual increase in Social Security benefits to offset the effects of inflation on fixed incomes.

COUNTABLE BURIAL SPACE: The value of burial plots owned in excess of the one excluded for each household member (individual, community spouse, and/or disabled/minor child if applicable).

COUNTABLE EARNED INCOME: Total earned income considered in a MA case minus appropriate deductions.

COUNTABLE UNEARNED INCOME: Total unearned income considered in a MA case minus appropriate deductions.]

COURT ORDERED SUPPORT FOR COMMUNITY SPOUSE: An amount court ordered to be paid by an institutionalized spouse for monthly support of the community spouse.

DEDUCTIBLES: The amount that an individual must pay before insurance will start paying for any costs.

DEDUCTIONS: Amounts which vary by case type, subtracted from income to allow for specific expenses or allowances.

[DEPENDENT CHILDREN OF INSTITUTIONALIZED/COMMUNITY SPOUSE: A biological child, a step child, or a child gained through adoption who lives with a parent in the community and are claimed as dependents by either parent under the Internal Revenue Service (IRS) Code.]

DEPENDENT PARENTS OF INSTITUTIONALIZED/COMMUNITY SPOUSE: Parents of either spouse who reside with the community spouse and are claimed as dependents by either spouse for tax purposes under the IRS Code.

DEPENDENT SIBLINGS OF INSTITUTIONALIZED/COMMUNITY SPOUSE: A brother or sister of either spouse, including half-brothers and half-sisters and siblings gained through adoption, who reside with the community spouse and are claimed by either spouse for tax purposes under the IRS Code.

[DISABLED ADULT CHILD (DAC): A person, age 18 or older, who receives RSDI benefits based on disability which was determined prior to age 22 and has received SSI.]

EARNED INCOME: Money derived from direct involvement in a work related activity.

EARNED INCOME TAX CREDIT (EITC): A credit given to individuals who file Federal taxes as "head of household" or "married filing jointly" and who have children. The credit is determined using a scale with the largest credit going to the individuals that fall in the middle of the income range. The credit is received as part of the individual's federal income tax refund.

ELECTRONIC INCOME VERIFICATION (EIV): A method of verifying income through the transmission of information by various electronic systems.

[ELIGIBLE SPOUSE: The aged, blind, or disabled spouse of an applicant or recipient.

ELIGIBILITY DETERMINATION GROUP (EDG): A method of forming groups for each individual to determine eligibility for Medicaid. This grouping establishes which individuals are considered in the household size and identifies what income will be considered when determining eligibility.]

ENTITLED BENEFIT: Payments made to individuals who meet established qualifications set by a federal, state or local government.

EPSDT LONG TERM CARE (LTC) CHILD: A child with special health care needs who receives treatment in an Early and Periodic Screening Diagnosis and Treatment

benefits (EPSDT) LTC facility in or out-of-state, certified by the Department for Medicaid Services (DMS), EPSDT program.

EQUITY VALUE: The assessed value of a piece of property or an asset minus indebtedness.

EXCLUDED INCOME: Income received by a MA household member that is not considered when determining MA eligibility.

EXCLUDED RESOURCE: Money, real property, personal property or other assets not considered when determining MA eligibility.

FACE VALUE (FV) OF LIFE INSURANCE: The basic death benefit or maturity amount specified by the policy. The face value does not include dividends, additional amounts payable because of accidental death or other special provisions.

FAIR MARKET VALUE (FMV): The prevailing price of property or a resource at the time of transfer based on the sale of like property in the vicinity. The FMV is considered to be at least equal to the assessed value.

FAMILY INCOME ALLOWANCE: An amount deducted from the income of the institutionalized spouse in the post eligibility determination for the maintenance of each minor or dependent child, dependent parent or sibling of the institutionalized or community spouse residing with the community spouse and who has insufficient income to meet their needs. The deduction is equal to 1/3 of the difference between the family members' gross income and the designated standard. The deduction is allowed regardless of whether the income is actually made available to the family members.

[FULLY FUNDED/PAID IN FULL PREARRANGED FUNERAL CONTRACT: A prearranged funeral contract for which the individual has provided adequate funding (through a life insurance policy, cash, etc.) to pay for all services and goods needed for the individual's burial. The only time fully funded status must be verified is when the individual wishes to add additional funding to the prearranged funeral contract.]

GROSS INCOME: The total sum of earned or unearned income prior to any deductions.

HOME: Shelter, including adjoining land and buildings, which is the principle place of residence, whether occupied or unoccupied. The homestead can be the shelter, the shelter and land, or land only. If the property has more than one house, only one house may be designated as the homestead property.

HOUSEHOLD EQUIPMENT: Household furniture, furnishings, and goods commonly found in or about a house and used for the operation, maintenance, and occupancy of the home.

INCOME: Earned or unearned money received from any source of funding such as statutory benefits, child support, labor or services, rental property, investments, business operations, or non-recurring lump sum income.

INCREASED PERSONAL NEEDS ALLOWANCE: Deductions allowed in vendor payment cases from any earned/unearned income. These deductions are not for the community spouse.

A. Blind Work Expense (BWE): Allow earned income deductions for any work expense incurred for employed blind individuals such as federal, state and local income taxes, F.I.C.A., or special equipment directly related to enable the individual to work.

B. Impairment Related Work Expense (IRWE): Certain deductions are allowed from earned income for any amount expended for specific items or services which enable the disabled individual to work.

C. Mandatory Withholdings: An amount deducted from the LTC recipient's earned and unearned income for mandatory withholdings that are a condition of employment, such as mandatory payroll deductions, and federal, state, and local taxes. Deductions for withholdings resulting from recipient-induced actions such as indebtedness or financial obligations, voluntary income tax withholdings, court ordered deductions for child support or other garnishments are not allowed.

INCURRED MEDICAL EXPENSE: An owed or paid medical expense.

[IN-KIND INCOME: Any gain or benefit (not in the form of money) payable directly to the household for a service. Example: meals, clothing, free rent or produce from a garden.

IRREVOCABLE ASSIGNMENT OF OWNERSHIP: When ownership of a resource is legally transferred to a person or funeral home and ownership cannot be changed again.

IRREVOCABLE FUNERAL TRUSTS: A legal agreement funded by cash entered into between the member and a specific funeral home. This agreement outlines the arrangement and pre-selection of goods and services. The trust must be accompanied by the Irrevocable Funeral Trust Agreement Form signed within 30 days of the MA application, <u>and</u> an itemized statement of goods and services.]

INSTITUTIONALIZED SPOUSE: An individual in an LTC facility legally married (or considered legally married by a state that recognizes common-law marriage) to a spouse who is not in an LTC facility. Individuals receiving waiver services such as Home and Community Based Services (HCBS) and Support for Community Living (SCL) are considered institutionalized spouses if married to and living in the home with a spouse not receiving those services. An individual in a Personal Care Home (PCH) or Family Care Home (FCH) with a spouse remaining at home is not considered an institutionalized spouse.

Note: Kentucky does not recognize common-law marriage.

KYHEALTH CARD: The permanent, plastic MA identification card issued to recipients for use in obtaining medical services.

LAND CONTRACT: A contract in which a purchaser of real property, upon making an initial payment, agrees to pay the seller specified amounts at established times until the total purchase price is paid.

LEGAL GUARDIAN: An individual appointed through the state district courts to be in charge of the affairs and finances of a minor. Additionally, the individual is usually required to be bonded upon appointment and to file periodic financial settlements with the district court on behalf of his ward.

LIFE ESTATE INTEREST: A form of legal ownership where the individual possesses and uses the property until death. The life estate owner cannot sell the property.

LIQUID ASSETS: Cash, savings accounts, checking accounts, stocks, bonds, mutual fund shares, promissory notes, mortgages, land contracts, certificates of deposit, or other reserves readily convertible into cash.

LIVING APART: Not sharing a common household due to divorce, separation, disability, or illness.

LIVING WITH: Sharing a common living arrangement in a household.

[LONG TERM CARE FACILITIES (LTC): Licensed Nursing Facilities (NF) and Mental Hospitals (MH) approved for participation in Title XVIII and licensed Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF IID).

LOOK BACK PERIOD: During a Property and Asset check, this is the time period reviewed for a prohibited transfer of resources. The look back period for a transfer of resources is 60 months.

MANAGED CARE: The practice of making informed judgments of what an individual needs and managing treatment to ensure necessary and appropriate care is provided.

MEDICAID (MA): Medical benefits provided to aged, blind, or disabled individuals who are categorically or medically needy. The MA program is in compliance with Title XIX of the Social Security Act as administered by DCBS under contract to DMS. Kentucky's MA program is a health insurance program for low-income and needy individuals, which is jointly funded by Federal and State funds. It covers children, the aged, blind, and/or disabled, or those who receive Supplemental Security Income (SSI) and State Supplementation.]

MEDICARE: The Federal program of health insurance for aged individuals and certain disabled persons which provides for Hospital Insurance Benefits (HIB or Medicare Part A), Supplementary Medical Insurance (SMI or Medicare Part B) and which covers additional medical costs and prescription drugs (Part D), effective 1/1/06, for eligible individuals.

[MINOR CHILDREN OF INSTITUTIONALIZED/COMMUNITY SPOUSE: Children of the couple age 21 and younger who live with the community spouse and are claimed as dependents by either member of the couple for tax purposes under the IRS Code.

MODEL II WAIVER: Provides up to 16 hours a day for nursing services approved by DMS. "Model Waiver II services" means 1915(c) home and community based waiver program in-home ventilator services provided to an MA eligible recipient who:

(a) Is dependent on a ventilator; and

(b) Would otherwise require a nursing facility level of care in a hospital based nursing facility which will accept a recipient who is dependent on a ventilator.]

MORTGAGE: The written claim by which the pledging of property to a creditor as security for the payment of a debt is made.

NATURAL ASSETS: Rights to oil, gas, coal, timber, or other natural resources on land not owned by the individual.

NET WAGES: Wages minus appropriate deductions.

NON-HOME PROPERTY: Property, other than a home, owned by an individual.

NON-RECURRING LUMP SUM INCOME: Income received at one time and not expected to continue.

NURSING FACILITY (NF): A licensed facility in which individuals are eligible for vendor payment. These facilities meet all requirements for participation in Kentucky's Medicaid program.

[PARTICIPATING ICF IID: A licensed Intermediate Care Facility (ICF) for the treatment of individuals with an intellectual disability which has a valid provider contract with DMS.]

PARTICIPATING NF: A licensed NF that has submitted a completed Application for Participation, been certified by DMS for participation and been issued a time limited agreement.

[PARTNERSHIP: A regional group of health care providers, such as doctors, hospitals, drug stores, therapists, and laboratories. Kentucky is divided into eight partnership regions. Each region has a unique name. This applies to Managed Care.

PARTNERSHIP REGION: A group of counties designed by DMS as a geographical coverage area of a partnership health plan in Kentucky. There are eight regions. This applies to Managed Care.

PASS THROUGH: A MA program which allows the receipt of MA for individuals who lost their SSI or State Supplementation benefits due to an increase in, entitlement to, or recomputation of RSDI benefits.]

PATIENT STATUS: A classification based on the available clinical and social data determining level of care needs of the institutionalized recipient.

[PEER REVIEW ORGANIZATION (PRO): The organization responsible for conducting patient status determinations for recipients in need of NF, ICF IID and psychiatric care.]

PER DIEM RATE: The daily rate a facility receives from DMS for each recipient in LTC. The per diem rate varies for each facility.

PERSONAL NEEDS ALLOWANCE (PNA): A basic amount for maintenance deducted from the gross income of recipients in NF, non-institutionalized Hospice, HCBS, SCL, etc.

PERSONAL PROPERTY: Any property which can be moved such as jewelry or furniture, other than real property.

[PREARRANGED FUNERAL CONTRACT: A contractual agreement between the client and funeral home that itemizes the selection of goods and services. All prearranged funeral contracts must have an itemized statement of goods and services selected for the individual and signed by both the funeral home and the client. This contract can be funded by multiple sources such as life insurance and cash.]

PREPAID BURIAL FUND: Monies deposited in a financial institution to a fund in the name of a mortician, bank official, or any other individual or group licensed to accept burial reserves, who the individual has a written agreement for funeral services.

[PRIMARY CARE PROVIDER (PCP): The provider of specialist, selected by the recipient, who authorizes the recipient's health care.]

PROFIT: Amount remaining after allowable deductions to income from self-employment.

PROMISSORY NOTE: A written promise to pay on demand or on a specified date, a certain sum of money to a seller or lender for a piece of property or other asset.

QUALIFYING INCOME TRUST: For individuals in LTC with income in excess of the special income standard, this is a means of excluding income in order to establish Medicaid eligibility.

REAL PROPERTY: Land, including the buildings or improvements, natural assets, and mobile homes or trailers when used as a dwelling.

[RESOURCE ASSESSMENT: An evaluation of the combined countable resources of the institutionalized spouse and community spouse completed at the beginning of the continuous period of institutionalization. The resource assessment, which may be completed without applying for MA, involves documenting and verifying all countable resources owned by the couple if the receipt of a vendor payment services began on or after September 30, 1989. The combined countable resources are compared to the current MA resource allowances for the institutionalized spouse and the community spouse to determine if the institutionalized spouse meets initial resource eligibility for MA. Resource assessments are only completed if there is a community spouse. However, at any time an institutionalized applicant, a spouse, committee or representative acting on behalf of the institutionalized applicant makes contact with the agency, a resource assessment is completed.]

RESOURCES: Available money, property or other assets.

RESTRICTED MEDICAID COVERAGE: Restricted MA coverage involves denial of vendor payment status. The individual may be eligible for all other MA services on an ongoing or spend down basis.

[RETIREMENT, SURVIVORS, DISABILITY INSURANCE (RSDI): Social Security benefits payable under Title II of the Social Security Act. RSDI is the three types of benefits that the SSA pays. These payments are made to workers who are at full retirement age (62-67), survivors of workers (children, widows, widowers), or to workers (and qualified dependents) who are now disabled and are younger than full retirement age. To be eligible for all retirement and disability benefits, you need to have worked for a certain number of years, paying FICA taxes into the Social Security system. RSDI is also known by other acronyms such as:

A. SSD – Social Security Disability;

B. SSDI – Social Security Disability Insurance; or

C. Title II Benefits.

SELF SERVICE PORTAL (SSP): A web-based system where an individual can create an account and apply for MA.]

SEPARATION MONTH: The month a couple ceases living together in a household.

[SOCIAL SECURITY ADMINISTRATION (SSA): A Federal agency that administers Social Security programs.]

SPEND DOWN: Time-Limited MA issued to an individual or a family who meets all technical and resource eligibility but has income in excess of the MA scale for the family size.

SSI ALERT: An institutionalized individual receiving SSI with other income of $50 or more.

[STATE SUPPLEMENTATION: The payment from state funds made to an aged, blind or disabled individual who has insufficient income to meet special needs for care in a licensed Personal Care Home (PCH), licensed Family Care Home (FCH), Community Integration Supplementation (CIS) living arrangement, or to purchase Caretaker Services to prevent institutionalization.

SUBSTANTIAL GAINFUL ACTIVITY (SGA): A term used by the SSA to describe a level of work and earnings. It is considered in situations involving disabled or blind individuals.]

Work can be classified as “substantial” if it involves physical or mental activity or a combination of both. Full or part-time work can be classified as substantial.

In order for a work activity to be classified “gainful”, it must be:

A. Performed for pay or profit; or

B. Generally performed for pay or profit; or

C. Intended for profit, whether or not a profit is realized.

[SUPPLEMENTAL SECURITY INCOME (SSI): A federally funded program that makes monthly payments to individuals who have limited income and resources if they are 65 years of age or older, or are blind or have another disability. Being eligible for SSI means an individual receives a monthly SSI payment and Medicaid.

TERM LIFE INSURANCE: Life insurance that covers a specified period of time during which premiums are paid over time. The face value is payable only if death occurs within that time period. There is generally no loan value or cash surrender value on a term life insurance policy. Modified Term Life policies may have a cash surrender value.]

TOTAL COUNTABLE INCOME: The sum of countable earned and unearned income.

TRANSFER OF RESOURCES: Transfer of resources is any cash, liquid asset or property which is voluntarily transferred, sold, given away or otherwise disposed of at less than fair market value, solely for the purpose of establishing MA eligibility.

TRUST PROPERTY: Any property that is placed in a trust where the principal amount in the trust and distribution from the trust are controlled by the terms of the trust. Property which can be placed in trust includes, but is not limited to, stocks, bonds, certificates of deposit, cash, checking accounts, savings accounts, and real estate.

UNCOMPENSATED EQUITY VALUE: Uncompensated equity value is the difference between the fair market value, less any outstanding debt owed on the resource, and the amount received for the resource.

UNDUE HARDSHIP: Undue hardship is when the denial of Medicaid, due to a transfer of resources penalty or consideration of funds placed in a trust, deprives an individual of medical care to the extent the individual's health and life would be endangered. Undue hardship also exists when application of the transfer of resources or trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

UNEARNED INCOME: Money received which does not involve direct physical activity by the individual.

[WHOLE LIFE INSURANCE: Insurance on an individual for a fixed amount that is paid each year during the entire lifetime of the insured. Whole life insurance may have a loan value and a cash surrender value.

WORKER PORTAL: A web-based eligibility system where DCBS workers will enter information in order to determine eligibility for services.]

MS 1015 ABBREVIATIONS AND ACRONYMS (1)

The following abbreviations and acronyms are commonly used in the Division of Family Support Operations Manuals.

ABI	Acquired Brain Injury
AR	Authorized Representative
BIC	Beneficiary Identification Code
BWE	Blind Work Expense
CD	Certificate of Deposit
CDO	Consumer Directed Option
CIS	Community Integration Supplementation
CMS	Centers for Medicare and Medicaid Services
COLA	Cost of Living Adjustment
CSV	Cash Surrender Value
DAC	Disabled Adult Child
DCBS	Department for Community Based Services
DFS	Division of Family Support
DMS	Department for Medicaid Services
DPL	Deferred Payment Loan
ECF	Electronic Case File
[EDG	Eligibility Determination Group]
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FCH	Family Care Home
FMV	Fair Market Value
FPL	Federal Poverty Level
FV	Face Value
HCBS	Home and Community Based Services
HEP	Home Equity Plan
HIB	Hospital Insurance Benefits
ICF IID	Intermediate Care Facility for Individuals with an Intellectual Disability
IMD	Institution for Mental Diseases
IRS	Internal Revenue Service
IRWE	Impairment Related Work Expense
KTAP	Kentucky Transitional Assistance Program
LIS	Low Income Subsidy
LTC	Long Term Care
MA	Medicaid
[MAGI	Modified Adjusted Gross Income]
MCO	Managed Care Organization
MFP	Money Follows the Person
MRT	Medical Review Team
MSBB	Medical Support and Benefits Branch
[MSP	Medicare Savings Program]
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
OLS	Office of Legal Services
PASS	Plan for Achieving Self-Support
PCH	Personal Care Home

PCP	Primary Care Provider
[PE	Presumptive Eligibility]
PNA	Personal Needs Allowance
POA	Power-of-Attorney
PRO	Peer Review Organization
PRTF	Psychiatric Residential Treatment Facility
QDWI	Qualified Disabled Working Individuals
QI1	Medicare Qualified Individuals Group 1
QIT	Qualifying Income Trust
QMB	Qualified Medicare Beneficiaries
RAM	Reverse Annuity Mortgage
RFI	Request for Information
RSDI	Retirement, Survivors, Disability Insurance
SCL	Support for Community Living
SGA	Substantial Gainful Activity
SLMB	Specified Low-Income Medicare Beneficiaries
SMI	Supplementary Medical Insurance
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security Number
SSP	Self Service Portal
[TOA	Type of Assistance]
TPL	Third Party Liability
VA	Veteran's Administration

MS 1020 AGENCY RESPONSIBILITY (1)

[The Department for Medicaid Services (DMS) is the single state agency with designated responsibility for the administration of Medicaid (MA) in compliance with Title XIX of the Social Security Act.

A. Determination of initial and continuing eligibility for medical services of aged, blind or disabled individuals receiving Supplemental Security Income (SSI) is performed by the Social Security Administrations (SSA). Issuance of MAID Cards to SSI eligible individuals is the responsibility of the Department for Community Based Services (DCBS).

   Eligibility determination for all other aged, blind, or disabled individuals (including those individuals losing SSI eligibility) is the responsibility of DCBS.]

B. The scope of medical services provided and payment for those services is the responsibility of DMS.

MS 1030 [TYPE OF ASSISTANCE (TOA) (1)

The following are types of assistance, program names, and descriptions for each group used to identify eligible Medicaid (MA) individuals:

TOA	Program Name	Description
ABDM	Non-SSI Regular MA	Aged, blind, or disabled individuals with income at or below the MA scale who are not receiving SSI or State Supplementation.
ADLT	Adult	Modified Adjusted Gross Income (MAGI) Adult
APTC	Advanced Premium Tax Credit (APTC)	Advanced Premium Tax Credit
ASMA	Adoption Subsidy Medicaid	Children that have adoption assistance payments being made on their behalf. This also includes ICAMA children.
BCC1	Breast and Cervical Cancer Treatment Program: Breast Cancer	Women who have been screened by a local health department and found to need treatment for breast or cervical cancer can receive treatment through MA
BCC2	Breast and Cervical Cancer Treatment Program: Cervical Cancer	Women who have been screened by a local health department and found to need treatment for breast or cervical cancer can receive treatment through MA
BCC3	Breast and Cervical Cancer Treatment Program: Pre-Cancerous Condition	Women who have been screened by a local health department and found to need treatment for breast or cervical cancer can receive treatment through MA
CHEX	Expanded MA for Children	Child >=1 and <19. KCHIP. 159% FPL
CHIP	KCHIP	Child < 19 without insurance. 213/218% FPL
CHL1	Child < 1	Newborn child less than 1. 195/200% FPL.
CHL2	Child	Child >=1 and < 6. 142/147% FPL.
CHL3	Child	Child >=6 and <19. KCHIP. 142/147% FPL.
CHL4	Child	Child >=6 and <19. 109% FPL.
CONV	Conversion Child	Children losing MA due to conversion.
DJJM	Department of Juvenile Justice (DJJ) MA	Children under DJJ custody who are in residential homes or in the community. Not residing in a DJJ facility.
EMCA	Time-Limited MA for Aliens who are Aged, Blind, or Disabled	Time-limited MA for an aged, blind, or disabled alien with an emergency medical condition who does not meet qualified alien requirements for ongoing MA.
EMC1	Time-Limited MA for MAGI	Time-limited MA for an alien under age

	Child Aliens	19 with an emergency medical condition who does not meet qualified alien requirements for ongoing MA.
EMC2	Time-Limited MA for Pregnant Aliens	Time-limited MA for a pregnant alien with an emergency medical condition who does not meet qualified alien requirements for ongoing MA.
EMC3	Time-Limited MA for PACA Aliens	Time-limited MA for a parent/caretaker relative alien with an emergency medical condition who does not meet qualified alien requirements for ongoing MA.
EMC4	Time-Limited MA for MAGI Adult Aliens	Time-limited MA for a low-income adult alien with an emergency medical condition.
ESHI	Employer Sponsored Health Insurance	Individual has health insurance through employment.
EXPT	Exparte	Two months MA for individuals who lost SSI due to excess income or resources, living arrangement, or refusal to obtain drug/alcohol treatment.
FCMA	Foster Care MA	Children who have foster care maintenance payments being made on their behalf.
FFCC	Former Foster Care	Former Foster Care Child > 18 < 26
FFS2	Pregnancy Fee for Service	Incarcerated individual
FFS3	MAGI MA Child >=6 or <19 (P5)	Fee for Service (FFS)—not subject to managed care.
FFS4	MAGI Adult MA	FFS—not subject to managed care.
FFS5	MAGI MA Parent/Caretaker Relative	FFS—not subject to managed care.
FFS6	Former Foster Care MA	FFS—not subject to managed care.
FSC4	MAGI MA Child >=6 or <19 (P1)	FFS—not subject to managed care.
FSCP	KCHIP	FFS—not subject to managed care.
FSCV	MAGI MA Conversion Child	FFS—not subject to managed care.
FSCX	MAGI Expanded MA for Children	FFS—not subject to managed care.
LTCM	LTC MA	Vendor payment MA to categorically needy individuals. These individuals use the special income standard.
MAWR	Medicaid Works	Disabled individuals age 16 through 64 who have earned income (i.e. working individuals) and are unable to engage in Substantial Gainful Activity (SGA) but are working and are financially eligible for regular MA.
PACA	Parent/Caretaker	A parent or caretaker relative with a minor child in the household.
PEAD	Presumptive Eligibility (PE) Adult	Presumptive eligibility for MAGI adult

PEC1	Presumptive Eligibility	PE for MAGI Child < 1
PEC2	Presumptive Eligibility	PE for MAGI Child >=1 or < 6
PEC4	Presumptive Eligibility	PE for MAGI Child >=6 or < 19
PEFC	Presumptive Eligibility	PE for Former Foster Care
PEPC	Presumptive Eligibility	PE for MAGI MA Parent/Caretaker Relative
PEPR	Presumptive Eligibility Pregnancy	PE for pregnant woman
PREG	Pregnancy	Pregnant Woman
PTCC	Pass Through – Correct and Concurrent	Individuals who previously received SSI/State Supplementation and Retirement, Survivor's, Disability Insurance (RSDI) correctly and concurrently (in the same month) and lost SSI/State Supplementation due to an increase in income.
PTDC	Pass Through – Disabled Adult Children	Blind or disabled individuals, age 18 and older, who lose SSI as a result of an entitlement to or increase in RSDI Disabled Adult Child (DAC) benefits.
PTEW	Pass Through – Disabled Early Widow(er)s or Disabled Surviving Divorced Spouses	Individuals, age 60 through 64, who lost SSI/State Supplementation as a result of entitlement to RSDI early widow's or widower's benefits, and who are not yet entitled to Medicare Part A. Individuals age 50 through 59 who received SSI/State Supplementation and who lost SSI/State Supplementation as a result of entitlement to RSDI disabled widow's or widower's or disabled surviving divorced spouse's benefits and not yet entitled to Medicare Part A.
QDWI	Qualified Disabled Working Individuals (QDWI)	Provides for Buy-In of Medicare Part A
QHCP	Qualified Health Plan	Qualified Health Plan
QI1P	QI1 – Additional Low-Income Medicare Beneficiaries	Provides for payment of Medicare Part B premium for individuals with income above 120% FPL and below 135% FPL.
QMBP	Qualified Medicare Beneficiaries (QMB)	Provides for payment of Medicare Part A and Medicare Part B premiums, Medicare deductibles, and Medicare coinsurance amounts for individuals with income under 100% of the Federal poverty level (FPL).
SLMB	Specified Low-Income Medicare Beneficiaries (SLMB)	Provides for payment of the Medicare Part B premium only for individuals with income above 100% FPL and below 120% FPL.
SPDN	Spend Down	Time-limited MA for an individual with medical expenses who meets all resource and technical eligibility requirements but has income in excess

		of the MA scale for the family size.
SPMA	Spend Down	Spend Down for MAGI MA
SPNM	Spend Down	Spend Down for Non-MAGI MA
SSIM	SSI State Supplementation	State Supplementation payment
SSIP	Potential SSI Recipient	Aged, Blind, or Disabled individual whose income is below the SSI standard
SSIR	Regular SSI MA	Individuals who receive Supplemental Security Income (SSI).
SSPM	State Supplementation MA	MA for State Supplementation approved individuals who are not SSI recipients, but are aged, blind, or disabled.
SSPP	State Supplementation	State Supplementation payments for aged, blind, or disabled individuals.
TP45	Deemed Eligible Newborn	Deemed Eligible Newborn]

MS 1060 MEDICARE/MEDICAID RECIPIENTS

Medicaid benefits available to Medicare covered individuals are limited to:

A. Buy-In, which covers SMI charges for SSI or State Supplementation recipients;

B. J, K, M individuals in long term care (LTC) who are allowed an income deduction to cover SMI charges. Other Medicare covered individuals who are allowed the deduction as a spend down item;

C. Deductibles and co-insurance for physician services limited to a portion of the attendance and/or consultation fee;

D. Inpatient hospital deductible; and

E. Co-insurance up to the 14th day of readmission during the same illness.

MS 1065 CO-PAY FOR MEDICAID RECIPIENTS (1)

Some Medicaid recipients are subject to co-payments for medical services and prescription drugs. Field staff must explain the co-payment requirements to individuals during the application and recertification interviews.

A. Recipients who are responsible for paying prescription drug co-payments must make the co-payment to the pharmacy at the time the prescription is filled.

The following is a list of co-payments on prescription drugs:

1. $1 co-payment for generic drugs or atypical antipsychotic drugs without a generic equivalent;

2. $2 co-payment for drugs without a generic equivalent and that are available supplemental rebate program; and

3. $3 co-payment for non-preferred brand name drugs.

Note: If the recipient is unable to pay the co-payment at the time the prescription is picked up, the pharmacy cannot deny his/her prescriptions. However, the individual is still responsible for making the co-payment. The recipient has the obligation to pay what is owed to the pharmacy. Pharmacies that have trouble collecting these co-payments may decide to stop providing services to Medicaid patients.

B. Recipients who are responsible for paying service co-payments must make the co-payment to the provider.

The following is a list of co-payments for service co-pays:

1. A co-payment of $3 is charged at the time of service for an emergency room visit that Medicaid deems a non-emergency, such as for allergies or a sore throat.

2. A co-payment of $2 is required at the time of rendered services by the following providers:

   a. General ophthalmologic services provided by physicians;
   b. Advanced Registered Nurse Practitioners (ARNP);
   c. Rural health clinics;
   d. Primary care centers; and
   e. Physician's office

3. Recipients are required to pay $50 per recipient, per provider, per date of service for each covered admission to a hospital for inpatient hospital services.

4. A $2 co-payment is required for some Medicaid, QMB and KCHIP recipients for certain services rendered by the following providers:

a. Dentists;
b. Optometrists;
c. Opticians;
d. Audiologists;
e. Hearing Aid Dealers;
f. Chiropractors; and
g. Podiatrists.

Note: Recipients cannot be denied care by a provider because of the inability to make required co-payments at the time of service. However, the co-payment remains the responsibility of the recipient. With prior notice, providers may, as a business practice, choose to discontinue future services for recipients with a history of non-payment.

C. The following recipients are exempt from co-payment requirements:

1. Children under age 18:

a. If the 18th birthday is on the first day of the month, the individual is subject to the co-payment.
b. If the 18th birthday is after the first day of the month, the individual is exempt from the co-payment until the following month.

2. Recipients in long-term care facilities (Nursing Facilities and ICF IID's);

[3. Recipients receiving State Supplementation who reside in Personal Care Homes (PCH), Family Care Homes (FCH), or Community Integration Supplementation (CIS);]

4. Recipients receiving Hospice services (institutionalized and non-institutionalized);

6. Pregnant women, through the 60-day postpartum period;

7. Presumptively eligible pregnant women, during the presumptive eligibility period;

8. Recipients age 18, who are in state custody and are in foster care or residential placement; and

9. KCHIP recipients, age 18-19, who are of Alaskan/Native American ethnicity.

D. Waiver recipients (ABI, Adult Day, HCBS, Model Waiver II and SCL) are exempt from service co-payments but are responsible for prescription drug co-payments.

E. Recipients eligible for a medical deduction may use verified co-payments in their SNAP and Medicaid cases.

MS 1235* DISCLOSURE OF MEDICAID INFORMATION

Information concerning Medicaid released to the following, provided they comply with HIPAA. Refer to Volume I, MS 0127:

A. Public employees including any identified representative of the Department of Health and Human Services in the performance of his/her duties in connection with the administration of the public assistance or child support enforcement programs pursuant to part D of Title IV of the Social Security Act.

B. Law enforcement agencies and their representatives including county and commonwealth attorneys, district and circuit court judges, and grand juries in discovering and prosecuting cases involving fraud.

A potential fraud situation in the K-TAP, Medicaid and other benefit programs may be identified by the Kentucky State Police during the course of other investigations. Form KSP-58, Request for Confidential Information, is utilized by the Kentucky State Police when requesting information concerning fraud or potential fraud investigations, whether identified by DCBS or another source.

Upon presentation of form KSP-58 for the release of information, ensure it is completed in its entirety.

If the form KSP-58 is not completed in its entirety, DO NOT release the information and DO NOT sign the form. Refer to the procedural instructions for form KSP-58.

If the requesting officer indicates he/she wishes to take case record material with him/her, offer to provide photo copies. If he/she indicates only originals will suffice, make photo copies for the case record. Annotate the case record.

If the entire case record is requested, discuss with the officer what specific pertinent information may be acceptable rather than the entire case record. If the entire case record is still requested and photo copies will not suffice, make photo copies of the last two packets for the case record.

C. Members of Congress and the General Assembly, limited to cases of individual constituents who have requested information regarding their application or payment status.

D. Any representative that has requested a hearing before an agency hearing officer, to the extent necessary for the proper presentation of the case. The

release of information under this provision is limited to only that information applicable to the hearing request. In addition, any information or names obtained shall not be used for commercial or political purposes.

E. Any audit or similar activity; e.g., review of expenditure reports or financial review, conducted in connection with the administration of any federal or federally assisted program. For Medicaid, the audit/activity must be conducted in connection with the administration of the Medicaid program. This is limited to governmental entities authorized by law to conduct such an audit or activity.

F. Officials administering any title IV-E foster care and adoption assistance programs.

G. Local law enforcement agency, the Kentucky State Police, Commonwealth or county attorney to report known or suspected instances of child abuse or neglect of a child receiving assistance. The local office cooperates in providing information necessary to verify a suspected or known, senior or child abuse situation which has been reported to the proper authorities.

H. Attorneys, absent parents, etc., who appear in the local office with a COURT ORDER carrying a signature of a judge or an individual with the authority of a judge such as a Domestic Relations Commissioner. If the court ordered information is due within 10 calendar days, the information can be released. If the local office has any questions on whether the court order meets the specified criteria or the local office has in excess of 10 calendar days to provide the information, contact the Eligibility Services Branch through the Regional office. Unless otherwise notified by regional office staff or the court, court orders must be followed. For procedures regarding subpoena requests, refer to MS 0130.

I. Only Board of Elections officials may view forms and/or information utilized directly in the voter registration process. Otherwise, voter registration information remains confidential.

Note: Any material released via fax to the above mentioned entities is monitored per HIPAA requirements. The receipt of faxes must be arranged so that the person receiving the fax is available to immediately retrieve the faxed information.

MS 1240 KYHEALTH CARD (1)

[The KYHealth card is issued at initial approval to all individuals eligible for Medicaid (MA) coverage. The KYHealth card is also issued at initial approval for Spend Down eligibility periods. A new card is not issued for subsequent Spend Down approval periods unless the individual no longer has the original card and requests a new one be issued.

Individuals use the KYHealth card to obtain medical services from participating providers. The KYHealth card is presented to the medical provider at the time of service.

Non-exempt Managed Care individuals are issued a one-time managed care card in addition to the KYHealth Card. Individuals must also keep their KYHealth Card and use it when they are not managed care.

If the individual has no fixed or permanent address, and cannot provide a mailing address, the KYHealth card can be issued in care of a Department for Community Based Services (DCBS) office. This procedure is used at the individual's request when no other means of delivering the KYHealth card is available.

A. If an undelivered KYHealth card is received in a DCBS office, take the following action:

   1. Send the KYHealth card to the new address, if available, and assure appropriate action is taken to correct the address; or

   2. If the new address is unavailable, attempt to contact the individual. If the individual provides a change of address, update Worker Portal and send the KYHealth card to the appropriate address. If the individual cannot be located, assure appropriate action is taken to discontinue eligibility.

B. DCBS offices should maintain a centralized file for KYHealth cards returned by Central Office. If an individual requests a duplicate KYHealth card, the centralized file in the DCBS office is to be checked before issuing a new card.

C. Do not process requests for duplicate KYHealth cards on new approvals less than 10 days from the case disposition except in emergency medical need situations.

D. Requests for duplicate cards for MA individuals are processed by DCBS staff. These cards are issued by selecting MAID Card Request on the Case Summary Screen on Worker Portal.

E. Requests for duplicate cards for Supplemental Security Income (SSI) individuals are processed by DCBS staff on Worker Portal.]

MS 1340 INTRODUCTION TO MANAGED CARE (1)

[The Department for Medicaid Services (DMS) contracts with Managed Care Organizations (MCOs) to coordinate health care for most Medicaid (MA) members. MCOs link MA individuals with participating physicians who are responsible for coordinating and providing their primary medical care.]

A. The purpose of managed care is to:

1. Assure needed access to care;

2. Provide for continuity of services;

3. Strengthen the patient/physician relationship;

4. Promote the educational and preventive aspects of health care;

5. Prevent unnecessary utilization and cost; and

6. Improve the quality of care received.

[B. Non-exempt individuals are required to enroll with an MCO. Upon disposition of an application, if the worker does not enter the shopping module and assist the individual in making their MCO selection, Worker Portal will trigger the auto assignment process. An MCO will be assigned for the individual using auto assignment rules.

C. Individuals also have the option of selecting a Primary Care Provider (PCP) in the shopping module after MCO selection. If a PCP is not selected after enrollment, the MCO will assist the individual in selecting one. The individual will receive a handbook and informational materials from the MCO.]

D. The Department for Medicaid Services (DMS) maintains a managed care toll-free telephone number to assist providers and recipients who have specific questions pertaining to managed care. The Medicaid managed care number is 1(855)446-1245, and is available from 8 a.m. to 5 p.m. Eastern Standard Time, Monday through Friday.

[E. MCO website at https://prd.chfs.ky.gov/ManagedCare/ may be accessed by workers and recipients to search for:

1. Participating managed care providers and physicians in a particular county;

2. The MCO and ID number;

3. The provider's name, address, phone number, provider type, and the National Physicians Identification Number; or

4. The provider's specialty.]

MS 1343 MANAGED CARE ENROLLMENT (1)

[Non-exempt managed care Medicaid (MA) applicants are given the opportunity to select a Managed Care Organization (MCO) and a Primary Care Provider (PCP) during the application process.

The individual may change that MCO/physician within the first 90 days of initial enrollment. This begins with the coverage start date under current enrollments on the Case Summary Page on Worker Portal. Individuals also have the opportunity to switch their MCO annually, during open enrollment periods, similar to private health insurance open enrollment. Every effort should be made to complete the MCO/physician selection for all members during the application interview.

A. During the application interview if:

1. The individual is subject to managed care; provide a brief explanation of the managed care program;

2. The individual knows who their preferred MCO is, select the MCO from the shopping module on Worker Portal; and

3. The individual knows the PCP they wish to utilize, capture that information.

B. If the individual does not know which MCO they wish to select during the interview, Worker Portal will automatically assign an MCO once the application is disposed. Once the application has been disposed and the MCO selected, the DCBS worker can no longer complete an assignment on Worker Portal. The member will need to contact Managed Care Member Services at 1-855-446-1245 for any changes.

C. Once a member is approved for MA, they are contacted by their MCO for enrollment and selection of a PCP. Members are issued a one-time managed care card in addition to the KYHealth card that is issued to all MA recipients. If members have specific managed care questions refer them to Managed Care Member Services at 1-855-446-1245 or members can call their designated MCOs:

- Aetna Better Health of KY 1-855-300-5528
- WellCare of Kentucky 1-877-389-9457
- Passport 1-800-578-0603
- Humana 1-855-852-7005
- Anthem 1-855-690-7784

D. For reapplications approved within 60 days of the effective date of discontinuance, members will be reassigned to the same MCO unless a new MCO is requested.

E. For member adds, follow procedures in items A, B, and C. If an individual is added to an active case the effective date is the first day of the month of the requested change.

F. Individuals who are exempt from managed care are issued a KYHealth Medicaid card.

G. Individuals requiring services when out of state must contact their MCO to arrange care.

H. There are no fair hearing procedures for managed care as the delivery method of MA is not a qualifying event for a fair hearing. Managed Care has a grievance procedure for issues such as dissatisfaction with a provider assignment. These are explained in the member handbook which is issued upon request.

I. A deemed eligible newborn is required to have the same MCO as the mother for the initial two months of MA eligibility.]

MS 1346 EXEMPT/NON EXEMPT MANAGED CARE RECIPIENTS (1)

Workers determine eligibility and provide basic information about managed care to applicants and recipients.

[A. The following Medicaid (MA) members are non-exempt and required to participate with an MCO:

1. Individuals receiving MA who are aged, blind or disabled;

2. Pass Through recipients;

3. State Supplementation recipients;

4. Supplemental Security Income (SSI) recipients;

5. Children under 21 years of age, in a Psychiatric Residential Treatment Facility (PRTF);

6. Individuals receiving Non-institutionalized Hospice waiver services;

7. Individuals receiving PRTF I/II or Mental Health/Psych services;

8. Individuals receiving Exparte; and

9. Individuals in DJJ/Subsidized Adoption/Foster Care.

B. The following MA members are exempt and not required to participate in an MCO:

1. Members receiving waiver services except non-institutionalized Hospice waiver services;

2. Members in long term care (LTC) facilities, such as nursing facilities, Institutionalized Hospice, and Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);

3. Members receiving Medicare Savings Program benefits;

4. Incarcerated individuals requiring care outside of the institution;

5. Members whose eligibility is time limited: Spend Down and time limited aliens; and

6. Members in the Medicaid Works Program.]

MS 1350 APPLICATION FOR ENTITLED BENEFITS (1)

Require individuals to apply for any benefits to which they may be entitled. These benefits include, but are not limited to, Veteran's Compensation and/or Pension, Black Lung, Retirement, Survivors, Disability Insurance (RSDI), Railroad Retirement, annuities, pensions, retirement accounts (including IRA's) and Unemployment Insurance Benefits.

A. KTAP, State Supplementation, Supplemental Security Income (SSI), VA Aid and Attendance or welfare program cash benefits of a similar nature are NOT considered entitled benefits.

[B. If an individual is potentially eligible for SSI, enter an application on Worker Portal. Form PA-5.1, Report or Referral to the District Social Security Office, will system generate for the individual to apply for SSI.]

C. If an individual refuses to apply for entitled benefits, eligibility does not exist unless good cause for not applying is established. Good cause includes reasons such as previous denial of benefits with no change in circumstances or inability to prove eligibility. If any type of denial of potential benefits is alleged, require the individual to present written documentation of the denial.

D. Individuals are required to access IRA funds if they are at least 59 1/2 years of age, and the funds are available. The applicant/recipient must provide verification from the financial institution that the required minimum withdrawal, based upon the individual's age is being made. Individuals receiving disbursements from Roth IRA's must withdraw the same amount as from a traditional IRA. The Department for Medicaid Services (DMS) does not make any distinctions between traditional and Roth IRA's. Failure to comply with these procedures results in ineligibility for Medicaid (MA).

Note: The community spouse is not required to take available disbursements from their retirement account. However, the community spouse income allowance must be reduced by at least the minimum amount that can be drawn on the account. This amount is entered as other unearned income for the community spouse and documented thoroughly in case comments.

E. Before approval, obtain verification from the appropriate agency of application for the potential entitled benefit; however, do not deny assistance based on projected income.

[F. Refer individuals who have reached 64 years and 9 months of age to the Social Security Administration (SSA) for a determination of eligibility for Medicare benefits.]

MS 1353 ELIGIBILITY FOR ENTITLED BENEFITS (1)

[Use the following guidelines to determine if an individual is potentially eligible for these common entitled benefits.]

A. Worker's Compensation:

1. Eligibility is based on injury, occupational disease, or death resulting from, and in the course of, employment.

2. The Worker's Compensation Board determines eligibility and benefit amount after applying through the employer.

B. United Mine Workers of America (UMWA) Health and Entitlement Funds:

1. Miners, disabled miners, widows of miners, and their families may be eligible for retirement or other benefits.

2. Applications are available in the local UMWA office.

C. Retirement, Survivors, Disability Insurance (RSDI):

1. Benefits are based on wages from employment or earned income from self-employment.

2. Eligible individuals include a:

a. Retired person, age 62 or older;
b. Disabled person with the minimum employment quarters;
c. Dependent spouse, age 62 or older;
d. Spouse with a dependent child under age 16;
e. Unmarried child to age 18, up to age 19 if attending high school full-time; and
f. Surviving family member under certain circumstances.

[3. Individuals apply at the Social Security Administration (SSA) office serving the county of residence.]

D. Black Lung Benefits:

[1. Individuals eligible for benefits based on disability or death due to Black Lung related to employment in coal mines include:]

a. Miners totally disabled due to Black Lung;
b. The individual’s spouse;
c. A dependent child under age 18, or if disabled before age 22; and
d. A surviving family member- under certain circumstances.

[2. Individuals apply at the SSA office serving the county of residence.]

E. Veteran's Benefits (VA) Compensation payments:

1. Benefits are based on injury or disease incurred in or aggravated by active military service.

2. Eligible individuals include:

   a. Veterans;
   b. Widows;
   c. Unmarried children under age 18;
   d. Certain helpless children; and
   e. Certain parents of a serviceman or veteran who died from service-connected injury or disease.

[3. Individuals apply with a field representative serving the county in which the individual lives.]

F. Veteran's Benefits (VA) Pension payments:

1. Benefits are based on injury or disease that is non-service connected.

2. Eligible individuals include;

   a. Veterans; and
   b. If there are dependents, payments will be increased.

3. [Individuals apply with a field representative serving the county in which the individual lives.]

G. Railroad Retirement:

1. Benefits are based on wages from railroad employment.

2. Information regarding retirement, disability and death benefits may be obtained from the appropriate District Office serving the county of residence as shown below:

Counties:	Send to:
Boone, Bracken, Campbell, Gallatin, Grant, Kenton, Mason, Pendleton and Robertson	Cincinnati District Office CBLD Center, RM. 201 36 East 7th Street Cincinnati, Ohio 45202 Telephone: (877) 772-5772
Boyd, Carter, Elliott, Floyd, Greenup, Johnson, Lawrence, Lewis, Martin and Pike	Huntington District Office New Federal Bldg., RM. 145 640 4TH Ave. Huntington, WV 25721 Telephone: (877) 772-5772

Henderson and Union	Indianapolis District Office The Meridian Centre 50 South Meridian, Ste. 303 Indianapolis, IN 46204 Telephone: (877) 772-5772
All other counties	Louisville District Office 629 South 4th Street Suite 301 Louisville, Ky. 40202. Telephone: (877) 772-5772

H. Medicare Hospital Insurance Benefits (HIB) or Medicare Part A and Supplementary Medical Insurance (SMI) or Medicare Part B:

1. Benefits are based on age, blindness or disability.

2. Eligible individuals include:

   a. Persons at least age 65 and entitled to RSDI benefits; and
   b. Persons receiving RSDI benefits for 2 years or more as a disabled worker, disabled child, or disabled widow.

3. HIB is at no cost to enrollees entitled to RSDI benefits. It is available on a premium basis to others. HIB payments, supplemented by benefits of the Kentucky Medical Assistance Program, provide for virtually all services ordinarily furnished by a hospital.

4. SMI is available on a premium basis to eligible individuals who enroll during certain enrollment periods. Any individual who does not enroll for SMI at the first available opportunity has their rate increased by 10% for each 12 month period in which they could have enrolled. SMI payments provide for certain medical costs in addition to those covered by HIB.

   Note: An individual cannot be required to take Medicare Part B if their premium would not be covered by Medicaid (MA) through the buy-in program.

5. The amounts of premium payments are recomputed annually, effective each January.

[6. Individuals apply at the SSA office serving the county of residence.]

MS 1360 APPLICATION AFTER DENIAL OF SSI BENEFITS

[Deny MA applications based on disability for individuals denied SSI within the prior 12 months due to an SSA determination of nondisability.] Refer to SSA for reconsideration of their SSI claim, all individuals who allege, within the 12 month period, a disabled condition different from or in addition to that considered by SSA in making their most recent determination.

A. If an individual applies for MA based on disability and more than 12 months have elapsed since the most recent SSA determination denying disability, follow procedures outlined in MS 4660.

B. An individual who believes an SSI denial is incorrect can ask the SSA for a reconsideration within 60 days of the initial SSI denial notice. If a reconsideration is requested within the 60 day period, SSA reviews the application and supporting documentation. If the initial denial is upheld, the claimant may then ask for a hearing within 60 days after the unfavorable reconsideration decision is rendered.

C. If the individual applies for MA in any category within 60 days of an SSI denial based on nondisability and the individual would have been MA eligible in a category other than disability had the individual applied earlier, use the SSI application date as the MA application date.

D. [If an SSI application is denied for reasons other than nondisability, and the individual applies for MA within 60 days of the SSI denial, the date of the DCBS application is the date of the SSI application that was denied.]

MS 1371 AUTHORIZED REPRESENTATIVE (AR) (1)

An authorized representative (AR) may apply on behalf of a Medicaid applicant if the applicant is unable to come into the local office for a face-to-face interview; provided the AR has appropriate written consent.

[A. Form MAP-14, Authorized Representative, MUST be used as the written consent and be presented at the time of application. The MAP-14 is available on the Department for Medicaid Services (DMS) website at: https://chfsnet.ky.gov/dms/pages/forms.aspx. The MAP-14 also authorizes the AR and/or the company representing the client to inquire about the applicant's Medicaid case, including forms completed by the recipient, worksheets, correspondence to or from the recipient, MRT decisions, and non-confidential records.

NOTE: The signature on the form is valid from the date of signature until the applicant or AR rescinds the form or the case discontinues. If the case discontinues due to agency error, a new MAP-14 is not required. An applicant can only have one AR at a time.]

Example: Ivan from Company X applies on behalf of Mr. Jim and provides a completed MAP-14. Betty, also from Company X, takes over responsibility for Mr. Jim's case. Although Ivan made the application and brought in the signed MAP-14, Betty is able to inquire about Mr. Jim's case as the MAP-14 names Company X, not the individual who brought the signed form, as the AR.

B. Form MAP-14 is NOT necessary if the person applying is:

1. The payee of the applicant;

2. The spouse of the applicant if currently married and there is NO existing divorce decree;

3. The court appointed guardian (with documentation);

4. The Power of Attorney (with documentation);

5. The representative of a ICF IID facility; or

6. A potential representative of a nursing facility resident incapable of declaring intent.

Note: If the applicant is hospitalized rather than being in a nursing facility, inability to declare intent does not apply.

[C. If the AR presents a signed MAP-14 at the time of the interview, continue the application process and proceed to item E.

D. If a MAP-14 is NOT presented, complete the following:]

1. Enter the first four pages of the application to protect the filing date.

[2. Give the AR a MAP-14. Advise the AR that the MAP-14 must be completed, before the application interview can continue with the individual as the applicant's AR.]

3. Send an RFI with an appointment to the applicant. The AR does not get a copy of the RFI but is to be informed that the worker is sending an appointment letter to the applicant.

4. If the AR returns with the MAP-14 prior to the scheduled appointment with the applicant, complete the application with the AR.

5. If the applicant keeps the appointment after the AR has returned with the signed MAP-14, use that appointment to confirm the information given by the AR.

6. If the applicant does not keep the appointment, send form PAFS-2, Application Letter or Notice of Expiration, requesting that the applicant contact the worker to confirm the information.

7. If the AR returns after the interview has been conducted with the applicant, advise the AR to contact the applicant.

E. Advise the AR that eligibility determinations may take up to 30 days to be completed from the date the application is filed.

[F. The applicant/recipient is the primary source of information in furnishing verification of financial and technical eligibility. However, the AR may inquire about the Medicaid applicant's case, beyond the application interview, provided that a MAP-14 is on file.]

Note: Local offices have the authority to determine best practice for meeting the needs of the applicants. Therefore, workers are to advise the AR of a feasible time to call and inquire as to the progress of the application. If the AR chooses to ignore the given timeframes of when to contact the worker or if the AR abuses the time of a worker, workers are to send the AR's contact information up through the regional chain of command to allow management to address the AR's concerns.

G. All notices and MA cards are sent to the applicant.

H. Due to HIPAA requirements, if the AR requests a release of information the request must contain the following:

1. The specific information to be released;

2. A specific time frame;

3. An original signature (no photocopies); and

4. To whom the information can be released.

For more on HIPAA requirements refer to Volume I, MS 0160.

MS 1372 [Non-MAGI MA APPLICATION/INTERVIEW PROCESS (1)

All individuals have the right to make an application and receive a decision on their eligibility for Medicaid (MA). Individuals may apply in-person, via telephone by calling the Department for Community Based Services (DCBS) Call Center, online at benefind@ky.gov, or by a home visit for programs administered by the agency. No individual is refused the right to apply even if it appears that eligibility requirements are not met.

Individuals initiating an application or recertification on the benefind self-service portal, are required to complete an interview before the application/recertification can be processed. Individuals applying for the Medicare Savings Program using the mail-in application are not required to complete an interview. For additional information on the mail-in process, refer to MS 4420.

Applications and/or recertifications with an authorized representative (AR) must be completed in-person for a first-time interview if the AR has not been previously established.

The following procedures are followed when conducting an interview:

A. Inquire KAMES, Worker Portal, and SDX to determine if an individual has previously received MA. If so, review the case(s) thoroughly.

B. Run all system checks, i.e. BENDEX, UI Benefits, Wage Records, Vehicle Reg-Avis, the Work Number, etc. to review for potential income and resources.

C. Enter comments on Worker Portal as the interview progresses while the applicant/recipient is still present.

D. Inform individuals of their rights and responsibilities:

1. Provide all mandatory informational pamphlets/forms required at application/recertification. If the interview is by phone, inform the applicant of the forms they can expect to receive and explain which forms, if any, must be signed and returned.

2. Advise the individual that changes impacting eligibility must be reported within 10 days of the date of change, as well as any changes which occur prior to processing the application.

3. Explain the potential for prosecution for committing fraud. Have the individual electronically sign form MA-2, Medicaid Penalty Warning, for in-person interviews. For phone interviews, the client may choose to sign form MA-2 by voice signature. Otherwise, Worker Portal will mail form MA-2 to the individual for signature and the case will pend for its return.

4. Advise the individual of the right to appeal any adverse decision.

5. If the applicant is age 18 or will be 18 before the next election, explain the voter registration process and complete the voter registration question on Worker Portal.

E. Inform the individual of the MA eligibility processes:

1. Explain the KYHealth card is issued upon approval of the application and is used for services not covered by a Managed Care Organization (MCO). Advise the applicant that the KYHealth card is a plastic card which is intended to be permanent. Instruct the applicant not to throw away the card, even if the case is discontinued or the household moves to another county. Advise the applicant/recipient that Medicaid Member Services answers all questions regarding coverage/billing and the phone number is listed on the back of the KYHealth card. For additional information regarding the KYHealth card, refer to MS 1240.

2. Explain retroactive MA coverage and how eligibility is determined. For information regarding retroactive MA, refer to MS 1450.

3. Explain the Managed Care program. For information on Managed Care, refer to MS 1340.

4. Explain third party liability (TPL). Ensure the client understands that MA is always the payer of last resort and any other health or hospital insurance is billed before MA. Enter all health insurance information on Worker Portal.

F. Explain to the applicant/recipient what is required to process the case timely and that the case will be denied if mandatory verification is not returned within allotted timeframes.

Note: Individuals have 30 days to return requested information before the application denies, unless additional time is requested by the individual.

G. Explain the difference between mandatory and optional verification.

H. Explain that additional time can be requested in order to obtain mandatory verification. If additional time is allowed, ALWAYS note in comments why more time is needed and the new due date for return of information.

I. Ensure that all of the applicant/recipient's questions are answered.

J. If the interview is in-person, the application summary can be signed by electronic signature pad or by printing it out and having the individual sign it. If the interview is by phone, the application summary can be signed by voice signature. Otherwise, Worker Portal will mail the application summary to the individual for signature and the case will pend for its return.

Note: The application can be signed by the applicant, the applicant's statutory benefit or Supplemental Security Income (SSI) payee, guardian, power of attorney (POA), or authorized representative (AR). If the application summary is signed by a mark (X), another person, either related or unrelated, must sign the application as a witness. The statutory benefit payee is the payee for the applicant/recipient's SSI or statutory benefits (RSDI, VA, Railroad Retirement).

K. If all verification is provided at the time of the interview, dispose the application/recertification at that time.

L. After the Interview:

1. Individuals may return information or verification by mail, fax, to any DCBS office, to the Centralized Mail Center, or by uploading documentation to the self-service portal (SSP).

2. Scan documentation such as insurance policies, trusts, annuities, Qualifying Income Trusts (QIT's), etc. into the Electronic Case File (ECF). All documents pertaining to eligibility for the current certification period must be scanned into ECF. Do not scan medical records into ECF. Once verification is scanned into ECF, a task is created for a worker to process.

3. Applications for NF and Waiver Services:

   a. Within two days of the interview, send form PAFS-18, to two different banks. If form PAFS-18, Liquid Asset Verification and Invoice for Payment, is not returned within 10 days send a new PAFS-18 to a different bank. Two completed PAFS- 18's are required to process the case.
   b. Within two days of the interview, complete form PA-16 Property Check. If the county of residence is the county where the application is being processed, contact the local PVA office. If the county of residence is not the county where the application is being processed send form PA-16 to the local DCBS office in the county of residence.
   c. Check for property transfers at the County Clerk's office in the applicant's county of residence. This is done in person if the property records check is not available by telephone.

4. If additional information is required from the Medical Support and Benefits Branch (MSBB), send the request to the regional Program Specialist immediately to prevent delays in processing the case.

M. If the individual is physically or mentally disabled or is elderly, provide reasonable accommodation to any special needs the individual may have no matter where the interview is conducted. Accommodation to special needs may include, but is not limited to:

1. Interpreter services for hearing impaired individuals. For information on interpreter services for hearing impaired, refer to Volume I, MS 0220;

2. Additional space for the interview to accommodate an individual in a wheelchair;

3. Scheduling appointments when special transportation services are available; or

4. Making a home visit.

N. If the individual is non-English speaking, obtain interpreter services. For information on interpreter services, refer to Volume I, MS 0230.]

MS 1373* ELECTRONIC SIGNATURE (1)

At each application and recertification, clients have the option of choosing to sign future applications electronically. This only applies to future applications that are submitted via a telephone interview. Clients cannot sign an **initial** application electronically.

Note: Electronic signatures are only permitted for "Z" applications and recertifications and Spend Down applications.

A. These questions will display at disposition for an application or recertification:

1. "Do You Want To Sign Future Applications Electronically, If Eligible?" If "Y", the client must provide a PIN number.

2. "If Yes, What Is The PIN To Be Used For Future Electronic Signatures?" The PIN must be a 4 digit number. The PIN is retained in KAMES. In cases of reapplication, the PIN will display at disposition if the reapplication is within 20 days from the date the case denied or discontinued.

B. At the next application or recertification completed by a telephone interview, "Do You Agree to Submit This Application by Signing Electronically?" "PIN:___" will appear on screen HRKIMA05 of the Application (this is the first screen AFTER the household member screen HRKIMA04). If a PIN for electronic signature has previously been set up for that case and the answer is "Y" to "Pend For Signed Application" and if the reason is "PI", then the "sign electronically" signature fields can be answered:

1. If the client states that they will sign electronically, ask for their PIN number.

2. If the entered PIN matches what is stored in KAMES, the application is considered signed.

3. If the PIN does not match, the client has 2 more attempts. If the correct PIN is not entered on the 3rd attempt, the client cannot sign electronically. In this situation, the application pends for a signed application. The client will have the opportunity at case disposition to request future applications be signed electronically.

C. "Electronically" is printed on the client signature line of applications signed electronically. Comments must include a statement on who the worker interviewed as this is not shown on the signature line.

D. KAMES inquiry indicates if an application was signed electronically.

E. DO NOT enter the client's PIN number in case comments.

MS 1374 APPLICATIONS FOR THE DECEASED (1)

[Applications for the deceased are accepted, but additional requirements apply depending on the nature of the deceased individual's circumstances. Applications for the deceased may be completed by anyone applying on the deceased individual's behalf, such as a spouse, the next of kin, or approved agencies, such as Chamberlin Edmonds.]

A. Accept and process Medicaid (MA) applications made after the applicant's death if:

1. Medical bills were incurred during the 3 months prior to application or in the application month; and

2. The individual was technically and financially eligible at the time services were rendered.

B. Take an application for a Supplemental Security Income (SSI) applicant who dies before SSI entitlement is established or dies before a hearing can be requested and held. See Volume IVA, MS 4662.

C. A field determination of disability can be made if MA eligibility is requested only for the month of death.

D. If an individual is determined eligible for MA and dies prior to case approval, if all technical and financial requirements are met process the application accordingly.

MS 1380 ADULT MEDICAID DOCUMENTATION (1)

[Documentation for Adult Medicaid cases is necessary in order to capture pertinent case information which may conflict with system entries or that requires explanation beyond data found on KAMES inquiry screens. Due to the complexity of Adult Medicaid case work, comprehensive and thorough case comments are crucial with statewide processing of Adult Medicaid cases. Documentation is also necessary to address any unusual circumstances regarding an individual's case.**]**

Along with general items found in Volume I, MS 0130, Documentation, the following is a list of additional items that, though not all inclusive, may be required to be addressed in case comments. Service Region Administrators (SRA) and other management can request added documentation beyond the minimum requirements for areas in which workers have difficulty applying correct policy.

A. Technical Eligibility:

1. Methods used to verify citizenship/identity.

[2. Level of care:

a. How patient status was verified (PRO-Cert); or
b. Changes in level of care.

3. Household composition and reasons for excluding a household member.

4. Residency.

B. Resources:

1. Vehicles; document ownership, whether the vehicles are countable or excluded, and the reason for exclusion.

2. Resources that require a review or approval by the Department for Medicaid Services (DMS) such as: undue hardship requests or lifetime care agreements.

3. Resources that require a review or approval by the Office of Legal Services (OLS) such as: annuities and trusts.

For resources which require a review by DMS or OLS, document when the request was submitted and response was provided. Document the determination and/or case specific instructions provided by DMS or OLS.**]**

4. For LTC cases, document that appropriate forms such as the PA-16, Real Property Verification Request, and PAFS-18, Liquid Asset Verification, are complete. Comment on any resources or transfers found as a result of the asset check.

[5. Life insurance, burial reserves, prepaid burials, pre-arranged funeral contracts, etc. Document how these are considered. If any are excluded, explain how and why they are excluded. Comment on irrevocability or ownership assignment, if applicable.

6. Document that appropriate forms such as MA-33 Supp. A, Checklist for Prearranged Funeral Contract funded by Cash, MA-33 Supp. B, Checklist for Prearranged Funeral Contract funded with Life Insurance, and MA-33 Supp. C, Checklist for Prearranged Funeral Contract funded by a Life Insurance Policy Purchased through the Funeral Home, are complete.

7. Property, including homestead property and non-home real property. Document the fair market value (FMV) and how it was verified. Document how the property is considered. If the homestead is exempt, document the reason for the exemption. If the property is exempt due to effort to sell, document that form MA-10, Reasonable Effort to Sell Checklist, has been completed.]

8. Whether transferred resource penalties apply and why.

9. Inaccessible resources and an explanation of why any resources are not being considered.

C. Income:

1. Income computations which conflict with standard procedures.

2. Unusual expenses and deductions given for self-employment, rental, and farm income.

3. When the $90 disregard is not allowed for VA income such as compensation.

4. Situations where relative responsibility exists.

5. Income that is deemed, conserved or excluded.

[6. If a Qualifying Income Trust (QIT) is required and that form MA-8, QIT Checklist, has been completed.]

D. Community Spouse:

1. Excluded real property, motor vehicles, life insurance, burial reserves, and liquid assets.

2. Disregards and excess shelter expenses increased due to a fair hearing order or a court order mandate.

3. The completion of PA-1A, Sup C, Institutionalized Spouse Resource and Income Statement and two forms PAFS-18, Liquid Asset Verification and Income for Payment.

[4. Resource Assessment has been completed.]

E. Medical Expenses:

1. Retroactive coverage explored and whether or not it was issued.

[2. Third Party Liability (TPL) was explored and the requirement to report other health insurance was explained.]

3. How medical expenses were verified and utilized for Spend Down cases.

4. If the MA effective date for a Spend Down quarter was incorrectly established.

5. Unusual consideration of deductible expenses such as HCBS prescription co-payments.

F. Procedural/Case Record Information:

1. Whether the MA effective date was backdated or if the standard of promptness was not met.

2. Required spot check(s) that were entered.

3. If computer matches were resolved.

4. If a suspected fraud claim referral for Medicaid was completed or if an overpayment of State Supplementation was calculated. Comment on the reason for referral for a fraud investigation and the final determination.

5. Whether information entered on the LTC screen changed.

6. Changes in the certification period.

7. Document any special circumstance or State Supplementation issuance.

8. Program inquiries/directives from Central office.

9. Reasons for any delays in case processing.

10. The household's voluntary request for a denial or discontinuance.

11. All required forms provided.

NOTE: As with ALL programs, DO NOT editorialize, offer personal opinions, or air disagreements in case comments. DO NOT include names of Central Office personnel, regional management, program specialists, or any supervisory staff when specific case mandates are received. Case comments are a part of the official case record, which is subject to review by supervisory staff, Central

Office, Quality Control, Management Evaluation staff, the Hearing Branch, Department for Medicaid Services staff, clients and their legal counsel.

MS 1420 SCOPE OF INVESTIGATION

ALL income and resources MUST BE verified and documented BEFORE authorizing assistance to ensure the applicant meets technical and financial requirements.

A. Verify and document resources for each of the 3 months following approval if resources are near the maximum.

B. If total countable resources exceed limits when a recertification is processed, the case is resource ineligible. KAMES will send a timely notice to discontinue the case effective the first possible month.

C. Determine if medical services were received during any of the 3 months prior to application.

   1. If medical services were received, determine financial and technical eligibility for each of the 3 prior months.

   2. If medical services were not received during any of the 3 months prior to application, retroactive eligibility does not exist.

D. Obtain a nearby telephone number, if available, for any individual that does not have a telephone.

MS 1425* CASE NUMBER ASSIGNMENT

The case number for a KAMES case is the SSN, whether verified or unverified, of the head-of-household.

1. If the head-of-household does not know his/her SSN or has never applied for SSN, assign a pseudo number by entering an “X” on the “Application/Recertification” Menu in the field, “For Option 1, if you wish an SSN assigned, please enter “X”. Refer to SSN Applications, MS 2012.

2. DO NOT manually assign the case a pseudo number unless this is a reapplication which was originally assigned a pseudo number. In this particular instance, enter the same pseudo number.

MS 1430 AUTHORIZING BENEFITS (1)

[Applications for Adult Medicaid are processed on KAMES. Medicaid benefits for non-SSI individuals are issued through KAMES. Medicaid benefits for SSI individuals are issued through SDX but SSI LTC coverage is issued through KAMES.

A. Authorize denials, withdrawals, or approvals by entering case action on KAMES for SSI and non-SSI individuals.

B. When an application for assistance is denied, investigate MA eligibility for the three months prior to application to determine if the individual may be eligible for benefits in the spend down program.

C. For individuals eligible for on-going Medicaid review the three-month period prior to the application month to:

1. Authorize regular MA coverage in any month technical and financial eligibility is met and medical expenses are incurred; or

2. Authorize Spend Down MA coverage on KAMES where technical and resource eligibility factors are met but income exceeds permitted limits.]

MS 1435 PROCESSING SPECIAL CIRCUMSTANCES (1)

[The following are procedures in regards to Non-Modified Adjusted Gross Income (MAGI) Medicaid (MA) and State Supplementation for issuing benefits by special circumstance.

A. Situations when the special circumstance function is used:

1. To authorize a retroactive special payment to correct an administrative error on a denied or discontinued case;

2. To correct MA eligibility for prior months not issued through regular issuance;

3. To issue a vendor payment for an inactive case; and

4. To correct patient liability for an active or an inactive case on Worker Portal.

B. When completing a special circumstance to issue MA or vendor payment, check inquiry to determine if MA eligibility existed for the time period to be covered by the special circumstance action.

C. Special circumstance actions will pend for supervisory approval.

D. The supervisor cannot update or change any data on a pending special circumstance action. Any needed changes must be given back to the worker initiating the action for corrections.

E. Supervisors cannot initiate a special circumstance action.]

MS 1440 [ELECTRONIC CASE FILE (1)

The Electronic Case File (ECF) must contain documentation of eligibility for assistance and contain sufficient material to substantiate validity of all authorized assistance.

A. ECF should contain the following documents, as appropriate:

1. A signed application for each eligibility period when an electronic or voice signature is not used;

2. Income verification;

3. Resource verification;

4. Documentation and verification of technical and financial eligibility;

5. Hearing information that cannot be found in correspondence;

6. Information regarding overpayments and underpayments;

7. Any additional pertinent information or verification; and

8. Information regarding Quality Control review.]

MS 1450 ONGOING/RETROACTIVE MEDICAID (1)

[A separate determination of retroactive Medicaid eligibility is made independent of the ongoing determination.**]**

A. ONGOING ELIGIBILITY

Criteria for Adult Medicaid eligibility must be established for ongoing months in order to approve an application. The effective date of ongoing MA eligibility is:

1. The 1st day of the month;

2. For Medicaid Works recipients, coverage begins effective the date of application. There is no retroactive coverage.

3. The specific day during the 3-month period spend down liability is met.

4. The 1st day of the month the applicant has established permanent residence in Kentucky, if the applicant has moved to Kentucky from another state.

B. RETROACTIVE ELIGIBILITY

To be eligible for retroactive coverage, criteria for Adult Medicaid eligibility must be established and;

1. Medical services must be received during the 3 months prior to application. If the applicant states medical services were not received, document in comments and DO NOT authorize retroactive coverage.

2. If medical services were received, determine if technical, resource, and income eligibility exists for each of the 3 months prior to application. If technical, resource, and income eligibility exists:

   a. In each of the 3 prior months, authorize coverage effective the 1st day of the 3rd month prior to the month of application.
   b. In months medical services were received but income eligibility does not exist, determine spend down status for the months medical services were received.
   c. In one or two of the months, authorize coverage only for the months eligibility exists and medical services were received.

C. Document the case record to indicate the method used to establish months of coverage and that the applicant was given an explanation of retroactive Medicaid coverage.

MS 1470 STANDARD OF PROMPTNESS (1)

[The Department for Medicaid Services (DMS) determines time-frames, policy, and procedures. The Department of Community Based Services (DCBS) is contracted by DMS to determine eligibility for individuals using the policy and procedures set by DMS. All applications must be processed within 30 days of the date of application. The only exception is for those applications requiring a disability determination which must be processed within 90 days.

A. The 30 day time frame allows:

1. The individual time to return the requested information;

2. The Office of Legal Services (OLS) to review annuities and trusts; and

3. Qualifying Income Trusts (QIT's) to be completed.

All applications or reapplications must be acted on promptly. The case is to be processed the day all verification is returned, if possible, but no later than 5 days from the date the information is received. No more than 30 days should elapse between the application date and the approval or denial action date. If the case cannot be processed within the time standard, document in case notes the reason for the delay.

B. For applications when the 30th day falls on a weekend or holiday:

1. If all verification is received before the 30th day, the case must be processed prior to the 30th day.

2. If verification is not received before the 30th day, and the individual has not requested good cause, Worker Portal will deny the case on the 30th day or the first workday following the weekend or holiday.

Cases processed on the first workday following the 30th day are not considered past-due when the 30th day falls on a weekend or holiday.

C. If the case cannot be processed within the time standard due to UNUSUAL CIRCUMSTANCES, document the reason for the delay. Examples of unusual circumstances include:

1. A program inquiry was requested timely but a timely response is not received from MSBB (document in case notes);

Note: To ensure that processing timeframes are met, send program inquiry requests to MSBB on a daily basis through your regional chain of command.

2. Waiting for an annuity, QIT or trust to be completed or reviewed.

3. Within two days of the interview, send form PAFS-18, Liquid Asset Verification and Invoice for Payment, to two different banks. If form PAFS-18, is not returned within 10 days send a new PAFS-18 to a

different bank. Two completed PAFS-18's are required to process the case.

4. The individual, spouse, Power of Attorney (POA), or authorized representative (AR) requests more time to provide mandatory verification such as a copy of an insurance policy, annuity or trust.

5. Delay in receiving MRT decisions for applications involving disability determinations.

6. Delay in receiving the Medicare Explanation of Benefits for spend down cases.

7. Something is discovered that the worker was not aware of at application. Mail a new RFI requesting the additional verification.

Note: If the newly discovered information was worker error, allow additional time if needed and send an RFI with a new due date. However, if the newly discovered information was due to the individuals failure to report, mail a new RFI with an explanation of the additional information that is needed, a new due date is not appropriate, the original due date assigned is left as is.

D. When additional time is requested by the client, ask how much additional time is needed. Provide the client with a new due date and document in case comments. If a case has pended longer than 30 days the client must provide proof of action taken to obtain the mandatory verification such as an email from their attorney or a copy of paperwork sent to their insurance company(document in case notes).

Note: If the applicant cannot show that effort was made to obtain the required documentation, allow the application to deny. Do not assume more time is needed.]

