

Division of Family Support

OPERATION MANUAL
Volume IVB

[OMTL-509](#)

MAGI Medicaid	
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MS 1000 INSURANCE AFFORDABILITY PROGRAMS (IAPs) OVERVIEW (1)

[Effective November 1, 2016, applications for Insurance Affordability Programs (IAPs) will be accepted on the benefit Self-Service Portal (SSP), Worker Portal, and through Account Transfer from the Federally Facilitated Marketplace (FFM). IAPs include Modified Adjusted Gross Income (MAGI) Medicaid and KCHIP. Beginning with the 2017 coverage year eligibility for Advanced Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), and Qualified Health Plans (QHP) will be determined by the Federally Facilitated Marketplace (FFM). 2016 coverage year eligibility for APTC, CSR, and QHP will still be determined by the Kentucky Health Benefit Exchange (KHBE).

Medicaid is extended to adults and children who meet certain technical and financial eligibility criteria. The Department for Medicaid Services (DMS) is the state agency with designated responsibility for the administration of Medicaid in compliance with Title XIX of the Social Security Act. KHBE is the state agency with the designated responsibility for the administration of all 2016 coverage year APTC, CSR, and QHPs.]

- A. MAGI rules will be used to determine eligibility in four categories:
 - 1. Children under age 19;
 - 2. Pregnant Women;
 - 3. Parents and Caretaker Relatives; and
 - 4. Low Income Adults age 19 through 64.
- B. Individuals must meet Technical (non-financial) and Financial eligibility requirements to qualify for MAGI Medicaid. Both Federal and State data sources will be used to help determine if the individual(s) meets these requirements. MAGI household composition is based on the tax filing status of the individual(s) applying for benefits.
- C. [A deduction of 5% of the appropriate federal poverty level (FPL) is applied to the total income for the family size for Medicaid determination when applicable. The 5% deduction is not applied to APTC and CSR income determinations.]
- D. Resources are not considered in the eligibility determination of MAGI Medicaid.
- E. Applicants will be required to provide verification of citizenship, income, and incarceration if initial client stated information does not match with Federal or State data sources. Self-attestation or client statement is acceptable for residency, pregnancy, household composition, and relationship unless conflicting documentation is received.
- F. The 5 year ban to receive Medicaid for qualified aliens no longer applies to children under the age of 19.
- [G. MAGI Medicaid eligibility determinations will pend for 30 days to provide

required verification at initial application and recertification. 2016 coverage year APTC and CSR eligibility determinations will not pend for required verification. These types of assistance will automatically approve for an initial 90 day period.]

- H. Applications can be processed for individuals who are potentially eligible in MAGI Medicaid categories, including the Adult category, even though they have pending SSI applications.

CHILD: An individual who is under the age of nineteen (19). They are not self-supporting or participating in any of the United States Armed Forces.

[COST SHARING REDUCTIONS (CSR): A reduction of an individual's portion of payment for certain medical services, for example co-payments. CSR pertains only to APTC financial assistance. Beginning with the 2017 coverage year APTC will be issued through the Federally Facilitated Marketplace.]

DEEMED ELIGIBLE NEWBORN: A baby whose mother received Kentucky Medicaid during the month of the baby's birth. He or she is guaranteed Medicaid from the birth month through the 12th month without regard to technical or financial eligibility factors other than residency.

DEEMED ELIGIBLE PREGNANT WOMAN: A woman determined eligible for Medicaid due to pregnancy is entitled to continued coverage through the post-partum period. This does not apply to individuals who move out of state during this period.

DEPARTMENT OF HOMELAND SECURITY (DHS): The Federal agency responsible for the determination of citizenship or alien status.

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

EMPLOYER SPONSORED INSURANCE (ESI): Insurance offered through employers.

[ENROLLEE: An eligible individual enrolled in a QHP for the 2016 coverage year.]

FEDERAL HUB: A collection of trusted data sources that will be matched against client stated information in order to verify certain eligibility factors. Some of the trusted data sources include, but are not limited to: Social Security Administration (SSA), Department of Homeland Security (DHS) and Internal Revenue Service (IRS).

[FEDERALLY FACILITATED MARKETPLACE (FFM) – A shopping and enrollment service for APTC and QHPs that is operated by the Federal Government.]

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

INCOME: Earned or unearned money received from sources including, but not limited to: wages; statutory benefits, such as RSDI and UIB; rental property; business operations, etc.

[INSURANCE AFFORDABILITY PROGRAMS (IAPs): Modified Adjusted Gross Income (MAGI) Medicaid and KCHIP.]

KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM (KCHIP): Program of Medicaid coverage for uninsured children under age 19, in compliance with Title XXI of the Social Security Act.

[KENTUCKY HEALTH BENEFIT EXCHANGE (KHBE): An online marketplace for individuals and employers to compare and shop for 2016 coverage year health insurance.]

KYHEALTH CHOICES CARD: The permanent plastic card issued to all Medicaid and KCHIP recipients used as an identification card. The Medicaid ID number found on the card is used by providers to verify current eligibility.

LEGAL GUARDIAN: An individual appointed through the State district courts to be in charge of the affairs and finances of an individual.

LOW INCOME ADULT CATEGORY: Individuals age 19 through 64 who are not pregnant, entitled to Medicare A or B, or enrolled in another Medicaid eligibility group. The total countable income is less than or equal to 133% of FPL.

MEDICAID (MA): Medical benefits provided to eligible individuals in compliance with Title XIX of the Social Security Act.

MANAGED CARE ORGANIZATION (MCO): Organizations that link Medicaid recipients with participating physicians who are responsible for coordinating and providing their primary medical care.

MINIMUM ESSENTIAL COVERAGE (MEC): Coverage that meets the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, KCHIP, TRICARE and certain other coverage types.

[MIXED HOUSEHOLD – A household in which at least one individual receives Medicaid or KCHIP, and at least one individual receives APTC or QHP.]

MODIFIED ADJUSTED GROSS INCOME (MAGI): Taxable income minus specific deductions, for example, alimony, student loan interest, and educator expenses.

NON-MAGI: Individuals exempt from MAGI based eligibility determinations.

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

NON-TAX FILER: An individual who does not intend to file taxes for the current benefit year. They may or may not be claimed as a tax dependent by another individual.

PARENT: The natural, adoptive, or step-parent of a child.

PASSIVE RENEWAL: Occurs when an individual has authorized on-going data checks from trusted data sources. If the information returned matches the data sources or is within reasonable compatibility, the case is updated and recertified with no worker or recipient action required.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA): Federal statute signed into law in March 2010. It is primarily aimed at reducing overall health care costs and decreasing the number of uninsured Americans.

[QUALIFIED HEALTH PLAN (QHP): A commercial insurance plan offered to

Kentucky residents through the KHBE for the 2016 coverage year and the FFM for the 2017 coverage year.

QUALIFIED INDIVIDUAL: An individual determined eligible to enroll through the KHBE for a 2016 coverage year QHP in the individual market.]

REASONABLY COMPATIBLE: The allowable difference between an individual's stated amount of income and verification provided by the Federal HUB. The current standard for reasonably compatible is 10%.

RETIREMENT, SURVIVORS, DISABILITY INSURANCE (RSDI): Social Security benefits payable under Title II of the Social Security Act.

SELF-ATTESTATION: Client statement.

SELF-EMPLOYMENT: Earned income for which NO taxes are withheld before it is received by the individual.

[**SELF SERVICE PORTAL (SSP):** A web-based eligibility system where an individual can create an account and apply for IAPs. Application Assistors can also access this portal on an individual's behalf.]

STATUTORY BENEFIT PAYEE: The payee for the applicant/recipient's SSI or statutory benefits, such as RSDI, VA, or Railroad Retirement.

SUPPLEMENTAL SECURITY INCOME (SSI): Federal money payments to aged, blind, or disabled individuals under Title XVI of the Social Security Act.

TAX DEPENDENT: An individual for which a tax filer claims a personal exemption deduction during the taxable year.

TAX FILER: An individual who has filed or intends to file an income tax return for the current benefit year and cannot be claimed as a dependent by another individual.

[**WORKER PORTAL:** The part of benefind where DCBS workers will enter information in order to determine eligibility for Medicaid and KCHIP, as well as APTC, CSR, and QHP for the 2016 coverage year.]

MS 1070*

CATEGORIES OF ASSISTANCE

(1)

MAGI eligibility is divided into four categories: Children under age 19, pregnant women, parents and caretaker relatives, and Low Income Adults age 19 thru 64. A 5 percent increase to the Federal Poverty Level (FPL) is applied only when needed to gain eligibility. It is not applied to move an applicant to a higher level of coverage. The four categories are listed below with a brief description:

- A. Children under age 19: This category includes Medicaid and Kentucky Children's Health Insurance Program (KCHIP) individuals. **Medicaid** includes children age 18 and under who meet school attendance requirements. **KCHIP** includes children up to their 19th birthday who do not have health insurance. KCHIP has no school attendance requirements.

Categories	FPL	FPL with 5%increase
Medicaid Children age 6-18 (P1)	133%	138%
Medicaid Children ages 1-5 (P2)	142%	147%
Medicaid Children under age 1 (P3)	195%	200%
KCHIP Children age 6-19 (P5)	142%	N/A
KCHIP Children age 0-19 (P6)	159%	N/A
KCHIP III Children under age 19 (P7)	213%	218%

- B. Pregnant Women: This group includes individuals who are pregnant or in postpartum and whose income is less than or equal to 195% FPL (FPL may be increased to 200% only if needed to gain eligibility).
- C. Parents and Caretaker Relatives: This group includes individuals who are a parent or caretaker relative of a dependent child in the home and whose income is less than or equal to 133% FPL (FPL may be increased to 138% only if needed to gain eligibility).

Note: Step parents are included in this group.

- D. Low Income Adults ages 19 through 64 who are not:

1. Pregnant;
2. Enrolled in Medicare A or B; or
3. Enrolled in another Medicaid eligibility group;

These individuals have income less than or equal to 133% of FPL (FPL may be increased to 138% only if needed to gain eligibility).

MS 1200*

RIGHT TO APPLY

(1)

All individuals have the right to make an application and receive a decision on their eligibility for all Insurance Affordability Programs (IAPs) and Qualified Health Plans (QHPs). Individuals may make application for any program offered by the agency in any county office, regardless of the county of residence. Applications may be made by the individual, spouse, parent or caretaker relative of a minor child, statutory benefit payee, guardian, power of attorney, or authorized representative.

- A. Applicants have 30 days to provide mandatory verification, however if they do not provide requested verification and the case denies, there is an additional 30 day grace period from which the case can be put back on kynect without a new application being made by the applicant. This is referred to as 30/60 as the grace period is 30 days from the date of denial or 60 days from date of application.

For example: An applicant applies on May 1, 2014 and income fails to match against trusted data sources. A Request for Information (RFI) is issued requesting income verification by May 30, 2014. The applicant does not return the information and the application denies. On June 15th, the applicant returns the requested income verification. As this information was returned within the 30/60 grace period, the case is to be put back on kynect.

This individual DOES NOT need to reapply.

Note: This grace period applies only to Medicaid applications on kynect; Advance Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), and Qualified Health Plan (QHP) applications conditionally approve for 90 days.

- B. Effective January 1, 2014 individuals will be allowed to make an application by any of the following methods:
1. Calling the Health Benefit Exchange (HBE) Contact Center at 1-855-4kynect or 1-855-459-6328;
 2. Calling the Department for Community Based Services Call Center at 1-855-306-8959;
 3. Mailing a paper application to:

Office of the Kentucky Health Benefit Exchange
12 Mill Creek Park
Frankfort, KY 40601;
 4. Faxing a paper application to 1-502-573-2005;
 5. Making application through the Self Service Portal (SSP); or
 6. In person.

- C. The application is signed by the applicant, the applicant's statutory benefit or SSI payee, guardian, power of attorney (POA), or authorized representative (AR). If the application is signed by a mark (X), another person, either related or unrelated, must sign the application as a witness. Use the applicant's name for the case name even if the application is signed by someone other than the applicant.