MS 1500 ADULT MA RECERTIFICATIONS/INTERIM CHANGES (1)

[All technical and financial requirements are reviewed to ensure the recipient continues to be eligible for Medicaid. Do not re-determine disability unless form PA-601T, Referral for Determination of Incapacity/Disability, indicates the need for reexamination or an improvement in the condition of the recipient is noted. Recertification interviews may be conducted face-to-face, by telephone, or a home visit. Z case recertifications are completed using the mail-in recertification forms. For additional information on the mail-in process see MS 4500.

NOTE: Telephone interviews are not permitted for Pass Through or long term care (LTC) programs, including nursing facility (NF) and waiver.**]**

A. Refer individuals who have reached 64 years and 9 months of age to the Social Security Administration (SSA) for a determination of eligibility for Medicare benefits.

B. Some Adult MA (including non-SSI LTC, SCL, Hospice, and Waiver Services) cases require a recertification every 12 months. The 12 month period begins the month after the month of approval. Do not change the recertification date as the result of an interim change transaction.

[For QMB, SLMB, QI1 and QDWI cases, recertifications are processed by means of the automated form KIP-2Q, Renewal form for Medicare Savings Plan, and KIP-2QA, Renewal Form for the Medicare Savings Plan – Final Notice. A face-to-face interview or telephone interview may be conducted at the request of the recipient. However, the option to schedule these cases for a face-to-face interview is not available on KAMES.**]**

C. Recertification appointments must be entered on the appointment scheduling screen.

1. System-generated appointment letters are mailed for interview types “RC”, recertification interview, and “HR”, recertification interview that is rescheduled. Other interview codes, such as “RV”, block out time but do NOT send notices. The interview types are listed on the Appointment Calendar Screen and the KAMES Codes List at the bottom of screen HRKIMP02.

2. On the 8th day of the month, the list of Cases Requiring Recertification appears on the worker’s DCSR. If the 8th falls on a weekend or a holiday, the list will appear the next work day after the 8th. The last day to schedule recertifications is the 15th calendar day of the month. If the 15th day falls on a weekend or a holiday, the last day to schedule recertification appointments will be the last work day prior to the 15th of the month. Print the list and schedule recertification appointments as follows:

   a. On the Main Menu select “D”, Appointment Scheduling, press enter, and the Appointment Calendar screen appears.

b. Enter the date as MMDDYYYY, press enter, and the Appointment Calendar appears.

c. Enter the "case number" and type "RC" to schedule an appointment and generate an appointment letter. The system permits you to schedule appointments 7 days a week, including weekends and holidays, from 7:00 a.m. to 6:30 p.m.

d. If a SNAP case and IM case with the same head of household are scheduled on the same day in adjacent time slots, a joint appointment notice is sent.

1) List both appointments on the calendar before pressing enter.

2) The appointment time listed on the notice will be that of the earlier appointment.

3) If not scheduled by a worker these cases will automatically be scheduled together in one hour time slots if an hour time slot is available.

e. Reschedule a recertification appointment by using interview type "HR". If rescheduled before the 15th of the month (or the last work day prior if the 15th is a weekend or holiday), only the rescheduled appointment generates a notice.

3. When a case appears on the list of Cases Requiring Recertification and is later reassigned between caseworkers, use the following procedures:

a. Reassignments completed between the 8th and the day before the system automatically schedules appointments will appear on the worker's DCSR the day following the reassignment. The new caseworker must schedule the appointment for recertification. If the previous worker has already scheduled an "RC" appointment, "HR" is used to reschedule the appointment.

b. Reassignments done on the last day for workers to schedule appointments will have the appointment scheduled to the caseworker the case was reassigned to, if there are openings on the new worker's calendar.

D. Complete a face-to-face interview in the local office or a home visit for individuals institutionalized in a nursing facility. In unusual circumstances, such as the statutory payee or guardian lives out of state, a telephone interview may be completed.

E. Process an interim case change if:

1. A spot check is posted displaying a change in the household circumstances; or

2. A change is reported at any time. Take action on reported changes within 10 days.

MS 1505* NO SHOW RECERTIFICATIONS (1)

The following explains the procedures related to the automatic discontinuance of Medicaid cases for failure to keep recertification appointments.

A. When an individual fails to keep a recertification appointment, form KIM-105.5 is generated that evening to inform the individual that the case will be discontinued. At the end of the 10-day timely notice period, the system discontinues the case.

Example: The individual fails to keep an appointment on 6/3. The KIM-105.5 is generated the evening of the no show appointment. The case discontinues the evening of 6/13, effective 7/1.

B. KAMES recognizes only one rescheduled recertification appointment if the appointment is rescheduled on KAMES no later than the end of the day of the first scheduled appointment.

Example 1: The individual is scheduled for a recertification on 6/6. The individual calls on 6/5 to reschedule her appointment to 6/12. The worker reschedules the appointment on KAMES that same day. Form KIM-105.5 is not generated on 6/6, but if the individual fails to show on 6/12, form KIM-105.5 will be generated the evening of 6/12.

Example 2: The individual is scheduled for a recertification on 6/3. The individual fails to show and form KIM-105.5 is generated the evening of 6/3. On 6/6, the individual calls to reschedule her appointment for 6/11. If the individual fails to keep her 6/11 recertification appointment, the case will discontinue the evening of 6/13. The discontinuance date of 6/13 was set based on the individual failing to show for the original 6/3 recertification date because she did not reschedule her appointment on or before 6/3.

If the individual reschedules a second time or more, even when the additional appointments are rescheduled on KAMES, the system only recognizes the first rescheduled appointment date in applying the no show recertification process. If the original appointment on KAMES is rescheduled due to a conflict in the worker's schedule, this counts as the first rescheduled appointment.

C. If the appointment is not kept, or rescheduled on or before the first appointment date, the auto discontinuance process starts and the case discontinues at the end of the 10-day period, or cutoff, whichever comes first.

1. If during the 10-day period, the individual reschedules, keeps the appointment and the RECERTIFICATION is entered on KAMES within the 10-day period, the case will not discontinue.

2. If a recertification is not entered by the 10th day of the timely notice period, the case will discontinue.

3. If an individual calls to reschedule the recertification appointment prior to the end of the 10-day period, but the appointment cannot be rescheduled until after the expiration of the 10-day period, when the individual keeps the rescheduled appointment, an application must be entered on KAMES.

4. If the timely notice period expires after the monthly cutoff date, the system discontinues the case at cutoff. In this instance, if the individual comes in for recertification during the 10-day period (but the case discontinued at cutoff), an application must be entered on KAMES.

D. The case is entered as a REAPPLICATION if the case is correctly discontinued (e.g., the individual failed to show or call to reschedule his/her recertification appointment prior to the end of the 10-day period).

MS 1510 [TIMELY NOTICE OF DECREASE/DISCONTINUANCE

If information in an MA case indicates reduction or discontinuance of benefits for any or all members in a case, the client must be notified of the proposed action 10 calendar days prior to the effective date, unless one of the exceptions to the timely notice requirement applies. The 10-day period is the timely notice period.

A. KAMES sends form KIP-105 when the change is entered on the system. If the system issued notice has an incorrect denial/discontinuance reason, immediately send a manual form MA-105, Notice of Eligibility or Ineligibility, informing the client of the correct denial/discontinuance reason.

B. Case changes entered on the system with a timely notice period expiring on or before the monthly KAMES adverse action date for the current month are effective the following month.

Example: Client reports an increase in income on 10/5/10. The change is processed on 10/9/10. KAMES issues form KIP-105 notifying client of adverse action. Because the change was processed PRIOR to adverse action, the change will be effective 11/1/10.

C. If the timely notice period does not expire in the month the KIP-105 is sent, action is taken by KAMES the day following the expiration of the timely notice period, and is effective the next administratively feasible month.

Example: Client reports an increase in income on 10/11/10. The change is processed on 10/25/10. KAMES issues form KIP-105 notifying client of adverse action. Because the change was processed AFTER adverse action, the change will be effective 12/1/10.

D. The following situations are EXCEPTIONS to the 10-day timely notice:

1. Death of a recipient has been verified.

2. Location of the recipient is unknown and mail has been returned.

3. The recipient has moved out of state or it has been verified that assistance has been applied for or approved in another state.

4. The recipient enters a penal or correctional facility, or is under age 65 and enters a TB hospital or is between age 21 and 65 and enters a mental hospital.

5. A recipient requests discontinuance by a signed statement.

6. Time limited Medicaid is terminated and the recipient was informed in writing at the time of approval that automatic termination at the end of a specified period or under specified conditions would take place.

7. A state supplementation recipient has entered a long term care facility resulting in vendor payment status.]

MS 1530 REASONS FOR NEGATIVE ACTION (1)

[Denials and discontinuances result from failure to meet technical or financial eligibility requirements for Medicaid (MA), failure to comply with technical requirements to meet patient status, or for other reasons. Worker Portal generates negative action notices when income increases or medical expenses decrease. The MA-105, Notice of Eligibility or Ineligibility, is only completed if Worker Portal does not generate the required notice. Prepare form MA-105 according to procedural instructions in the Forms Manual on the DCBS Intranet and give a brief but thorough and easily understood explanation of the reason for the action. Refer to one of the following reasons for negative action:

A. Financial reason:

1. Income or resources exceed MA standard;

2. Income has increased;

3. Medical expenses decreased;

4. Ineligibility period is still in effect;

5. Ineligible due to transfer of resources; or

6. Income or resources within SSI standard.

B. Technical eligibility does not exist:

1. The individual is not age 65, disabled, or blind;

2. The individual is not under age 21 and an inpatient of a psychiatric hospital;

3. Other technical reason, such as individual living in a public institution;

4. Citizenship requirements are not met; or

5. Individual receives, has applied for or has reconsideration rights for Supplemental Security Income (SSI).

C. Failure to comply with technical requirement:

1. Failure to fully complete or return application forms;

2. Failure to keep an appointment for an interview; including an OIG interview;

3. Failure to provide sufficient information or clarify conflicting information so that a determination of eligibility could be made;

4. Failure to provide birth verification;

5. Failure to explore eligibility for entitled benefits, e.g., Veterans Benefits, Railroad Retirement Benefits, pensions, IRA distributions, Black Lung Benefits, Social Security Benefits, etc.; or

6. Disqualified, no extraordinary circumstance.

D. Failure to meet patient status.

E. Other reasons, including:

1. Request of individual or formal withdrawal;

2. Inability to locate;

3. Change of agency policy; or

4. Individual is not a resident of Kentucky.]

MS 1540 MISREPRESENTATION AND FRAUD (1)

[Medicaid (MA) fraud occurs when a client deliberately makes a false or misleading statement or withholds factual information in order to receive MA benefits, permits an individual not listed on the KYHealth card to obtain health care benefits, or misuses an MA covered service, such as medical transportation, for a non-medical purpose.

If a worker discovers that a recipient or responsible party withheld information in order to receive MA for which they were not entitled, refer to Volume I, MS 1240.

If an individual reports fraud regarding MA to the Department for Community Based Services (DCBS), provide the Office of Inspector General (OIG) toll-free fraud hotline telephone number at 1-800-372-2970.

If situations of suspected provider fraud or abuse are reported, send a memorandum with a summary of the situation to OIG at the address below or email OIG at CHFS.fraud@ky.gov. Attach a copy of any available documentation with the OIG memorandum. Scan the original documentation into the Electronic Case File (ECF).

Office of Inspector General
Division of Audits and Investigations
275 E. Main Street, 5E-D
Frankfort, Kentucky 40621-0001]

MS 1547 [RECIPIENTS MOVING INTO OR OUT OF KENTUCKY

System edits in KAMES prevent individuals from receiving duplicate benefits within the state of Kentucky. However there are no system edits available to prevent duplicate benefits for individuals who move into Kentucky and have received out-of-state benefits or for individuals who move out of Kentucky and apply in their new state of residence. In order to avoid overlapping Medicaid eligibility for individuals or households who move into Kentucky or move out of Kentucky follow these procedures:

A. Recipients Moving Into Kentucky

For applications with members who received in another state:

1. Contact the other state to determine the effective date of discontinuance;

2. If the benefit period from the other state is still in effect take a hardcopy application;

3. Deny the application for the months already issued in the other state. Issue by a special circumstances action any remaining period of eligibility.

Example: Client applies on September 5. The other state has advised that their effective date of discontinuance will be September 10. The first day of potential eligibility in Kentucky is September 11. Deny the application for the month of September and approve ongoing benefits beginning October 1. Authorize benefits by special circumstance for the time period of September 11 through September 30.

4. Document the action in comments.

B. SSI Recipient Moving Into Kentucky

SSI recipients who move from another state into Kentucky and require medical services can receive a KY Health Card use based on the following:

1. SSI and Medicaid eligibility is on the SDX system; or

2. The Social Security Administration verifies to the Medical Support and Benefits Branch (MSBB) that eligibility exists.

Send the recipient's name and social security number to the program specialist who will then forward to MSBB. MSBB will contact SSA to verify eligibility. If eligibility is verified MSBB issues the eligibility.

C. Recipients Moving Out of Kentucky

When an individual contacts the local office to have their case benefits discontinued because they have moved out of the state close the case effective the next feasible month.

If the applicant is unable to obtain Medicaid coverage in another state because Kentucky has issued Medicaid coverage for a specific month, the applicant may request immediate termination of Kentucky Medicaid. Refer out-of-state recipients requesting immediate termination of Medicaid to the Member Services Branch, at (800) 635-2570 or (502) 564-2574.

Note: DMS will require the individual to provide a signed statement requesting that Medicaid coverage be terminated. If no medical claims have been paid on the recipient's behalf for the requested month of termination, DMS will provide a written statement verifying Medicaid termination effective with the requested month.

D. Individuals from other states who need information regarding Medicaid are referred to the Member Services at 1-800-635-2570.]

MS 1550 INTRODUCTION

Technical eligibility based on age, blindness or disability uses the SSI criteria for the specific factor and is established for all non-SSI beneficiaries except:

A. Persons losing SSI status due to income or resources, including moving into long term care; and
B. Persons for whom technical eligibility has previously been established for another state program.

MS 1560 ENUMERATION

A. As a condition of eligibility, require each applicant for or recipient of MA or State Supplementation to furnish a social security number (SSN) or apply for a number if one has not been issued.

B. Approve applications, add members or continue eligibility during the period pending issuance of a number by SSA.

C. Enumeration requirements are unchanged for anyone who does not have an SSN. Refusal to enumerate carries possible exclusion from benefits if requirements are not met.

D. Verification procedures for MA approvals or active cases on the PA-62 System.

1. Review the case record during each application/recertification to determine if enumeration is complete.

2. Enter the SSN for all MA individuals on form PA-62.

3. **[**Accept applicant's statement as verification of SSN**]**.

4. If an individual who must be enumerated is not currently enumerated, complete form SS-5, Application for a Social Security Number Card, if:
   a. **[**A verified SSN application has not been completed in the past 75 days.
   b. Or the individual is NOT an alien or a person requiring a mandatory in-person interview.**]**

5. If application for a social security number with SSA is verified, do not complete form SS-5. Obtain a copy of verification for the case record.

E. Verification procedures for MA approvals or active cases on KAMES.

1. **[**Enter "CS" for verification of the individual's stated SSN.**]**

2. Validation of all SSN's entered on KAMES is outlined in Volume VI, MS 1500.

3. **[**SVES procedures are outlined in Volume VI, MS 1505.**]**

F. For additional information on enumeration, refer to Volume I, MS 0650 and MS 0653. Refer to Volume I, MS 0656 for information concerning the SSN application process.

MS 1562* SSN APPLICATIONS

If an application for an SSN with the Social Security Administration (SSA) is verified, do not complete form SS-5, Application for a Social Security Card. Obtain a copy of the signed system-generated receipt issued by SSA for the case record.

Form SS-5 is available on the SSA website at: http://www.ssa.gov/ssnumber/. In completing form SS-5 for a member, verify the date of birth, identity, and citizenship of the individual using evidence required by SSA and procedures for form SS-5.

Ensure each individual who completes form SS-5 understands the use of the number and has read and understands "The Privacy Act and Your Request for a Social Security Number" which is printed on page 4 of form SS-5.

To preserve the anonymity of the natural parents and to assure the contents of the original case record remain confidential for children placed for adoption or subsidized adoption, follow enumeration procedures outlined on the SSA website at the above address.

A. VERIFICATION. Acceptable proofs of age include:

1. Birth certificate from any hospital NOT shown in the appendix to the procedural instructions for form SS-5;

2. Verification of birth registration (Notification of Birth Registration issued by Vital Statistics);

3. Kentucky Vital Events (KVETS) Birth Index File data;

4. Hospital record;

5. Baptismal record;

6. School record; and

7. INS records.

If a birth certificate, birth registration, baptismal record, etc., is used for proof of date of birth, additional verification is required to establish that the document is actually that of the applicant. Procedural instructions to form SS-5 give a complete listing of acceptable evidence of age and identity. Any document showing a birth place in the United States establishes citizenship.

DO NOT use one document to verify both age and identity (e.g., driver's license); a driver's license verifies identity only. An additional document to verify age is required.

Applicants born outside the United States, Puerto Rico, Guam, U.S. Virgin Islands or American Samoa must prove legal entry into the United States or present proof of citizenship

B. INTERVIEWING. The SSA conducts the required face-to-face interviews for all individuals age 12 or over applying for the first SSN card.

C. PROCESSING. Send completed forms SS-5 along with original verification of birth and identity each week to the Regional or District SSA office serving the specific county, unless the applicant wishes to submit the application himself/herself. SSA is responsible for returning original verification to the applicant.

1. Enumeration is completed by entering an SSN change on KAMES immediately upon receipt of the verified SSN.

2. Spot check the case at 90 days for the receipt of the SSN. Contact the member to determine if the member has received the SSN. Spot checks are posted to the DCSR Report Menu, Pending Case Actions, Expiring Enumeration.

   a. If the member has received the SSN, manually enter the SSN.
   b. If the member has applied for the SSN but has not received the SSN, reinitiate the SS-5 process.

3. At recertification, review the case to ensure enumeration is complete and the SSN has been entered for all members.

MS 1564* FAILURE TO COMPLY WITH ENUMERATION

A. Failure to comply with enumeration requirements means:

1. A statement of intent not to provide/apply for a SSN;

2. Failure to apply for a SSN; or

3. The member fails to supply documentation required for completion of form SS-5 without good cause. As long as a good faith effort is being made to provide the SSN, good cause exists for failing to provide the number.

B. Technically exclude the members, other than a deemed eligible newborn, who are not enumerated. A member technically excluded for enumeration may be included in the MA family size if advantageous to the assistance group.

The excluded household member becomes eligible upon providing the Agency with a SSN or applying for a SSN at the local office, if otherwise eligible.

MS 1566* ENUMERATION GOOD CAUSE CRITERIA

Good cause criteria for non-cooperation with enumeration requirements are as follows:

A. If the household member, based on religious grounds refuses to provide an SSN, the member has good cause for failing to comply.

B. If the household member is unable to provide evidence such as out-of-state birth records which are necessary for completing form SS-5, the member has good cause for failing to comply as long as he is making a good faith effort to obtain the evidence.

If you question whether the member is making a good faith effort to obtain the out-of-state birth records, require the household to provide verification such as copies of letters sent to request the information.

MS 1568* USE OF THE SSN

The Department for Community Based Services is authorized to use SSN's in the administration of benefit programs. The SSN is used in the following ways:

A. Access BENDEX information regarding individuals who currently receive K-TAP, MA, or State Supplementation benefits and receive benefits under Title II of the Social Security Act (RSDI);

B. Access the State Data Exchange (SDX), to determine if any household member is currently receiving SSI income and the amount;

C. Access other computer files available to the Department, e.g., IEVS, UI, etc.; and

D. Prevent duplicate participation and determine the accuracy and/or reliability of other income information given by households, e.g., wage records.

MS 1570 [CITIZENSHIP AND IDENTITY REQUIREMENTS FOR ADULT MA]

All individuals applying for Medicaid must present proof of citizenship and proof of identity as a technical eligibility requirement or they must present proof that they are a qualified alien as specified in MS 1577 to be eligible for MA, including State Supplementation. Aliens currently in this country on a temporary visa, including students and tourists, may be eligible for a time-limited medical card if an emergency medical condition exists. See Vol. IVA, MS 1578.

[Applicants who declare U.S. citizenship status but do not have adequate citizenship verification at the time of application can be approved for benefits for up to 90 days from the date of application while they attempt to obtain mandatory citizenship verification.

Benefits cannot be denied, delayed, reduced or terminated for a period of up to 90 days from the date of application for individuals who are determined otherwise eligible and have provided all other mandatory verification while the individual is attempting to obtain the mandatory citizenship verification. See MS 1575 for additional information on the 90-day time frame.]

These citizenship and identification procedures have no effect on Medicaid eligibility determinations for qualified aliens per procedures outlined in MS 1577.

A. Citizenship requirements for all MA programs are as follows:

1. The following individuals are not required to verify citizenship or identity:

   a. Deemed eligible newborns under age 1;
   b. Two-Month Emergency Time-Limited Medicaid applicants;
   c. SSI individuals;
   d. Medicare recipients;
   e. Foster care children;
   f. Subsidized adoption Title IV-E children; and
   g. RSDI recipients receiving benefits based on disability.

2. All other individuals must present verification of citizenship. The document must be original and show a U.S. place of birth or that the person is a U.S. citizen. First look for verification of citizenship from the primary tier, Tier 1. If verification cannot be obtained

   from Tier 1, look into subsequent tiers for possible acceptable forms of verification. When verification of citizenship is obtained from tiers 2, 3, 4, or if notarized statements are used, verification of identity must also be provided. If verification of identity is required, the verification must be an original document.

The following are the tiers of acceptable verification.

a. TIER 1 (highest reliability)
Acceptable primary documentation for identification and citizenship may be one of the following:
1) A U.S. Passport;
2) A Certificate of Naturalization (DHS Forms N-550 or N-570); or
3) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).

b. TIER 2 (satisfactory reliability)
Acceptable secondary documentation to verify proof of citizenship:
1.) A Certification of Birth issued by the Department of State (Form DS-1350, FS-240 or FS-545);
2.) A U.S. birth certificate (workers may print a copy of a birth certificate from KVETS, the birth index file search program). Workers may access the website for vital statistics to obtain information for the applicant/recipient on how they can request birth certificates from other states at http://www.vitalchek.com/listphone.asp;
3) A U.S. Citizen I.D. card (DHS Form I-197 or I-179);
4) The SAVE database confirms citizenship for naturalized citizens;
5) An American Indian Card, Form I-872, issued by the Department of Homeland Security with the classification code "KIC";
6) Final adoption decree;
7) Evidence of Civil Service employment by the U.S. government before June 1976;
8) An official military record of service showing a U.S. place of birth; or
9) A Northern Mariana Identification Card, Form I-873.

c. TIER 3 (satisfactory reliability – use only when primary or secondary evidence is not available)

Acceptable third-level documentation to verify proof of citizenship:
1.) U.S. hospital birth record on hospital letterhead that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth. (DO NOT accept a souvenir birth certificate.);
2.) Life, Health or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date;
3.) Religious records recorded in the U.S. within three months of the birth; or
4.) Early school records.

d. TIER 4 (lowest reliability)
Acceptable fourth-level documentation to verify proof of citizenship:

1) Birth records of citizenship filed with Vital Statistics within five years of the birth; or
2) Federal or State census record showing U.S. citizenship or a U.S. place of birth for persons born 1900 through 1950. The applicant or worker completes Form DC-600, Application for Search of Census Records and Proof of Age. In remarks, state U.S. citizenship data requested for Medicaid eligibility. This form is on the U.S. Census website at http://www.census.gov; or
3) Institutional admission papers from a nursing home, skilled nursing care facility or other institution that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth; or
4) A medical (clinic, doctor, or hospital) record created at least 5 years before the initial Medicaid application date that indicates a U.S. place of birth unless the application is for a child under age 5; or
5) Indian tribal records. Forward this type verification to the Medical Support and Benefits Branch for approval by the Department for Medicaid Services.

e. LAST RESORT

Notarized statements may be accepted for citizenship verification only when no other documentation is available. Naturalized citizens are permitted to utilize this process as well.

Procedures are as follows:

1.) Written notarized statements MUST be signed under penalty of perjury, from two individuals of which only one can be related;
2.) These two individuals MUST have personal knowledge of the events establishing the applicant's claim of citizenship. At least one statement must contain information regarding why other documentation is not available;
3.) The person signing the notarized statement must provide proof of his/her own citizenship and identity.

B. [Identification requirements for MA programs for individuals 16 and older are as follows:

1. Individuals who provide acceptable primary documentation from Tier 1 have met the identification technical requirements for MA.

2. Individuals who verify citizenship by documentation items listed in Tiers 2, 3 or 4, as well as those signing notarized statements for applicants, must also provide proof of identification. Acceptable original documentation to verify identity consists of the following:

a. Current state driver's license bearing the individual's picture or state identity document with the individual's picture; or
b. Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document; or

c. Other official documentation issued by the state in which the individual resides; or
d. The use of three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas, and employer ID cards; or
e. Data matches or documentation from other agencies which include:
    1) SNAP (for head of household only);
    2) Child Support;
    3) Law enforcement;
    4) Correctional agencies, including juvenile detention;
    5) Division of Motor Vehicle records;
    6) Expired driver's license – unless questionable;
    7) Protection and Permanency documentation, including materials relating to child protection; or
    8) Other official documentation issued by local, state or federal governments from the individual's place of birth or residence.
f. The facility director or administration may attest to the identity for disabled individuals in a residential care facility.
g. An affidavit or notarized statement signed under penalty of perjury by a parent or guardian attesting to the child's identity for children age 16 or older.]

C. [Identification for children age 16 or younger may be documented by one of the following:]

a. School identification card with a photograph;
b. Military dependent's identification card if it contains a photograph;
c. School record that shows date and place of birth and parent(s) name;
d. Daycare or nursery school record showing date and place of birth;
e. [Form KIP-106, Attestation of Identity, can be generated and used to verify the identity of children under the age of 16 applying for Medicaid, when no other proof of identity is available.
Note: Form KIP-106 can only be generated at application, program transfer or recertification.]

As always, assist individuals who encounter any difficulty in obtaining documentation for verification of identification and citizenship. Please be especially mindful of potential challenges facing the elderly, the disabled, the blind and those coping with other types of limitations.

MS 1575

ADULT MA CASE PROCESSING FOR CITIZENSHIP VERIFICATION

(1)

To be eligible for MA, an individual must be a citizen of the United States or qualified alien.

A. If the applicant declares qualified alien status follow procedures in Vol. IVA, MS 1577.

B. If a client has verification of citizenship at the time of the application, re-application or member add, answer a "Y" to the question, "IS HE/SHE A U.S. CITIZEN?" and enter the citizenship verification source original record "OR" or written statement "WS". Document the original citizenship verification source in case comments and copy verification for the case record.

[C. If the applicant declares United States citizenship but does not have adequate verification:

1. Accept the applicant's statement and approve benefits by answering a "Y" to the question, "IS HE/SHE A U.S. CITIZEN?".

2. Enter the citizenship verification source "CS".

3. Explain to the applicant they are being approved to receive benefits for up to 90 days from the date of application while they attempt to obtain the required citizenship verification.

D. System processing when verification is not provided:

1. A file is sent to the Social Security Administration (SSA) for verification of citizenship for all members that are pending or new approvals with a "CS" verification source.

2. If citizenship is not verified by the SSA, a Request for Information (RFI) is sent by KAMES to the member advising them they have 90 days to verify.

If verification is not returned within the first 60 days from the date of application, a 2nd notice is sent by KAMES requesting verification of citizenship be returned within 30 days. If verification is not received after the 30 days the system change the "CS" verification source to "NV", not verified. The member is removed from the case and is not eligible until citizenship verification is provided.

Note: If the verification source of "CS" was manually removed and verification is not returned the system applied verification code of "98" appears discontinuing Medicaid for that member.

The case will remain active for the members that have met the citizenship and identity requirements if all other technical and financial requirements have been met.

3. Do not deny, delay, reduce or terminate benefits for a period of up to 90 days from the initial application for benefits. If the member is removed from case but provides verification that they are making a good faith effort and the delay in obtaining the documentation is beyond their control, issue eligibility for missed months of coverage once verification is received.

   Note: Assist the applicant in obtaining documentation if feasible however the burden of providing verification lies with the applicant.

E. If the member(s) removed for failure to verify citizenship reapplies for Medicaid, either by reapplication or member-add, they must provide verification of citizenship to be reapproved for Medicaid. The “NV” or “98” verification source cannot be replaced with “CS” for citizenship as the member has already been provided 90 days to verify citizenship and failed to respond. The client is advised the member will not be approved until verification is received.]

F. ACCEPTABLE worker entered verification source for citizenship are;

1. WS (written statement);

2. OR (original record);

3. CS (client statement); or

4. Not Verified (NV)

Any other codes entered will trigger an error message and the screen cannot be exited.

G. Individuals who are receiving Medicare Part A, Medicare Part B or who are conditionally enrolled in or are entitled to enroll in Medicare Part A are not required to verify citizenship as they have already provided this information to the Social Security Administration. Enter a “Y” to the question, “IS HE/SHE A U.S. CITIZEN?” and enter the citizenship verification source “OR”.

[H. Applications in behalf of a deceased individual are not allowed 90 days to provide verification of citizenship as the individual is not being denied access to services while the documentation is located.

I. Individuals applying for spend down are allowed the 90 days to return verification of citizenship. The application is processed if otherwise eligible and the individual is attempting to obtain satisfactory citizenship verification. If the case is inactive when verification is received, file in the case record for future applications as the individual is not allowed another 90 days to provide verification.]

MS 1577 CRITERIA FOR QUALIFIED ALIENS (1)

[Individuals must be U.S. citizens or qualified legal aliens to receive Medicaid benefits. Nationals of Puerto Rico, U.S. Virgin Islands, American Samoa, the Northern Mariana Islands or Swain's Island are equivalent to U.S. citizens. Qualified legal aliens are individuals that have been granted legal immigration status through the U.S. Citizenship and Immigration Services (USCIS). Depending on how a qualified alien acquired qualified legal status is what determines if they are subject to the 5 year date of entry ban imposed by Medicaid.

A. The following qualified aliens are subject to the 5 year date of entry ban imposed by Medicaid and cannot receive Medicaid (except for the time-limited MA, see MS 2038) until they have remained in qualified alien legal status for at least 5 years from their date of entry into the United States:

1. Aliens lawfully admitted for permanent residence ON or AFTER August 22, 1996;

2. Aliens paroled in the U.S. under Section 212(d)(5) of the INA for a period of one year. If INS document I-94 indicates the individual will be in U.S. for at least 1 year, eligibility may potentially start after parolee status is granted;

3. Any individuals listed in item B. 6 below that have a final, non-appealable, legally enforceable order of deportation or exclusion entered against them; they are NOT eligible under the provision listed below in B. 6.

4. Aliens who are battered or subjected to extreme cruelty in the U.S.

   a. Either as an adult or as a child if battered or subjected to extreme cruelty by:
      1) A spouse or a parent of the alien without the active participation of the alien in the battery or cruelty; or
      2) A member of the spouse or parent's family residing in the same household as the alien – and the spouse or parent consented to the battery or cruelty;
   b. The battered individual must:
      1) No longer reside in the household with the individual responsible for the battery or cruelty;
      2) Have a substantial connection between the battery or cruelty and the need for the benefit; and
      3) Have been approved or has a petition pending for:
         a) Status as a spouse or child of the U.S. citizen;
         b) Status as a permanent resident alien;
         c) Suspension of deportation status pursuant to Section 244(a)(3) of the INA.B

   Note: "Battered or subjected to extreme cruelty" means an individual who has been subjected to:

1) Physical acts that resulted in, or threatened to result in, physical injury to the individual;
2) Sexual abuse;
3) Sexual activity involving a dependent child;
4) Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities;
5) Threat of, or attempts at, physical or sexual abuse;
6) Mental abuse; or
7) Neglect or deprivation of medical care;

B. The following qualified aliens can receive Medicaid and are <u>not</u> subject to the 5-year ban from their date of entry:

1. Aliens lawfully admitted for permanent residence before August 22, 1996;

2. Afghan and Iraqi aliens who are granted special immigration status under Section 1059 of the National Defense Authorization Act (NDAA) of 2006 or Section 1244 of the NDAA of 2008 are treated in the same manner as refugees admitted under Section 207 of the Immigrations and Nationality Act. These Iraqi and Afghan aliens served as translators for the U.S. military. This special immigration status also applies to their spouses and unmarried dependent children. The law applies to Afghan and Iraqi aliens who were already in the U.S. with special immigration status on the effective date of the law, December 19, 2009, and who enter on or after that date.

3. Refugees who were admitted under Section 207 of the Immigration and Nationality Act (INA) and asylees who were granted asylum under Section 208 of the INA.

   Note: Sometimes refuges and asylees are granted permanent legal resident status after only 1 year of being admitted into the United States. Their status changes from being covered under sec. 207 or 208 of the INA act to being covered under sec. 209 of the INA act. Individuals covered under sec. 207, 208 or 209 are not subject to the 5 year entry ban.

4. Children under the Child Citizenship Act of 2000, who automatically acquire citizenship on the date that all of the following requirements are satisfied:

   a. At least one parent is a U.S. citizen whether by birth or naturalization;
   b. The child is under 18 years of age; and
   c. The child is residing in the United States in the legal and physical custody of the citizen parent pursuant to a lawful admission for permanent residence.

   The parent can apply for a Certificate of Citizenship by filing Form N-600. They can also apply for a U.S. passport. If the applicant has other documentation that verifies the parent to the child is a U.S.

citizen, such as the child's birth certificate or the parent's birth certificate, this can be used and the Certificate of Citizenship is not necessary.

5. Aliens who are verified by the Office of Refugee Resettlement (ORR) to be victims of human trafficking, and eligible relatives. Refer to Vol. I, MS 0562.

6. Aliens granted status as a Cuban and Haitian entrant (as defined by Section 501(e) of the Refugee Assistance Act of 1980) whose I – 94 is annotated with the words "refugee".

   Section 501(e) defines Cuban and Haitian entrants as any individual who is:

   a. Granted parole status as a Cuban/Haitian entrant (status pending);
   b. Granted parole status as a Cuban/Haitian entrant under Section 212 which is considered in the same manner as those entering under Section 501.
   c. Granted any other special status established under INA laws for these nationals;
   d. Being a national of Cuba or Haiti, paroled into the U.S. and has not acquired another status under INA;
   e. Subject to exclusion or deportation proceedings under INA; or
   f. Having an application for asylum pending with Immigration and Naturalization Service (INS).

      If any of the individuals listed in item 6 have a final, non-appealable, legally enforceable order of deportation or exclusion entered against them, they are NOT eligible under this provision.

7. Aliens granted status as a Cuban or Haitian refugee who present an I-551 with a category status of 'CU6' (for Cuban refugee), 'HA6' (for Haitian National paroled under Haitian Refugee Fairness Act), or 'RE6' (Refugee who entered the U.S. on or after Apr. 1, 1980).

8. Aliens admitted as an Amerasian immigrant under Section 584 of the Foreign Operations Export Financing and Related Programs Appropriation Act of 1988 (letter coded AM-1, AM-2, AM-3, AM-6, AM-7 and AM-8);

9. Aliens whose deportation is being withheld (I-94 annotated with the words political asylees) under Section 243(h) of the INA or after April 1, 1997, the renumbered Section 241(b) of the INA;

10. Permanent resident aliens who are veterans honorably discharged for reasons other than alien status, their spouses or unmarried dependent children;

11. Permanent resident aliens who are on active duty, other than active duty for training in the Armed Forces of the United States and fulfills

the minimum active duty service requirements established in 38 U.S.C. 5303A(d), their spouses or unmarried dependent children;

12. Aliens who are granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to 4/1/80;

C. Aliens designated as PRUCOL, permanently residing under color of law, are NOT eligible for Medicaid (except for time-limited MA, see MS 1578).

D. The unqualified aliens may receive for their children if the children are citizens or qualified aliens.]

MS 1578* TIME-LIMITED MA ELIGIBILITY

Effective October 1, 1999, any alien, legal, illegal or legalized who, does not meet the qualified alien requirements for ongoing MA, may be eligible for time-limited MA due to an emergency medical condition. Aliens currently in this country on a temporary visa, including students and tourists, may be eligible for time-limited emergency Medicaid coverage, if eligibility requirements are met. Aliens with a visa designation of "T1" victims of human trafficking, qualify for time-limited emergency medical coverage.

A. The alien must still meet all and financial and technical requirements (i.e., deprivation, disability, etc.) for Adult or Family MA, with the exception of enumeration to be eligible for time-limited emergency coverage. KCHIP3 (150% - 200% of the Federal Poverty Level) does not provide alien time-limited MA coverage.

B. Aliens applying for time-limited MA due to an emergency medical condition are exempt from enumeration requirements.

   1. Enter the SSN if provided, but do not require the alien to apply for an SSN if there is none.

   2. If there is no SSN, KAMES will assign a pseudo number.

C. Time-limited MA coverage includes the first day of the month in which the emergency medical condition begins and continues through the following month. It is important to note that no service related to any transplant may be provided on an emergency basis.

D. An emergency medical condition is defined as a medical condition in which the absence of immediate medical treatment could result in:

   1. Placing the patient's health in serious jeopardy;

   2. Serious impairment to bodily functions; or

   3. Serious dysfunction of any bodily organ or part.

Verify the emergency medical condition by obtaining a written statement from the medical provider. The statement must contain information about the medical condition, the date of the emergency treatment, and indicate the medical provider considers the condition an emergency medical condition.

If the statement is lacking information or the information is unclear, contact the medical provider for additional information or clarification. This contact may be done by telephone or letter.

The emergency medical condition must have occurred in the month of application or within the 3 months prior to application.

E. Use procedures outlined in Volume IV or Volume IVA to determine program category, technical and financial eligibility. Establish a separate case for two month time-limited recipients. Do not include time-limited recipients in the same case with ongoing eligible household members.

MS 1579* EXTENSION OF TIME-LIMITED MA

An extension of time-limited MA may be requested by a recipient if the emergency medical condition continues. The individual must file a new application and submit a new physician's statement verifying the emergency event is an on-going/continuing condition.

A. An extension of time-limited emergency medical coverage for a non-qualified alien is based on an approval by the Department for Medicaid Services (DMS). The extension request must be received by the Medical Support and Benefits Branch (MSBB) within 30 days of the end of the emergency Medicaid eligibility period. MSBB forwards the request to DMS.

   For aliens who request additional coverage 30 days beyond the expiration of the eligibility period, send form MA-105, Notice of Eligibility or Ineligibility, for denials of the extensions.

B. Obtain a new written statement from the medical provider verifying the emergency medical condition will exist for a period beyond the time-limited coverage. The new statement must contain detailed information of the recipient's emergency medical condition including the medical provider's estimate of how long the emergency medical condition will continue.

C. Mail or fax a memorandum to Medical Support and Benefits Branch (MSBB):

   Division of Family Support
   Attn: Medical Support and Benefits Branch
   275 East Main Street, 3E I
   Frankfort, Kentucky 40621

   (502) 564-4021 (fax)

   The memorandum must contain the following information:

   1. Case name and number;

   2. Case member for whom the extension is requested;

   3. A statement of how long the emergency medical condition will continue; and

   4. Attach the medical provider's statement.

D. Retain a copy of the memorandum and the medical provider's statement in the case record.

E. MSBB forwards the request to the Department for Medicaid Services (DMS) who approves or denies the extension. For approvals, DMS provides the effective dates of the extension.

F. After the DMS determination is made, MSBB notifies field staff of the decision.

G. Upon receipt of an extension approval, update the case accordingly.

1. Enter the extension information on disposition screen PC14.

2. KAMES discontinues MA for the alien once the approved coverage expires.

MS 1580 [RESIDENCY (1)

The receipt of Medicaid (MA) is limited to residents of the state.

Kentucky residents who are temporarily absent are considered residents as long as they state they intend to reside in Kentucky. Example: An individual is out of state for college, military, vacation, etc.

A. Individuals are considered residents if they:

1. Live in Kentucky with intent to remain or for an indefinite period;

2. Have moved to Kentucky seeking employment, with or without a job commitment; or

3. Live in Kentucky and are:

a. Incapable of stating intent; or
b. Blind or disabled and under 21 years old.

B. Institutionalized individuals must meet residency requirements.

1. The state of residence for individuals under age 21, who reside in an institution, including a personal care home (PCH), is:

a. The state where the parent or legal guardian lives at the time of placement; or
b. The state where the person lives who files the application, if the individual has been abandoned by his or her parents, does not have a legal guardian, and is institutionalized in that state.

2. For the institutionalized or PCH individual who is age 21 or older who became incapable of indicating intent prior to age 21 the state of residence may be that of the parent, or guardian when parental rights have been terminated, applying for MA on the individual's behalf, if the parents reside in separate states.

3. For the institutionalized or PCH individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically located, unless another state made the placement.

C. Individuals who are residing in the state on a temporary basis DO NOT meet residency requirements for MA eligibility. Individuals residing in the state on a temporary basis include, but are not limited to, students who state they will return to their home state at the end of the school year, Job Corps participants whose caretaker relative resides out-of-state, visitors, tourists and certain aliens who enter the U.S. on a temporary basis.

1. If there is reason to believe that an applicant is residing in the state on a temporary basis, the worker is to thoroughly question the individual and

document the case record regarding the individual's statements of residency.

2. Aliens who are legally present in the U.S. with a valid visa, such as students and tourists, DO NOT meet state residency requirements due to the time-limited status of their stay in the state/country. These aliens are identified by the following types of INS documentation:

(1) Form I-185, Canadian Border Crossing Card;
(2) Form I-186, Mexican Border Crossing Card;
(3) Form SW-434, Mexican Border Visitor's Permit;
(4) Form I-95A, Crewman's Landing Permit; and
(5) Form I-94, Arrival-Departure Record with letter codes A through L. The letter code indicates the entry status and has a number after it (e.g., B-2, H-3, etc.).

The following list defines the specific letter codes:

A – Foreign government official;
B – Visitor for business or pleasure;
C – Alien in travel status;
D – Alien crewman;
E – Treaty trader and investor and family;
F – Alien student;
G – Representative and personnel of international organizations;
H – Temporary worker;
I – Members of foreign press, radio or other information media;
J – Exchange visitor;
K – Fiancé or fiancée of U.S. citizen and their children; or
L – Intra-company transferees and their families.

Undocumented aliens and aliens who remain in the U.S. after the expiration dates of their visas may meet residency requirements for time-limited MA coverage if the individual indicates he/she resides in the state and declares intent to remain in the state or for an indefinite period of time.

D. Do NOT deny MA because the individual:

1. Has not lived in the state for a specified period;

2. Did not establish residence in the state before entering an institution; or

3. Does not maintain a fixed or permanent address.

E. In cases of disputed residency, where two or more states cannot resolve which is the state of residence, the state of residency is the state where the individual is physically located.]

MS 1590 PLACEMENT BY ANOTHER STATE

[The Department for Medicaid Services (DMS) places individuals in out of state placements. The individual's Medicaid (MA) remains active even though they have been placed out of state. Placements by a state or an entity recognized under state law as acting on behalf of the state are considered placements by that state. The state arranging or actually making the placement is considered as the placed individual's state of residence.]

Providing basic information to individuals about another state's MA program or assisting an individual in locating an institution in another state is not considered a placement when the individual is capable of indicating intent and independently decides to move.

When a competent individual leaves the facility in which he/she was placed by a state, the individual becomes a resident of the state in which he/she is physically located.

MS 1600 [PRISONS/PUBLIC INSTITUTIONS

Eligibility for individuals in public institutions is limited or discontinued depending on what type institution the person is in.

A. Eligibility for specified age groups in mental or psychiatric hospitals is determined according to LTC eligibility.

B. Inmates of a public institution such as a prison, jail, state-operated hospital for mental illness, or similar facility, are not eligible for Medicaid benefits. For information on prison matches refer to Volume I, MS 0720.

C. Veterans Administration (VA) hospitals are not considered public institutions for Medicaid purposes. Individuals in a VA hospital, if otherwise eligible, may be approved for MA; however, the cost of care in the VA hospital is not covered.]

MS 1610 INTERRUPTION OF PUBLIC INSTITUTIONAL STATUS

[Contact MSBB for Medicaid approval on the following:]

A. Persons who are committed to a penal institution and are an inpatient in a acute care hospital outside the prison walls; or

B. Who are residing in an institution for mental disease (IMD) and are admitted to an acute care hospital outside the IMD facility grounds.

MS 1615* HOME INCARCERATION

Medicaid services must be provided to Medicaid eligible individuals who are on home incarceration.

MS 1620 SPOUSE ABUSE CENTER

MA eligibility is not affected by residence in a Spouse Abuse Center.

MS 1630 EMERGENCY SHELTER (1)

When an individual or family group is in a public institution on a temporary basis while awaiting a placement appropriate to their needs, consider the individual living in an emergency shelter.

A. Technical eligibility does not exist if the individual is in a public institution serving a sentence or awaiting trial, or is in a public detention facility because of a delinquent or status offense.

B. Individuals or family groups who are in an emergency shelter for a temporary period of time are eligible for Medicaid (MA) under certain conditions if:

1. [The individual or family group are residents of emergency shelters no more than 6 months in any 9 month period; and

2. The individual or family group is otherwise eligible when outside the emergency shelter. Eligibility must have existed immediately prior to admittance to the shelter or must exist immediately after leaving the shelter.

C. Take appropriate case action when they leave the shelter.]

MS 1660 THIRD PARTY LIABILITY (TPL) (1)

[As a condition of eligibility for Medicaid (MA), Federal law requires the assignment of rights for third party health insurance payments to the Cabinet for Health and Family Services (CHFS). It is also mandated by State law, that MA is payer of last resort, therefore other health or hospital insurance is billed before MA.

A. At Application/Recertification/Case Change:

1. Explain the following to the individual:

   a. The technical eligibility requirement to cooperate with TPL;
   b. The obligation to notify medical providers if they have other medical coverage;
   c. The obligation to reimburse MA for medical expenses paid by MA if later they are covered by insurance settlements or payments.

   Example: An individual was involved in a car wreck. MA pays for the treatment of the individual's injuries. A couple of years later the individual is awarded a $10,000 settlement for the car wreck. MA must be reimbursed for the medical expenses they paid which have now been covered by the settlement.

2. Determine if the individual has health insurance or other health care coverage, such as a health maintenance plan or TRICARE, or has had changes in coverage previously reported. If it appears that health care coverage information has been deliberately withheld, report to the fraud hotline at 1-800-372-2970.

3. If the individual is covered by health insurance or other health care coverage, enter the insurance information on the Health Insurance Screen.

   Note: If the individual has Medicare, enter it on the Medicare Details Screen.

   If an individual has multiple health insurance policies, enter all of them separately on the Health Insurance Screen.

4. Re-determine eligibility if the Department for Medicaid Services (DMS) reports resources received from insurance settlements, etc.

   Note: If any member requesting MA is expecting an accident settlement, it must be entered on Worker Portal.

5. If it is determined the individual no longer has health insurance enter the end date on Worker Portal.

B. Refusal to Cooperate:

If the individual refuses to cooperate with TPL, without good cause, vendor payment IS NOT approved as the individual is not MA eligible. This also applies

to Supplemental Security Income (SSI) individuals. Non-cooperation with TPL requirements DOES NOT affect eligibility for the SSI payment, but DOES affect eligibility for the receipt of MA. Refer to MS 1680.

C. Good Cause for Refusing to Cooperate:

Good cause reasons for the individual's inability to cooperate with TPL may be considered if one of the following applies:

1. The applicant and spouse are estranged, therefore the applicant is unable to provide the requested TPL information; or

2. Due to a physical and/or mental impairment of the applicant, the TPL information cannot be provided.]

MS 1680 TPL AND SSI

SSA staff advises the SSI applicant or recipient of the TPL requirements for MA eligibility. Assignment of rights and cooperation with TPL requirements for SSI applicants/recipients DOES NOT affect eligibility for the SSI payment, but DOES affect eligibility for and receipt of MA from the State Agency.

A. If an SSI applicant/recipient refuses to cooperate with TPL requirements AND does not have good cause for refusing to cooperate, vendor payment IS NOT appropriate as MA eligibility does not exist.

B. If the individual cooperates with regard to TPL requirements, SSA staff:

1. Gathers the TPL information at that time;

2. Annotates the SSI application/redetermination form indicating assignment of rights and cooperation in identifying and providing third party information; and

3. [Provides the information to DCBS with a Third Party Insurance Indicator code (below birthdate) through SDX as follows:]

a. A - Refused to assign rights.
b. R - Refused to provide third party information.
c. Y - Assigned rights and provided third party information.
d. N - Assigned rights and does not have third party coverage.

C. If the individual refuses to cooperate, SSA staff:

1. Advises the individual that SSA cannot complete the application/recertification for MA;

2. Annotates the SSI application/recertification form indicating refusal to assign rights and/or refusal to cooperate; and

3. [Refers the individual to the local DCBS office.]

D. When this individual comes into the local office:

1. Discuss TPL requirements with the individual;

2. Determine the reason for refusal to assign rights and/or cooperate;

3. Explore good cause, if applicable. For good cause criteria, see Volume IV, MS 2120; and

4. Complete form PA-40 or the KAMES Health Insurance screen unless good cause exists or refusal to cooperate continues.

E. If good cause exists or if the individual cooperates:

1. Inform the SSA District Office, using form PA-5.1, of ANY change which affects the Third Party Insurance code indicator shown on SDX.

2. Access SDX to determine whether SSA has completed the SSI application process. If SDX contains no current information on the SSI individual, contact the appropriate SSA District Office by telephone to verify the status of the individual's SSI application.

3. If SSA HAS NOT completed the SSI application process, refer the individual to the SSA District Office.

4. If SSA HAS completed the SSI application process, collect the health insurance information, AND notify SSA, using form PA-5.1, to delete the refusal code on SDX and to assign the correct code.

MS 1700* AGED

To receive assistance as aged:

A. The applicant must be age 65 or over. If there is reason to doubt the applicant's age, request verification.

B. Use any reasonably authentic document to verify age, such as:
   1. SSA verification or Medicare card;
   2. Birth registration or certificate;
   3. Confirmation, communion, or baptismal records;
   4. School records;
   5. Census records;
   6. Insurance policies;
   7. Marriage records;
   8. Licenses at least 5 years old;
   9. Bible records; or
   10. Other acceptable records.

MS 1710* BLIND

The Medicaid definition of blindness is the same as for SSI and SSA. This definition is:

> "... central visual acuity of 20/200 or less in the better eye with the use of a correcting lens."

A determination of blindness by the Medical Review Team (MRT) is required for all MA applications based on blindness. Follow the same procedures for obtaining an MRT determination of disability as outlined in MS 1720.

MS 1720 DISABLED

The Medicaid definition of disability is the same as for SSI and SSA. These programs define disability as:

"...inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months."

A. [WHEN A FIELD DETERMINATION CAN BE MADE]

1. Verify resource eligibility prior to making a field determination of disability or submitting medical data.

2. Deny the application if resource ineligible.

3. If resource eligible, make a field determination of disability if the individual provides the following proof:

   a. RSDI or Railroad Retirement Benefits based on disability are received;
   b. SSA has established disability but entitlement is pending due to the five-month durational requirement on some disabilities. View notification establishing entitlement.
   c. A copy of the favorable hearing decision from SSA, Bureau of Hearings and Appeals is presented.
      (1) If benefits are not being received, complete a monthly spot check to verify receipt of benefits.
      (2) If a check is not received within 6 months, send medical information to the Medical Review Team (MRT).
   d. SSI was received during any portion of the 12 months preceding application with the Agency, provided the SSI discontinuance was due to income or resources and not an improvement in condition.
      (1) An SSI determination of Presumptive Eligibility DOES NOT constitute a basis for a field determination.
      (2) Submit medical information to MRT for a disability determination prior to the next recertification unless the SSI decision states no reexamination is necessary.
      (3) If reexamination status cannot be determined, send a memorandum to MRT asking if a redetermination is necessary.
      (4) Include name and SSN of applicant/recipient and the date the applicant/recipient first received SSI in the memorandum.
   e. The individual has End Stage Renal Disease.

f. Disability has previously been determined by MRT, Hearing Officer, Appeal Board or Circuit Court and decision states no reexamination is necessary and there is no visible improvement in condition. Documentation is by reference to previous decision.

g. MA eligibility is requested only for the month of death.

h. Division of Disability Determination Services (DDS) has previously made a determination of disability which includes the MA application date and the onset of disability date if needed for retroactive months. The month and year of disability as determined by DDS is reflected as the MED DATE on the RDS report, HRPASRAN, "DSI Date of Disability Report", which is updated mid-month.

i. If Life-Time payments from workers compensation are received.

B. WHEN A FIELD DETERMINATION CANNOT BE MADE. [If an individual has not been determined disabled by the Social Security Administration (SSA), follow current policy and refer the individual to SSA for a disability determination. If the individual is denied by SSA due to resources or income and a Medical Review Team (MRT) determination is required, send completed PA-601T, Referral for Determination of Incapacity or Disability, (revised 1/07) and several signed/witnessed forms MRT-15 (with a revision date of 5/01 or after), Authorization for Information/Release of Information.] Determine that resource eligibility exists before sending form PA-601T and attached information to MRT. The MRT decision is returned on form PA-610.

C. SPECIAL EXAMINATION:

1. [If the MRT schedules a special examination, the applicant and the worker are notified by memorandum from MRT;]

2. Explain to the individual the necessity for such an examination;

3. Assist the individual in making any needed arrangements;

4. Contact the individual at least two days before the scheduled special examination appointment to determine intent to keep the appointment;

5. A representative of MRT will contact the local office on the day prior to the scheduled appointment to confirm whether the appointment is to be kept;

6. If, after confirmation to MRT, you learn the individual cannot keep the appointment, the Field Services Supervisor notifies MRT by telephone and MRT notifies the physician;

7. If the appointment is kept, the physician sends the report of special examination and statement of fee directly to MRT; and

8. MRT notifies the local office of the disability determination resulting from the special examination.

D. IF STATUTORY BENEFITS ARE DISCONTINUED, and eligibility is based on receipt of those statutory benefits, an MRT decision is required if the individual continues to allege disability. Submit all necessary information to MRT and continue eligibility until the MRT decision is received.

MS 1750 INTRODUCTION TO FINANCIAL ELIGIBILITY (1)

This section defines and explains resource and income eligibility for families or individuals applying for or receiving Medicaid (MA) in an Adult category.

Depending on the assistance requested, certain allocations, allowances, and standards are used to determine eligibility for Aged, Blind or Disabled MA.

A. Supports for Community Living (SCL) waiver standard is $4,394, effective 1/1/15.

B. Community Spouse Resource Allowance minimum is $23,844, effective 1/1/15; maximum is $119,220, effective 1/1/15.

[C. Community Spouse Income Allowance minimum is $2,003, effective 7/1/16; maximum is $2,981, effective 7/1/15.

D. Community Spouse Minimum Shelter Allowance is $601, effective 7/1/16.

E. Family Member Income Allowance Standard is $2,003, effective 7/1/16.]

F. Personal Needs Allowance (PNA) for basic maintenance in a licensed nursing facility (NF) is $40 (this amount does not change).

G. PNA for Non-Institutionalized Hospice, Home and Community Based Services (HCBS), Acquired Brain Injury (ABI), and SCL waiver is $753 (SSI Standard $733 plus SSI general exclusion $20 = $753), effective 1/1/15.

H. Special Income Standard for NF and waiver cases is $2,199, effective 1/1/15.

I. Blind or Disabled Child Allocations, effective 1/1/15.

1. Ineligible sibling allocation is $367;

2. Parent allocation for unearned income, or a combination of earned and unearned is $773 for one parent in the home or $1,140 for two parents in the home; and

3. Parent allocation for earned income is $1,591 for one parent in the home or $2,325 for two parents in the home.

J. Medicaid Works standards:

1. The total income limit for applicants is 250% of the Federal Poverty Level (FPL).

2. The resource limits are $5,000 for a single applicant and $10,000 for a couple effective 11/1/07.

3. The income limit for a spouse is $3,750 per month.

4. The unearned income limit is $753 (the SSI standard of $733 plus the SSI $20 general exclusion), effective 1/1/15.

MS 1770 [APPLICANT WITH A SPOUSE (1)

A. If spouses are living together, consider income according to MS 2610 and MS 2620. Consider resources to be available to each other, regardless if the resources are individually or jointly owned.

B. If spouses are living apart, consider their income and resources as follows.

1. Living apart due to institutionalization of 1 spouse.

a. Eligibility determination for the institutionalized spouse:
(1) Income:

- Consider only the income of the institutionalized spouse beginning with the month of separation.

EXCEPTION: If at the time the application is processed it is determined that the institutionalized spouse did not reside in a nursing facility for 30 consecutive days, consider the income of the community spouse available to the institutionalized spouse.

(2) Resources:

- For individuals institutionalized on or after 9/30/89, complete a resource assessment of combined countable resources to determine the community spouse resource allowance. For more information, refer to MS 2120.
- For individuals institutionalized prior to 9/30/89, consider resources of the couple as available to each other for the month of separation. Beginning the month after the month of separation, consider resources of the spouse which are contributed to the institutionalized individual.

b. Eligibility determination for the community spouse:
(1) Income:

- Consider income of the couple as available to the community spouse through the month of separation.
- Beginning the month after the month of separation, consider the income of the community spouse plus any income of the institutionalized spouse actually made available to the community spouse.

(2) Resources:

- Consider resources of the couple available to the community spouse through the month of separation. The month after the month of separation, consider only the resources of the institutionalized spouse actually made available to the community spouse.

2. Living apart due to reason other than institutionalization:

   a. In the month of separation, treat spouses as living together. Consider income and resources of both spouses according to MS 2610 and 2620.
   b. Beginning the month after the month of separation, consider only the income and resources of the out-of-home spouse that are actually contributed to the spouse who is applying.]

MS 1810 BLIND OR DISABLED CHILD LIVING WITH PARENTS

DETERMINE FINANCIAL ELIGIBILITY FOR A BLIND OR DISABLED CHILD UNDER AGE 18 OR AGE 18 THROUGH 20 IF IN SCHOOL, LIVING WITH PARENT as follows:

A. Consider total resources and income of the parent.

B. Allow appropriate income deductions from income of the parent according to MS 2480.

C. Take the following special deductions from income of the parent:

1. Deem parental income, as needed to raise the sibling's income to the maximum ineligible sibling allocation. Allow an ineligible sibling allocation for each ineligible sibling under age 18 living in the home of the blind or disabled child;

2. Deduct from unearned parental income, up to the maximum parent allocation for unearned income only or a combination of unearned and earned income;

3. Deduct from earned parental income up to the maximum parent allocation for earned income only;

4. If there are two parents in the home, use the parent allocation for two, even if only one has the income;

5. [See MS 1750 for parental and sibling allocation maximums.]

E. Deem the parent's remaining income to the disabled child.

F. Consider total resources and income of blind or disabled child.

G. Allow appropriate income deductions from the income of the blind or disabled child according to MS 2480.

H. Combine the countable income of the blind or disabled child and the deemed income of the parent.

I. Use the MA Scale for one in the eligibility determination.

MS 1820 BLIND OR DISABLED CHILD LIVING APART FROM FAMILY

Determine financial eligibility for a blind or disabled child, living apart from family due to institutionalization or hospitalization in an acute care hospital as follows:

A. For the month of separation and retroactive MA eligibility consider resources and income of the parent.

1. Allow appropriate income deductions from the income of the parent according to MS 2480.

2. Deduct from income of the parent:

a. Income as needed to raise the siblings' income to the maximum ineligible sibling allocation. Allow a separate deduction for each ineligible sibling under age 18 living in the home. If application is made for more than one blind or disabled child in the same family, hospitalized or institutionalized, allow allocation of parental income to the ineligible siblings living in the home in each case;
b. The maximum parent allocation for unearned income only, or a combination of unearned income and earned income;
c. Up to the maximum parent allocation for earned income only;
d. If there are two parents in the home, use the parent allocation for two, even if only one of the parents has the earned or unearned income; and
e. See MS 1750 for parental and sibling allocation maximums.

B. Consider total resources and income of the child.

1. Allow appropriate income deductions from the income of the child according to MS 2480;

2. Combine the deemed income of the parent and the countable income of the child;

3. Allow verified incurred medical expenses of the parent, sibling, and the child; and

4. Use the MA Scale for one in the eligibility determination.

C. After the month of separation consider only the child's resources and income, including any continuing contribution, and compare to the MA Scale for one.

MS 1850 OVERVIEW OF RESOURCES (1)

Resources are defined as assets an individual or couple own and can use, to meet basic needs of food, clothing, and shelter. Resources may be available money, real property, personal property or other assets subject to provisions for relative responsibility. When litigation is pending to determine to whom resources belong, the resources are not considered available.

[Resources must be verified and documented in the case as to whether they are countable or excluded. Obtaining verification of resources is the applicant's responsibility.

Verify and document resources:

A. At the initial eligibility determination:

1. For the application month;

2. For the prior 3 months if retro eligibility is requested; and

3. For the month of application and prior 3 months for all long term care applications.

B. At recertification, verification of resources is required for the current or prior month to assure resources are within limits; and

C. Whenever there is an indication that a transfer of resources has occurred or that the individual has received additional resources.

Whenever resources are near the limit, workers must make the applicants/recipients aware, and remind them of the requirement to report all changes in circumstances timely.]

MS 1860 RESOURCE LIMITS

A. Aged, Blind, or Disabled Individuals.

Size of Family	Allowance
1	$2,000
2	$4,000
3 or more	Add $50 for each additional member

[B Blind or Disabled Medicaid Works Individuals.

Size of Family	Allowance
1	$ 5,000
2	$10,000

C.] Blind or Disabled Child.

Parent/Child	Allowance
1 Parent	$2,000
2 Parents	$3,000
1 Child	$2,000

A separate resource limit is used to determine resource eligibility of a blind or disabled child applying for or receiving assistance.

1. Consider as surplus, parental resources that exceed $2000 or $3000, as appropriate.

2. Determine the parent's surplus resources by comparing parent's total countable resources to the appropriate resource limit for 1 or 2 parents with any excess considered as the parent's surplus.

3. Add the parent's surplus to the child's resources and compare to the child's resource limit of $2000.

[D. Medicaid does NOT recognize prenuptial agreements, therefore include all resources in a prenuptial agreement in the total combined resources for the MA applicant or recipient when comparing to the above limits.

E.] Do not count the current month's income as both income and a resource. EXAMPLE: If income for the current month is deposited in a bank account, deduct that amount from the account balance to determine actual resources.

[F.] If resources exceed limits, reduce the countable resources by any verified liability against them, such as, outstanding checks drawn against an account.

[G.] The case is resource eligible for that month if total countable resources are equal to or less than the limits when an application or recertification is processed.

[H.] The case is resource ineligible if total countable resources exceed limits when an application or recertification is processed. In this situation, deny the application or send timely notice to discontinue an active case.

[I.] The case is resource eligible for the month of discontinuance or denial, if reapplication is made and resources are reduced at or below the resource limit during the month without transfer of resources to establish eligibility.

MS 1880 EXCLUDED RESOURCES (1)

Excluded resources are available money, real property, personal property or other assets not counted in determining eligibility. When an excluded resource is sold, such as a vehicle equipped for the disabled, the proceeds are not considered income, but a change in the type of resource and must be compared to the resource limit.

The following resources are excluded:

A. Home. Exclude proceeds from the sale of a home (or insurance payments from the loss of a home) for 3 months from the date of receipt of the proceeds, if the intent is to use them to purchase another home. Transfer of the home for less than fair market value (FMV) as of 8/1/95 is a prohibited transfer unless it is made to specified individuals. See MS 2070A, regarding transfer of the home. For consideration of homestead property after 6 continuous months of institutionalization, see MS 1975.

B. Household equipment and personal effects.

C. Homestead property becomes non-home real property after six months of institutionalization. Non-home real property may be excluded if:

1. It can be demonstrated that there is a reasonable effort being made to sell the property at FMV. The individual must publicly make known the intent of selling the property at FMV by a newspaper ad, contract with a realtor, or correspondence with a financial institution.

   [The exclusion for effort to sell is determined by completion of form MA-10, Reasonable Effort to Sell Checklist and may be extended for an additional six months after the initial six month exclusion on a case-by-case basis. This extension also requires the completion of form MA-10.]

2. The member signs a letter stating an intention to return home.

   Review the situation at each recertification/reapplication and obtain a new statement of intention to return home.

D. Property being purchased by an applicant/recipient on a land contract.

E. Life estate interest in real estate property or other property, e.g., oil lease. If an individual is in a vendor payment case (NF, ICF IID, SCL, ABI, HCBS, Michelle P, ABI LTC) and/or the individual's community spouse transfers property to establish the life estate, see transfer of resource policy outlined in MS 2050 - MS 2110.

F. The first $6,000 in equity value of non-home, income producing property whether or not it is used in a trade or business, if it is essential for self-support of the individual, spouse, or family group. The remaining equity value is a countable resource.

For the purposes of this exclusion, rental property is not considered a trade or business.

NOTE: If the individual is in a nursing facility (NF), income producing property cannot be considered as essential for self-support of that individual, as his/her support is being provided by the NF.

G. Equity value of all equipment (including tools, machinery, etc.), livestock, or other inventory used in a farming or self-employment enterprise.

H. Relocation Assistance. Relocation assistance provided by a state or local government comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, which is subject to the treatment required by Section 216 of such Act.

I. A vehicle, regardless of value, if used by a member of the household for one of the following reasons:

1. It is used to obtain medical treatment;

2. It is specially equipped for the disabled;

3. It is used by the community spouse;

4. It is used for employment or self-employment; or

5. It is used as an owner occupied home.

Exclude $4500 from the total equity value of all non-excluded vehicles, except for recreational vehicles. If a recreational vehicle cannot be excluded for one of the reasons listed above, the entire equity value of the non-excluded recreational vehicle is considered as a countable resource. Enter the value of non-excluded recreational vehicles on the KAMES Resources screen as “Other” resources.

NOTE: At the time of admission, if an institutionalized individual does not own a vehicle, and wishes to use his/her resources to purchase a vehicle, this vehicle cannot be excluded unless it meets one of the criteria listed above and there is verification, such as a statement from the nursing facility, that the client can use the vehicle being purchased.

Example: Bob is in LTC. He has $20,000 in excess resources which he uses to purchase a van; however, he is physically limited to stretcher transportation, therefore this vehicle cannot be excluded.

J. All resources of an SSI individual. Also exclude all resources of an SSI essential person whose MA eligibility is based on inclusion in the SSI case. This includes the spouse of the SSI individual if he/she is designated as the SSI essential person.

K. Burial space items such as conventional gravesites, crypts, mausoleums, urns, vaults, caskets, headstones, and opening and closing of the grave.

L. Term and burial insurance policies.

M. The value of a prearranged funeral contract funded by a life insurance policy with:

1. An irrevocable assignment of ownership to the funeral home;

2. Irrevocable assignment of the funeral home as beneficiary; or

3. An irrevocable assignment of the life insurance policy to the funeral home.

N. The value of a prearranged funeral contract purchased with cash that has an irrevocable funeral trust agreement that was signed no more than 30 days prior to the application.

O. $1500 from burial reserves for each member of the assistance group for the following:

1. Whole life insurance policies;

2. Burial funds;

3. Cash set aside for burial purposes; and

4. Prearranged funeral contracts <u>without</u> an irrevocable assignment.

P. Interest on burial reserves, if allowed to accrue.

Q. Cash received to repair or replace a damaged, lost, or stolen excluded resource, including interest accruing from cash, or an in kind item. Allow 9 months for the repair or replacement of the excluded item and an additional 9 months when the individual shows good cause.

R. Retirement plans, such as IRAs, KEOGH plans, deferred compensation, tax deferred retirement plans and other tax deferred assets are excluded from consideration as a resource; however, regular withdrawals, such as monthly, quarterly, or yearly disbursements, are considered as other unearned income.

[S. Medicaid Qualifying Trust. Principal and accrued interest of a Medicaid Qualifying Trust established on or before 8/10/93, if the trustee has limited authority to access and distribute the trust funds to the beneficiary. All trusts must be reviewed by the Office of Legal Services (OLS).]

T. Lump sum back payments. Lump sum back payments from SSI and/or RSDI are excluded for the first 6 months following the month of receipt. Deduct current month's benefits from the back payment prior to determining the excluded resource amount. Set up a spot check for the end of the 6-month period. Consider any remaining amount as a countable resource.

U. Reimbursement for a medical or social service. Consider as excluded resources in the month of receipt and in the calendar month following receipt any cash payments received for medical or social services. However, the cash payment is considered a resource if still held the second month following receipt.

Determine the purpose of the contribution:

1. Paying for a medical expense not covered by insurance or MA;

2. Paying for a social service expense, such as drug counseling;

3. Paying for any amount of reimbursement for a medical or social service bill the individual has already paid.

V. Earned Income Tax Credit (EITC) payments for 12 months from the month of receipt.

W. Aleutian payments. Up to $12,000 to Aleutians and up to $20,000 to individuals of Japanese ancestry for payments made by the federal government to compensate for hardships experienced during World War II. All recipients of these payments are provided with written verification by the federal government.

X. All payments received from Agent Orange.

Y. Victims Compensation payments. Exclude completely for nine months payments received for losses and incurred expenses, such as lost wages or property, medical treatment, etc. Victim compensation payments received from a fund established by a state to aid victims of crime, to the extent that the individual can verify that the amount was paid as compensation for pain and suffering purposes, for expenses incurred, or losses suffered as a result of a crime.

Z. Austrian payments. Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

AA. Nazi Persecution Victims payments. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.

BB. Hemophiliacs. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using the SSI standards. This resource is NOT excluded by SSA, so these recipients should not be SSI eligible. Enter these applications on KAMES as usual. If the hemophiliac is resource ineligible for some other reason, pend the application and contact the Medical Support and Benefits Branch through your Regional Program Specialist for further instructions.

CC. Susan Walker class action suit. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.

DD. Exempt resources which are inaccessible for 30 days or more in the resource eligibility determination until these resources are accessible. This policy applies in case situations when the applicant/recipient is attempting to

liquidate excess resources. (Life insurance policies are not included in this exemption.)

1. Require written verification of inaccessibility of the resource from the institution holding the resource.

2. Set up a monthly spot check to track the inaccessibility of the resource as accessing the resource can make the individual ineligible for MA in the future.

EE. Resources included in a Plan for Achieving Self-Support (PASS).

FF. Tax rebate checks are excluded in the month of receipt and the following two months. Any proceeds from the rebate retained after the third month are considered a countable resource.

GG. LTC Partnership Insurance Program designated resources. Applicants who own a LTC insurance policy that is qualified as a Partnership insurance policy are eligible for a “dollar for dollar” asset disregard from Medicaid for benefits used under their partnership qualified (PQ) policies. See MS 1885.

HH. Energy Employees Occupational Illness Compensation (EEOIC). These payments must be kept separate and not comingled with other countable resources. Interest on the unspent EEOIC payment is a countable resource the month after receipt.

MS 1885 LONG TERM CARE PARTNERSHIP INSURANCE PROGRAM (1)

The Kentucky Long Term Care Partnership Insurance Program is designed to encourage individuals to purchase long term care (LTC) insurance. It is a partnership between the Department for Medicaid Services (DMS), the Department of Insurance (DOI), and private LTC insurance companies. Under this program, certain LTC insurance policies known as Partnership policies provide coverage of LTC costs to the consumer and may allow the consumer to qualify for Medicaid services for the cost of LTC without exhausting all their assets.

Not all LTC insurance policies are Partnership policies. LTC Partnership insurance policies have been certified by the DOI to meet inflation protection requirements. These policies are referred to as Partnership Qualified (PQ).

A. WHAT PQ POLICIES COVER

PQ LTC insurance policy holders are eligible for a “dollar for dollar” asset disregard from Medicaid for benefits used under their PQ policies. This means that for every dollar the insurance policy pays for an individual’s LTC needs, a dollar of his/her resources can be excluded should an application be made for Medicaid.

For example: John has a LTC Partnership Insurance policy which pays benefits of $3,000.00 a month for a maximum of 36 months. He applies for Medicaid when his insurance benefits are exhausted. His insurance paid a $108,000.00 for his care prior to his application for Medicaid; therefore, Medicaid will exclude $108,000.00 of his assets or resources when determining eligibility. These assets will also be protected from estate recovery.

B. THE MEDICAID APPLICATION

The applicant is not required to exhaust the full benefits of the policy prior to making an application for Medicaid, however:

1. The date of application locks in the dollar amount of assets to be excluded as long as the application is approved;

2. The applicant must identify the assets to be protected when applying for Medicaid; and

3. The individual cannot change his/her choice after Medicaid approval.

   Note: If an application is denied, the dollar amount of assets to be disregarded may increase if the client continues to use benefits from a PQ policy, and additional assets may be identified for disregard at the new application. A new statement of benefits is required.

Protected resources are not “locked in” until the application is approved.

C. VERIFICATION

Require a copy of the LTC insurance policy. The applicant will contact the insurance company for a Statement of Benefits Paid. This statement will verify the amount of benefits that have been paid by the PQ policy.

D. CONSIDERATION

All policies believed to be PQ policies should be submitted to MSBB and will be forwarded to DMS for review and guidance.

E. PROTECTED ASSETS WHEN THERE IS A COMMUNITY SPOUSE

The determination of the applicant’s assets that are protected is not based on the completion of a resource assessment. The assets which are protected are determined at an application which results in an approval for LTC Medicaid. In order for the applicant to understand his/her options, resource assessment requests with a PQ policy are handled as follows:

1. Complete form PA-22, Resource Assessment;

2. Ask the individual the amount of benefits paid by the PQ policy and inform the individual of the impact the benefits paid will have on the amount of resources to be spent down;

3. If the individual then opts to make application, proceed accordingly.

At application, review form PA-22 to determine which resources the institutionalized spouse wishes to protect. Remind the applicant that once resources are selected and the case approved, choices cannot be changed. The dollar amount of assets to be protected is determined by the “Statement of Benefits Paid.”

F. PQ POLICY BENEFITS EXCEED THE LTC SPOUSE’S SHARE OF RESOURCES

If the paid amount listed on the Statement of Benefits Paid exceeds the institutionalized spouse’s share, he/she can identify resources to protect that is greater than his/her share.

Example: Betty is a resident of a LTC facility and has exhausted her PQ policy benefits. Her spouse, Bob, has applied for Medicaid on her behalf. Bob verifies that he and Betty have $250,000.00 total countable resources. Bob’s half of their combined resources exceeds the maximum community spouse resource allowance. Bob provides a Statement of Benefits Paid to verify Betty’s PQ policy has paid LTC benefits in the amount of $140,000.00. The amount paid by the PQ policy exceeds Betty’s share of the resources by $15,000.00 so Betty can identify up to $15,000.00 of Bob’s resources to protect, thereby reducing the amount of resources Bob has to spend down.

G. ESTATE RECOVERY

Resources selected by the recipient as excluded assets are protected from estate recovery.

H. If an application is denied, the applicant will continue to use his/her PQ policy benefits if they have not been exhausted. At the new application a new Statement of Benefits Paid will be required.

Protected resources are not “locked in” until the application is approved.

MS 1890 ANNUITIES (1)

[An annuity is an investment from which an individual receives fixed payments for a lifetime or for a specified number of years. The Office of Legal Services (OLS) reviews certain types of annuities for the determination of Medicaid (MA) eligibility at applications, recertifications and resource assessments.

A. The following pension annuities are not required to be forwarded to the Medical Support and Benefits Branch (MSBB) for OLS review:

1. United States Office of Personnel Management Annuities;

2. New York Life Polyone Merged Pension Plan Annuities; and

3. GE Retirement Services Annuities.

B. In addition to those specific pension annuities listed above, OLS review is not required for the following:

1. Any annuity designated as a Traditional Individual Retirement Account;

2. Any annuity designated as a Pension Account; and

3. Any annuity designated as a Retirement Account.

C. All other annuities must be forwarded to MSBB via the regional Program Specialist to be submitted for an OLS review.

D. For annuities owned by the applicant and signed on or after February 8, 2006, or those annuitized after that date, the Department for Medicaid Services (DMS) must be named as a beneficiary, after a spouse or minor/disabled child. For annuities owned by the community spouse, DMS is to be named before the institutionalized spouse. This also applies in situations where both spouses are institutionalized.

Example 1: An individual purchased an annuity on December 1, 2005 and it was annuitized at that time. It is not required that DMS be named beneficiary.

Example 2: An individual purchased an annuity on December 1, 2005 but it was not annuitized until February 15, 2006. DMS must be named as a beneficiary, after a spouse or minor/disabled child.

Example 3: An individual purchased an annuity on February 8, 2006. DMS must be named as a beneficiary, after a spouse or minor/disabled child.

For individuals who have an annuity that was signed, dated, and annuitized before February 8, 2006, or who do not have any annuities, the institutionalized or community spouse or power of attorney (POA) initials the first statement on form MA-34, Declaration of Annuities, and signs and

dates the form. The following two questions on KAMES capture annuity information.

1. “Individual/Spouse has annuity?” and

2. “Reviewed by DMS? Ver Scr: Date:”

These are answered “Y” or “N” and the verification source can be either written statement (“WS”) or original record (“OR”). The ownership of the annuity, either the applicant or the spouse, is documented in case comments.

Form MA-34 MUST be completed for ALL Long Term Care (LTC) or waiver resource assessments, applications, and recertifications, whether or not the individual has an annuity.

E. The types of cases requiring form MA-34 are:

1. Nursing Facility (NF);

2. Home and Community Based Services (HCBS);

3. Support for Community Living (SCL), including Michelle P;

4. Model Waiver II;

5. Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF IID);

6. Mental Health/Psychiatric Facility (for age 65 or older);

7. Adult Day Care;

8. Institution for Mental Diseases (IMD);

9. Acquired Brain Injury (ABI)/ABI Long Term Care (LTC);

10. Hospice Non-Institutional; or

11. Hospice NF.

F. OLS determines how annuities are to be considered. Use the following procedures when forwarding an annuity for review:

1. Review the applicant’s annuity to determine the following:

a. If the annuity was set up with the individual’s money; and

b. If the applicant is receiving disbursements on a regular basis.

If the annuity meets the above criteria, DMS must be added as a beneficiary and form MA-34 is signed.

2. Advise the applicant of DMS' position in the order of beneficiary assignment in relation to who is currently listed on the annuity. For example: DMS would be the second beneficiary if there is a community spouse or minor/disabled child, third beneficiary if there is a community spouse and a minor/disabled child. If there is neither a community spouse nor a minor/disabled child, then DMS is named as the first beneficiary.

   NOTE: For individuals/community spouses who do not comply with adding DMS as beneficiary, the annuity will be considered a transfer of resources for less than fair market value (FMV). This may result in an ineligibility period. The transfer of resource penalty must be served out unless a hardship determination is requested and approved by DMS. Refer to MS 2070H regarding hardship determination requests.

3. When the annuity is received with the change of DMS beneficiary position, scan the annuity into the Electronic Case File (ECF).

   Note: For recertifications, do not forward an annuity that has been previously reviewed unless changes have been made to the annuity.

4. Ensure that any attachments listed in the annuity have been provided. If any part of the annuity or attachments is missing, request the missing information from the client and submit the annuity when complete.

5. To ensure that processing timeframes are met, scan and email form MA-33, DMS Review/Cover Sheet, with the ECF Document ID #'s listed on the form, on a daily basis to the MSBB mailbox at DFS.Medicaid@ky.gov. The case is to remain pending until a response is received from OLS. OLS will give priority to annuity reviews for applications. Refer to Volume IVA, MS 1470, for cases pending over 30 days with good cause.

6. Following completion of the review, MSBB will send an email regarding the consideration of the annuity to the regional Program Specialist.

G. For recertifications, do not hold a recertification pending for receipt of the annuity review response. Complete any changes reflected on the response as required by OLS to be effective the next administratively feasible month.

H. Questions concerning the status of an annuity review are directed to MSBB at DFS.Medicaid@ky.gov.

I. The Division of Program Integrity tracks the annuities for changes and the death of the applicant.]

MS 1900 LIFE EXPECTANCY TABLE (1)

[2009 Period Life Table

Exact	Life Expectancy			Exact	Life Expectancy			Exact	Life Expectancy	
Age	Male	Female		Age	Male	Female		Age	Male	Female
0	75.90	80.81		40	38.23	42.24		80	8.10	9.65
1	75.43	80.28		41	37.31	41.29		81	7.60	9.07
2	74.46	79.31		42	36.40	40.35		82	7.12	8.51
3	73.48	78.32		43	35.50	39.42		83	6.66	7.97
4	72.50	77.34		44	34.60	38.49		84	6.22	7.45
5	71.51	76.35		45	33.70	37.56		85	5.80	6.95
6	70.53	75.36		46	32.82	36.64		86	5.40	6.48
7	69.54	74.37		47	31.94	35.73		87	5.02	6.03
8	68.55	73.38		48	31.06	34.82		88	4.66	5.61
9	67.55	72.39		49	30.20	33.92		89	4.33	5.22
10	66.56	71.39		50	29.35	33.02		90	4.02	4.85
11	65.57	70.40		51	28.50	32.13		91	3.73	4.50
12	64.57	69.41		52	27.66	31.24		92	3.46	4.19
13	63.58	68.41		53	26.84	30.36		93	3.22	3.89
14	62.60	67.42		54	26.02	29.48		94	3.00	3.63
15	61.62	66.44		55	25.21	28.60		95	2.81	3.69
16	60.64	65.45		56	24.41	27.73		96	2.64	3.18
17	59.68	64.47		57	23.61	26.87		97	2.49	2.98
18	58.72	63.49		58	22.82	26.00		98	2.36	2.81
19	57.77	62.51		59	22.04	25.15		99	2.24	2.65
20	56.83	61.53		60	21.27	24.30		10	2.12	2.49
21	55.89	60.56		61	20.50	23.46		101	2.01	2.35
22	54.96	59.58		62	19.74	22.63		102	1.90	2.21
23	54.03	58.61		63	18.99	21.81		103	1.80	2.07
24	53.11	57.64		64	18.24	20.99		104	1.70	1.94
25	52.18	56.67		65	17.51	20.19		105	1.60	1.82
26	51.25	55.70		66	16.79	19.39		106	1.51	1.70
27	50.32	54.73		67	16.08	18.61		107	1.42	1.59
28	49.39	53.76		68	15.39	17.84		108	1.34	1.48
29	48.45	52.79		69	14.70	17.08		109	1.26	1.38
30	47.52	51.82		70	14.03	16.33		110	1.18	1.29
31	46.59	50.86		71	13.37	15.59		111	1.11	1.19
32	45.65	49.89		72	12.72	14.87		112	1.03	1.10
33	44.72	48.93		73	12.09	14.16		113	0.97	1.02
34	43.79	47.97		74	11.47	13.47		114	0.90	0.94
35	42.86	47.01		75	10.87	12.79		115	0.84	0.87
36	41.93	46.05		76	10.28	12.13		116	0.78	0.79
37	41.00	45.09		77	9.71	11.48		117	0.72	0.73
38	40.07	44.14		78	9.16	10.86		118	0.67	0.67
39	39.15	43.19		79	8.62	10.24		119	0.61	0.61

Note: The period life expectancy at a given age for 2009 represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for 2007 over the course of their remaining life.]

MS 1930* HOME EQUITY PLANS

HOME EQUITY PLANS (HEP) allow elderly homeowners to convert the equity value of their homes into cash without being forced to leave their homes. The following HEP are currently available.

A. DEFERRED PAYMENT LOANS (DPL) are one-time lump sum loans used to repair or improve a home or to pay property taxes. They are usually offered by local government housing or community development departments with no repayment due until the homeowner dies, sells the home or moves.

B. REVERSE MORTGAGES allow a homeowner to borrow, via a mortgage contract, some percentage of the appraised value of their home. The homeowner can receive periodic payments and/or a line of credit to draw against. Some reverse mortgages involve the purchase of an annuity and are called Reverse Annuity Mortgages (RAM). In most reverse mortgages the loan to the homeowner is not repaid until the homeowner dies, sells the home or moves.

C. SALE-LEASEBACK allows the homeowner to transfer title of the home to a buyer in exchange for an installment note satisfied by regular payments. The installment note may bear interest. The buyer then allows the former homeowner to remain in the home in exchange for rent. Because the rent is a lesser amount than the former homeowner receives from the installment note, they are provided with needed proceeds. Some sale-leaseback arrangements involve the purchase of an annuity.

D. TIME SALE allows the homeowner to sign a contract to sell their home at death but maintain title to and continue to live in the home. The buyer of the contract makes regular payments to the homeowner. The contract may provide for payment of interest and/or the purchase of an annuity.

E. VERIFICATION. Copy of the HEP such as a reverse mortgage, time sale, sale-leaseback or loan.

F. CONSIDERATION. Carefully review the HEP to determine the type of compensation the homeowner is to receive, frequency, schedule of receipt, amounts, etc.

1. If the money from the mortgage establishes a line of credit, consider the entire amount of the line of credit as a countable resource effective the month the line of credit becomes available.
2. If the money from the mortgage is paid to the MA applicant/recipient as a lump sum payment and/or a down payment, consider the amount paid as a countable resource in the month the lump sum and/or down payment is received.

3. Proceeds other than a line of credit, lump sum payment and/or a down payment, such as annuity, including reverse annuity mortgages, other than reverse equity arrangements, are not considered to meet the definition of a converted resource, but are considered as unearned income, according to MS 2260.

MS 1940 JOINTLY HELD RESOURCES

JOINTLY HELD RESOURCES are resources owned or held by more than 1 person. Allow individuals the opportunity to rebut the ownership if they state that they do not contribute to or withdraw from a jointly held resource, such as checking, savings, CD, or savings bonds, etc.

A. VERIFICATION OF JOINTLY HELD RESOURCES. Document in case record the amount of the resource and type of verification used.

B. [CONSIDERATION OF JOINTLY HELD RESOURCES. For transfer of resources consideration of jointly held resources transferred after 8/10/93 for HCBS, HCBS Model Waiver 2, ICF IID, SCL and LTC cases, see MS 2050.]

1. Do not consider the placement of another's name on an account or asset as a joint owner set up as "or" to be a transfer of assets until:

   a. Action is taken to withdraw funds from the account; or

   b. Action is taken to remove the asset from the control of one of the joint owners.

   [For jointly held resources, the 36 month look back period for the transfer of resources policy applies to LTC, ICF IID, SCL, HCBS Model Waiver 2 and HCBS cases when any action is taken after 8/10/93 by the individual or any other party to reduce or eliminate the individual's ownership or control of the resources. Effective February 9, 2009 the look back period will progressively expand from 36 months to 60 months. At this point the look back period will increase daily until February 8, 2011, at which point the look back period will have reached 60 months.]

   Note: There is no change in the look back period for resources transferred into a trust or used to establish a trust. The look-back period remains 60 months.

2. Total amount of joint checking/savings account is available to the individual when only one signature is required to withdraw funds.

3. When more than 1 signature is required to withdraw funds from joint checking/savings account, only the individual's share is available. Establish shares by a signed statement from other parties as to the division. If the other owner refuses to co-sign to make the resource available, do not count the resource. Obtain verification of the other owner's refusal to sign.

4. If more than one of the account holders is an eligible individual, divide the funds equally among the eligible individuals when determining resources. Use this policy even if all the funds in the

account were deposited by an ineligible individual and the eligible individuals have never made a withdrawal from the account.

5. If there is no predetermined allocation of shares from a business enterprise, determine individual's available share by dividing the value of the business enterprise by the number of owners.

6. If resources are held jointly, other than checking/savings accounts and business enterprises, determine recipient's share by dividing value of the jointly held resource by the number of owners, or if otherwise specified, by percentages. A parent's share is available to the children for whom assistance is requested, regardless of whether the parent is included.

7. Consider no resources available when any of the parties of the jointly held resource are not willing to release their portion of the resource or one party cannot be contacted for a release of their portion. It must be verified that litigation would be required or is pending, such as divorce settlement, probate of will, etc., to determine to whom a resource belongs. Spot check monthly or in the month the litigation is expected to be completed.

C. VERIFICATION OF REBUTTAL OF JOINTLY HELD RESOURCES. In order for the individual to rebut the ownership of jointly held resources, the individual must provide:

1. A written statement from the individual regarding ownership, who deposits and withdraws;

2. A written statement from each of the other account holders which corroborates the individual's statement, unless the account holder is a minor or is incompetent; and

3. Verification that the individual's name has been removed from the joint account.

   Do not consider the resource available the month the individual's name is removed from the account.

MS 1960 LIFETIME CARE AGREEMENT

LIFETIME CARE AGREEMENTS are entered into with another individual or organization for lifetime care of an individual or family, in exchange for resources of the individual or family.

A. VERIFICATION OF LIFETIME CARE AGREEMENT. Obtain a copy of the agreement or statement from organization or individual providing care.

B. CONSIDERATION OF LIFETIME CARE AGREEMENT.

1. If resources are still available to the individual or organization with whom the agreement is made, the case is ineligible.

2. If the individual or organization holding an agreement provides a written statement that the resources have been exhausted or reduced, compute current resources to determine if within the resource limit.

[C. The Department for Medicaid Services (DMS) reviews all lifetime care agreements for the determination of Medicaid eligibility at application and recertification. DMS will advise how the agreements are to be considered in each determination. Forward a lifetime care agreement for consideration as follows:

1. For all applications and recertifications which include a lifetime care agreement, forward a copy of the agreement document(s) to MSBB at DFS.Medicaid@ky.gov. Retain a copy of the agreement for the case record.

2. For recertifications, do not send a lifetime care agreement that has been previously reviewed by DMS staff unless changes have been made to the agreement.

3. Ensure that any attachments listed in the lifetime care agreement are provided. If any part of the agreement or attachments is missing, request the missing information from the client and submit the agreement when complete.

4 . Forward the complete lifetime care agreement even if the case is pending for additional information. Forward complete copies to MSBB at DFS.Medicaid@ky.gov on a daily basis to assure processing timeframes are met.

5. Following completion of the review, MSBB staff will send consideration of the agreement to the worker with a copy to the Program Specialist. The copy of the lifetime care agreement will not be returned.

6. For applications, hold the application pending until a response is received.

7. For recertifications, do not hold a recertification pending for receipt of the agreement review response. Complete any case action necessary as a result of the review response with the next administratively feasible month.

8. Questions concerning the status of a lifetime care agreement review are to be directed to the supervisor, MSBB, at DFS.Medicaid@ky.gov.]

MS 1970 LIQUID ASSETS

[Liquid assets are reserves that can be easily converted into cash for immediate use; these include but are not limited to:

1. Cash, checking accounts;
2. Savings accounts, certificates of deposit;
3. Stocks, mutual fund shares, bonds;
4. Promissory notes, mortgages, land contracts; and
5. Any other item readily convertible to cash.

A. CONSIDERATION OF LIQUID ASSETS

1. Resources in excess of the maximum when the case is processed result in denial/discontinuance of the case.

2. The proceeds from the conversion or sale of any resource are not income but a change in the type of resource.

3. The value of stocks, mutual fund shares, and bonds is based on market value on day verified.

4. If negotiable or salable, promissory notes, loans, mortgages, and land contracts are considered resources, see MS 2330.

5. Consider the portion of interest from interest bearing checking and savings accounts, remaining after the month of receipt, as a resource beginning the month after the receipt month.

6. Consider as a countable resource the total value of a certificate of deposit (CD), including the interest which is posted to the CD and not paid directly to the individual owner of the CD.

   If interest posted to the CD is paid directly to the individual owner of the CD, consider as a countable resource the total amount remaining in the CD.

7. Certain cash payments received for medical or social services are considered to be a resource, if still held the second month following receipt.

   These cash payments are money (cash, check, specified fund) contributed to an individual from either an agency or interested party, for the specific purpose of paying for a medical expense not covered by insurance or MA, or a social services expense. A social services expense may include but is not limited to drug counseling through a church organization or social service agency.

   Consider as a countable resource reimbursements for medical or social service bills already paid by the individual.

8. Resources which are inaccessible for 30 days or more are exempt in the resource eligibility determination until these resources are accessible. This policy applies in case situations when the applicant/recipient is attempting to liquidate excess resources. Require written verification from the institution holding the resource of the inaccessibility of the resource to the applicant/recipient. Set up a monthly spot check to track the inaccessibility of the resource as accessing the resource may make the individual ineligible for MA in the future. This exclusion DOES NOT apply to life insurance policies.

   EXAMPLE: An applicant has excess resources in the form of non-homestead property. This property is listed for sale, however there have been no offers made. Consider the resource to be inaccessible.]

B. Verification

1. If resources are declared, the applicant must make available the appropriate documents, such as:

   a. Statements from banks or other financial institutions;
   b. Checking account statements;
   c. Savings account statements;
   d. Stocks, bonds, or certificates of deposit;
   e. Financial instrument;
   f. Land contracts, promissory notes or mortgages; or
   g. Other sources of documentation.

2. Before LTC vendor payment is authorized, use form PAFS-18, Liquid Asset Verification and Invoice for Payment, and check for declared or undeclared resources in at least 2 banks in the vicinity in which the individual lives or lived prior to entering LTC. The individual and spouse, if appropriate, or committee or Power of Attorney must sign form CFS-1, Informed Consent and Release of Information and Records. [Document the case record if unable to check 2 banks for reasons such as; only 1 bank is in the community.]

   All IM vendor payment cases subject to transfer of resource penalties will pend on KAMES for a resource check refer to MS 2050. The question, “Has bank and courthouse asset check been done?” must be answered “Y” or “N”, with verification code “OR” or “WS” entered, before the system will process the vendor payment approval.

   The following types of care are excluded from the resource check:

   - Hospice Non-Institutional;
   - Hospice NF;
   - Mental Health/Psychiatric Facility;
   - PRTF; and
   - EPSDT.

If the county of residence prior to entering LTC is out-of-state and no resources are declared, accept the statement of the LTC individual as verification. No further verification is required.

MS 1975 RECOGNITION OF AN INSTITUTIONALIZED INDIVIDUAL'S HOMESTEAD RESOURCES (1)

[A Medicaid (MA) recipient is considered permanently institutionalized after 6 consecutive months in a long term care (LTC) facility. After the 6th consecutive month, the homestead property is no longer the individual's residence and is considered non-home property. Individuals with an equity interest in their home greater than $552,000 are ineligible for MA coverage for Nursing Facility (NF) or waiver services, unless a community spouse, minor/dependent or disabled child(ren) reside in the home. Waiver services are: HCBS, SCL, Michelle P, Model Waiver II, ICF IID, Mental Health/Psychiatric Facility for Age 65 or older, Adult Day Care, IMD, ABI, AND ABI LTC.]

A. When homestead property is excluded:

1. When a dependent family member lives in the home:
Homestead property with an equity value less than $552,000 is exempted only when a community spouse or other dependent family member resides in the home. A dependent family member is a child, stepchild or grandchild; parent, stepparent or grandparent; aunt, uncle, niece or nephew; brother or sister, stepbrother or stepsister, half-brother or half-sister; cousin; or in-law. A dependent is defined as an individual who received more than one-half of their annual financial support from the institutionalized recipient.

2. The first 6 months of institutionalization.

3. When there is a verified continuing effort to sell (second 6 months). The non-home property may be excluded for an additional six months if there is a verified continuing effort to sell it at fair market value (FMV). Criteria for "reasonable effort to sell" are outlined in Item F below.

[Form MA-10, Reasonable Effort to Sell Checklist, must be completed when an individual is requesting real property to be excluded from resource consideration for reasonable effort to sell.]

Note: Equity value of the home is determined by the current market value minus any encumbrance on the home. Current market value is the going price of the home, or the amount for which it can reasonably be expected to sell on the open market in a particular geographic area. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan or other debt that is secured by the home. Obtain verification from the Property Value Assessment (PVA) office to verify the current market value of the property. The equity value of the home is determined by subtracting any outstanding debts or liens against the property from the fair market value. The PVA assessment or tax notice, without any homestead or other exemptions, can be used to verify fair market value. Some tax bills list the fair market value as the fair cash value.

4. [The exclusion for “effort to sell” may be extended past the additional 6-month exclusion for an additional 6 months on a case-by-case basis. This extension requires verification that the criteria listed in item F below continue to be met and completion of form MA-10, Reasonable Effort to Sell Checklist.

   Note: If the worker cannot establish reasonable effort to sell on form MA-10, then the extension will be denied and the equity value of the property is considered a countable resource. If the resources exceed the allowable limits, allow the case to discontinue. If a reapplication is taken, the applicant/representative must provide verification that an attempt is being made to sell the property at FMV. If the recipient has been discharged from the facility and the case has been inactive for more than 30 days, allow the 6-month exclusion. During the period of discontinuance they are resource ineligible for MA.]

5. When the individual states intent to return home. An individual’s homestead property may be exempt after the first six months of institutionalization if the individual states an intention to return home. The individual must provide a written statement indicating the intent to return and the estimated time (as in the number of months). The statement must be signed by the recipient. If the recipient is unable to sign, the statement must be signed by the Power-of-Attorney (POA). If there is no POA, the statement must be signed by the representative. Do not spot-check the case for the expiration of the time period designated in the statement unless the time period designated will expire prior to the next recertification. Reinvestigate the matter and require a new written statement at each recertification.

B. When homestead property is not excluded:

1. When there are no exemptions and the six months of continuous institutionalization has expired.

[2. When the equity interest in the home is greater than $552,000 and a community spouse, minor/dependent or disabled child(ren) does not reside in the home, the client is not eligible for LTC vendor payment. A screen on KAMES is available to capture information regarding homestead property with an equity value greater than $552,000. KAMES automatically applies a 468 disqualification code to these cases and the LTC is denied or discontinued for being over the resource limit due to the equity value of their homestead property. This disqualification can only be removed by a supervisor.

   If an individual is ineligible for vendor payment due to homestead with equity interest greater than $552,000 and a community spouse, minor/dependent or disabled child(ren) does not reside in the home, KAMES will determine eligibility for MA only. If the person’s income exceeds the limit of $235, the case will deny for over the income limit.]

C. How to process a case with homestead property

At the time of the application interview:

1. Explain that the homestead property is considered a countable resource after six months of institutionalization, if not otherwise exempt.

[2. Explain that if the property is not exempt or the equity value of the home is greater than $552,000 and a community spouse, minor/dependent or disabled child(ren) does not reside in the home, the vendor payment will deny due to excess resources.]

3. Advise the applicant that the sale of the home must be reported within 10 days.

4. Advise the applicant of the exemption if there is a spouse or dependent family member living in the home.

   a. Verification is needed that a family member, other than a spouse, lives in the home and is a dependent.
   b. The dependent family member must have been living with the institutionalized individual prior to admission to an LTC facility.

5. Advise the applicant of the exemption for intent to return home

D. New admissions of 6 months or less

For applications with a new admission of 6 months or less to a LTC facility, enter a spot check to send a “request for information” (RFI) to the recipient after six months of institutionalization. The six-month count starts with the month of institutionalization of the individual rather than with Medicaid eligibility. REMINDER: After six months of institutionalization, the homestead property becomes non-home property.

If the non-home property is considered a countable resource complete the following:

1. Allow the recipient 10 days to respond with verification of the sale or the effort to sell the non-home property, or to provide a statement of intent to return home.

2. If the verification is not returned, enter the value of the property on the non-home real property screen. If the equity value causes ineligibility, the case will discontinue for excess resources and KAMES will send the appropriate notice.

[3. Upon receipt of verification for “effort to sell”, complete form MA-10 and, if criteria are met, allow the recipient 6 months and enter a spot check to send a request for information (RFI) at the end of the 6 month period. Criteria for “reasonable effort to sell” is outlined in section F.]

4. Once the property is sold, obtain a copy of the closing statement and consider the proceeds a resource. Enter the amount received on the sale of the property resource screen and answer “N” to “is this homestead property?” KAMES will send the appropriate notice of discontinuance if resources exceed limits.

   Note: If the individual no longer has the money from the sale of the property, they would need to provide verification of how the money was spent. Any money left over would be entered on KAMES as a countable resource.

E. When the individual has been institutionalized for 6 months or more prior to the application.

   The individual must provide verification of the sale or “effort to sell” the non-home property, or a statement of intent to return home, before the application is processed. Once this is complete:

   1. Approve the case for individuals who provide verification of “effort to sell” or a statement of the intent to return home. Spot-check the case for 6 months from approval to send a RFI for additional information on the sale of the non-home property.

   2. At the 6-month spot check, if no exemptions apply, obtain verification of an effort to sell at FMV.

   3. Once the property is sold, follow procedures in section D, 4.

F. Reasonable effort to sell

   A reasonable effort to sell the property shall consist of:

   1. Listing the property with a real estate agent. Obtain a copy of the sales agreement or contract and verify:

      a. A “For Sale” sign has been placed on the property which is clearly visible from the nearest public road; and
      b. [The property is advertised in the local newspaper, on local television or radio stations, or the internet.]

   2. If the individual is trying to sell the property privately a combination of at least two of the following actions must occur:

      a. [Advertising the property in the local newspaper, on local television or radio stations, or the internet;]
      b. Placing a “For Sale” sign on the property which is clearly visible from the nearest public road;
      c. Distributing fliers advertising the property for sale;
      d. Posting notices regarding availability of the property on community bulletin boards; or
      e. Showing the property to interested parties on a continuing basis, documented on a log with dates.

MS 1980 NON-HOME REAL PROPERTY (1)

Non-home real property is property, other than a home, that is owned by an individual. Only the equity value is considered as a countable resource. When entering non-home real property on KAMES, enter both the fair market value (FMV) and the amount owed as KAMES automatically calculates the countable equity value.

A. Follow these procedures when verifying non-home real property for all non-SSI LTC applications:

1. Determine county of residence. If necessary, contact any responsible relatives, interested parties, or the facility to determine county of residence.

   a. If the county of residence prior to entering long term care (LTC) is the same county where the facility is located complete form PA-16, Real Property Verification Request:
      1) To check property transfer and mortgage records in the county court clerk's office to determine if property in the name of the individual and/or spouse is owned or has been bought or sold; and
      2) To check records in the county property valuation office to determine if property is listed in the name of the individual and/or spouse.
   b. If the county of residence prior to entering LTC is different from the county in which the facility is located:
      1) Send form PA-16, Real Property Verification Request, to the Family Support Supervisor in the LTC individual's county of residence prior to entering LTC. Complete the form in duplicate. File the original in the case record and
      2) The out-of-county DCBS office completes the property check by using the criteria in 1a above. When the completed form is received, it is filed in the case record to document verification of non-real property.

2. The KAMES Resource Check

   All vendor payment cases such HCBS, Michelle P., NF, etc. subject to transfer of resource penalties will pend on KAMES for the resource check, which is verified by form PA-16.

   The question, "Has bank and courthouse asset check been done?" must be answered, with verification code "OR" or "WS" entered, before the system will process the vendor payment approval.

   The following types of care are not subject to transfer of resource penalties and are excluded from the KAMES property resource check. These cases will not pend for the bank and courthouse asset check on KAMES:

a. Hospice Non-Institutional;
b. Hospice NF;
c. Mental Health/Psychiatric Facility;
d. PRTF; and
e. EPSDT.

Note: Recipients of these benefits are required to verify resources such as bank accounts, CD's, and life insurance policies.

5. If the county of residence prior to entering LTC is out-of-state, accept the individual and/or spouse's statement for non-home real property unless questionable.

6. Document the case record regarding ownership of real property and indicate method of verification.

B. KAMES determines the equity value of non-home real property by taking the FMV of the property and subtracting any debt owed on the property. The FMV can be verified by using records maintained by the county property valuation office such current tax statements.

Example: Applicant owns her home and the adjoining property. She also owns a one-acre tract with a small house in another location. The one-acre tract with the small house is non-home real property. The FMV of the property is $30,000. The applicant has verified that she owes $10,000 on it. The countable equity value of the property is $20,000 ($30,000 - $10,000).

If non-home real property is not income producing, combine the equity with other countable resources and compare to resource limits.

C. **[**Exclusion of property due to inability to sell: Non-home real property may be excluded as a resource for a reasonable effort to sell. This exclusion is not permanent. At each recertification or reapplication, it must be reviewed and verified that there has been and continues to be a reasonable effort to sell the property at FMV. Form MA-10, Reasonable Effort to Sell Checklist, must be completed at each recertification or reapplication when the individual requests the property to be excluded for reasonable effort to sell. The individual must make it known publicly their intention of selling the property at FMV by a newspaper ad, correspondence with a financial institution, listing with a realtor, etc. For consideration of non-homestead property after six months of institutionalization, see MS 1975.**]**

D. Consideration of jointly owned property: If non-home property is owned jointly, determine the recipient's share by dividing the equity value by the number of owners. Exclude the property from resource consideration if the other owner(s) refuse to sell. The other owner(s) must verify in writing an unwillingness to sell his/her interest in the property. This must be re-verified at each application and recertification.

MS 1990 NON-RECURRING LUMP SUM INCOME (1)

A nonrecurring lump sum is money received at one time which is normally considered as income, but is not anticipated to continue. Common examples of nonrecurring lump sum income are accumulated back payments from unemployment insurance (UI), escrow child support money forwarded by CSE, child support received as a result of an IRS intercept, back payments from employment, severance payments, money received from insurance settlements, workers compensation settlements, gifts, inheritances, and lottery winnings.

Income from the sale of property, including the initial or down payment from a land contract sale, IS NOT a nonrecurring lump sum but a change in the type of resource.

A. Income is considered when actually available and when the applicant or recipient has a legal interest in a nonrecurring lump sum and has the legal ability to make such sum available for support and maintenance.

Example 1: Jack receives MA in the "J" category. Jack receives a $5,000 settlement from an accident in which he was involved. Jack tells his attorney he wants $2,500 to set up in a trust and the rest to purchase certificates of deposits. In this example, Jack has control over the settlement and therefore a legal interest and ability to make this money available for maintenance. This lump sum is countable.

Example 2: Jon receives MA in the "M" category. Jon receives a $25,000 settlement from an accident in which he was involved. The court ordered that the $25,000 be set up in a trust and can be used only for Jon's medical needs. In this example, Jon's family has no control of the money and no legal interest. This lump sum is excluded.

[Note: All trusts must be reviewed by the Office of Legal Services (OLS).**]**

B. Consider the non-recurring lump sum, minus any amount verified as earmarked and used for the purpose for which it was paid, as income in the month of receipt and a resource beginning with the following month.

C. Determine if any of the lump sum earmarked is actually used for the purposes for which it is paid (e.g., money for back medical bills resulting from accidents or injury, funeral and burial costs, replacement or repair of lost or damaged resources, or designated attorney fees).

Verify how the money is spent by receipts, court or insurance records, or bills.

D. Exceptions:

1. If the lump sum is from a federal or state income tax refund it is excluded as income for 12 months from the month of receipt.

2. If the lump sum is from a worker's compensation settlement and includes a one-time lump sum payment and continuing weekly or monthly benefits, consider the one-time payment as a nonrecurring lump sum payment and the continuing benefits as unearned income in the appropriate month.

3. If the lump sum is from accumulated annual leave or severance pay, it is considered continuing earned income in the month received, not a nonrecurring lump sum.

4. Tax rebates are excluded in the month of receipt and the following two months. Any proceeds from the rebates after the third month are considered a countable resource.

5. If the lump sum is from an insurance settlement, inheritance, or lottery winning, it is countable income.

   a. Reduce insurance settlements by subtracting verified amounts used, or obligated, to repair or replace items damaged or destroyed and by any associated medical expenses not covered by MA.
   b. Consider as countable income, the remainder of the insurance settlement or the actual amount of other windfall profit received by the individual.

6. Lump sums from accumulated back-payments of SSI and RSDI are excluded as a resource for the first 6 months following the month of receipt. If the back-payment includes current benefits for the month in which the payment is received, deduct that amount prior to determining the excluded resource amount. Set up a spot check for the end of the 6 month period. Consider any remaining amount as a countable resource.

E. Verify the lump sum amount using a:

1. Statement from lawyer/trustee;

2. Letters of award; or

3. Check.

[The Office of Legal Services (OLS) reviews all trusts, other than funeral trusts, pertaining to the determination of Medicaid (MA) eligibility. OLS will advise how the trust should be considered in each eligibility determination.

A. For applications, case changes and recertifications that include a trust, scan a copy of the trust into the Electronic Case File (ECF). Annotate on the front page of the copy whether it is an application, case change, or recertification. Complete and attach form MA-33, DMS Review/Cover Sheet. To assure processing timeframes are met, the regional Program Specialist must forward all trusts to MSBB daily.

1. Review the trust to ensure all attachments listed in the trust have been provided. If any parts of the trust or attachments are missing, request the missing information from the client and DO NOT submit the trust until everything has been provided. The following information is needed when forwarding a trust for review:

   a. All pages of the trust;
   b. If the individual's home was placed in a trust, include a copy of form PA-16, Real Property Verification Request, and the deed placing the home in the trust;
   c. If an MRT is completed for the individual, include a copy of the front page of the MRT determination;
   d. Verification of funding of the trust (documentation of what is in the trust);
   e. If a guardian established the trust, include a copy of the guardianship court documents; and
   f. A list of all parties involved on the trust and what is the relationship to the member.

2. Scan form MA-33, DMS Review/Cover Sheet with the ECF Document ID #'s listed and send to MSBB by email at DFS.Medicaid@ky.gov.

   Note: For recertifications, do not send a trust that has been previously reviewed unless changes in the trust have occurred.

B. MSBB is responsible for forwarding the trust to OLS for review.

C. Following completion of the review, MSBB will send an email regarding the consideration of the trust to the regional Program Specialist.

D. For applications, hold the application pending until a response from OLS is received. OLS will give priority to trust reviews for applications. Refer to Volume IVA, MS 1470, for cases pending over 30 days with good cause.

E. For recertifications, do not hold a recertification pending for receipt of the trust review response. Complete any case action necessary as a result of the review response effective with the next administratively feasible month following receipt of the response.

F. In some situations, OLS may need additional information to complete the review. The worker should promptly request the additional information upon notification from MSBB.**]**

G. Workers who have questions concerning the status of a trust review are to contact MSBB through their regional Program Specialist.

H. For recipients, representatives or attorneys who have questions about the regulations in establishing a trust, refer them to the following websites:

1. The Center for Medicare and Medicaid Services Medicaid Manual refer to http://www.cms.hhs.gov/medicaid/ for section 3259 the "Treatment of Trust";

2. Kentucky Administrative Regulations refer to: http://www.lrc.ky.gov for title 907 KAR "Cabinet for Health Services, the Department for Medicaid Services"; and

3. Department for Medicaid Member Services at 1-800-635-2570.

MS 2011 CONSIDERATION OF INCOME FROM A MEDICAID QUALIFYING TRUST ESTABLISHED ON OR BEFORE 8/10/93 (1)

[The Office of Legal Services (OLS) reviews all trusts for Medicaid (MA) eligibility determinations. OLS will advise how the trust is to be considered in their response once the trust has been reviewed. Based on OLS determination on how the funds are to be considered in the case the applicant/recipient could be considered for an undue hardship determination.

For Medicaid Qualifying Trusts established on or before 8/10/93, if OLS finds that there is a set monthly payment, that payment amount would be considered unearned income whether or not the individual actually receives the full payment amount.**]**

If the individual alleges consideration of the full payment amount causes an undue hardship, the individual may request exemption from this requirement. An undue hardship is considered to exist if the trustee is legally unable to pay the maximum monthly payment allowed by the trust; for example, if the individual is obligated to pay court ordered child support or alimony.

Submit a memorandum to CHFS/DCBS Supervisor, MSBB, 275 East Main Street, 3E-I, Frankfort, Kentucky 40621, requesting an undue hardship determination for a Medicaid Qualifying Trust. Include in the memorandum the reason(s) the individual is alleging an undue hardship due to consideration of the total income from the Medicaid Qualifying Trust. Attach copies of verification of the reason(s) furnished by the individual.

MS 2030 VEHICLES (1)

[Vehicles may or may not be considered a countable resource if the vehicle is registered under the name of a member in the applicant's household and depending on what the vehicle is used for by the household.

A. Excluded Vehicles

Vehicles, regardless of value (including some recreational vehicles) are considered an excluded resource if used by a member of the household for one of the following reasons:

1. It is used to obtain medical treatment;

2. It is specially equipped for the disabled;

3. It is used by the community spouse;

4. It is used for employment or self-employment; or

5. It is used as an owner occupied home.

B. Purchase of a Vehicle Once Institutionalized

At the time of admission, if an institutionalized individual does not own a vehicle, and wishes to use his/her resources to purchase a vehicle, this vehicle <u>cannot</u> be excluded unless:

1. One of the criteria listed above in section "A" is met;

2. It is verified by a statement from the nursing facility the recipient resides in, that the vehicle being purchased is specially equipped for the recipient's use;

   Example: Bob is in LTC. He has $20,000 in excess resources which he uses to purchase a van; however, he is physically limited to stretcher transportation. This vehicle cannot be excluded as it is not equipped to meet Bob's needs.

3. The vehicle purchased is in the recipient's name. If the vehicle is not in the recipient's name, it is a transfer of resources. Refer to MS 2905.

B. Non-Excluded Vehicles

Non-excluded vehicles are any vehicles owned by a member of the Medicaid recipient's household which do not meet the criteria in section "A" above. $4500 is excluded from the total equity value of all non-excluded vehicles.

C. Non-Excluded Recreational Vehicles

The total equity value of recreational vehicles (such as boats, four wheelers, Jet Skis, motor homes, campers, etc.) is a countable resource unless the recreational vehicle can be excluded for one of the reasons listed in section “A” above. The total equity value of non-excluded recreational vehicles is entered under “Other” on the KAMES Resources screen.

Note: The $4500 vehicle exclusion is NOT allowed for recreational vehicles not used for purposes identified in section “A” above.

E. Anytime a vehicle is excluded to obtain medical treatment the individual is not eligible for non-emergency transportation services.

F. How to Verify the Value of a Vehicle

The following resources may be used when verifying the value of a vehicle:

1. National Automobile Dealers Association (NADA) when at all possible;

2. If the client states the vehicle is not worth the value verified by NADA, use the value listed on Program 68 – Vehicles Reg-Avis;

   When using program 68, sometimes several vehicles may be listed under an individual but those vehicles may be in poor condition (“junk cars”) and not worth the value listed. Explain to the client the option of junking a car. The client may be able to go to the courthouse to get a junk title. Advise client that there is a fee to get a junk title.

3. If the client states the vehicle is not worth the value being counted as verified by NADA or program 68, accept a statement on letterhead from a used car dealer, mechanic, or wrecker services.]

MS 2031 OVERVIEW OF BURIAL RESERVES (1)

Burial Reserves are resources that are set aside or designated by the recipient to pay for funeral expenses. Burial reserves may be in the form of:

A. Prearranged funeral contracts;

B. Life insurance policies;

C. Burial funds; or

D. Cash set aside for burial purposes.

Each individual is allowed a $1,500 exclusion for burial reserves in addition to the normal $2,000 resource allowance. The $1,500 exclusion can be applied to a combination of any of the above by the signing of form MA-36, Burial Designation. If form MA-36 is signed at application it also covers the designated burial reserve for the retroactive three months. For example, a MA-36 is signed for a life insurance policy at application on June 4th. The client was admitted to a nursing facility on March 4th, and level of care was met on March 4th. The signed MA-36 is good for March, April, and May and ongoing. If the MA-36 is not signed, the entire resource is countable.

At application, burial reserves may be commingled with other resources, but must be separated in order to be excluded. When burial reserves are mixed with other resources, consider the difference between the account balance and the designated amount for burial a liquid asset (account balance minus burial reserve equals liquid asset). After the case is approved, burial reserves must be separated from other resources within 30 days.

[NOTE: **ALL** prearranged funeral contracts, regardless of the amount of funding, must be reviewed and the appropriate checklist must be completed by the worker and scanned into the Electronic Case File (ECF).**]**

MS 2033 EXCLUDED BURIAL ITEMS

The following burial items are considered as excluded resources:

A. Burial space items including conventional gravesites, crypts, mausoleums, urns, vaults, caskets, headstones, and opening and closing of the grave. Each household member is allowed one burial container and location, one headstone and opening of closing of grave or other repository;

B. Burial insurance policies that are payable only for the disposal of the remains of the deceased;

C. Value of a prearranged funeral contract funded by the purchase of life insurance policy with an irrevocable assignment or irrevocable of ownership/beneficiary of the life insurance policy to the funeral home;

D. The value of a prearranged funeral contract with an Irrevocable Funeral Trust Agreement;

E. Allow a $1500 exclusion from burial reserves by completion of form MA-36, Burial Designation, for each member of the assistance group when the client indicates that the burial reserve is to be used for burial and no other burial arrangements have been made; or

F. Term insurance policies with no cash surrender value (CSV).

Consider any reserves withdrawn from a resource that has been excluded as a burial reserve a countable resource during the first possible month after the Agency becomes aware of the withdrawal. Consider reserves remaining in the burial reserve as excluded resources.

MS 2034 BURIAL FUNDS

Burial funds are resources held in an account at a financial institution (i.e. a bank) to be disbursed for burial expenses only for the account holder. The funds are not accessible by the Medicaid recipient or any other individual and can only be disbursed for burial expenses at the time of the recipient's death. Naming the funeral home as the beneficiary on the account is not necessary. The funeral home can be chosen at the time of need. All documentation from the financial institution must be forwarded with a completed cover sheet to Medical Support and Benefits Branch (MSBB) for Department for Medicaid Services (DMS) review. Applications cannot be processed and must be held pending until receipt of DMS review of the burial fund.

A. VERIFICATION:

The following must be verified and documented:

1. Verify burial funds by copies of the contractual agreement from the financial institution.

2. Verify that the monies contained in the burial fund are inaccessible and can only be released at the recipient's death.

B. CONSIDERATION:

Field staff will be advised on how to consider the burial fund when response from the DMS review is received. MSBB will forward a memo detailing how the fund is to be considered.

C. SYSTEM ENTRY:

Burial funds are entered on the KAMES system on the RESOURCES (KIMA31) screen by:

1. Answering yes to "Does He/She Have Any Money Set Aside for Burial Other than Life/Burial Insurance Policy or a Prearranged Funeral Contract?"

2. Follow the instructions that will be given in the memo from MSBB on system entry of the burial fund.

MS 2035 CASH SET ASIDE FOR BURIAL PURPOSES

An individual can set aside up to $1,500 to designate for burial purposes. This can be in the form of a bank account, a Certificate of Deposit (CD), a savings account, or money stored under the mattress, in the cookie jar, lingerie drawer, etc.

If funds are commingled at the time of application, the burial reserves must be separated within 30 days of the case approval in order to allow the $1,500 exclusion.

A. VERIFICATION:

The following must be verified and documented.

1. Bank accounts - verified by a copy of the bank statement;

2. CD's – verified by a copy of the CD;

3. Savings Accounts – verified by a copy of the savings passbook; or

4. Hidden money – verified by a written statement of the money stored in the home from the client.

B. CONSIDERATION:

Form MA-36, Burial Designation, must be signed in order to allow a $1,500 exclusion from the cash set aside.

C. SYSTEM ENTRY:

Money set aside for burial is entered on the KAMES system on the RESOURCES (KIMA31) screen by:

1. Answering yes to "Does He/She Have Any Money Set Aside for Burial Other than Life/Burial Insurance Policy or a Prearranged Funeral Contract?"

2. Entering the total amount of this money after "If Yes, Amount:"

3. Answering "Y" to "Are These Funds Clearly Designated As Set Aside for Burial?"

4. Entering OR as your verification source after the appropriate verification is received. This will allow the $1,500 exclusion.

D. EXAMPLE:

Individual states they have $1,600 in their cookie jar. This money is to be used for their burial expenses.

$1,600 in cookie jar
-1,500 Burial exclusion
$ 100 Countable Resource

The $1,500 must be separated from the $100 within 30 days of the case approval. The individual agrees to this action by signing the MA-36.

MS 2036 LIFE INSURANCE POLICIES

Life insurance is a means to set aside money to be used at the time of the individual's death. Policy holders buy insurance from an insurance company and pay specific periodic amounts (premiums) for the duration of the policy (either a set period of time or for a lifetime).

A client can designate a life insurance policy for burial purposes. This will allow a $1,500 exclusion from the cash surrender value (CSV) of the policy. This can be done by completing and signing Form MA-36, Burial Designation. There is no limit to the number of insurance policies that may be designated for burial. If the total combined CSV of the policies exceed $1,500, any amount in excess of $1,500 is a countable resource.

There are three distinct types of insurance policies: term life, burial insurance and whole life insurance. While the verification requirements are identical, each type of life insurance policy is considered individually.

A. TERM LIFE INSURANCE POLICIES

Term Life Insurance policies are active and payable for a designated period of time. Term Life Insurance policies are those that generally have no cash surrender value or loan value. The benefits for these policies can be accessed at the death of the policyholder. Although these policies are totally excluded from consideration for Medicaid, we are still required to enter these policies on KAMES.

1. VERIFICATION:

The following must be verified and documented:

a. Name of policy owner
b. Name of covered individual
c. Name of company
d. Policy Number
e. Face Value

A copy of the policy must be filed in the case record.

2. CONSIDERATION:

Term Life Insurance policies are an excluded resource. Therefore, an MA-36 is not required for Term Life Insurance policies.

3. SYSTEM ENTRY:

When entering term insurance policies:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;

b. Enter the insurance company's name, policyholder's name and SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 1 – TERM INS;
d. Enter face value, date of policy issuance. The KAMES system will exclude the value of this policy.

Another option for Term Life Insurance policies that has recently appeared on the market are Modified Term Life policies. These can have a cash surrender value and verification is required to determine the amount. If the policy has a cash surrender value, it is to be entered under Option 3, Whole Life Insurance and the verified cash surrender value entered appropriately. Document in case comments the reason this was entered under Whole Life. Do not enter Modified Term Life policies with cash surrender values under Option 1 as the system will not accurately calculate the resources. All Modified Term Life policies must be verified at application and annually at recertification as this benefit may not be in effect for the entire life of the policy. Form MA-36 is required for Modified Term Life Insurance policies in order to exclude $1,500 from consideration.

B. BURIAL INSURANCE POLICIES

A burial insurance is a life insurance policy that can only be used to pay the burial costs for the deceased policyholder. Burial Life Insurance policies are those that have no cash surrender value or loan value. The benefits for these policies are only received at the time of death of the policyholder. Although these policies are totally excluded from consideration for Medicaid, we are still required to enter these policies on KAMES.

1. VERIFICATION:

The following must be verified and documented:
a. Name of policy owner
b. Name of covered individual
c. Name of company
d. Policy Number
e. Face Value

A copy of the policy must be filed in the case record.

2. CONSIDERATION:

Burial Insurance is an excluded resource. Form MA-36 is not required for Burial Insurance policies.

3. SYSTEM ENTRY:

When entering burial insurance policies"

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the insurance company's name, policyholder's name and SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 2 – BURIAL INS;

d. Enter face value, date of policy issuance. The KAMES system will exclude the value of this policy.

C. WHOLE LIFE INSURANCE POLICIES

Whole life insurance builds a Cash Surrender Value (CSV) over time, which the policyholder can withdraw or borrow against. This is considered an available resource. The individual can designate a whole life insurance policy for burial purposes which will allow a $1,500 exclusion from the countable resource by signing Form MA-36.

1. VERIFICATION

The following must be verified and documented:

a. Name of policy owner
b. Name of covered individual
c. Name of company
d. Policy Number
e. Face Value
f. Cash Surrender Value (at application, reapplication and recertification)
g. Loan Balance, if any (at application, reapplication and recertification)

A copy of the policy must be filed in the case record. If the whole life insurance policy does not have a current table of cash surrender values, verification of current values (face and cash surrender/loan value) is required. This typically occurs when the policy is over 20 years old as most policies only have a table for that length of time. It is the responsibility of the individual to request the verification from the insurance company. If the policy was written by a company no longer in business in Kentucky, the Department of Insurance can be contacted to determine what company has taken responsibility for this policy. The current phone number for the Department of Insurance is (800) 595-6053.

2. CONSIDERATION:

Compare the Face Value and the Cash Surrender Value (minus any loan balance) of a whole life insurance policy. The lesser amount of the two is a countable resource. A $1,500 exclusion is only allowed if the individual signs the form MA-36. Any remaining amount is a countable resource. There is no limit to the number of life insurance policies that may be designated for burial purposes. However, only one $1,500 exclusion is allowed. If the form MA-36 is not signed, the $1,500 exclusion is not allowed.

If an individual has more than one form of burial reserve, only one can be excluded.

Example: Client has a prearranged funeral contract for $3,000 that is irrevocably assigned to the funeral home. Client also has two whole life insurance policies with a CSV of $1,400 (no loan value). The entire amount ($3,000) of the prearranged funeral contract is an excluded

resource. Therefore, the $1,500 exclusion cannot be allowed for the two life insurance policies. The total countable resources in this example would be $1,400.

3. SYSTEM ENTRY:

When entering whole life insurance policies:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the insurance company's name, policyholder's name and SSN and account number on the KAMES Burial Reserve screen.;
c. Choose Option 3 – WHOLE LIFE INS
d. Enter face value, date of policy issuance, cash surrender value, and amount of loans (if any).
e. If a MA-36 has been appropriately signed for this policy, answer "Y" to "If Life Insurance Policy, Has the Policy Been Designated for Burial Purposes?"
f. Enter a verification source of WS. KAMES will allow the $1,500 exclusion and calculate the remaining countable resources (if any).

EXAMPLE 1:

An individual has a whole life insurance policy with a CSV of $1,250, which is not designated for burial (no form MA-36 signed). There is a $300 loan against the policy.

$1,250 CSV
- 300 Loan against policy
= 950 Countable resource

EXAMPLE 2:

An individual has a whole life insurance policy with a CSV of $2,000, which has been designated for burial (form MA-36 signed). There is a $600 loan against the policy.

$2,000 CSV
- 600 Loan against policy
$1,400 Remainder
-1,500 Burial exclusion (MA-36 signed)
0 Countable resource

EXAMPLE 3:

An individual has two whole life insurance policies with Silver Life, with a cash surrender value of $600 each. They have two policies with Gold Shield, with a cash surrender value of $1,000 each. There is one policy with Golden Age, with a cash surrender value of $2,000. There are no outstanding loans on any of the policies, and a MA-36 has been signed for each policy to designate for burial.

$ 600 – Silver Life policy
600 – Silver Life policy
1,000 – Gold Shield policy
1,000 – Gold Shield policy
2,000 – Golden Age policy
5,200 – total CSV for all policies

$5,200 – total CSV for all policies
-1,500 – burial exclusion (MA-36's signed)
$3,700 – total countable resource

MS 2037 PREARRANGED FUNERAL CONTRACTS (1)

[Prearranged funeral contracts are contractual agreements between the recipient and the funeral home. They may be funded by life insurance policies, cash, or a combination of both. All prearranged funeral contracts must include an itemization of goods and services selected for the individual and signed by both the funeral home and the client. The signature can be from the client, the spouse, power of attorney (POA), or the legal guardian. The required statement must list each item separately with its value, and cannot be a total package value. Without an itemization of goods and services, only the $1500 exclusion can be allowed.

For **ALL** prearranged funeral contracts funded by cash, complete form MA-33 Supp. A, Checklist for Prearranged Funeral Contract funded by Cash.

For **ALL** prearranged funeral contracts funded with life insurance, complete form MA-33 Supp. B, Checklist for Prearranged Funeral Contract funded with Life Insurance.

For **ALL** prearranged funeral contracts funded by a life insurance policy purchased through the funeral home, complete form MA-33 Supp. C, Checklist for Prearranged Funeral Contracts funded by a Life Insurance Policy Purchased through the Funeral Home.

NOTE: For prearranged funeral contracts funded by a combination of sources, a checklist is required for each source of funding.

The following are some general rules that apply to all prearranged funeral contracts:

- There can be no clauses in the contract which indicate that any excess funds, after arrangements are paid, may be returned to a designated individual, such as the beneficiary. Such provisions indicate possible prohibited transfer of resources. If an excess remains after all funeral expenses have been paid, the excess must be designated to the estate of the deceased.

- If a recipient makes changes or additions to an existing prearranged funeral contract, obtain a written, detailed explanation from the funeral home as to the purpose and nature of the changes. Obtain verification from the recipient as to the source of the funds added to the contract. If it is verified that these upgrades or services are not included in the original contract, this is allowable. A new contract is not required; a signed addendum can be accepted. If the circumstances are questionable, refer the matter to MSBB for consideration.

- If cash, which is paid to a funeral home for a burial contract, is used by the funeral home to purchase an insurance policy, such as Forethought, Investor's Heritage or Kentucky Funeral Director's Life Insurance, it is considered a prearranged funeral contract funded by a life insurance policy.

- Any interest or dividends that accrue on a prearranged funeral contract are excluded.

- If a recipient has a prearranged funeral trust agreement with an out of state funeral home, DMS has clarified that we cannot compel the funeral home to follow Kentucky policy.

There are five distinct types of prearranged funeral contracts identifiable according to how they are funded:

A. **Prearranged funeral contracts funded by a whole life insurance policy with an irrevocable assignment.** This is a prearranged funeral contract in which the individual has a life insurance policy that they have turned over to the funeral home. This contract is an excluded resource if the irrevocable assignments to the funeral home have been made by the insurance company.

1. VERIFICATION:

   The following must be verified and documented:

   a. Verification from the insurance company that the irrevocable change has been made;
   b. Detailed itemized statement of goods and services signed by both the funeral home and the client;
   c. Face Value (FV); and
   d. Source of cash, such as copy of the check or receipt.

2. CONSIDERATION:

   The entire value of the prearranged funeral contract is an excluded resource. Form MA-36, Burial Designation, is not required for this type of burial reserve.

3. SYSTEM ENTRY:

   a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
   b. Enter the name of the funeral home, not the life insurance company, the individual's name, SSN and account number on the KAMES Burial Reserve screen;
   c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
   d. Enter the face value of the contract minus any accrued interest or dividends, and the date issued;
   e. Answer "Y" to the "If Prearranged Funeral Contract, is there Irrevocable Assignment or Trust Agreement?"; and
   f. Enter verification source of WS. This will exclude the entire amount of this contract.

   EXAMPLE: An individual has a $4500 funeral contract funded by a Golden Life Whole Life insurance policy. Verification has been received that this policy has been irrevocably assigned to the funeral home. An itemized statement of goods and services was provided. The entire $4500 is excluded.

B. **Prearranged funeral contract funded by cash with no Irrevocable Funeral Trust Agreement**. This type of contract is an available resource with certain considerations.

1. VERIFICATION:

The following must be verified and documented:

a. Detailed itemized statement of goods and services signed by both the funeral home and the client; and
b Source of cash, such as a copy of the check or receipt.

2. CONSIDERATION:

The value of the prearranged funeral contract is considered an available resource with the following considerations:

a. Interest or dividends on burial reserves are excluded if allowed to accrue;
b. The value of the burial space items is excluded;
c. $1,500 is excluded if Form MA-36 is signed; and
d. Any remaining value after the above exclusions is a countable resource.

3. SYSTEM ENTRY:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the name of the funeral home, the individual's name, SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
d. Enter the face value of the contract (minus interest and dividends that have accrued), and the date issued;
e. Answer "Y" to "Is there a Loan Against the Policy or are Exempt Items (Casket, Vault, Etc.) in the Prearranged Funeral Contract?";
f. Enter the amount of the excluded items in space indicated by "If Yes, What is the Total Amount of the Loan/Exempt Items.";
g. Answer "Y" to "If Life Insurance policy, Has the Policy Been Designated for Burial Purposes?"; and
h. Enter verification source of WS. This will exclude $1,500 if form MA-36 has been signed.

EXAMPLE: A $6,000 prearranged funeral contract is purchased with cash. The individual has selected a casket for $2,500, burial plot valued at $1,000, opening and closing of grave for $500, funeral services for $1,000, embalming cost of $500, clothing valued at $200, limousine at $200, and flowers at $100.

The excluded burial space items are determined by adding: casket at $2,500, burial plot valued at $1,000, and $500 for the opening and closing of the gravesite for a total of $4,000. The clothing, funeral service, flowers, and limousine are not deducted. The calculations for the countable resource are:

$6,000 Value of the contract
-4,000 Value of burial space items
2,000 Remainder

-1,500 Burial Reserve Exclusion
$ 500 Countable Resource

C. **Prearranged funeral contract funded by cash with an Irrevocable Trust Agreement**. This is an excluded resource if the Irrevocable Funeral Trust Agreement is signed not more than 30 days prior to the Medicaid application.

1. VERIFICATION:

The following must be verified and documented:

a. Detailed itemized statement of goods and services signed by both the funeral home and the client;
b. Irrevocable Funeral Trust Agreement signed not more than 30 days prior to the Medicaid application; and
c. Source of cash, such as a copy of the check or receipt.

2. CONSIDERATION:

The value of the prearranged funeral contract is considered an excluded resource if the following criteria are met:

a. All entries are completed on the Irrevocable Funeral Trust Agreement;
b. The form is signed and dated no more than 30 days prior to the date of application; and
c. A detailed itemized statement of goods and services for the amount of the cash is provided.

A new irrevocable funeral trust agreement is required if the client leaves vendor payment status for over 30 days.

3. SYSTEM ENTRY:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the name of the funeral home, the individual's name, SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
d. Enter the face value of the contract, the date issued;
e. Answer "Y" to "If Prearranged funeral Contract, Is There Irrevocable Assignment or Trust Agreement?"; and
f. Enter OR as verification source. This will exclude the entire amount of the prearranged funeral contract.

D. **Prearranged Funeral Contract funded by cash with a purchase of an insurance policy through the funeral home.** These contracts require a copy of the policy showing it is irrevocably assigned or that the funeral home is the owner and a detailed itemized Statement of Goods and Services.

Examples of this type of policy are Forethought and Investors Heritage. This is an excluded resource if the policy is assigned to the funeral home and is accessible only at the death of the insured.

1. VERIFICATION:

The following must be verified and documented:

a. Detailed itemized statement of goods and services signed by both the funeral home and the client;
b. A copy of the insurance policy showing it is irrevocable or that it is assigned to the funeral home and can only be accessed at the death of the insured;
c. Face Value (FV); and
d. Source of cash, such as a copy of the check or receipt.

2. CONSIDERATION:

When a contract is funded by cash and a policy is purchased at the funeral home and the policy has an irrevocable assignment, or an irrevocable assignment of beneficiary or ownership to funeral home, the entire value of the prearranged funeral contract is an excluded resource. The Irrevocable Funeral Trust agreement is not required. The MA-36 is also not required.

3. SYSTEM ENTRY:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the name of the funeral home, not the life insurance company, the individual's name, SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
d. Enter the face value of the contract minus any accrued interest or dividends, and the date issued;
e. Answer "Y" to the "If Prearranged Funeral Contract, is there Irrevocable Assignment or Trust Agreement?"; and
f. Enter verification source of WS. This will exclude the entire amount of this contract.

E. **Prearranged Funeral Contracts funded by a combination of funding sources**. These types of contracts require an irrevocable assignment of the life insurance policy and an Irrevocable Funeral Trust agreement for the cash, signed no more than 30 days prior to the Medicaid application. If both are provided with a detailed itemized Statement of Goods and Services, the entire prearranged funeral contract is excluded.

1. VERIFICATION:

The following must be verified and documented:

a. Verification from the insurance company that the irrevocable change has been made;
b. A detailed itemized statement of goods and services signed by both the funeral home and the client;
c. Irrevocable Funeral Trust Agreement for the cash portion of the contract signed no more than 30 days prior to the Medicaid application; and
d. Source of the cash, such as a copy of the check or receipt.

2. CONSIDERATION:

When a prearranged funeral contract is purchased with a combination of life insurance and cash, the following applies:

a. An Irrevocable Funeral Trust Agreement with all entries completed for the cash portion of the contract signed no more than 30 days prior to application;
b. An irrevocable assignment of beneficiary or ownership to the funeral home for the life insurance portion (verification must be received from the insurance company, not funeral home); and
c. A detailed itemized statement of goods and services.

A new irrevocable funeral trust agreement is required if the client leaves vendor payment status for over 30 days.

Form MA-36 is not required.

3. SYSTEM ENTRY:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the name of the funeral home, the individual's name, SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
d. Enter the face value of the contract and the date issued;
e. Answer "Y" to "If Prearranged funeral Contract, Is There Irrevocable Assignment or Trust Agreement?"; and
f. Enter OR as verification source. This will totally exclude the entire amount of the prearranged funeral contract.

F. General funding rules:

UNDER-FUNDED: An underfunded contract means the individual has selected goods and services that total more than the funds allocated by cash or a life insurance policy. The individual still has a liability to the funeral home for the remaining balance. If the individual has selected over $10,000 in goods and services but has only provided the funeral home with $5,000 in cash or life insurance, this is an under-funded funeral contract. The funding provided to the funeral home is the value of the contract and the amount entered into the system.

FULLY FUNDED: A fully funded contract means all goods and services needed for the individual's burial are paid for and the funeral home has guaranteed the price. Guaranteed prices limit inflationary costs of funeral services and merchandise. If the individual has a fully-funded prearranged funeral contract, and is not upgrading (such as oak casket exchanged for a cherry casket), they cannot add funds to this prearranged funeral contract.

OVER FUNDED: An over funded contract means the individual has provided funds in excess of the selected goods and services. When reviewing an over funded funeral contract, verify the date the source of funding (cash or life insurance) was assigned (life insurance) or put in a trust (cash).

If the date is beyond the look back period for transfer of resources, the entire amount of the contract is entered on the KAMES system. KAMES will exclude the entire contract as long as all requirements for exclusion are met.

If the date is within the look back period, enter the prearranged funeral contract on the KAMES system and input the amount of itemized goods and services as the funeral value. The remainder of the funding above this amount is input on the transferred resource screen using the date of the assignment as the transfer date.**]**

MS 2050 TRANSFER OF RESOURCES (1)

Transfer of resources policy and penalties apply to individuals who transfer resources for less than fair market value (FMV) to gain Medicaid (MA) eligibility. Penalties include restricted MA coverage resulting in ineligibility for vendor payment status for an otherwise eligible institutionalized individual during the prohibited period.

A. Transfer of resources policy and penalties apply to individuals (including SSI recipients, see MS 2110) who apply for or receive MA for LTC, ABI/ABI LTC, ICF IID, SCL, waiver services, individuals in Guardianship, and/or the individual's community spouse.

B. Do not apply the transfer of resources policy to transfers made by recipients in an ICF IID or SCL setting prior to 8/10/93.

   Example: An SCL recipient became MA eligible in 10/92 with recertification due in 10/94. A transfer of resources occurred in 9/92. Transfer of resources policy effective 8/10/93 does not apply.

C. Effective February 9, 2009 the look back period has progressively expanded from 36 months to 60 months for transfers made on or after February 8, 2006. Effective February 8, 2011, the look back period will reach 60 months.

   There is no change in the look back period for resources transferred into a trust or used to establish a trust. The look-back period remains 60 months.

D. Form PA-16, Real Property Verification Request, must be completed for all IM vendor payment cases. Both the county court clerk's office and the county property valuation office must be checked when completing the form. All IM vendor payment cases subject to transfer of resource penalties will pend on KAMES for the resource check (verified by form PA-16). The question, “Has bank and courthouse asset check been done?” must be answered, with verification code “OR” or “WS” entered, before the system will process the vendor payment approval.

   The following types of care are not subject to transfer of resource penalties and are excluded from the KAMES property resource check. These cases will not pend for the bank and courthouse asset check on KAMES:

   a. Hospice Non-Institutional;
   b. Hospice NF;
   c. Mental Health/Psychiatric Facility;
   d. PRTF; and
   e. EPSDT.

   Note: These recipients are required to verify resources such as bank accounts, CD’s, life insurance policies, etc.

E. Transfer of resources penalties can apply to the institutionalized spouse when the community spouse transfers resources for less than FMV prior to the month of separation.

1. If the community spouse transfers assets that result in a penalty period for the institutionalized spouse and the community spouse later becomes institutionalized, any remaining penalty period is apportioned between the spouses (divided in amounts requested by both spouses), if the former community spouse is MA and vendor payment eligible.

2. If one spouse is no longer subject to the penalty, such as, the spouse no longer receives nursing facility services or dies, the rest of the penalty period applicable to both spouses must be served by the remaining spouse.

Note: Assets transferred by the community spouse for less than FMV must be entered on KAMES under the institutionalized spouse in order for KAMES to calculate the penalty.

F. Do not apply transfer of resources policy to funds attached to an irrevocable funeral trust agreement or a prearranged funeral contract with an irrevocable assignment of ownership.

G. Apply transfer of resources policy to assets, such as lump sum payments, not yet considered as a resource. Consider lump sum payments given away in the month of receipt a transfer of resources.

H. Apply transfer of resources policy to property, including homestead property, when ownership was transferred to another individual while retaining life estate interest in that property. As actual ownership of the property has passed to another individual, the transfer to life estate interest carries a penalty period. Refer to MS 2055 for these resource calculations. For consideration of homestead property after six months of institutionalization, refer to MS 1975.

I. [The placing of homestead property into a trust may be subject to transfer of resources penalties. Forward a copy of the homestead trust to the Medical Support and Benefits Branch (MSBB). The Office of Legal Services (OLS) is responsible for making the determination.]

MS 2055 [CALCULATING LIFE ESTATE TRANSFERS/TERMINATIONS

Under a life estate, an individual retains life estate interest in a real estate property until death. Apply transfer of resource policy to property, including homestead property, in which ownership was transferred to another individual while retaining life estate interest in that property OR if the property was sold and the life estate interest was terminated.

NOTE: A life estate interest in a property entitles an individual to income produced by the property. Income producing life estates must be sent to DMS for review. Forward all pertinent information to MSBB for DMS determination. DMS will advise how the income is considered.

When property belonging to the member is TRANSFERRED during the look back period, but Life Estate interest is retained:

A transfer of resources occurs whenever the value of the transferred property is greater than the value of the life estate.

A. Use the following steps to determine the value of the transferred resource at the time of the transfer:

1. Determine the market value at the time of transfer of the transferred property.

2. Calculate the recipient's age at the time of transfer. Use that age to select the Life Estate Factor from the Life Estate Table in MS 2056.

3. Multiply the property value by the Life Estate Factor to get the transfer of resource amount.

   Example: Mom, age 79, is in a Nursing Facility. She deeded her $78,000 homestead to her children 2 years ago but retained a life estate interest. Her representative has come in to apply for Medicaid. To calculate the Life Estate Transfer, take the following steps:

   Step 1:

Value of property at time of transfer	$78,000
Age at time of transfer (79-2)	77
Life Estate Factor (Vol. IVA, MS 2056)	.51258

   Step 2:

Value of property	$78,000	
Life Estate Factor	x.51258	
Transfer of resource amount		$39,981.24

   The result is the value of the transferred resource at the time it was transferred. Use this amount when determining the transferred resource penalty period, per MS 2080.

B. Use the transfer of resource amount from the calculation in the example above to determine the current value of a life estate in the following steps:

1. Divide the transfer of resource amount ($39,981.24) by the number of years of life expectancy determined from the Life Expectancy Table in Vol. IVA, MS 1900, to get the yearly value of the property.

   Based on the EXAMPLE in A.3 above:

   Step 3:

Transfer of resource amount	$39,981.24
Divided by years of life expectancy (based on age 77)	10.96
Yearly value of property	$3,647.92

2. Multiply the yearly value of property ($3,647.92) by the number of years remaining in the individual's life expectancy since the transfer to get the dollar amount of the current life estate.

   Based on the EXAMPLE in A.3 above:

   Step 4:

Yearly value of property	$3,647.92
Remaining years of life expectancy	8.96
Amount of current life estate	$32,685.36

When a property with Life Estate Interest is SOLD:

If the owner of the life estate signs a deed to allow the property to be sold, this action terminates the life estate interest and is considered a transfer if:

1. The individual is NOT compensated for the fair market value (FMV) of the life estate interest; and

2. The transfer occurred within the look back period.

If the owner of the life estate is compensated for the FMV of the life estate interest, the proceeds are considered a countable resource.

NOTE: DMS must review case situations in which property with life estate interest is sold. Forward all pertinent information to MSBB for DMS determination.**]**

MS 2056* LIFE ESTATE TABLE

Use the following table to identify the Life Estate Factor necessary to determine the value of life estate. Age in this table refers to the individual's age at the time the transfer took place.

Age	Factor	Age	Factor	Age	Factor
0	.02812	37	.06974	74	.46138
1	.01012	38	.07433	75	.47851
2	.00983	39	.07917	76	.49559
3	.00992	40	.08429	77	.51258
4	.01019	41	.08970	78	.52951
5	.01062	42	.09543	79	.54643
6	.01116	43	.10145	80	.56341
7	.01178	44	.10779	81	.58033
8	.01252	45	.11442	82	.59705
9	.01337	46	.12137	83	.61358
10	.01435	47	.12863	84	.63002
11	.01547	48	.13626	85	.64641
12	.01671	49	.14422	86	.66236
13	.01802	50	.15257	87	.67738
14	.01934	51	.16126	88	.69141
15	.02063	52	.17031	89	.70474
16	.02185	53	.17972	90	.71779
17	.02300	54	.18946	91	.73045
18	.02410	55	.19954	92	.74229
19	.02520	56	.20994	93	.75308
20	.02635	57	.22069	94	.76272
21	.02755	58	.23178	95	.77113
22	.02880	59	.24325	96	.77819
23	.03014	60	.25509	97	.78450
24	.03159	61	.26733	98	.79000
25	.03322	62	.27998	99	.79514
26	.03505	63	.29304	100	.80025
27	.03710	64	.30648	101	.80468
28	.03938	65	.32030	102	.80946
29	.04187	66	.33449	103	.81563
30	.04457	67	.34902	104	.82144
31	.04746	68	.36390	105	.83038
32	.05058	69	.37914	106	.84512
33	.05392	70	.39478	107	.86591
34	.05750	71	.41086	108	.89932
35	.06132	72	.42739	109	.95455
36	.06540	73	.44429		

MS 2070 EXCEPTIONS TO TRANSFER OF RESOURCES

[Do not apply a transfer of resource penalty or restrict MA coverage to an individual if one of the following exceptions exists.]