- D. IF THE INDIVIDUAL IS PHYSICALLY OR MENTALLY DISABLED OR ELDERLY, provide reasonable accommodation to any special needs the individual may have no matter where/how the interview is conducted. Accommodation to special needs may include, but is not limited to:
 - 1. Interpreter services for hearing impaired individuals. Refer to Vol. 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.

- E. IF THE INDIVIDUAL IS NON-ENGLISH SPEAKING, obtain interpreter services. Refer to Vol. I, [MS 0230](#).

MS 1212*

INTERVIEW PROCESS

(1)

Individuals applying for Modified Adjusted Gross Income (MAGI) Medicaid, Advanced Premium Tax Credit (APTC), or Qualifying Health Plans (QHPs) through Department for Community Based Services (DCBS) must be interviewed. Interviews may be conducted in-person, by phone, or home visit.

Interviews are not required for applications made via the Self Service Portal (SSP).

The following procedures must be followed when conducting an interview:

A. Before the interview:

1. Gather any mandatory forms that must be provided to the individual;
2. If an individual has previously received benefits, review the case record thoroughly including information on KAMES and kynect;
3. Inform the individual that if determined over the income limit for MAGI Medicaid, kynect will automatically determine eligibility for APTC and CSR; and
4. Inform the individual that in addition to determining eligibility for MAGI Medicaid, APTC, and CSR, kynect also automatically determines eligibility for QHP.

B. During the interview:

1. Enter comments on kynect as the interview progresses;
2. Inform the individual of their rights and responsibilities;
3. If the individual is applying for MAGI Medicaid review form MA-2, Medicaid Penalty Warning and obtain client signature on form;
4. If the individual is applying for MAGI Medicaid, review form MA-203, Factual Information for all Medicaid Actions. Worker should sign form attesting that the following fact sheets were provided to client;
 - a. PAFS-4, Important Information for All Who Apply,
 - b. Civil Rights Pamphlet,
 - c. PAFS-600, Do You Know,
 - d. MAP-065, Kentucky Department for Medicaid Services Notice of Privacy Practices, and
 - e. PA-3, Facts About the EPDST Services
5. Advise the individual that changes must be reported within 30 days;
6. Advise the individual of the right to appeal any adverse action;

7. If the head of household is present at the interview and is age 18 or older or will be age 18 before the next election, explain the voter registration process and complete the voter registration questions on kynect;
8. Explain services available related to child care and Women, Infants, and Children (WIC) program; and
9. Inform the client that if they are a Medicare Recipient, they are considered as having minimum essential coverage and therefore are not eligible for APTC/CSR or Medicaid in the Low Income Adult Category. If the individual wishes to explore eligibility for Medicare Savings programs (QMB, SLMB, or QI1), the worker should enter an application on KAMES.

C. Inform the individual of the Medicaid Eligibility Processes:

1. Explain that tax filing status is used in determining eligibility, therefore it is essential that the individual gives accurate information regarding their status;
2. Explain that if income or incarceration verification is required, an individual will have 30 days to return the requested information, but a determination of eligibility will not be made until documentation is received;
3. Explain that if verification of citizenship is the only documentation requested, initial eligibility will be determined and if approved the individual has 90 days to return the requested information. If verification of citizenship is not returned at the end of 90 days, Medicaid eligibility will end the next administratively feasible month;
4. Explain the KYHealth card is issued upon approval of a new application and is used for services not covered by a Managed Care Organization (MCO). The individual should be advised that the KYHealth card is intended to be permanent and should not be thrown away, even if Medicaid eligibility ends;
5. Advise the individual that Medicaid Member Services answers all questions regarding coverage and/or billing and that the phone number is listed on the back of the KYHealth Card;
6. Explain retroactive Medicaid coverage and how eligibility is determined. The worker should ask if any members applying for Medicaid have medical expenses in the three prior months. Refer to Volume IVB, [MS 1600](#);
7. Explain the Managed Care Program. For more information on Managed Care refer to Volume IV, [MS 1600](#);
8. Explain third party liability (TPL) and that Medicaid is the payer of last resort. Any other health or hospital insurance is billed before Medicaid. Enter all health insurance information on kynect; and

9. If a member of the assistance unit appears to have a disabling health condition, refer the individual to apply for Social Security benefits with the Social Security Administration using form PAFS 5.1, Report or Referral to the District Social Security Office;

D. Inform the individual of the APTC/CSR eligibility processes:

1. Explain that individuals applying for APTC must agree to file a federal income tax return for the time period any benefits are received;
2. Explain spouses must file a joint return;
3. Explain that individuals must attest that no one else will claim them as a dependent on their federal income tax return for the benefit year;
4. Explain that individuals must attest that they will claim a personal exemption deduction on their federal tax return for any individual who is listed on the application as a dependent, who is enrolled in coverage through kynect, and whose premium for coverage is covered in whole or part by APTC in the benefit period;
5. Explain that all changes are required to be reported within 30 days of the date of the change;
6. Explain that individuals may apply the full amount of APTC they have been approved to receive or any *portion* of that amount towards the purchase of any metal level plan of their choosing;
7. Explain that any and all discrepancies will be reconciled by the Internal Revenue Service when the individual files their tax return for the benefit year;
8. Explain if determined eligible for CSR, the individual must enroll in a silver level metal plan to receive this benefit; and
9. Explain that if additional verification is required for the APTC/CSR application the case will approve for 90 days based on client attested information. The individual will be issued a Request for Information (RFI) with what documentation is required. If the requested documentation is not provided at the end of 90 days, the case will discontinue the next administratively feasible month.

E. Inform the individual of the QHP eligibility processes:

1. Explain that insurance agents are the only individuals qualified to recommend a plan;
2. Explain that an individual does not have to select a plan on the day of application, however if they do not make their selection by the 15th of month, the plan will not be effective the first of the next month.

- For example, an individual applies for QHP and is approved on January 3rd. They do not select and enroll in a plan until January 20th. Their plan will be effective March 1st as they enrolled after the 15th of the month;
3. Explain that individuals can only select a plan outside the open enrollment period if they have a qualifying event (refer to Volume IVB, [MS 4300](#));
 4. Explain that the initial payment for a QHP must be received by the issuer within 7 calendar days of the coverage effective date; and
 5. Explain to the individual that kynect will direct an individual to an issuer's website for online payments. If an individual does not wish to pay online, payment arrangements must be made through the issuer in accordance with their payment process.
- F. If trusted data sources match within reasonable compatibility, dispose the case and kynect will process the application. If client information fails the Federal Hub and the applicant has the information available at the time of the interview, enter the verification and dispose the case. If the client does not have the verification with them at the time of the interview, ensure that kynect issues an RFI.
- G. Enter all required comments, plus comments on any unusual circumstances or documentation.
- H. Answer all of the individual's questions.
- I. Scan into the Electronic Case File (ECF) all documents pertaining to eligibility, signed application, MA-2, and MA-203.
- J. 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.

MS 1213*

WHO SIGNS THE APPLICATION

(1)

The individual(s) allowed to sign the application may vary depending on specific program requirements. Below are the policy specifications regarding who can sign the application:

- A. Applications for all Insurance Affordability Programs (IAPs) and Qualified Health Plans (QHPs) may be signed by one of the following:
 1. The applicant;
 2. The applicant's spouse;
 3. The statutory benefit payee, legal guardian, power of attorney (POA), or the authorized representative; or
 4. The parent or caretaker relative of a child.
- B. If an individual or their representative signs an application by making a mark (X), the mark must be witnessed by one person, related or unrelated to the individual, who can write.

MS 1220*

ENTITLED BENEFITS

(1)

MAGI Medicaid eligible individuals are required to apply for any benefits to which they may be entitled. An individual is not required to apply for entitled benefits to receive Advance Premium Tax Credits (APTC), Cost Sharing Reductions (CSR), or Qualified Health Plan (QHP).

These benefits include, but are not limited to, Veteran's compensation and/or pension, Black Lung, RSDI, Railroad Retirement, annuities, pensions, IRA disbursements, retirement and Unemployment Insurance Benefits.

- A. Self-attestation is acceptable for the application of benefits.
- B. For Modified Adjusted Gross Income (MAGI) Medicaid eligibility purposes, the Department for Medicaid Services (DMS) considers IRA funds in the same manner as entitled benefits. Individuals are required to withdraw IRA funds if the funds are available.

At age 59 ½, a withdrawal is required, but there is no minimum amount. At 70 ½, the required minimum disbursement (RMD) must be withdrawn annually. Minimum amounts are determined by the financial institution. Failure to comply with this requirement results in ineligibility for Medicaid.

- C. K-TAP or State Supplementation payments, SSI benefits, VA Aid and Attendance Allowance or cash benefits of a similar nature are NOT considered entitled benefits.
- D. An individual is not required to apply for RSDI to receive APTC, however if upon approval for RSDI they are entitled to Medicare Part A, they are not eligible for APTC as this is considered minimum essential coverage.

MS 1230*

SSI APPLICATIONS

(1)

Accept and process an application for Modified Adjusted Gross Income (MAGI) MA for an individual with a pending SSI application. This also includes individuals eligible in the MAGI Low Income Adult category.

Spot check each month to verify approval or denial of SSI. Take appropriate action if SSI is approved.

If the individual applies for MA in any category within 60 days of an SSI denial based on non-disability and the individual would have been MA eligible in any of the MAGI categories had the individual applied earlier, use the SSI application date as the MA application date.

If an SSI application is denied for reasons other than non-disability, and the individual applies for MA within 60 days of the SSI denial, use the SSI denial date as the MA application date.

MS 1240*

APPLICATIONS FOR THE DECEASED

(1)

Applications for the deceased are accepted but may require additional information before they can be processed. All MAGI Medicaid applications are processed on kynect. Deceased individuals who fall into the Non-MAGI categories must be processed on KAMES.

In addition the following applies:

- A. Medical bills must have been incurred during the three months prior to application or during the application month.
- B. The individual must have been financially and technically eligible at the time services were rendered.

MS 1250*

CASE FILE CONTENT

(1)

All case records represent a continuing documentation of eligibility for Insurance Affordability Programs (IAPs) and Qualified Health Plans (QHPs) and must contain sufficient material to substantiate validity of all authorized assistance.

A. The electronic case files (ECF) for IAPs and QHPs should contain the following material as appropriate:

1. Applications;
2. Documentation and verification of technical and financial eligibility;
3. All appropriate forms;
4. Hearing information;
 - a. Notice of scheduled hearing;
 - b. Recommended Order;
 - c. Final Order; and
 - d. Appeal Board Order. (Medicaid only)
5. Information regarding Quality Control review (Medicaid Only), including;
 - a. QC 343, Review Finding Notification; and
 - b. PAFS 343.1, Response to Quality Control Errors.
6. Information regarding overpayments and underpayments, as appropriate (Medicaid Only); and
- 7 Any additional pertinent information or verification.

MS 1290* CHANGES (1)

Individuals are required to report changes in circumstances within 30 days. Individuals may report changes in person, in writing, via phone call, or through the Self Service Portal (SSP).

- A. A change in circumstances is defined as a change in income, household composition, or residency which may affect ongoing eligibility for Insurance Affordability Programs (IAPs) or Qualified Health Plans (QHPs).

This includes:

1. Beginning or ending employment;
2. Increase or decrease in the number of work hours;
3. Pay rate change;
4. Increase or decrease in unearned income;
5. Change in farming/self-employment activities;
7. Change in household composition; or
8. Change of residency, including moving out of state.

- B. Do not consider normal fluctuations in income as a change in circumstances. This includes:

1. A change in work hours which will not exceed 30 days;
2. A 5th or periodic paycheck; or
3. Holidays, vacation days or sick leave not to exceed 30 days.

- C. When a change is entered on kynect, the system will attempt to verify the change in circumstances via Federal and State Data Sources. If kynect is unable to verify the reported change, a Request for Information (RFI) is issued. This includes changes reported by the individual via the SSP.

- D. If the change is not entered on kynect at the time that the individual is reporting the change in person or by phone, form PAFS-126 is completed. Form PAFS-126 is also used to report changes when the individual has a companion case on KAMES.

- E. When adding a new member on kynect the effective date is the date the change was reported. The effective date for Deemed Eligible Newborns is always the 1st day of the birth month.