A. Transfer of homestead property on or after 8/10/93, to:

1. The spouse;

2. A natural, adopted or step child who is under 21, blind or disabled;

3. A sibling who has equity interest in the home and lived with the institutionalized individual one year prior to institutionalization; or

4. [An adult child, other than the above, who lived with the institutionalized individual two years immediately before the individual was institutionalized, has lived there continuously since that time and can prove that he/she provided care to the individual that may have delayed institutionalization. The child may be a natural, adopted or step child. Use birth, adoption, and marriage records to establish relationship. The age of the child is not a factor. Verification must be provided to prove that the child lived for two years with the recipient prior to institutionalization and provided care that may have delayed institutionalization. Require two statements from collateral contacts. One of the statements should be from a collateral contact medically qualified to verify that the care provided delayed institutionalization.]

Consider transfer of homestead property on or after 8/10/93 to any individual not listed above as a transfer of assets. Transfer of the homestead property into a trust on or after 9/1/03 is considered a transfer of resources. Additionally, adding another individual's name to homestead property on or after 9/1/03 constitutes a transfer of resources, even if the name of the original owner remains on the deed.

B. A resource which would have been exempt from consideration had the transfer not occurred, such as transfer of a vehicle regardless of value if specially equipped for the disabled. This exception DOES NOT APPLY to homestead property or the transfer of property where the member retained a life estate interest.

C. The individual presents convincing evidence the transfer was exclusively for a purpose other than establishing MA eligibility. For example:

1. Satisfactory proof is provided indicating the individual intended to dispose of the resources at their fair market value (FMV). e. g. A copy of the ad showing FMV sale price and date is provided.

2. The transfer was for services rendered for care of the individual if the individual can provide a signed, dated, notarized statement verifying that the payment arrangements were in effect when the services were initiated.

3. The transfer was for expenses incurred as a result of a family emergency.

D. The resource was transferred to the community spouse, or to another for the sole benefit of the community spouse.

E. The resource was transferred to the individual's child of any age who is blind or permanently and totally disabled.

F. The resources were transferred to a trust for the sole benefit of a blind or permanently and totally disabled child.

G. A determination is made that the individual had good cause for transferring the resource.

1. Good cause may be established if the expense incurred due to one of the following events is equal to or greater than the remainder calculated considered for the transferred resource AND one of the following occurs:

   a. A natural disaster, fire, flood, storm, earthquake;
   b. Illness resulting from accident or disease, hospitalization or death of a member of immediate family; or
   c. Civil disorder or other disruption resulting in vandalism, home explosions, or theft of essential household furnishings.

2. To request a good cause determination, submit a memorandum to the CHFS DFS Medicaid Policy inbox. Include in the memorandum an explanation of the circumstances regarding the good cause claim, the amount of good cause expenses and resources remaining after calculation. Attach a copy of all verified good cause expenses.

3. Case action is completed after a written response to the request for good cause determination is received.

[H. A determination is made that denial of eligibility creates an undue hardship.] Undue hardship exists when:

1. Application of transfer of resource penalties or consideration of funds placed in a trust deprives an individual of medical care to the extent that the individual's health and life would be endangered;

2. Application of the transfer of resources or trust provisions would deprive the individual of food, clothing, shelter or other necessities of life.

   Include an explanation of the undue hardship exception when notifying recipients of the application of transfer of resources or trust provisions by form MA-105, Notice of Eligibility/Ineligibility.

   To request an undue hardship:

[(a.) A family member or the facility must compose and submit the request for undue hardship. This request must include an explanation of the circumstances that led to the Medicaid LTC denial or discontinuance. The local office cannot compose this request.

(b.) This request must include a statement from the facility that states that the individual will be discharged and the date of discharge due to non-payment.

(c.) The caseworker completes the MA-33 with a short summary of what is going on in the case such as a penalty period applied or case discontinuance.

(d.) Forward undue hardship requests to MSBB for a determination. The Department of Medicaid Services renders a decision on a case-by-case situation.]

NOTE: A hardship request cannot be made on a pending application.

MS 2080 CONSIDERATION OF TRANSFERRED RESOURCES (1)

This policy affects new applicants who transferred resources on or after February 8, 2006, or resource transfers that became known to the agency after February 8, 2006.

A. The look back period is 60 months for transfers made on or after February 8, 2006. Transfers made prior to February 8, 2006 are beyond the look back period and are not considered.

B. If a resource was transferred during the past 60 months and none of the exceptions apply, it is presumed that the transfer was for the purpose of establishing MA eligibility.

1. Transfer of resources made prior to February 8, 2006, other than a trust, is beyond the look back period and is not considered.

2. For transfer of resources from February 8, 2011 forward, the look back period will be 60 months.

3. For trusts established on or before August 10, 1993 and resources were transferred into the trust after August 10, 1993, the look back period is 36 months.

4. For trusts established after August 10, 1993, the look back period is 60 months.

NOTE: The addition of another's name to an asset after September 1, 2003 is a transfer of resources even if the name of the original owner remains on the asset as owner. The burden of rebutting this presumption rests with the individual. The opportunity for rebuttal is allowed through the fair hearing process.

C. The start date of the penalty period for prohibited transfers of resources that occurred during the 60 month look-back period is either the first day of a month during which resources have been transferred for less than fair market value (FMV) OR the day the individual is eligible for Medicaid vendor payment. Use whichever date occurs last.

Determine the period of restricted coverage or period of vendor payment ineligibility as appropriate.

1. Once eligibility has been determined and a penalty period has been established, it continues until expiration. The penalty period applies only to payment for long term care services, not to all Medicaid services.

2. For ineligibility periods that result in partial months, the individual will not be penalized for the whole month.

EXAMPLE:

An applicant's penalty period ends February 13th. He reapplies for Medicaid on March 1st. His eligibility may be backdated to February 14th.

3. A denial notice is system generated to all new Medicaid applicants when a penalty period has been imposed. The case will deny due to excess income as the system will not use the special income standard. A KIP-105.13, Disqualification, notice is also issued.

   NOTE: The case will only deny for excess income if the applicant's income exceeds the regular Medicaid standard (see MS 2190). If the income is within the limits, the case will remain eligible for Medicaid only. The recipient will not be eligible for vendor payment until the penalty period expires.

   EXAMPLE:

   An applicant is disqualified for transfer of resources. Her income is $200.00 monthly RSDI. Her case will remain active for Medicaid only. She will not be eligible for vendor payment until her penalty period expires.

4. A 10-day adverse action notice is system generated for active cases, with penalty periods imposed on an individual who is already eligible for Medicaid vendor payment. The ineligibility period is effective either the month of the transfer for less than FMV OR the date on which the individual became eligible for Medicaid vendor payment, whichever occurred last.

5. The penalty period cannot begin until the expiration of any other existing ineligibility periods.

6. Once the ineligibility period is imposed, it will not be interrupted or temporarily suspended. The ineligibility period will continue even if the individual subsequently stops receiving institutional level of care.

D. At application

At application, determine if property/assets were transferred during the look back period (refer to MS 2050). Document the reason for the transfer.

1. Determine the uncompensated equity value of the transferred resource;

2. **[**Divide the uncompensated equity value by the transferred resource factor. Use the transferred resource factor for the year in which the transfer was made known to the agency. When calculating the

individual's total ineligibility period, round down. The transfer of resource divider is a daily amount for transfers made on or after February 8, 2006. This amount changes each January. Effective January 1, 2015, the transfer of resource divider is $199.46.

EXAMPLE:

An application is taken on 1/3/15. The applicant is income and resource eligible. Applicant was admitted to LTC on 1/2/15. $50,000 was given away on 12/10/13 resulting in a disqualification period for LTC vendor payment. The disqualification period is determined as follows:

$50,000 divided by $199.46 (daily transfer of resource factor) = 250.68. The ineligibility period is rounded down to 250 days.

In this example, the count begins with the day of admission to the LTC facility because the applicant has met all other technical and financial eligibility criteria. The disqualification period is 1/2/15 through 9/8/15. September 9, 2015, is the first day the client would be eligible for LTC vendor payment.**]**

E. At Recertification/Interim:

Determine if property/assets were transferred since the last recertification. Document the reason for the transfer.

1. If a recipient transfers resources, determine the number of months of vendor payment ineligibility.

2. The month of vendor payment ineligibility begins with the month of transfer.

EXAMPLE:

[At the recertification appointment on 1/3/15 it is discovered that the client sold property for less than FMV on 12/15/14. The FMV of property was $10,000. The client sold the property for $3,000. The money received was used to pay outstanding debt. There are no countable resources to consider from the sale of the property. The transferred resource amount is $7,000. Determine the disqualification period as follows:

$7,000 divided by $199.46 = 35.09 days rounded down to 35 days.

In this situation the date of discovery is 1/3/15. The date of transfer occurred after the application date, therefore the count will begin with the date of transfer. The current year transfer resource divider is used since the transfer was reported after it occurred.

The disqualification "from" date will be 12/15/14 and continue for 35 days. The disqualification "through" date will be 1/18/15. As the disqualification ends in the recertification the case will remain active.**]**

F. Multiple Transfers are treated as a single transfer. For multiple transfers, calculate and impose a single period of ineligibility.

EXAMPLE:

[Application was made on January 3, 2015. There were multiple transfers that occurred prior to the application. All transfers occurred after February 8, 2006.

$4,000 was given away on 3/1/13.
$2,000 was given away on 5/15/13.
$2,000 was given away on 7/19/13.

Total all transfers together that occurred on or after 2/8/06:
$4,000 + $2,000 + $2,000 = $8,000

Divide the total by the current transfer of resource factor.

$8,000 divided by $199.46 = 40.11 days rounded down to 40 days. The client became vendor payment eligible on 1/4/15. The disqualification "from" date will be 1/4/15. The disqualification "through" date will be 2/12/15.**]**

G. Member Disqualification

1. The KAMES "Member Disqualify – Inquiry" screen displays the ineligibility period as days, not months. The disqualification "from" and "through" dates can be any day of the month.

2. The text of the KIP-105.13 notice for disqualification reason 414 reads:

   "Section 1917(c)(2)(D) of the Social Security Act states that if you will be discharged from the nursing home or if you will lose your waiver services because you are unable to pay, you can request a Hardship Determination. Contact your worker or long term care provider for more information."
   Follow Hardship policy in MS 2070H if a request for a Hardship Determination is received.

3. A field for number of days disqualified is displayed directly below number of months disqualified. There should be a numeric field to the right of the day's field and directly below the number of months disqualified field. The numeric value can be any amount from 0 to 9999. This field is used only when a 414 disqualification is applied and the disqualification is determined after the disqualification is entered.

All other 414 disqualifications that are determined under the old rules will retain the count for the number of months disqualified. Both fields will be displayed but only one field will be populated depending on the time when the disqualification is added. For disqualification 414 ONLY, the beginning and end dates do not necessarily correspond to the beginning and end of the calendar month(s). The 414 can be imposed to begin any day of the month and to end any day of the month. When changing or updating a record, be sure that the “through” date is equal to the “from” date plus the number of days or months disqualified.

H. Ongoing MA

Determine ongoing or spend down MA eligibility using the regular MA standard.

1. If the application is approved for ongoing MA eligibility, spot-check the case at the end of the restricted coverage period for reinstatement of vendor payment status.

2. Take appropriate action to initiate vendor payments.

MS 2081* Entering Transfer of Resources Disqualifications

System changes for implementation of the transfer of resource daily factor are in place.

A. Applications

KAMES will automatically determine the disqualification period for new applications with no history on KAMES and no 414 disqualification history, provided all of the transfer of resources information is entered correctly.

B. Re-applications

Depending on the disqualification history on KAMES, when the existing disqualification period ends and whether the case becomes eligible during the application; determines whether KAMES will automatically apply the disqualification period or if the worker has to manually:

1. Update/change the disqualification (option 2);
2. Delete the disqualification (option 3). Delete requires supervisor approval;
3. Change the begin date; or
4. Remove the end date.

Note: You cannot manually add a 414 disqualification.

C. If the number of days is left unchanged, the worker needs to change the start date and KAMES will compute a new end date. If the begin date is left unchanged, the worker is to change the number of days, remove the end date and KAMES will compute a new end date.

D. If once the disqualification period is determined and imposed, the client and/or representative brings verification that the transfer of resource has been cured (value of resource transferred given back to the client), then the disqualification period can be reduced by the appropriate number of days (value divided by daily transfer factor). If a disqualification period is reduced using option 2 (change/update) on the disqualification menu, worker will need to document thoroughly on KAMES what actions were taken and why.

If a case appears to be approving incorrectly, please notify the Help Desk prior to exiting the application.

MS 2105 SPECIAL PROCEDURES FOR TRANSFER OF RESOURCES BY A POWER OF ATTORNEY/LEGAL GUARDIAN

For those cases in which the Agency is aware that the power of attorney or legal guardian transferred resources during the 36-month or 60-month period immediately preceding the application month, apply transfer of resource policy at the next recertification. If it is determined that the transfer was completed to establish MA eligibility, apply the penalty beginning with the month of transfer.

[A hardship determination may be requested when resources that were inappropriately transferred by the POA/Legal Guardian are unavailable to pay the LTC cost of care, and the recipient has received a discharge notice from the facility or waiver provider. For hardship determination procedures, see MS 2160.]

MS 2110 SSI RECIPIENTS AND TRANSFER OF RESOURCES

Transfer of resources policy and penalties also apply to individuals receiving SSI.

A. Federal law requires SSA to identify and provide information to assist the Agency in determining whether the transfers will result in a period of restricted MA coverage.

B. Use the following procedures for SSI cases identified by SSA as transferring resources.

1. A listing titled, "HR PAS Transferred Resources Listing," is available on RMDS to indicate SSI individuals identified by SSA as transferring resources.

   The listing includes: the SSI individual's name; social security number; the date of the resource transfer; the type of resource transfer; estimated value of the resource; individual transferring the resource; and the individual to whom the resource was transferred.

2. Access the listing to determine if currently active SSI individuals applying for or receiving LTC or HCBS services are identified as transferring resources. Thereafter, access the listing for SSI individuals whenever a PA-62 document is completed for vendor payment approval for individuals active on SDX. [These individuals will appear on the RDS report titled, "PRO Certification Not Matched to KAMES". See MS 3650.]

3. If the listing indicates a transfer of resources occurred, send the SSI individual form PAFS-2 scheduling an appointment to discuss the transfer. Verify information provided by SSA on the listing and make a determination regarding the transfer prior to imposing a penalty.

MS 2120 SPECIAL RESOURCE CONSIDERATIONS FOR AN INSTITUTIONALIZED SPOUSE WITH A COMMUNITY SPOUSE

Resources of an institutionalized spouse who has a spouse living at home in the community are treated differently to prevent financial hardship which results when one spouse is institutionalized.

A. Provisions of the policy include an assessment of the institutionalized and community spouse's combined countable resources. [Form PA-22, Resource Assessment, is completed at the request of either spouse or the representative acting on behalf of the couple for most recent continuous period of institutionalization.] This assessment may be completed independent of the MA application.

B. The Resource Assessment provides a prescreening of resource eligibility to assist the couple in financial planning and in their decision to apply for MA. Included in the provisions is a community spouse resource allowance. [This resource allowance is determined by the total combined countable resources of a couple, regardless of the existence of a prenuptial agreement.] The allowance represents the amount of resources necessary for the noninstitutionalized spouse to maintain themselves in the community. [Form PA-1A, Supplement C, Institutionalized Spouse Resource and Income Statement, must be completed prior to approval of the application to substantiate intent to transfer resources to the community spouse.]

C. [By law, the community spouse resource allowance cannot exceed the maximum allowable amount which is subject to an annual change. In giving this allowance as a deduction, the policy requires that the amount of the couple's combined countable resources deducted in the community spouse resource allowance actually be made available to the community spouse for their use. This may involve the legal transfer of resources from the institutionalized spouse to the community spouse without penalty for transfer. Allow 6 months for the transfer of resources to be completed. Spot check the case 6 months after approval and contact the community spouse or representative to verify the resources of the institutionalized spouse.] Resource considerations for the community spouse who applies for or receives MA have not changed.

D. Apply the policy to spouses admitted on or after 9/30/89 to a long term care (LTC) facility, institutionalized Hospice, mental hospital and Institutions for Mental Diseases, or who elect HCBS, Supports for Community Living, or noninstitutionalized Hospice.

E. There is no requirement that the institutionalized individual be receiving a vendor payment or be vendor payment eligible to complete PA-1A, Supplement C and PA-22.

EXAMPLE 1: If an institutionalized spouse is eligible for a vendor payment and declines the vendor payment, the community spouse resource allowance is applied in the institutionalized spouse's case.

EXAMPLE 2: If an institutionalized spouse is vendor payment ineligible for any reason, but eligible for a spend down, the community spouse resource allowance is applied in the institutionalized spouse's case.

F. For spouses institutionalized or receiving HCBS, Supports for Community Living or Hospice before 9/30/89, follow previous policy for consideration of resources. If the spouse leaves the facility, HCBS, Supports for Community Living or Hospice for a 30 consecutive day period and is readmitted, apply current resource policy. If an institutionalized spouse is not likely to be institutionalized for at least 30 consecutive days, DO NOT APPLY the community spouse resource allowance in the institutionalized spouse's case. If a change in circumstance results in a couple no longer having an institutionalized/community spouse situation, i.e., one spouse dies, community spouse is institutionalized, etc., do not apply the special resource considerations the month following the month in which the change occurs.

MS 2130 RESOURCE ASSESSMENT (1)

An assessment of the combined countable resources of the institutionalized spouse and community spouse is completed at the initial Medicaid Long Term Care eligibility inquiry. The assessment is completed on form PA-22, Resource Assessment. Form PA-22 is NOT completed if the potential applicant is not institutionalized. A continuous period of institutionalization begins when the spouse enters LTC, receives institutionalized Hospice or non-institutionalized Hospice, or any waiver services and is expected to remain in the facility or receive services for at least 30 consecutive days. LTC facilities, Hospice and HCBS and SCL providers are responsible for advising all new admissions of the availability of the resource assessment.

Form PA-22 is completed at every inquiry or application for applicants with a community spouse. Whenever there is a break in institutionalization of more than 30 days, a new form PA-22 must be completed at re-application based on the new circumstances.

A. The resource assessment, which may be completed without applying for MA, involves documenting and verifying all countable resources owned by the couple if institutionalization in LTC, Hospice or waiver, began on or after September 30, 1989. Compare the combined countable resources to the current MA resource allowances for the institutionalized spouse and the community spouse to determine if the institutionalized spouse meets initial resource eligibility for MA.

B. When an inquiry regarding eligibility for LTC/waiver is made and there is a community spouse, schedule an interview and advise the individual of the verification necessary for the assessment. Complete form PA-22, Resource Assessment, in its entirety during the face-to-face interview with spouse, committee or representative. If all verification is furnished, provide each member of the couple, committee or representative with a copy of the assessment. File the original in a designated file location in the local office. If additional information/verification is required, request the information by form PAFS-2 and tell the individual that if the information is not provided, the assessment cannot be completed. Upon receipt of the requested information, complete the assessment, provide copies to spouse, committee or representative and file the form as indicated above.

C. The community spouse resource allowance amount is calculated only one time for a continuous period of institutionalization of the institutionalized spouse. If a resource assessment is not requested and completed prior to the application, form PA-22 must be completed at application.

D. If either member of the couple disagrees with the results of the assessment, the determination of the countable resources at the time of the assessment cannot be appealed. Opportunity to appeal the assessment is provided if and when an application for MA for the

institutionalized spouse is made. This information is stated on form PA-22.

E. The resource assessment must be completed within 45 days of the date of request unless there are delays due to non-receipt of verification from the requesting party or a third party, such as, a bank, insurance company, etc. Do not use the 45 day period as a waiting period to initiate/complete the assessment.

F. **[**When an application for MA is made for the institutionalized spouse, obtain the previously completed form PA-22 from the designated local office file, follow directions for entry on KAMES per MS 2135, item A.2. and scan into electronic case file (ECF). If the assessment was completed in another county, request the PA-22 assessment form from their file. Compare resources owned by the couple at the time of the assessment to currently owned resources. If resources are no longer owned, explore potential transfer of resource. Verify the amount of the remaining resources plus any resources obtained since the assessment to determine current resource eligibility. Home equity resources in excess of $552,000 are excluded only when a community spouse, minor/dependent or disabled child(ren) reside in the home. If none of these individuals live in the home, the LTC or waiver application is denied.**]**

G. When a resource assessment is completed in another state and the applicant subsequently moves to Kentucky, and there has been no interruption in institutionalization, contact the appropriate state agency and request a copy of the resource assessment completed by that state. Complete form PA-22 to determine the spouse's share. This is accomplished by using the resource amounts/types verified by the previous state's resource assessment, but applying Kentucky's resource policies.

H. If a pre-application resource assessment is completed and the institutionalized spouse applies for Medicaid in the same period of continuous institutionalization, the community spouse resource allowance calculated for the pre-application assessment is used to determine Medicaid resource eligibility. To capture this information, the questions, "Was pre-application resource assessment done? If yes, enter total _____", are on line 18 of the KAMES Application General Information screen. If worker answers "Y" (yes) to the first question, the amount of the couple's combined countable resources from item 10a on form PA-22 is entered. The entry is up to 8 digits and includes dollars and cents (e.g., $56,455.97 is entered 5645597).

MS 2135 COMMUNITY SPOUSE RESOURCE ALLOWANCE CALCULATION (1)

The community spouse resource allowance is a designated amount deducted from the combined countable resources of the institutionalized spouse and community spouse prior to determining resource eligibility of the institutionalized spouse. The allowance represents the amount of resources necessary for the non-institutionalized spouse to maintain themselves in the community. The allowance is calculated based on the couple's circumstances.

A. Community Spouse Resource Allowance Calculation

1. The calculation makes a comparison to the minimum and maximum community spouse resource allowances established by the Centers for Medicare and Medicaid Services (CMS). These allowances are revised by CMS. For the current minimum and maximum community spouse resource allowance, see Volume IVA, MS 1750. The community spouse resource allowance can be no less than the minimum but not greater than the maximum.

2. **[**The community spouse resource allowance is equal to one-half of the couple's combined countable resources up to the maximum allowance ($119,220). If the spousal resource allowance is less than the minimum ($23,844), the community spouse resource allowance is the minimum allowance.

   Example 1: The combined countable resources of a couple are $250,000. One-half of the couple's resources is $125,000 ($250,000 divided by 2 = $125,000). As the amount is greater than the maximum amount allowable, the community spouse resource allowance is the maximum, $119,220. For the institutionalized spouse to be resource eligible $128,780 must be spent down.

   Example 2: The combined countable resources of a couple are $128,000. The community spouse resource allowance is $64,000 ($128,000 divided by 2 = $64,000) which is less than the maximum allowance. For the institutionalized spouse to be resource eligible $62,000 must be spent down.

   Example 3: The combined countable resources of a couple are $22,000. One-half of the couple's resources is $11,000 ($22,000 divided by 2 = $11,000). The community spouse resource allowance is $23,844. As the community spouse is allowed the minimum resource allowance, the institutionalized spouse can transfer their portion to the community spouse.**]**

B. The community spouse resource allowance may exceed the calculated amount or the maximum only by court order or a fair hearing decision per MS 2140.

C. Institutionalized Spouse Resource Eligibility Determination

To determine the resource eligibility for the institutionalized spouse, subtract the community spouse resource allowance from the combined countable resources of the couple. If the remainder is greater than $2,000, the resource limit for the institutionalized spouse, the institutionalized spouse is resource ineligible.

[(Using Example 3 in item A2)

Combined resources of the couple	$22,000
Minus Community Spouse Allowance	-23,844
Remainder	$ 0

Resource eligible – remainder is less than $2,000

(Using Example 2 in item A2)

Combined resources of the couple	$128,000
Minus Community Spouse Allowance	-64,000
Remainder	$ 64,000

Resource ineligible – remainder exceeds $2,000.**]**

D. The community spouse resource allowance remains constant for the same continuous period of institutionalization or waiver services. The continuous period ends when there is an absence from institutionalization or waiver services are terminated for 30 consecutive days. If the institutionalized spouse reapplies following a 30-day period of absence from the facility or waiver services, a new community spouse resource allowance is calculated.

E. To identify cases in the same eligibility period, enter an “N” on the KAMES Application General Information screen to the question “Has an interruption in long term care occurred?” and KAMES will use the previously established community spouse resource allowance to determine resource eligibility. For a new continuous period of institutionalization, application, re-application and program transfer, answer the question with a “Y” and complete a new resource assessment.

Example 1: An institutionalized spouse applies for Medicaid and nursing facility coverage. The application is denied due to excess resources. The institutionalized spouse remains in the facility as a private pay patient. A re-application is filed 4 months later. Because the institutionalized spouse is in the same continuous period of institutionalization as the first application, enter “N” to the above referenced question. KAMES will use the same community spouse resource allowance calculated for the first application.

Example 2: A worker receives form MAP-24 stating the institutionalized spouse had been discharged from the nursing facility and the MA case is closed. Two weeks later the worker receives a Pro Certification notice indicating the individual has been approved for HCBS services. Although there was a change in the type of care, the interruption in services is less than 30 consecutive days. Answer “N” to the question. A new community spouse resource is not calculated.

Example 3: The institutionalized spouse is approved for Medicaid and nursing facility services in June. In September, the institutionalized spouse is discharged from the facility and returns home. In December, the individual is readmitted to the nursing facility and reapplies for Medicaid. As the individual was out of the facility for more than 30 consecutive days, a new community spouse resource allowance is calculated. Answer “Y” to the question and complete a new resource assessment.

F. For cases determined resource eligible, completion of form PA-1A, Supplement C, Institutionalized Spouse Resource and Income Statement, is required to obtain the institutionalized spouse’s declaration of intent to transfer resources in excess of $2,000 to the community spouse within 6 months.

MS 2140 [RESOURCE ELIGIBILITY DETERMINATION FOR APPLICANTS WITH A COMMUNITY SPOUSE]

Resources of the community spouse are not considered the month after the month in which MA/patient liability is established. Any additional resources, inheritance, lump sum, etc., subsequently received by the community spouse does not affect eligibility of the institutionalized spouse.

A. If neither spouse was institutionalized during the retroactive period, compare the couple's resources and income to the MA Scale/MA Standard for 2 to determine eligibility for each of the 3 retroactive months.

B. If a spouse was institutionalized during the retroactive period, use the following procedures to establish resource eligibility of the institutionalized spouse for the retroactive period and ongoing MA eligibility.

1. Determine the CURRENT combined countable resources of the couple.

2. Complete forms PA-1A, Supplement C, and PA-22, if applicable, verifying resources of the couple.

3. Deduct the community spouse resource allowance. The community spouse resource allowance is the maximum amount of the couple's combined resources which may be retained by the community spouse. The community spouse resource allowance may exceed the maximum only if:

   a. A court order against the institutionalized spouse for the support of the community spouse; or

   b. A fair hearing decision establishes that resources in excess of the allowance are required for the community spouse.

   Either member of the couple, the committee or representative may request the fair hearing. Hearings for this purpose are conducted within 30 days of the hearing request to facilitate timely processing of the application. The hearing officer designates a higher resource allowance, if appropriate, in the fair hearing decision.

4. The remainder is compared to the resource allowance for an individual.

If the remaining resources are equal to or less than the allowance, the institutionalized spouse meets initial eligibility. The institutionalized spouse is resource ineligible if the remaining resources exceed the limit.

MS 2150 PATIENT LIABILITY TRANSFER OF RESOURCES

Once initial resource eligibility is established, determine the amount, if any, of resources belonging solely or jointly to the institutionalized spouse which were attributed to the community spouse allowance in the initial resource eligibility determination.

A. Advise the individual that the resources of the institutionalized spouse above the resource allowance for an individual must actually be made available to the community spouse to meet his/her needs in order to be excluded in determining continued resource eligibility.

1. The institutionalized spouse must indicate intent to legally transfer resources to the community spouse and to complete the transfer within 6 months of the initial MA approval.
2. To indicate intent, the institutionalized spouse must sign form PA-1A, Supplement C, Institutionalized Spouse Resource and Income Statement.
3. If the institutionalized spouse fails or refuses to sign the statement of intent, deny the application due to excess resources.

a. If the institutionalized spouse is incapable of indicating intent due to mental impairment, the community spouse, committee or representative acting on the behalf the institutionalized spouse may indicate intent.
b. Accept the statement of the community spouse, committee or representative regarding mental impairment of the institutionalized individual and document the case record accordingly.

B. [Allow the institutionalized spouse 6 months from the month of MA approval to transfer resources to the community spouse. Form PA-1A, Supplement C, is required to be signed prior to case approval.] Allow additional time if verified court action is involved or there is a delay through no fault of the recipient. Carefully document any delays and set up spot checks for the anticipated completion date. If there are no documented delays, consider all transfers completed within the specified timeframes. Spot check the case for the 6th month following approval to ensure transfers are completed. If resources remain in the institutionalized spouse's name, discontinue the case effective with the first administratively feasible month.

C. If resources were transferred to an individual other than the community spouse, determine if the transfer was a prohibited transfer according to, MS 2050-2110. If the transfer was a prohibited transfer, take appropriate action to restrict MA coverage.

D. If the institutionalized spouse obtains additional resources, such as inheritance, gift, etc., after the initial eligibility determination, exclude these resources if:

1. The new resources combined with current resources do not exceed the resource allowance for one; or
2. The institutionalized spouse indicates intent to transfer the resource to the community spouse who has resources below the community spouse resource allowance at the time the additional resources were received. [Complete form PA-1A, Supplement C for the additional resources.]

MS 2160 ADDITIONAL CONSIDERATIONS

Additional considerations are provided to establish resource eligibility when the institutionalized spouse's countable resources exceed the resource allowance for an individual and the individual maintains that the excess resources are not available to cover the cost of care in the LTC facility, Hospice, HCBS, SCL or ICF IID. Refer to MS 2130.

This situation occurs when all or a majority of the couple's combined resources are in the name of the community spouse and the community spouse refuses to make the resources available to the institutionalized spouse. [This special consideration applies ONLY to resources which belonged to the community spouse prior to the marriage. Consideration does NOT apply to resources jointly held by both spouses.]

Calculate the combined resources of the couple. Subtract the community spouse resource allowance from the combined resources of the couple.

Do not establish initial resource eligibility if countable resources exceed the resource allowance for an individual.

A. If it is verified that the community spouse refuses to make the excess resources available to the institutionalized spouse, exclude the excess resources if:

1. The institutionalized spouse agrees to assign support rights of the excess resource to the State.

   a. The institutionalized spouse agrees to reimburse the State in the amount of the excess resource for medical care provided, if and when the resource becomes available to the institutionalized spouse.
   b. To assign support rights, the institutionalized spouse must sign form PA-1A, Supplement C.
   c. If the institutionalized spouse is unable to assign support rights to the State due to mental impairment, the community spouse, committee or representative acting on behalf of the institutionalized spouse may assign support rights and sign form PA-1A, Supplement C. Accept the statement of the community spouse, committee or representative regarding mental impairment of the institutionalized spouse.

2. If the institutionalized spouse agrees to assign support rights to the excess resources, exclude these resources in the resource eligibility determination and subsequent recertifications. When the excess resource is determined available to the institutionalized spouse, send a memorandum identifying case information and information regarding availability of the resource along with a copy of the signed agreement to:

Cabinet for Health and Family Services
Department for Medicaid Services
Office of the Inspector General
Division of Program Integrity
275 E. Main St., 6E-B
Frankfort, KY 40621

3. If the institutionalized spouse or community spouse, committee or representative acting on behalf of the institutionalized spouse refuses to assign support rights, request a hardship determination.

B. A hardship determination is appropriate when excess resources cannot be excluded by assignment of support rights and the institutionalized spouse will be discharged from the LTC facility or lose HCBS or SCL services due to inability to pay.

1. To request a hardship determination, send a memorandum to:

Department for Community Based Services
Medical Support and Benefits Branch
3rd Floor, 3E-I
275 E. Main Street
Frankfort, Ky. 40621

Include in the memorandum identifying case information, the amount of excess resource, and the reason for refusal to assign support rights to the State.

2. Complete case action after a written response to the request for a hardship determination is received.

3. If it is determined that hardship criteria is met, exclude the excess resources specified in the hardship determination.

[C. A hardship determination may be requested when resources that were inappropriately transferred are unavailable to the LTC recipient to pay the cost of care, and the LTC recipient has received a discharge notice from the facility or wavier provider. This situation generally occurs when a payee or POA mishandles the recipient's resources. Request the hardship determination according to procedures in section B above.]

MS 2170 RECERTIFICATION/INTERIM

Consider only the resources of the institutionalized spouse in determining ongoing eligibility.

A. Resources of the community spouse and those resources that the institutionalized spouse has indicated intent to transfer to the community spouse within six months from the date of application, are not considered available to the institutionalized spouse, effective the month following the month in which eligibility is established.

B. Compare the institutionalized spouse's resources to the resource allowance for an individual.

1. [The case is resource eligible for that month if total countable resources are equal to or less than the limits when the recertification is processed.
2. The case is resource ineligible if total countable resources exceed limits when the recertification is processed.]
   a. Send timely notice to discontinue an active case.
   b. If resources are reduced to the limit or less during the month of discontinuance without a prohibited transfer of resources to establish eligibility, the case is resource eligible for that month if reapplication has been made.

MS 2180 [INTRODUCTION TO INCOME (1)

Income is money received from any source such as statutory benefits, rental property, investments, pension plans, non-recurring lump sums, self-employment, child support, unemployment benefits, contributions, etc. or wages for labor or services. Income may be earned or unearned. Earned income is money derived from the direct involvement in a work related activity. Unearned income is money received which does not involve direct physical or mental activity.

Income may be counted or excluded. Excluded income is income received but not considered in determining financial eligibility. Refer to Volume IVA, MS 2470, for types of excluded income. If income is not listed in MS 2470 as excluded income, it is counted in the Medicaid eligibility determination.

Income must be verified at each application, recertification, and reported change in income. Verify gross income before any withholdings such as taxes, health insurance or Medicare premiums, overpayments, etc.

Document any unusual circumstances related to income in case notes. Scan income verification into the Electronic Case File (ECF).]

MS 2190 INCOME LIMITS (1)

In determining income eligibility, total countable income is compared to the MA Scale for the appropriate household size.

[A. MA Scale:

Size of Family	Monthly Amount
1	235
2	291]

B. If gross income is equal to or less than the MA scale, income eligibility is met. If the gross income exceeds the MA scale but the countable income (gross income minus any deductions) is equal to or less than the MA scale, income eligibility is met.

C. If total countable income is greater than the MA Scale, explore spend down eligibility as outlined in MS 2650.

MS 2200 INCOME ROUNDING

A. DO NOT round unearned income.

B. Determine gross monthly wages. When rounding, 50 cents is rounded to the next dollar.

1. HOURLY - Multiply the number of hours in the work week by the hourly rate and round to the nearest dollar.
2. WEEKLY - Round weekly income to nearest dollar. Combine rounded weekly amounts, average, and round to nearest dollar. Multiply by 13, divide by 3, and round result to nearest dollar.
3. BIWEEKLY - Round to nearest dollar. Combine rounded bi-weekly amounts, average, and round to nearest dollar. Multiply by 13, divide by 6, and round to nearest dollar.
4. SEMIMONTHLY - Round to nearest dollar, average, and round if 2 pay periods are used, and multiply by 2.
5. MONTHLY - Round to nearest dollar.

C. For self-employment income:

1. Use actual dollar and cent amount of gross income.
2. Use actual dollar and cent amount of expenses.
3. Subtract actual expenses from actual income and round the difference to the nearest dollar.

D. Round the total of each type of other earned income to the nearest dollar.

E. Total all types of income.

F. Round the total income to the nearest dollar and compare to the appropriate MA Scale.

MS 2220 ANNUITIES

An annuity is an investment from which an individual receives fixed payments for a lifetime or a specified number of years.

A. Payments received are considered unearned income.

B. Payments received less frequently than monthly, are converted to a monthly amount.

MS 2230 ADULT MA: CHILD AND SPOUSAL SUPPORT

Child and spousal support income is the amount of legally established or voluntary support regularly received by an applicant or recipient. Voluntary payments are support payments made by a legal, alleged or adjudicated parent without a court order. If court ordered, the child support and spousal support may be in two separate orders. When child or spousal support is court ordered, it can be considered as non-continuing only if terminated by a court order and months of zero receipt are verified. Any amount of a military allotment designated as child or spousal support is considered as support.

A. VERIFICATION

Verification includes court records, checks or a statement from the Non-Custodial Parent (NCP) or KASES. Use the column "DATE" on the KASES Benefit Summary Inquiry Screen to determine the month of receipt.

1. If child support is paid through CSE:

   a. Use the KASES Accounting Function, "05" to determine if child or spousal support is paid.
   b. Select option "21", Benefit Summary to display the Benefit Selection Inquiry screen.
   c. Select the appropriate IVD# to display the Benefit Summary Inquiry screen.
   d. Use the column "DATE" on the KASES Benefit Summary Inquiry screen to determine the month of receipt.
   e. Tax intercept money may appear in the $ ARR FAMILY column prior to issuance. Access KASES during the interview, and review the amounts appearing on the KASES Benefit Summary Inquiry screen with the individual. If the individual states they have not received a payment listed in the $CSUP FAMILY or $ARR FAMILY column, contact CSE staff or the contracting official to resolve the discrepancy.

2. If the amount of child support is representative of ongoing income, manually calculate the total amount of child support for the 3 prior months and average the total to get the average monthly amount. Do not round.

3. If the amount of child support income is not representative of ongoing income due to a VERIFIED change in circumstances, consider the anticipated child support in the ongoing budget.

   EXAMPLE: Alice applies in August. She received $200 in the last 3 months; however, she provided a written statement from the NCP which verified that due to job loss he would be paying $75 a month until he regained employment. Consider $75 child support income in the ongoing budget.

4. Child support income received for a child is excluded in the parents' aged, blind, or disabled case.

B. CONSIDERATION

If the child support income calculated is entered correctly:

1. KAMES excludes one-third of child support payments received for, or by, a blind or disabled child in a "K", "B", "M" or "D" case when determining Medicaid eligibility. The remainder is considered as unearned income;

[2. KAMES considers child support payments received for, or by, a blind or disabled child in a nursing facility or in a "K", "B", "M" or "D" case as unearned income in its entirety when determining the patient liability for nursing facility or PRTF cases.

3. If the child receiving child support payments begins receiving waiver services after Medicaid eligibility has been approved, the child's patient liability will be $0.]

C. SYSTEM ENTRY

Enter the calculated monthly child support under the IM Child Support unearned income screen on KAMES. Do not round.

D. DOCUMENTATION

Document the verification source used, such as KASES, written statement from the NCP or check stubs. Document the method used to calculate child support income. A calculator tape that shows the computations can be maintained in the case record as part of the documentation.

MS 2240* CONTRIBUTIONS

CONTRIBUTIONS are cash received from any source, including a parent involuntarily absent from the home.

A. VERIFICATION. Statement from individual providing contribution or copy of checks.

B. CONSIDERATION. To determine the monthly amount of contribution, average amounts received from previous 3 months if contributions are expected to continue.

MS 2250 FARM/BUSINESS

[Farm/business income is unearned if there is no direct involvement in farm/business activities. In cases of divided ownership, divide profit between the owners, unless by mutual consent entire proceeds are available to the individual. If the Social Security Administration (SSA) considers all income as available to the SSI parent, do not enter income from this source in the MA case. If the SSA considers only part of the farm/business income available, consider appropriate shares available to the MA case.

A. For verification use records maintained by the individual, current income tax returns, or a copy of a lease agreement.

B. CONSIDERATION. To determine profit, deduct work expenses directly related to producing the goods or services without which the goods or services could not be produced. If the farming arrangements have changed, use anticipated income from the new arrangement.

1. ALWAYS annualize farm and business income and the expenses; use the tax return, client accounts etc. for the past year to compute the countable income if available, otherwise average previous 3 months actual reported income and expenses.

2. If the farming arrangement has changed, do not consider the income of the past year. Spot check the case for the month the new crop is to be sold. At that time, use the income received from the sale of the new crop to anticipate the income.

3. If this is a new farm or farming activity AND:

a. The farm or farming activity has been in existence for less than a year and the individual has received income from the farm or farming activity, prorate the income over the period of time the farm or farming activity has been in operation. Use the monthly amount as the anticipated income for the next year.
b. The farm or farming activity has not been in existence long enough to receive income, no income is considered. Spot check the case for the month the income is to be received. At that time, use the income received to anticipate the income.

4. If farming activities have been discontinued, no income is considered.

5. Deduct the following:

a. Wages paid to employees;
b. Rent or interest on a mortgage and taxes, but only if the enterprise is carried on from a site other than the home;
c. Interest payments only on the purchase of capital assets, equipment, etc;
d. Cost of stock offered for resale;

e. Cost of materials and supplies including seed, feed, crop insurance, fertilizer, and utilities required to carry on the enterprise;
f. Mileage rate allowed as a deduction for business purposes if the vehicle expenses are directly related to the operation of the business enterprise – provided the person uses their private vehicle. The mileage deduction is equivalent to the amount shown on the federal tax return. If a tax return is not filed use the IRS mileage rate. This information can be accessed at: http://www.irs.gov. To access the current year's mileage rate enter the term "mileage rate" in the search box;
g. Other non-personal items directly related to producing the goods or services;
h. Repairs or maintenance of equipment and property used in the business. If the business is carried on from the home DO NOT allow a deduction for repairs to the home; and
i. Management fees incurred in managing property, including management fees charged by a relative.

6. Do not deduct the following:

   a. Personal work or business expenses such as taxes, FICA, lunches, etc;
   b. Amounts claimed for depreciation;
   c. Prior or current losses;
   d. Purchase of capital equipment;
   e. Payments on principal for the purchase of property, durable goods, capital assets, equipment, etc;
   f. Entertainment expenses;
   g. Personal transportation;
   h. Salary or commission paid to the individual by the self-employment enterprise; and
   i. Rent, when the self-employment enterprise is based in the individual's residence.

7. Rental income is unearned if the individual is not actually involved in collecting the rent, making or supervising repairs, etc.

   a. For verification use a statement from a tenant, a current income tax return or other records.
   b. Determine net profit by the same method used to determine earned rental income.

C. DOCUMENT how the income and expenses were calculated and verified.]

MS 2260* HOME EQUITY PLANS

HOME EQUITY PLANS (HEP) are designed to allow elderly homeowners to convert the equity value of their homes into cash without being forced to leave their homes.

A. The following HEP are currently available.

1. REVERSE MORTGAGES allow a homeowner to borrow, via a mortgage contract, some percentage of the appraised value of their home. The homeowner may receive periodic payments and/or a line of credit to draw against. Some reverse mortgages involve the purchase of an annuity and are called Reverse Annuity Mortgages (RAM). In most reverse mortgages the loan to the homeowner is not repaid until the homeowner dies, sells the home or moves.

2. SALE-LEASEBACK allows the homeowner to transfer title of the home to a buyer in exchange for an installment note satisfied by regular payments. The installment note may bear interest. The buyer then allows the former homeowner to remain in the home in exchange for rent. Because the rent is a lesser amount than the former homeowner receives from the installment note, they are provided with needed proceeds. Some sale-leaseback arrangements involve the purchase of an annuity.

3. TIME SALE allows the homeowner to sign a contract to sell their home at death but maintain title to and continue to live in the home. The buyer of the contract makes regular payments to the homeowner. The contract may provide for payment of interest and/or the purchase of an annuity.

4. DEFERRED PAYMENT LOANS (DPL) are one-time lump sum loans used to repair or improve a home or to pay property taxes. They are usually offered by local government housing or community development departments with no repayment due until the home-owner dies, sells the home or moves.

B. VERIFICATION. Copy of specific HEP, such as a reverse mortgage, time sale, sale-leaseback or loan.

C. CONSIDERATION. Carefully review the plan to determine the type of compensation the homeowner is to receive, frequency/schedule of receipt, amounts, etc.

1. Payments made from a plan, such as, annuity, including reverse annuity mortgages or other reverse equity arrangement or regular installment payments, are considered as unearned income in the month received.

2. The interest portion of any installment note or contract payment is considered as unearned income in the month received.

3. Proceeds other than interest, regular installment payments and annuity payments, i.e., lump sum payments and line of credit are not considered to meet the definition of income, but are considered as converted resources, according to MS 1970.

MS 2270* INCOME SUPPLEMENTATION

INCOME SUPPLEMENTATION is money received by the individual from the Bureau for Rehabilitation Services, an income protection plan or hospital confinement policy, etc., not used to reimburse actual costs of care.

A. VERIFICATION.

1. Statement from Bureau for Rehabilitation Services;
2. Copy of income protection plan; or
3. Hospital confinement policy, etc.

B. CONSIDERATION. Consider regular monthly income supplementation in determining initial and ongoing eligibility.

MS 2290* LOANS

LOANS are amounts of money borrowed which require repayment.

A. VERIFICATION. Form PAFS-73, Verification of Contributions-Loans-Roomer/Boarder Payments, is completed and signed by the lender and borrower when the loan is not from a legal lending institution.

B. CONSIDERATION.

1. Exclude loans verified by form PAFS-73 or from a legal lending institution.

2. If a completed form PAFS-73 is not received, consider this income:

a. A contribution if regularly received; or
b. A nonrecurring lump sum if received once.

LONG TERM CARE INSURANCE

Long term care (LTC) insurance policies provide a benefit to help individuals pay for services received while residing in a nursing facility. These policies may also pay for LTC services received in the individual's home.

A. VERIFICATION. A copy of the LTC insurance policy.

B. CONSIDERATION. Review the policy to determine who receives payment.

1. If the payment is made directly to the nursing facility, it is excluded as the facility will reduce this amount from the amount billed to Medicaid. The patient liability does not change.

[2. If payment is made directly to the individual, it is considered a reimbursement for medical services and is used to determine only the patient's liability. If gross income is greater than the special income standard refer to MS 3505.]

C. SYSTEM ENTRY. LTC insurance payments are entered on the KAMES system.

[1. Payments paid directly to the nursing facility must be entered on the second LTC/Waiver (HRKIPA0C) screen by answering "Y" to "Is any third party pmt made for cost of care?" Answer "Y" to "Is pmt from LTC Ins?" Enter the name of the payer. If payment is made to the facility, answer "N" to the question "Is pmt made directly to the client?" Enter the amount after "Monthly amt paid." Enter "OR", "WS", or "CC" as the verification source after verification is received.

2. Payments paid directly to the individual must be entered on the second LTC/Waiver (HRKIPA0C) screen by answering "Y" to "Is any third party pmt made for cost of care?" Answer "Y" to "Is pmt from LTC Ins?" Enter the name of the payer. If payment is made to the client, answer "Y" to "Is pmt made directly to the client?" Enter the amount after "Monthly amt paid." Enter "OR", "WS", or "CC" as the verification source after verification is received.]

MS 2320 OTHER UNEARNED INCOME (1)

Other unearned income includes, but is not limited to miner's benefits, pensions, dividends, oil leases, mineral rights, income received from an income indemnity policy, and trust income actually available, unless from a Medicaid Qualifying Trust.

A. VERIFICATION.

1. Checks;

2. Award letters;

3. Written verification from company;

4. Contract;

5. Bank and other financial statements (for investments only); or

6. Trust agreement.

B. CONSIDERATION.

1. Consider all continuing unearned income.

2. Compute monthly amount if necessary.

3. If unearned income is received irregularly or in irregular amounts, average the prior 3 months' actual income, even if some of the months have zero income, to arrive at the monthly amount. If the income is averaged, complete a spot check every 3 months for changes. Sixty dollars per quarter is excluded from the calculation of irregular and infrequent unearned income.

4. Income from IRA's. Individuals are required to withdraw funds from an IRA when available. If the individual is at least age 59½ and eligible to withdraw funds, failure to apply for withdrawals results in ineligibility for Medicaid. There are no distinctions between traditional and Roth IRA's. Amounts of required withdrawals are determined by the financial institution. If disbursements are not received monthly, then the amount received is prorated over the period of time it is intended to cover. For example, a quarterly payment is divided by 3 and is considered as monthly income.

   [Note: An individual may have several IRA's from the same company but only have a disbursement withdrawn from one account. This is allowable as long as proper verification is provided. A written statement is required from the financial institution verifying that the total disbursement amount is based on the value of all the IRA's combined.]

MS 2330 PROMISSORY NOTES, LOANS, MORTGAGES, LAND CONTRACTS (1)

PROMISSORY NOTES, LOANS, MORTGAGES, AND LAND CONTRACTS are written promises, claims or contracts for which payment is received by the recipient over a period of time.

A. VERIFICATION. Contract or other written agreement.

B. Promissory Notes, Loans, Mortgages and Land Contracts have to meet the following criteria:

1. The repayment term must be actuarially sound (cannot be set up in terms which exceed the applicant/recipient's life expectancy- see Volume IVA, MS 1900, Life Expectancy Table).

2. Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments; and

3. [The promissory note, loan, mortgage or land contract must prohibit the cancellation of the balance upon the death of the lender. If a balance remains upon the death of the lender, it must be designated to the estate of the deceased in order for the promissory note to be considered valid.]

C. CONSIDERATION. If the criteria in B are NOT met, the purchase of the promissory note, loan, land contract or mortgage must be treated as a prohibited transfer of resources. Ineligibility periods must be determined and applied. The ineligibility period is based on the amount of the transfer minus the principal payments received since the date of the transfer.

Example: Daniel transfers a $10,000 motorcycle to his nephew Jon in exchange for a promissory note. Jon makes five $100 payments to Daniel. $90 of each payment goes to the principal and the remaining $10 of each payment goes to interest, making it a total of $450 ($90 x 5) applied to the principal. The ineligibility period is based on the amount of the transfer minus the principal payments received since the date of the transfer. $10,000 - $450 = $9,550. The amount to be considered in calculating the ineligibility period is $9,550.

D. CONSIDERATION. If the criteria in B are met and:

1. The resource remains in the client's name, the Fair Market Value is a countable resource and the interest portion of the continuing payments is counted as unearned income.

2. The resource is no longer in the client's name; consider both principal and interest of payments received as unearned income.

Note: If payments received on a land contract are treated as income in the case, deduct any verified amounts the client pays for mortgage, insurance and taxes, to determine total countable income.

MS 2340 STATUTORY BENEFITS

Statutory benefits include RSDI, Railroad Retirement, Black Lung, Veterans pension or compensation, Veterans Administration Improved Pension (VAIP), including Agent Orange payments issued by the Department for Veterans Affairs, according to P.L. 102-4 enacted on February 6, 1991, Worker's Compensation, Unemployment Insurance or other pensions. If an individual is receiving statutory benefits at the time of application, entitlement amount of benefits, SMI charges if appropriate, and amount of check MUST be verified and documented BEFORE approval.

A. VERIFICATION.

1. Current benefit verification letters;
2. Checks if no SMI coverage;
3. SSA verification forms;
4. PA-1610A;
5. Railroad Retirement Board;
6. Any other documentation from the payor of benefits; or
7. IMS program HR 39, NEW BENDEX, etc. NOTE: When accessing IMS Program HR 39, use the amount shown as "NET".

B. REQUIREMENT.

1. Individuals must apply for statutory benefits if potential eligibility exists, unless good cause is established. Good cause includes previous denial with no change in circumstances or inability to prove eligibility.
2. If applying for the VAIP reduces the total annual VA payment, they are not required to apply for the VAIP.
3. Verify application for statutory benefits. Refusal to explore entitlement results in ineligibility of the individual.
4. Do not withhold approval or discontinue an active case during the period entitlement is being determined.
5. Set up a monthly spot check to determine if statutory benefits are received or denied.

C. CONSIDERATION. Count statutory benefits in determining income as follows:

1. DESIGNATED BENEFITS. Income as designated by benefit verification letter, benefit statement, PA-1610A, SSA verification forms, etc. Count statutory benefits of individual included in the MA case. Count statutory benefits of responsible relative(s), if any, according to MS 1770 - 1820.

2. NONDESIGNATED STATUTORY BENEFITS. Income not assigned to a specified individual e.g., VA benefits.
   a. When the only individual covered by the statutory benefit is in the MA case, count entire amount.

b. When all individuals covered by the statutory benefit are not in the MA case, prorate the benefit to establish the amount used to determine eligibility by dividing the total statutory benefit by the number it is intended to cover. Count the individual's prorated share in the case. Count prorated shares of responsible relative if any, according to MS 1770-1820. Subtract prorated shares of all others covered by the benefit.

3. Consider entitlement amount of statutory benefits. DO NOT deduct amounts withheld due to an overpayment.

MS 2350* SSI

Supplemental Security Income (SSI) is the federally funded and administered money payment assistance program for needy aged, blind or disabled individuals.

A. VERIFICATION. Verify and document by using any of the following sources:

1. Current benefit verification letters;

2. Copy of check;

3. SSA verification forms; or

4. Computer inquiry.

B. CONSIDERATION. Count SSI benefit received to determine the unearned income of the State Supplementation or LTC recipient. If SSI withholds income due to overpayment, the amount actually received is the amount considered.

MS 2410* CONTRACT EMPLOYMENT

Contract employment is income from jobs in which there is a signed agreement such as, school teachers, bus drivers.

A. VERIFICATION.

1. Contract stating salary and terms.
2. Employer contact to establish salary.
3. Employer statement or contact to verify termination of contract.

B. CONSIDERATION.

1. When the individual has a contract/payment agreement, compute gross monthly wages by dividing contracted agreed upon amount by 12 and round to the nearest dollar, unless the contract/payment agreement states income will be paid for fewer months.

   a. If the contract/payment agreement states the income will be received in fewer than 12 months, divide the contracted agreed upon amount by the number of months in the contract/payment agreement and round to the nearest dollar.
   b. If the contract/payment agreement states the income will be received monthly for 12 months and the individual requests the remainder of their pay in a lump sum prior to the end of the 12 month period, continue using the annualized figure for the remainder of the 12 month period.

2. If contract employment is self-employment, consider as self-employment, such as, contract to paint house, install roof, etc.
3. Prorate other contract employment over the life of the contract.

MS 2420 OCCASIONAL AND COMMISSIONED EMPLOYMENT

Occasional employment is income from working an irregular schedule that is not known in advance. Commissioned employment is income received as a percentage of the money received from sales.

A. VERIFICATION. Pay stubs or employer contact.

B. CONSIDERATION. Compute anticipated monthly income by totaling actual amounts of income received in prior 3 months and divide by 3. [Exclude $30 per quarter.]

MS 2430 OTHER EARNED INCOME

[A. Other earned income may be accumulated annual leave and severance pay, cash benefits directly related to employment or payments with taxes withheld which are received under the Senior Community Service Employment Program (SCSEP) as authorized by Title V of the Older Americans Act, P.L. 100-175.

Organizations that receive Title V funds are:

1. Green Thumb;
2. National Council on Aging;
3. National Council of Senior Citizens;
4. American Association of Retired Persons;
5. U.S. Forest Service;
6. National Association for Spanish Speaking Elderly;
7. National Urban League; and
8. National Council on Black Aging.

B.] VERIFICATION. Check or check stubs, employer statements or contact.

[C.] CONSIDERATION. Consider as continuing income.

MS 2440 SEASONAL EMPLOYMENT

Seasonal employment is income from employment during a limited period each year.

A. VERIFICATION.

1. Pay stubs.

2. Employer contact.

3. Current income tax return.

4. Records maintained by individual.

B. CONSIDERATION.

1. Count anticipated earnings or actual earnings received in the month.

2. If employment has terminated before action can be effective, do not consider this income.

3. Spot check next year before anticipated seasonal employment.

MS 2450 SELF-EMPLOYMENT

Self-employment income is income derived from farming, small business enterprise, rental, roomers/boarders, etc. where taxes are NOT withheld prior to receipt of pay.

A. VERIFICATION. Records maintained by individual, statement from tenant, current income tax return, copy of lease agreement or other records.

B. CONSIDERATION.

1. ALWAYS annualize farm income.

2. Annualize non-farm self-employment income and expenses if Individual Income Tax Return reports self-employment income.

3. When non-farm self-employment income is not filed on Individual Income Tax Return, average previous 3 months actual income and expenses.

4. To determine profit, deduct work expenses directly related to producing the goods or services and without which the goods or services could not be produced.

C. FARM/SELF-EMPLOYMENT INCOME is considered earned income if derived from active physical engagement or managerial responsibilities in farming/self-employment. In such instances, it is subject to earnings deductions.

1. If farming/self-employment activity is done by one or more family members, prorate to determine individual family member's share from profit.

2. If farming/self-employment arrangements have changed, use anticipated income from the new arrangement.

3. If the individual has never farmed or been self-employed, base anticipated income on the previous year's crop/self-employment activity for the particular farm/self-employment.

4. If farming/self-employment activities have been discontinued, consider no income.

5. In cases of divided ownership of farm/self-employment, divide profit between the owners, unless by mutual consent entire proceeds are available to the individual.

6. If SSA considers all farm/self-employment income available to an SSI individual, do not enter income from this source in the MA case. If SSA considers only part of the farm/self-employment income available, consider appropriate shares available in the MA case.

7. Allowable deductions are:

   a. Wages paid to employees;
   b. Rent or interest on a mortgage and taxes, as appropriate, but only if the enterprise is carried on from a site other than the home;
   c. Interest payments only on the purchase of capital assets, equipment, etc.;
   d. Cost of stock offered for resale;
   e. Cost of materials and supplies including seeds, feed, crop insurance, fertilizer, and utilities required to carry on the enterprise;
   f. [Mileage rate allowed as a deduction for business purposes if the vehicle expenses are directly related to the operation of the business enterprise – provided the person uses their private vehicle. The mileage deduction is equivalent to the amount shown on the federal tax return. If a tax return is not filed use the IRS mileage rate. This information can be accessed at: http://www.irs.gov. To access the current year's mileage rate enter the term "mileage rate" in the search box;]
   g. Other non-personal items directly related to producing the goods or services;
   h. Repairs or maintenance of equipment and property; and
   i. Management fees incurred in managing property, including management fees charged by a relative.

8. DO NOT ALLOW the following deductions:

   a. Personal work or business expenses, such as, taxes, FICA, lunches, personal transportation, entertainment expenses, etc.;
   b. Amounts claimed for depreciation, prior losses or loss from one business to another;
   c. Purchase of capital equipment;
   d. Payments on principal for the purchase of property, durable goods, capital assets, equipment, etc.; and
   e. Improvements, such as paving a drive, new roof, putting up a fence, etc.

D. RENTAL/BOARDER income is considered earned income if the individual personally collects the rent, makes or supervises repairs or gives other services in relation to the property. Consider profit from rental of property owned or being purchased by the individual.

1. The total amount of allowable deductions may be either prorated or annualized to offset income. Allow the deduction to the advantage of the individual.

   a. The total amount of expenses may be averaged over a timeframe which is less than or greater than 12 months if necessary to allow the whole deduction.
   b. A spot check is required to ensure the deduction is removed once the total amount of the allowable deduction has been used.

2. From rental income of non-home property deduct the following:

   a. Property taxes, state and local taxes on rental property;
   b. Interest on mortgages, debts, property improvement loans for rental property;
   c. Insurance on property;
   d. Repairs or maintenance to keep rental property in good operating condition; and
   e. Expenses for managing the property.

   If the home is not occupied and not being rented, do not allow deductions to offset income.

3. For roomer or rental income from renting or sub-renting a portion of the home occupied by the individual, determine deductions as follows:

   a. Deduct a fraction of the expenses equal to the fraction of the home rented, e.g., if 2 rooms of a 6 room house are rented, then 1/3 of the expenses are used in calculating rental deductions. Do not use halls, baths, etc., in determining the number of rooms.
   b. Determine the total cost of repairs or maintenance of the home, the home's utilities, property insurance, property taxes and interest on mortgage, if any. Multiply the monthly expenses by the fraction of the home rented to obtain the rental deduction.

      EXAMPLE:

Interest on mortgage	$1,200
Utilities	800
Property Insurance	300
Property Taxes	100

      $2,400 divided by 12 = $200 Monthly Cost

      $200 x 1/3 = $66.67 monthly rental deduction

4. For boarder only, deduct an amount equal to the food stamp allotment for the number of boarders.

   EXAMPLE: There are 3 boarders; the deduction equals the food stamp allotment of a 3 person household.

5. For roomer/boarder:

   a. Deduct an amount equal to food stamp allotment. If roomer/boarder is a member of the food stamp case, do not allow a food deduction.
   b. Rental deduction is computed the same as for a roomer. Do not compute if the roomer/boarder payment is the same as, or less than, the food stamp allotment.

MS 2460 WAGES (1)

Wages are salaries from full-time or part-time employment where taxes are withheld prior to receipt of pay. Wages include odd jobs, occasional, seasonal or contract employment.

A. VERIFICATION.

1. Pay stubs;

2. Employer statement, written or verbal; or

[3. Electronic Income Verification (EIV). See Volume IVA, MS 2461.]

If new employment is reported, spot check within 1 week of anticipated receipt of first check, not to exceed 6 weeks.

B. CONSIDERATION.

1. To determine the estimated monthly income, verify and use income from all pay periods in the last two calendar months. If the last two calendar month's income does not represent the ongoing situation due to sick leave, holiday plant closing, etc., use information available which best indicates the ongoing income.

2. Count gross income. Garnishments on salary ARE NOT deducted.

3. For individuals obtaining employment who have not received a pay check or do not have a full month's pay stubs, consider the anticipated earnings. Compute anticipated earnings based on the hourly rate and the estimated number of hours to be worked during a pay period. When the first full month's pay is verified by check stubs provided by individual or employer contact, recompute using actual earnings and appropriate deductions.

Therapeutic Wages for ABI LTC Waiver recipients/applicants are entered on the earned income screen on KAMES. The system will apply the $65 and ½ the remainder deduction. Answer "Y" to the question "DOES HE/SHE RECEIVE EARNINGS FROM THERAPEUTIC PLACEMENT?" on the second long term care screen.

*MS 2461 ELECTRONIC INCOME VERIFICATION (EIV) (1)

Electronic Income Verification (EIV) is a method of obtaining verification of a client's earned income online. An online service may be used to assist clients when verification of earned income is not readily available and the client advises the worker that the income is available by a free on-line service. See Volume I, MS 0131.

It remains the client's responsibility to provide verification of earned income if information from the online service is incorrect or incomplete.

Some online services may have gross wages and tip income combined, therefore, since the income is not separated, workers must request check stubs and a daily tip log. See Volume IV, MS 3720.

If the client receives bonuses included in the gross amount that are not expected to continue, the client must provide check stubs to verify earned income.

If the client receives paid overtime included in the gross amount and which is not expected to continue, the client must provide check stubs to verify earned income.

MS 2465 NON-RECURRING LUMP SUM (1)

[A nonrecurring lump sum is money received at one time which will not recur, such as accumulated back-payments from unemployment insurance (UI), escrow child support money forwarded by CSE, child support money received as a result of an IRS intercept, back-pay from employment, severance payments, money received from insurance settlements, workers compensation settlements, gifts, inheritances, lottery winnings, etc.

Income from the sale of property, including an initial down payment from a land contract sale, IS NOT considered a nonrecurring lump sum, but a change in the type of resource.

A. CONSIDERATION. Lump sum payments, other than accumulated back payments of SSI and/or RSDI or tax rebates, are considered as unearned income in the month received, if possible. After the month of receipt, consider any portion remaining as a resource.

EXAMPLE #1: An active LTC recipient receives and gives away a lump sum back-payment from VA in May and reports receipt in the same month. Since MA benefits would already be issued for May, the lump sum cannot be considered as income in the month of receipt. However, any amount remaining as of June would be considered as a resource.

Transfer of resources policy also applies to assets, such as lump sum payments, not yet considered as a resource. Consider lump sum payments given away in the month of receipt a transfer of resources for individuals receiving LTC, HCBS, SCL or ICF IID. Follow transfer of resource policy outlined in MS 2050.

EXAMPLE #2: A SCL applicant receives VA in the month of application and reports the lump sum before the case is processed. Consider the lump sum as income in the application month, and any remaining amount as a resource in following months.

B. VERIFY the lump sum amount by:

1. Statement from lawyer/trustee;

2. Award letter; or

3. Check.

C. EXCEPTIONS. If the lump sum is from a federal or state income tax refund, it is excluded income for 12 months from the month of receipt. If the lump sum is from a worker's compensation settlement and includes a one-time lump sum payment and continuing weekly or monthly benefits, consider the one-time payment as a nonrecurring lump sum payment and the continuing benefits as unearned income in the appropriate month. If the lump sum is from accumulated annual leave or severance pay it is

considered continuing earned income, not a nonrecurring lump sum, in the first possible month following the month received.

Lump sums from accumulated back-payments of SSI and/or RSDI are excluded as a resource for the first 6 months following the month of receipt. If the back-payment includes current benefits for the month in which the payment is received, deduct that amount prior to determining the excluded resource amount. Set up a spot check for the end of the 6 month period. Consider any remaining amount as a countable resource.

Tax rebates are considered as excluded in the month of receipt and the following two months. Any proceeds from the rebates after the third month is considered a countable resource.]

MS 2470 EXCLUDED INCOME (1)

Excluded income is income received but not considered in determining financial eligibility.

A. K-TAP and Kinship Care payments of an individual, other than a parent, not included in the MA family size for a separate case which includes a minor parent (SSI recipients are not included in the MA family size).

B. SSI benefits and any other income of SSI beneficiaries if the beneficiary is:

1. An individual in a Family Related MA family or

2. The spouse of an individual applying for or receiving LTC, Pass Through or Aged, Blind, or Disabled non-State Supplementation.

C. Low Income Home Energy Assistance Program (LIHEAP) payments.

D. Any payment made for child foster care, adult foster care, subsidized adoptions or personal care assistance.

E. In kind income.

F. Home produce for household consumption.

G. Vendor payment income. Payments on behalf of or for the benefit of an individual, other than the State Supplementation individual made DIRECTLY to a doctor, pharmacist, landlord, or utility company by another individual.

H. Replacement of income already received. If income is lost, stolen or destroyed and the individual receives a replacement, the replacement is not income.

I. Cash, including interest accruing from cash, or an in kind item received to repair or replace a damaged, lost or stolen excluded resource. Allow 9 months to repair or replace the excluded item, and an additional 9 months when the individual shows good cause.

J. Educational grants and scholarships obtained and used under conditions that preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill and educational payments made under the Carl D. Perkins Vocational and Applied Technology Educational Act Amendments of 1990 made available for attendance costs. Attendance costs are described as:

1. Tuition and fees normally assessed a student carrying the same academic workload required of all students in the same course of study as determined by the institution, including cost for rental or purchase of any equipment, materials or supplies; and

2. An allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

K. Principal of loans, including educational loans. Verify the loan by a commercial loan contract, form PAFS-73, Verification of Contributions – Loans – Roomer/Boarder Payments. When verification is received, exclude the loan amount. If verification is not received, consider the principal of the loan as a contribution in the month received and any remaining amount as a resource in subsequent months.

L. 20% RSDI increase received in August, 1972, if the individual was a money payment recipient.

M. For Nursing Facility and Waiver cases, exclude the first $90 of Veterans Administration (VA) pensions. For VA pensions less than $90, exclude the entire amount. Note: This exclusion is for pensions only; it does not include VA compensation.

N. Highway relocation assistance.

O. Urban renewal assistance.

P. Federal disaster assistance and State disaster grants.

Q. **[**KAMES excludes one-third of child support, received by an eligible blind or disabled child, when determining Medicaid eligibility. However, when determining patient liability, the entire amount of child support received is counted.**]**

R. Federal tax refunds are excluded as income for 12 months from the month of receipt. This includes advance Earned Income Tax Credit (EITC) payments.

S. Payments by credit life or credit disability insurance.

T. Experimental housing allowance program payment made under annual contributions contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended, and HUD Section 8 payments or existing housing under Title 24, Part 882.

U. Reparation payments from the Republic of Germany.

V. Public Law benefits and payments to:

1. Elderly persons under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;

2. Elderly persons receiving unearned income or payments with no taxes withheld under the Senior Community Service Employment Program (SCSEP) as authorized by Title V, of the Older Americans Act P.L. 100-175;

Organizations that receive Title V funds are:

a. Green Thumb;
b. National Council on Aging;
c. National Council of Senior Citizens;
d. American Association of Retired Persons;
e. U.S. Forest Service;
f. National Association for Spanish Speaking Elderly;
g. National Urban League; and
h. National Council on Black Aging.

3. VISTA volunteers under Title I of PL 93-113 pursuant to Section 404(g);

4. Individual volunteers for supportive services or reimbursement of out-of-pocket expenses while serving as foster grandparents, senior health aides, or senior companions and to persons serving in Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE), and any other programs under Titles II and III, pursuant to Section 418 of PL 93-113; and

5. Indian tribe members under PL 92-524, PL 93-134, PL 94-114 pursuant to Section 5 effective October 17, 1975 or PL 94-540.

W. Up to $12,000 to Aleutians and $20,000 to individuals of Japanese ancestry for payments made by the federal government to compensate for hardship experienced during World War II. All recipients of these payments are provided with written verification by the federal government.

X. VA Aid and Attendance Allowance (VA A&A), VA Unreimbursed Medical Expenses (VA UME), and VA Compensated Work Therapy (VA CWT).

Y. Income of the ineligible spouse/parent, if less than or equal to $50, when determining MA or spend down eligibility for the aged, blind or disabled spouse/parent.

[Z. All payments received from Agent Orange.**]**

AA. Victim compensation payments received from a fund established by a state to aid victims of crime.

BB. Interest on burial reserves if allowed to accrue.

CC. Income included in a Plan for Achieving Self-Support (PASS).

DD. Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

EE. All student work study income, educational grants and loans to any undergraduate made or insured under any program administered by the

U.S. Commissioner of Education or under the Bureau of Indian Affairs student assistance programs.

FF. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.

GG. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using SSI standards. This income is NOT excluded by SSA, so these recipients should not be SSI eligible. Enter the applications on KAMES as usual. If the hemophiliac is income ineligible for some other reason, pend the application and contact MSBB at DFS.Medicaid@ky.gov through your Regional Program Specialist for further instructions.

HH. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.

II. Payments made from the Crime Victims Funds.

JJ. Section 401 of the Veterans Benefits and Health Care Improvement Act of Public Law 106-149, provides for certain benefits for individuals with covered birth defects during the Vietnam era. There is no age limit for recipients of these benefits. These individuals will receive the benefits until they die. The amount of these Vietnam Veterans benefits are considered as excluded income and resources.

KK. Thirty dollars per quarter of infrequent/irregular earned income from an employer, a trade, or a business. Income is considered to be received infrequently if an individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not these payments occur in different calendar quarters. Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.

LL. Sixty dollars per quarter of infrequent/irregular unearned income received from an individual, a household, an organization, or an investment. Income is considered to be received infrequently if an individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not these payments occur in different calendar quarters. Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.

MM. The earned income of a blind or disabled child who is a student in regular school attendance.

NN. All interest and dividend income of recipients, community spouses and parents of disabled children. This income is excluded in both Medicaid eligibility and LTC vendor payment determinations.

OO. Tobacco Settlement Income is excluded in the month of receipt and the month after receipt. It is considered a countable resource in the third month and thereafter.

PP. For Adult Medical Assistance, military combat pay is excluded.

QQ. Placing Adults in Competitive Employment (PACE) income.

MS 2480 DEDUCTIONS

Deductions are subtracted from income to allow for specific expenses or allowances.

A. VERIFICATION. Verify related work expenses by viewing and documenting receipts, checks, etc.

B. CONSIDERATION. Deduct the following items in the following order.

1. The $20 general exclusion, first to unearned income, with the balance, if any, applied to earned income.

2. $65 from earned income.

3. The Impairment Related Work Expense (IRWE) is allowed for individuals who are disabled, for any amount expended for specific items or services which enable an individual to work.

   Deduct the following IRWE items and/or services only if not included in a PASS. Allow deductions in the month incurred, or divide over a 12 month period, beginning with the month of the first payment, whichever is more beneficial to the individual.

   a. Payment for attendant care services such as assistance in traveling to and from work, and assistance with personal functions at home in preparing for work such as eating, personal hygiene, dressing, etc.
   b. Payment for medical devices such as durable medical equipment such as wheelchairs, canes, crutches, inhalators, pacemakers, etc.
   c. Payment for prosthetic devices such as, but not limited to, artificial arm, leg, etc.
   d. Payment for work-related equipment for specialized use such as one-handed typewriter, telecommunication devices for the deaf, etc.
   e. Payment for residential modifications that aid an individual to work such as the installment of a ramp or enlargement of a doorway for a wheelchair.
   f. Payment for nonmedical appliances and equipment essential for the control of a disabling condition that are medically verified as necessary, such as an electric air cleaner for an individual with a respiratory disease, etc.
   g. Payment for drugs and medical services to control an individual's impairment, such as anticonvulsant drugs or anticonvulsant blood test monitoring for epilepsy, medications for mental disorders, immunosuppressive medications, etc.

h. Payment for medical supplies and services which enable a person to work such as incontinence pads, catheters, irrigating kits, physical therapy, speech therapy, etc.

i. Payment for transportation costs associated with vehicle structural or operational modifications and payment for use of driver assistance.

j. Payment for installing, maintaining, and repairing impairment related items.

A blind individual may receive either the Blind Work Expense (BWE) or the Impairment Related Work Expense (IRWE), but can not concurrently receive both.

4. 1/2 the remaining earned income.

5. The Blind Work Expense (BWE) is any expense incurred as the result of working. Deductions for employed blind individuals may include, but are not limited to, transportation, lunches, federal, state and local income taxes, F.I.C.A., union dues, prosthetics, special equipment, job related training, etc. Do not allow usual living expenses, rent, food, etc., and educational expenses which are not job related. The special deductions are applicable to both the individual and responsible relative, only if not included in a PASS.

6. Plan for Achieving Self-Support (PASS). Work-related allowances or expenses included in an approved PASS. See MS 2490.

MS 2490 PLAN FOR ACHIEVING SELF-SUPPORT (PASS)

[PASS is an income and/or resource exclusion that allows a blind or disabled applicant/recipient who does not have the capability for self-support, to set aside income and/or resources for a work goal such as education, vocational training, or starting a business.

PASS can enable an individual to maintain or establish SSI eligibility when the individual would otherwise be ineligible due to excess income and/or resources. A PASS may decrease an individual's net income used to determine MA eligibility and vendor payment, when the income considered in the PASS is excluded.

Individuals inquiring about the PASS program are referred to the Social Security Administration (SSA). Applications for PASS are approved or denied by SSA personnel who are trained to evaluate vocational/rehabilitative plans. Individuals that are approved for PASS will receive Supplemental Social Security (SSI). If an individual is denied for PASS the individual has appeal rights which are filed with SSA for reconsideration. While the PASS application is in appeal for a final decision the SSI/Medicaid application also remains pending with SSA.]

MS 2560 TECHNICALLY ELIGIBLE APPLICANT

Do the following to determine the income eligibility of a technically eligible applicant.

A. Determine gross unearned income

B. Deduct $20 general exclusion. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

C. Determine gross earned income.

D. Allow appropriate deductions according to MS 2480.

E. Combine countable earned and unearned income.

F. Deduct the MA Scale for 1.

[G.] If there is no excess, the individual is MA eligible.

[H.] If the countable income exceeds the MA scale, determine spend down eligibility.

MS 2570 TECHNICALLY ELIGIBLE APPLICANT AND SPOUSE

Use the following income computation steps to determine MA eligibility of the aged, blind, or disabled individual with a technically eligible spouse.

A. Combine unearned income of the couple.

B. Deduct one $20 general exclusion. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

C. Combine earned income of the couple.

D. Allow appropriate deductions according to MS 2480.

E. Combine countable unearned and earned income.

F. If total countable income is less than or equal to the MA Scale for 2, both are eligible.

G. If total countable income is more than the MA Scale for 2, multiply the excess by 3 to determine the quarterly excess for spend down eligibility.

MS 2580 TECHNICALLY ELIGIBLE APPLICANT WITH TECHNICALLY INELIGIBLE SPOUSE

If the spouse is technically ineligible, compute the amount of income, if any, to be deemed from the ineligible spouse to the applicant. Additionally, when determining spend down eligibility of the applicant with a technically ineligible spouse, compute two budgets. Use the result of the higher budget to compute the applicant's quarterly excess amount.

A. If the ineligible spouse's gross income is:

1. [Less than or equal to $50, deem no income to the applicant. Follow MS 2480 to determine income eligibility.]

2. More than $50, proceed to item B.

B. Compute the income of the couple as follows:

1. Determine gross unearned income of the applicant.

2. Add gross unearned income of the ineligible spouse.

3. Deduct $20 general exclusion. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

4. Determine gross earned income of the applicant.

5. Add gross earned income of the ineligible spouse.

6. Deduct appropriate deductions according to MS 2480.

7. Add countable unearned and earned income (result of items 3 and 6).

8. Deduct the MA Scale for one.

a. If there is no excess, the individual is MA eligible.

b. If there is excess income, determine spenddown eligibility for the applicant. Use medical expenses of the ineligible spouse to reduce the excess income of the applicant. Follow regular spend down procedures to determine medical expenses used to reduce the excess income of the aged, blind, or disabled individual.

MS 2600 COMPANION CASES INTRODUCTION

COMPANION CASES are those in which more than one member of a family is an applicant for or recipient of MA and relative responsibility exists: husband and wife or parent and child.

For purposes of technical eligibility, case number assignment and authorization, consider companion cases individually.

MS 2610 BOTH INDIVIDUAL AND SPOUSE ARE TECHNICALLY ELIGIBLE

A computation is required to determine the amount of income to be considered when both the applicant and his/her spouse are technically eligible.

A. Combine unearned income of the couple.

B. Deduct one $20 general exclusion.

C. Combine earned income of the couple. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

D. Deduct one $65 and 1/2 the remainder deduction for the couple. Deduct other earned income deductions for each spouse, if applicable.

E. Combine countable unearned and earned income.

F. If total countable income is less than the MA Scale for 2, both are eligible.

G. If total countable income is more than the MA Scale for 2, use spend down procedures.

H. If one of the technically eligible spouses becomes institutionalized during a spend down quarter, the spend down liability for the community spouse remains the same through the remainder of the established quarter. If the community spouse reapplies for a subsequent quarter, consider only the community spouse's gross income plus the amount actually made available to the community spouse from the institutionalized spouse. Compare income to MA family size of 1.

   Compute the institutionalized spouse's eligibility and patient liability using policy in MS 3540.

MS 2620 TECHNICALLY ELIGIBLE INDIVIDUAL WITH TECHNICALLY INELIGIBLE SPOUSE

[A computation is required to determine the amount of income to be deemed from the ineligible spouse to the aged, blind, or disabled spouse.

Two budgets are computed. The result of the higher budget is used for the aged, blind, or disabled spouse's spend down amount.]

A. Step I - Technically ineligible spouse:

1. [If the ineligible spouse's gross income is less than or equal to $50, no income is deemed to the aged, blind, or disabled spouse. Use countable income computed in Step II to determine the aged, blind, or disabled spouse's ongoing MA eligibility or spend down liability.] Do not complete Step III.

2. If the ineligible spouse's income is greater than $50, complete Step II and Step III.

B. Step II - Aged, blind, or disabled technically eligible individual:

1. Determine gross unearned income of the aged, blind, or disabled individual.

2. Deduct $20 general exclusion.

3. Determine gross earned income of the aged, blind, or disabled individual. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

4. Deduct one $65 and 1/2 the remainder and other earned income deductions as appropriate.

5. Combine countable unearned and earned income.

6. Deduct MA Scale for 1.

7. If the result is $0, and there is no spousal income to consider, the aged, blind, or disabled individual is MA eligible. Otherwise proceed to Step III.

C. [Step III - For an aged, blind, or disabled but technically eligible individual and technically ineligible spouse:]

1. Determine gross unearned income of aged, blind, or disabled individual.

2. Add gross unearned income of ineligible spouse.

3. Deduct the $20 general exclusion.
4. Determine gross earned income of aged, blind, or disabled individual.

5. Add gross earned income of ineligible spouse. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

6. Deduct one $65 and 1/2 the remainder for the couple, as appropriate. Deduct other earned income deductions for each spouse, if applicable.

7. Add the results from items 3 and 6. This is total countable income.

8. Deduct the MA Scale for 1.

9. If the result is $0, in Step II and Step III, the aged, blind, or disabled individual is MA eligible.

   If the result is greater than $0, in Step II or Step III the result reflects a potential spend down amount for the aged, blind, or disabled individual. Proceed to Step IV.

D. Step IV - Spend down comparison:

1. Compare the spend down amount computed in Step II to the spend down amount computed in Step III.

2. Use the greater amount to determine spend down eligibility for the aged, blind, or disabled individual.

3. Follow regular spend down procedures to determine medical expenses used to reduce the excess income of the aged, blind, or disabled individual.

MS 2650 [SPEND DOWN PROCESS] (1)

Spend down provides time-limited Medicaid to an individual or family who meets all resource and technical requirements of eligibility but has income in excess of the MA Scale for the family size. Eligibility is determined on a quarterly basis using the month of application and two following months or some or all of the three months prior to the month of application.

[A household that includes an aged, blind or disabled parent can choose a spend down determination that includes their spouse and children in Family MA or Adult MA for themselves. The worker is to review the situation and explain the option which would be the applicant's best advantage.]

A. Spend down Medicaid eligibility begins on the day an individual meets the spend down obligation amount; i.e., the day medical expenses equal or exceed the excess income amount. Advise recipients the spend down obligated amount is met with medical bills incurred by any case member during the spend down time period. The household's obligated amount is met with the first providers who bill Medicaid. Use medical expenses that are incurred during the quarter or currently owed from a prior period that was not previously covered by spend down or regular Medicaid.

   Example: The spend down obligation amount is $100.00 for the spend-down period of 3/23/11 through 5/31/11. The household is responsible for payment of bills prior to 3/23/11 used to meet the obligated spend down amount, as well as the $100 spend down obligation. If the first bill received by DMS is for services on 4/6/11 for $50.00, the amount of that bill is deducted from the obligated amount of $100.00. The next bill received by DMS is $25.00 for services on 3/23/11, and a bill is submitted the same day to DMS for $25.00 for services on 5/1/11. These are deducted from the obligated amount, the client is responsible for paying them, and the spend down obligated amount is met. Any subsequent bills paid by DMS as long as they are within the spend down period of 3/23/11 through 5/31/11.

B. Notices for spend downs show the case obligation amount rather than the individual's obligation amount. The obligation amount is the amount the client must pay for the spend down time period.

C. When processing a "J", "K", or "M" spend down for a couple (husband & wife), it is necessary for the worker to enter 1 cent as a bill for a month in which one member of the couple does not have medical expenses.

   Example: A "J" case spend down is appropriate for prior 2 months only with an application taken in August. The husband has medical bills for May only, and the wife has medical bills for June. KAMES correctly approves a 2-month spend down for the husband, but for the wife's spend down to process correctly, worker will need to enter a 1 cent bill for May.

D. For spend downs processed by special circumstance, enter the household's obligated amount by each member of the case. The worker enters each member's spend down liability amount in the "SPD/LIAB" field on the Special Circumstance - 1 screen. The member spend down liability amount is the

amount the member is obligated to pay on the date the spend down eligibility is met. For instructions on processing a special circumstance, refer to MS 1435.

Example: A household's spend down obligation amount is $100.00. For each member listed, enter $100.00 as the spend down obligation amount.

Tom	# Jones	xxx xx xxxx	07021989	100.00
Shirley	# Jones	000 00 0000	10101989	100.00
Cutie	# Jones	111 11 1111	06062007	100.00

Workers will receive an error message, "SPD LIAB AMTS MUST BE EQUAL", if the spend down obligated amount is not entered as shown above.

[For individuals with an active QMB cases, use the recipient status code "HH". For active SLMB cases use "S2". These recipient status codes will prevent the recipients from losing their QMB/SLMB benefits with the issuance of the spend down special circumstance. Individuals eligible for buy-in under the Qualified Individuals Group 1 (QI1) and Qualified Disabled Working Individual (QDWI) programs are not dually eligible and are allowed a medical deduction for the SMI premium. QI1 and QDWI recipients are to be advised that the SMI premium will be recouped for the months that they are eligible for the spend down.]

E. If health insurance coverage other than Medicaid exists, that insurance provider's payment for the incurred services must be determined prior to approving the spend down application. Only the amount the individual is responsible to pay can be considered towards the spend down excess. Because of the time involved in determining the insured's liability from the other insurance, Medicaid may not be approved, in some situations, until the eligible quarter has expired. Inform applicants of this possibility.

F. When quarterly excess income equals verified recognized incurred medical expenses, paid or owed, the application may be approved on a time-limited basis. Effective dates of coverage begin on a specific day and end on the last day of the month approved.

G. A spend down application is approved as soon as possible, but not to exceed 30 days from the date of application. If a spend down application cannot be processed within 30 days due to additional information being requested or if it is the beginning of the spend down quarter and client's obligation for payment of bills has not been met, the application is held pending for receipt of incurred expenses up to 90 days. Refer to MS 1470, for cases pending over 30 days with good cause. When the verification is received, the case must be worked WITHIN 5 WORK DAYS from receipt of the required verification.

H. Advise recipients they need to wait until they receive a statement from the provider that DMS has been billed, and the bill was denied for use in meeting the obligated amount, before they make any payments for services during the spend down timeframe. This is necessary to establish which provider bills are adjusted based on the family/member's obligation amount.

[I. If, after a determination has been made, additional verification of medical expenses is provided by the recipient, a re-computation is completed.

1. If it is determined that their spend down liability was met earlier in the quarter, complete a Special Circumstance Transaction to authorize Medicaid eligibility for the earlier date.

2. If the re-computation results in the determination that the applicant met the spend down liability later in the quarter, no action is required.

J. If medical expenses for the quarter are less than the quarterly excess income; deny the application.]

MS 2670 ESTABLISHING THE RETROACTIVE SPEND DOWN QUARTER (1)

[KAMES reviews for regular Medicaid eligibility before it determines spend down eligibility. Months to which medical expenses can be applied are broken up into quarters. Eligibility established for a RETROACTIVE quarter may include any of the three prior months from the month of application during which an applicant incurred a medical expense. Which months are included in the retroactive quarter is a decision left up to the applicant as eligibility may be established for only one or two months of the RETROACTIVE quarter even if there are medical bills in the other months.**]**

A. To determine eligibility for the RETROACTIVE quarter spend down the following must be VERIFIED:

1. The applicant must verify that MEDICAL EXPENSES were incurred in any of the retroactive months for which the spend down application is made. The medical bills used must be currently owed. The bills can be owed by any member of the Medicaid household even if that member is not applying for or receiving Medicaid. However, if the medical bills have been turned over to a collection agency, the bills are no longer considered as owed and cannot be used. Any bills already used in a previous spend down approval cannot be used again for the current application; and

2. The applicant must verify INCOME received in any of the retroactive months for which the spend down application is made.

B. CONSIDERATION

1. The application may or may not be approved as a RETROACTIVE quarter spend down depending on the income.

a. If the applicant meets technical and financial eligibility and has an incurred medical expense in any of the three months prior to the application month, regular MA coverage is approved for those months. Check each month separately.

Example: A RETROACTIVE quarter spend down is established for Mary who is 72. She had medical expenses for the RETROACTIVE quarter but only had $220 per month income for those three months. She now gets $875/mo in RSDI. Mary is currently over the standard MA scale for 1 ($217) and has no current quarter medical expenses therefore she is denied for ongoing MA. She was under the MA scale for the RETROACTIVE months therefore regular MA is approved for those months.

b. If the applicant does NOT meet income eligibility for any of the three months prior to the application month but meets technical and resource eligibility and has incurred medical expenses for one, two or three months, there is a liability.

Example: A RETROACTIVE quarter spend down is established for Annie who is 98. She had medical expenses for the RETROACTIVE quarter and had $975 per month income for each of those three months. Annie was over the MA scale for the retro months therefore she does have spend down liability.

C. SYSTEM ENTRY

Income and medical expenses are entered on KAMES for the RETROACTIVE quarter the same as it would be entered for a regular Medicaid application however the disposition screens will display eligibility differently depending on whether the application is denied/approved and what months of eligibility are issued:

a. If the applicant does not have enough medical bills to meet spend down eligibility for any of the months in the RETROACTIVE quarter the application is denied.

b. If the applicant meets eligibility for just 1 or two months due to not having enough medical expenses then the applicant has the choice to change the spend down from a quarter spend down to a 2 or 1 month spend down (whichever is appropriate). This option must be explained in detail to the applicant in order to help them make the correct choice and avoid wasting a spend down month. Explain to the applicant that the bills that would have been used in the month they were actually incurred will now be used for the months for which eligibility is met to lower the obligation amount and meet the liability sooner. If the applicant chooses to complete a 1 or 2 month spend down instead of a 3 month spend down complete the following on KAMES:

1. Revisit the medical expenses screen (screen HRKIMA1E) and change the dates for the bills that would have been used in the denied month to the first day of the month of spend down approval;

2. Change the “type” of medical bill that was previously entered to “14-Prior Medical Exp” and navigate back through the application.

Example: Tom applies in July and is disabled. He pays He has medical bills for April, May, and June. He receives $1200/mo in RSDI. After the appropriate deductions Tom’s liability for June is $963 for each of the three RETROACTIVE months with a total liability for all 3 months being $2889.

Tom had $200 in medical bills for June, $900 in July and $1700 in August. He is denied for June as he does not have enough medical bills to meet the June liability. He meets his spend down liability on 7/15/11.

After the worker discusses the advantages of changing the spend down from a 3-month spend to a 2-month spend down the case is re-worked. The “type” and “dates” for all of June’s medical expenses are adjusted:

“type 01-Medical/Dental for 6/5/11, 6/9/11” are changed to “type 14-Prior Medical Exp., with the July dates (7/1/11)”.

Now Tom will meet his spend down on 7/5/11 as the June bills combined with the first few July bills helped him meet his spend down sooner.

c. Once the system has determined which months of Medicaid will be issued the eligibility system calculations for the RETROACTIVE quarter will display as follows:

1. On the first disposition screen HRKIPC14, a regular 12-mo. cert period (like a regular MA application) will upload;

2. On the second disposition screen HRKIPC15, the “actual” months for which a spend down card will be issued is displayed. Based on the example above KAMES would show 07/5/11 – 08/31/11.

3. On the third disposition screen HRKIPC19, enter a “Y” for the spend down month. The actual income considered and the excess for that particular month will display.

4. On the fourth disposition screen HRKIPC35, the worker will see:
   a. The type of medical bill used to meet the spend down liability (i.e. 01-Medical/Dental, 14-Prior Medical Exp., etc);
   b. The medical bill used to meet the spend down liability;
   c. The date the spend down liability was met; and
   d. The amount of the bill used to meet the spend down liability.

D. A RETROACTIVE and current quarter can be processed simultaneously. When all information is verified, the system approves both quarters and discontinues the case. If the spend down liability is met for the RETROACTIVE quarter, but not for the current quarter, KAMES processes the retroactive Medicaid and leaves the current quarter pending. KAMES generates a Request For Information (RFI) to request verification of additional medical expenses for the current quarter spend down.

MS 2671 ESTABLISHING THE CURRENT SPEND DOWN QUARTER (1)

[KAMES reviews for regular Medicaid eligibility before it determines spend down eligibility. Months to which medical expenses can be applied are broken up into quarters. Eligibility established for a CURRENT quarter includes the current month and the two following months. The spend down liability for the current month and the following two months must be met before the current quarter spend down application is approved. The applicant is allowed until the last day of the current quarter to meet the current quarter spend down liability.

Before initiating the CURRENT quarter spend down it is important that the applicant understands all options. If the applicant has one large bill to be paid and does not expect to incur bills in the next two months, a CURRENT quarter spend down is not advisable. Explain to the applicant it is to their advantage to complete a retro quarter spend down as their obligation amount will be less. Refer to MS 2670. If the applicant chooses to wait to apply provide the applicant with an appointment date and time for them to return to complete the application.

If payment of the bills is of lesser importance to the applicant than having Medicaid coverage for all three months in the current quarter proceed with the CURRENT quarter spend down application.**]**

A. VERIFICATION

To determine eligibility for the CURRENT quarter spend down verify the following:

1. The applicant must verify they have enough unpaid medical expenses to meet the liability for the entire current quarter. The medical bills can be old bills incurred in previous months however they must be currently owed. The bills can be owed by any member of the Medicaid household even if that member is not applying or receiving Medicaid. However, if the medical bills have been turned over to a collection agency, the bills are not considered owed and cannot be used. Any bills used in a previous spend down approval cannot be used again for the current application; and

2. The applicant must verify INCOME received in the prior two months from the month of application. If the applicant states that income received for the prior two months is not representative of ongoing, verification from the employer of ongoing income must be provided.

B. CONSIDERATION

If the applicant meets technical and resource eligibility for the CURRENT quarter spend down, KAMES averages and converts income received in the previous two months to calculate the CURRENT quarter spend down liability.

EXAMPLE: Janie applies for a current quarter spend down in June and has a $3,000 medical bill for surgery in June. She anticipates more medical expenses for July and August. She gets $875 month in RSDI. After KAMES takes the average of the prior two months of income ($875) and subtracts the standard MA scale for 1 ($217) it calculates an excess of $658. KAMES applies the appropriate income deductions, in this case, the $20 unearned income general exclusion. KAMES determines the current quarter spend down liability to be $638 month. Since all three months must be considered for a current quarter spend down Janie must incur $1914 ($638x3) in medical bills during the current quarter (June, July, August) before the current quarter spend down can be approved.

Note: Applicants are allowed the entire current quarter to meet the spend down liability.

C. SYSTEM ENTRY

Income and medical expenses are entered on KAMES for the CURRENT quarter the same as for a regular Medicaid application however the disposition screens will display eligibility differently depending on whether the application is denied or approved:

1. If the applicant does not meet spend down eligibility due to a lack of medical bills, KAMES pends the application until the last day of the current quarter in order to allow the applicant time to meet the spend down obligation. If after that date the obligation is not met KAMES denies the application.

2. If the applicant meets the current quarter eligibility, when the spend down obligation is met KAMES will calculate the CURRENT quarter spend down obligation and display the system calculations as follows:

   a. On the first disposition screen HRKIPC14 – the three month current quarter spend down period will display to show the months of eligibility.
   b. On the second disposition screen HRKIPC15 – an “A” for approval will be displayed next to the applicant’s name with a “Y” uploaded under “MAID”.
   c. On the third disposition screen HRKIPC19 – the averaged/converted countable income, the excess for the current month and the combined three month excess that must be met before the case can be approved will display.
   d. On the fourth disposition screen HRKIPC35, the following is displayed:

      1) The type of medical bill used to meet the spend down liability (i.e. 01-Medical/Dental, 14-Prior Medical Exp., etc);
      2) The medical bill used to meet the spend down liability;
      3) The date the spend down liability was met; and

4) The amount of the bill used to meet the spend down liability.

D. A retro and current quarter can be processed simultaneously. When all information is verified, the system approves both quarters and discontinues the case. If the spend down liability is met for the retro quarter, but not for the current quarter, KAMES processes the retroactive Medicaid and leaves the current quarter pending. A Request For Information (RFI) is generated to request verification of additional medical expenses for the current quarter spend down.

MS 2720 CONSIDERING MEDICAL EXPENSES IN SPEND DOWN (1)

Spend down medical expenses are expenses incurred by an individual, a spouse or dependent child under 21 in the home or away from home for the purpose of school attendance. Unless already receiving MA, these expenses are allowed regardless of whether or not these family members are included in the case and/or regardless of whether or not their income is considered in the MA eligibility determination.

[Consideration of Medical Expenses:

A. Consider any verified recognized medical expense(s) incurred DURING the established quarter. Begin with the first day of the quarter and list daily expenses.

B. Consider the unpaid balance of any verified recognized medical expense incurred PRIOR TO the established quarter.

1. Consider the expense as incurred on the first day of the first month of the established quarter.

a. Medical expense type code “14 – PRIOR MEDICAL EXP” on the Application Medical Expense screen and is used to identify allowable unpaid medical expenses incurred prior to the established quarter. When using prior medical expenses to meet the spend down amount, always show the date the expense was incurred as the first day of the spend down quarter. If the spend down amount is met with prior medical expenses only, the member spend down liability will be $0.

b. Unpaid medical expenses from a prior quarter must be verified as still owed. If the bill has been written off or has been paid by a third party, it cannot be used. If verification cannot be provided that the bill is still owed, it cannot be used to meet the spend down liability. The “SPD LIAB” (spend down liability) field on the third General Member Information Inquiry screen is uploaded with the member’s spend down liability amount.

2. Consider only the portion of the expense needed to obligate the spend down excess.

a. If consideration of a portion of the expense obligates the spend down excess, then the remaining balance of the expense can be used to obligate a future spend down excess. For these situations, annotate the amount used to obligate the excess for the established quarter, and the amount remaining for future spend down use in case comments.

b. Review the case record to ensure the expense has not been considered in a previous quarter to establish MA eligibility.

EXAMPLE: An individual's spend down excess for the current quarter is $1,200. Two years ago, the individual incurred a $1,600 hospital bill, made a payment of $100 leaving an unpaid balance of $1,500. The $1,200 portion of the hospital bill is considered on the first day of the first month of the current quarter for spend down. The remaining $300 of the bill can be used to obligate a future spend down excess.

C. Verified payments on medical bills for services when MA was not received are deducted if paid during the quarter.

EXAMPLE: Two years ago, an individual purchased an $800 hearing aid and charged the full amount. Each month a $25 payment is made on the account. The individual applies for MA as a spend down case. Consider the $25 as a recognized medical expense and record as a spend down expense the day the $25 payment is made.

D. When all verified recognized medical expenses presented by the individual are recorded, determine if, on any day in the quarter, the total amount of expenses for the period is as much as the excess income.

Verification of Medical Expenses:

A. Medical bills or statements;

B. Receipts for payment of medical expenses;

C. Medicare Summary Notices (MSN) which shows covered/uncovered and paid/unpaid medical expenses;

D. Health insurance statements showing amount paid;

E. Other appropriate means.

Medical Expense Restrictions:

A. Do not list any expense to be paid by a third party, such as Medicare, health insurance, insurance settlement, family member, etc.

EXCEPTIONS:

1. DO NOT hold spend down applications pending for verification of payment of medical expenses as a result of an unforeseen accident which may be covered by liability insurance owned by another person. It is the responsibility of DMS to obtain reimbursements from third party liability sources.

This procedure does not apply to health insurance policies, such as, Medicare, Blue Cross/Blue Shield, Humana, etc. and Worker's Compensation. Spend down applications are held pending verification of payment of medical expenses by these third party liability sources.

2. For persons undergoing renal dialysis treatment, do not hold spend down applications pending for Medicare Summary Notices (MSN) if:

   a. They have Medicare but no other health insurance; and

   b. The renal dialysis clinic provides a statement verifying the date of service, cost of service and the anticipated amount of Medicare reimbursement for each date of service. The difference between the Medicare billed amount and the anticipated Medicare payment amount is allowed as the spend down medical expense.

Use this statement and any other verified medical expenses that will not be reimbursed by Medicaid, such as prescriptions. Other verified medical expenses subject to Medicare reimbursement cannot be used to meet the spend down liability as the application is to be processed prior to receipt of the MSN.

These cases are given priority and processed as soon as the spend down liability is met. When MSN's are received for other medical expenses, the case is reworked at the individual's request, to determine if an earlier date was met for the spend down program.

B. Do not consider medical expenses for which individual is absolved from payment, such as a medical bill written off by provider as uncollectible. If the medical expense is more than 90 days old, OR if the individual's responsibility for payment of the medical expense is questionable, the appropriate provider MUST be contacted to determine whether or not the individual is liable for payment of the expense.

C. Do not consider medical bills or payment on medical bills used to obligate the liability amount for any previous spend down quarter.

   EXAMPLE: During the current quarter, an individual purchased eyeglasses costing $129. The total amount was charged on the 6th day of the 1st month of the current quarter. The total amount is considered on the 6th for spend down. During the next quarter, $25 a month has been paid on the $129 charge. The $25 payments cannot be used as the entire $129 was used in the quarter the expense was incurred.

D. Unpaid medical expenses are allowed as a spend down medical expense unless B or C of this section apply.

E. For the child excluded from an K-TAP grant and for whom a separate spend down case has been established:

   1. Combine income and resources of the K-TAP group and the excluded child.

   2. Apply verified incurred medical expenses of the excluded child.

   3. Apply uncovered verified incurred medical expenses of the responsible relative to the spend down amount.

4. Do not consider medical expenses of the K-TAP children.

F. For a blind or disabled child living at home:

1. Consider income and deductions of the parent and the blind or disabled child according to MS 1810; and

2. Apply uncovered, verified incurred medical expenses of the parent, blind, or disabled child and siblings to the spend down amount.

G. All bills, statements, and receipts, must show the actual date of service and daily charge to determine the day the excess is met.

H. Deductions for prescription drug expenses incurred during a period of Medicaid eligibility may be allowed ONLY if the recipient verifies that Medicaid denied coverage of the drug at the time, and that a prior authorization request was also denied. A deduction can be given for a Medicare Part D premium if paid by the recipient.]

MS 2730 ALLOWABLE SPEND DOWN MEDICAL EXPENSES (1)

The following are allowable recognized medical expenses used in determining spend down eligibility:

A. Health insurance premiums including SMI, and specified disease policies such as cancer and/or any other policies paying for services within the scope of the program. Consider the entire amount when paid or prorate payment for months of actual coverage, to the benefit of the client whichever they choose.

EXAMPLE: A $90 premium is paid July 15 to cover August, September and October. Allow $30 for August 1, September 1 and October 1 or use the entire $90 on July 15.

B. Insurance policies paying specific benefits per day to an individual while hospitalized or during recuperation. Premiums paid on these policies are considered a medical expense.

C. Nursing facility insurance premiums.

D. Transportation expenses for health care that are not available free of charge. Costs for use of the individual's own car are deductible at the current federal standard medical mileage rate. This information is accessed at www.irs.gov. To access the current year's medical mileage rate enter the term "mileage rate" in the search box;

E. **[**The actual amount paid for caretaker, Family Care, Personal Care, or Community Integration Supplementation (CIS) services if the individual is paying the private pay rate.**]**

If medical expenses of a spouse are being considered and the spouse is receiving state supplementation payments then consider the payment for caretaker services as a medical expense.

F. In-patient hospital services including services in institutions for tuberculosis, mental disease or other specialty hospitals regardless of age;

G. Laboratory and x-ray services;

H. Nursing Facility services, including services in institutions for tuberculosis or mental disease, for all individuals regardless of age;

I. Any physician's services;

J. Medical care or any other type of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice as defined by state law;

K. Home health care services, including intermittent or part-time services of a nurse or home health aid according to a physician's plan of treatment;

L. Private duty nursing services by a Licensed Practical Nurse or Registered Nurse;

M. Clinic services;

N. Dental services, including dentures prescribed by a licensed and practicing dentist;

O. Physical therapy and related services including supplies such as hearing aids;

P. Drugs prescribed by a licensed physician, osteopath or dentist;

Q. Prosthetic devices, including braces, and artificial limbs;

R. Eye glasses and other aids to vision, prescribed by an ophthalmologist or an optometrist;

S. Ambulance services when medically indicated and/or other transportation costs necessary to secure a medical examination or treatment;

T. X-ray, radium and radioactive isotope therapy;

U. Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations, including surgical dressings and related items, used at the direction of a physician for continuing treatment of a health problem;

V. If not available from a Home Health Agency, rental or purchase of durable medical equipment including, but not limited to iron lung, oxygen tents, hospital beds, wheelchairs, crutches, braces and artificial limbs including replacements if required because of change in the patient's condition;

W. Purchase, care and maintenance costs of Seeing Eye dogs;

X. Consider the cost of lodging, which may include the lodging cost of a nurse/attendant, a necessary medical expense if it can be determined lodging was necessary to secure required medical service or treatment.

1. Question the client to determine if circumstances necessitated lodging and annotate case record.

2. If the need for lodging cannot be determined, request a physician's statement to verify reported expenses were actually medically necessary.

3. The allowable amount may not exceed commercial lodging costs prevalent in area.

Y. Incurred medical expenses paid by a public program of the State or a political subdivision without federally designated funds. Political subdivisions include city, county, or local governments. These medical expenses are also allowed as deductions for LTC, waiver and Hospice cases if MA eligibility is determined by exceptional spend down, Step II process.

1. Examples of public programs of the State include;
   a. Hospitals such as, UK Medical Center, Humana University Hospital;
   b. Health departments;
   c. Community Service Centers;
   d. Primary Care Centers operated by local health departments; and
   e. Comprehensive Care Centers.

2. Medical expenses paid by programs of the federal government, including Medicare and VA. Bills that have been written off as uncollectible are not allowable as spend down deductions.

3. Obtain a copy of the bill to verify that a medical expense was incurred and that the expense was paid by a State public program or political subdivision without federally designated funds prior to allowing the deduction.

Z. Any item verified by a doctor's statement that is medically necessary for controlling a patient's allergy problem. Items may include:

1. The purchase of electrostatic air filters;

2. Humidifiers;

3. Air conditioning;

4. Central heating systems;

5. Hardwood floors;

6. Payment for carpet/upholstered furniture cleaning; and

7. Carpet removal.

AA. Other items clearly identified as medical in nature.

1. This includes:
   a. Aspirin;
   b. Antacids;
   c. Peroxide;
   d. Band-Aid’s;

e. Nutritional supplements such as Ensure; and
f. Incontinent care products.

2. Cash register receipts are acceptable verification of the expense. If the receipt does not specify the item, the individual's statement is accepted.

BB. Consider charges from a physician who is not enrolled in the Medicaid program as a medical expense on the date of service in the spend down calculation. While the expenses can be deducted, Medicaid cannot make payments to a physician who is not an enrolled provider.

MS 2770 PATIENT LIABILITY FOR INDIVIDUALS OTHERWISE MEDICAID ELIGIBLE (1)

When an individual who is already Medicaid eligible begins receiving waiver services, the individual has a $0 patient liability regardless of income. This applies only to waiver admissions, not to nursing facility admissions. The case remains in the original category.

[Explore Pass Through eligibility when adding waiver services to an active case. Determine if the individual lost Medicaid due to the loss of SSI or State Supplementation eligibility. If SSI was lost, complete form PA-9, Pass Through Verification Letter, to determine Pass Through eligibility. The individual's patient liability is $0 if Pass Through eligible.**]**

Example: If an individual is currently receiving Pass Through and is admitted to HCBS, add the waiver information to the Pass Through case. KAMES will calculate the $0 patient liability because the individual was otherwise Medicaid eligible. Do not alternate program to the "J", "K" or "M" category.

MS 2800 Consumer Directed Option (CDO) (1)

Consumer Directed Option (CDO) is a service provided under existing types of care such as Home and Community Based Services (HCBS), Adult Day, Supports for Community Living (SCL), and Acquired Brain Injury (ABI). CDO services CANNOT be entered on KAMES as a type or a level of care. The Area Agency on Aging "AAA" has to be entered as a provider on the LTC screen (even though they are not an actual provider) and KAMES requires workers to enter a provider type. If the provider number begins with 43, KAMES requires "adult day" be entered as the type. CDO services are not an increase in or expansion of current services. All technical and financial criteria for Medicaid and waiver eligibility must be met.

CDO services are available through "AAA" but they do not provide services to clients. They serve as a support broker and help recruit, hire, and manage employees. They also negotiate rates. CDO services can be provided by family members, friends, or neighbors.

Note: Pay received by a CDO employee is countable when that employee or a member of their family applies for MA benefits. CDO income is considered the same way as if the wages were from a regular employer. This is true for CDO employees who are relatives of the member for whom they provide services, as well as for non-related CDO employees.

By choosing CDO services, the individual can maintain better control over how services are provided.

A. Individuals may choose to receive only traditional services such as HCBS, Adult Day, SCL or ABI, or they can combine HCBS, Adult Day, SCL or ABI with CDO services depending on the individual's needs and approved plan.

B. CDO services are entered on KAMES by using the "AAA" provider number obtained from the PRO Certification.

C. CDO services for HCBS members:

HCBS members can use CDO services for respite care, personal care, homemaking and attendant care. Sometimes it is not necessary to discharge the HCBS provider, the "AAA" is added on KAMES as a second provider. However, sometimes a "AAA" PRO Cert may be issued to change the HCBS provider to the "AAA" provider. Always follow what is on the PRO Cert.

Note: HCBS and Adult Day can co-exist but a recipient cannot have two HCBS providers.

D. CDO services for Adult Day:

1. Adult Day individuals can use CDO services in the following instances:

   a. When the individual already has both HCBS and/or Adult Day and also chooses CDO services. The “AAA” PRO Cert is issued to change the Adult Day provider to the “AAA” provider.
   b. When the individual only has Adult Day but is also approved for CDO services. The “AAA” PRO Cert is issued in this instance as the Adult Day provider must be changed to the “AAA” provider.

2. When changing Adult Day providers use the admit date on the PRO Cert as the discharge date and enter the provider number for the “AAA”.

3. Advise HCBS members to contact their HCBS provider or Adult Day Health Care agency with any questions regarding CDO services.

Note: HCBS and Adult Day can co-exist but a recipient cannot have two Adult Day providers.

E. CDO services for SCL:

SCL members can use CDO services for respite care, community living supports and adult day training.

1. CDO services can be chosen by new approvals and existing SCL members.

2. Only members who do not receive residential services through the SCL waiver can participate in CDO services.

3. A PRO Certification is issued for existing SCL waiver members when CDO services are chosen. Discharge the member from the traditional SCL provider using the admit date on the PRO Cert as the discharge date and enter the provider number for the AAA.

4. Advise SCL members to contact their case manager with any questions regarding CDO services.

Note: SCL can only have one provider even if approved for CDO services.

F. CDO services for ABI:

ABI members can use CDO services for respite care, companion care and personal care.

1. CDO services can be chosen by new approvals or existing ABI members.

2. Only members who do not receive residential services through the ABI waiver can participate in CDO services.

3. Existing ABI Members:

   For existing ABI members, discharge the member from the ABI case manager as well as the ABI provider by using the admit date on the "AAA" PRO Cert as the discharge date. To determine which provider is added as the "C" and which provider is added as the "P" refer to the PRO Certification. This is necessary ONLY if two PRO Certs are issued; if one is issued the worker only needs to change the C or the P.

4. New ABI Members:

   a. When two PRO Certifications are issued:

      When CDO services are chosen by ABI recipients, and the case manager and provider services comes from two different agencies, two PRO Certifications are issued, one for the case manager "C" and one for the provider "P". In that situation the ABI PRO Cert has a "C" or a "P" at the end of the provider number. To determine which provider is added as the "C" and which provider is added as the "P" refer to the PRO Certification.

   b. When one PRO Certification is issued:

      When CDO services are chosen by ABI recipients, in some instances, the case manager and provider services come from the same agency. In that situation the ABI PRO Cert has a "B" (instead of a "C" or a "P") at the end of the provider number. Enter the provider number on KAMES twice, once with a "C" and once with a "P".

5. Advise ABI members to contact their case manager with any questions regarding CDO services.

   Note: ABI must have two providers, one as a case manager and one as a provider.

G. Michelle P. and ABI LTC recipients are NOT eligible to receive CDO services.

H. HCBS and Adult Day can co-exist but a recipient cannot have two HCBS providers or two Adult Day providers. ABI must have two providers, one as the case manager and one as the provider. All other waivers can only have one provider, even if they receive CDO services. If they receive CDO services, discharge from traditional services and enter the "AAA" provider.

I. [An individual can receive State Supplementation for Caretaker Services and CDO for Adult Day Services, if it is verified that there is no duplication of services between the two providers. The worker is to request a list of services from both providers for verification.]

MS 2810 [SCL WAIVER PROGRAM]

[Supports for Community Living (SCL) provides home and community based services for mentally retarded MA recipients who would otherwise require institutional care in an ICF IID facility. Intermediate care services for the mentally retarded and developmentally disabled are provided by community mental health centers certified by the Department for Medicaid Services (DMS). SCL is available statewide. Individuals eligible for SCL are eligible to choose theses services to be delivered through the Consumer Directed Option (CDO) or in a combination of SCL and CDO. Refer to MS 2800.]

The following are covered services:

A. Adult Day Habilitation Component - Includes services provided in outpatient settings designed to provide an organized program of training in developmental skills, using age-appropriate methods.

B. Case Management/Recipient Evaluation - Includes case coordination, evaluation, preparation of plan of care, and follow-up assessment.

C. Habilitation Component - Includes behavior management; medical and psychological services; occupational, physical and speech therapy; etc.

D. In-Home Support Component - Includes in-home training, home-maker/home health aide services, and personal care services provided to SCL recipients residing at home.

E. Prevocational Services - Includes services aimed at preparing the SCL recipient for paid or unpaid employment and assists the recipient in acquiring and maintaining basic work and work-related skills.

F. Residential Component Services - Includes training, homemaker, personal care services provided to SCL recipients in alternative living units (ALUs) by ALU staff. The residential component does not include room and board.

G. Respite Component - Includes short term care and supervision of SCL recipient provided for the temporary relief of the family or residential staff, or for the safety and relief of the SCL recipient.

H. Supported Employment - Includes paid work in a variety of work settings in which individuals with mental retardation/developmental disabilities are employed. These services may include development of physical capacities, psychomotor skills, interpersonal and communicative skills, development of appropriate work behavior, work performance skills, and job seeking and job keeping skills.

MS 2815 MICHELLE P. WAIVER (1)

The Michelle P. Waiver offers many of the same services as the Home and Community Based (HCB) waiver and Supports for Community Living (SCL) waiver. In order to qualify for Michelle P. Waiver a person must meet Medicaid financial eligibility and the level of care for an Intermediate Care Facility (ICF) or Nursing Facility (NF) established by Medicaid. Refer the individual to the local Community Mental Health Center (CMHC) for an assessment to see if they meet the level of care. This level of care is applicable for the following program codes: A, B, D, F, G, H, AP, BP, DP, FP, GP, HP, C, W, KC, E, I, J, K, L, M, N, P, T and Y.

The Michelle P. Waiver requires a PRO certification before benefits can be issued. The correct verification entry on KAMES is “PR” for “Document Type”. If any other documentation type is entered, an error message “DOCUMENT TYPE DOES NOT MATCH PROVIDER TYPE” will display.

The provider type is “17” with institutional status of “MP”. When type “17” is entered, the first two digits of the provider number must begin with 33, 42 or 43.

The Michelle P. Waiver has the same personal needs allowance that is allowed for non-institutionalized individuals receiving waiver services.

Residents of Personal Care Homes (institution status P1 or P2) are not eligible for waiver services from the Michelle P. Waiver or any other waiver program. If an attempt is made to add the Michelle P. Waiver at application, recertification, program transfer or case change for state supplementation recipients in a personal care home setting, a prompt “PERSONAL CARE AND WAIVER CANNOT CO-EXIST” displays. If the worker proceeds on past the LTC screen, at disposition the waiver services are denied and the message “NOT WAIVER ELIG IF PC” displays.

Individuals receiving state supplementation who reside in a Family Care Home or receive Caretaker Services (program codes AP, BP, DP, FP, GP and HP) are eligible to receive services from the Michelle P. Waiver.

[When an otherwise Medicaid eligible individual begins receiving Michelle P. Waiver, the patient liability is $0 regardless of income, as Michelle P. Waiver is a type of waiver services.]

To issue Michelle P. Waiver benefits by special circumstance, use the institutional status of “MP” and the facility code of “17”. If the incorrect facility code is entered, an error message “MUST AGREE WITH INST STAT AND FAC CODE” will display. If institutional status code is “MP” and the facility code is “17” but the provider number does not begin with 33, 42 or 43, an error message of “INVALID PROVIDER FOR FACILITY CODE” will display.

MS 2820 TECHNICAL ELIGIBILITY REQUIREMENTS

A. The applicant must meet MA criteria for ICF IID level of care. The level of care is determined by the Peer Review Organization (PRO) using medical, psychological, and social data. [The Department for Mental Health/Mental Retardation (MH/MR) produces a letter of approval and form MAP-24C, Support for Community Living Admission/Discharge, and sends a copy of the letter of approval to the Support Coordination Agency, to the client and to the local office. This letter shows the level of care met. The Support Coordination Agency sends form MAP-24C to the local office showing the provider name, provider number and date of admission.]

B. The DMR-001 is a placement form used for provider changes and is not required for approvals.

C. The applicant must meet all technical eligibility requirements for MA eligibility including age, blindness, disability, enumeration, third party liability, etc. However, an individual not aged, blind or disabled may be eligible for SCL if MA eligible in another category and KMP criteria is met.

MS 2830 SCL ELIGIBILITY DETERMINATION PROCEDURES

A. MEDICAID ELIGIBILITY. Determine MA eligibility by comparing the individual's gross income to the special income standard and considering the number of days the individual has been receiving SCL.

1. Determine MA eligibility according to procedures outlined in MS 3500 - MS 3610.

2. Determine MA eligibility in Step II by comparing adjusted income to the SCL Standard. Adjusted income is determined by deducting the MA Scale for one, the SSI general exclusion and incurred medical expenses of the individual from gross income.

3. Do not redetermine MA eligibility if the individual is MA eligible in another category.

B. Determine the MA effective date using the first day of the month the individual met Kentucky Medicaid Program (KMP) criteria for SCL as indicated on the DMS letter of approval.

C. Determine patient liability for SCL recipients, in a manner similar to the determination for individuals in an ICF IID or NF. However, SCL allows the use of a personal needs allowance, computed as the SSI Standard plus the SSI general exclusion of $20, which replaces the personal needs allowance used for institutionalized individuals.

1. Use the personal needs allowance, SSI Standard plus SSI general exclusion.

2. Compute patient liability for a SCL recipient with a non-AIS/MR spouse the same as computations for an institutionalized spouse with a community spouse. See MS 3550.

3. If ineligibility exists the month of application, a redetermination of eligibility is determined for the month after the month of admission to SCL.

[D. As SCL is a waiver program, when an individual who is already Medicaid eligible begins receiving waiver services the patient liability is $0, regardless of income.]

MS 2840 SCL INDIVIDUAL (1)

Determine MA and patient liability for the single SCL individual as follows:

Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the SCL individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been in SCL for 30 full consecutive days, the individual is MA eligible. Complete Step III to determine patient liability.

3. If gross income is greater than the special income standard for an individual OR the individual has been in SCL less than 30 full consecutive days, complete Step II to determine MA eligibility.

Step II - Determining Medicaid Eligibility

1. Determine countable income of the SCL individual. Consider gross income and/or net profit, less the $20 general exclusion and work related expenses, if appropriate.

2. Deduct the MA Scale for 1.

3. Deduct any verified, incurred medical expenses of the SCL individual, such as the monthly SMI charge, prorated health insurance premiums and actual payment on a current or prior medical bill if not covered by MA.

4. Deduct the SCL standard.

5. If there is no excess, the individual is MA eligible. Complete Step III to determine patient liability.

   If an excess remains, do not complete Step III. The individual is ineligible for a vendor payment. Process as a spend down, using the regular MA Scale.

Step III - Determining Patient Liability

1. Determine gross income and/or net profit of the SCL individual.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the SCL individual.

4. If the individual has dependents, deduct an amount to bring total income of dependents up to the MA Scale for the appropriate family size.

5. Deduct verified, incurred medical expenses of the SCL individual, such as the monthly SMI charge, prorated health insurance premiums and actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

6. Add any third party payment paid directly to the SCL provider, if appropriate. Do not use these payments for conservation or other deductions.

7. The result is the individual's patient liability or payment toward cost of care.

   [NOTE: When an individual who is already Medicaid eligible begins receiving SCL waiver services, the patient liability is $0 regardless of income, as SCL is a type of waiver services.]

MS 2850 SCL CHILD

Determine MA and patient liability for the SCL child living with parents as follows.

For the month of admission, consider the income of the SCL child and parent, as appropriate.

After the month of SCL admission, recalculate considering only the income of the SCL child. See MS 2880.

Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the SCL child.

2. Add gross income of parent.

3. If gross income is equal to or less than the special income standard for an individual AND the child has been in SCL for 30 full consecutive days, the child is MA eligible. Complete Step III to determine patient liability.

4. If gross income is greater than the special income standard for an individual OR the child has been in SCL less than 30 full consecutive days, complete Step II to determine MA eligibility.

Step II - Determining Medicaid Eligibility

1. Determine countable parental income of the SCL child. Consider gross income and/or net profit, less $20 general exclusion and work related expenses, if appropriate.

2. [To allocate income for each ineligible sibling under 18 living in the home of the parent consider the remainder of the ineligible sibling allocation minus gross income of each ineligible sibling. See MS 1750 for sibling allocation maximums.

3. Deduct a parent allocation for unearned income only or a combination of unearned income and earned income for one parent or for two parents; or a parent allocation for earned income only for one parent or for two parents. See MS 1750 for parental allocation maximums.]

4. Consider total income of the SCL child.

5. Allow appropriate income deductions from income of the SCL child according to MS 3480.

6. Combine the deemed income of the parent and the countable income of the SCL child.

7. Deduct any verified incurred medical expenses of the SCL child, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill if not covered by MA.

8. Deduct verified, incurred medical expenses of the parent and any sibling.

9. Deduct the MA Scale for one.

10. Deduct the SCL Standard.

11. If there is no excess, the child is MA eligible. Complete Step III to determine patient liability.

If an excess remains for the month of admission or after the month of SCL admission, do not complete Step III. The child is ineligible for a vendor payment. Process as a spend down, up to three months prior to the month of application, if applicable, using the regular MA Scale.

Step III - Determining Patient Liability

1. Determine gross income and/or net profit of the SCL child.

2. Add excess income of parent. Gross income/net profit less MA Scale for the appropriate family size, excluding SCL child, if appropriate.

3. Deduct the personal needs allowance.

4. Deduct an increased personal needs allowance from income of the SCL child, if appropriate.

5. If the individual has dependents deduct an amount to bring total income of dependents up to the MA Scale for the appropriate family size.

6. Deduct verified incurred medical expenses of the SCL child, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

7. If income of the parent is considered, deduct verified, incurred medical expenses of the parent.

8. Add any third party payments paid directly to the SCL provider, if appropriate. Do not use these payments for conservation or other deductions.

9. The result is the child's patient liability or payment toward cost of care.

MS 2860 [SCL INDIVIDUAL WITH NON-SCL SPOUSE]

Determine MA and patient liability for SCL individual with a non-SCL spouse in the home as follows.

Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the SCL individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been in SCL for 30 full consecutive days, the individual is Medicaid eligibile. Complete Step III to determine patient liability.

3. If gross income is greater than the special income standard for an individual OR the individual has been in SCL less than 30 full consecutive days, complete step II to determine MA eligibility.

Step II - Determining MA Eligibility

1. Determine countable income of the SCL individual. Consider gross income and/or net profit, less $20 general exclusion and work related expenses, if appropriate.

2. Deduct the MA scale for 1.

3. Deduct any verified, incurred medical expenses of the SCL individual, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill if not subject to third party payment or covered by MA.

4. Deduct the SCL standard.

5. If there is no excess, the individual is MA eligible. Complete Step III, IV and V to determine patient liability.

If an excess remains, do not complete Step III, IV, and V. The individual is ineligible for a vendor payment. Process as a spend down, using the regular MA Scale.

Step III - Determining Community Spouse Income Allowance

[Determine community spouse income allowance, not to exceed the community spouse income allowance maximum according to MS 3550.] The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process.

Step IV - Determining Family Income Allowance

Determine family income allowance if there is a minor child or dependent child, dependent parent or dependent sibling of either the community spouse or SCL recipient who is residing with the community spouse. Subtract the dependent member's verified gross income from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income allowance. Compute the family income allowance for EACH dependent member.

Step V - Determining Post Eligibility for SCL recipients

1. Determine gross income and/or net profit of the SCL recipient.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the SCL recipient.

4. Deduct the community spouse income allowance up to the maximum.

5. Deduct family income allowance.

6. Deduct verified, incurred medical expenses of the SCL recipient such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

7. Add any third party payment paid directly to the SCL provider, if appropriate. Do not use these payments for conservation or other deductions.

8. The result is the individual's patient liability or payment toward cost of care.

MS 2870 [SCL COUPLE

Determine MA and patient liability for couple, both receiving SCL as follows.]

Step I - Determining MA Eligibility Using Special Income Standard

1. [Determine gross income for each member of the SCL couple.

2. If gross income of each member of the couple is equal to or less than the special income standard for an individual AND each member of the couple has been receiving SCL for 30 full consecutive days, each member of the couple is MA eligible.] Complete Step III to determine patient liability.

3. If gross income of either member of the couple is greater than the special income standard for an individual OR either member of the couple has received SCL less than 30 full consecutive days, complete Step II, item 1 or 2, as appropriate, to determine MA eligibility.

Step II - Determining MA Eligibility

1. [If one member of a couple has income which exceeds the special income standard or has been receiving SCL less than 30 full consecutive days and the spouse has income less than the special income standard, AND has been receiving SCL for 30 full consecutive days do the following:]

   a. Determine countable gross income and/or net profit of the member with excess income less $20 general exclusion and work related expenses, if appropriate.
   b. Deduct the MA scale for 1.
   c. Deduct any verified medical expenses of the member with excess income, such as monthly SMI charges, prorated health insurance premiums and/or actual payment on prior medical bills if not covered by MA.
   d. [Deduct the SCL Standard for the member with excess income.]
   e. If there is no excess, the member is MA eligible. Complete Step III to determine patient liability.

   If an excess remains, DO NOT complete Step III. The member is ineligible for a vendor payment. Process as a spend down, using the regular MA Scale.

2. [If both members of a couple are ineligible using the special income standard or both have been in SCL less than 30 full consecutive days:]

   a. Determine countable gross income and/or net profit of the couple less one $20 general exclusion and work related expenses, if appropriate.
   b. Deduct the MA scale for 2.

c. Deduct any verified medical expenses of the couple such as monthly SMI charge, prorated health insurance premium and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

d. [Deduct the couple's actual cost of care for SCL from the SCL Standard x 2.]

e. If there is no excess, the couple is MA eligible. Complete Step III to determine patient liability.
If excess remains, DO NOT complete Step III, the couple is ineligible for a vendor payment. Process as a spend down, using the regular MA Scale.

Step III - [Determining Patient Liability for SCL couple]

1. Determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case.

2. Deduct the personal needs allowance in each case.

3. Allow 1/2 of total deductions as an increased personal needs allowance in each case.

4. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA scale for the family size. Deduct 1/2 of the amount in each case.

5. Determine the couple's verified medical expenses and actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case.

6. [Add any third party payment paid directly to the SCL provider, if appropriate.] Do not use these payments for conservation or other deductions. Deduct 1/2 of the amount in each case.

7. The result is the individual's patient liability or payment toward cost of care.

MS 2880 [SCL INCOME AND RESOURCE CONSIDERATION

A. SCL INDIVIDUAL WITH NON-SCL. If an SCL individual has a non-SCL spouse, use the procedures outlined below.

1. Consider only the income of the SCL individual in determining MA eligibility and patient liability beginning the month of SCL admission.]
2. Consider the resources according to MS 2120.

B. [SCL COUPLE. If both members of couple receive SCL, use the following policy.]

1. [Consider income and resources of couple as available to each other during the month of SCL admission.
2. Beginning the month after the month of SCL admission, consider only income and resources of the spouse which are actually contributed to the other spouse.

C. DISABLED OR BLIND SCL CHILD UNDER 18 OR AGE 18 THROUGH 20 IF IN SCHOOL LIVING WITH PARENTS.

1. For the month of admission, consider the income and resources of the SCL child and parent according to Step I or II as appropriate.
2. Consider only the income and resources of the SCL child after the month of SCL admission.

D. [K-TAP/FAMILY RELATED MA PARENT OR CHILD RECEIVING SCL

1. Consider resources and income in the K-TAP/Family MA case for up to one year.]
2. Consider resources and income on basis of living apart when it becomes apparent SCL will be received for more than 1 year. Determine technical eligibility for aged, blind or disabled MA program. [Establish a separate J, K or M case for the SCL recipient.
3. When separate cases are established, remove the SCL recipient from the K-TAP or Family Related MA case.]

A. [A PRO-Certification notifies the local office of an individual's placement in SCL. The Confirmation Notice is provided to the local office for informational purposes only and identifies the level of care that the individual requires. The PRO-Certification notifies the local office of the date level of care is met for SCL.

B. Form DMR-001, A Confirmation Notice and the DMS Letter of Approval, is a placement form used for provider changes and is not required for approvals.

C. INTERRUPTION OF STAY IN SCL WHEN AN SCL RECIPIENT ENTERS A NURSING FACILITY FOR 60 DAYS OR LESS. The SCL provider annotates and forwards form MAP-24C to the local office to verify that patient status continues to be met without a new patient assessment if the recipient has been in a nursing facility for 60 days or less and is reinstated to the same SCL provider. Vendor payment is to be authorized upon receipt of this form.

Form MAP-24C includes an entry for the provider to indicate that the recipient was reinstated to the same SCL provider within 60 days of the nursing facility admission.

D. MA APPLICANT. If the individual does not currently receive MA, the provider notifies the family or responsible party to apply for MA for the individual. Determine eligibility for SCL. The special income standard does not apply if patient status is not met. If no application is made, retain a copy of MH/MR letter of approval and form MAP-24C in a central file in the local office.

E. SSI RECIPIENT. If the individual is an SSI recipient, establish a case record. Authorize vendor payment upon receipt of a PRO-Certification. Send form MA-105 notifying the recipient and SCL provider of vendor payment eligibility.

If SSI is discontinued, and the recipient subsequently applies for MA and continues to participate in SCL, use the PRO-Certification as verification that patient status is met and that the recipient continues to participate in SCL. If the application is approved, authorize vendor payment. Notify the recipient and SCL Provider of vendor payment eligibility.

F. PASS THROUGH RECIPIENT. When a PRO-Certification is received, authorize vendor payment. Do not determine MA eligibility since the recipient is MA eligible as Pass Through. Program code is unchanged. KAMES will send notices to the recipient and SCL provider of eligibility.

If the recipient is discharged from SCL, discontinue vendor payment. KAMES will send notices to the recipient and SCL provider of

ineligibility. Continue Pass Through eligibility. Program code and case status code are unchanged.

G. STATE SUPPLEMENTATION RECIPIENT (CARETAKER SERVICES ONLY). SCL recipients receiving State Supplementation for caretaker services may continue to receive these benefits if the caretaker services are not provided under SCL.

When a PRO-Certification is received, authorize vendor payment. Do not determine MA eligibility since the recipient is MA eligible as a State Supplementation recipient. Program code and case status code are unchanged. KAMES will send notices as required.

If the recipient is discharged from SCL, discontinue vendor payment. KAMES will send notices as required. State Supplementation eligibility is continued if caretaker services are received. Program code and case status code are unchanged.

H. STATE SUPPLEMENTATION RECIPIENT (PERSONAL CARE, FAMILY CARE, OR COMMUNITY INTEGRATION SUPPLEMENTATION (CIS)). Individuals receiving State Supplementation and residing in a Personal Care Home (PCH), Family Care Home (FCH), or CIS living arrangement may receive SCL if patient status for SCL is met.

When a PRO-Certification is received, authorize vendor payment. Do not determine MA eligibility since the recipient is MA eligible as a State Supplementation recipient. Program code and case status code are unchanged. KAMES will send notices as required.

If the recipient is discharged from SCL, discontinue vendor payment. KAMES will send notices as required. Program code and case status code are unchanged, and State Supplementation eligibility is continued if the recipient continues to reside in a PCH, FCH, or CIS living arrangement.**]**

MS 2900 [HCBS Waiver Program]

A. Home and Community Based Services (HCBS) allow MA individuals who would otherwise be institutionalized to receive necessary services at home to prevent institutionalization. HCBS individuals are considered institutionalized for financial eligibility even when they live in their own home. HCBS are provided by home health agencies certified by MA and are available statewide.

[Individuals eligible for HCBS are eligible to choose these services to be delivered through the Consumer Directed Option (CDO) or in a combination of HCBS and CDO. Refer to MS 2800.]

B. The following are HCBS covered services:

1. Adult Day Health Services - Provides health and social services in a licensed and certified Adult Day Health Care Center. Case management services are available to recipients enrolled in Adult Day programs. The Adult Day provider (type “43”) may be the recipient’s sole provider or may be either primary or secondary to the HCBS provider (type “42”).

2. Assessment - An RN or social worker evaluates an individual's mental needs and physical abilities. The PRO determines level of care. If the individual does not meet HCBS criteria, the assessment will not be paid by KMP.

3. Case Management - Arranges for needed services, monitors services provided, etc.

4. Homemaker Services - Performs general household activities, such as meal preparation and routine household chores for the individual.

5. Minor Home Adaptations - Includes adding rails, ramps, etc., to individual's home.

6. Personal Care - Performs medically oriented tasks such as assistance with bathing, dressing, ambulation, medications, etc.

7. Respiratory Therapy Services - Provides a qualified respiratory therapist for ventilator dependent recipients who are also receiving home health services.

8. Respite Care - Provides short term relief for caregiver.

MS 2910 TECHNICAL ELIGIBILITY REQUIREMENTS

A. The individual must meet MA criteria which includes determination of level of care for NF services. The level of care is determined by the PRO using medical, psychological and social data.

1. An automated certification is also sent to the local office if level of care is met and is filed in the case record. See MS 3650. DMS determines program eligibility according to HCBS criteria and, if the individual qualifies, forwards form MAP-4200, or Prior Authorization letter to the local office.

2. An automated certification notifies the local office of the date eligibility for HCBS is met and contains an itemized list of the approved monthly HCBS services which may be provided to the individual and the anticipated monthly cost of these services.

B. The individual must meet all technical eligibility requirements for MA eligibility including age, blindness, disability, enumeration, third party liability, etc. [However, an individual not aged, blind or disabled may be eligible for HCBS if MA eligible in another category and all eligibility criteria are met.]

MS 2920 MEDICAID ELIGIBILITY

Medicaid eligibility is determined by comparing the individual's gross income to the special income standard and considering the number of days the individual has been receiving HCBS.

A. Use procedures found in MS 3500 and 3510.

B. Do not redetermine MA eligibility if the individual is MA eligible in another category.

C. [Determine the MA effective date using the first day of the month the individual met Kentucky Medicaid criteria for HCBS as indicated on form MAP-4200 or Prior Authorization letter.] This can only be 3 months prior to the date of application.

MS 2930 [HCBS PATIENT LIABILITY] (1)

Patient liability for a single HCBS recipient or a couple when both receive HCBS is determined in a manner similar to the determination used for individuals in a NF or ICF IID. However, HCBS allows the use of a personal needs allowance which is computed as the SSI standard plus SSI general exclusion.

A. Use the personal needs allowance for the patient liability determination.

B. Patient liability for an HCBS recipient with a non HCBS spouse is computed like an institutionalized spouse with a community spouse. See MS 3550.

[C. When an individual who is already Medicaid eligible begins receiving HCBS waiver services, patient liability is $0 regardless of income, as HCBS is a type of waiver services.]

MS 2940 HCBS INDIVIDUAL (1)

Determine MA and patient liability for a single HCBS individual as follows:

A. Step 1 – Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the HCBS individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving HCBS for 30 full consecutive days, the individual is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual OR the individual has been receiving HCBS less than 30 full consecutive days, refer to MS 3505.

B. Step II - Determining Patient Liability

1. Determine gross income and/or net profit of the HCBS individual.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate.

4. If the individual has dependents, deduct an amount to bring total income of the dependents up to the MA Scale for the appropriate family size.

5. Deduct verified, incurred medical expenses of the HCBS individual such as the monthly SMI charge, prorated health insurance premiums and actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

6. [Add any third party payment, such as LTC insurance. Do not use these payments for other deductions, such as medical deductions.]

7. The result is the HCBS individual's patient liability or payment toward cost of care.

[C. When an individual who is already Medicaid eligible begins receiving HCBS, the patient liability is $0 regardless of income, as HCBS is a type of waiver services.]

MS 2950 HCBS CHILD LIVING WITH PARENT (1)

Determine MA eligibility for a HCBS child living with parent, who is under age 18 or age 18 through 20 and in school as follows:

For the month of admission, consider the income of the HCBS child and parent, as appropriate.

After the month of HCBS admission, recalculate considering only the income of the HCBS child. See MS 2940.

A. Step I - Determining MA Eligibility using the Special Income Standard

1. Determine gross income of the HCBS child.

2. Add gross income of parent.

3. If gross income is equal to or less than the special income standard for an individual AND the HCBS child has been receiving HCBS for 30 full consecutive days, the HCBS child is MA eligible. Complete Step II to determine patient liability.

4. If gross income is greater than the special income standard for an individual OR the HCBS child has been receiving HCBS less than 30 full consecutive days, refer to MS 3505.

B. Step II - Determining Patient Liability

1. Determine gross income and/or net profit of the HCBS child.

2. Add excess income of the parent. This is determined by considering gross income/net profit, less the MA Scale for the appropriate family size, excluding the HCBS child, if appropriate.

3. Deduct the personal needs allowance.

4. Deduct an increased personal needs allowance, if appropriate, from the income of the HCBS child.

5. Deduct verified, incurred medical expenses of the HCBS child, such as the monthly SMI charge, prorated health insurance premiums and actual payment on a current or prior medical bill not subject to third party payment or covered by MA. See MS 3480.

6. If income of the parent is considered, deduct verified, incurred medical expenses of the parent.

7. [Add any third party payment such as LTC insurance. Do not use these payments for other deductions, such as medical deductions.]

8. The result is the HCBS child's patient liability or payment toward cost of care.

[C. When a disabled child who is already Medicaid eligible begins receiving HCBS, the patient liability is $0 regardless of income, as HCBS is a type of waiver services.]

MS 2960 HCBS RECIPIENT WITH NON-HCBS SPOUSE (1)

A. Step I - Determining MA Eligibility using Special Income Standard

1. Determine gross income of the HCBS individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving HCBS for 30 full consecutive days, the individual is MA eligible. Complete Step III to determine patient liability.

3. If gross income is greater than the special income standard for an individual OR the individual has been receiving HCBS less than 30 full consecutive days, refer to MS 3505.

B. Step II - Determining Community Spouse Income Allowance

Determine a community spouse income allowance, not to exceed the community spouse income allowance according to MS 3550. The community spouse income allowance can only exceed the maximum allowable amount if there is a court order for a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process.

C. Step III - Determining Family Income Allowance

Determine a family income allowance if there is a minor child or dependent child, dependent parent or dependent siblings of either the community or HCBS spouse who is residing with the community spouse. Verify the dependent member's gross income and subtract it from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income. Compute the family income allowance for each dependent member.

D. Step IV - Determining Patient Liability for HCBS Individual

1. Determine gross income and/or net profit of the HCBS individual.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the HCBS individual.

4. Deduct the community spouse income allowance up to the maximum.

5. Deduct family income allowance.

6. Deduct verified, incurred medical expenses of the HCBS individual, such as monthly SMI charge, prorated health insurance premiums and actual payment on a current or prior medical bill not subject to third party payment or covered by MA. See MS 3480.

7. [Add any third party payment such as LTC insurance. Do not use these payments for other deductions, such as the community spouse income allowance or medical deductions.]

8. The result is the individual's patient liability or payment toward cost of care.

[E. When an individual who is already Medicaid eligible begins receiving HCBS, the patient liability is $0 regardless of income, as HCBS is a type of waiver services.]

MS 2970 HCBS RECIPIENT WITH HCBS SPOUSE (1)

A. Step I - Determining MA Eligibility Using the Special Income Standard

1. Determine gross income for each member of the HCBS couple.

2. If gross income of each member of the couple is equal to or less than the special income standard for an individual AND each member of the couple has received HCBS for 30 full consecutive days, each member is MA eligible. Complete Step II to determine patient liability.

3. If gross income of either member of the couple is greater than the special income standard for an individual OR either member of the couple has received HCBS less than 30 full consecutive days, refer to MS 3505.

B. Step II - Determining Patient Liability for HCBS Couple

1. For the month of admission only, determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case. After the month of admission, consider each member as an individual.

2. Deduct the personal needs allowance in each case.

3. Allow 1/2 of the total of deductions as an increased personal needs allowance in each case, if appropriate.

4. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA Scale for the family size. Deduct 1/2 of the amount in each case.

5. Determine the couple's incurred medical expenses such as the monthly SMI charge, prorated health insurance premiums and actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case. See MS 3480.

6. [Add any third party payment such as LTC insurance. Do not use these payments for other deductions, such as medical expenses. Consider 1/2 of the amount in each case.]

7. The result is the individual's patient liability or payment toward cost of care.

[C. When an individual who is already Medicaid eligible begins receiving HCBS, the patient liability is $0 regardless of income, as HCBS is a type of waiver services.]

MS 2980 INCOME AND RESOURCE CONSIDERERATION

A. HCBS Individual with Non-HCBS Spouse. If an HCBS individual has a non-HCBS spouse, use the procedures as outlined below.

1. Consider only the income of the HCBS individual in determining MA eligibility and patient liability during the month of HCBS election/admission.
2. Consider the resources according to MS 1770.

B. HCBS Couple. If both members of a couple are receiving HCBS, use the following policy.

1. Consider resources of couple as available to each other.
2. Consider HCBS couples as individuals beginning with the month after the month of admission to HCBS.

C. Disabled or Blind HCBS Child Under Age 18 or Age 18 Through 20 if in School Living with Parent.

1. For the month of separation and for retroactive eligibility, consider the income and resources of HCBS child and parent.
2. Consider only the income and resources of the HCBS child after the month of HCBS admission.

D. K-TAP, AFDC Related or Family Related MA Parent or Child Receiving HCBS.

1. Consider resources and income in the K-TAP/Family Related MA case for up to one year.
2. Consider resources and income on the basis of living apart when it becomes apparent HCBS will be received for more than 1 year. Determine technical eligibility for Aged, Blind or Disabled MA program. Establish a separate J, K or M case for the HCBS parent/child.
3. When separate cases are established, remove the HCBS parent/child from the K-TAP, AFDC Related or Family Related MA case.

A. An automated certification notifies the local office of the date level of care is met for HCBS. See MS 3650.

B. INTERRUPTION OF STAY IN HCBS WHEN AN HCBS RECIPIENT ENTERS A NURSING FACILITY FOR 60 DAYS OR LESS. The HCBS provider completes form MAP-24, Memorandum to DCBS, to verify that patient status continues to be met, without a new patient assessment, if the recipient has been in a nursing facility for 60 days or less and is reinstated to the same HCBS provider. Vendor payment should be authorized upon receipt of this form.

Form MAP-24 includes an entry for the provider to indicate the recipient was reinstated to the same HCBS provider within 60 days of the nursing facility admission.

C. MA APPLICANT. If the individual does not currently receive MA, the HCBS provider notifies the family or responsible party to apply for MA for the individual. The special income standard does not apply if level of care is not met or the automated certification is not received. See MS 3650.

D. SSI RECIPIENT. If the individual is an SSI recipient, set up a case record. Authorize vendor payment on KAMES upon receipt of the PRO certification. KAMES will notify the recipient and HCBS provider of eligibility.

If SSI is discontinued, and the recipient subsequently applies for MA and continues to participate in HCBS, use the PRO certification notice as verification that patient status is met and the recipient continues to participate. If the application is approved, authorize vendor payment. KAMES will send notices of eligibility to the recipient and HCBS provider.

E. PASS THROUGH RECIPIENT. When the PRO certification notice is received, complete a case change on KAMES to authorize vendor payment. Do not determine MA eligibility since the recipient is MA eligible as Pass Through. Program code and case status code are unchanged. KAMES will send notices of eligibility to the recipient and HCBS provider.

Discontinue vendor payment if a recipient is discharged from HCBS. The recipient and HCBS provider are notified of vendor payment ineligibility. Continue Pass Through eligibility.

NOTE: When an individual, such as a Pass Through recipient, begins receiving waiver services, the patient liability is $0 regardless of income.

[F. STATE SUPPLEMENTATION RECIPIENT (CARETAKER, FAMILY CARE, OR COMMUNITY INTEGRATION SUPPLEMENTATION (CIS)). Individuals receiving State Supplementation for Caretaker Services, Family Care, or CIS can receive HCBS if patient status is met and there is no duplication of service by the HCBS or State Supplementation providers. If questionable, contact both providers to obtain information.

When the automated notice is received, authorize vendor payment. Do not determine MA eligibility since the individual is MA eligible as an State Supplementation recipient. KAMES will notify the recipient and HCBS provider of vendor payment eligibility.

Discontinue vendor payment if the recipient is discharged from HCBS. KAMES will notify the recipient and HCBS provider of vendor payment ineligibility. State Supplementation eligibility is continued if the recipient continues to receive caretaker services or to reside in a family care home.**]**

MS 3000 ACQUIRED BRAIN INJURY WAIVER PROGRAM

The Acquired Brain Injury (ABI) Waiver Program allows MA eligible individuals suffering from an injury to the brain after birth, that is not hereditary, congenital or degenerative, to receive necessary services at home to prevent institutionalization.