1. If a member being added to the household is under age 21, provide form PA-3, Facts About the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.
2. Each member of the benefit group, other than a deemed eligible newborn, is required to furnish a Social Security Number (SSN) or apply for an SSN as a technical eligibility requirement. Members who are not enumerated, but are cooperating with the enumeration process should be included if they are requesting assistance.

If the individual returns verification for the new member, but fails to enumerate that member or indicate they are cooperating with the enumeration process, the new member is technically excluded from the case.

Do NOT require an individual to provide an SSN or apply for an SSN who will not be a member of the benefit group.

MS 1320*

STANDARDS OF PROMPTNESS

(1)

The Department for Medicaid Services (DMS) sets time frames, policy and procedures. DCBS is contracted by DMS to determine eligibility for individuals using the policy and procedures set by DMS. Applicants have 30 days to provide mandatory verification. If additional time is requested to obtain mandatory verification, pend the case over 30 days.

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 the case record the reason for the delay. A case must never pend indefinitely.

- A. The 30 day time frame allows the client time to return requested information.
- B. 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 policy clarification was requested timely and a response has not been received from MSBB (document in the case record).

- To ensure that processing time frames are met, send clarification requests to MSBB on a daily basis through your regional chain of command.

- 2. Information is discovered that the worker was not aware of at application. Mail a new RFI requesting the additional verification.

- 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 client's failure to report, mail a new RFI with an explanation of the additional information that is needed. A new due date is not appropriate and the original due date assigned is left as is.

- C. Requested documentation from a third party may take more than 30 days. If the applicant/representative can show that effort has been made to obtain the required documentation, the worker may allow a reasonable amount of time past the 30 days. This must be approved by a supervisor and the case comments are to be documented.

- 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 1460* TIMELY NOTICE OF DECREASE/DISCONTINUANCE (1)

If action is taken to discontinue benefits for an Insurance Affordability Program (IAP) 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. This 10-day period is the timely notice period.

A. Kynect will send a notice when action is taken on the system. If the system issued notice has an incorrect denial/discontinuance reason for Medicaid, immediately send a manual form MA-105, Notice of Eligibility or Ineligibility, informing the client of the correct denial/discontinuance reason. Scan form MA-105 into Electronic Case Files (ECF).

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

Example: Client reports an increase in income on 10/5/14. The change is processed on 10/9/14. Form HBE-005, Health Benefits Eligibility Notice, is issued notifying the recipient(s) of the adverse action. As the change was processed PRIOR to adverse action it will be effective 11/1/14.

C. If the timely notice period does not expire in the month form HBE-005, Health Benefits Eligibility Notice, is sent, action is taken by kynect 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 10/11/14. The change is processed on 10/25/14. Form HBE-005 is issued notifying the recipient(s) of the adverse action. As the change was processed AFTER the adverse action date, it will be effective 12/1/14.

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, is under age 65 and enters a TB hospital, or is between age 21 and 65 and enters a mental hospital or ineligible facility.
5. A recipient requests discontinuance by a signed statement.
6. Transitional Medicaid Assistance (TMA) 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.

- E. When an individual dis-enrolls from a Qualified Health Plan (QHP), kynect sends a notice to the insurance provider. The insurance provider sends the appropriate notice to the individual regarding termination of coverage. The individual's Self Service Portal (SSP) account is updated with the termination date.

MS 1490* REASONS FOR NEGATIVE ACTION (1)

Denials and discontinuances result from failure to meet technical and/or financial eligibility requirements for Insurance Affordability Programs (IAPs) and Qualified Health Plans (QHPs). Kynect generates form, "Health Benefits Eligibility Notice," for any change in eligibility.

Below are the Negative Action Reasons for Modified Adjusted Gross Income (MAGI) Medicaid, Advance Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), and QHP:

A. Financial reasons:

1. Income exceeds limit;
2. Income has increased/decreased;
3. Eligibility denied since individual did not provide premium amount for potential employer insurance.

B. Technical reasons:

1. Already received Medicaid (SSI, LTC, etc.);
2. Individual is above age limit of 64;
3. Child is above age limit;
4. Individual is over age 26 and no longer eligible for parent's QHP;
5. Ineligible for Medicaid for Transitioning Foster Care Youth as over age 25;
6. Ineligible alien/citizenship;
7. Refused to cooperate with Medical Support Enforcement (MSE);
8. Recipient deceased;
9. Individual is incarcerated;
10. Individual is not a resident of Kentucky or intends to reside in Kentucky;
11. Failure to provide Social Security Number (SSN);
12. Individual lost Minimum Essential Coverage (MEC) without good cause-ineligible for APTC;
13. Individual has not intended to file taxes;
14. Individual denied APTC as he/she is ineligible for QHP;
15. Individual denied APTC since he/she did not file a return reconciling the

- advance payments with any tax credit available;
16. Individual ineligible for American Indian/Alaskan Native (AIAN) categories, since he/she did not verify AIAN status;
 17. Individual denied APTC, since he/she has affordable employer insurance;
 18. Individual denied APTC, since his/her tax filer is APTC ineligible;
 19. Individual has MEC and is not eligible for APTC or Medicaid in the Adult or KCHIP categories;
 20. Eligibility is denied since individual has employer insurance that doesn't end 60 days from today;
 21. Individual does not meet all eligibility requirements for CSR;
 22. Failed/refused to cooperate with third party liability;
 23. Failure to sign application;
 24. Failure to provide required information during specified time frame;
 25. Pregnancy post-partum has ended.

C. Other reasons:

1. Individual denied Employer Sponsored Health Insurance (ESHI) as he/she opted out;
2. Eligibility denied as individual is neither related to nor a tax dependent of any of the members in the case;
3. Case is withdrawn for an individual;
4. Client request;
5. Unable to locate;
6. Employee terminates coverage from QHP;
7. Already received benefits;
8. Individual does not meet QHP relationship requirement;
9. Individual denied QHP, since he/she is a child of head of household and is married;
10. Approved for QHP, but outside open enrollment, individual cannot select a plan.

MS 1500*

MISREPRESENTATION AND FRAUD

(1)

If a worker discovers that the recipient or responsible party withheld information or provided false information in order to receive Modified Adjusted Gross Income (MAGI) Medicaid for which they were not entitled, refer to Volume I, [MS 1200-1240](#) for appropriate action.

If an individual reports fraud regarding MAGI Medicaid to the local office, provide the Office of Inspector General (OIG) toll-free fraud hotline telephone number 1(800) 372-2970.

Internal Revenue Service reconciles all potential over payments for Advance Premium Tax Credit (APTC).

If an individual reports fraud regarding Qualified Health Plans provide the Office of Kentucky Health Benefit Exchange (OKHBE) toll free telephone number 1(800) 459-6328.

If situations of suspected provider fraud or abuse are reported, send a memorandum with a summary of the situation to OIG. Attach a copy of any available documentation with the OIG memorandum. Scan original documentation into Electronic Case Files (ECF). Send correspondence for OIG to:

Office of Inspector General
Division of Special Investigations
275 E Main Street, 5E-D
Frankfort, KY 40621-0001

MS 1530*

KYHEALTH CARD

(1)

Kynect issues a KYHealth card at initial approval to all individuals eligible for ongoing Medicaid coverage. Kynect also issues a KYHealth Card to those individuals who have not received Medicaid on KAMES or SDX in the three prior months. If an individual has had an interruption in coverage on kynect or has received Medicaid on KAMES or SDX in the three prior months, a new card is not automatically issued. The individual should utilize the original KYHealth card, unless the individual no longer has the original card and requests a new one be issued.

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.

If the individual maintains no fixed or permanent address, and cannot provide a mailing address, the KYHealth card can be issued in care of the local DCBS office. This procedure is used only at the individual's request when no other means of delivering the KYHealth card are available.

- A. If an undelivered KYHealth card is received in the local 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 recipient. If the recipient provides a change of address, update kynect and send the KYHealth Card to the appropriate address. If the individual cannot be located, assure appropriate action is taken to discontinue eligibility.
- B. Local 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 local office is to be checked before issuing a new card.
- C. Do not process requests for duplicate KYHealth cards on new approvals less than ten days from the case disposition except in emergency medical need situations.
- D. Requests for duplicate cards for Modified Adjusted Gross Income (MAGI) Medicaid recipients are processed by Department for Community Based Services (DCBS) staff. These cards are issued by selecting MAID Card Request off of the case summary screen on kynect.
- E. Requests for duplicate cards for SSI recipients are processed by DCBS staff. These cards are issued by accessing the MAID-ISS file off the Application Selection Screen on KAMES.

MS 1600*

RETROACTIVE MEDICAID

(1)

Effective January 1, 2014 if an individual is technically AND financially eligible for Modified Adjusted Gross Income (MAGI) Medicaid during the month of application and has medical expenses in any of the three months prior to the application month, they are considered potentially eligible for retroactive coverage.

- A. An individual does not have to be ongoing eligible to receive retroactive MAGI Medicaid benefits.
- B. Client attestation is acceptable for verification of expenses.
- C. Retroactive benefits should only be issued for those months that the individual attests expenses were incurred. For example, an individual applies in April and states they incurred medical expenses in January and March. Retroactive coverage should only be issued for those two months.

DO NOT issue retroactive coverage for months that an individual did not incur a medical expense.

- D. If an individual is eligible for at least one day in the prior month, the individual is eligible for retroactive benefits for the entire month. For example, an individual was incarcerated the first 10 days of the month and then released. If all other eligibility criteria are met, the individual is eligible for MAGI Medicaid benefits for the entire month.

The Department for Medicaid Services (DMS) will ensure that no medical expenses are paid for the incarceration period.

- E. Eligibility for children who fall into the former P7 category is no longer date specific. Therefore, these individuals are potentially eligible for retroactive coverage if all other eligibility factors are met.
- F. For those individuals requesting coverage prior to January 1, 2014, eligibility must be determined on KAMES.

MS 1900* INTRODUCTION TO MANAGED CARE (1)

Managed Care Organizations (MCOs) link Medicaid recipients with participating physicians who are responsible for coordinating and providing primary medical care to these recipients.

A. The purpose of managed care is to:

1. Assure access to needed care;
2. Provide for continuity of services;
3. Strengthen the patient/physician relationship;
4. Promote the educational and preventive aspects of health care;
5. Control unnecessary utilization and related cost; and
6. Improve the quality of care received.

B. The following Modified Adjusted Gross Income (MAGI) Medicaid recipients are exempt from enrolling with an MCO:

1. Members in long term care (LTC) facilities such as nursing facilities, Hospice and ICF/MR/DD;
2. Members receiving waiver services with the exception of Non-Institutionalized Hospice;
3. Members with eligibility that is time limited such as Spend Down and Time Limited Aliens;

C. Non-exempt recipients are required to enroll with an MCO. Upon disposition of an application, if the worker does not enter shopping and assist the member in making their MCO selection, kynect will trigger the auto assignment process. An MCO will be assigned for the member using auto assignment rules.

D. Members 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 member in selecting one. Members will receive a welcome packet from the MCO that includes a handbook and other instructional material.

E. Department for Medicaid Services (DMS) maintains a managed care toll-free telephone number to assist providers and recipients who have questions pertaining to managed care. The Managed Care Member Services phone number is 1-(855) 446-1245, and is available from 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday.

The following is a list of definitions used for managed care:

[A. Managed Care Organization (MCO) – the name of the Kentucky plan approved by the Centers for Medicare and Medicaid Services (CMS), which administers managed care for Medicaid recipients through regional groupings of Medicaid providers.

The names of the KY MCO's and contact numbers are:

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

B. Managed Care – the practice of making informed judgments of what an individual needs and managing treatment to ensure necessary and appropriate care is provided.

C. 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.

D. Partnership Region – A group of counties designated by the Department for Medicaid Services (DMS) as a geographical coverage area of a partnership health plan in Kentucky. There are eight regions in the state.

E. Primary Care Provider (PCP) – The provider or specialist selected by the recipient and/or assigned by MCO, who authorizes the recipient's healthcare. Workers are not involved in the PCP selection process, beyond capturing member preference during initial shopping. Recipients should contact their MCO for information about selecting or changing a PCP.

F. Behavioral Health Services – medical services related to the treatment of mental disorders and substance abuse.

MS 1903

(2)

assignment. These are explained in the member handbook which is issued upon request.