[Individuals eligible for ABI are eligible to choose these services to be delivered through the Consumer Directed Option (CDO) or in a combination of ABI and CDO. Refer to MS 2800.]

[The individual must meet criteria for the ABI waiver as determined by the Department for Mental Health/Mental Retardation (MHMR) who forwards form MAP-24C to the local DCBS office. At least two providers are listed for each recipient: the primary provider and the case manager. The primary provider collects the patient liability. The case manager and any other providers listed on form MAP-24C are paid by the primary provider.]

MS 3005 [ACQUIRED BRAIN INJURY (ABI)
MEDICAID ELIGIBILITY DETERMINATION

The following information is used to determine eligibility, to outline Consumer Directed Option (CDO) procedures for ABI recipients, and to list ABI covered services.

I.] Medicaid eligibility criteria for ABI waiver services are as follows:

A. The individual must meet ABI level of care criteria;

B. Must currently be 21 to 65 years of age. There is no restriction with regard to the age of the individual at the time of injury;

C. [Must be income eligible for Medicaid or establish a Qualifying Income Trust (QIT) if not income eligible using the special income standard processing determination. See MS 3505.]

D. Resource limits must be within the aged, blind or disabled standards; and

E. Spousal impoverishment rules apply to ABI individuals.

[II. Consumer Directed Option (CDO) procedures and options for ABI recipients are as follows:

A. Effective January 30, 2007, DMS implemented CDO for ABI wavier members. ABI members can use CDO to provide respite, companion care and personal care. CDO can be chosen by new approvals and existing ABI members. Only members who do not receive residential services through the ABI waiver can participate in CDO.

B. If CDO or blended services are chosen, the CDO support broker will notify the local DCBS office on form MAP-24C. For existing ABI members, DCBS staff will discharge the member from the ABI case manager as well as the ABI provider using the CDO admit date as the discharge date on KAMES. Add the support broker as the case manager using the support broker's ABI provider number as shown on the MAP-24C and add the ABI/CDO using provider number "1717000878002" as the primary provider number.

C. Advise ABI members to contact their case manager with any questions regarding CDO.

III.] The following are ABI covered services if not provided during periods of hospitalization or residence in a nursing facility:

A. Case Management services;

B. Personal care, respite care and companion services;

C. Structured day program in a licensed adult day health center or outpatient rehabilitation facility;

D. Pre-vocational and supported employment services;

E. Behavior Programming;

F. Counseling and training;

G. Occupational therapy, speech, hearing, language services;

H. Specialized medical equipment and supplies;

I. Environmental modifications, limited to $1,000 per six month period; and

J. Community residential services as a last resort to remaining in the community.

MS 3010 ACQUIRED BRAIN INJURY (ABI)
PATIENT LIABILITY DETERMINATION (1)

For individuals admitted to an ABI facility, use the following procedures:

A. The form MAP-24C, ABI, Admission, Discharge, Program Transfer, notifies the local office of the primary provider. However, a PRO Certification notice is needed to approve services for an ABI waiver.

B. The individual is eligible for 3 months of retroactive coverage;

C. Individuals determined eligible for the ABI waiver program are excluded from managed care;

D. Make an eligibility determination based on criteria in MS 2940 to MS 2990;

[E. When an individual who is already Medicaid eligible begins receiving ABI waiver services, this individual will have a $0 patient liability regardless of income.]

F. Process ABI cases within 30 days of receipt of a complete application.

MS 3015 ABI INDIVIDUAL (1)

Determine MA and patient liability for the single ABI individual as follows:

A. Step I - Determining MA Eligibility Using the Special Income Standard

1. Determine gross income of the ABI individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving ABI for 30 full consecutive days, the individual is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Patient Liability

1. Determine gross income and/or net profit of the ABI individual.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the ABI individual.

4. If the individual has dependents, deduct an amount to bring total income of the dependents up to the MA Scale for the appropriate family size.

5. Deduct verified, incurred medical expenses of the ABI individual such as monthly SMI charge, prorated health insurance premiums or actual payments on a current or prior medical bill not subject to third party payment or covered by MA.

6. [Add any third party payment, such as LTC insurance. Do not use these payments for other deductions, such as medical expenses.]

7. The result is the ABI individual's patent liability or payment toward cost of care.

[C. When an individual who is already Medicaid eligible begins receiving ABI, the patient liability is $0 regardless of income, as ABI is a type of waiver services.]

MS 3017 ABI RECIPIENT WITH NON-ABI SPOUSE (1)

A. Step I - Determining MA Eligibility Using the Special Income Standard

1. Determine gross income of the ABI individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving ABI for 30 full consecutive days, the individual is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining a Community Spouse Income Allowance

Determine a community spouse income allowance, not to exceed the maximum community spouse income allowance. The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process. Refer to MS 3550.

C. Step III - Determining a Family Income Allowance

Determine a family income allowance if there is a minor child or dependent child, dependent parent or dependent siblings of either the community or ABI spouse who is residing with the community spouse. Verify the dependent member's gross income and subtract it from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income. Compute the family income allowance for each dependent member.

D. Step IV - Determining Patient Liability for the ABI Individual

1. Determine gross income and/or net profit of the ABI individual.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the ABI individual.

4. Deduct the community spouse income allowance up to the maximum.

5. Deduct family income allowance.

6. Deduct verified, incurred medical expenses of the ABI individual such as a monthly SMI charge, prorated health insurance premiums or actual payments on a current or prior medical bill not subject to third party payment or covered by MA. See MS 3480.

7. [Add any third party payment, such as LTC insurance. Do not use these payments for other deductions, such as community spouse income allowance or medical deductions.]

8. The result is the individual's patient liability or payment toward cost of care.

[E. When an individual who is already Medicaid eligible begins receiving ABI waiver services, the patient liability is $0 regardless of income.]

MS 3020 ABI RECIPIENT WITH ABI SPOUSE (1)

A. Step I - Determining MA Eligibility Using the Special Income Standard

1. Determine gross income for each member of the ABI couple.

2. If gross income of each member of the couple is equal to or less than the special income standard for an individual AND each member of the couple has received ABI for 30 full consecutive days, each member of the couple is MA eligible. Complete Step II to determine patient liability.

3. If gross income of either member of the couple is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Patient Liability for the ABI Couple

1. Determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case.

2. Deduct the personal needs allowance in each case.

3. Allow 1/2 of total of deductions as an increased personal needs allowance in each case, if appropriate.

4. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA Scale for the family size. Deduct 1/2 of the amount in each case.

5. Determine the couple's incurred medical expenses such as the monthly SMI charge, prorated health insurance premiums and actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case. See MS 3480.

6. [Add any third party payment, such as LTC insurance. Do not use these payments for other deductions, such as medical deductions. Deduct 1/2 of the amount in each case.]

7. The result is the individual’s patient liability or payment toward the cost of care.

[C. When an individual who is already Medicaid eligible begins receiving ABI waiver services, the patient liability is $0 regardless of income.]

MS 3025 ABI INCOME AND RESOURCE CONSIDERATION

A. ABI INDIVIDUAL WITH NON-ABI SPOUSE. If an ABI individual has a non-ABI spouse, use the procedures as outlined below.

1. Consider only the income of the ABI individual in determining MA eligibility and patient liability during the month of ABI admission.

2. Consider resources according to MS 1770.

B. ABI COUPLE. If both members of a couple are receiving ABI, use the following policy:

1. Consider resources of couple as available to each other. Consider income according to Step I during the month of ABI admission.

2. Consider ABI couples as individuals beginning with the month after the month of admission to ABI.

C. K-TAP, AFDC-RELATED OR FAMILY MA PARENT RECEIVING ABI. Use the following procedures.

1. Consider resources and income in the K-TAP, AFDC-Related or Family MA case for up to one year.

2. Consider resources and income on the basis of living apart when it becomes apparent ABI will be received for more than 1 year. Determine technical eligibility for aged, blind or disabled MA program. Establish a separate J, K or M case for the ABI parent.

3. When separate cases are established, remove the ABI parent from the K-TAP, AFDC-Related or Family MA case.

MS 3030 ABI LONG TERM CARE (LTC) WAIVER (1)

The Acquired Brain Injury waiver, also known as ABI LTC Waiver, is designed for individuals who meet ABI level of care criteria, but require ongoing supportive services beyond the intensive rehabilitation services provided by the traditional ABI waiver program. In the ABI LTC waiver program, individuals are not expected to recover. Eligibility is determined as follows:

A. In addition to LTC technical eligibility requirements in MS 2940 to MS 2990, the applicant must also:

1. Meet ABI level of care (see MS 3005);

2. Be age 18 or older;

3. Be within the aged, blind or disabled Medicaid resource limits. Spousal Impoverishment rules apply to ABI LTC Waiver individuals. See MS 3025;

4. Be within LTC/Waiver income guidelines for Medicaid or establish a Qualifying Income Trust (QIT) if not income eligible using the special income standard (see MS 3505):

a. The personal needs allowance (PNA) is the same as for non-institutionalized individuals receiving waiver services.
b. Recipients/applicants with earned income are allowed the $65 and ½ the remainder deduction.
c. Therapeutic wages are entered on the earned income screen on KAMES. The system will apply the $65 and ½ the remainder deduction. Answer “Y” to the question “DOES HE/SHE RECEIVE EARNINGS FROM THERAPEUTIC PLACEMENT?” on the second LTC screen.

B. Program requirements for ABI LTC Waiver are:

1. Recipients may have only one provider.

2. Recipients are identified by a “provider type 18” indicator on the PRO CERT.

3. Process the ABI LTC Waiver case within 30 days of receipt of a complete application.

4. The individual is eligible for three months of retroactive coverage. However, coverage cannot start prior to the onset date of the program, 10/1/08.

5. If the individual is already receiving Medicaid when they start receiving ABI LTC the patient liability will be $0 regardless of income. If the individual is not otherwise Medicaid eligible a patient liability may be incurred depending on the case income.

6. Consumer Direct Option (CDO) is an option available to ABI LTC Waiver recipients and can be used to provide respite companion care and personal care. CDO recipients, with an “18” type of care on KAMES and “B2” institution status will have a provider number with a prefix of 17.

[7. State Supplementation recipients in a Family Care Home (FCH), Community Integration Supplementation (CIS), or receiving Caretaker Services are eligible to receive ABI LTC Waiver. Workers add the LTC segment to the existing State Supplementation case.

8. Individuals receiving Personal Care Home (PCH) services with an institutional status code of “P1” or “P2” are not eligible to receive ABI LTC Waiver services. If a worker adds ABI LTC Waiver services (type 18) to a State Supplementation case for a recipient in a PCH (INST STAT CODE: “P1” or “P2”), the following error message will display: “PERSONAL CARE AND WAIVER CANNOT CO-EXIST”. At this point the worker must:**]**

   a. Use the “F3” key to back out of the case; or
   b. Continue past the 1st page of the LTC screen and deny the application at case disposition. The following denial reason will display: “NOT WAIVER ELIGIBLE IF PC.”

C. System Entry:

Entering ABI LTC Waiver cases on KAMES:

1. This level of care is applicable for any Medicaid recipient age 18 or older.
2. Enter a provider number that begins with 17, 33, 42 or 43.
3. Enter provider type “18” in response to the question “WHAT IS THE TYPE OF CARE PROVIDED?”. If Type 18 and the provider number does not begin with 17, 33, 42 or 43, the following message will display: “INVALID PROVIDER FOR FACILITY CODE”.
3. Enter “PR” as the documentation type. If anything other than “PR” is entered the following error message will display: “DOCUMENT TYPE DOES NOT MATCH PROVIDER TYPE”.
4. Enter the date for the level of care as 10/1/08 or after. If a level of care date prior to 10/1/08 is entered, the following error message will display: “PROVIDER NUMBER OR ADMISSION DATE INVALID”.

MS 3050 SCOPE OF PROGRAM

The Hospice program offers specific medical services to terminally ill individuals with a life expectancy of six months or less who are MA eligible. An individual may elect MA Hospice services instead of regular MA services. Noninstitutional Hospice services are provided in an individual's home and Institutional Hospice services are provided in a Nursing Facility (NF).

A. MEDICAID HOSPICE SERVICES. The Hospice program offers a greater variety of medical services to the terminally ill recipient. The following are an array of services offered only to individuals enrolled in a certified Hospice program.

1. Nursing care provided by or under the supervision of a registered nurse.
2. Medical social services provided by a social worker under the direction of a physician.
3. Counseling services, including dietary counseling, provided to the terminally ill individual and the family members or other persons caring for the individual at home.
4. Short term inpatient care, including both respite care and procedures necessary for pain control, acute and chronic symptom management provided in a MA participating hospital or NF.
5. [Long term inpatient care in a NF with the NF as the individual's place of residence.]
6. Continuous home care, full time nursing care, during a period of acute medical crisis, minimum of 8 hours per day.
7. Medical appliances and supplies, including drugs and biologicals.
8. Home health aide services and homemaker services.
9. Physical and occupational therapies and speech/language pathology services.

B. BENEFIT PERIOD. Hospice services consist of 4 benefit periods consisting of 90/90/30 days with unlimited 60 day benefit periods thereafter.

1. The individual may elect at any time to revoke Hospice services without showing cause or may change Hospice providers.
2. DMS tracks the benefit periods.
[3. Forms MAP-374, MAP-375, MAP-376 and MAP-378 are used by the designated Hospice to notify the Department for Community Based Services (DCBS) staff of Hospice elections, revocations, provider changes and terminations. The designated Hospice is responsible for providing these forms to the local DCBS office.

a. Elections: MAP-374, Election of Medicaid Hospice Benefits, notifies DCBS staff of an individual’s choice for Hospice benefit and it verifies medical eligibility requirements (terminally ill, life expectancy of 6 months or less) and identifies admissions into skilled nursing facilities, if appropriate. If an individual revokes

or terminates Hospice benefits, a second form MAP-374 is required to determine eligibility for a second Hospice program. Initiate the application process when form MAP-374 is received. File the form in the case record; or

b. Revocations: MAP-375, Revocation of Medicaid Hospice Benefits, notifies DCBS staff that an individual has chosen to revoke Hospice benefits. Hospice benefits may be revoked at any time and for any reason. Recipients who revoke Hospice may re-elect Hospice at any time in the future. Terminate Hospice benefits and re-determine Medicaid eligibility using regular MA policy when form MAP-375 is received. File the form in the case record; or

c. Hospice Vendor Changes: MAP-376, Change of Hospice Providers, notifies DCBS staff of a change in Hospice providers. Complete the Hospice provider change when form MAP-376 is received. File form MAP-376 in the case record; or

d. Terminations: MAP-378, Termination of Medicaid Hospice Benefits, notifies DCBS staff that Hospice benefits are terminated as a result of death or other reason as indicated on the form. A termination of Hospice benefits is NOT a revocation of benefits. Discontinue Hospice benefits and re-determine Medicaid eligibility using regular MA policy, if appropriate. File the form in the case record; and

e. Hospice Patient Change: MAP-403, Hospice Patient Status Change, notifies DCBS staff that an individual went from a NF to a home setting or other changes. The use of MAP-403 avoids the necessity of doing a new election form. Make the necessary changes and file in case record.]

MS 3060 HOSPICE RATES

The following are DMS Hospice rates by county. The Hospice rates are used to determine spend down eligibility for a non-institutionalized Hospice recipient.

The Hospice rates are established by county and not the service area of the Hospice provider.

The Hospice recipient's county of residence determine the Hospice rate.

A. [Boone, Campbell, Gallatin, Kenton and Pendleton counties' monthly Hospice rate is $3,672.51.]

B. [Boyd, Carter, Christian and Greenup counties' monthly Hospice rate is $3,721.35.]

C. [Bullitt, Jefferson and Oldham counties' monthly Hospice rate is $3,626.44.]

D. [Henderson County's monthly Hospice rate is $3,408.41.]

E. [Bourbon, Clark, Daviess, Fayette, Jessamine, Madison, Scott, and Woodford counties' monthly Hospice rate is $3,477.14.]

F. [Daviess County's monthly Hospice rate is $3,393.56.]

G. [For all other counties the monthly Hospice rate is $3,286.06.]

The Hospice rates change every January. These rates are effective January 1, 2005.]

MS 3070 HOSPICE TECHNICAL ELIGIBILITY REQUIREMENTS

A. The applicant must be enrolled with a DMS certified Hospice provider. Form MAP-374 verifies Hospice election, date of enrollment, and long term inpatient care in a nursing facility, if appropriate. [A person who is receiving Hospice Services in a Nursing Facility is not required to be in a Medicaid certified bed.] The Hospice provider forwards form MAP-374 to the local office.

B. The applicant must meet all technical eligibility requirements for MA eligibility including age, blindness, disability, enumeration, third party liability, etc. However, an individual not aged, blind or disabled may be eligible for Hospice services if MA eligible in another category.

C. If a recipient revokes or terminates Hospice benefits, a second form MAP-374 is forwarded by the Hospice provider to the local office verifying Hospice election for the remaining benefit periods.

MS 3100 NONINSTITUTIONAL HOSPICE MEDICAID ELIGIBILITY

Determine MA eligibility by comparing the applicant's gross income to the special income standard for an eligible individual, considering the number of days the applicant has been receiving Hospice.

A. Use the special income standard if:

1. The individual's gross income is equal to or less than the special income standard for an individual AND the individual has been receiving Hospice for 30 full consecutive days. [The 30 full consecutive days is effective the 32nd day and includes days the individual received LTC, HCBS or SCL.]

2. Gross income is equal to or less than the special income standard for an individual AND the Hospice election is less than 30 full consecutive days as a result of death. THIS IS THE ONLY EXCEPTION.

3. MA eligibility is determined by comparing gross income to the special income standard and considering the number of days the individual has been in Hospice. In some situations the individual's gross income may be equal to or less than the special income standard for an individual but more than the actual cost of Hospice. These individuals are ongoing MA eligible, but may be vendor payment ineligible.

B. DO NOT use the special income standard if the applicant's gross income is greater than the special income standard OR if the individual has not been receiving Hospice for 30 full consecutive days.

1. Determine MA eligibility by a quarterly spend down for these individuals.

2. Do not determine MA eligibility if the individual is MA eligible in another category.

MS 3110* NONINSTITUTIONAL HOSPICE MA EFFECTIVE DATE

Determine the MA effective date using the first day of the month the individual elected Hospice as indicated on Form MAP-374.

A. If the individual has been in LTC for 30 full consecutive days at the time of case processing, compare the income to the special income standard for current and retroactive eligibility beginning with the first day of the month in which patient status was met.

B. Use regular MA policy for retroactive months during which patient status was not met.

MS 3120 NON-INSTITUTIONAL HOSPICE PATIENT LIABILITY (1)

Patient liability is determined in a manner similar to the determination for individuals in an NF or ICF IID. The Hospice Program allows the use of a Hospice personal needs allowance of the SSI Standard plus the SSI general exclusion of $20, which replaces the LTC personal needs allowance.

A. Use the Hospice personal needs allowance if gross income is equal to or less than the special income standard for an individual AND the applicant has been receiving Hospice for 30 full consecutive days.

B. Use the Hospice personal needs allowance if gross income is equal to or less than the special income standard for an individual and the Hospice election is less than 30 full consecutive days as a result of death. THIS IS THE ONLY EXCEPTION.

[C. When an individual who is already Medicaid eligible begins receiving Non-Institutionalized Hospice, the patient liability is $0 regardless of income, as Non-Institutionalized Hospice is a type of waiver services.]

MS 3130 NON-INSTITUTIONALIZED HOSPICE INDIVIDUAL OR CHILD LIVING WITH PARENTS (1)

Determine MA and patient liability for a single Hospice individual or a Hospice child under age 18, or age 18 through 20 if in school and living with parents, as follows.

Consider the income of the Hospice child and parent the month of Hospice election. After the month of Hospice election, recalculate considering only the child's income. See MS 3160.

A. Step I - Determining MA Eligibility Using the Special Income Standard

1. Determine gross income of the Hospice applicant. For a Hospice child, combine parental income and the child's income, and compare to the special income standard for an individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving Hospice services for 30 full consecutive days, the applicant is MA eligible. Complete Step III to determine patient liability.

3. If gross income is greater than the special income standard for an individual OR the individual has been receiving Hospice services less than 30 full consecutive days, determine quarterly spend down eligibility, using the regular MA Scale. Do not complete Step II or Step III on form PA-1A.

B. Step III - Determining Patient Liability

1. Determine gross income and/or net profit of the Hospice individual.

2. Add excess income of the Hospice child's parent. Consider gross income/net profit less the MA Scale, for the appropriate family size, excluding the Hospice individual.

3. Deduct the personal needs allowance.

4. Deduct an increased personal needs allowance, if appropriate, from the income of the Hospice individual/child.

5. If dependents have income less than the MA Scale, deduct an amount to bring total income of dependents up to the appropriate MA Scale for the family size.

6. Deduct verified, incurred medical expenses of the Hospice individual not subject to third party payment. This may cause a monthly change in the individual's liability.

7. If income of the parent is considered, deduct verified, incurred medical expenses of the spouse/parent.

8. [Add any third party payment such as LTC insurance. Do not use these payments for other deductions, such as medical deductions.]

9. The result is the individual's patient liability or payment toward cost of care.

[C. When an individual who is already Medicaid eligible begins receiving Non-institutionalized Hospice, the patient liability is $0 regardless of income, as Non-Institutionalized Hospice is a type of waiver.]

MS 3140 NON-INSTITUTIONALIZED HOSPICE COUPLE (1)

Determine MA and patient liability for a couple, both receiving Hospice, as follows.

Consider the income of the couple the month of Hospice election. After the month of Hospice election, recalculate considering only the Hospice individual's income and the spouse's income actually contributed to the Hospice individual. See MS 3160.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income for each member of the Hospice couple.

2. If each member's gross income is equal to or less than the special income standard for an individual AND each member of the couple has received Hospice for 30 full consecutive days, both are MA eligible. Complete Step III to determine patient liability.

3. If gross income of either member of the couple is greater than the special income standard for an individual, OR either member of the couple has received Hospice less than 30 full consecutive days, DO NOT complete Step II or Step III on form PA-1A. If there is excess income, the case is processed as a spend down, using the regular MA scale.

B. Step III - Determining Patient Liability for Hospice Couple

1. Spouses using same Hospice provider.

a. Determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case.
b. Deduct the personal needs allowance in each case.
c. Allow 1/2 total of deduction as an increased personal needs allowance in each case.
d. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA Scale for the family size. Deduct 1/2 of the amount in each case.
e. Determine the couple's combined, verified, incurred medical expenses such as monthly SMI charge, prorated health insurance premiums and/or actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case. This may cause a monthly change in the individual's patient liability.
f. [Add any third party payment, such as LTC insurance. Do not use these payments for other deductions, such as medical expenses.] Deduct 1/2 of the amount in each case.
g. The result is the individual's patient liability or payment toward cost of care.

2. Spouses using different Hospice providers.

   a. Determine gross income and/or net profit of the individual. Do not consider income as a couple.
   b. Deduct the personal needs allowance in each case.
   c. Deduct an increased personal needs allowance for the individual, if appropriate.
   d. If dependents have income less than the MA Scale, determine the amount required to bring the dependent's total income up to the MA Scale for the family size. Deduct the amount in only one case. Apply the deduction to the case which will most advantage the couple, unless the couple chooses otherwise.
   e. Deduct verified, incurred medical expenses of the individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the individual's patient liability.
   f. [Add any third party payment, such as LTC insurance. Do not use these payments for other deductions, such as medical expenses.]
   g. The result is the individual's patient liability or payment toward cost of care.

[C. When an individual who is already Medicaid eligible begins receiving Non-Institutionalized Hospice, the patient liability is $0 regardless of income, as Non-Institutionalized Hospice is a type of waiver services.]

MS 3150 NON-INSTITUTIONALIZED HOSPICE APPLICANT WITH NON-HOSPICE SPOUSE (1)

[Determine MA and patient liability for a non-institutionalized Hospice applicant with a non-Hospice spouse in the home as follows:]

A. Step I - Determining MA Eligibility Using the Special Income Standard

1. Determine gross income of the individual.

2. If gross income is equal to or less than the special income standard for an individual AND Hospice has been received for 30 full consecutive days, the individual is MA eligible. Complete Steps II, III,
3. If gross income is greater than the special income standard for an individual OR the individual has been receiving non-institutionalized Hospice less than 30 full consecutive days, determine quarterly spend down eligibility, using the regular MA Scale. Do not complete Steps II, through V on form PA-1A, Supplement B.

B. Step II - Determining Community Spouse Income Allowance

Determine a community spouse income allowance, not to exceed the community spouse income allowance, according to MS 3550. The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes the need for a higher amount through the fair hearing process.

C. Step III - Determining Family Income Allowance

Determine a family income allowance if there is a minor child or dependent child, dependent parent or dependent siblings of either the community spouse or Hospice applicant who is residing with the community spouse. Verify the dependent member's gross income and subtract it from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income allowance. Compute the family income allowance for each dependent member.

D. Step IV - Determining Patient Liability for a Hospice Applicant

1. Determine gross income and/or net profit of the Hospice applicant.

2. Deduct Hospice personal needs allowance, which is the SSI Standard plus the SSI general exclusion.

3. Deduct an increased personal needs allowance, if appropriate, from the income of the Hospice applicant.

4. Deduct the community spouse income allowance up to the maximum.

5. Deduct the family income allowance.

6. Deduct verified, incurred medical expenses of the Hospice applicant, such as monthly SMI charge, prorated health insurance premiums and actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

7. [Add any third party payment, such as LTC insurance. Do not use these payments for other deductions, such as community spouse income allowance or medical deductions.]

8. The result is the applicant's patient liability or payment toward cost of care.

[E. When an individual who is already Medicaid eligible begins receiving Non-Institutionalized Hospice, the patient liability is $0 regardless of income, as Non-Institutionalized Hospice is a type of waiver services.]

MS 3160 NONINSTITUTIONAL HOSPICE INCOME AND RESOURCE CONSIDERATION

A. NONINSTITUTIONALIZED HOSPICE INDIVIDUAL WITH NON-HOSPICE SPOUSE

Consider only the income of the individual according to MS 3150. Resources of the couple are considered according to MS 2120.

B. NONINSTITUTIONALIZED HOSPICE COUPLE

1. Eligible Noninstitutionalized Hospice Couples Using the SAME Hospice Provider.

a. During the month of Hospice election:

(1) To determine MA eligibility, consider resources of the couple as available to each other. Consider income according to Step I. EXCEPTION: Do not consider income of an SSI spouse.
(2) Divide the couple's income and medical expenses equally, and consider equal amounts to each spouse to determine patient liability.
(3) If the couple has dependent(s), determine an amount to bring the dependent's income up to the appropriate MA Scale for the family size. Deduct 1/2 of the amount in each case.

b. Beginning the month after the month of Hospice election, consider only income and resources of the spouse which are actually contributed to the individual.

2. Eligible Noninstitutionalized Hospice Couples Using DIFFERENT Hospice Providers.

a. During the separation month:

(1) To determine MA eligibility, consider resources of the couple as available to each other. Consider income according to Step I. EXCEPTION: Do not consider income of an SSI spouse.
(2) Consider income and medical expenses of each individual to determine patient liability. (Do not consider income and medical expenses as a couple.)
(3) If the couple has a dependent(s), determine an amount to bring the dependent's income up to the appropriate MA Scale for the family size. Deduct the income in only one case. Apply the deduction to the case which will most advantage the couple, unless the couple chooses otherwise.

b. Beginning the month after the month of Hospice election, consider only income and resources of the spouse which are actually contributed to the individual.

C. BLIND OR DISABLED NONINSTITUTIONALIZED HOSPICE CHILD (UNDER AGE 18 OR AGE 18 THROUGH 20 IF IN SCHOOL) LIVING WITH PARENTS

1. Consider the income and resources of the Hospice child and parent(s) during the month of Hospice election.
2. Consider only the income and resources of the Hospice child after the month of Hospice election.

D. [K-TAP/FAMILY MA PARENT RECEIVING NONINSTITUTIONAL HOSPICE]

1. Consider resources and income in the K-TAP/Family MA case for up to one year.
2. Consider resources and income on basis of living apart when it becomes apparent Hospice services will be received more than 1 year. Determine technical eligibility for the Aged, Blind or Disabled MA program.

MS 3170 NON-INSTITUTIONAL HOSPICE CASE ACTION

A. FORM MAP-374. Form MAP-374 notifies local staff of the date Hospice is elected and verifies that medical eligibility requirements, terminally ill, life expectancy of six months or less, are met. The Hospice provider forwards form MAP-374 to the local office. When application is received, file form MAP-374 in the case record and take appropriate case action to authorize vendor payment.

B. MA APPLICANT. If the individual does not currently receive MA, the Hospice provider notifies the individual's family or responsible party to apply for MA. **[**The special income standard does not apply if form MAP-374 is not received.**]** File form MAP-374 in the case record.

C. SSI RECIPIENT. If the individual is a SSI or a SSI/other income recipient, establish a case record. **[**Authorize vendor payment upon receipt of form MAP-374 and establish a case on the PA-62 system.**]**. Consider the SSI or SSI/other income, if received. KAMES will send appropriate notices.

If SSI is discontinued and the individual subsequently applies for MA and continues to participate in the Hospice program, use form MAP-374 as verification that eligibility requirements are met. If the application is approved, authorize vendor payment. **[**KAMES will send appropriate notices.**]**

D. PASS THROUGH RECIPIENT. If the individual is a Pass Through recipient, authorize vendor payment upon receipt of form MAP-374. File form MAP-374 in case record. **[**KAMES will notify the recipient and Hospice provider of eligibility.**]**

If the recipient revokes or terminates Hospice benefits, discontinue vendor payment. **[**KAMES will notify the recipient and Hospice provider of ineligibility.**]** Continue Pass Through eligibility.

E. STATE SUPPLEMENTATION RECIPIENT. If the individual is a State Supplementation recipient, authorize vendor payment upon receipt of form MAP-374.

1. File form MAP-374 in case record.
2. Do not change program code and case status code.
3. **[**Send form MA-105 notifying the recipient and Hospice provider of eligibility for case on PA-62; for cases on KAMES the appropriate notices will be system generated.**]**
4. If the recipient revokes or terminates Hospice benefits, discontinue the vendor payment.
   a. **[**Send form MA-105 notifying the recipient and Hospice provider of ineligibility if on PA-62; for cases on KAMES the appropriate notices will be system generated.**]**
   b. Continue State Supplementation eligibility.

c. Do not change program code and case status code.

MS 3180

INSTITUTIONAL HOSPICE
MA ELIGIBILITY DETERMINATION

MA eligibility is determined by comparing the individual's gross income to the special income standard for an eligible individual and considering the number of days the applicant has been receiving Hospice.

A. Follow eligibility determination procedures found in MS 3500.

B. [The 30 full consecutive days is effective the 32nd day and may include days the individual received LTC, HCBS or SCL.]

MS 3190 [INSTITUTIONAL HOSPICE MA EFFECTIVE DATE]

Determine the MA effective date using the first day of the month the applicant elected Hospice as indicated on form MAP-374.

If case is processed prior to 30 full consecutive days of admission, use regular MA policy to determine if the individual is potentially eligible for retroactive MA for the three months prior to the month of application.

If the individual has been in LTC for 30 full consecutive days at the time of case processing, compare the income to the special income standard for current and retroactive eligibility beginning with the first day of the month in which patient status was met. Use regular MA policy for retroactive months during which patient status was not met.

MS 3200 [INSTITUTIONAL HOSPICE PATIENT LIABILITY]

Determine patient liability in the same manner as for individuals in an NF or ICF IID. The Hospice program allows the use of the personal needs allowance for individuals receiving Hospice services in an LTC facility.

Compute patient liability for an institutionalized Hospice recipient with a community spouse in a manner consistent with patient liability computation for an institutionalized spouse with a community spouse. See MS 3550.

MS 3210 INSTITUTIONALIZED HOSPICE INDIVIDUAL

A. Step I - Determining MA Eligibility Using Special Income Standard

1 Determine gross income of the Hospice individual.

2. [If gross income is equal to or less than the special income standard for an individual AND the individual has been in Hospice for 30 full consecutive days, the individual is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Patient Liability]

1. Determine gross income and/or net profit of the individual.

2. Deduct the personal needs allowance.

3. Deduct, if appropriate, increased personal needs allowance from income of the individual.

4. If dependents have income less than MA Scale, deduct an amount to bring total income of dependents up to the MA Scale for the appropriate family size.

5. Deduct verified, incurred medical expenses of the Hospice individual not subject to third party payment. This may cause a monthly change in the individual's patient liability.

6. Add any third party payment paid directly to the Hospice provider for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.

7. The result is the individual's patient liability or payment toward cost of care.

MS 3220 INSTITUTIONALIZED HOSPICE CHILD

Determine MA and patient liability for the institutionalized Hospice blind or disabled child under age 18 or age 18 through 20 if in school, applicant or recipient, living with parents as follows:

For the month of admission, consider the income of the Hospice child and parent, as appropriate.

After the month of Hospice admission, recalculate considering only the income of the Hospice child. See MS 3210.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the Hospice child.

2. [If gross income is equal to or less than the special income standard for an individual AND the Hospice child has been in Hospice for 30 full consecutive days, the Hospice child is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Patient Liability]

1. Determine gross income and/or net profit of the Hospice child.

2. Add excess income of parent. Consider Gross income/net profit less appropriate MA Scale.

3. Deduct the personal needs allowance.

4. Deduct, if appropriate, increased personal needs allowance from income of the Hospice child.

5. If dependents have income less than MA Scale, deduct an amount to bring total income of dependents up to the MA Scale for the appropriate family size.

6. Deduct verified, incurred medical expenses of the Hospice child not subject to third party payment. This may cause a monthly change in the Hospice child's liability.

7. If income of the parent is considered, deduct verified, incurred medical expenses of the parent.

8. Add any third party payment paid directly to the Hospice provider for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.

9. The result is the Hospice child's patient liability or payment toward cost of care.

MS 3230 INSTITUTIONALIZED HOSPICE INDIVIDUAL WITH NON-HOSPICE SPOUSE

A. Step I – Income Consideration

1. Determine gross income of the Hospice individual.

2. [If gross income is equal to or less than the special income standard for an individual AND the applicant has been receiving Hospice for 30 full consecutive days, the applicant is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual refer to MS 3505.

B. Step II - Determining Community Spouse Income Allowance

Determine a community spouse income allowance as per MS 3550.] The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process.

[C. Step III - Determining Family Income Allowance]

Determine a family income allowance if there is a minor child or dependent child, dependent parent or dependent sibling of either the community or Hospice spouse who is residing with the community spouse. Verify the dependent member's gross income and subtract it from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income allowance. Compute the family income allowance for each dependent member.

[D. Step IV - Determining Patient Liability for Hospice Spouse]

1. Determine gross income and/or net profit of the Hospice individual.

2. Deduct the personal needs allowance.

3. Deduct, if appropriate, an increased personal needs allowance from income of the Hospice individual.

4. Deduct community spouse income allowance up to maximum.

5. Deduct family income allowance.

6. Deduct verified incurred medical expenses of the Hospice individual, such as monthly SMI charge, prorated health insurance

premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

7. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.

8. The result is the individual's patient liability or payment toward cost of care.

MS 3240 INSTITUTIONALIZED HOSPICE COUPLE

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income for each member of the Hospice couple.

2. If each member's gross income is equal to or less than the special income standard for an individual AND each member of the couple has received Hospice for 30 full consecutive days, each member of the couple is MA eligible. [Complete Step II to determine patient liability.

3. If gross income of either member of the couple is greater than the special income standard for an individual refer to MS 3505.

B. Step II - Determining Patient Liability for Hospice Couple]

1. Spouses in same LTC facility.

a. Determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case.
b. Deduct the personal needs allowance in each case.
c. Allow 1/2 total of deduction as an increased personal needs allowance in each case.
d. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA Scale for the family size. Deduct 1/2 of the amount of each case.
e. Determine the couple's combined, verified medical expenses such as monthly SMI charge, prorated health insurance premiums and/or actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case. This may cause a monthly change in the individual's patient liability.
f. Add any third party payment paid directly to the Hospice provider, if appropriate. Do not use these payments for conservation or other deductions. Deduct 1/2 of the amount in each case.
g. The result is the individual's patient liability or payment toward cost of care.

2. Spouses in different LTC facilities.

a. Determine gross income and/or net profit of the individual. Do not consider income as a couple.
b. Deduct the personal needs allowance in each case.
c. Deduct an increased personal needs allowance for the individual, if appropriate.
d. If dependents have income less than the MA Scale, determine the amount required to bring the dependent's total income up to the MA Scale for the family size. Deduct the

amount in only one case. Apply the deduction to the case which will most advantage the couple, unless the couple chooses otherwise.

e. Deduct verified, incurred medical expenses of the LTC individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the individual's patient liability.

f. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions

g. The result is the individual's patient liability or payment toward cost of care.

MS 3250 [INSTITUTIONAL HOSPICE INCOME AND RESOURCE CONSIDERATION

A. INSTITUTIONALIZED HOSPICE INDIVIDUAL WITH NON-HOSPICE SPOUSE]

1. If an institutionalized Hospice individual has a non-Hospice spouse, consider only the income of the Hospice individual in determining MA eligibility and patient liability during the month of Hospice election/admission.

2. Consider the resources according to MS 2120.

B. [INSTITUTIONALIZED HOSPICE COUPLE]

1. [Eligible institutionalized Hospice couples in the SAME LTC facility.

a. During the separation month:
1) Consider resources of the couple as available to each other. Consider income according to Step I or Step II, as appropriate. EXCEPTION: Do not consider income of an SSI spouse.
2) To determine patient liability, divide the couple's income and medical expenses equally, and consider equal amounts to each spouse.
3) If the couple has dependents, determine an amount to bring the dependent's income up to the appropriate MA Scale for the family size. Deduct 1/2 of the amount in each case.

b. Beginning the month after the month of Hospice election, consider only income and resources of the ineligible spouse which are actually contributed to the recipient.]

2. Eligible institutionalized Hospice couples in DIFFERENT LTC facilities.

a. [During the separation month:
(1) Consider resources of the couple as available to each other.] Consider income according to Step I or Step II, as appropriate. EXCEPTION: Do not consider income of an SSI spouse.
[(2) To determine patient liability, consider income and medical expenses of each individual. Do not consider income and medical expenses as a couple.
(3)] If the couple has dependents, determine an amount to bring the dependent's income up to the appropriate MA Scale for the family size. [Deduct the amount in only one case.

b. Beginning the month after the month of separation, consider only income and resources of the ineligible spouse which are actually contributed to the eligible applicant.]

C. [BLIND OR DISABLED INSTITUTIONALIZED CHILD UNDER AGE 18 OR AGE 18 THROUGH 20 IF IN SCHOOL

1. Consider the income and resources of the Hospice child and parent according to Step I or Step II, as appropriate, during the month of Hospice election.

2. Consider only the income and resources of the Hospice child after the month of Hospice election.

D. K-TAP/FAMILY RELATED MA PARENT OR CHILD RECEIVING INSTITUTIONAL HOSPICE

1. Consider income and resources in the K-TAP/Family Related MA case for up to one year.

2. Consider income and resources on the basis of living apart when it becomes apparent Hospice will be received more than 1 year.] Determine technical eligibility for the Aged, Blind or Disabled MA program. Establish a separate J, K, or M case for the Hospice parent/child.

3. [When separate cases are established, remove the institutionalized Hospice parent/child from the K-TAP/Family Related MA case.]

MS 3260 INSTITUTIONAL HOSPICE CASE ACTION

A. FORM MAP-374. Form MAP-374 notifies local staff of the date Hospice is elected and verifies that medical eligibility requirements are met, that is terminally ill, life expectancy of six months or less. In addition, form MAP-374 identifies the LTC facility where the individual is residing and includes the level of care received at the LTC facility.

B. MA APPLICANT. If the individual does not currently receive MA, the Hospice provider notifies the individual's family or responsible party to apply for MA. Determine eligibility for Hospice. The special income standard does not apply if form MAP-374 is not received. [File form MAP-374 in the case record once vendor payment is authorized.]

C. SSI RECIPIENT. If the individual is a SSI or a SSI/other income recipient, consider the SSI or SSI/other income, if received. Authorize vendor payment when form MAP-374 is received. [If SSI is discontinued, then the PA-62 case is also automatically discontinued, including the vendor payment information section.] When the case is reapproved as a J, K or M, complete an application using the appropriate notification form as verification that medical eligibility requirements are met.

MS 3300 WHO IS ELIGIBLE FOR LTC VENDOR PAYMENT

[Individuals who meet all technical and financial eligibility requirements may receive vendor payment services in a Long Term Care (LTC) category.

A. Individuals that are aged, blind or disabled may receive in the following Adult Medicaid category:

1. SSI recipients may receive in the "A", "B or "D" category.

2. Non-SSI recipients may receive in the "J", "K" or "M" category.

B. Individuals with children in the household may receive in the following Family MA, AFDC Related MA or KTAP category (with the exception to TMA and K-CHIP III):

1. A specified relative or a second parent may receive in the "T", "E", "W","C" "N", "L", "P", "Y" or "I" category (with the exception to TMA and K-CHIP III).

2. Children may receive LTC vendor payment in the same categories mentioned above (B.1) as long as the parent continues to exercise control over the child or the child remains in foster care status.

3. Refer to Volume IV, MS 4170 for information regarding EPDST LTC vendor payment.

Note: If it is known to the agency that a Medicaid recipient will receive LTC longer than a year, it is more advantageous to the client to make the application in an Adult Medicaid category.

C. The following criteria must be met by any individuals applying for LTC vendor payment:

1. Patient status and level of care must be established by the Department for Medicaid Services (DMS), the Peer Review Organization (PRO) or Medicare;

2. The applicant has been in LTC for 30 full consecutive days. If the applicant dies prior to the 30th day, the 30 day requirement does not apply.

Note: If the individual leaves the LTC facility and is admitted into the hospital and then goes from the hospital to another facility, the individual is still considered to be meeting the 30 day requirement without it being considered a break in coverage.]

3. Income is below the special income standard or the individual has an approved QIT; and

4. The individual is in an institution such as a nursing facility (NF), an inpatient hospital NF bed, or Psychiatric Residential Treatment Facility (PRTF) if age 18 to 21, or to age 22 if in uninterrupted treatment beginning prior to age 21, or age 65 or over; or

5. The individual is in an institution classified as an Institution for Mental Diseases (IMD) and is age 18 to 21, or to age 22, if institutionalized on his/her 21st birthday, or age 65 or over. Facilities currently certified in Kentucky as IMDs for nursing facility level of care are Glasgow State Hospital and Western State Hospital. A Confirmation Notice is required for level of care determination for these IMDs. The remaining three facilities are personal care, and vendor payment for level of care does not apply. The three PC level IMDs are: Caney Creek PCH, Bluegrass PCH located at Eastern State Hospital, and the Center for Rehabilitation located at Central State Hospital.

D. Levels of care for LTC vendor payment are:

1. Nursing Facility;

2. HCBS;

3. Adult Day;

4. Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);

5. Mental Hospital Care (MH);

6. IMD;

7. ABI/ABI LTC;

8. Hospice NF/Hospice Non-Institutional

MS 3320* SPECIAL PROCEDURES FOR LTC APPLICANTS

A. Individual in LTC has income of less than $50.

1. Explain SSI and refer to SSA if potentially eligible.
2. Complete application.
3. Determine eligibility.

B. Individual receiving time-limited MA enters an LTC facility.

1. Before the end of the MA eligibility period, complete application for vendor payment.
2. Determine technical eligibility.
3. Determine patient liability.
4. Determine case status.

MS 3350 [SSI RECIPIENT INSTITUTIONALIZED] (1)

Caseload responsibility for an SSI recipient who enters long term care is determined according to MS 1378.

Refer to Volume I, MS 0060, for instructions on case transfers.

A. Immediately authorize vendor payment via KAMES, upon receipt of either a PRO certification or MAP-374, Election of Hospice Benefits, received for an SSI recipient. See MS 3650.

B. Cases requiring a vendor payment with a statutory benefit payee/committee/guardian are carried in the county where the statutory benefit payee/committee/guardian resides and are transferred only if that person moves or changes. Cases are carried in the county of the power of attorney ONLY if that person is also the designated statutory benefit payee for other forms of assistance such as SSI, RSDI, RR or VA.

   Additionally, the case may be carried in the county where the statutory benefit payee/committee/guardian works at his/her request, if different than the county residence.

   Cases requiring a vendor payment whose statutory benefit payee/committee/guardian/power of attorney live out-of-state are carried in the county where the applicant/recipient resides.

C. Send form PAFS-5.1, Report or Referral to the District Social Security Office, to report the SSI recipient's move into an LTC facility. For EPSDT long term care children, comment on form PAFS-5.1 that the child placed for medical treatment remains a Kentucky resident. Spot check at the end of 3 months from the date form PAFS-5.1 was sent to determine SSI status. If SSI income has not been reduced to $30, contact the provider to see if the client is still in the facility and request a MAP-24, Memorandum to DCBS, if discharged. If still there, contact the local SSA office to see why income has not yet been reduced.

D. SSA determines continuing SSI eligibility using a standard of $30.

   1. If income other than SSI is $50 or more, SSI will be discontinued. For SSI Alert:

      a. The client will receive form PA-10-SSI.2 notifying them that their SSI benefits have been terminated.
      b. Notification is given that for a determination of Medicaid eligibility to contact the Department for Community Based Services.

   2. If income other than SSI is less than $50, consider $30 of SSI income and the other income in the case. The case remains in the A, B or D program code. The client will have $40 PNA and any remaining income will be considered in the patient liability.

   3. If income is SSI only, consider to $30 SSI income in the A, B or D program case. The client will a patient liability of zero.

MS 3380 PATIENT STATUS NOT MET

If a non-SSI LTC recipient does not meet patient status, but applies or remains eligible MA in the aged, blind, or disabled MA category, the following applies:

A. Program code is J, K, or M.
B. Determine MA eligibility using noninstitutionalized aged, blind, or disabled MA policy.
C. Since patient status is not met, cost of care cannot be paid by MA; therefore, do not authorize vendor payment. If spend down determination is made, consider verified facility costs as a recognized medical expense.
D. [Authorize vendor payment when an automated certification is received or the member information appears on the "PRO Certifications Not Matched to KAMES" Report. See MS 3650.]

MS 3390 QMB RECIPIENT IN LTC

A. [For the QMB recipient admitted to LTC:

1. Send an appointment letter to the representative/payee to complete a new application.
2. Enter a program transfer to J, K or M when the appointment is kept.]
3. Obtain all verification and information forms which are required for MA and LTC eligibility.
4. [When all verification and information have been received and the applicant has been determined to be eligible for LTC vendor payments for J, K or M cases, approve as an LTC case with dual eligibility status.
5.] If the program transfer denies, the case should continue as a "Z" only.

[B.] Process these cases without loss of QMB benefits by the individual.

MS 3410 **[**SSI/STATE SUPPLEMENTATION RECIPIENT INSTITUTIONALIZED**]** (1)

Supplemental Security Income (SSI) benefits and State Supplementation are continued for certain individuals, who are admitted to a public institution.

A. Uninterrupted SSI/State Supplementation benefits for up to 3 full months are provided to recipients who are temporarily institutionalized for medical care in an LTC facility and who otherwise would receive a reduced benefit or none at all.

1. This allows the recipient to pay some or all of the necessary expenses to maintain their home or living arrangement where they may return upon discharge from the facility. Do not count the continued SSI/State Supplementation benefits when determining patient liability.

2. In order to qualify for continuation of payments, the following conditions must be met:

a. The individual must be eligible for SSI or for both SSI and State Supplementation in the month prior to the first month they would be ineligible, or eligible for a reduced amount due to residence in a LTC facility.
b. The individual must continuously reside throughout the affected month in a LTC facility where Medicaid pays more than 50 percent of the cost of care.
c. A physician must verify that the individual is expected to be medically confined for 90 consecutive days or less. The physician statement is provided to the SSA.

B. SSA makes the determination of eligibility for continued payments and sends notification to the SSI recipient.

1. A copy of the notification letter is also sent by SSA to the local office located in the same county as the SSI recipient's mailing address.

2. If the worker responsible for the case is located in another county, the notification letter is forwarded within 2 working days to the appropriate local office.

C. For an SSI recipient temporarily institutionalized for medical care in an LTC facility, take the following action:

1. If the member information appears on the “PRO Certification Not Matched to KAMES” Report and the SSA notification letter is received by the local office:

a. Set up a case record file using the A, B or D category case number;
b. Exclude all SSI income;
c. Enter LTC coverage on KAMES; and

d. Annotate form PAFS-116, Case History Folder. Refer to MS 3650.

2. If the member information appears on the "PRO Certification Not Matched to KAMES" Report and is received prior to the SSA notification letter:

   a. Count the $30 continuing SSI eligibility amount if the recipient has no other income;
   b. If the recipient has other income, treat the case as an SSI Alert; and
   c. When the SSA notification letter is received, immediately remove the SSI income. Refer to MS 3650.

3. If the SSA notification letter is received prior to the "PRO Certification Not Matched to KAMES" Report do not take any action until this information is received. When received, follow procedures in item C, 1. Refer to MS 3650.

D. For an SSI and State Supplementation recipient temporarily institutionalized for medical care in an LTC facility, take the following action:

1. If the member information appears on the "PRO Certification Not Matched to KAMES" Report and the SSA notification letter is received by the local office, enter LTC coverage on KAMES excluding all SSI and State Supplementation income. File a copy of the information in the SSI or State Supplementation case record. Annotate form PAFS-116, Case History Folder. Refer to MS 3650.

2. If the member information appears on the "PRO Certification Not Matched to KAMES" Report prior to receiving the SSA notification letter, take action to discontinue the State Supplementation counting the $30 continuing SSI eligibility amount if the recipient has no other income. If the recipient has other income, treat the case as an SSI Alert. When the SSA notification letter is received, immediately reinstate the State Supplementation case with retroactive payment, if appropriate, and complete a case change on KAMES removing the SSI and other income. Refer to MS 3650.

3. If the SSA notification letter is received prior to receipt of the "PRO Certification Not Matched to KAMES" Report, do not take any action until the PRO certification is received. Upon receipt, follow procedures in item D, 1. Refer to MS 3650.

E. Set up a spot check for these cases for 1, 2, and 3 months from the date of admission. If the individual remains in LTC longer than 3 months, follow established policy for SSI/State Supplementation individuals admitted to an LTC facility.

MS 3420* MEDICARE RECIPIENT IN LTC

For the individual admitted to LTC with Medicare responsible for payment:

A. Medicare covers 100% of the LTC cost for the first 20 days, and 80% of the LTC cost for the following 80 days.

B. For the latter 80 days, a 20% copayment must be made.

C. If the individual is QMB eligible, QMB must cover this Medicare copayment and the individual will have a $0 patient liability.

MS 3430* MEDICARE AND MEDICAID RECIPIENT IN LTC

For the individual admitted to LTC as Medicare pay and who apply for or are already receiving Medicaid and QMB:

A. Establish the patient liability using regular Medicaid policy.

B. To insure the QMB recipient is aware of the patient liability when Medicare is the primary payor, include a statement on form MA-105 advising the QMB recipient that patient liability will be $0 for any LTC period of Medicare coverage.

C. Since the patient liability will be $0 for some months, the recipient's resources may accumulate in excess of the resource limit. For those cases where there is a potential for accumulation of excess resources, complete a spot check for excess liquid assets during the LTC Medicare payment period. Annotation of form MA-105 and the spot check for potential excess resources are the only actions required.

MS 3450* COST OF CARE

Determine the amount of income an individual pays toward the cost of LTC.

A. The effective date income is available from an individual initially admitted to LTC, Medicare or Medicaid eligible, is determined by the system. Consider an individual readmitted after being out of a facility for more than 30 days an initial admission.

B. The individual admitted to LTC as private pay has income considered available for MA eligibility when the source for private pay is insufficient or exhausted. Private pay sources include Worker's Compensation, VA, private insurance or the individual's own resources.

MS 3460 COUNTABLE INCOME FOR PATIENT LIABILITY DETERMINATION (1)

Consider the following types of income when computing the amount of income available to pay the cost of care. Do not consider as income any payment made by a relative or other authorized representative, to obtain a private room, telephone, television services, etc.

A. Earnings from therapeutic placement. The facility must supply a written statement showing employment is for therapeutic and rehabilitative purposes.

B. The amount of a VA pension over $90. Exclude the first $90 of Veterans Administration (VA) pensions. For VA pensions less than $90, exclude the entire amount.

1. For veterans who are approved for a VA pension and who receive a lump sum retroactive payment, the $90 exclusion and the $40 personal needs allowance (PNA) must be applied retroactively in the patient liability determination. Consider any remainder of the payment as a lump sum in the month of receipt, if possible.

   EXAMPLE: A veteran is approved for a $300 VA pension effective January and receives and reports a $1,800 ($300 x 6) lump sum payment in June. Since the first $90 is excluded and the individual is entitled to the $40 PNA, a total of $780 ($90 + $40 = $130 x 6) would be deducted from the lump sum. The remainder, $1,800 - $780 = $1,020 is considered lump sum income. Since the lump sum was reported in the month of receipt (June), it is not administratively feasible to count the lump sum as income since MA benefits have already been issued for June. Therefore, any remainder of the $1,020 is considered a resource beginning the month following the month of receipt.

2. Do not complete a correction transaction for patient liability for the retroactive months. However, complete the computation to determine the lump sum payment amount. Complete a change transaction if it is possible to consider the lump sum income.

[C. Due to a change in the Federal law, effective August 1, 2002, VA Aid and Attendance (A&A) and VA Unreimbursed Medical Expenses (UME) are countable for VA beneficiaries in state-operated veteran's nursing facilities that accept Medicaid.**]**

D. VA Dependency and Indemnity Compensation is countable income in Medicaid eligibility determinations.

E. Consider the RSDI entitlement amount. Allow SMI charges, if appropriate as a medical deduction. If accessing IMS Program HR 39, NEW BENDEX, for the RSDI benefit amount, use the amount shown as "NET" in the calculation process.

F. Accumulated back payments of statutory benefits are considered according to MS 2465.

G. For the SSI only recipient, count $30 of the SSI payment.

H. If an SSI recipient has other income of less than $50, count $30 of the full SSI payment.

I. For SSI children in EPSDT LTC who continue to receive full SSI benefits 3 months after form PAFS-5.1 was sent to SSA, allow the personal needs allowance and count the remaining SSI.

J. State Supplementation payments continuing beyond the month of LTC admission:

1. If the admission is not temporary, request the check(s) be returned to the Division of Family Support, Medical Support and Benefits Branch, 275 E. Main St., 3E-I, Frankfort, KY 40621.

2. If not returned, show the total State Supplementation payment as income the month following the month of admission.

K. Income received from property. This includes rental property, leases, and royalties.

1. Unless a legal document specifically states otherwise, or the institutionalized spouse establishes that ownership interest of income produced from property is other than stated below, consider the income from such property in both the MA eligibility and post-eligibility determination as follows:

a. Consider income paid solely to the institutionalized spouse or the community spouse available to that person.
b. Divide income paid in the names of the institutionalized spouse and the community spouse between them.
c. Consider income paid in the names of the institutionalized spouse, community spouse, and at least one other person, available to each individual on an equal share basis, unless one or more of the persons can verify a different share of ownership exists.
d. Divide income paid to a couple from property when there is no legal document establishing ownership between them.

2. Allow the institutionalized spouse to rebut the ownership of income produced from property. The institutionalized spouse must provide:

a. A written statement from the applicant regarding ownership of income;
b. A written statement from each of the other persons receiving income from the property which corroborates the applicant's statement, unless the individual is a minor or is incompetent; and

c. Verification the applicant's name has been removed from the property.

Do not consider the income available the month the applicant's name is removed from the property.

3. A fair hearing may be requested when the institutionalized spouse disagrees with the Agency's decision on the ownership of this income.

L. Consider income available from trust property to each member of a couple in accordance with the specific terms of the trust. When the trust document is not specific as to the couple's ownership interest in income, use the same procedures used to establish ownership interest in property.

M. Long Term Care (LTC) insurance policies provide payment for services while an individual is residing in a nursing facility. If the payment is paid directly to the individual, it is considered a reimbursement for medical services. NOTE: The money is countable only in the determination of patient liability. See Volume IVA MS 2310.

N. Nazi Persecution Victims Eligibility Benefits Act (P. L. 103 286) provide for payments to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required. Consider payments as income in the patient liability determination ONLY.

MS 3470 EXCLUDED INCOME FOR LTC/WAIVER (1)

Do not use the following types of income when calculating cost of care.

A. Do not consider as income, any payment made by a relative or other interested party to obtain a private room, telephone, television service, etc.

B. VA beneficiaries in LTC are usually eligible for an Aid and Attendance Allowance (VA A&A) and/or Unreimbursed Medical Expenses (VA UME). [Exclude the VA A&A and/or VA UME in the MA and patient liability determination.]

1. Refer individuals to the Regional VA Office to apply for VA Aid and Attendance Allowance and/or VA Unreimbursement Medical Expenses.

a. Application for VA A&A is NOT a condition of MA eligibility.
b. Require the individual to apply for VA UME.

2. Spot check to verify receipt of the increase, if application is made.

[C. Exclude the first $90 of Veterans Administration (VA) pensions. For VA pensions less than $90, exclude the entire amount.]

D. Exclude the uninterrupted SSI and State Supplementation payments for up to 3 full months for recipients who are temporarily institutionalized for medical care in an LTC facility, and who otherwise would receive a reduced benefit or none at all.

E. Exclude the entire SSI payment for the SSI recipient with other income of $50 or more.

[A. LTC recipients retain a personal needs allowance (PNA) for personal and incidental needs, unless their income is lower than the personal needs allowance. Residents of nursing facilities retain $40.00 monthly PNA and recipients of waiver services retain $753.00 monthly PNA.]

B. Allow a separate amount as an increased PNA, if appropriate, for the following specific expenses.

1. Verified mandatory withholdings from earned and unearned income of the LTC recipient such as legal, mandatory payroll deductions that are a condition of employment and/or required federal, state and local taxes deducted before payment is made to the payee.

   a. Do not include withholdings that result from recipient decisions and/or actions, such as voluntary income tax withholding and court-ordered deductions for child support or other garnishments resulting from recipient-induced indebtedness or financial obligations.
   b. Verify withholdings that are mandatory.

2. The Blind Work Expenses (BWE) is a work related expense or allowance.

   a. It is applied to aged cases if the aged individual received MA coverage prior to his/her 65th birthday.
   b. Allow the BWE for any work expense incurred. The BWE includes, but is not limited to, transportation to and from work, dog guide, lunches, federal, state and local income taxes, F.I.C.A., union dues, prosthetics, special equipment, job related training, etc.

3. Apply the Impairment Related Work Expense (IRWE) to aged cases if the aged individual received MA coverage prior to his/her 65th birthday.

   a. The IRWE includes any amount expended for specific items or services which enable an aged or disabled individual to work as long as the specific items or service are not included in a PASS (refer to MS 2490).

   b. Allow deductions, if not included in a PASS, in the month incurred, or divide over a 12-month period, beginning with the month of the first payment, whichever is more beneficial to the individual.

      (1) Payment for attendant care services such as assistance in traveling to and from work, and assistance with personal functions, (eating, personal hygiene, dressing, etc.) at home in preparing for work.

(2) Payment for medical devices such as durable medical equipment such as wheelchairs, canes, crutches, inhalators, pacemakers, etc.
(3) Payment for prosthetic devices such as artificial arms, legs and other parts of the body.
(4) Payment for work related equipment for specialized use such as a one-handed typewriter, telecommunication devices for the deaf, etc.
(5) Payment for residential modifications that aid an individual to work, such as the installment of a ramp or enlargement of a doorway for a wheelchair.
(6) Payment for nonmedical appliances and equipment essential for the control of a disabling condition that is medically verified as necessary, such as an electric air cleaner for an individual with a respiratory disease, etc.
(7) Payment for drugs and medical services to control an individual's impairment such as anticonvulsant drugs or anticonvulsant blood test monitoring for epilepsy, medications for mental disorders, immunosuppressive medications, etc.
(8) Payment for medical supplies and services which enable a person to work, such as incontinence pads, catheters, irrigating kits, physical therapy, speech therapy, etc.
(9) Payment for transportation costs associated with vehicle structural or operational modifications and payment for use of driver assistance.
(10) Payment for installing, maintaining and repairing impairment related items.

C. Compute a family income allowance for each dependent family member with income less than the family income allowance, who is claimed by either spouse for tax purposes.

1. This can include minor children, dependent children, dependent parent or dependent siblings who are residing with the community spouse.

2. Require verification if a dependent is age 18 or over.

3. Subtract the family member's gross income from the family income allowance standard. Divide the remainder by three, round to the nearest dollar and allow that amount as a deduction from patient liability. The deduction can be allowed without proof that the money is made available to the family member.

D. For an institutionalized individual who has a community spouse, consider the amount needed to bring the community spouse's gross monthly income up to the community spouse income allowance as calculated per MS 3550.

1. Allow the community spouse income allowance only if the money is actually given to the community spouse.

2. This amount can be increased only:

   a. If a court has entered an order against an institutionalized spouse for monthly support for the community spouse in an amount which exceeds the difference between the community spouse's available income and the community spouse income allowance. Allow the greater amount as a deduction to the institutionalized spouse's income; or
   b. An Administrative Hearing officer establishes through the fair hearing process that the community spouse needs income above the level established as the community spouse income allowance. Either spouse may request a hearing to present evidence that additional income is needed due to significant financial duress. These hearings must be held within 30 days of the request. If the hearing officer determines that exceptional circumstances which cause financial duress exist, the hearing officer grants the increase in the community spouse allowance for a stated period of time. The case is spot checked to remove the increase at the end of the time granted. If the client is dissatisfied at this action, a new hearing may be requested. At recertification, if it is determined that the exceptional circumstances causing financial duress no longer exists, a memorandum outlining the change in circumstances, along with a copy of the hearing decision should be sent to the Commissioner's Office, Department for Community Based Services, 3rd Floor, 3W-A, CHR Bldg., 275 East Main Street, Frankfort, KY 40621, for administrative review. Retain a copy of the memorandum in the case record. Take no action until notification is received from Central Office.

3. Do not apply the community spouse income allowance, if an institutionalized spouse is not likely to be institutionalized for at least 30 consecutive days.

E. All members receiving long term care (LTC) waiver services in the following types of care will be allowed a $65 and ½ the remainder disregard from earned income in determining patient liability:

1. Home and Community Based Services (HCBS);

2. Hospice Non-Institutionalized;

3. Supports for Community Living (SCL);

4. Model Waiver II;

5. Adult Day Care;

6. Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);

7. Acquired Brain Injury (ABI)/ABI LTC; or

8. Michelle P.

Compute $65 plus ½ the remainder of earnings.

F. All SSI recipients are covered by the State SMI Buy-In. Do not show SMI as a deduction for any recipient with program code of A, B or D.

G. Allow the cost of SMI if the J, K or M recipient verifies he/she is responsible for the premium.

H. Allow the cost of Medicare Part D if the recipient verifies he/she is responsible for the premium. If the recipient receives Low Income Subsidy (LIS) but has chosen a plan with a premium that exceeds the subsidy amount, a deduction can be given for the difference if the recipient verifies he/she is responsible to pay the difference.

I. Allow premiums for medical insurance actually incurred and paid by the LTC recipient.

1. Prorate premiums if paid prospectively. Allow as a deduction for months the premium covers. For example, if health insurance of $90 is paid in May to cover June, July and August, allow $30 as an expense in each covered month or allow the entire premium in the month incurred (May).

2. View all medical insurance policies and record identifying information.

3. Complete form PA-40 or the KAMES Health Insurance screen as appropriate.

J. Deduct verified, incurred medical expenses the facility is not required to provide; for example, eyeglasses, hearing aids, dentures, chiropractic services. In no case will a deduction be allowed for a period prior to the month in which the change was reported to the worker.

1. Deduct the cost of a medically necessary attendant if payment for such an attendant is not available from another MA provider at no cost to the individual. Example: A 22-year-old HCBS individual lives in the home with his parents. Both parents work outside the home and must hire a person to take care of the individual, who is a quadriplegic. The parents request cost of attendant care be allowed as a deduction in the HCBS case. The parents provide a doctor's statement that it is medically necessary for the individual to have care at all times. Attendant care cannot be provided by a family member.

2. Allow as deductions against current patient liability computations any unpaid, incurred medical expenses from a period of time prior to MA eligibility for which the individual is currently responsible.

a. If the individual requests the deduction for the purpose of paying the incurred medical expense, it is not necessary to verify that

the individual is actually using the amount deducted to pay the incurred medical expense.

b. The total allowable deduction cannot exceed the amount of the outstanding medical expense. Example: If an outstanding medical expense is $4,000.00 when the deduction is first allowed, the total amount of the allowable deduction cannot exceed $4,000.00.

c. Allow the deduction to the advantage of the individual. The total amount may be averaged over a time frame selected by the individual.

d. Post a spot check to ensure the deduction is removed once the total amount of the allowable deduction is used.

3. When allowing a deduction for incurred medical expenses owed to a LTC provider for months prior to MA eligibility, the individual's portion of the monthly cost of care is subtracted from the medical expense, as the individual would have been responsible for his/her patient liability in those months had the individual been MA eligible.

   Example: An individual is ineligible for vendor payment for the month prior to application due to excess resources. The recipient requests a medical deduction for nursing facility costs of $5,000.00 for that month. Client has income of $800.00 per month. He has no monthly deductions other than his personal needs allowance of $40.00. Had he been eligible, his monthly patient liability would have been $760.00. Subtract $760.00 from the $5,000.00 cost of care expense for a patient liability deduction of $4, 240.00.

4. Do not allow as a medical expense deduction an unpaid cost of NF care incurred during vendor payment ineligibility period due to a transfer of resource penalty.

K. Do not deduct items and/or services the facility is required to provide, such as, wheel chairs, crutches, walkers, incontinent supplies, durable medical equipment, furniture, personal care items, etc.

L. Allow a deduction for co-pays when computing patient liability. The recipient can choose to use an average of the prior 3 months co-pays or provide the actual co-pays for each month.

M. Allow a deduction for prescription drug expenses IF the applicant/recipient verifies that the Department for Medicaid Services has denied coverage and that a prior authorization for coverage has also been denied. Obtain a copy of the applicant/recipient's denial letter for documentation.

N. Enter medical expenses for KAMES cases as follows:

1. If a medical expense is one-time only, such as a hospital bill, enter "Y" to "One-time only?"

2. When processing a joint application, expenses to be counted in both cases are entered twice on the Medical Expenses screen.

a. Answer “IM” for the first entry.
b. Answer “FS” for the second entry.

3. Enter a current month’s date in “Date Paid/Incurred” on the Medical Expenses screen for ongoing medical expenses. For member add in an IM case, enter past dates as appropriate, for retroactive MA.

O. Monthly representative payee service fees charged by facilities to their recipients are not allowable medical deductions.

MS 3500 SPECIAL INCOME STANDARD

Compare gross income to a special income standard for an individual to determine MA eligibility for LTC applicant. Consider the applicant's income and the number of days the applicant has been in LTC when determining MA eligibility.

A. Use the special income standard if the applicant's gross income is equal to or less than the special income standard AND the applicant has been in LTC for 30 full consecutive days or died prior to the 30th day.

1. [The 30 full consecutive days is effective the 30th day of admission and may be spent in different facilities or at different levels of care, including days the applicant received Hospice, HCBS or SCL.

NOTE: Although the effective day of admission is the 30th day, KAMES will not process the application until the 32nd day. If an applicant is discharged on the 30th or 31st day, allow the case to approve and then complete the discharge as a case change transaction.]

2. Determine MA eligibility by comparing gross income to the special income standard and considering the number of days the applicant has been in LTC.
   a. In some situations the gross income may be equal to or less than the special income standard for an individual but more than the monthly private pay rate or actual cost of care.
   b. These individuals are ongoing MA eligible, but may be vendor payment ineligible.

B. DO NOT use the special income standard if the applicant has not been in LTC for 30 full consecutive days. For these individuals, determine MA eligibility by spend down procedures.

C. For applicants in LTC greater than 30 full consecutive days with income over the special income standard refer to MS 3505.

MS 3505 QUALIFYING INCOME TRUST (QIT) (1)

[The Kentucky Medicaid Program allows for the establishing of a Qualifying Income Trust (QIT), also known as a Miller Trust, for those individuals whose income is over the special income standard. Income placed in a QIT is excluded from determination of Medicaid (MA) eligibility but is considered in the calculation of the patient liability.**]**

Note: A QIT is not required in order to complete a Resource Assessment.

A. The Department for Medicaid Services (DMS) requires that a QIT meets the following criteria:

1. The QIT must be irrevocable.

2. Income must be put into the QIT to bring the individual below the special income standard.

3. No resources may be put into the QIT. For example: Any money in a savings account cannot be put into the QIT.

4. A separate account must be established. The individual cannot use an existing bank account for the QIT or co-mingle QIT funds with funds from another account.

5. Upon the death of the individual, DMS receives all monies remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the individual by MA. Any funds remaining after MA is reimbursed will be the property of the individual's estate.

6. The trustee must consult with MA on payments from the trust before they are made in order to assure that those payments are allowable under federal and state laws.

B. Rules for funds entering and leaving the trust are as follows:

1. All of the individual's countable income over the special income standard must go into the trust.

2. Monies placed in the trust can be disbursed for:

   a. The personal needs allowance (PNA);
   b. Community spouse/family support;
   c. The cost of other health insurance; or
   d. Patient liability paid to the nursing facility/waiver provider.

3. DMS must approve all other expenditures (e.g. eyeglasses, dentures, hearing aids, attendant care and other expenses not covered by MA or other health insurance of the individual).

4. Send a written request for the expenditure to the Medical Support and Benefits Branch (MSBB) through your Program Specialist. The request must include:

   a. A physician's statement as to why the expenditure is needed;
   b. A copy or estimate of the bill;
   c. The date the expense was incurred; and
   d. Verification of the balance owed.

5. Payments from the trust must be made at regular intervals (monthly or by the end of the month following the month funds were placed in the trust.)

C. At application, if the individual is over the special income standard:

1. Explain that the individual may set up a QIT.

2. Provide a fact sheet MAP-007, Qualifying Income Trust.

3. If the individual indicates intent to establish a QIT, request that a copy of the QIT be returned in 10 days.

4. A question, "Has a DMS approved Qualifying Income Trust?" is on KAMES on the LTC/Waiver screen. Answer "Y" to this question if the individual intends to create a QIT. Leave "VER" source blank.

[5. Once a QIT is returned, all documentation must be reviewed and form MA-8, QIT Checklist, must be completed.

6. If the QIT is approved, enter "OR" as verification source.

7. If the QIT is denied, change the answer to "Has a DMS approved Qualifying Income Trust?" to "N". The case will deny for being over the income limit.**]**

If an individual with a QIT is discharged from LTC/Waiver services or is no longer eligible to receive MA, the QIT will remain in place until the death of the individual, but the individual will no longer be required to place income in the QIT. DMS is not reimbursed from the QIT until the individual dies.

MS 3510 LTC MA EFFECTIVE DATE

[Determine the LTC MA effective date using the first day of the month the applicant met patient status not to exceed 3 months prior to the application. The patient status date is found on the Automated PRO certification or form MAP-24, as appropriate.]

A. If a case is processed prior to 30 full consecutive days of admission, use regular MA policy to determine if the applicant is potentially eligible for the retroactive period.

B. If the applicant has been in LTC for 30 full consecutive days at the time of case processing, compare the income to the special income standard for current and retroactive eligibility beginning with the first day of the month in which patient status was met not to exceed 3 months prior to application. Use regular MA policy for retroactive months during which patient status was not met.

MS 3520 INTERRUPTION OF STAY

A. Redetermine MA eligibility if there is an interruption in the individual's stay in the LTC facility.

B. [Redetermine MA eligibility if the recipient is discharged and admitted to ANOTHER LTC facility, Hospice, HCBS or SCL with no interruption in stay and Step II was used to determine the recipient's prior MA eligibility.] A change in the deduction of the private pay rate or cost of care may affect MA eligibility.

MS 3530 LTC INDIVIDUAL

Do the following to determine MA eligibility and patient liability for the single applicant.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the individual.

2. If gross income is equal to or less than the special income standard AND the applicant has been in LTC for 30 full consecutive days, the applicant is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard refer to MS 3505.

B. Step II - Determining Patient Liability for the LTC single individual.

1. Determine gross income and/or net profit of the individual.

2. Deduct the personal needs allowance.

3. Deduct increased personal needs allowance, if appropriate, from income of the applicant.

4. If dependents have income less than MA Scale, deduct an amount to bring total income of dependents up to the MA Scale for the family size.

5. Deduct verified, incurred medical expenses of the LTC individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the applicant's liability.

6. The result is the individual's patient liability or payment toward cost of care.

MS 3540 LONG TERM CARE (LTC) COUPLE

[To be considered an eligible couple, both spouses must be aged, blind or disabled, income and resource eligible as a couple, living in the same facility and room, and both must apply for Medicaid. The applications do not have to be made at the same time.]

Re-determine MA eligibility and patient liability for both members if the spouse of an institutionalized individual enters the same or a separate LTC facility any time during the month of separation. Coordinate the re-determination with the caseworker responsible for the case of the first spouse who entered LTC, if different.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income for each member of the couple.

2. If gross income of each member of the couple is equal to or less than the special income standard AND each member of the couple has been in LTC for 30 full consecutive days, each member is MA eligible. Complete Step II to determine patient liability.

3. If gross income of either member of the couple is greater than the special income standard refer to MS 3505.

B. Step II - Determining Patient Liability for LTC individual.

1. Spouses in the Same LTC Facility

[To determine MA and patient liability for LTC individuals when both spouses are in the same LTC facility and in the same room, complete the following if it is more advantageous to the couple:]

a. Determine the couple's combined income and divide by 2. Consider one half of the couple's income in each spouse's case.
b. Deduct the personal needs allowance in each case.
c. If dependents have income less than the MA scale, determine the amount required to bring the dependents' total income up to the MA Scale for the family size. Deduct one half of the amount in each case.
d. Determine the couple's combined medical expenses and deduct one half of the verified, incurred medical expenses in each case which are not subject to third party payment. Deduct actual payments on a current or prior medical bill not covered by MA. This may cause a monthly change in the recipient's patient liability.
e. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Deduct one half of the amount in

each case. Do not use these payments for conservation or other deductions.

f. The result is the individual's patient liability or payment toward cost of care.

[Note: If it is more advantageous to the couple to treat them as separate even if they are in the same facility and same room, complete the steps below in B.2.]

2. Spouse in a Different LTC Facility

[Treat the LTC couple as a couple during the month of separation even though they are not residing in the same household. Beginning the month after the month of separation, treat the couple as individuals and complete the following:]

a. Determine gross income and/or net profit of the applicant. Do not consider income as a couple.
b. Deduct the personal needs allowance in each case.
c. Deduct increased personal needs allowance for each individual if appropriate, from the income of the individual.
d. If dependents have income less than the MA Scale, determine the amount required to bring the dependents' total income up to the MA Scale for the family size. Deduct the amount in only one case. Apply the deduction to the case which will most advantageous to the couple, unless the couple chooses otherwise.
e. Deduct verified, incurred medical expenses of the LTC individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the recipient liability.
f. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.
g. The result is the applicant's patient liability or payment toward cost of care.

[Note: The couple is considered living apart during the month of separation when one spouse is institutionalized in LTC and the other spouse is in a Personal Care Home (PCH) or Family Care Home (FCH).]

MS 3550 LTC INDIVIDUAL WITH COMMUNITY SPOUSE (1)

Complete the following steps to determine Medicaid (MA) eligibility and patient liability for an institutionalized individual with a community spouse.

A. Step I - Determining MA Eligibility Using the Special Income Standard:

1. Determine gross income of the individual.

2. If gross income is equal to or less than the special income standard ($2,199 effective 1/1/15) AND the applicant has been in long term care (LTC) for 30 full consecutive days, the applicant is MA eligible.

3. If gross income is greater than the special income standard, refer to MS 3505.

B. Step II - Determining the Community Spouse Income Allowance:

Income of an institutionalized spouse who has a spouse living at home in the community is treated differently to prevent financial hardship which may result when one spouse is institutionalized. Federal regulations require computation of a community spouse income allowance taking into consideration the community spouse's income and shelter expenses.

1. The following allowances and standards are used to calculate the community spouse income allowance:

   [a. $2,003-Minimum Community Spouse Income Allowance, effective 7/1/16.]
   b. $2,981-Maximum Community Spouse Income Allowance, effective 7/1/15.
   [c. $601–Minimum Community Spouse Shelter Allowance, effective 7/1/16.

2. Worker Portal calculates the community spouse income allowance for an institutionalized spouse case. The Shelter Expense and Utility Expense Screens are used to collect and verify the monthly shelter expenses of the community spouse. Shelter expenses include:]

   - Rent or mortgage;
   - Property taxes;
   - Home insurance costs;
   - Utility expenses; and
   - Telephone standard of $36, if applicable.

   For a deduction to be allowed for shelter expenses the expense must be verified. The telephone standard is given for verified phone expense.

PART I

Community Spouse Excess Shelter Expense Computation:

a. Add verified shelter expenses and the telephone standard together to arrive at the total monthly shelter expenses for the community spouse.
[b. Subtract the community spouse minimum shelter allowance of $601.]
c. The remainder is the community spouse excess shelter expense.

Verification of shelter expenses is NOT mandatory and is NOT a reason for case denial or discontinuance. The case may be worked without the shelter expenses if all other technical and financial eligibility have been met.

PART II

a. Add the minimum community spouse income allowance to the excess shelter expense from PART I.
b. The result is the community spouse income allowance. This amount cannot exceed the community spouse maximum income allowance ($2,981, effective 7/1/15).
c. If the result is greater than the maximum, the community spouse allowance is the maximum ($2,981, effective 7/1/15).
d. Subtract the community spouse's gross income from the income allowance to determine the amount which may be deemed to the community spouse.

3. The community spouse income allowance may exceed the calculated amount or the maximum ONLY by a court order or fair hearing decision per MS 3480.

[4. Policy and procedures for allowing a community spouse an income allowance as a deduction from the patient liability determination is outlined in MS 3480. The deduction is allowed only if the income is actually made available to the community spouse each month. The LTC Income Statement Screen is completed to confirm that the institutionalized spouse understands this stipulation.]

C. Step III - Determining Family Income Allowance:

Determine a family income allowance if there is a minor child, dependent child, dependent parent or dependent siblings of either the community or institutionalized spouse, who is residing with the community spouse.

1. Verify the dependent member's gross income;

[2. Subtract that income from the family income allowance standard ($2,003, effective 7/1/16);]

3. Allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income allowance; and

4. Compute the family income allowance for each dependent member.

D. Step IV - Determining Patient Liability for LTC Spouse:

1. Determine gross income and/or net profit of the institutionalized spouse.

2. Deduct the personal needs allowance (PNA) ($40).

3. Deduct the increased PNA, if appropriate, from the income of the institutionalized spouse, refer to MS 1750.

4. Deduct the community spouse income allowance computed in Step II up to the maximum.

5. Deduct the family income allowance computed in Step III.

6. Deduct verified, incurred medical expenses of the institutionalized individual NOT subject to third party payment, including Medicare and/or other health insurance premiums, deductibles, and coinsurance. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in patient liability.

7. Add any third party payment, such as LTC insurance. Do not use these payments for other deductions such as the community spouse income allowance or medical expenses.

8. The result is the individual's patient liability or payment toward cost of care to the facility.

MS 3560 LTC BLIND OR DISABLED CHILD

Blind or disabled child (under age 18 or age 18 through 20 if in school whether applicant or recipient).

Determine MA and patient liability for a child admitted to LTC and living with parents as follows:

A. For the month of admission and for any retroactive eligibility, consider the income of the child and the parent.

B. Allow appropriate income deductions from the income of the parent according to MS 2480.

C. Allocate income up to the ineligible sibling allocation for each ineligible sibling under age 18 living in the home of the LTC child. This is the ineligible sibling allocation minus gross income of each ineligible sibling.

1. If more than one blind or disabled child applies for LTC, allocate parental income to the ineligible sibling living in the home when computing deemed income to the LTC child.

2. Deduct a parent allocation for unearned income only or a combination of unearned income and earned income for one parent or for two parents.

3. Deduct a parent allocation for earned income only for one parent or for two parents.

4. If there are two parents in the home, use the parent allocation for two, whether one or both of the parents have the earned or unearned income.

5. See MS 1750 for parental and sibling allocation maximums.

D. Consider total income of the LTC child.

E. Allow appropriate income deductions from the income of the LTC child according to MS 2480.

F. Combine the countable income of the parent and income of the LTC child.

G. Allow verified, incurred medical expenses of the parent, sibling and the child in LTC.

H. Allow the MA Scale for one in the eligibility determination.

I. After the month of separation consider only the child's income, including any continuing contribution, and compare to the MA Scale for 1.

J. Refer the parent to SSA if the child is potentially eligible for SSI. If Family Related MA eligibility exists, see policy in Volume IV, MS 1220.

MS 3580 SPEND DOWN FOR LTC

[Ineligibility for vendor payment exists if there is income in excess of the special income standard and the individual does not have an approved QIT or is institutionalized less than 30 consecutive days.]

A. [Process as a spend down case, using the regular MA scale, refer to MS 2650.]

B. The time limited MAID card cannot be used for LTC vendor payments.

MS 3590* CHANGE IN STATUS

Changes requiring recomputation of continuing eligibility are as follows:

A. Recipient's income increases or decreases;

B. Recipient's level of care or facility changes;

C. Recipient's medical expenses or health insurance premiums increase or decrease;

D. Recipient's spouse's income is considered or is no longer considered in LTC case;

E. Recipient is discharged from LTC facility; or

F. Recipient dies.

MS 3610 EFFECTIVE DATE OF VENDOR PAYMENT

Determine the effective date for vendor payment changes as follows:

A. When increasing patient liability for any vendor payment apply 10-day adverse action policy. [Patient liability is never increased retroactively.] PA-62 documents submitted and accepted:

1. Before cutoff are effective the current month.

2. After cutoff are effective the first day of the following month.

B. When decreasing patient liability for LTC individuals, waiver programs or Hospice, the effective date of vendor payment is the first day of the month the change is entered on KAMES or the PA-62 document is accepted. [Patient liability may be decreased retroactively if patient liability was incorrectly inflated due to agency error for the period in question.]

MS 3650 PEER REVIEW ORGANIZATIONS (1)

The designated peer review organization (PRO) is responsible for conducting patient status determinations for individuals in a NF, HCBS, SCL, Model Waiver II, ICF IID, Mental/Psychiatric facilities, PRTF, Adult Day Care, IMD, Acquired Brain Injury, Michelle P. Waiver, and ABI LTC:

A. Who enter long term care (LTC) and are not covered by Medicare; or

B. Have been Medicare covered and either:

1. Reach the 100th day of stay; or

2. Exhaust Medicare benefits.

C. The review process involves rendering level of care determinations by matching the individual's care needs with the level of care which meets those needs.

D. The PRO for LTC facilities is National Health Services, 9200 Shelbyville Road, Suite 215, Louisville, Kentucky 40222. The peer review organization is responsible for notifying the agency with:

1. Electronic LTC certifications with the admission date, level of care and the date level of care was met. The automated process includes an SSN matching function that searches KAMES for an active or pending member. If a match is found, the system posts a spot check to the worker's DCSR with the message, "Pending PRO Certifications". The spot check appears on both the worker's and supervisor's DCSR if the worker is on probationary status. The spot check will appear on the supervisor's DCSR for a non-probationary worker if no action is taken after 10 days.

2. Workers access the certification files for identified matches from item "P", PRO Certifications, on the KAMES Inquiry Menu. The certification is printed and filed in the case record when case action is taken.

3. If no SSN match is found on KAMES, the member name, SSN and facility number appear on RDS report HRKIPR94 titled, "PRO Certifications Not Matched to KAMES". The member information is sorted by county code. This will be the location of the certifications for SSI individuals and individuals that are not active Medicaid recipients on KAMES at the time the file is received. Supervisors are responsible for monitoring this report on a daily basis and assuring vendor payment approvals for individuals active on SDX are completed on KAMES. Workers access the certification of files for identified clients on item "P" of the KAMES Inquiry Menu. The certification is printed and filed in the case record when case action is taken.

4. When a worker adds a new LTC segment to KAMES, matching the provider number and member number of a pending PRO Certification,

the spot check will disappear when the batch cycle is run. Only the supervisor has the capability to manually delete the PRO Spot Check.

The worker enters a verification source of “PR” on the KAMES LTC screen for the following types of care:

01 (Nursing Facility);
02 (HCBS), 05 (SCL);
07 (Model Waiver II);
08 (ICF IID);
09 (Mental Health/Psychiatric);
10 (PRTF);
11 (Adult Day Care);
12 (IMD);
16 (Acquired Brain Injury);
17 (Michelle P. Waiver); and
18 (ABI LTC).

MS 3660 PEER REVIEW ORGANIZATION
INITIAL CERTIFICATION

[The admission review is completed by the PRO prior to the individual entering the facility or as soon as possible after the individual is admitted to the facility. A retrospective on site review is conducted within 30 days of the provider's request for certification.]

A. [For LTC level of care determinations, the automated certification notifies the local office of the approvals to or changes in LTC with the admission date, level of care, and date level of care met. See MS 3650.

B. For mental/psychiatric level of care determination, the automated certification notifies the local office of the approval with the admission date. See MS 3650.

C. A continued stay review is completed by PRO during the initial level of care determination. The review is performed by examining the individual's medical records and conducting an on site visit with the individual. When a LTC recipient is certified for a continued stay, no notification is sent to the local office. For mental hospitals, the PRO completes a new automated certification if a patient's stay is continued. See MS 3650.]

MS 3670 PEER REVIEW ORGANIZATION DENIAL

An adverse determination is made by the PRO when an individual does not require the level of care being provided.

A. The adverse determination notice is issued when an applicant's admission or a continued stay review is denied.

B. An adverse determination is effective 10 days from the date an adverse determination notice is issued.

C. The PRO allows a 10 day grace period for an individual receiving an adverse determination notice to find other placement.

D. MA benefits continue during the grace period.

E. If an adverse determination notice is received at the initial admission, no grace period is allowed.

MS 3680 PEER REVIEW ORGANIZATION RECONSIDERATION

A reconsideration may be requested if the individual, physician of record or facility is dissatisfied with an adverse determination.

A. The request for a reconsideration is accepted by the PRO in written form only and must be received within 40 days of a continued stay denial or within 3 days of an admission denial.

   1. If the reconsideration request for continued stay denial is received within the 10 day grace period, MA benefits continue until the reconsideration decision is determined.

   2. A hearing is scheduled by the PRO following the receipt of the reconsideration request and is held within 10 days of a continued stay denial and within 3 working days of an admission denial.

   3. The local office is notified in writing when a hearing decision is rendered.

B. When an adverse determination is reversed by the hearing officer, vendor payments continue uninterrupted or the application process is initiated to start vendor payments. The local office is notified in writing of the reinstatement action and the retroactive time period the individual is certified.

C. If the adverse determination is upheld by the hearing officer, discontinue vendor payments or deny the care being provided.

MS 3690 PEER REVIEW ORGANIZATION APPEAL

An appeal may be filed with the PRO by the individual or the individual's responsible party if the PRO decision on an adverse determination is upheld by the hearing officer. Do not continue MA benefits during the appeal process.

A. Accept the appeal in written form only. The appeal must be received by the PRO within 20 days of the date of the results of the hearing notice received by the individual or responsible party.

1. The appeal must include the name of the individual, facility, and the reason the individual or responsible party disagrees with the hearing officers decision.

2. The appeal is sent to the appropriate PRO.

B. A decision is rendered within 15 days of receipt of the appeal request.

A. [Privately owned/operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF IID) in Kentucky:

1. Cedar Lake Lodge, Oldham County;

2. Higgins Learning Center, Union County; and

3. Wendel Foster Center, Daviess County.

B. Placement services in privately owned/operated facilities:

1. If the Confirmation Notice shows the appropriate level of care, placement services are not required.

2. If the Confirmation Notice shows level of care is not appropriate and an alternate level of care is indicated, immediately request placement services.

   a. Send a memorandum to MH/MR.
   b. Give the individual's name, case number, name of facility and level of care required.

3. If the Confirmation Notice shows level of care is not appropriate but an alternate level of care is not indicated, immediately:

   a. Send a memorandum to MH/MR.
   b. Give the individual's name, case number and name of facility.
   c. Request an assessment by the PRO to determine the level of care needed.

C. Placement in or from ICF IID cannot be accomplished within 30 days of receiving the confirmation notice:

1. MH/MR notifies DCBS by memorandum of efforts to place individual.

2. Forward this report to the Department for Medicaid Services (DMS), Division of Administration and Financial Management.

3. MH/MR submits progress reports at 60 day intervals, for forwarding to DMS, until placement is accomplished.

4. Continuing vendor payment is contingent on DMS receiving progress reports.

D. Acceptance/refusal of beds:

1. Approved bed becomes available.

    a. First name on waiting list is expected to accept placement.
    b. Do not consider bed available if facility refuses to accept the individual.

2. Available bed refused:

    a. Send form MA-105 to the recipient/committee and a copy to MH/MR.
    b. The vendor payment is discontinued.

E. Appeal Panel Hearing Procedure:

1. ICF IID hearings on patient status must be conducted by an Appeal Panel.

2. The panel is composed of:

    a. A DCBS hearing officer who chairs the Appeal Panel;
    b. A representative from the facility;
    c. A neutral representative from the county in which the facility is located appointed by the County Judge/Executive; and
    d. A DCBS worker, with the case record, who represents the Agency.

3. Action following the hearing.

    a. The chair takes a vote of the panel.
    b. The decision is written.
    c. The chair notifies the parent/payee/guardian/committee of the decision.

4. Decisions of the Appeal Panel.

    a. Decision reversed, vendor payment continues.
    b. Decision upheld, may be appealed within 30 days of date of decision to either:
        (1) The Circuit Court of the county where the State facility is located;
        (2) The Circuit Court of the home county of the parents, guardian, committee or payee; or
        (3) The Franklin Circuit Court.

F. Hearings on Patient Status. Recipients in ICF IID have the same hearing rights as any other recipients.]

1. When a hearing is requested:

    a. Send the PAFS-78 form to the Hearing Branch.
    b. Attach a copy for MH/MR.
    c. Indicate if the request is timely.

d. If timely, vendor payment continues during hearing process.
e. Hearing Branch sends a copy of the decision to MH/MR for action regarding vendor payment.

2. Decisions of Hearing Branch.

a. Decision reversed, vendor payment continues.
b. Decision upheld:
(1) DMS notifies Service Region Administrator by memorandum that payment continues for 10 days to allow for appropriate placement.
(2) Immediately notify MH/MR of the decision and request placement in the appropriate level of care.

A. [State owned/operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF IID) in Kentucky:

1. Hazelwood, Jefferson County;

2. Oakwood, Pulaski County;

3. Outwood, Hopkins County; and

4. Central State, Jefferson County.

B. Placement services in State owned/operated facilities are not the responsibility of the Department for Community Based Services (DCBS).

C. Reclassification of ICF IID recipients: MH/MR is responsible for sending written notice of reclassification to the parent/guardian/payee/committee to advise of hearing rights.

D. Hearings on Patient Status/Reclassification:

1. When a hearing request is received within 30 days of the notice of reclassification, vendor payment continues until the decision is rendered.
2. The DCBS office:

   a. Accepts all hearing requests.
   b. Sends requests to:

      Cabinet for Health and Family Services
      Division of Administrative Hearings
      Families and Children
      Administrative Hearings Branch
      105 Sea Hero Road, Suite 2
      Frankfort, KY 40601]

3. The Administrative Hearings Branch sends a copy of the acknowledgement of the request to the DCBS office in the county where the facility is located.

MS 3715 MONEY FOLLOWS THE PERSON (MFP) (1)

MFP is a program for individuals who have met level of care for a nursing facility (NF), SCL, or ICF IID for at least six months and have been eligible for Medicaid at least one month. The program is designed to provide transitional assistance to these individuals to enable them to move back into the community and live more independently. Individuals cannot apply for MFP. Recipients are identified by the Department for Medicaid Services (DMS) staff.

A. DMS and Department for Community Based Services (DCBS) Responsibilities:

1. Individuals that qualify for MFP are identified by DMS and the services are managed by DMS MFP staff.

2. When an individual is identified as participating in MFP:

a. [When a member moves from the facility to a home environment the worker receives form MAP-24M, Initial Admission, Change or Discharge of an Individual in KY Transitions Money Follows the Person, which indicates the required level of care. DMS certifies the individual for MFP and sends the MAP-24M to the Medicaid Support and Benefits Brach (MSBB) which is then forwarded to field staff. No Pro Certification will be received for MFP benefits.

b. DMS sets the MFP indicator on KAMES and SDX. The worker can confirm the case has been identified as MFP by inquiring the case on KAMES under “A” the general information screen (HRKIMK26). The MFP indicator shows placement and begin date. If the MFP individual is an SSI recipient the worker can confirm placement in MFP on the “SDX Inquiry Page”. For those SSI MFP individuals that exparte, refer to MS 4770.]

c. An individual identified as MFP, cannot lose Medicaid eligibility for any reason during the first 365 days of MFP eligibility. To ensure that the 365 days are not interrupted, when the DMS identifies the change on KAMES to reflect the recipient’s move from LTC to a waiver, a two-year certification period is assigned. The 365 days are tracked by DMS. The 365 days only apply to days the member remains in the community setting. The 365 day count of MFP period ends if the participant enters a hospital or returns to a nursing home.

3. If an MFP recipient returns temporarily to a hospital or a nursing facility:

a. The worker receives notification of this change through form MAP-24M from DMS. When a recipient has shelter expenses while residing in the community, an increased Personal Needs Allowance (PNA) deduction is allowed to make it feasible for the recipient to continue to pay the shelter expenses to maintain the

dwelling while institutionalized. Upon receipt of form MAP-24M the worker:

1) Enters the PNA deduction amount on screens HRKIPA0C (LTC/WAIVER) or HRKIPD23 (CHANGE LTC/WAIVER). Enter the amount of the shelter deduction on the line in front of the "MFP Shelter Deduction?" question and enter the "Start Date". The amount entered will be reflected on disposition screen HRKIPC05 on the "Increased Personal Needs Allowance" line; and

   Note: If the worker receives an error message while trying to enter the shelter deduction, contact the DMS staff person listed on line 3 of form MAP-24M.

2) Makes appropriate changes in the long term care (LTC) providers on KAMES to indicate the recipient has returned to a nursing facility or a hospital.

b. The PNA deduction is allowed for 6 months from the date the recipient returns to the nursing facility or enters into a hospital. On the first day of the 6th month after the MFP shelter deduction start date, a "MFP Shelter Deduct to Expire" spot check will post to the workers DCSR. The spot check will display the program code, case number, case name, timely date (10 days from date posted), the reason and the worker code. Upon the expiration of 6 months the worker must:

   1) Remove the deduction from screens HRKIPA0C (LTC/WAIVER) or HRKIPD23 (CHANGE LTC/WAIVER); and
   2) Process the change according to the instructions on form MAP-24M; and
   3) Delete the spot check and document in case comments the case change.

B. At the end of MFP participation, DMS notifies the worker of the effective date, by sending form MAP-24M. Upon receipt of form MAP-24M, shorten the certification date to the next applicable month (based on IM cut-off) and send the recipient a recertification appointment. DMS staff assisting with the transition may inquire on the recipient's behalf regarding potential eligibility for additional benefits.

MS 3720 ESTATE RECOVERY

Estate recovery results in the State filing a claim against the estate of an individual in order to recoup Medicaid (MA) expenditures paid on the individual's behalf.

A. Estate recovery is made against a deceased individual's estate. This includes all assets such as cash, personal possessions, and homestead property.

1. A claim is filed against the estate for the total amount of MA expenditures accruing on and after February 2, 1994.

2. MA expenditures prior to February 2, 1994 are not subject to estate recovery.

B. [An estate is subject to estate recovery if the individual is at least 55 years of age at the time of death AND at any time received MA that paid for any of the following:

1. NF, not including institutionalized Hospice;

2. HCBS;

3. Adult Day Care;

4. SCL;

5. Michelle P. Waiver;

6. ABI/ABI LTC;

7. ICF IID services; or

8. Mental Health Psychiatric Care Facility (age 65 or older).]

C. The estates of individuals under 55 years of age are also subject to estate recovery if the individual has been receiving MA for NF or ICF IID services for a total of six consecutive months or more at the time of death.

MS 3730 DCBS RESPONSIBILITIES FOR ESTATE RECOVERY (1)

[The Department for Community Based Services (DCBS) obtains information for purposes of Estate Recovery from all individuals applying for or receiving services in a nursing facility (NF), HCBS, Adult Day Care, SCL, ICF IID, Mental Health Psychiatric Care Facility (age 65 or over), Michelle P, Acquired Brain Injury (ABI) or ABI LTC. Estate Recovery information passes directly from KAMES to the DMS system.]

A. The Department for Medicaid Services (DMS) will recover against ALL assets held by the recipient at the time of death. Form MAP-708, Medicaid Estate Recovery Fact Sheet, advises the applicant or recipient that the estate may be subject to recoupment of monies expended on their behalf for services received during periods of institutionalization.

1. Post form MAP-708, Medicaid Estate Recovery Fact Sheet, in each local office waiting room to notify the applicants and recipients of estate recovery information. Form MAP-708 is system generated to SSI recipients at vendor payment approval.

2. [Advise individuals requesting additional information to write to:

Department for Medicaid Services
Division of Program Integrity
Third Party Liability Branch
275 East Main Street, 6E-A
Frankfort, KY 40621]

3. Complete form PA-1A, Supplement E, Estate Recovery Notification and Information Sheet Statement, at application and re-application. This form advises applicants or recipients that their estate may be subject to recoupment of monies expended on their behalf for services received during periods of institutionalization. The value of homestead property, the name of the spouse, the names of minor dependent children, the names of blind or disabled children, and the name and address of the executor or administrator of the will are collected on the form. If there is no will, obtain the name and address of the next of kin or authorized representative. For SSI recipients, form PA-1A, Supplement E is also system generated at vendor payment approval.

4. File form PA-1A, Supplement E in the most recent application or recertification packet. Review the form at each recertification to include any reported changes or additional estate recovery information.

5. Form PA-707, Estate Recovery Notice, is system generated to SSI recipients at approval and advises the recipient to review the MAP-708 and PA-1A, Supplement E and complete, sign, and mail form PA-1A, Supplement E to DMS at the address in A.2.

B. Cooperation in estate recovery is not a technical eligibility requirement for receipt of MA benefits. Do not deny an application or hold other case action pending the receipt of a completed form.

C. For SSI only recipients requesting services in HCBS, SCL, ICF IID or a nursing facility, form PA-1A, Supplement E is system generated at the time the vendor payment is authorized to the SSI recipient or payee with form PAFS-2, Application Letter or Notice of Expiration, requesting that the form be completed and returned within 10 days. Refer to procedural instructions for the form. Inclusion of the PA-1A, Supplement E in the case record is not an eligibility requirement for SSI recipients.

D. A notice of death is sent electronically to DMS from the Vital Statistics death match and KAMES discontinuances due to the death of the recipient via nightly batch match. A notice is system generated from the Office of Inspector General (OIG) to the individual designated as the Executor or Administrator at case approval, recertification or case change. This notifies the designated individual of the ability/intent of DMS to recover against assets of the individual for cost of care, unless certain exemptions are met. If the member is inactive at the time of death, OIG will contact the designated individual concerning the estate of the deceased once the date-of-death match is received from Vital Statistics.

MS 3800 NON-EMERGENCY MEDICAL TRANSPORTATION

[Medicaid recipients are eligible for medical transportation services if non-emergency medical transportation criteria are met. Non-emergency medical transportation services are provided through the Human Services Transportation Delivery (HSTD) system, with the exception of stretcher services. Stretcher services are requested by contacting the stretcher service provider directly. The HSTD system is administrated by the Kentucky Transportation Cabinet. The HSTD toll-free customer service hotline is (888) 941-7433 or recipients can call (502) 564-7433. Recipients may call to report problems in requesting services or complaints with services provided by the transportation brokers.

Long Distance travel beyond the service area covered by regional transportation brokers of the HSTD system is requested by contacting the Department for Medicaid Services (DMS) at 502-564-8196. Reimbursement for lodging and meals is handled directly by DMS and is requested when scheduling the long distance travel.]

MS 3810 Non-Emergency Medical Transportation Brokers

The following list of transportation brokers lists the counties in which they provide Non-emergency Medical Transportation (NEMT) and phone numbers at which they are contacted to request services.

Region 1
Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Marshall, and McCracken counties LKLP Community Action Council (LKLP)
1-800-245-2826

Region 2
Caldwell, Christian, Crittenden, Hopkins, Livingston, Lyon, Muhlenberg, Todd, and Trigg counties
Pennyrile Allied Community Services (PACS)
1-800-467-4601 or (270) 886-6641

Region 3
Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster counties
Audubon Area Community Service, Inc (GRITS)
1-800-816-3511 or (270)686-1651

Region 4
Breckinridge, Grayson, Hardin, Larue, Marion, Meade, and Nelson counties LKLP Community Action Council (LKLP)
1-800-245-2826

Region 5 A
Butler, Edmonson, Hart, Logan, Simpson, and Warren counties
GRITS
1-888-781-8312 or (270)782-8312

Region 5B
Adair, Allen, Barren, Green, Metcalfe, and Taylor counties
RTEC, LLC
1-800-321-7832

Region 6
Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, and Trimble counties
Federated Transportation Services of the Bluegrass (FTSB)
1-888-848-0989

Region 8
Anderson, Boyle, Casey, Franklin, Garrard, Jessamine, Lincoln, Mercer, Scott, Washington, and Woodford counties
Bluegrass Community Action Partnership (BGCAP)
1-800-456-6588 or (502)695-4290

Region 10
Fayette county
Federated Transportation Services of the Bluegrass (FTSB)

1-888-848-0989 or (859)233-0066

Region 12

Bell, Clinton, Cumberland, Knox, Laurel, McCreary, Monroe, Pulaski, Rockcastle, Russell, Wayne, and Whitley counties
Rural Transit Enterprises Coordinated (RTEC)
1-800-321-7832 or (606)256-9835

Region 13

Bath, Boone, Bourbon, Boyd, Bracken, Breathitt, Campbell, Carroll, Carter, Clark, Clay, Elliott, Estill, Fleming, Gallatin, Grant, Greenup, Harlan, Harrison, Jackson, Kenton, Knott, Lawrence, Lee, Leslie, Letcher, Lewis, Madison, Mason, Menifee, Montgomery, Morgan, Nicholas, Owen, Owsley, Pendleton, Perry, Powell, Robertson, Rowan,
and Wolfe counties
LKLP Community Action Council
1-800-245-2826 or (606)439-1362

Region 14

Floyd, Johnson, Magoffin, Martin, and Pike counties Sandy Valley Transportation Services (SVTS) 1-800-444-7433 or (606)886-1936

MS 3900* MEDICAID WORKS OVERVIEW

The Kentucky Medicaid Works program offers disabled individuals who are unable to engage in Substantial Gainful Activity (SGA), but are working and are not financially eligible for regular MA the opportunity to "buy in" into Medicaid. For an explanation of SGA, refer to MS 3912. Medicaid Works applicants who receive Medicare may also receive Qualified Medicare Beneficiaries (QMB) or Special Low-Income Medicare Beneficiaries (SLMB) if their income is below the income limits for the specific program.

Medicaid Works applicants with spouses must meet an initial income test. The income limit for an ineligible spouse is $3,750 per month. If the ineligible spouse's income exceeds $3,750 per month, the applicant is not eligible. If the income of the ineligible spouse does not exceed $3,750, then apply the remaining appropriate income tests as explained next.

Medicaid Works applicants that have already been determined disabled by a Federal/State entity have to pass two different income limit tests. The first test is the unearned income limit test set by the SSI income standards. The second is the earned income limit set by the 250% Federal Poverty Level (FPL).

Medicaid Works applicants that have NOT been determined disabled have to pass three different income limit tests. The first test is the unearned income limit set by the SSI income standards. The second test is the earned income limit set by the 250% FPL. The third test is the SGA income standards. For an explanation of SGA, refer to MS 3912.

Medicaid Works recipients that stop working can continue to be eligible for up to 6 months as long as they intend to return to work.

MS 3910 MEDICAID WORKS APPLICATION (1)

Applications for Medicaid Works are taken in the "K" (blind) or "M" (disabled) program categories. In order to be technically eligible for Medicaid Works an applicant must be:

1. Between the ages of 16 and 64;

2. Actively employed or actively self-employed;

3. Under the unearned income limit AND the earned 250% Federal Poverty Level income limit;

4. Determined to be totally and permanently disabled;

[5. UNABLE to engage in Substantial Gainful Activity (SGA).

   a. A disabled individual earning $1,090 per month (effective 1/1/15) or more is considered ABLE to engage in SGA.
   b. A blind individual earning $1,820 per month (effective 1/1/15) or more is considered ABLE to engage in SGA; and**]**

6. Meet all other technical and financial eligibility requirements for Medicaid.

Applications for Medicaid Works are processed as follows:

A. For applicants who have NOT been determined disabled:

1. Determine if the applicant's income and resources are within the Supplemental Security Income (SSI) standard. If so, advise the applicant to apply for SSI with the Social Security Administration (SSA) and deny the KAMES application.

2. For those applicants whose income and resources are over the SSI standard, make a Medical Review Team (MRT) referral by sending a completed form PA-601T, Referral for Determination of Incapacity or Disability, and signed/witnessed forms MRT-15 (with a revision date of 5/01 or after), Authorization for Information/Release of Information. Refer to MS 1720. In the nature of illness section, workers note it is a Medicaid Works application.

3. Prior to sending the MRT, determine if the Medicaid Works applicant is able to engage in SGA. Refer to MS 3912. If a Medicaid Works applicant is able to engage in SGA, then he/she is NOT eligible for a disability determination and an MRT referral is not appropriate. If the applicant is unable to engage in SGA, see instructions in MS 3912. The worker is to annotate the PA-601T that the applicant is not engaged in SGA.

B. For applicants already determined disabled:

Coverage is effective the date of application. Explain to the applicants that the effective date of medical assistance is the date of application, not the 1st day of the month of application. Enter the date of application as well as all other information on KAMES. There is no retroactive coverage. Cases will alternate program to “K” or “M” spend down for applicants with income over the limit.

C. If an applicant has medical expenses prior to the date of application, up to the 3 prior calendar months, explore eligibility for spend down coverage. Do not process a spend down for the same month in which a member has been approved for coverage. The client may elect to wait until the first of the following month to apply for on-going benefits if they need to apply for spend down for the current month. It is the decision of the client; however, ensure the client understands that no coverage will exist prior to the date of application in the application month.

If spend down coverage is requested for any portion of the prior quarter, complete the spend down as a special circumstance transaction, provided all verification has been received. Document the case comments accordingly. Refer to MS 2650, Spend Down Process, for the instructions for processing spend downs by special circumstance on KAMES.

MS 3912 MEDICAID WORKS SUBSTANTIAL GAINFUL ACTIVITY (SGA) (1)

Substantial Gainful Activity (SGA) is a term used by the Social Security Administration (SSA) to describe a level of work activity and earnings. It is considered in situations involving disabled or blind individuals. Individuals determined to be engaged in SGA are not eligible for Medicaid Works.

HOW TO DETERMINE SUBSTANTIAL GAINFUL ACTIVITY

For applicants who have not been determined disabled, establish if the applicant meets the criteria to have MRT complete a review by determining if the applicant is engaged in SGA.

To determine if an applicant is engaged in SGA, compare the applicant's actual income received for the prior month to the SGA income limits set by SSA annually. The current SGA monthly income limit is:

[SGA for Disabled Individual	SGA for Blind Individual
$1090 Effective 1/1/15	$1820 Effective 1/1/15]

NOTE: If the income for the prior month is not representative of ongoing, compute the income by totaling actual amounts of income received in the prior 3 months and dividing by 3. If the applicant claims his/her income will change, but is over the SGA standard for the current month, the application is denied for the current month and the individual is advised to reapply in the next month.

At application complete an MRT referral, but prior to sending it to the MRT for review, determine if the applicant's income is more than the SGA standards. If it is, the applicant is considered to be engaged in SGA and does NOT meet the definition of disability. Do not send the referral to the MRT. If the applicant earns less than the SGA standards, send the referral to the MRT for review.

A. The MRT referral is NOT sent for review and the worker is to:

1. Annotate the top of form PA-601-T, Referral for Determination of Incapacity or Disability, indicating the applicant does not meet the requirements for a disability determination and is engaged in SGA.

2. Due to system limitations, at this time, applicants will not receive a notice informing them that they do not qualify due to being engaged in SGA. Send form MA-105, Eligibility Notice, to the applicants informing them that income exceeds the SGA income guidelines set by the federal government for an individual to be eligible for Medicaid Works;

3. File the annotated form PA-601-T in the case record; and

4. Document in comments why the MRT referral was not sent for review.

Example 1: Disabled Dan (under the age of 65) works and earns $1,080 and receives $300 in RSDI monthly.

Disabled Dan passed the unearned income test because the $300 in RSDI is under the SSI income standards. Disabled Dan also passed the second income test as his total combined income ($1,300/mo.) is less than the 250% Federal Poverty Level for one. However, disabled Dan's verified earned income is above the SGA income limit. Therefore, he is considered to be engaged in SGA and does not meet the definition of disability.

B. The MRT referral is sent for review and the worker is to:

1. Completes forms PA-601T and MRT-15 (with a revision date of 5/01 or after), Authorization for Information/Release of information. Refer to MS 1720. In the nature of illness section, note that this is a Medicaid Works application.

2. Annotate the top of form PA-601T indicating an SGA review has been completed and that the client meets the requirement for a disability determination;

2. Sends the annotated form PA-601T along with forms MRT-15's for review; and

4. Documents in comments that the applicant meets the requirement for a disability determination and the MRT referral has been sent for review.

Example 2: Dan's co-worker Jimmy (also disabled and under age 65) earns $979 and receives $200 in VA benefits monthly.

Jimmy has passed the unearned income test and his VA benefit is under the SSI standards. Jimmy has also passed the second income test as his total combined income ($1,139) is less than the 250% Federal Poverty Level for one. Additionally, Jimmy's verified earned income is below the SGA income limit. Therefore, he is considered to NOT be engaged in SGA and DOES meet the definition for disability.

MS 3920 MEDICAID WORKS FINANCIAL ELIGIBILITY (1)

The following are the resource and income limits for individuals in the Medicaid Works program.

A. The resource limits are:

1. $5,000 for a single individual; and

2. $10,000 for a couple.

B. The income limits are:

[1. The income limit (gross earned and unearned) for applicants is 250% of the Federal Poverty Level (FPL) which is $2,475, effective 3/1/16;]

2. The income limit for an ineligible spouse is $3,750 per month. If the ineligible spouse's gross income is over $3,750 per month, the applicant is not eligible;

3. The unearned income limit is $753 (Supplemental Security Income (SSI) standard plus $20).

Note: If there are any changes in the SSI standard they are effective January of each year.

Calculate income as follows:

1. For a technically eligible applicant, refer to Volume IVA, MS 2560.

2. For a technically eligible applicant and spouse, refer to Volume IVA, MS 2610.

3. For a technically eligible applicant with a technically ineligible spouse, refer to Volume IVA, MS 2620.

For financial eligibility and verification of employment, refer to Volume IVA, MS 2480 for allowable income deductions. Refer to Volume IVA, MS 2470 for a list of excluded income. Cases will alternate program to spend down for applicants when income is over the limit.

Applicants who receive Medicare Part A and/or Part B and whose income is under the 100% FPL scale are also eligible for Qualified Medicare Beneficiaries (QMB). They are eligible for Specified Low-Income Medicare Beneficiaries (SLMB) if income falls under the 120% FPL scale and they have Medicare Part B. Refer to MS 4455.

[Income Scale effective 3/1/16

Family Size	100% FPL (QMB)	120% FPL (SLMB)	250% FPL
1	$ 990	$1188	$2475
2	$1335	$1602	$3338]

MS 3940 DENIAL/DISCONTINUANCE CODES FOR MEDICAID WORKS (1)

The following are denial/discontinuance codes for Medicaid Works cases:

1. Code 270 – Case denied – “Working Disabled Recipient Not Working” (member code 870);
2. Code 670 – Case discontinued – “Working Disabled Recipient Not Working” (member code 870);
3. Code 271 – Case denied – “Does Not Meet Age Requirements of 16 – 64” (member code 871);
4. Code 671 – Case discontinued – “Does Not Meet Age Requirements of 16 – 64” (member code 871);
5. Code 272 – Case denied – “Spouse’s Income Over the Income Limit” (member code 872); and
6. Code 672 – Case discontinued – “Spouse’s Income Over the Income Limit” (member code 872).

MS 3951* MEDICAID WORKS RECERTIFICATIONS/INTERIM CHANGES/UNTIMELY CHANGES

Determine continuing MA eligibility for Medicaid works cases as follows.

A. FOR RECERTIFICATIONS:

1. Process a recertification every 12 months.
2. Verify and document continued resource and income eligibility.
3. If, during the recertification month, the member has failed to pay the monthly premium by the due date, KAMES will discontinue the case. If the recertification is pending at cut-off, eligibility is issued for the coming month.
4. Individuals who are recertified and are in good standing with the Premium Payment Center (PPC) will continue to receive medical assistance.

B. FOR INTERIM CHANGES

1. Process as interims, the results of spot checks or recipient reported changes considered to be a change in circumstances that require a re-computation of countable income.
2. Once a case is pending for Premium Payment only, do NOT make any changes which would cause the case to pend for any other reason. If the client reports a change for which verification is required, the worker is to manually mail a PAFS-2 to the client requesting that needed verification be returned within 10 days.
3. Upon receipt of verification, act upon the change.
4. Recipients who report that they have stopped working may remain eligible for up to six months provided they intend to return to work. The question, “DOES WORKING DISABLED RECIPIENT INTEND TO RETURN TO WORK?” appears on the disposition screen HRKIPC23 for cases in which no earned income is entered/removed. Appropriate responses are “Y” or “N”. If, at the end of the six-month period, the recipient has not returned to work, the case will automatically discontinue as no earned income has been entered.

C. FOR UNTIMELY CHANGES

For verified changes that miss cut-off, due to no fault of the client, and the completed change results in approval in a category that does not require a premium payment, the supervisor is to contact the KCHIP Branch with the following information:

1. Case name;

2. Case number;
3. Reason for the change (decreased income);
4. Reason the change was not processed timely (worker on leave, system not available, etc.); and
5. Month(s) in question.

The KCHIP Branch will advise the PPC of the change to a non-premium payment category and the PPC will refund any premium overpayments.

MS 4150 PASS THROUGH OVERVIEW (1)

Federal law protects MA eligibility for certain RSDI beneficiaries. The MA category for such individuals is called Pass Through. These beneficiaries previously received MA as a Supplemental Security Income (SSI) or State Supplementation recipient, and lost those benefits due to an increase in, entitlement to, or recomputation of RSDI benefits. Increases in RSDI benefits may be the result of a cost of living adjustment (COLA).

There are three Pass Through groups:

A. Those who previously received SSI/State Supplementation and RSDI correctly and concurrently (in the same month). Applicants in this group can receive in the “F”, “G”, or “H” category based on age, blindness, or disability.

B. Those losing SSI/State Supplementation benefits due to an entitlement to or increase in RSDI Disabled Adult Child (DAC) benefits. Applicants in this group can receive in the “F”, “G”, or “H” category based on age, blindness, or disability. **[**If approved in “G” or “H”, there is no need to change the category once age 65 or older.**]**

C. Disabled or early widows/widowers or disabled surviving divorced spouses who are not yet eligible for Medicare Part A. Applicants in this group can only receive in the “G” or “H” category.

These individuals may be technically eligible in more than one category. Case workers are to first apply DAC or widows eligibility before applying correct and concurrent receipt.

When an individual who formerly received SSI applies for Medicaid, Pass Through eligibility must be explored. If an individual is otherwise Medicaid eligible (such as Pass Through eligible) and receiving waiver services, the individual’s patient liability is $0.

[Technical eligibility for Pass Through is verified for previous SSI recipients by worker completion of form PA-9. In addition to entering the Pass Through information on KAMES, workers are required to manually compute income eligibility of the Pass Through individual on form PA-1A, Supplement A, Pass Through Computation Sheet.

Form PA-9 is not used for applicants who are no longer eligible for State Supplementation. Inquire the case on KAMES to determine why the individual lost State Supplementation benefits. These individuals can only receive Pass Through in the correct/concurrent Pass Through category.**]**

MS 4160 CONCURRENT SSI/STATE SUPPLEMENTATION

Current RSDI recipients who, after April 1977, previously received SSI or State Supplementation and RSDI correctly and concurrently (in the same month) and lost SSI or State Supplementation may be eligible in this category of Pass Through. Concurrent receipt must also be correct receipt. Concurrent receipt is considered correct if any portion of an RSDI lump sum payment is awarded for the month of SSI receipt.

There are three types of individuals who may fall into the Concurrent SSI/State Supplementation grouping:

A. Those individuals who would still be eligible for SSI/State Supplementation benefits if all RSDI cost-of-living adjustments (COLA) since last receiving SSI/State Supplementation were deducted from countable income. It is not necessary to wait for another COLA to pass before applying. For example: An individual loses SSI due to COLA effective December 2007. He will meet the Pass Through requirement without having to wait for another COLA.

   1. If the individual has a spouse and the spouse receives RSDI, deduct every COLA the spouse has received since the time of SSI discontinuance from the individual's countable income in determining the individual's Pass Through eligibility.

   2. If the individual is a child, and the child's responsible relative receives RSDI, deduct every COLA the responsible relative has received from the time of SSI discontinuance from the child's countable income in determining the child's Pass Through eligibility.

   3. The individual's claim number will end in an A, B, C, D or W.

   4. Eligibility in this category is not affected by receipt of Medicare Part A.

   5. If SSI is discontinued due to a RSDI COLA increase, the old amount of RSDI (smaller amount) is used to calculate the Pass Through amount. This RSDI amount can be found on the PA-9, Part II, A2. This is the RSDI amount to be entered on the Pass Through screen on KAMES.

   6. For those individuals who lost SSI/State Supplementation as a result of a COLA, the Pass Through amount is the sum of all COLA increases received since the termination of the SSI/State Supplementation payment.

B. Those individuals who lost SSI/State Supplementation due to a recomputation of RSDI or to a new RSDI entitlement. At least one COLA must have been received since termination of SSI/State Supplementation for the Pass Through requirement to be met.

1. The loss of SSI/State Supplementation must be the individual's, not the spouse's.

2. The individual's claim number will end in an A, B, C, D or W.

3. If SSI/State Supplementation is discontinued due to a recomputation of RSDI, the amount of RSDI (larger amount) which caused the SSI/State Supplementation to discontinue is used. This RSDI amount can be found on the PA-9, Part II, A4. This is the RSDI amount to be entered on the Pass Through screen on KAMES.

4. Eligibility in this category is not affected by receipt of Medicare Part A.

5. These individuals may be technically eligible in this category, but not financially eligible.

C. Those individuals who lost SSI/State Supplementation due to an increase in income other than RSDI. This refers to only the Pass Through applicant's income, not any other household member's income. At least one COLA must have been received since termination of SSI/State Supplementation for the Pass Through requirement to be met. In many instances, these individuals may not be financially eligible even though technical eligibility is met.

1. Eligibility in this category is not affected by receipt of Medicare Part A.

2. The individual's claim number will end in an A, B, C, D or W.

3. If SSI/State Supplementation is discontinued due to an increase in income other than RSDI, the RSDI amount to be used on the Pass Through screen can be found on the PA-9, Part II, A4. This is the RSDI amount to be entered on the Pass Through screen on KAMES. This RSDI amount should match the amount found on the PA-9, Part II, A2. This is the RSDI amount to be entered on the Pass Through screen on KAMES. You will find the amount of the other income that caused the loss of the SSI on Part I B, 3, c of the PA-9.

   For those who lost SSI/State Supplementation due to an increase in income other than RSDI, do the following when completing the PA-1A Supp A, Part II, A or B:

   a. Add the other income which caused the loss of the SSI/State Supplementation to the current gross RSDI benefit to determine total income.
   b. Verification of the other income must be requested from the individual.

5. These individuals may be technically, but not financially eligible in this category.

MS 4180 DISABLED ADULT CHILD

[Continued MA coverage is provided to certain blind or disabled individuals, age 18 and older, who lose SSI as a result of an entitlement to or increase in RSDI Disabled Adult Child (DAC) benefits. Neither concurrent receipt of RSDI and SSI or receipt of an RSDI COLA is a technical eligibility requirement for this group of Pass Through applicants/recipients. Once an individual is technically qualified as a DAC, he/she is always a DAC. However, the individual could become financially ineligible for Pass Through.

A. To be classified as a DAC, an individual would have to be determined to be disabled by the Social Security Administration (SSA) before age 22.

B. These individuals previously received SSI and lost SSI on or after July 1, 1987 due to:

   1. An entitlement to RSDI DAC benefits; or
   2. Previously received RSDI DAC benefits concurrently with SSI and lost SSI due to an increase in RSDI DAC benefits.

C. These individuals would still be eligible for SSI if all COLAs and the amount of the RSDI DAC entitlement or increase were deducted from countable income.

D. The RSDI claim number for a DAC is the social security number of the parent the individual is receiving on followed by the letter “C”.

E. Eligibility in this category is not affected by receipt of Medicare Part A.

F. A listing of potential applicants is on RDS report HRSDXRDA, Disabled Children Report. This report is released on a quarterly basis.

G. For individuals who received SSI and RSDI and lost SSI due to a new entitlement or increase in RSDI DAC benefits, the Pass Through amount is the amount of the RSDI DAC benefits which resulted in the SSI discontinuance plus all subsequent COLA’s received since SSI was lost. Calculate the Pass Through amount using the RSDI amount found on the PA-9, Part II, B2. This is the RSDI amount to be entered on the Pass Through screens.

H. For individuals who received SSI only and who lost SSI due to a new entitlement to RSDI DAC benefits, the RSDI amount to be used on the Pass Through screen is zero and may be found on the PA-9, Part II, B2. This is the RSDI amount to be entered on the Pass Through screens.

I. To receive benefits in the Pass Through category as a DAC, an individual must be at least 18 years of age. For applications and program transfers, the age will be determined by the age of the individual on the first day of the application/program transfer month.

Example: An application is taken on 2/6/06. The birthday of the applicant is 3/6/88. The individual is 17 years of age. An "N" will be uploaded for the question, "Did he/she lose SSI/SSP due to entitlement/increase in Disabled Adult child Benefits (DAC)?". This field will be protected to prevent the worker from answering "Y" to the question.

KAMES has an edit in place which prevents an applicant under 18 years of age from receiving benefits in the "G" or "H" category as a DAC.]

MS 4190 DISABLED EARLY WIDOWS AND WIDOWERS OR DISABLED SURVIVING DIVORCED SPOUSES WITH NO MEDICARE PART A

The following individuals are to be considered for Pass Through eligibility:

[A. Individuals, ages 60 through 64, who lost SSI or State Supplementation as a result of entitlement to RSDI early widow's or widower's benefits, and who are not yet entitled to Medicare Part A.] The RSDI claim number will end with a “D” or “W”.

[B. Individuals, ages 50 through 59, who received SSI or State Supplementation and who lost SSI or State Supplementation as a result of entitlement to RSDI disabled widow's or widower's or disabled surviving divorced spouse's benefits, and are not yet entitled to Medicare Part A.] The RSDI claim number will end with a “D” or “W”.

The following criteria apply to both A and B individuals listed above:

[1. Concurrent receipt of SSI/State Supplementation and RSDI is not a requirement.
2. Once an individual’s entitlement to Medicare Part A is established, Pass Through eligibility terminates in this category. Explore eligibility in the concurrent receipt category.] When Pass Through terminates, explore eligibility for QMB, SLMB, QDWI, or QI1.
3. Set up a spot check for those individuals who will reach age 65 or become entitled to Medicare Part A prior to the next case recertification.
4. Terminate Pass Through when entitlement to Medicare Part A is established, even if the individual fails to enroll.
5. This category of Pass Through does not require that a COLA occur prior to determining eligibility.
6. [For individuals who received SSI/State Supplementation and RSDI and lose SSI/State Supplementation due to a new entitlement or increase in RSDI, the Pass Through amount is calculated using the amount of the RSDI benefit which resulted in the SSI/State Supplementation discontinuance plus all COLA increases received since SSI/State Supplementation was lost. The RSDI amount is found on the PA-9, Part II, C2. This is the RSDI amount to be entered on the Pass Through screen on KAMES.
7. For an individual who received SSI/State Supplementation only and who lost SSI/State Supplementation due to a new entitlement to RSDI, the Pass Through amount is calculated using the RSDI benefit amount of 0. This is the RSDI amount to be entered on the Pass Through screen on KAMES.
8. If the individual reaches age 65 or becomes entitled to Medicare Part A and receipt was correct and concurrent, the RSDI amount to be used to calculate the Pass Through amount can be found on the PA-9, Part II, C4. This is the RSDI amount to be entered on the Pass Through screen on KAMES.]

MS 4220 [PASS THROUGH RESOURCES

Verify and consider countable resources according to policy and procedures in MS 1810 and 1820. If resources exceed limits, the case is ineligible. The total countable resources allowed for individuals or couples receiving Pass Through are:

1. Individual $2000

2. Couple $3000]

MS 4230 INCOME CALCULATION (1)

[Follow the steps below to calculate income for Pass Through eligibility:

A. To obtain the amount of RSDI the individual received at the time of SSI discontinuance, complete form PA-9, Pass Through Verification Letter, according to procedural instructions for the form. Do not complete form PA-9 for State Supplementation discontinuance. See MS 4150 for instructions for State Supplementation discontinuance.

1. It is not necessary to complete a new form PA-9 for a recertification or subsequent reapplication unless the information on the form is in question or the form is out-of-date. If the previously completed PA-9 is in the hardcopy case record, scan it into the electronic case file (ECF). The case record must contain form PA-9 with a revision date no earlier than 11/08.

2. If the system information entered on form PA-9 is questionable or not available and the issue cannot be resolved, forward to MSBB through the program specialist.

B. Workers are required to manually compute income eligibility of the Pass Through individual on form PA-1A, Supp A, Pass Through Computation Sheet and scan it into ECF. KAMES makes these calculations internally.**]**

C. Income eligibility is determined by comparing the individual's countable income minus the Pass Through amount to the current SSI or State Supplementation standard for one. If the remainder is equal to or less than the standard, income eligibility exists.

D. Determine countable income according to policies stated for the Aged, Blind, or Disabled MA Program. These policies can be found in MS 2180 – MS 2480 of this volume.

MS 4235* APPLICANT WITH ELIGIBLE SPOUSE

A. For an individual or couple who received SSI, and who lost SSI, compare countable income to the current SSI standard for an individual or couple, as appropriate.

   1. If a couple received SSI and lost SSI and both are applying, a PA-9 is required for the individual and spouse to determine Pass Through for each.
   2. For a couple where only one wants to apply for Pass Through, use the information on the individual's PA-9, Part III, for spouse's information.

B. For a couple, who both received State Supplementation caretaker services and lost State Supplementation, compare the couple's countable income to the current State Supplementation caretaker services standard for a couple, both eligible.

MS 4240 APPLICANT WITH INELIGIBLE SPOUSE

For a couple, when one loses SSI or State Supplementation and the other spouse is technically or financially ineligible for SSI or State Supplementation:

A. **[**If a technically or financially ineligible spouse's income EXCEEDS the difference between the SSI or State Supplementation standard for an individual and the SSI or State Supplementation standard for a couple, only one requiring care, add the ineligible spouse's income to the applicant's income.

Subtract one $20 general exclusion, earned income deductions, if applicable, and the total Pass Through amount. Compare the remaining income to the SSI standard for an individual or the State Supplementation standard for an eligible individual with an ineligible spouse.

If the remaining income is LESS THAN OR EQUAL TO the SSI or State Supplementation standard, the applicant is income eligible for Pass Through. If the remaining income is OVER the standard, the applicant is not eligible. On PA-1A Sup A this calculation would be completed on Part III, B1.

B. If a technically or financially ineligible spouse's income is EQUAL TO OR LESS THAN the difference between the SSI or State Supplementation standard for an individual and the SSI or State Supplementation standard for a couple, only one requiring care, DO NOT consider that spouse's income in the calculation.

After subtracting one $20 general exclusion, earned income deductions, if applicable, and total Pass Through amount. Compare the applicant's remaining income to the current SSI or State Supplementation standard for an individual.

If the applicant’s remaining income is LESS THAN OR EQUAL TO the SSI or State Supplementation standard, the applicant is income eligible for Pass Through.

If the applicant’s remaining income is OVER the standard, the applicant is not eligible. On the PA-1A, Sup. A, this calculation would be completed on Part III, B2.**]**

MS 4245* PASS THROUGH FOR INDIVIDUAL LOSING STATE SUPPLEMENTATION

For those individuals who received State Supplementation and lost State Supplementation, compare the individual's countable income to the appropriate current State Supplementation standard. Refer to MS 4910.

An individual with a spouse who is approved for Long Term Care (LTC) vendor payment is considered an individual the month following the month of separation. This individual's countable income is also compared to the appropriate current State Supplementation standard.

MS 4250 PASS THROUGH APPLICATION PROCESS (1)

[Adult Medicaid applications are completed during a face to face interview in the local office or at a home visit, except for individuals who choose to submit a mail-in application in the "Z" category (see MS 4500) or individuals who apply in the "Z" category via an Low Income Subsidy (LIS) referral. The application process is completed as follows:

A. The application is signed by the applicant, statutory benefit payee, power of attorney (POA), committee/guardian, authorized representative (AR), or a witness (related or unrelated) if the applicant signs by a mark (X).

If the payee does not live in Kentucky, a phone interview may be permitted if it is a hardship to the payee to come to the local office. The application is entered on KAMES on the date assistance is requested and the case is carried in the county where the applicant lives.

B. PROGRAM CODE. Use the appropriate program code for aged (F), blind (G), or disabled (H) individuals.**]**

C. CASE NUMBER. Use the SSN of the applicant as the case number.

D. CASE NAME. Use the applicant's full legal name for the case name even if the application is filed by someone other than the applicant.

E. APPROVAL. If countable income, minus the Pass Through amount, is equal to or less than the current SSI standard or current State Supplementation standard for one, income eligibility is established. If all other eligibility criteria are met, approve the case.

[Establish the effective date as the first day of the month, up to 3 months prior to the month of application.**]**

F. CONTINUING ELIGIBILITY. Complete a recertification every 12 months.

G. CASE RECORD. The case record must contain:

1. **[**Form PA-9, Pass Through Verification Letter, (except in cases where State Supplementation has been received);**]**

2. Form PA-1A, Supp A, Pass Through Computation Sheet. A new PA-1A Supp A must be completed at each recertification.

H. Refer to MS 1350 – MS 1380 for further information on the application process.

MS 4260 DISCONTINUANCES

Discontinue a Pass Through case when:

[A. RSDI less Pass Through amount(s) plus other income exceeds the current appropriate SSI/State Supplementation standard for one;]

B. Resources exceed limits;

C. Recipient dies;

D. Recipient leaves the state; or

E. Recipient address is unknown and mail directed to the individual has been returned. Such cases are reinstated if the recipient is located and no other reason for discontinuance is valid. Restore the original recertification month if the reinstatement is within the certification period.

[F. A Disabled or Early Widow/Widower or Disabled Surviving Divorced Spouse becomes entitled to Medicare Part A and no other Pass Through category applies. Explore eligibility in other MA categories of assistance.]

MS 4270 PASS THROUGH INDIVIDUAL MOVING TO A NURSING FACILITY OR INSTITUTIONAL HOSPICE (1)

[When a PRO Certification or a MAP-374, Election of Hospice Benefits Form, is received for a Pass Through recipient who has entered a nursing facility (NF) or institutional Hospice:]

A. Answer "Y" to "HAS HE/SHE ENTERED a NURSING FACILTY?" on the Pass Through screen on KAMES. Enter the appropriate information on the "LL", LTC/Waiver screen. Allow the case to alternate program to the "J", "K" or "M" category. Income will be calculated per MS 3530- MS 3570. Do not change the recertification date.

B. Complete necessary forms, including form PA-16, Real Property Verification Request, and form PAFS-18, Liquid Asset Verification and Invoice for Payment. These forms may be accessed online at https://chfsnet.ky.gov/dcbs/dfs/Pages/FormsLibrary-ListView.aspx

[C. If the recipient is discharged from the NF or Institutionalized Hospice, the case must be reinstated to the Pass Through category.]

MS 4280 [PASS THROUGH INDIVIDUALS RECEIVING WAIVER OR HOSPICE SERVICES] (1)

[When a PRO Certification or form MAP-374, Election of Hospice Benefits Form, is received for a Pass Through recipient indicating receipt of waiver services or non-institutional hospice, an interim change is completed.

A. Enter the appropriate information on the “LL” LTC/Waiver screen on KAMES. The case will remain in the Pass Through category.

B. Patient liability will always be $0 for Pass-Through recipients approved for waiver services because they were otherwise eligible for Medicaid.

C. If the recipient is discharged from Waiver or Hospice, notify the recipient of vendor payment ineligibility. Do not change the program code. Continue Pass Through eligibility.

A Pro Certification is used to verify the individual has met level of care in Home and Community Based Services (HCBS) Model II Waiver, Supports for Community Living (SCL), Acquired Brain Injury Waiver (ABI), Adult Day and Consumer Directed Options (CDO).

Form MAP-374 verifies admission to Non-Institutional Hospice.

Form MAP-24C, SCL or ABI Admission, Discharge or Program Transfer, verifies changes and discharges for Supports for Community Living (SCL) and Acquired Brain Injury Waiver (ABI) recipients.]

MS 4300* INTRODUCTION

Qualified Disabled Working Individuals (QDWI) are individuals who lose RSDI benefits due to earnings, but who continue to be eligible for or eligible to enroll in Medicare. QDWI recipients are eligible ONLY for Buy-In of Medicare Part A. Medicare deductibles and co-insurance are not paid. As Buy-In is the only benefit of the QDWI program, Medicaid Identification Cards are not issued to QDWI recipients. Additionally, QDWI individuals may not receive QDWI and regular MA as a dual eligibility case, nor may QDWI eligibility exceed 48 months from the date of eligibility notification by the SSA.

MS 4310 GENERAL INFORMATION

[Take applications for Qualified Disabled Working Individuals (QDWI) individuals and process in the same manner as QMB applications using program code "Z".]

Since the QDWI recipients are working individuals, they do not meet the disabled criteria for MA eligibility. However, discontinue if a QDWI recipient chooses to be included in a case with a dependent child. Since these individuals are not entitled to dual benefits, do not include the QDWI individual in the case for any month in which they received QDWI benefits.

[QDWI recipients are not dually eligible for any other category of Medicaid. QDWI recipients approved for Spend Down lose their buy-in for the months of Spend Down coverage. Workers are to allow a medical deduction for the SMI premium for each Spend Down month, and are to advise recipients that the SMI premium for those months may be recouped by the Centers for Medicare and Medicaid Services (CMS).]

MS 4320 TECHNICAL ELIGIBILITY

A. To be eligible for QDWI, the individual must meet the following criteria:

1. Has not attained age 65;
2. Has been entitled to RSDI based on disability;
3. Has lost RSDI due to earnings exceeding the Substantial Gainful Activity (SGA) level; [See MS 3912.]
4. Continues to have a disabling physical or mental condition;
5. Has or is entitled to enroll in Medicare Part A;
6. Is not eligible for MA; and
7. Has not received QDWI benefits for more than 48 months.

B. The SSA sends notice to the individual at the time RSDI entitlement ends advising them of QDWI.

1. The individual has seven months in which to enroll in Medicare Part A if Medicare has been terminated.
2. After that period of time, the individual may enroll for Medicare Part A only during the general enrollment period, January, February and March of each year.
3. The SSA notification letter may be used to verify that the individual meets QDWI requirements. Otherwise, verification must be obtained from SSA.

C. All other technical eligibility requirements for Aged, Blind, or Disabled MA, except Third Party Liability, must be met.

MS 4330 FINANCIAL ELIGIBILITY for QDWI (1)

The resources of a Qualified Disabled Working Individual (QDWI) are considered the same as for a Qualified Medicare Beneficiaries (QMB) individual with the exception that the prior 3 months resources must be verified to receive retroactive coverage.

Resource Limits:

Family Size	Resource Limit
1	$4,000
2	$6,000

Consideration of income for a QDWI individual is the same as consideration for a QMB individual with the exception that the QDWI Scale is used.

Compare total countable income to the following QDWI Income Scale.

[200% Poverty Level MA Scale (effective 3/1/16)

Family Size	Income Limit
1	$1,980
2	$2,670]

If countable income is equal to or less than the appropriate QDWI Scale, income eligibility is met.

MS 4340*

QDWI EFFECTIVE DATES

Effective date of eligibility can be retroactive to 3 months prior to month of application, if all eligibility criteria were met during the 3 month period. QDWI eligibility cannot exceed 48 months.

MS 4350 INTERIMS/RECERTIFICATIONS

[Complete interims/recertifications for QDWI individuals in the same manner as interims/recertification for QMB individuals per MS 4530.]

Benefits for QDWI individuals end when:

A. A disabling condition no longer exist;
B. Recipient requests voluntary termination of coverage;
C. Recipient becomes eligible for Medicare under some other provision, i.e., premium-free Medicare; or
D. 48 months of eligibility have expired. Spot check the case for the expiration of the 48 month period of eligibility.

MS 4390 MEDICARE PART D

Medicare Part D is the prescription drug plan offered to individuals receiving Medicare A and B. There are multiple companies who offer Part D plans, at various costs and benefit levels. Low income individuals can apply for "Extra Help" with the cost of this plan through Low Income Subsidy (LIS). LIS is a federal payment that is equal to the average cost of a basic Part D plan in each state and is adjusted annually according to premium cost. If a person receiving LIS enrolls in a Medicare Part D plan which has a premium higher than the LIS payment, the beneficiary is responsible for paying the difference in the premium. Individuals who receive any form of Medicaid, including Medicare Saving Plan (QMB, SLMB and QI1) automatically meet the criteria for LIS.

The Social Security Administration's (SSA) definition of dual eligibility is an individual who receives Medicare Part A and/or Part B and some form of Medicaid benefit at the same time. Partial duals are those receiving cost sharing assistance under Medicare Savings Program (QMB, SLMB or QI1). Full dual eligibility is and individual that receives Medicaid. Individuals that receive either dual or partial dual eligibility are deemed as qualified for LIS. Qualified individuals who are not already enrolled in a Part D plan are automatically enrolled with LIS for the full calendar year. Dual eligibility includes the receipt of Medicaid by way of spend down Medicaid coverage. Even if the spend down card is received for only one month, the receipt of Medicaid for that one month qualifies the individual for LIS benefits through the end of the calendar year, which exempts recipients from the "Donut Hole" for the remainder of the current calendar year.

> Note: The "Donut Hole" is as follows; once the total retail cost of covered medications reaches the allowed amount for that calendar year, the participants enter a coverage gap and are responsible for their prescription costs until they meet the obligated amount for that calendar year. This period is referred to as the "Donut Hole". Once an individual passes the "Donut Hole" period, they enter into the last phase of the Medicare Part D program. During this phase Medicare Part D will pay at a higher amount than before the coverage gap.

Individuals who receive Medicaid for nursing facility stays are qualified for Medicare Part D and therefore, automatically eligible to receive LIS and will be auto enrolled if they have not opted out of Medicare Part D. Once enrolled in a Part D plan, these individuals do not have co-pays and do not have a "Donut Hole" period. If the individual has a Part D plan upon entering the nursing facility, their Part D provider is notified of the change in their status automatically qualifying them for LIS. This change in status could take several months and until the change is completed the incurred co-pays and premiums are to be used as a medical deduction in calculating patient liability. Field staff must spot check case to verify and remove these deductions after two months of continuous stay in the nursing facility. If the individual selected a plan with a higher premium than the LIS payment, the difference can be given as a medical

deduction through the end of the calendar year. Note: Individuals receiving Medicaid for HCBS waiver services will continue to be responsible for co-pays.

Full benefit dual eligible for LIS may opted out of or affirmatively decline auto enrollment into a Part D plan. The primary method for doing so is by calling 1-800-MEDICARE, but they can also call the provider of the Part D plan which they have been assigned. If the member has opted out of Medicare Part D, Medicaid will not pay for the individual's prescriptions and the prescription expense cannot be given as a deduction to reduce patient liability. However, the current cost of the prescriptions or the amount of those still owed can be used to reduce the individual's portion of liability for a spend down case. Individuals who opt out do not permanently surrender their eligibility for enrollment in a Part D plan. Those eligible for LIS can re-enroll at any time, they are not limited to open enrollment.

MS 4395 APPLICATION FOR MEDICARE SAVINGS PROGRAM THROUGH LOW INCOME SUBSIDY (LIS) (1)

Applications received by the Social Security Administration (SSA) for LIS are treated as an application for Medicare Savings Programs at the individual's request. These are the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI1). When an individual applies for LIS, to assist with the cost of their Medicare Part D prescription drug coverage with SSA, the information contained on that application will be received electronically and is used as an application for QMB, SLMB and QI1 as appropriate.

[A face-to-face interview is not required as the SSA referral is considered to be a signed application.**]**

LIS applications are processed on KAMES by staff in the Division of Family Support (DFS) located in Central Office. All appropriate documentation is scanned into the Electronic Case File (ECF). Once an LIS application is approved, it is transferred to the appropriate county supervisor or principal worker's code. The local DCBS office staff is responsible for maintaining the case.

The information from the LIS referral is loaded to KAMES inquiry and a new Daily Case Status Report (DCSR) screen listing the LIS referrals displays for designated staff. Referrals will remain on the designated staff DCSR until they are completed.

Before entering the application on KAMES, complete an inquiry of KAMES and SDX to make sure that the individual does not have or is a member of an active case. If an active case is found, review the case to make sure that all Medicare information is listed and deduction of any premiums is being given if appropriate.

The worker completes any changes needed on KAMES. For applicants who are active SSI recipients with C01 payment status code on SDX, the referral is to be deleted.

When an application is entered on KAMES, the referral is removed from the worker's DCSR. If a completed referral remains on the worker's DCSR or the individual already has an active case, the referral can be deleted by a supervisor.

The delete function is located on the KAMES Daily Case Status Maintenance Menu field "M". Note: Make a screen print of the referral before deleting. This will allow the referral to be entered if a referral is incorrectly deleted.

SSA has advised that Railroad Retirement Benefits (RRB), Veterans and Government pensions listed on the application, and RSDI income for a single individual have been verified. RSDI for a couple and earned income must be verified by contacting the applicant.

The worker will need to request verification of income if not found through system match along with resources listed on the application. SSA does not consider life insurance as a resource. Therefore, field staff will need to add a request on the RFI for verification of life insurance such as a copy of life insurance policies. Workers are to allow 30 days for return of information.

Note: LIS applications that have RSDI benefits, RRB, Veterans and/or Government pension income that is higher than the income limit for the Medicare Savings Program can be denied without verifying the income or resources with the applicant. Private pensions or other income will need to be verified before an application can be denied.

Accessing LIS Referral and processing application:

1. The worker accesses the LIS referral information from the KAMES inquiry screen by selecting “R” and entering the Social Security number (SSN);

2. Print referral;

3. Enter the application on KAMES within 10 days of the date of the referral;

4. Pend the application for needed information by the applicant;

5. Send a Request for Information (RFI) to the applicant;

6. Once the requested information is received, process the “Z” application.

7. If the requested information is not received within the 30 day timeframe, allow the application to deny.

MS 4400 MEDICARE SAVINGS PROGRAM OVERVIEW

Medicare Savings Programs can assist individuals/couples in paying for their Medicare Premiums. Medicare Savings Programs include: Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Medicare Qualified Individuals Group 1 (QI1). QMB, SLMB and QI1 individuals must meet all technical eligibility requirements for Aged, Blind or Disabled MA.

Individuals may receive benefits in the QMB or SLMB categories in addition to regular MA benefits in another category. This is dual eligibility. However, QI1 recipients are not dually eligible for any category of Medicaid.

A. QMB

QMB recipients are eligible for limited MA and for Buy-In. Coverage for QMB individuals provides for payment of Medicare Part A and Medicare Part B premiums, Medicare deductibles, and Medicare coinsurance amounts. Due to payment of coinsurance amounts, QMB coverage is extended to all Medicare services or items outside the scope of MA coverage except:

1. Limit coverage for individuals eligible only for QMB to the above. Other MA covered services such as prescription drugs and medical transportation are not covered.

2. QMB does not cover Medicare deductibles and coinsurance for individuals age 21, or age 22 if uninterrupted treatment began prior to age 21, through 64 in a psychiatric hospital.

B. SLMB

For individuals whose countable income is in excess of the QMB standard, determine eligibility for SLMB. SLMB recipients meet all of the technical requirements for QMB benefits, except for having income in excess of the QMB standard but less than or equal to the SLMB scale maximum limit. Coverage for SLMB individuals provides for payment of the Medicare Part B premium only and may be effective three months prior to the SLMB application month. SLMB eligibility cannot be met through spend down.

C. QI1

Individuals who receive Medicare Parts A and B can be eligible for payment of the buy-in for their Part B payment (QI1). Individuals ineligible for SLMB must be evaluated to see if eligibility for QI1 exists. Because the QI1 program has limited annual funding, applications can only be approved until funds are exhausted. DMS will advise when funding has been exhausted.