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

MS 2110*

ENUMERATION

(1)

Each individual (including children) applying for Insurance Affordability Programs (IAPs) and Qualified Health Plans (QHPs) must provide his/her Social Security Number (SSN). The Federal HUB will verify each individual's SSN with the Social Security Administration (SSA).

Deemed eligible newborns are not required to provide an SSN during the deemed period.

- A. If an individual has an SSN, but refuses to provide it or does not meet one of the acceptable exemptions below, that individual will be deemed ineligible. If the individual does not have an SSN or it is not verified, the individual is temporarily approved and given 90 days to provide verification.
- B. The following are acceptable exemption reasons for not providing an SSN:
 - 1. Religious objections;
 - 2. Alien status; and
 - 3. Only issued an SSN for valid non-work reasons.
- C. Those individuals not seeking coverage for themselves, but who are included in the applicant's household, are not required to provide an SSN.

MS 2150 CITIZENSHIP AND IDENTITY REQUIREMENTS (1)

[All individuals applying for Modified Adjusted Gross Income (MAGI) Medicaid must verify he/she is a United States (US) citizen **or** a Qualified Alien. Refer to Volume IVB, [MS 2152](#) for Qualified Alien Criteria. Nationals of Puerto Rico, U.S. Virgin Islands, American Samoa, the Northern Mariana Islands or Swain's Island are equivalent to U.S. citizens. Individuals who are not US citizens or Qualified Aliens may still be eligible for time-limited Medicaid. See Volume IVA, [MS 1578](#).]

All individuals applying for Advanced Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), and Qualified Health Plans (QHPs) must verify he/she is a US citizen **or** a Lawfully Present Resident (LPR).

Substantiation of citizenship is an automated process performed by the Social Security Administration (SSA) and/or the Department of Homeland Security (DHS) for individuals who attest he/she is a citizen or LPR of the United States.

[Identity is considered **automatically verified** upon documentation of citizenship or Lawful Present Resident.]

Once the individual's SSN and citizenship have been verified and documented, he/she is no longer required to verify this information.

- A. Substantiation of citizenship returns one of three results:
 1. US Citizen;
 2. Non-citizen; or
 3. Additional information required.
- B. If citizenship is not verified, the case is temporarily approved and the individual will receive automatic notification that additional verification is required. Eligibility for Medicaid, APTC, CSR and QHPs is granted to the individual for up to 90 days to provide the requested verification. If the individual provides verification, the status is changed to "verified." If no verification is provided or it is insufficient, benefits are terminated at the next administratively feasible month following the end of the 90 days. If the individual reapplies, the case will only pend for 30 days to allow the individual to return the proper verification.
- C. Citizenship requirements for all MA programs are as follows:
 1. [The following individuals are not required to verify citizenship:]
 - 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 verify 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.]

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 also utilize KVETS for verification by viewing the certificate online and documenting in comments. 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) An American Indian Card, Form I-872, issued by the Department of Homeland Security with the classification code "KIC";
- 5) Final adoption decree;
- 6 Evidence of Civil Service employment by the U.S. government before June 1976;
- 7) An official military record of service showing a U.S. place of birth; or
- 8) 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 that was 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 (MSBB) 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.

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

MS 2152* CRITERIA FOR QUALIFIED ALIENS (1)

To qualify for Advanced Premium Tax Credit (APTC) or Qualified Health Plan (QHP) non-U.S. Citizens must be "Lawfully Present." These are individuals who are immigrants or noncitizens that have been inspected and admitted into the U.S. and have not overstayed the period for which they were admitted or who have current permission from the U.S. Citizenship and Immigration Services (USCIS) to stay or live in the U.S.

To qualify for Modified Adjusted Gross Income (MAGI) Medicaid non-U.S. Citizens must meet qualified legal alien status. Qualified legal aliens are individuals lawfully admitted for permanent residence who have been granted legal immigration status through the USCIS.

In addition, the Personal Responsibility and Work Opportunity Act imposed a 5 year ban for Medicaid that affects certain qualified noncitizens who entered the U.S. after August 22, 1996.

A. The following qualified aliens are subject to the 5 year date of entry ban imposed by Medicaid and **cannot** receive MAGI Medicaid (except for the time-limited MA) 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 Immigration and Nationality Act (INA) for a period of one year. If Immigration and Naturalization Service (INS) document I-94 indicates the individual will be in the 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 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; or
- 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 MAGI Medicaid and are **NOT** subject to the 5-year ban from their date of entry:

1. Lawfully present aliens under the age of 18;
2. Aliens lawfully admitted for permanent residence before August 22, 1996;
3. 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 2009 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;
4. Refugees who were admitted under Section 207 of the INA and asylees who were granted asylum under Section 208 of the INA;

Note: Sometimes refugees 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 sections 207 or 208 of the INA act to being covered under section 209 of the INA act. Individuals covered under sections 207, 208, or 209 are not subject to the 5 year entry ban.

5. 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 the lawful admission for permanent residence.

Note: The parent can apply by completing a Form N-600, Certificate of Citizenship. 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, then this can be used and the Certificate of Citizenship would not be necessary.

6. 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;
7. Aliens granted status as Cuban or 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 INS.

Note: 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.

8. 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 April 1, 1980);
9. 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);
10. 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;

11. Permanent resident aliens who are veterans honorably discharged for reasons other than alienage, their spouses or unmarried dependent children;
 12. Permanent resident aliens who are on active duty, other than active duty for training in the Armed Forces of the United States and fulfill the minimum active duty service requirements established in 38 U.S.C. 5303A(d), their spouses or unmarried dependent children;
 13. Aliens who are granted conditional entry pursuant to Section 203(a) (7) of the INA as in effect prior to 4/1/1980.
- C. Aliens designated as PRUCOL, permanently residing under color of law, are NOT eligible for MAGI Medicaid (except for time-limited MA, see MS 2153).

MS 2160*

TIME-LIMITED MA ELIGIBILITY

(1)

Effective January 1st, 2014 any alien, legal, illegal or legalized who does not meet the qualified alien requirements for ongoing Modified Adjusted Gross Income (MAGI) Medicaid, may be eligible for time-limited MA due to an emergency medical condition, if eligibility requirements are met. 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.

- A. Individuals must still meet all financial and technical requirements for MAGI Medicaid with the exception of enumeration to be eligible for time-limited coverage. Use procedures outlined in Volume IVB to determine program category, technical, and financial eligibility. Kentucky Children Health Insurance Program (KCHIP) does not provide time-limited coverage for those individuals in the P7 category.
- B. Aliens applying for time-limited MA due to an emergency medical condition are exempt from enumeration requirements. Enter the SSN if provided, but do not require application for an SSN.
- 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.
- D. Time-limited MA coverage does not include coverage for organ transplant procedure.
- E. 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
 2. Serious dysfunction of any bodily organ.
- F. Verify the emergency medical condition by obtaining a written statement from the medical provider. The statement must contain the following information:
 1. Information about the medical condition;
 2. The date of the emergency treatment; and
 3. Indicate the medical provider considers the condition an emergency medical condition.
- G. 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. All clarifying information not included in the written statement must be clarified in case notes.

- H. The emergency medical condition must have occurred in the month of application or within the 3 months prior to application.
- I. The normal delivery of a baby is considered an emergency and a covered service and the following conditions apply:
 - 1. The MA eligibility only covers the month of delivery and the following month;
 - 2. The individual is not eligible for postpartum coverage; and
 - 3. The newborn is considered deemed eligible.

MS 2162* EXTENSION OF TIME LIMITED MA (1)

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).
 - 1. 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.
 - 2. 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 that the emergency medical condition will exist for a period beyond the time-limited coverage.
 - 1. The new statement must contain detailed information regarding the recipient's emergency medical condition including the medical provider's estimate of how long the emergency medical condition will continue;
 - 2. Scan the written statement into Electronic Case Files (ECF); and
 - 3. Thoroughly document case notes than an extension has been requested.
- C. Complete all the applicable entries on form MA-33, Department for Community Based Services Medical Support and Benefits Branch DMS Review/Cover Letter and forward to MSBB mailbox at DFS.Medicaid@ky.gov via regional office.
- D. MSBB forwards the request to DMS who approves or denies the extension. For approvals, DMS provides the effective dates of the extension.
- F. MSBB notifies field staff through regional contacts of the decision.
- G. Upon receipt of an extension approval or denial, update the case accordingly.

MS 2170* AMERICAN INDIAN/ALASKAN NATIVE (AIAN) (1)

AIAN status is only relevant for Cost Sharing Reduction (CSR) benefits and special enrollment situations.

There are no tribal lands in the state of Kentucky, but tribal members do reside here. AIAN must be verified only if the individual is applying for Cost Sharing Reduction (CSR) benefits.

Tribal members carry adequate documentation of tribal affiliation at all times and this should be requested when AIAN must be verified.

No electronic sources exist to verify AIAN status.

MS 2200*

RESIDENCY

(1)

In order to be eligible for Insurance Affordability Programs (IAPs) and Qualified Health Plans (QHPs) on kynect, an individual must be a resident of Kentucky and intend to remain. An individual does not have to reside in the state for any specified amount of time to be considered a resident.

If residency criteria are not satisfied, the application will pend and at the end of 30 days, the application will deny.

State residency is based on client statement unless conflicting information is returned from a trusted data source such as returned mail from the Post Office or a Public Assistance Reporting Information System (PARIS) match is received. If there is reason to doubt, the request for information (RFI) process will be initiated and the client will be given 30 days to provide verification.

State residency is verified individually for each member in the household.

Do not deny MA because the individual:

1. Has not lived in the state for a specified period; or
2. Does not maintain a fixed or permanent address.

Kentucky residents that are temporarily absent are considered residents as long as they state they intend to reside in Kentucky.

MS 2350

INCARCERATION

(1)

An inmate of a prison, county jail, or similar facility is not eligible for benefits through the Kentucky Health Benefit Exchange (KHBE), including Modified Adjusted Gross Income (MAGI) Medicaid, enrollment in an Advanced Premium Tax Credit (APTC), Cost Sharing Reduction(CSR) or Qualified Health Plan (QHP).

- A. [The following individuals are **NOT** considered incarcerated:
1. Individuals residing in a halfway house;
 2. Individuals on house arrest; and
 3. Individuals sentenced to week-end jail. (These individuals are eligible for Medicaid; however, any expenses incurred while incarcerated on the week-end are the responsibility of the jail.)]
- B. Self-attestation is acceptable for non-incarceration status unless there is reason to doubt or worker has received information not consistent with the internal data sources.
- C. Medicaid cases will pend at application and recertification if client stated information regarding incarceration is inconsistent with data sources. An individual is given 30 days to verify non-incarceration. If verification is not provided, the individual will be denied or discontinued for incarceration.
- D. Federal Data sources will conduct ongoing checks for changes in non-incarceration status. If an individual is determined to be incarcerated, Medicaid benefits will be terminated at the next administratively feasible month.
- E. APTC, CSR, and QHP **will** approve if the information given is inconsistent with trusted data sources. In these situations, the individual is given 90 days to verify non-incarceration. If non-incarceration is not verified at the end of 90 days the case will terminate at the next administratively feasible month.

MS 2600*

PREGNANCY

(1)

Client attestation is sufficient for verification of pregnancy and due date unless there is reason to doubt.

Medicaid coverage will be given through the estimated due date plus the post-partum period.

The following conditions are applicable in this category:

- A. Post-partum begins the date the pregnancy ends and extends 60 days, ending the last day of the month in which the 60 days concludes. In order to be eligible for post-partum coverage, a woman must be eligible for Medicaid when the child is born.
- B. Once the benefits are determined, the client continues to receive through the post-partum period regardless of situation unless she moves out of state.
- C. If the pregnancy is terminated for any reason, post-partum coverage will be given to the client.
- D. If the client reports any due date changes, the length of coverage will be re-determined.

If the pregnancy estimated due date has passed and client has not reported any changes, the system will automatically discontinue pregnancy-related Medicaid benefits at the next administratively feasible month.

If a woman enrolled in the Low Income Adult category later becomes pregnant, she will automatically be enrolled in the Pregnant Women category once the information is known to the agency. After post-partum eligibility ends, she will be returned to the Adult category unless eligible in another category.

MS 2645* PRIVATE NON-PROFIT ADOPTIONS OVERVIEW (1)

Once an adoption is final, a child in a private non-profit adoption is considered the same as any other children in a parent's case. The family may apply for Modified Adjusted Gross Income (MAGI) Medicaid and eligibility will be determined based on the household situation.

If the adoption proceedings are **pending** the following criteria applies:

- A. If the private non-profit adoption agency **is not** registered with the Office of the Inspector General (OIG) during the adoption proceedings the expenses paid for any purpose related to the non-profit adoption shall be submitted to the court, supported by an affidavit, setting forth in detail a listing of expenses for the court's approval or modification.

If the private non-profit adoption agency refuses to include reimbursement for medical expenses paid by Medicaid, the child **is not** technically eligible for medical assistance.

- B. **If** the private non-profit adoption agency **is** registered with the Office of the Inspector General (OIG) the affidavit and Medicaid reimbursement requirements do not apply. These agencies are exempt from providing the documentation outlined in item A.

To view a listing of the agencies registered with OIG refer to <http://chfs.ky.gov/os/oig/drcc>. Scroll to the bottom of the website and under the DRCC Directories section click on the Child Placing Agencies Directory.

For the children meeting the criteria in items A or B the following procedure is followed:

1. The child is entered on kynect and worker should review if the child meets criteria for deemed eligibility;
2. The case is in the child's name;
3. Inquire if parental rights are terminated. Annotate this information in case notes;
4. Ask if the adoption agency carries health insurance on the child. Annotate this information in case notes; and
5. All required verification must be provided.

Note: If the adoption is subsidized, the adoptive parents will have a copy of the subsidy agreement. Subsidized adoptions are handled through the Division for Protection and Permanency (DPP). These cases are Non-MAGI and are processed by the Children's Benefits Worker (CBW). There are no special cases for private non-profit adoption children unless the adoption is subsidized by the state.

MS 2650* DEEMED ELIGIBLE NEWBORNS (1)

A newborn baby born to a mother who received Medicaid in Kentucky at the time of the newborn's birth is considered deemed eligible. This includes receipt of Medicaid in any category, including Modified Adjusted Gross Income (MAGI) Medicaid, Non-MAGI Medicaid, Time-Limited Medicaid, SSI, or K-TAP.

Once deemed eligible, the newborn is guaranteed Medicaid from the birth month through the 12th month regardless of whether the mother and/or other case members remain eligible to receive Medicaid. Medicaid must be issued for a deemed eligible newborn even if the mother does not want the coverage.

- A. A child is considered a deemed eligible newborn even in situations where:
1. The Medicaid application for the mother is made after the birth of the newborn, as long as the birth month is the month of application or one of the 3 retroactive months for which the mother is approved.
 2. The mother is approved for spend down eligibility and the excess is obligated on or before the newborn's date of birth.
- B. Kynect will interface with Vital Statistics regarding newborns. If the mother's case is identified on kynect, the deemed eligible newborn will be automatically added to the case and coverage will be issued. If the mother's information is not found on kynect, the newborn information will be sent to Department for Medicaid Services (DMS) for resolution.
- C. If the deemed eligible newborn's birth information is reported to the Department for Community Based Services (DCBS) and the newborn is not active on kynect, action must be taken to add the child and issue coverage.
- D. If the newborn's mother receives MA in an SSI case, an Adult Medicaid or in a Foster Care (P), Subsidized Adoption(S), or DJJ case set up a separate case for the newborn on kynect.
- E. After the newborn's first birthday, all technical and financial eligibility requirements must be met for the child to continue to receive MAGI Medicaid. If a child's birthday is after the first day of the month, deemed eligibility ends that month.

For example: A deemed eligible child's date of birth is 5/15/13, therefore deemed eligibility will end 5/31/14 and the child must meet all eligibility requirements effective 6/1/14 in order to continue to be eligible for MAGI Medicaid

If the child's birthday is the first day of the month, deemed eligibility ends the prior month.

For example: A deemed eligible child's date of birth is 5/1/2013, therefore deemed eligibility will end 4/30/14 and the child must meet all eligibility requirements effective 5/1/2014 in order to be continued eligible for MAGI Medicaid.

MS 2660*

TARGETED LOW INCOME CHILD

(1)

With the new MAGI calculation of income, some children may be found income-eligible for Medicaid when their case is converted from KAMES to kynect. A child receiving Medicaid prior to the Affordable Care Act (ACA) rules who is determined financially ineligible during conversion may be eligible to receive for an additional year.

- A. Any child enrolled in Medicaid as of December 31, 2013 who is considered income ineligible when the conversion to MAGI Medicaid occurs, will have continued eligibility until his/her next renewal period.
- B. Children meeting the above criteria must complete a recertification interview in order to continue to receive benefits under this new category (conversion renewal).
- C. Deemed eligibility for this group will expire a year following the conversion process.
- D. Children receiving KCHIP III (P7) with income in the 150% - 200% Federal Poverty Level (FPL) will not remain eligible as a targeted low income child.

MS 2700* MAGI SPEND DOWN PROCESS (1)

Modified Adjusted Gross Income (MAGI) spend down provides time-limited Medicaid (MA) to individuals in all MAGI categories, except Low Income Adults, who meet technical requirements but have income in excess of the appropriate Federal Poverty (FPL) Scale for the Eligibility Determination Group (EDG) size.

MAGI spend down eligibility is explored only in the retro quarter due to potential ongoing eligibility for Advance Premium Tax Credit (APTC). Individuals may apply for a retro spend down the following month(s) provided they were not approved APTC and enrolled in a Qualified Health Plan (QHP) during the month the medical expense was incurred.

Example: Bob had surgery on 2/5/16 and applies for financial assistance on 2/10/16. He is technically eligible in the PACA category but over the income limit for MA and is approved APTC. He enrolls in a QHP effective 3/1/2016; however wishes to explore potential spend down eligibility for February due to medical expenses. Bob should be advised to apply for retroactive spend down coverage the following month.

Worker Portal reviews for regular MA eligibility before it determines spend down eligibility. Eligibility may be established only for a RETROACTIVE quarter and 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 applies:
1. The applicant must verify the actual MEDICAL EXPENSES that 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 MA household even if that member is not applying for or receiving MA. 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 a spend down application is made.
- B. Spend down MA 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 MA. 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 MA.

Example: The spend down obligation amount is \$1200.00 for the spend down period of 3/23/16 through 5/31/16. The household is responsible for payment of bills prior to 3/23/16 used to meet the obligated spend down amount, as well as the \$1200.00 spend down obligation. If the first bill received by DMS is for services on 4/6/16 for \$600.00, the amount of that bill are deducted from the obligated amount of \$1200.00. The next bill received by DMS is \$300.00 for services on 3/23/16, and a bill is submitted the same day to DMS for \$300.00 for services on 5/1/16. 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 are paid by DMS as long as they are within the spend down period of 3/23/16 through 5/31/16.

If an individual has a large bill covering several days, it is appropriate to enter daily amounts rather than the total so that worker portal can determine the correct date the individual met the spend down obligation.

Example: Mary applies for retroactive spend down coverage on 3/1/16. Her spend down obligated amount is \$1600.00. She was hospitalized 2/6/16 through 2/10/16 and the total bill is \$ 9000.00. The itemized bill provided shows that Mary was charged \$1500.00 on 2/6/16, \$2500.00 on 2/7/16, \$2500.00 on 2/8/16, and \$1500.00 on 2/9/16, and \$1000.00 on 2/10/16. By entering the daily amounts, Worker Portal will correctly determine that Mary met her spend down obligation on 2/7/16.

- C. 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.
- D. If health insurance coverage other than MA 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.
- E. 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.
- F. A spend down application is approved as soon as possible, but not to exceed 30 days from the date of application unless additional time is requested by the applicant. When the verification is received, the case must be worked WITHIN 7 WORK DAYS from receipt of the required verification or the 30th day, whichever is first.
- G. 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.
- H. If, after a determination has been made, additional verification of medical expenses are provided by the recipient, a recomputation is completed.

1. If it is determined that the spend down liability was met earlier in the quarter, complete a Special Circumstance Transaction to authorize MA 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.
- I. If medical expenses for the requested period (one, two, or three months) are less than the excess income, deny the application.

Example: Sue requests a one month spend down and her excess income is 1000.00, however total medical expenses are 800.00.

MS 2710* MEDICAL EXPENSES IN MAGI 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 school attendance. Unless already receiving Medicaid (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.

A. Consideration of Medical Expenses:

1. Consider any verified allowable medical expense(s) incurred DURING the retro quarter. Begin with the first day of the quarter and list daily expenses.
2. Consider the unpaid balance of any verified allowable medical expense incurred PRIOR TO the established quarter.
 - a. Consider the expense as incurred on the first day of the first month of the established quarter.
 - 1) 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.
 - 2) 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.
 - b. Consider only the portion of the expense needed to obligate the spend down excess.
 - 1) 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.
 - 2) Review the case record to ensure the medical expense has not been considered in a previous quarter to establish MA eligibility.

EXAMPLE: An individual's spend down excess for the prior 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 retro quarter for spend down. The remaining \$300 of the bill can be used to obligate a future spend down excess.

3. 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. Every month a \$25 payment is made on the account. The individual applies for a MA spend down case. Consider the \$25 as an allowable medical expense and record as a spend down expense the day the \$25 payment is made.

4. When all verified allowable 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.

B. Verification of Medical Expenses:

1. Medical bills or statements;
2. Receipts for payment of medical expenses;
3. Medicare Summary Notices (MSN) which shows covered/uncovered and aid/unpaid medical expenses;
4. Health insurance statements showing amount paid;
5. Other appropriate means.

C. Medical Expense Restrictions:

1. Do not list any expense to be paid by a third party, such as Medicare, health insurance, insurance settlement, family members, etc. with the following exceptions:
 - a. 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.
 - b. For persons undergoing renal dialysis treatment, do not hold spend down applications pending for Medicare Summary Notices (MSN) if the following applies as these cases are given priority and processed as soon as the spend down liability is met:
 - 1) They have Medicare but no other health insurance;
 - 2) 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; and

- 3) 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.
2. Unpaid medical expenses are allowed as a spend down medical expense however:
 - a. 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.
 - b. 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.

3. All bills, statements, and receipts, must show the actual date of service and daily charge to determine the day the excess is met.
4. Deductions for prescription drug expenses incurred during a period of MA eligibility may be allowed ONLY if the recipient verifies that MA 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.

D. Allowable Spend Down Medical Expenses

The following are allowable medical expenses used in determining spend down eligibility:

1. 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 individual 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.

2. 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.
3. Nursing facility insurance premiums.
4. Transportation expenses for health care that are not available free of charge. Costs for use of the individual's own are deductible at the state rate per mile;
5. The actual amount paid for caretaker, Family Care or Personal Care 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.
6. In-patient hospital services including services in institutions for tuberculosis, mental disease or other specialty hospitals regardless of age;
7. Laboratory and x-ray services;
8. Nursing Facility services, including services in institutions for tuberculosis or mental disease, for all individuals regardless of age;
9. Any physician's services;
10. 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;
11. Home health care services, including intermittent or part-time services of a nurse or home health aide according to a physician's plan of treatment;
12. Private duty nursing services by a Licensed Practical Nurse or Registered Nurse;
13. Clinic services;
14. Dental services, including dentures prescribed by a licenses and practicing dentist;
15. Physical therapy and related services including supplies such as hearing aids;
16. Drugs prescribed by a licensed physician, osteopath, or dentist;
17. Prosthetic devices, including braces and artificial limbs;

18. Eye glasses and other aids to vision, prescribed by an ophthalmologist or an optometrist;
19. Ambulance services when medically indicated and/or other transportation cost necessary to secure a medical exam or treatment;
20. X-ray, radium and radioactive isotope therapy;
21. Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations and related items used at the direction of physician for the continuing treatment of a health problem;
22. 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;
23. Purchase, care and Maintenance costs of Seeing Eye Dogs:
24. 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.
 - a. Question the individual to determine if circumstances necessitated lodging and explain in case comments.
 - b. If the need for lodging cannot be determined, request a physician's statement to verify reported expenses were actually medically necessary.
 - c. The allowable amount may not exceed commercial lodging costs prevalent in area.
25. 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.
 - a. Examples of public programs of the State include hospitals, health departments, community service centers, primary care centers operated by local health departments, and comprehensive care centers.
 - b. 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.
 - c. 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.
26. Any item verified per a doctor's statement that is medically necessary for controlling a patient's allergy problem such as purchase of electrostatic air

filters, humidifiers, air conditioner, central heating system, hardwood floors, payment for carpet/upholstered furniture clearing, and carpet removal.