D. KYHealth cards are ONLY issued for recipients receiving QMB. SLMB or QI1 recipients do not receive a KYHealth card.

E. For services requiring co-payments refer to MS 1060.

MS 4420 * MAIL-IN APPLICATIONS FOR MEDICARE SAVINGS PROGRAM

A face-to-face interview is not required of individuals applying for the Medicare Savings Program which includes the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI1). Applicants may complete form MAP-205, Application for Medicare Savings Program, a mail-in application for those applying in the "Z" category.

NOTE: A face-to-face interview is still completed at the request of any individual who makes application.

Processing the Mail-In Application

A. Form MAP-205 instructs individuals to return the completed form, along with verification, to their local DCBS office. The applicant may return the form by mail, fax, or in person.

   1. The mail-in application is date stamped the day it is received in the local office. It is then assigned to the appropriate worker for processing.

   2. The date the mail-in application is received in the local office is the date of application. The application must be entered on KAMES within 3 days of the stamped date of receipt.

   NOTE: QMB coverage is effective the month after the month of approval and retroactive coverage cannot be issued; therefore it is very important to adhere to the 3-day timeframe and to give QMB eligibility determinations priority.

B. If an application is received unsigned by the applicant, enter the application on KAMES and answer "Y" to the question "Is this a phone interview?" KAMES will generate a request for information (RFI) requiring the return of a signed application. Mail the KAMES generated application to the individual for signature. A case cannot be approved without a signed application. Document thoroughly in case comments.

C. If an application is received with incomplete verification, generate a RFI and send it to the applicant. The applicant has 30 days from the date the application was received to return the requested information before the application is denied.

D. If form MAP-205 is received for an individual who is active in a QMB, SLMB, or QI1 case, review the form for possible changes in address, income, resources, etc. and send form MA-105, Eligibility Notice, advising the individual that no application is needed as he/she is currently active in a Medicare Savings Program case.

MS 4430 TECHNICAL ELIGIBILITY FOR MEDICARE SAVINGS PROGRAM

The individual must meet all technical eligibility requirements for Aged, Blind, or Disabled MA, except Third Party Liability. The QMB individual must receive Medicare Part A. SLMB and QI1 individuals must receive both Medicare Part A and B. Receipt of Medicare may be verified by: making a copy of the Medicare card, written verification from SSA, or by viewing IMS Bendex file, Program 39. Document in case comments how Medicare receipt was verified.

A. Technical Eligibility for QMB:

Individuals applying for QMB must receive Medicare Part A. Open enrollment for Medicare Part A is January - March of each year. Individuals may enroll in Medicare Part A during the annual open enrollment period.

1. Annual Open Enrollment Period

   a. Individuals who do enroll in Medicare Part A during the annual open enrollment period do not become eligible for receipt of Part A until July. If these individuals request QMB benefits prior to becoming eligible for Medicare Part A, complete an Inquiry/Update PA-97, on KAMES. Specify on the KAMES PA-97 that the applicant has been advised to return to the local office in May or June to make application to determine QMB eligibility. Process the QMB application no later than the end of June to coincide with the first month of Medicare Part A receipt in July.
   b. Individuals who miss the open enrollment period in the current year cannot enroll in Medicare Part A until the open enrollment period in the following year.

2. Conditional Enrollment

   Some individuals enroll in Medicare Part A with the condition that they are eligible for QMB benefits so that the incurred premium will be paid under the QMB program. These individuals still must meet all technical and financial eligibility requirements for the QMB program. SSA provides the names of conditional enrollees to the Agency and verifies eligibility for and the effective date of Medicare Part A.

   a. Send appointment letters to each individual to schedule a QMB application appointment.
   b. Schedule the appointment in a timely manner to allow the QMB application to be processed with a QMB effective date to coincide with the Medicare Part A effective date.

c. Appointment letters for individuals who fail to keep a scheduled appointment are to be kept in a designated local office file for a period of 1 year.
d. As these individuals do not have Medicare cards, document the case record regarding conditional enrollment and verification of Medicare Part A eligibility by SSA.

B. Technical Eligibility for SLMB and QI1:

SLMB and QI1 individuals must receive both Medicare Part A and B. These individuals only receive buy-in for their Part B Medicare premium. SLMB and QI1 individuals do not receive limited MA for Medicare co-pays and deductibles.

MS 4450 RESOURCE LIMITS FOR MEDICARE SAVINGS PROGRAM (1)

Use the regular Age, Blind or Disabled MA policy for relative responsibility, resource verification and consideration to determine resource eligibility.

[A. Total countable resources for QMB, SLMB and QI1 are compared to the following limits:

- Individual $7,280
- Couple $10,930]

B. The following exceptions apply to QMB, SLMB and QI1 when determining resource eligibility:

1. Resources of a child are not considered in determining eligibility of a parent.

2. Resources of a married couple is compared to a couple resource limit whether the spouse is eligible or not.

3. Resources of an ineligible spouse are counted even if their income is not being counted.

C. Dual Eligibility (QMB or SLMB and regular MA benefits in another category)

For individuals dually eligible for QMB, SLMB and waiver services, SCL, or non-institutionalized Hospice, consider spousal resources following the first month after election to waiver services, SCL, or non-institutionalized Hospice for the QMB or SLMB eligibility determination.

NOTE: There is no dual eligibility for QI1 recipients.

D. Resource requirements for retroactive eligibility

1. QMB – Retroactive coverage for QMB recipients does not exist, therefore verification of resources for 3 months prior to the application month IS NOT required.

2. SLMB – Individuals eligible for SLMB may be eligible for retroactive coverage. Verification of resources for 3 months prior to the application month IS required for consideration of retroactive coverage.

3. QI1 – Individuals eligible for QI1 may be eligible for retroactive coverage. Verification of resources for 3 months prior to the application month IS required for consideration of retroactive coverage.

MS 4455 INCOME LIMITS FOR MEDICARE SAVINGS PLAN (1)

Compare total countable income to the appropriate income scale to determine Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Medicare Qualified Individuals Group 1 (QI1) eligibility. QMB/SLMB/QI1 eligibility cannot be met through spend down.

[A. The QMB income limit is equal to the 100% Federal Poverty Level (FPL) MA Scale for 2016.

Family Size	Limit
1	$ 990
2	$1,335

If countable income is equal to or less than the appropriate QMB Scale, income eligibility is met.

B. The SLMB income limit is equal to the 120% FPL MA Scale for 2016.

Family Size	Minimum Limit	Maximum Limit
1	$991	$1,188
2	$1,336	$1,602

If countable income is equal to or greater than the minimum limit, and equal to or less than the maximum limit, income eligibility is met. If countable income is less than the minimum limit, explore potential QMB eligibility. If countable income exceeds the maximum limit, explore potential QI1 eligibility.

C. The income limit for QI1 is equal to the 135% FPL MA Scale for 2016.

Family Size	Minimum Limit	Maximum Limit
1	$1,189	$1,337
2	$1,603	$1,802]

MS 4460 MEDICARE SAVINGS PROGRAM INCOME (1)

For an individual or a married couple living together or apart, use regular Aged, Blind or Disabled MA policy for relative responsibility, income verification and consideration to determine financial eligibility for Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), or Medicare Qualified Individuals Group 1 (QI1) with the following exceptions.

For each of the following situations, use the maximum income limit from the appropriate QMB, SLMB, or QI1 income scale for a married couple:

A. If there is an ineligible spouse and dependent children:

1. The spouse's gross income can be allocated to each child to reduce the countable income of the ineligible spouse. The allocation is equal to ½ of the QMB, SLMB or QI1 income scale for each child.

   [Example 1: A household consists of a Medicare recipient receiving unearned income of $936.90 RSDI; her ineligible spouse receives RSDI of $850 and 2 dependent children. Use the current QMB income standard for an individual. Allocate ½ of the standard to each child of $490.50 for a total of $981 subtracted from ineligible spouse's income leaving $0 income considered to the Medicare recipient. Client would be eligible for QMB.**]**

   Note: Do not allocate income from the ineligible spouse to any child whose countable income exceeds ½ the appropriate maximum income limit for one. Using the example above, if one of the children had income over ½ of the QMB standard then none of the ineligible spouse's income would be allocated to that child.

   [Example 2: A household consists of the same members as example 1, except that the one child receives child support of $300 monthly. In that situation this child would be allocated $190.50 ($490.50 - $300) and the other child would be allocated $490.50. Add $190.50 + $490.50 = $681. Subtract $681 from $850 for a countable amount of $169 for the ineligible spouse.**]**

2. Compare the ineligible spouse's remaining income to the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two.

   [Example: Using example 2 above, add the allocation deemed to the children for a total of $681. Subtract the result from the ineligible spouse's income; $850- $681 = $169. Compare the remainder to the difference between the QMB standard for an individual of $981 and the QMB standard for a couple of $1328 for a difference of $347.**]**

   a. If the result is **equal to or less than** the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two, DO NOT consider any of the ineligible spouse's income to the QMB/SLMB/QI1 individual; or

b. If the result is **greater than** the difference between the appropriate maximum income limit for one and the appropriate maximum limit for two, consider the remaining amount available to the QMB/SLMB/QI1 individual.

Note: In the example above the income of the ineligible spouse would not be considered towards the Medicare recipient.

3. If the income is over the limit for a QMB couple, the same calculations to reduce the ineligible spouse's income are applied by using the SLMB income scales.

Note: Using the SLMB scales may reduce the countable income to within the QMB income limit, however, SLMB is approved rather than QMB as the SLMB disregard was used to get to the net income. The same applies for QI1.

B. If there is an ineligible spouse and no dependent children:

1. Compare the ineligible spouse's gross income to the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two;

a. If the ineligible spouse's gross income is **equal to or less than** the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two, DO NOT consider any of the ineligible spouse's gross income to the QMB/SLMB/QI1 individual; or

b. If the ineligible spouse's gross income is **greater than** the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two, consider the gross income as being available to the QMB/SLMB/QI1 individual.

2. The countable income of the QMB/SLMB/QI1 individual is compared to the appropriate maximum limit for two, even if there is deemed spousal income.

C. For individuals dually eligible for QMB/SLMB and SCL, waiver services, State Supplementation, Pass Through or non-institutional Hospice, who have a spouse living in the home:

1. Continue to consider the eligible spouse's income. Compare the countable income to the appropriate scale for a couple.

2. Continue to consider the ineligible spouse's income if greater than the difference between the appropriate maximum income limit for one to the appropriate maximum income limit for two. Compare the countable income to the appropriate income scale for a couple.

[Example: The ineligible spouse's income is $300 monthly. The difference between the QMB maximum for one of $981 subtracted

from the maximum for two of $1328 equals $347. Compare the gross income of the ineligible spouse of $300 to the difference of $347. If less than the difference, then none of the ineligible spouse's income is considered towards dual eligibility for individual.**]**

If greater than the difference, consider this income during the month of election as well as the months after election to SCL, waiver services, State Supplementation, Pass Through or non-institutional Hospice for the QMB/SLMB eligibility determination.

Although KAMES does not consider the ineligible spouse's income available for purposes of waiver vendor payments after 30 days separation, it does count the income of the ineligible spouse when determining dual eligibility.

MS 4470 Medicare Savings Program Deductions

To determine the countable income to be compared to the minimum and/or maximum QMB/SLMB/QI1 limits:

A. Deduct the $20 general exclusion:

1. From the unearned income;

2. Deduct the balance, if any, from the earned income; and

3. If spousal income is considered, apply the exclusion to the combined unearned and earned income of the QMB/SLMB/QI1 individual and spouse.

B. Deduct $65 and 1/2 the remainder:

1. From earned income;

Note: If spousal income is considered, combine the earned income of the QMB, SLMB or QI1 individual and spouse and allow only one $65 and 1/2 the remainder deduction; and

2. Allow other work related deductions, if appropriate.

MS 4500 MEDICARE SAVINGS PROGRAM CASE ACTIONS (1)

[Applications for QMB, SLMB and QI1 benefits are entered on KAMES using program code "Z". A face-to-face interview is not required as applicants may complete the mail-in application form MAP-205, Application for Medicare Savings Program. Telephone interviews for applications/reapplications are permitted; However, a face-to-face interview is completed if the applicant prefers. Individuals applying for QMB, SLMB or QI1 are allowed 30 days to return information before the application denies. Cases with dual eligibility are maintained in a single case record.**]**

Note: SSI recipients with Medicare Part A are automatically converted to dual eligibility by SDX. QMB eligibility is designated by a "QMB on/off date" on the SDX file. Neither an application nor accrete is necessary for SSI recipients.

A. Approvals/Denials

When approving a QMB, SLMB or QI1 individual with a companion SNAP case, a spot check is generated to the SNAP case worker to determine if QMB, SLMB or QI1 eligibility affects the amount of medical deductions currently allowed in the SNAP case.

1. Retroactive Eligibility:

a. QMB – Coverage cannot be issued retroactively or met through spend down. Therefore, give QMB eligibility determinations priority. For dual applications, QMB eligibility should be approved prior to the ongoing or spend down MA eligibility determination.
b. SLMB – For determination of retroactive eligibility, enter the earliest SMI premium on the medical expense screen. KAMES determines the SLMB eligibility date based on the date the SMI expense is incurred, if all eligibility requirements are met.
c. QI1 - Retroactive benefits are only available for the federal fiscal year (October 1st through September 30th) of application for QI1 cases. If someone applies in November, retroactive benefits can only go back to October 1st.

2. Ex-Parte:

For individuals that ex-parte from SDX to the KAMES database, enter an application on KAMES. Applications can be approved at any time, however if approved in the first month of ex-parte, the individual will lose regular MA eligibility for the second month of ex-parte. When an application is taken in the first month of ex-parte, pend the application until benefits are issued for the 2nd month.

B. Recertifications

Recertify QMB, SLMB and QI1 cases annually. Recertifications are processed using the automated forms KIP-2Q, Renewal Form for the

Medicare Savings Program, and KIP-2QA, Renewal Form for the Medicare Savings Program – Final Notice. Do not require a face-to-face interview. Recertification interviews cannot be scheduled for Medicare Savings Program cases. For regular MA cases with dual eligibility only, re-determine QMB or SLMB eligibility once a year. If the MA case becomes ineligible when completing a recertification or interim change, determine ongoing QMB or SLMB eligibility. Dual eligibility does NOT exist for QI1.

Note: The certification period ends for QI1 cases on September 30 of each year. All QI1 cases must be recertified each September to receive ongoing benefits for the coming year.

MAIL-IN RECERTIFICATION PROCEDURES

1. "Z" cases coming due for recertification are identified on the coming due list with the message "Mail-In Recert Due". Because Federal regulations prohibit the requirement of a face-to-face interview for recertification of Medicare Savings Program cases, workers do not have the option of scheduling these recertifications on KAMES.

2. Form KIP-2Q is generated on the 9th of the month prior to the recertification month. If the 9th falls on a weekend or holiday, the form is generated on the last workday prior to the 9th of the month.

3. The completed form KIP-2Q is due in the local office the last workday of the month prior to the renewal month (e.g., the form due date for February renewals is January 31st).

4. Form KIP-2Q's due date is used to encourage recipients to return forms prior to the 5th workday of the recertification month, when a second notice is system generated.

   a. Enter all forms KIP-2Q on KAMES that are received prior to close of business on the 5th workday of the recertification month, even if all mandatory verification is not provided with the form.

      Note: If the KIP-2Q is returned timely, to keep KAMES from incorrectly generating a KIP-2QA, the KIP-2Q must be entered on KAMES by the close of business on the 5th workday of the recertification month.

   b. If mandatory verification is not provided with form KIP-2Q, allow the case to pend for request of information. If the mandatory information is returned after the due date but prior to the last day of the month, enter the application on KAMES and answer "Y" to the question, "Is this a reinstatement?".

   c. If form KIP-2Q is received completed with all mandatory verification, the recertification can be entered and processed after cut-off in the month prior to the recertification month and KAMES will assign the correct recertification dates.

5. If the recipient fails to return form KIP-2Q by close of business on the 5th workday of the month, form KIP-2QA is generated to the recipient the next workday and allows the recipient 10 calendar days to return the form. Form KIP-2QA provides timely notice of negative action for failure to recertify benefits. The form notifies recipients that they must complete the form and provide all required verification within 10

calendar days from the date form KIP-2Q was sent or medical benefits will be discontinued. If the 10th calendar day falls on a weekend or holiday, the due date will be the next workday. The due date is printed on the form.

Example: Form KIP-2Q is not returned by close of business on Friday, July 5th. Form KIP-2QA is generated the night of July 5th and dated July 5th. The form is not returned by close of business on Monday, July 15th. The case is discontinued effective August 1st.

6. If form KIP-2QA is received after the 15th, but before the close of business on the last day of the month, the recertification is entered on KAMES whether complete or incomplete. If complete, process the recertification. If incomplete, the recertification is entered on KAMES and the case is pended for mandatory verification.

   NOTE: If the worker receives the recertification form by cutoff but fails to enter it on KAMES, the case will incorrectly discontinue. An incorrect case discontinuance can create a hardship for the recipient. If the case is reinstated, there may be a delay in reinstating the buy-in process.

7. A system discontinuance reason code 705 is displayed on KAMES case inquiry for cases discontinued for failing to return the mail-in renewal form.

C. Interim Changes

QMB, SLMB, and QI1 interim changes are processed according to regular MA policy.

D. Spend Down

1. QMB and SLMB:

If QMB or SLMB recipients subsequently apply for a Spend Down in the “J”, “K” or “M” category:

a. Manually calculate the Spend Down amount.
b. Process through special circumstance on KAMES. Use recipient status code “HH” for QMB and “S2” for SLMB to prevent interruption or discontinuance of the QMB or SLMB benefits. For detailed Spend Down procedures, see MS 2740.
c. QMB or SLMB eligibility can be determined prior to spend down eligibility.
   1) QMB – Do not consider Medicare premiums for Part A or Part B, Medicare hospital or physician deductibles, or any Medicare coinsurance amounts paid by QMB benefits to obligate the quarterly excess.
   2) SLMB - Do not consider the Medicare SMI premium for Part B to obligate the quarterly excess.

2. QI1:

QI1 recipients approved for Spend Down lose their buy-in for the months of Spend Down coverage. Allow a medical deduction for the SMI premium for

each Spend Down month, and advise recipients that the SMI premium for those months will be recouped by the Centers for Medicare and Medicaid Services (CMS) as there is no dual eligibility for QI1.

For current quarter Spend Down, discontinue the QI1 case and complete the Spend Down application on KAMES. Once the Spend Down period has expired, reenter the QI1 case on KAMES.

For any month in the prior quarter Spend Down, issue the Spend Down by special circumstance.

MS 4515 QMB, SLMB, or QI1 EFFECTIVE DATE

The effective date for QMB is based on the date of approval. The effective date of SLMB and QI1 is based on the date of application.

A. QMB:

For QMB the effective date is the first day of the month after the month of approval. There is no retroactive coverage for QMB.

Note: For SSI individuals automatically eligible for QMB benefits, the QMB effective date is the month after the system takes action.

B. SLMB:

SLMB is effective the month of application. SLMB can be retroactive to 3 months prior to month of application, if all eligibility criteria are met.

C. QI1:

QI1 is effective the month of application. QI1 retroactive benefits are only available for the federal fiscal year (October 1st through September 30th) of application for QI1 cases. If someone applies in November, retroactive benefits can only go back to October 1st.

Note: For KAMES to issue SLMB/QI1 retro coverage, the SMI premium must be entered as a medical expense for the requested retro months.

MS 4525 ACCRETES, DELETES, AND RESTORATIONS

Buy-In is the purchase of Medicare coverage by the Department for Medicaid Services (DMS) for all eligible individuals. There is a 120-day processing period for cases approved for Buy-In as the transmittal of information passes from KAMES to DMS then to the Centers for Medicare and Medicaid Services (CMS). CMS forwards the approval to Social Security Administration (SSA) and DMS, and then to the recipient.

During the 120-day processing period CMS passes the information on to SSA to no longer deduct the SMI premium from the individual's SSA benefits and issue reimbursement, if necessary. If no changes have occurred to the recipient's SSA entitlements after 120 days, this may indicate a possible absence or break in the transmittal of information. If this occurs, the local office responds to the recipient's inquiries by completing and forwarding form PA-1Q, Sup. A, Buy-In Accrete/Delete/Restoration Request, to the Medical Support and Benefits Branch (MSBB).

A. The worker indicates on form PA-1Q, Sup A. whether the request is for an accrete, a delete or a restoration.

1. Accretes:

   Accretion is when buy-in eligibility is added to Medicaid's system (MMIS). A request for an accrete indicates that the SMI premium continues to be deducted from the beneficiary's entitlement.

   a. The 1st accrete request should be submitted <u>only</u> once 120 days have elapsed from date of approval.
   b. Once Medicaid has added eligibility for Buy-In based on the first request, a period of at least another 120 days must pass before another accrete request is submitted.

2. Deletes:

   A delete is a request to terminate Buy-In eligibility. This request indicates that the purchase of SMI coverage by Medicaid continues to exist when the recipient is no longer eligible for Buy-In benefits. This may occur when:

   a. An individual no longer meets income eligibility; or
   b. An individual requests that their case be discontinued.

3. Restorations:

   Restorations are requests for months of eligibility that were not issued and are the result of administrative errors. This may occur:

   a. If an application approval is completed untimely causing eligibility to be effective in a proceeding month; or

b. If retroactive coverage for prior months is not completed for SLMB or QI1 cases.

B. Before sending a Buy-In request for an accrete, delete or restoration, check case for accuracy. Review the case record and KAMES to check for the following discrepancies:

1. Has it been 120 days since the case was approved or since the last request was sent?

   a. If it has been 120 days, review and check the material for discrepancies before forwarding the request.
   b. If it has not been 120 days, do not forward the request.

2. If dually eligible, is the case status correct?

   a. If correct, annotate effective date of eligibility on request.
   b. If incorrect, make the necessary corrections.

3. Is the Medicare claim number correct? The Medicare card can be used if recently received but if not, the number needs to be verified through Social Security. There are many circumstances that can change an individual's Medicare account.

   a. If correct, include a copy of the Medicare card with the request.
   b. If incorrect, make the necessary corrections.

4. Are the Medicare questions answered correctly in the case record and on the system?

   a. If the questions are found to be answered correctly, forward the appropriate request to MSBB.
   b. If the questions are incorrectly answered, make the necessary changes to correct the information and then forward the appropriate requests to MSBB.

C. Once reviewed for discrepancies, if no corrections are required, submit a request by using the form PA-1Q, Supp. A, Buy-In Accrete/Delete/Restoration Request. A copy of the recipient's <u>current</u> Medicare card must be attached to the request form before forwarding to MSBB. All requests are to be submitted and tracked by the Regional MA Program Specialist. If discrepancies are found and corrections are made to the case, staff is to wait 120 days from the date correction is made before forwarding a request.

MS 4535 **[**EXPARTE WITH MEDICARE SAVINGS PLAN (1)

Supplemental Security Income (SSI) cases carry over their dual eligibility for buy-in and/or Long Term Care (LTC) coverage during periods when SSI cases are exparte/extended managed care. Unnecessary interruption of buy-in and/or LTC eligibility creates difficulties for recipients, possible insurance coverage delays, and additional work for field staff. Buy-in and/or LTC coverage without interruption provides a streamlined process for the benefit of the recipient, medical provider and caseworker. When an SSI recipient receiving Money Follows the Person (MFP) goes to exparte, refer to MS 4770 on how to continue Medicaid coverage.**]**

A. Individuals Discontinued from Receipt of SSI:

Exparte is an additional two months of Medicaid coverage after SSI benefits end. An SSI recipient can be exparte if payment status codes on SDX are NO1, EO1, NO4, N10 or N11.

Exparte cases with no LTC coverage are uploaded to a database on KAMES as active, for continuation of MA and buy-in benefits.

For those receiving LTC SSI on KAMES as an A, B, or D case, exparte on KAMES continues LTC coverage for the 2 months of exparte.

For additional information and instruction on issuance of a replacement card during this time period refer to MS 4770.

B. Non LTC SSI individuals who qualify for exparte receive notice KIP-10-SSI.2, Discontinuance Notice, which instructs them to contact the local DCBS office to apply for Medicaid benefits. These individuals' exparte benefits post to a database on KAMES that can be inquired under option H on screen HRKIMU53, KAMES inquiry screen.

1. The notice, KIP-10-SSI.2, advises the individual that due to the discontinuance of SSI, a redetermination of MA eligibility is necessary and additional information is required to complete the redetermination.

   a. The individual/representative has 20 calendar days from the date listed on form KIP-10.SSI.2 to contact the local office.
   b. An appointment interview is scheduled for a day in the second month of exparte after contact is made with the local office.
   c. At the appointment interview, explore all categories of assistance, with special attention addressed to Pass Through, QMB, SLMB, and QI1.

Note: Even though KAMES allows an application taken in the first month of exparte, if approved or denied in the first month of ex-parte the individual loses regular MA eligibility for the second month of exparte. For this reason, these applications are always entered in the second month.

2. Workers can access a listing of exparte cases on report HRKIPJ5Q, NEW EX-PARTE/ EXTENDED MANAGED CARE CASES, available on RDS.

C. SSI individuals who exparte while receiving LTC in a KAMES case are posted to the worker's DCSR to schedule an appointment. The appointment is scheduled for a day in the second month of exparte eligibility. These individuals receive an appointment notice, KIP-2EX, advising them of their scheduled appointment due to their SSI discontinuing. A listing of SSI LTC cases is available on the RDS report HRKRPR1E, EX-PARTE/EXT. MANAGED CARE REPORT.

Note: If an application is entered on an active LTC exparte case in the first month, KAMES completes a name match showing an active case and the application is denied. For this reason, these applications are always entered on KAMES in the second month.

D. For SSI individuals that have exparte review for Pass Through eligibility first. If not eligible, enter the new application on KAMES as a J, K, M or Z, whichever is appropriate based on the individual's circumstances.

MS 4650 DUPLICATE APPLICATIONS

An application for SSI pending with the SSA is also an application for Aged, Blind, or Disabled MA. Deny any duplicate application for Aged, Blind, or Disabled MA made with DCBS.

MS 4655 ENTITLEMENT

Entitlement to SSI and the amount of payment made are determined by the SSA, following application made at the Social Security Office serving the county in which the applicant lives. Application may also be made by telephone.

Individuals eligible for but not receiving SSI benefits are not eligible to receive MA in the Aged, Blind, or Disabled category.

A. These individuals must apply for and receive SSI benefits in order to receive MA.

   1. If the individual applies, accept and deny the application.

   2. If the individual or interested party chooses not to apply for MA, complete form PA-97, Add/Inquiry, Option I on KAMES Main Menu, and form PAFS-5.1, Report of Referral to the District Social Security Office.

   3. Do not discourage or refuse an MA application.

   4. Process all applications for State Supplementation as emergencies.

B. Obtain a determination of disability through the MRT, for any individual who applies for State Supplementation as a disabled adult and whose income and resources are within the SSI standards.

   1. Prior to approval, verify that application for SSI has been filed.

   2. Process the application once the MRT disability determination has been made.

   3. Do not wait for the SSI determination.

   4. Spot-check for the SSI determination and for possible changes in income.

[Note: Children applying in the M or K category are not required to apply for SSI if parental income is above the 150% federal poverty level (FPL). An MRT will need to be completed. Furthermore, a child must not be denied Medicaid if a parent refuses to apply for SSI for the child. For either of these situations, workers should answer “Y” to the question, “IS CLIENT INELIGBLE FOR SSI DUE TO A FINANCIAL OR TECHNICAL REASON?” on the KAMES IM disposition screen and document thoroughly in comments.**]**

MS 4662 MA ELIGIBILITY FOR DECEASED APPLICANTS

The Department for Community Based Services (DCBS) is responsible for determining MA eligibility for an individual, without a spouse or parent in the household, who dies during the application or appeal phase of an SSI request, prior to a determination being made. Application can be made by any individual on behalf of the deceased individual. The application date is the date the SSI application was filed. Take an application and send a completed PA-601T, Referral for Determination of Incapacity or Disability, and signed/witnessed MRT-15 (with a revision date of 5/01 or after) forms, Authorization for Information/Release of Information, to MRT for determination of disability. File any hearings on these actions through the local office. The MRT-15 may be signed by the next of kin, such as a spouse, child, sibling or parent. [If there is no next of kin, the individual's attorney, executor of the estate or other authorized representative may sign the form.] See also Volume IVA, MS 1374.

MS 4670 SSI FINANCIAL STANDARDS (1)

SSI income and resource policies are more restrictive than Medicaid policy. If an individual, who was denied MA or completed PA-97 inquiry due to potential SSI eligibility, is denied SSI for a financial reason and reapplies for MA within 60 days of the SSI denial date, use the date of the original MA application or form PA-97 as the application date.

For individuals who wish to apply for Aged, Blind, or Disabled MA, determine if countable income and resources are within SSI standards as follows:

A. Determine countable income according to MS 1770 through MS 1820.

1. Compare countable income to the SSI income standards.

2. SSI income standards are:

SSI ONLY	**[**Individual	$733
	Couple	$1,100 (Effective 1/1/15)**]**

B. Determine countable resources according to MS 1770 through MS 1820 and MS 1850 through MS 2030.

1. An exception in resource consideration is that SSI resource policy considers some items that are excluded by Medicaid. Examples are personal belongings, jewelry, and household items.

2. Compare countable resources to the SSI resource standard.

3. The current SSI resource standards are:

Individual	$2,000
Couple	$3,000

The SSI resource standard for a couple is less than the MA resource standard of $4,000 for a couple.

4. If resources are equal to or less than the standard, determine income eligibility.

MS 4680 SSI FINANCIAL ELIGIBILITY (1)

For individuals whose income and resources are within the SSI standards, potential SSI eligibility exists. For these individuals follow the steps below:

A. Deny the MA application and complete form PAFS-5.1, Report of Referral to the District Social Security Office.

B. If the individual exceeds the SSI income standard but meets the SSI resource standard, process an Aged, Blind, or Disabled MA application using the MA Scale for spend down eligibility or LTC eligibility under the special income standard.

C. If income and resources exceed the SSI standards, access the SDX file prior to requesting medical information for an MRT determination.

1. If the SDX file indicates an SSI denial based on non-disability within the prior 12 months, deny the application. Denial date and case processing date are on SDX.

2. If the SDX file does not indicate an SSI denial due to non-disability, request an MRT determination and process the application accordingly.

3. To ensure that SSA disability determinations are utilized, the SDX file is matched on a monthly basis to KAMES database.

a. KAMES automatically discontinues a disability MA case if the SDX file shows a denial based on non-disability.
b. If a fair hearing is requested, follow usual hearing request procedures.

MS 4690 INSTITUTIONALIZED APPLICANTS

[Institutionalized individuals are not eligible for SSI if other monthly income is $50 or more.] Do not deny these MA applications or refer these individuals to SSA.

MS 4710* RESIDENCY

The STATE OF RESIDENCE of an SSI recipient moving into Kentucky is determined by the SSA.

A. If the recipient is determined a Kentucky resident, the individual is eligible for MA. The MAID card shows coverage effective the month of transfer. In some situations, SSA issues form PA-527 allowing medical coverage to be provided more quickly.

B. If an SSI recipient moves out-of-state, the new state of residence may require verification of the date of discontinuance of Kentucky MA.

[If such requests are received, forward the inquiry by memorandum to the Department for Medicaid Services, who advises the requesting state of the correct date of MA discontinuance.**]**

C. For LTC cases, see residency policy in MS 3330.

MS 4720 MA ELIGIBILITY FOR SSI RECIPIENTS (1)

[Individuals who meet all eligibility factors are approved by the Social Security Administration (SSA) for Supplemental Security Income (SSI). Once approved for SSI, the individual is automatically approved for Medicaid. SSI benefits are effective the month after the month of SSI application.

No SSI payment is received for the month of application; however, the SSI recipient may be Medicaid eligible for that month.

A. Month of Application

If the SSI recipient requests retroactive Medicaid, provided eligibility is met, Medicaid will be issued for the month of application and the two months prior to the application month. Retroactive eligibility is issued by the Medical Support and Benefits Branch (MSBB).]

B. SSI Recipients Not Meeting Eligibility Requirements For One or More Months Prior to SSI Approval.

SSI recipients who have been approved for SSI benefits effective a month or more after their application month must have Medicaid eligibility determined for the period of time between the SSI application and approval. Since Medicaid income and resource policy is different than policy used to determine SSI eligibility, these individuals may be eligible for regular Medicaid or spend down benefits if SSI was denied due to excess income or resources.

1. Approvals, when the SSI eligible month is later than the application month, are identified on a monthly basis through a system match.

   a. These individuals are issued form PA-SSI-3 or PA-SSI-4, advising them to contact their local office to apply for Medicaid.
   b. A listing of all individuals receiving either form is on RDS.

2. The notice specifies the exact month for which the SSI recipient may apply.

   a. Determine MA eligibility for each specific month.
   b. The notice also advises the individual that application must be filed within 60 days from the date of the notice and what verification is required.

3. These applications ensure an MA eligibility determination for the period of time between SSI application and approval. This is in addition to the procedure for determining eligibility for the application month and the two months prior to the SSI application month. Form PA-11, Application for Extra Medical Coverage for SSI Approvals, will continue to be generated for an eligibility determination for that time period.

4. Recipients approved in a month following the application month but who are not considered disabled prior to the approval month will not receive notices. For example, if an SSI application is made in January but approved in March due to a determination that no disability exists prior to March, forms PA-SSI-3 or PA-SSI-4 will not be issued.

C. SSI Recipients Eligible for Retroactive MA.

[Retroactive MA coverage is available for individuals with medical bills during the application month and two months prior to the SSI application, if eligible.

1. CENTRAL OFFICE sends form PA-11, a computer generated application form and form PA-11 SSI, an insert explaining Hearing Rights, to the SSI individual.

   a. Form PA-11 is completed by the individual and returned to MSBB within the time frames specified on the form for the determination of eligibility for retroactive Medicaid coverage.
   b. If the recipient reports non-receipt of form PA-11, contact MSBB through your Regional Office to verify if the form has been generated.
   c. Form MA-105, Notice of Eligibility or Ineligibility, is used to notify individuals of eligibility determinations.

2. If an individual contacts the local office following denial of retroactive coverage due to excess income, determine financial eligibility for spend down status. The Medicaid application date is the date of application for SSI.

3. When the SSI individual contacts the local office to request a hearing on retroactive Medicaid coverage, complete form PAFS-78, Request for Hearing, Appeal or Withdrawal.

   a. Forward the original and one copy to the MSBB inbox at CHFS DCBS DFS Medicaid Policy.
   b. Case material relative to the hearing issue will be sent to the local office where the hearing will be held.

D. Receipt of excess income or resources may cause ineligibility of an SSI individual. This will trigger the ex-parte process. The case will automatically discontinue after the two months of ex-parte Medicaid coverage ends. See MS 4770. These individuals may apply for MA under codes F, G, H, J, K, M or Z if they remain ineligible for SSI.

E. SSI individuals in LTC whose SSI is terminated because of admission to a nursing facility are approved under the J, K or M program code effective the month of SSI termination. If all eligibility criteria are met, there should be no interruption in eligibility between SSI termination and Medicaid approval. Follow procedures in MS 3350.

To ensure QMB eligibility is not lost, follow policy in MS 3390.]

MS 4750 MEDICAID ELIGIBILITY REDETERMINATION (1)

A redetermination of MA eligibility is required for certain individuals who are discontinued from SSI.

[When an individual has been discontinued from SSI, explore Pass Through eligibility first. Individuals receiving Long Term Care (LTC) Waiver services can also be eligible for Medicaid under the Pass Through program.] For information on Pass Through, refer to MS 4150 – MS 4280.

If the individual is not eligible for Pass Through, explore eligibility for State buy-in. SSI individuals discontinued due to excess income or resources are not removed from buy-in until MA eligibility through the ex-parte program has ended. Timely notice of termination of MA eligibility is system generated advising the individual to contact the local DCBS office for redetermination.

Individuals with dependent children may be eligible in the K-TAP or AFDC Related MA categories if not eligible in any Adult Medicaid categories.

Individuals discontinued from SSI due to excess resources may be eligible for ongoing MA due to the difference in the resource standard for a couple and the difference in resource considerations between the SSI and MA programs.

Individuals whose Supplemental Security Income (SSI) is discontinued and request a hearing can only continue to receive Medicaid during the hearing process, if they continue to receive the SSI payment.

Individuals who contact the local office must be referred to the Social Security Administration (SSA) to appeal the termination of their SSI benefits. If SSA approves them for a continuation of benefits while they are in the appeal process, they receive MA coverage automatically and have a payment status code of C01, M01, or M02.

A. Exparte System Activity

The SDX (SSI file) monthly cutoff date is nine workdays from the end of the month. Individuals discontinued due to payment status code of excess income (N01), Living Arrangement such as going into a nursing home (E01), excess resources (N04), refuses treatment for drug addiction (N10) or refuses treatment for alcoholism (N11) are loaded to a database on KAMES as an active case for the two months continuation of MA and buy-in benefits if eligible. These cases have a program code of A, B, or D and are referred to as “exparte” cases. The MA on-date of these cases is the first day of the month following the SSI discontinuance through the end of the following month. The second month of exparte is considered the application month.

EXAMPLE: An SSI discontinuance identified in March has an MA on-date of April 1st, and application month is May.

B. Non Long Term Care (LTC) SSI

1. Issuing Replacement Cards and Discontinuance of Exparte

To view or issue replacement cards for exparte cases, access the KAMES inquiry menu, select “H” (EXPARTE/EXTENDED MC), type in the SSN and press enter. To access the issuance/MAID replacement screen enter “Y” to the question “SEE ISSUANCE/MAID REPLACEMENT?” and hit enter. Select the most current month issuance to issue a replacement card. Enter the number that coincides with the issuance date for “SEQUENCE NUMBER” and press enter. The address can be changed to allow the replacement to be mailed to a different address. Once appropriate changes are completed, enter a “Y” to the question “TO REISSUE MAID CARD (CURRENT MO ONLY) AND PRESS ENTER”.

The case can be discontinued manually if the recipient moves out-of-state or dies. This is completed through case change, selecting function “4” (DISCONTINUE NONLTC EXPARTE/EXT MC) and entering the exparte or extended managed care case number from the database and pressing enter. The case number for these cases will always have an alpha “A” as the 10th digit. Answer “Y” to the question “DO YOU

WANT TO DISCONTINUE THIS CASE", select the appropriate reason for discontinuance (1 or 2) and press enter. Discontinuance Reason Codes are as follows:

a. Manual discontinuance codes are:
523 – Recipient Deceased
512 – Moved Out of State
574 – Other (Central Office function only)

b. System discontinuance codes:
555 – Reapproved for SSI
581 – End of Time Limited MA
676 – Active on KAMES

2. Scheduling Appointments

The KIP-10-SSI.2 notice generated to SSI individuals not receiving LTC benefits advises them to contact their local DCBS office. When contacted, review the recipient's situation to see which category of Medicaid potential eligibility exists and advise the individual of the month an application should be submitted.

3. Taking the Application

The application is taken in the appropriate program code on KAMES. The exparte case will be inactive in the month of the appointment, but eligibility will have been issued for that month; therefore, once the application is processed the worker will get a denied/approved status.

C. LTC SSI

Exparte of LTC SSI cases discontinued with a payment status code of N01, N04, E01, N10 or N11 on SDX will have a case status 05 or EE. The vendor payment eligibility continues through the last day of the two-month period of extended Medicaid. Vendor payment information displays with the A, B, or D case information on KAMES.

1. Scheduling an Appointment

A message will be posted to the workers Daily Case Status Report (DCSR) the first month of exparte as a reminder to schedule an appointment with the individual in the second month of exparte eligibility. The appointment is scheduled within 5 work days of the message being displayed using option "D" on the KAMES Main Menu.

If an appointment is not scheduled within 5 work days, KAMES schedules the appointment automatically. An appointment can be rescheduled only once during the 5 work days. To view a list of cases not yet schedule for an appointment access option "F" (Daily Case Status Inquiry) on the KAMES Main Menu. Select option "H" (EXPARTE/EXT MANAGED CARE REQUIRING APPTS). Appointments are schedule by using the following codes:

a. AX (first appointment)

b. RX (reschedule appointment)

2. Issuing Replacement Cards and Discontinuance of Exparte

Replacement cards are issued through the A, B or D case on KAMES through case change under replacement. Discontinue the case through case change as well if the recipient moves out-of-state or dies.

The MA end date of exparte is the last day of the two-month period of Medicaid coverage. The MA end date will allow the case to automatically discontinue if the individual fails to keep an appointment with the agency to reapply for Medicaid benefits in another category. The worker does not need to manually discontinue these cases at the end of the two-month period.

3. Taking the Application

The application is taken in the appropriate program code on KAMES. If an application is completed in the second month of exparte the case will be inactive, but eligibility will have been issued for that month; therefore, once the application is processed the worker will get a denied/approved status.

If the application is not completed during the exparte period, backdate the application. KAMES will issue coverage up to 3 prior months from the backdated date.

For PRO Certifications issued with a “date level of care met” that is more than 3 months prior, backdate the application on KAMES up to 90 days prior to the current date.

EXAMPLE: An application is entered on KAMES June 7th but the PRO Certification shows February 10th as the date level of care was met. The application can be backdated to March 7th and KAMES will issue February as a prior month.

If coverage is requested for a month further back than what can be covered by KAMES through the regular application process, issue those months of assistance by KAMES special circumstance. Review dispositions screens for the dates that coverage has been issued.

4. LTC SSI with Money Follows the Person (MFP)

A spot check will post to the worker’s DCSR for MFP recipients who currently have an A, B or D case on KAMES advising to change the case to a J, K or M case due to SSI in exparte. The spot check is MFP-SSI DISC/LOAD JKM ELIG and is posted on the DCSR the first day of the second month of exparte. The timely date to process is the last day of the following month.

To complete this change, enter a J, K or M application on KAMES. No application interview is needed as these individuals have been certified by DMS and are eligible for 365 days of Medicaid coverage. Once the case is reapproved in the J, K or M category, the spot check is automatically deleted from the worker's DCSR.**]**

MS 4820 [CASES ELIGIBLE AFTER SSI DISCONTINANCE] (1)

Establish a case record for individuals who are determined eligible for ongoing benefits. All forms necessary for an application in the category of ongoing assistance are completed during the interview and maintained in the case record.

A. An appointment is scheduled in the second month of exparte to explore continued Medicaid eligibility such as Pass Through, LTC or QMB, SLMB or QI1 coverage.

B. When entering the application, use J, K, M or Z, as appropriate.

C. If the individual/representative fails to contact the Agency to schedule an appointment or fails to keep the appointment, the case will automatically discontinue.

Vendor payments cannot be authorized for an A, B or D case if a Pro Certification is received notifying the Agency the individual has been admitted to a nursing facility or waiver program while the case is in Ex-parte status. However, those months can be issued by special circumstance. An application is needed for ongoing benefits.

D. If an individual/representative requests a fair hearing, complete and submit form PAFS-78, Request for Hearing, Appeal or Withdrawal, according to regular policy and procedures.

MS 4900 STATE SUPPLEMENTATION PAYMENTS OVERVIEW (1)

State Supplementation is a payment to aged, blind or disabled individuals who are age 18 years or older and have insufficient income to meet special needs for care in a licensed Personal Care Home (PCH), licensed Family Care Home (FCH), residing in a Community Integration Supplementation (CIS) arrangement, or to purchase Caretaker Services (CS) to prevent institutionalization. Technical requirements of the SSI program for individuals who are aged, blind, or disabled must be met. If potentially eligible, application for SSI must be made and the application verified prior to State Supplementation approval. Medicaid pays the SMI premium for all State Supplementation recipients with Medicare Part B.

[Payment shall be issued for an eligible individual age 18 years or older who resides in a PCH, FCH, CIS arrangement, or receives Caretaker Services. The payment is considered the client's money. It is the responsibility of the client to pay the PCH, FCH, caretaker, designated care coordinator, or person(s) providing care to the individual.**]**

A. PCH/FCH:

The payment is the difference between the standard and countable income.

B. CARETAKER:

The payment is the difference between the standard and countable income of a single individual, or an eligible individual with an ineligible spouse, requiring care.

In caretaker cases of couples, where both individuals are aged, blind, or disabled, and ONE OR BOTH require care in their own home, the payment is the difference between the standard and countable income with each receiving one-half of the difference.

C. COMMUNITY INTEGRATION SUPPLEMENTATION (CIS):

The payment is the difference between the CIS standard and countable income.

D. SUPPLEMENTAL BENEFITS. Authorize supplements to correct an administrative error. Supplemental benefits manually issued for State Supplementation cases will pend for supervisory approval.

1. Use function "S", Restoration/Supplement, on the Case Change Menu.
2. Select "S" for the Change- Restoration/Supplement Menu. Enter "Y" to the question "Do you wish to add a restoration/supplement not listed above?"; "S", and the month/year of the supplement in "period in error".
3. On the Supplemental Screen, enter the discovery/report date, the reason for the supplement, and the amount of the supplement.
4. The supplement will pend for supervisory approval.

MS 4910 STATE SUPPLEMENTATION STANDARDS (1)

[A. CLASSIFICATIONS AND STANDARDS FOR STATE SUPPLEMENTATION:

1. Personal Care Home $1,253

2. Community Integration Supplementation (CIS) $1,253

3. Family Care Home $ 905

4. Caretaker Services:

a. Single individual in own home or receiving room, board and care $ 795

b. Eligible (aged, blind or disabled) individual with an ineligible (not aged, blind nor disabled) spouse $ 795

c. Couple, both eligible (aged, blind or disabled) but only 1 requiring care $1,161

d. Couple, both eligible (aged, blind or disabled) and both requiring care $1,215]

B. PERSONAL NEEDS ALLOWANCE included in Personal Care Home payments $ 60

C. PERSONAL NEEDS ALLOWANCE included in Family Care Home payments $ 40

MS 4930 APPLICATION PROCESS FOR STATE SUPPLEMENTATION (1)

Complete an application for State Supplementation according to procedural instructions as outlined below. Individuals applying will have 30 days to return requested information before the application will deny.

A. Complete an application for each member of a couple, when one or both require care, and BOTH are aged, blind, or disabled.

B. The application is signed by either:

1. The applicant;

2. The applicant's spouse, statutory benefits payee, Power Of Attorney (POA), committee or legal guardian;

[3. Representative from the Family Care Home (FCH), Personal Care Home (PCH), designated care coordinator, or other person(s) providing care to the individual; or]

4. One other person as witness, either related or unrelated, if the application is signed by a mark (X).

A signed statement from the client is needed authorizing anyone other than the spouse, POA, benefit payee or legal guardian to apply on their behalf. The MAP-14, Kentucky Medicaid Authorized Representative, is not allowed for this use as it only applies to Medicaid applications.

C. If the statutory benefit payee, committee or legal guardian does not live in Kentucky:

1. Register the application on the date assistance is requested;

2. Send the application and a cover letter to the statutory benefit payee, committee or guardian for completion and signature; and

3. Carry the case in the county where the applicant is located.

D. Determine program code for KAMES as follows:

1. SSI recipients:

a. AP - Aged;
b. BP - Blind;
c. DP - Disabled

2. Non-SSI Recipients:

a. FP - Aged;
b. GP - Blind;
c. HP – Disabled

E. Use the applicant's SSN for the case number.

F. Use the applicant's name for the case name even if the application is signed by someone other than the applicant.

G. Issue State Supplementation payments in the name of the applicant, statutory benefit payee, committee or legal guardian.

H. If the applicant age 18 or over is present at the time of the interview and not registered to vote or not registered to vote at his/her current address, complete form PAFS-706, Voter Registration Rights and Declination, and explain the voter registration process. See Volume I, MS 1230.

I. A recipient of State Supplementation shall have the State Supplementation benefits continued without interruption for any of the first three months of medical confinement if admitted to a hospital, a psychiatric hospital or a nursing facility. See MS 3410 and MS 5070.

J. Approve the case if all eligibility factors are met. The effective month of payment for AP, BP, DP, FP, GP, and HP cases is the month of application. The Medicaid effective date for FP, GP, and HP is the 1st day of the month of application. If there are medical bills in any of the prior 3 months for those eligible in FP, GP, or HP, explore spend down.

K. Deny the State Supplementation application if all eligibility factors are not met and explore eligibility for Aged, Blind or Disabled MA.

L. CONTINUING ELIGIBILITY. After recertification/review, spot check, or case change, authorize continuing eligibility if all eligibility factors are met.

M. KAMES automatically issues appropriate notification.

MS 4940 RECERTIFICATION/REVIEW PROCESS & DISCONTINUANCES

[Review all State Supplementation cases every 12 months. The 12-month count begins with the month of application for approvals or program transfers.

RECERTIFICATION/REVIEW PROCESS

A. AP, BP or DP and FP, GP or HP CASES. Complete a recertification every 24 months. The 24-month certification period begins with the month of application for approvals or program transfers. Every 12 months, review items subject to change such as living situation and income. Enter findings or comments on KAMES case comments and adjust payment, if appropriate.**]**

   Note: As long as an SSI recipient's State Supplementation case is active on KAMES, the medical card is issued from KAMES. This MA issuance may be inquired by selecting option "P" on the KAMES main menu.

B. SPOT CHECK. If changes are anticipated before the next review or recertification, set up a spot check for the appropriate month of anticipated change.

DISCONTINUANCES

A. Discontinuing AP, BP or DP State Supplementation payments does not automatically discontinue MA coverage, as MA eligibility is issued from the State Data Exchange (SDX) System.

   Note: If the State Supplementation case is discontinued for any reason, the medical card will revert back to being issued by the SDX system.

B. Discontinuing SSI due to income does NOT discontinue a State Supplementation payment but DOES require:

   1. Program transfer to an FP, GP or HP; and

   2. Adjustment of payment if eligibility continues.

C. Discontinuing FP, GP or HP discontinues BOTH the State Supplementation payment and MA. If an FP, GP or HP case is discontinued due to continuing income in excess of program standards, explore eligibility for aged, Blind or Disabled MA as a spend down case.

D. Discontinue the case if all eligibility factors are not met and explore eligibility for Aged, Blind or Disabled MA.

E. KAMES automatically issues appropriate notification.

MS 4950* SSI RECIPIENTS

SSA has determined the individual is either Aged, Blind, Disabled and without sufficient income from other sources to equal the SSI Standard.

MS 4960 NON-SSI INDIVIDUALS

Individuals who are not SSI recipients must meet the SSI technical eligibility criteria for age, blindness or disability.

A. AGE - The individual must be age 65 or older.

1. If there is reason to doubt the individual meets the age requirement, request verification of age.

2. Verification includes:

a. SSA verification forms;
b. Medicare card;
c. Birth registration or certificate;
d. Religious, school, or census records;
e. Insurance policies;
f. Marriage records;
g. Licenses at least 5 years old; or
h. Other acceptable documents.

B. BLINDNESS OR DISABILITY – The individual must be unable "to engage in any substantial gainful activity (SGA) by reason of a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." **[**See MS 3912**]**

1. Verification of disability is established if the individual provides proof of the following:

a. Receipt of RSDI or Railroad Retirement Benefits based on disability.
b. SSA has established disability but entitlement is pending due to the five month durational requirement on some disabilities. View notification establishing entitlement.
c. A copy of the favorable decision from SSA, Bureau of Hearings and Appeals, is presented. If benefits are not being received, complete a monthly spot check to establish receipt of benefits. If a check is not received within 6 months, send medical information to MRT.
d. SSI was received during any portion of the 12 months preceding application with the Agency, provided the SSI discontinuance was due to income or resources and not an improvement in condition. Send medical information to the MRT before the next reinvestigation unless the SSI decision stated no reexamination was necessary. If reexamination status cannot be determined, send a memorandum to the MRT asking if a redetermination is necessary. Include in the memorandum, the name and SSN of the individual and date the individual first received SSI.

e. Disability has previously been determined by the Medical Review Team, Hearing Officer, Appeal Board, or Circuit Court and the decision states no reexamination is necessary and there is no visible improvement in condition. Reference the previous decision as documentation.

2. MEDICAL REVIEW TEAM (MRT) – When submitting a request to MRT, write “State Supp. Application” on the front page of the completed form PA-601T in red ink. Submit the PA-601T with MRT-15 forms (1 per service provider + 2) in the following situations:

   a. Disability is not established by any of the above methods;
   b. A situation where an individual applies for State Supplementation benefits, based on disability, and a concurrent application for SSI has been filed but no determination of disability has been received; or
   c. Eligibility is based on receipt of statutory benefits, and benefits are discontinued because the individual is no longer disabled.

MS 4970 ENUMERATION

Everyone applying for or receiving State Supplementation is required to furnish an SSN or apply for a number if one has not been issued. For enumeration procedures for State Supplementation cases, see MS 1560.

MS 5000 THIRD PARTY LIABILITY (TPL) ASSIGNMENT

[Federal law requires cooperation in the assignment of rights for third party payments to DMS for care or services available under MA as a condition of eligibility for State Supplementation.**]**

MS 5020 GENERAL REQUIREMENTS

An individual must be a Kentucky resident to receive State Supplementation payments.

A. Individuals receiving State Supplementation as aged, blind or disabled are residents of the State making the payment.

B. **[**Accept client's statement as proof of residency, unless questionable. Request verification if client's statement is questionable.**]**

MS 5050 **[**PERSONAL CARE HOME (PCH) AND FAMILY CARE HOME (FCH) (1)

PCH's provide general supervision and residential care for individuals unable to manage normal activities of daily living and need monitoring to ensure health related services are carried out. FCH's provide 24-hour protective and personal care in a residential home for 2 or 3 individuals who do not have an illness or injury requiring nursing care, but need help with self-care. Payment is issued for an eligible individual age 18 years or older who resides in a PCH or FCH.

PCH's and FCH's must be licensed by the Certificate of Need and Licensure Board.

A. A listing of PCH's can be found on KAMES by completing the following steps:

1. Select option "B" Inquiry from the KAMES Main Menu;
2. Select option "I" Provider File from the KAMES Inquiry Menu;
3. Enter an "X" in the PCH/FCH field; and
4. Enter the county code of the facility.

The KAMES Personal Care Home Directory will appear and the facility number is located on the directory. Press "F8" to page forward and press "F7" to page back through the directory. The facility number is entered on the State Supplementation Screen on KAMES. FCH and Community Integration Supplementation (CIS) are not listed on the directory.

B. A directory of PCH's and FCH's can be found on the Office of Inspector General's (OIG) website: http://chfs.ky.gov/os/oig/directories.htm.

NOTE: If a PCH or FCH is not found on the listings it is not a DMS licensed facility.**]**

MS 5055 COMMUNITY INTEGRATION SUPPLEMENTATION (CIS) (1)

Community Integration Supplementation (CIS) allows individuals who are currently residing in a Personal Care Home (PCH) or at risk of entering a PCH or other institution an alternative living arrangement. Individuals applying for CIS must be at least 18 years of age or older, reside in a private residence or currently reside in a PCH but intend to move to a private residence, and have a serious mental illness. Individuals receiving CIS are eligible for Waiver services as long as there is no duplication of services.

[A. Individuals must provide a written statement at application, annual review, and recertification verifying that they have a serious mental illness which:**]**

1. Impairs or impedes the individual's functioning in at least one major area of living;
2. Is unlikely to improve without treatment, services, or supports; and
3. Does not include a primary diagnosis of Alzheimer's disease or dementia.

[Note: Scan the written statement into Electronic Case File (ECF).**]**

B. The written statement must be signed by one of the following qualified mental health professionals:

1. A licensed physician;
2. A licensed psychiatrist;
3. A certified psychologist;
4. A licensed registered psychiatric nurse;
5. A licensed clinical social worker;
6. A licensed marriage and family therapist; or
7. A credentialed professional counselor.

[C. Individuals must have care and support needs other than room and board. Written verification of care and support is required at the initial eligibility determination, whether by application or case change, annual review, and at recertification. The verification may be provided by the individual, authorized representative (AR), care coordinator, or by the person(s) providing care to the individual. Verification of care and support must include the following information:

1. The services required and how often each service is provided;
2. The amount and how often payment is made for the service; and
3. That the services provided prevent institutionalization.

Note: An individual's care coordinator or the person(s) providing care to the individual may complete form CIS-1, Community Integration Supplementation Optional Checklist, to verify care and support needs. Scan the form or other documentation into ECF.**]**

MS 5060 CARETAKER SERVICES (1)

CARETAKER SERVICES may be provided by someone hired to come to an individual's house on a regular basis to do light housekeeping, to assist them with taking medications, to help them with meal preparation, etc. for the individual. Services must prevent institutionalization in a nursing facility or other facility. The State Supplementation payment is issued to an eligible individual who receives caretaker services and is age 18 years or older.

A. Services provided by a caretaker must:

1. Enable an ill or infirm individual to remain safely and adequately at home, in some other family setting, or room and board situation;

2. Prevent institutionalization; and

3. Be provided at regular intervals.

B. Services may be provided by either:

1. A live-in attendant; or

2. One or more persons hired to come to the home.

C. Caretaker payments are not made if:

1. The individual is taken daily or periodically to the home of the caretaker, that is, a sitter type arrangement; or

2. The caretaker is the individual's spouse, parent, or adult child if those relatives live together.

Exception: Authorize payment if the individual's spouse, parent, or child does not live with the individual but comes to the home to provide care and all other factors are met.

Example: An individual requiring caretaker services lives with his son and daughter-in-law. The son cannot be the caretaker, but the daughter-in-law may be as she is not the spouse, parent, or child of the individual.

[D. A written statement from the caretaker must be provided at application, annual review, and recertification. The written statement must contain the following information:**]**

1. The types of services the caretaker is providing;

2. The services the caretaker is providing allows the individual to live at home, in some other family setting or in a room or board situation instead of being institutionalized;

3. How often each service is provided; and

4. How much and how often payment is made for the service.

[E. A written statement from a medical provider must be provided at application, annual review, and recertification to verify that services provided prevent institutionalization in an institutional facility such as nursing facility and Supports for Community Living (SCL). The statement must contain the following information:]

1. The medical condition which prevents the individual from caring for themselves; and

2. The types of services needed to prevent institutionalization.

F. An individual can receive State Supplementation for Caretaker Services and Consumer Directed Option (CDO) for Adult Day Services, if it is verified that there is no duplication of services between the two providers. The worker is to request a list of services from both providers for verification. See Volume IVA MS 2800.

G. State Supplementation recipients receiving Caretaker Services can also receive Acquired Brain Injury waiver (ABI LTC Waiver). Workers add the LTC segment to the existing State Supplementation case. See Volume IVA MS 3030.

MS 5070 TEMPORARY STAY IN A MEDICAL INSTITUTION FOR NON-SSI RECIPIENTS (1)

A non-SSI recipient who receives State Supplementation may be eligible for continuation of State Supplementation benefits without interruption for the first three full months of medical care in a health care facility.

A. The following are the reasons to continue State Supplementation benefits:

1. The recipient maintains his/her home or other living arrangement during a temporary admission to a health care facility;

2. A physician certifies in writing that the non-SSI recipient is unlikely to be confined for longer than ninety full consecutive days; and

3. A guardian, other payee, personal care home or family care home receiving a State Supplementation check for the recipient, provides the local DCBS office with:

a. Notification of the temporary admission; and
b. The physician statement specified in item A.2.

B. A temporary admission shall be limited to the following health care facilities:

1. Hospital;

2. Psychiatric hospital; or

3. Nursing facility.

If a State Supplementation recipient is discharged in the month following the last month of continued benefits, the temporary absence shall continue through the date of discharge. The 3-month count begins the first day of the month following the month of admission to the health care facility.

C. Upon receipt of the PRO Certification contact the recipient's representative to determine if the nursing facility stay is temporary.

1. If the stay is temporary:

a. Send form PAFS-2, Application Letter or Notice of Expiration, to the representative requesting the physician's statement be provided within 10 days;
b. Upon receipt of the physician's statement verifying a temporary stay, add the LTC segment to the State Supplementation case;
c. Add a spot check to the case to follow-up at the end of the three-month period; and
[d. Consider the cost of Personal Care, Family Care, or Community Integration Supplementation (CIS) payment as a medical

deduction in the patient liability calculation. A deduction for caretaker services is not an allowable expense.**]**

2. If the stay is not temporary:

   a. Program transfer to J, K, or M and remove the State Supplementation payment. Authorize vendor payment upon receipt of a PRO certification. See MS 3650.
   b. Do not take a new application unless a recertification is due.
   c. Do not change the month of recertification.
   d. At recertification review resources for transfer of resources.

D. If the individual is not discharged until the 4th month, benefits will continue through the date of discharge.

E. For SSI recipients, see MS 3410.

MS 5100 RESOURCES

Resources are assets an individual or couple own and can apply, either directly or by sale or conversion to meet basic needs of food, clothing and shelter.

A. LIMITS. The total countable resources an individual or couple may have to be considered financially eligible for State Supplementation are:

1. Aged, Blind or Disabled Individuals.

INDIVIDUAL	$2,000
COUPLE	$3,000

2. Blind or Disabled Child.

Parent/Child	Allowance
1 Parent	$2000
2 Parents	$3000
1 Child	$2000

A separate resource limit is used to determine resource eligibility of a blind or disabled child applying for or receiving assistance

a. Consider as surplus, any parental resources greater than $2000 or $3000, as appropriate.
b. Determine the parent's surplus resources by comparing the parent's total countable resources to the appropriate resource limit for 1 or 2 parents with any excess considered as parent's surplus.
c. Add the parent's surplus to the child's resources and compare to the child's resource limit of $2000.

B. CONSIDERATION AND VERIFICATION. **[**Consider and verify resources of the applicant or State Supplementation recipient according to MS 1860 and MS 1870.**]**

MS 5110 INTRODUCTION TO INCOME (1)

Income is any money received from entitled benefits, rental property, investments, nonrecurring lump sums, labor or services. Income is either unearned or earned and must be verified and documented at each application, recertification, and any reported income change.

A. LIMITS. Countable income is compared to the standard for the appropriate classification of State Supplementation.

B. CONSIDERATION AND VERIFICATION. Consider and verify amount of earned and unearned income, of the applicant or recipient as appropriate.

1. Consider payments made to a third party on behalf of an applicant/recipient, other than payments for medical insurance or medical care and services, as unearned income. EXAMPLE: The amount of rent paid to a landlord by a relative is unearned income.

[2. The standard for the appropriate level of care is payment in full for a recipient's cost of care in the Personal or Family Care Home. Consider any third party payment to a home or caretaker, on behalf of a recipient, as income to the recipient.]

3. When receipt of income causes SSI discontinuance for a State Supplementation recipient, immediately determine if eligible in F, G, or H category.

C. DEDUCTIONS/EXCLUSIONS.

1. DO NOT deduct the $20 general exclusion.

2. Allow earned income deductions according to MS 2480.

MS 5130* COUPLES LIVING TOGETHER

Calculate income for couples living together according to the following:

A. Caretaker Services, with both members determined to be aged, blind, or disabled:

1. DO NOT conserve income of the eligible couple for minor dependent children.

2. If an eligible spouse has income:

a. Combine this income with that of the spouse requiring care; and
b. Apply to standard of couple, both eligible, but only 1 requiring care.

B. Caretaker Services, with spouse ineligible:

1. DO NOT conserve income of the eligible individual for the ineligible spouse and/or minor children.

2. DO NOT deem income to the eligible spouse if the technically ineligible spouse's gross income is less than or equal to the difference between the SSI payment standard for an individual and the SSI payment standard for a couple.

3. Determine the amount of income available to eligible spouse if an ineligible spouse has gross income greater than the difference between the SSI payment standard for an individual and the SSI payment standard for a couple, as follows:

a. Determine income of ineligible spouse.
b. Deduct the following:
(1) For the ineligible spouse, deduct 1/2 the SSI payment standard;
(2) For each minor child without income, deduct 1/2 the SSI payment standard;
(3) For each minor child with income greater than 1/2 the SSI payment standard, make no deduction; or
(4) For each minor child with income less than 1/2 the SSI payment standard, deduct the difference between 1/2 the SSI payment standard and the child's income.
c. Consider remaining amount of ineligible spouse's income, if any, available to the eligible individual.
d. Apply to the Caretaker Services standard for a couple, eligible individual with ineligible spouse.

MS 5140 COUPLES LIVING APART

A. COUPLES IN SAME PCH OR FCH.

1. Couples residing in the same PCH or FCH or residing in the same room in a PCH or FCH are considered as living apart for relative responsibility purposes. Living apart means no longer living together in a household.

2. For the month the couple cease living together in a household, combine income of the couple and consider 1/2 available to each.

3. Consider each member of the couple as an individual the month following the month the couple cease living together in a household.

4. If consideration as an individual results in ineligibility of either spouse at any time, compute income as a couple, counting 1/2 their combined income available to each.

B. COUPLES IN DIFFERENT PCH OR FCH, BOTH APPLYING FOR OR RECEIVING PCH or FCH.

1. For the month the couple cease living together in a household, combine the income of the couple and consider 1/2 available to each.

2. Consider only income of the individual as available beginning the month after the month of separation.

3. If consideration as an individual results in ineligibility of either spouse, the ineligible spouse's State Supplementation payment is discontinued. Consider separate spend down eligibility for the ineligible spouse.

C. COUPLES, ONE APPLYING FOR OR RECEIVING CARETAKER SERVICES, PCH OR FCH, AND THE OTHER SPOUSE IS NOT RECEIVING STATE SUPPLEMENTATION.

1. For the month of separation.

a. Deem no income to the applicant if the spouse's gross income is less than or equal to the difference between the SSI payment standard for an individual and the SSI payment standard for a couple.
b. Determine the amount of income available to the applicant if the spouse has gross income greater than the difference between the SSI payment standard for an individual and the SSI payment standard for a couple, as follows:
(1) Determine income of the spouse.

(2) Deduct the following:

(a) For the ineligible spouse, deduct 1/2 the SSI payment standard;

(b) For each minor child without income, deduct 1/2 the SSI payment standard;

(c) For each minor child with income less than 1/2 the SSI payment standard, deduct the difference between 1/2 the SSI payment standard and the child's income; and

(d) For each minor child with income greater than 1/2 the SSI payment standard, make no deduction.

(3) Consider remaining amount of the spouse's income, if any, available to the applicant.

2. Beginning the month after the month of separation, consider income of the spouse actually contributed to the applicant.

[D. COUPLES, ONE APPLYING FOR OR RECEIVING STATE SUPPLEMENTATION AND THE OTHER SPOUSE INSTITUTIONALIZED.

If one member of the couple is institutionalized and the other spouse maintains a home, income in the amount of the SSI program standard for one is conserved for the spouse at home.**]**

MS 5180 CATEGORY CHANGE (1)

State Supplementation recipients who are admitted into a nursing facility or approved for waiver services are approved in the appropriate program category.

A. To transfer an AP, BP, or DP to an A, B, or D:

The AP, BP or DP case must be discontinued on KAMES.

Note: A State Supplementation recipient may have the State Supplementation benefits continued without interruption for any of the first three months of institutionalization if admitted to a hospital, a psychiatric hospital or a nursing facility on a temporary basis. This allows the recipient to pay some or all of the necessary expenses to maintain their home or living arrangement to which they may return upon discharge from the facility. In order to qualify for continuation of payments refer to MS 3410 and MS 5070.

B. To transfer an FP, GP, or HP to a J, K or M consider the following;

1. Do not complete a new application if the application was signed within 12 months.

2. If the recertification month is 12 months or less away, do not shorten the certification period. Record the information on the comments screen on KAMES or on bond paper.

3. If the recertification month is between the 12th and 24th month, because J, K, or M cases only have a 12 month certification period, shorten the certification period to the month following the program transfer.

   Example: An FP application was entered in January 2007. In March 2008 (the 14th month of MA coverage in the FP category) the case is program alternated to a J program code. In order for the J case to have a certification period of 12 months it must be reviewed the next feasible month which is April 2008.

4. When an individual enters LTC, discontinue the State Supplementation payment and alternate program the KAMES case to a J, K or M case.

   Note: As mentioned above in the note in item A1, the State Supplementation recipients may qualify for continuation of payments for any of the first three months of institutionalization. See MS 3410 and MS 5070.

C. J, K, M or F, G, H (Pass Through) to FP, GP, or HP (State Supplementation) requires an application interview and completion of a program transfer for a case on KAMES.

D. State Supplementation recipients may move from one Personal Care Home (PCH) or Family Care Home (FCH) to another within the month. The State Supplementation check can be prorated between the two homes. It is the responsibility of the recipient or representative to request a prorated refund from the former home when the individual moves from one home to another within the same month.

[E. If a member in a J, K, or M vendor payment case is approved for SSI, the worker can answer "Y" to "Is he/she receiving SSI?" on screen HRKIMA0F. KAMES will allow the worker to alternate program to a corresponding long term care (LTC) SSI case A, B, or D.

If action hasn't been taken by SDX cutoff, KAMES will automatically alternate program the J, K, or M case to A, B, or D as appropriate.**]**

MS 5210 [ERRONEOUS PAYMENTS

There are 3 types of erroneous payments: administrative errors, misrepresentation and fraud. Prompt action is to be taken to correct the current assistance payment when any error is found.

A. ADMINISTRATIVE ERRORS

1. Administrative errors are either overpayments or underpayments that result solely from:

   a. Misapplication of policy;
   b. Computation errors in determining the assistance payment;
   c. Failure to act on a change in the recipient's living situation that was reported timely;
   d. Failure to submit a correctly completed authorization form that results in untimely processing; or
   e. Failure of the worker to confirm or clarify information pertaining to eligibility.

NOTE: Erroneous payments resulting from an administrative deadline ARE NOT administrative errors, IF, the Agency acted promptly on the available information and correctly completed the action. Delay in completing a recertification does not constitute an administrative error even though the recertification results in an increased payment.

2. Overpayment - If the administrative error results in an overpayment, take prompt action to correct the case.

3. Underpayment - If the administrative error results in an underpayment, promptly submit:

   a. An authorization to correct the current assistance payment; and
   b. An authorization for a special payment. The amount of the special payment is the difference between the amount the individual actually received and the amount the individual should have received. The special payment is limited to the 12 months prior to the effective date of the correction. The special payment is to be logged on the PAFS-116, Case History Sheet. Include the date of the authorization, the amount of the special payment, and the word "Underpayment" under "Reason."

4. Case Action

   a. DISCONTINUANCE. If review of a case reveals that an administrative error resulted in the discontinuance of that case, the case is reinstated with the effective date of the ongoing payment entered as the month

of action and a special payment(s) authorized retroactively to the effective month of the discontinuance, not to exceed 24 months.

b. DENIAL. If review of a case reveals that an administrative error resulted in the denial of an application, take another application with the effective date of the original date of application, not to exceed 24 months. Determine eligibility and the amount of assistance for each month the individual was denied benefits, not to exceed 24 months.

B. MISREPRESENTATION

Misrepresentation is when a recipient or responsible party purposely withheld information in order to receive MA. For more on MA IPV procedures, see Volume I, MS 1760.

C. FRAUD

Fraud is when a provider is purposely billing Medicaid incorrectly. If situations of suspected provider fraud or abuse are reported, send a memorandum with a summary of the situation to:

Office of Inspector General (OIG)
Division of Special Investigations
275 E. Main Street, 5E-D
Frankfort, Ky. 40621-0001

Attach a copy of any available documentation with the OIG memorandum. Keep original documentation in the local office.

D. REINSTATEMENT

If reinstatement is accomplished within 30 days of the effective date of discontinuance, no new application is required. Supervisory approval is required.

If reinstatement would occur more than 30 days of the effective date of discontinuance, a new application is required.]

MS 5235 RETURN OF STATE SUPPLEMENTATION CHECKS (1)

[State Supplementation checks may be returned by the recipient, recipient's legal guardian, the recipient's payee, Personal Care Home (PCH), Family Care Home (FCH), designated care coordinator, or other person(s) providing care. If the State Supplementation check is returned to the local DCBS office, the worker must send the check, along with form PAFS-61, Disposition of Returned Check, to the Division of Family Support (DFS).**]**

State Supplementation checks must be returned the month after the month of:

A. Discharge to:

1. A Nursing Facility, unless the individual's anticipated stay is 90 days or less. Refer to MS 3410 and MS 5070;
2. Another PCH or FCH; or
3. A residence other than a private residence.

B. Death of the State Supplementation recipient.

C. Voluntary relinquishment of PCH or FCH license to the Cabinet for Health and Family Services.

[If the State Supplementation check has been cashed or direct deposited, the recipient, legal guardian, payee, PCH, FCH, designated care coordinator, or other person(s) providing care must provide a certified check or money order for the grant payment. The certified check or money order is made payable to the Kentucky State Treasurer.**]**

A PCH or FCH is to notify the local DCBS office within 5 working days of the death or discharge of a recipient or of the relinquishment of a license.

The State Supplementation checks are to be mailed to:

Division of Family Support
Medical Support and Benefits Branch
275 East Main Street, 3E-I
Frankfort, KY 40621