27. Other items clearly identified as medical in nature such as aspirin, antacids, peroxide, Band-Aids, nutritional supplements such as Ensure, and incontinent care products. Cash register receipts are acceptable verification of the expense. If the receipt does not specify the item, the individual's statement is accepted.
28. Consider charges from a physician who is not enrolled in the MA program as a medical expense, however even though the expense can be deducted, MA cannot make payments to a physician who is not enrolled an enrolled provider.

MS 2900 MAGI HOUSEHOLD DETERMINATION (1)

For Insurance Affordability Programs (IAPs) and Qualified Health Plans (QHPs), household composition is determined based on Filer or Non-Filer rules. Each individual is designated a Filer or a Non-Filer based on tax filing status.

Once designated either a Filer or Non-Filer, an Eligibility Determination Group (EDG) is constructed for each eligible individual. The EDG determines the household size and income that is considered for each individual. **[An individual DOES NOT have to be applying for assistance to be included in an EDG.]**

A. **Filer Group:** This includes those individuals considered either a tax filer or a tax dependent:

1. A tax filer is an individual who intends to file an income tax return for the benefit year and no other tax payer will claim this person as a dependent. This includes spouses filing a joint income tax return; or
2. A tax dependent is an individual for whom someone else claims a personal exemption deduction during the taxable year.

[The EDG for an individual designated a Filer includes all members of the tax household. This determination is made based on client attestation on how the individual intends to file federal income taxes the next possible filing year. All members of the tax household are included in the EDG regardless of living situation.]

B. **Non-Filer Group:** This is an individual who either does not intend to file taxes **or** meets one of exceptions listed below.

[Note: Non-Filers are not eligible for Advance Premium Tax Credits (APTC) or Cost Sharing Reductions (CSR).]

1. The individual expects to be claimed as a dependent by someone other than a spouse, biological, adopted or step-parent;
2. A child under the age of 19 living with both parents and the parents do not intend to file jointly;
3. A child under age 19 who will be claimed by a non-custodial parent; or

[The EDG for an individual considered a non-filer includes the individual plus the following members if living together:

- a. Spouse;
- b. The individual's children if they are under the age of 19; and
- c. If the individual is under age 19, includes the individual's parents and any siblings under the age of 19.

Note: Spouses who reside together count in each other's EDG, regardless of filing status.]

EDG Examples

[Example: #1: A Household applying for financial assistance for all members includes unmarried parents and their 3 children, ages 4, 6, and 10. They state they do not intend to file taxes; therefore, all members fall under Non-Filer rules.

The children's EDG size is 5 as they are all under the age of 19 and included are their siblings and parents.

Each parent's EDG is 4 including the parent and all children under the age of 19. They would not be included in each other's EDG as they are not married.

Example #2: Mother applies for financial assistance for herself and her 10 year old son. She states she files single and the child will be claimed as a dependent by a noncustodial parent for the next tax year.

The child's EDG is 2 as he meets one of the exceptions listed above and falls under Non-Filer rules. Non-Filer rules state to include parents who are living with any child under the age of 19.

The mother's EDG is 1 as she falls under Filer rules and this includes only her tax household.

Example #3: Grandmother is applying for financial assistance for herself and her 14 year old granddaughter. She files as head of household with the granddaughter as her dependent.

The child's EDG is 1 as she falls under Non-Filer rules. She is being claimed by someone other than a parent and therefore meets an exception.

The grandmother's EDG is 2 as she falls under Filer rules and included is everyone in her tax household.

Example #4: The household consists of married parents and their minor child. They state they intend to file a joint income tax return for the benefit year with minor child as a dependent.

The parents meet the definition of a tax filer and the child meets the definition of a tax dependent. Therefore all three fall under Filer rules and all members of the tax household would be included in each other's EDG. This would be an EDG size of 3 for each member.

Example #5: A 23 year old individual applies for financial assistance. He states he is a full-time student who maintains his own residence, but is claimed as a dependent on his parent's taxes. He states his parent's file "married filing jointly," and he is the only dependent claimed.

The 23 year old meets the definition of a tax dependent therefore, he falls under Filer rules and his EDG would be 3. His parents are included in his EDG even though they are not applying for assistance.

Note: If he works and files taxes to recover his withholdings, he is both a filer and dependent. IAP's default to dependent rules in these situations.

Example #6: A 35 year old applies for financial assistance. She states that she files as head of household and claims her 63 year old mother as a dependent. She meets the definition of a tax filer and falls under Filer rules.

EDG size is 2. EDG includes her and her mother as no exceptions apply and therefore is based on tax household.

Example #7: A 40 year old applies for financial assistance and is the only member of the household. He states he files taxes and claims his 14 year old son, who resides with the mother, as a dependent.

His EDG would be 2 as he follows Filer rules and includes everyone in his tax household.

Example #8: A 60 year old man and his 24 year old son reside together and both are applying for financial assistance. The father states he is a tax filer and claims his adult son as a dependent.

The EDG size is 2 for both members. EDG is determined by tax household as no exceptions apply in this situation.

Example #9: A 30 year old woman applies for financial assistance. She resides with her mother and states she files taxes as "single" and is not a dependent in any other tax household.

Her EDG size is 1. No exceptions apply and therefore the EDG is determined by tax household.]

MS 2910

MAGI INCOME SCALES

(1)

Modified Adjusted Gross Income (MAGI) income is compared to the appropriate Federal Poverty Level (FPL) for the Eligibility Determination Group (EDG) size for Advanced Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), and MAGI Medicaid categories for Children under age 19, Pregnant Women, and Low Income Adults.

Individuals in the Parent/Caretaker Relative category of MAGI Medicaid are compared to the current MA scale.

- A. Low Income Adults, Pregnant Women and Infants in P-3 Category, and children in the P-1, P-2, and P-7 category are allowed a 5% disregard if needed to gain eligibility. If income exceeds the initial income limit, 5% is added to the FPL for the appropriate EDG size and income compared to the increased scale for eligibility. Worker Portal automatically compares the income to the high FPL scale if necessary for eligibility.

For example, if an individual in the Low Income Adult Category has income that exceeds 133%, the countable income is compared to 138% FPL for determining eligibility.

- B. This 5% is not applied for individuals in the following categories:

1. Children in the P-6 Category;
2. Individuals in the Parent/Caretaker Relative Category; and
3. Individuals receiving APTC or CSR.
4. The FPL chart below outlines the appropriate FPL APTC, CSR, and the MAGI Medicaid categories of Children under 19, Pregnant Women, and Low Income Adults

Type	FPL	With 5% Disregard
Low-Income Adult age 19-64	133%	138%
Medicaid Children age 6-18 (P-1)	133%	138%
Medicaid Children Under age 6 (P-2)	142%	147%
Medicaid Infants under 1 and Pregnant Women (P-3)	195%	200%
KCHIP for children ages 0 -19 (P-6)	159%	n/a
KCHIP III for children ages 1-19 (P-7)	213%	218%
APTC	400%	n/a
CSR	250%	n/a

- C. If total countable income is equal to or less than the appropriate FPL Scale, income eligibility is met.

[D.MAGI Medicaid utilizes the most recent FPL income limits in eligibility determination. Refer to the chart below for MAGI Medicaid income limits effective 4/1/2016:

EDG Size	100%	133%	138%	142%	159%	195%	200%	213%	218%	250%	400%
1	990	1,317	1,366	1,406	1,574	1,931	1,980	2,109	2,158	2,475	3,960
2	1,335	1,776	1,842	1,896	2,123	2,603	2,670	2,844	2,910	3,338	5,340
3	1,680	2,234	2,318	2,386	2,671	3,276	3,360	3,578	3,662	4,200	6,720
4	2,025	2,693	2,795	2,876	3,220	3,949	4,050	4,313	4,415	5,063	8,100
5	2,370	3,152	3,271	3,365	3,768	4,622	4,740	5,048	5,167	5,925	9,480
6	2,715	3,611	3,747	3,855	4,317	5,294	5,430	5,783	5,919	6,788	10,860
7	3,061	4,071	4,224	4,346	4,867	5,969	6,122	6,520	6,673	7,652	12,243
8	3,408	4,532	4,702	4,839	5,418	6,645	6,815	7,258	7,428	8,519	13,630

E. APTC and CSR are required to use the same FPL limits for an entire coverage year. The charts below were effective 10/1/2015 and are utilized for APTC / CSR for the coverage year of 1/1/2016-12/31/2016:

Monthly

EDG Size	100%	150%	200%	250%	300%	400%
1	981	1,472	1,962	2,453	2,943	3,924
2	1,328	1,992	2,655	3,319	3,983	5,310
3	1,675	2,512	3,349	4,186	5,023	6,697
4	2,021	3,032	4,042	5,053	6,063	8,084
5	2,368	3,552	4,735	5,919	7,103	9,470
6	2,715	4,072	5,429	6,786	8,143	10,857
7	3,061	4,592	6,122	7,653	9,183	12,224
8	3,408	5,112	6,815	8,519	10,223	13,630

Yearly

EDG Size	100%	150%	200%	250%	300%	400%
1	11,770	17,655	23,540	29,425	35,310	47,080
2	15,930	23,895	31,860	39,825	47,790	63,720
3	20,090	30,135	40,180	50,225	60,270	80,360
4	24,250	36,375	48,500	60,625	72,750	97,000
5	28,410	42,615	56,820	71,025	85,230	133,640
6	32,570	48,855	65,140	81,425	97,710	130,280
7	36,730	55,095	73,460	91,825	110,190	146,920
8	40,890	61,335	81,780	102,225	122,670	163,560

F. Income for individuals in the Parent/Caretaker Relative Category is compared to the current MA scale below:

EDG SIZE	Standard
1	285
2	358
3	422
4	521
5	611
6	692
7	775
8	858

G. Individuals determined over the income limit in the Parent/Caretaker Relative category automatically have eligibility explored in the Low Income Adult category.]

MS 3000*

INCOME ELIGIBILITY

(1)

Income is considered verified for all Insurance Affordability Programs (IAPs) when the client stated amount and that received from the trusted data source is reasonably compatible. Reasonable Compatibility is defined as a 10 percent difference between the self-attested amount and the information returned by the trusted data sources.

If income information is returned by the trusted data sources and is not within the reasonable compatibility, the individual is given the opportunity to provide satisfactory documentation.

For Medicaid, if income information received from the Federal Hub is not within reasonable compatibility, eligibility is held pending for 30 days or until the verification is provided, whichever is earlier. If at the 30-day limit no verification is received, at worker discretion, more time may be allowed. If additional time is not deemed appropriate and verification has not been provided, eligibility will be determined by the information from the Federal Hub that was received at initial application.

For Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR), if income is not within the reasonable compatibility, the application is approved based on client stated information for an initial 90-day period. The individual is issued a Request for Information (RFI) to provide verification of the client stated amount. If this information is not provided at the end of the initial 90-day period, kynect will re-determine eligibility based on the trusted data sources.

The following are examples of reasonable compatibility:

- A. If the individual attests to income that is greater than the MAGI income limits, then he/she will be determined ineligible for MAGI Medicaid and the application will be denied, regardless of what the trusted data sources return. The individual has the opportunity to appeal this decision.
- B. If self-attestation of income and that returned by the trusted data sources are both below the MAGI income limits, then self-attestation is sufficient and the application is approved based on the self-attested amount.
- C. If self-attestation of income is below the MAGI income limit but the trusted data sources return information above the income limit, as long as the self-attested amount is reasonably compatible, then the self-attested amount will be taken and application approved based on this amount.
- D. For APTC, if the client stated income is above that of the trusted data sources, client stated amount is accepted and this is considered reasonably compatible.

Individuals are given the opportunity to dispute and provide satisfactory verification at any time if electronic information received will negatively impact the individuals' determination of eligibility.

MS 3100*

INCOME

(1)

Income is money received from sources including, but not limited to, wages, self-employment, nonrecurring lump sums and statutory benefits, such as Unemployment Insurance Benefits (UIB) and RSDI. Modified Adjusted Gross Income (MAGI) income is based on the previous year's tax return. If an individual states that the previous year's tax return is not representative of the current year or if income has changed, the individual must provide verification of the current income to be considered in the case.

Both Federal and State data sources are used to verify income. The Federal data source is the initial source for verification and takes precedence over all other data sources. The client stated amount and the income verified by the trusted data sources must be compatible within 10 percent or the individual must provide additional verification.

For MAGI Medicaid, the individual is allowed 30 days to return any required income verification. The 30 day count starts the day the Request for Information (RFI) is generated.

For Advanced Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR), if the individual is required to provide verification of income they are approved for an initial 90 days and an RFI is sent to the client. If the information is not provided at the end of 90 days, eligibility will be re-determined based on information received from the trusted data sources.

For MAGI Medicaid if the total countable income exceeds the appropriate Federal Poverty Level (FPL) kynect will apply a 5 percent increase to the FPL. Income is then compared to the increased FPL for the eligibility determination. This is only used to determine initial eligibility and is not used to move an applicant to a higher level of coverage, for example Medicaid to KCHIP. This deduction is not applied to APTC or CSR for eligibility determination.

MS 3150* MAGI INCOME DOCUMENTATION (1)

Modified Adjusted Gross Income (MAGI) calculation is based on federal tax rules. MAGI total is the Adjusted Gross Income (AGI) plus tax exempt interest, foreign income earned, RSDI received by adults, and taxable RSDI received by dependents if they have a tax filing requirement.

Client stated income entered in kynect should reflect an individual's current and ongoing situation. Client stated income is entered into the "Simplified" income calculation on kynect. If the stated income meets reasonable compatibility it is considered "Passed" and no further verification is required.

If the income does not meet reasonable compatibility it will "Fail" federal and state data matches. The worker will then enable the "Detailed" radio button on the Income Summary screen and enter income information. Documentation of income is required on "Detailed" entries.

Do not limit an individual to one particular type of verification. When documentation is requested, the worker should review the various acceptable sources with an individual. All documentation of income is scanned into Electronic Case Files (ECF).

Documentation may come from a variety of sources including but not limited to the following:

A. Federal Tax Forms:

1. Forms 1040, 1040A, and 1040EZ and appropriate supplemental federal forms.
2. Wages can be verified using tax forms as long as the individual states that what they earned last year, they anticipate earning this benefit year. This income can be entered as an annual amount; however, workers should ensure that the income covered the entire taxable year. If not, calculate and enter as monthly amount.

For example, an individual indicates that the wages verified on form 1040 are only for a six month period as current employment started on 6/1/2014. Divide the total by 6, enter as a monthly amount, and document in case notes.

3. Review all entries on the tax form and ensure that the income received the previous tax year is representative of the current situation.
4. If an IRA distribution is shown on the form, inquire if the individual plans to take the distribution in the current benefit year. A written statement from the individual is acceptable verification if he/she states they do not intend to take the distribution.
5. Tax forms should not be used to verify RSDI or Unemployment benefits. These are entitled benefits and should be verified using an award letter, system inquiry, or contact with the appropriate agency.

6. Self-Employment and Farm Income can also be obtained from these forms by reviewing the appropriate entries on federal tax forms.

B. Wage Stubs:

1. Request prior two months if representative. Documentation of prior two months may include but is not limited to the following: actual pay stubs, printout from employer, or pay information obtained from the Work Number.
2. Pay stubs should be entered according to pay date.

For example, if a person is paid weekly, workers should enter each pay stub as a separate weekly amount.

3. When entering income from pay stubs, do not include in the gross any pre-taxed amounts such as deductions for IRA or HealthCare Spending Accounts. Workers should review pay stubs for these pre-taxed amounts and clarify any questions with the individual.
4. Determine if all pay received in prior two months is representative of ongoing income. If it is determined that a pay stub(s) is not representative, answer "no" to "include in projections" on Income Pay Details screen. Document in case notes the reason(s) the check is not included in ongoing projections.

For example, the client states that a pay stub received is not representative as it included overtime and this is not anticipated ongoing.

C. Award Letters:

1. Current award letters can be used to verify entitled benefits such as RSDI or Unemployment Insurance Benefits (UIB).
2. Award letters can also be used to verify pensions such as VA or private pensions.

D. Written Statement:

1. Workers may use a written statement from an employer to verify ongoing income if prior wage stubs are unavailable or not representative.

For example, an individual has been employed for several months at the same business, but states that they are going to receive a raise in pay effective with their next pay period. Because the prior two months are not representative of the ongoing situation, request an employer statement including amount, effective date, and other pertinent information.

2. Forms such as PAFS-700 may also be used in lieu of a written statement.

E. Personal Records:

1. Personal Records may be used to verify income if tax forms are not appropriate.

2. Request income AND expenses if verifying self-employment.

F. System Inquiry:

1. Program 48, "WAGE RECORDS," on KYIMS
2. Program 39, "NEW BENDEX," on KYIMS
3. Program 4B, "UI BENEFITS," on KYIMS
4. SDX "Supplemental Data Exchange"

G. Collateral Contacts:

1. Person and/or Agency issuing payment;
2. Document in comments name, date, and phone number of collateral.

MS 3160* VERIFICATION OF NO INCOME (1)

Client statement of no income is accepted for all Insurance Affordability Programs (IAPs) including Modified Adjusted Gross Income (MAGI) Medicaid.

- A. Verification of no income is not required for any member of the household, including the head of household, unless questionable.
- B. For individuals whose statement of no income is accepted, select "No" from the drop down menu on kynect for the question, "Is no income verification required?"
- C. If the client's statement of no income is questionable, select "Yes" from the drop down menu on kynect for the question, "Is no income verification required?" and request verification. Document in case notes why verification is being requested.

Verification can be provided by collateral contact, a signed written statement from a non-household member, or Form PAFS-702, Proof of No Income.

MS 3180* MAGI DEDUCTIONS (1)

Modified Adjusted Gross Income (MAGI) calculations allow for certain deductions from the Adjusted Gross Income (AGI). Verification of MAGI deductions is not mandatory. If an individual fails to provide the requested documentation, eligibility will be determined without the deduction.

A. Tuition and Fees;

1. The deduction is allowed only for tuition/fees for post-secondary education in an eligible institution;
2. Maximum allowable deduction is \$4,000.00;
3. The deduction is entered under the person responsible for payment of the expense; and
4. Acceptable verifications are Form 1098-T, Federal Tax Forms 1040 (Line 34), or Federal Tax Form 1040A (Line 19).

B. Educator Expenses:

1. Maximum Allowable deduction is \$250.00 for a single filing status or \$500.00 for a married filing joint tax return;
2. Acceptable verifications are Federal Tax Forms 1040 (Line 23) or Federal Tax Form 1040A (Line 16).

C. Student Loan Interest:

1. Deductions should be entered on kynect under the person responsible for the expense;
2. Acceptable verification is Form 1098-E, Federal Tax Form 1040 (Line 33) or Federal Tax Form 1040A (Line 18).

D. Contributions to Health Savings Account:

1. Deductions should be entered on kynect under the person making the contribution;
2. Acceptable verifications are check stubs under Voluntary Deductions, annual statements or Federal Tax Form 1040 (Line 25).

E. IRA Contributions:

1. Deductions should be entered on kynect under the person responsible for the contribution;
2. Acceptable verification is Federal Tax Form 1040 (Line 32).

F. **Alimony:**

1. Deduction should be entered on kynect under the person making the contribution;
2. Acceptable verifications are Federal Tax Form 1040 (Line31a) or Court Documents.

MS 3200* EXCLUDED INCOME (1)

Excluded income is income received but not considered in determining financial eligibility. The following types of income are considered as excluded income in MAGI Medicaid

- A. Child Support;
- B. Black Lung;
- C. Worker's Compensation;
- D. Veteran's Disability (VA Pension is countable);
- E. K-TAP and Kinship Care payments;
- F. SSI benefits and any other income of SSI beneficiaries;
- G. SSI essential person's portion of the SSI payment;
- H. Low Income Home Energy Assistance Program (LIHEAP) payments;
- I. In-kind income;
- J. Any payment made by the Division of Protection and Permanency (DPP) for child foster care, adult foster care, subsidized adoptions, or personal care assistance;
- K. Home produce for household consumption;
- L. Vendor payment income, payments on behalf of or for the benefit of the individual, other than the State Supplementation individual made DIRECTLY to a doctor, pharmacist, landlord, or utility company by another individual;
- M. Income of a child technically excluded from MA case;
- N. MAGI Medicaid child's earnings when below the limit required to file Federal Income Tax;
- O. All student work-study income, education 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;
- P. Principal of loans, including educational loans;
- Q. Highway relocation assistance;
- R. Urban renewal assistance;
- S. Federal disaster assistance and State disaster grants;

- T. Reparation payments from the Federal Republic of Germany;
- U. Experimental housing allowance program payments made under the 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 for existing housing under Title 24, Part 882;
- 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. VISTA volunteers under Title I of PL 93-113 to Section 404(g);
 - 3. 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;
 - 4. Indian tribe members under PL 92-524, PL 92-134, and PL 94-114 pursuant to Section 5 effective October 17, 1975 or PL 94-540;
 - 5. Natural children of women's veterans who served in Vietnam during the Vietnam era who receive benefits based on Sec. 401 of the Veteran Benefits and Health Care Improvement Act of 2000, Public Law 106-419;
- W. Consider the income not available when the parties of jointly held income are not willing to release their portion of the income or one party cannot be contacted for a release of his/her portion. Verify that litigation would be required or is pending to determine to whom an income belongs. Spot-check monthly or in the month the litigation is completed;
- X. Reimbursement for:
 - 1. Training-related expenses made by a manpower agency to recipients in institutional or work experience training;
 - 2. Transportation, lodging and meals in performance of employment duties, if identifiable; and
 - 3. Training-related expenses or other reimbursements by WIA to a MA child.
- Y. Income excluded by terms of a trust;
- Z. Small nonrecurring cash gifts, of \$30 or less, but not totaling more than \$30 per member of the assistance group per month. See MS 4377;
- AA. Education related transportation payment and school supplies provided by a public agency or nonprofit organization;
- BB. 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;

- CC. Federal tax refunds are excluded as income for 12 months from the month of receipt. This includes advance Earned Income Tax Credit (EITC) payments;
- DD. All payments received from Agent Orange;
- EE. Interest on burial reserves, if allowed to accrue;
- FF. Any payments received from the Radiation Exposure Compensation Trust Fund;
- GG. Austrian social insurance payments based, in whole or part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act;
- HH. Educational grants and scholarships obtained and used, even if conditions do not preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill; education 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 for a student carrying the same academic workload as determined by the institution, and including cost for rental or purchase of any equipment, materials or supplies required of all students in the same course of study; and
 - 2. 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.
- II. AmeriCorps educational awards paid directly to the institution;
- JJ. Payments made by Nazi Persecution Victims Eligibility Benefits Act (PL 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;
- KK. Money paid to hemophiliacs as a 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;
- LL. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit;
- MM. Family Alternatives Diversion (FAD) payments;
- NN. Kentucky Works Program (KWP) supportive services and transportation

payments;

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; and

PP. Gifts and Inheritances.

MS 4300 QUALIFIED HEALTH PLAN (QHP) (1)

[Individuals who are not eligible for MAGI Medicaid or who are looking for affordable health care coverage may enroll in a 2016 coverage year QHP through the Kentucky Health Benefit Exchange (KHBE). In addition to enrolling in a 2016 coverage year QHP, individuals can also apply for financial assistance in paying for a 2016 coverage year QHP on KHBE through the Advanced Premium Tax Credit (APTC) program and Cost Sharing Reduction (CSR) program.

NOTE: Beginning with the 2017 coverage year, all QHP eligibility determinations and enrollments will occur through the Federally Facilitated Marketplace (FFM).

- A. A QHP is a commercial insurance plan offered through the KHBE for the 2016 coverage year and through the FFM for the 2017 coverage year ongoing. These plans are offered to residents at full premium cost without subsidy or with premium assistance for qualified individuals. These plans are available to all non-incarcerated individuals who are US citizens or are lawfully present and are residents of Kentucky.
- B. Individuals receiving Medicare are not eligible to purchase a 2016 coverage year QHP on kynect as this is considered duplicate coverage.
- C. 2016 coverage year QHPs available on the KHBE offer various levels of coverage. Each level ensures an approximate level of coverage for an individual regardless of which insurance plan they select.]

The following is a list of the levels of coverage offered with the approximate percent of the individual's expenses paid by the insurer:

- 1. Bronze - 60/40
- 2. Silver - 70/30
- 3. Gold - 80/20
- 4. Platinum - 90/10
- 5. Catastrophic plans

EXAMPLE: Bronze is the lowest level of coverage that meets the Affordable Care Act (ACA) requirements. A bronze plan should cover approximately 60 percent with the individual paying approximately 40 percent.

Issuers participating in the KHBE are only required to offer a Silver and Gold level plan and a catastrophic plan in the individual insurance market.

- D. An individual may submit an application for enrollment in a QHP at any time during the year, but the individual can only enroll during open enrollment and special enrollment periods.
 - 1. [Open enrollment- The initial open enrollment (for 2017) will begin

November 1, 2016, and extend through January 31, 2017.]

A plan selected during open enrollment cannot be effective prior to January 1st. However, the actual effective date after January 1st is dependent upon when an individual enrolls and when their premium payment is received.

2. [Special enrollment occurs when a qualified individual or enrollee experiences a qualifying event. An "enrollee" is an eligible individual enrolled in a 2016 coverage year health plan. A "qualified individual" is an individual who has been determined eligible but is not enrolled in a 2016 coverage year health plan.

The individual has 60 days from the date of the qualifying event to select a 2016 coverage year QHP. A qualified individual may enroll or make changes to the QHP when one of the following events occurs:]

- a. A qualified individual or dependent of the qualified individual loses minimum essential coverage (MEC), including employer-sponsored coverage;
- b. A qualified individual gains or becomes a dependent through marriage, birth, adoption, placement of adoption, or foster care;
- c. A qualified individual gains status as a citizen or lawful presence status is met;
- d. [A Qualified individual or dependent of a qualified individual enrolls or fails to enroll in a 2016 coverage year QHP due to an error, misrepresentation, or inaction of an officer, employee, or agent of the KHBE or Health and Human Services (HHS);]
- e. An enrollee or dependent of an enrollee demonstrates to the KHBE that the QHP substantially violates a provision of its contract;
- f. [An enrollee is determined newly eligible or newly ineligible for 2016 coverage year APTC or has a change in eligibility for CSR;
- g. A qualified individual or dependent of a qualified individual who is enrolled in an employer-sponsored plan is determined newly eligible for 2016 coverage year APTC in part on a finding that the individual will no longer be eligible for qualifying coverage in that plan in the next sixty days and is allowed to terminate existing coverage;
- h. A Qualified individual or dependent of a qualified individual or enrollee gains access to a new 2016 coverage year QHP as a result of a change in residence;
- i. An Individual is an American Indian/Alaskan Native who may enroll in a 2016 coverage year QHP or change from one 2016 coverage year QHP to another 2016 coverage year QHP one time per month; or]

- j. An Individual demonstrates to the KHBE exceptional circumstances.
- E. [Applications for enrollment in a 2016 coverage year QHP may be submitted by:
1. Visiting the KHBE website at www.kynect.ky.gov;
 2. Calling the KHBE Contact Center at 1-855-4kynect or 1-855-459-6328;
 3. Mail or fax; or
 4. In person.]
- F. An individual who has a Social Security number (SSN) must provide it to KHBE. Any individual not seeking coverage will not be required to provide an SSN.
- G. [An individual who requests an eligibility determination for a 2016 coverage year QHP only shall not have an eligibility determination for an insurance affordability program.]
- H. All individuals will be required to have health insurance under the ACA. There are certain exemptions that will allow an individual to be exempt from the requirement to maintain MEC as required by the ACA. The exemption reason is verified to see if it meets one of the following criteria:
1. A member of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits;
 2. A member of a recognized health care sharing ministry;
 3. A member of a federally recognized Indian tribe;
 4. Household income is below the minimum threshold for filing a tax return;
 5. A member went without coverage for less than three consecutive months during the year;
 6. The Kentucky Health Benefit Exchange has determined there is a hardship in obtaining coverage;
 7. A member cannot afford coverage because the minimum amount to pay is more than eight percent of the household income;
 8. A member is incarcerated; or
 9. A member is not a U.S. citizen or Lawfully Present.

MS 4310*

ACCOUNT TRANSFERS

(1)

Beginning with the 2017 open enrollment period (November 1, 2016 – January 31, 2017) all Advanced Premium Tax Credit (APTC) and Qualified Health Plan (QHP) eligibility determinations for the 2017 coverage year will be made by the Federally Facilitated Marketplace (FFM).

However, individuals are still able to begin an application for Insurance Affordability Programs (IAPs), APTC, and/or QHP through Worker Portal, the Self Service Portal (SSP), or the FFM. Depending on the program the individual is eligible or potentially eligible for their account will be transferred to the appropriate system for eligibility to be determined.

A. Individual applies through Worker Portal or the SSP:

1. If an individual is found to be eligible for Medicaid, no account transfer to the FFM will occur;
2. If an individual is found to be ineligible for Medicaid, their information will have an account transfer to the FFM as potentially eligible for APTC and/or QHP; or
3. If an individual's Medicaid application is denied for a procedural reason (ie. not returning mandatory verification), no account transfer will occur as Medicaid eligibility has not been determined.

B. Individual applies through the FFM:

1. If an individual is approved for APTC and/or QHP, no account transfer to Worker Portal will occur.
2. If an individual is found to be potentially eligible for Medicaid, an account transfer will occur from the FFM to Worker Portal so that a Medicaid eligibility determination can be made.
 - a. Account transfers from the FFM will attempt to automatically run eligibility; however, there are instances in which worker intervention will be required before eligibility can be determined. When worker intervention is required, one of the following tasks will be created:
 - 1) Incoming Application Task – Created when an incoming account transfer is missing necessary information for eligibility to be determined;
 - 2) Report a Change or Renewal Task – Created when an individual in a Mixed Household reports a case change, or initiates an APTC/QHP renewal at the FFM;
 - 3) Failed Member Match – Created when an individual in an account transfer has a partial or full member match with an individual already present in Worker Portal.

C. Mixed Households:

1. These are households which consist of at least one member receiving Medicaid or KCHIP and at least one member receiving APTC and/or QHP.
2. In these situations a household will have an account with, and eligibility determined by, both the FFM and DCBS.

EXAMPLE: A household consisting of a mother, father, and 10 year old daughter with an EDG size of 3 and \$2500 a month income applies for Medicaid through the Worker Portal.

The daughter is approved for KCHIP and will maintain an active case on Worker Portal.

The parents are both assessed as potentially eligible for 2017 coverage year APTC/QHP and have their account transferred to the FFM for their APTC/QHP eligibility to be determined.

MS 4320 ADVANCED PREMIUM TAX CREDIT (APTC) (1)

[Advanced Premium Tax Credit (APTC) is premium payment assistance offered through the Kentucky Health Benefit Exchange (KHBE) for the purchase of a 2016 coverage year Qualified Health Plan (QHP) to families whose income is between 100% and 400% of the Federal Poverty Level (FPL). The assistance is in the form of a tax credit that can be applied monthly or utilized as an annual tax credit when filing a federal income tax return. An individual must be determined ineligible for Modified Adjusted Gross Income (MAGI) Medicaid in order to qualify for APTC.

Note: Beginning with the 2017 coverage year, all APTC eligibility determinations and enrollments will occur through the Federally Facilitated Marketplace (FFM).

A. Along with the income guidelines, the individual must also meet the following requirements to qualify for 2016 coverage year APTC:

1. Citizenship or Lawful Presence;
2. Residency;
3. Non-incarceration; and
4. Must NOT be eligible for Minimum Essential Coverage (MEC).

NOTE: Individuals earning less than 100% FPL may be eligible to receive APTC when denied Medicaid due to immigration status only.

B. The maximum amount of 2016 coverage year APTC an individual may receive is calculated by the Federal HUB.

The tax credit is based on the total gross income compared to the appropriate FPL. This comparison determines the percentage of household income that is required to be contributed towards the cost of coverage and is based on estimated yearly income. The credit a person receives is the difference between that percentage and the cost of the second lowest silver plan that could cover eligible members.

Once an individual (tax filer) has been determined eligible for 2016 coverage year APTC, Worker Portal will display the amount they are eligible to receive. The individual will then select their plan and determine the amount of 2016 coverage year APTC he/she wishes to apply towards the purchase of that plan. An individual may choose to take the 2016 coverage year APTC at the time he/she purchases insurance or be reimbursed for the out-of-pocket premium expense when he/she files his/her annual income tax, up to the amount of the 2016 coverage year APTC.

If an individual chooses to use the 2016 coverage year APTC credit at the time they purchase a plan, the Issuer of the chosen plan will send an invoice to the Federal Government for the amount of the 2016 coverage year APTC. The monthly cost of the plan an individual is responsible to pay is reduced by the amount of 2016 coverage year APTC credit and no money is actually received

by an individual.

- C. If the income matched with the Federal HUB and the client stated amount of income are reasonably compatible, the client stated amount is accepted.

If the income matched with the Federal HUB and the client stated amount of income are not reasonably compatible, a Request for Information (RFI) is sent giving the individual 90 days to provide sufficient verification.

The individual can continue to receive APTC during the 90-day period. However, if sufficient verification is not received, eligibility is redetermined based on the income information obtained from the trusted data sources. The tax credit is reconciled at the end of the year and the individual may be required to pay back any amount of tax credit he/she received in error.

NOTE: If the 2016 coverage year APTC is terminated, the individual must pay the full amount of the premium for the 2016 coverage year QHP.

- D. Individuals who are currently covered through an affordable Employer Sponsored Insurance (ESI) are not eligible for 2016 coverage year APTC. However, if the ESI employee premium for employee-only coverage is more than 9.5 percent of the household income, the coverage is deemed unaffordable and the individual can dis-enroll from ESI and become eligible for APTC.
- E. Individuals are not eligible to receive 2016 coverage year APTC if they are eligible for MEC. MEC is the minimum amount of coverage an individual needs to have to meet the individual responsibility requirement as outlined in the ACA (Affordable Care Act).

Individuals should not be receiving 2016 coverage year APTC if:

1. The individual is eligible to receive Medicaid or KCHIP;
 2. The individual is enrolled in one of the following: Peace Corps insurance, Veteran's Affairs programs, TRICARE, or other qualifying government insurance programs;
 3. The individual's employer provides coverage that is affordable, of minimum value, and offered to all members of the family.
 4. The family's 2016 coverage APTC eligibility may not be affected if only one person in the household is receiving MEC and all remaining members are not. At least one of the remaining members may be eligible for 2016 coverage year APTC.
- F. 2016 coverage year APTC shall be authorized by KHBE, on behalf of a tax filer, only if the KHBE obtains necessary attestations for the tax filer that:
1. An income tax return will be filed for the benefit year;
 2. A joint tax return is filed, if the tax filer is married;

3. No other taxpayer will be able to claim the tax filer as a dependent for the benefit year; and
 4. The tax filer will claim a personal exemption deduction on the tax filer's return for the applicants identified as members of the tax filer's family.
- G. An individual can still receive 2016 coverage year APTC for the initial plan year even if he/she did not file a tax return for the previous year.]

MS 4340 COST SHARING REDUCTIONS (CSR) (1)

[CSR is a program offered through the Kentucky Health Benefit Exchange (KHBE) that reduces out-of-pocket expenses for consumers who are eligible for the Advanced Premium Tax Credit (APTC) for the 2016 coverage year and purchase a 2016 coverage year Qualified Health Plan (QHP) through the Exchange. This program lowers deductibles, co-pays, and co-insurance by the government sharing the costs with the consumer. In Kentucky, CSRs are referred to as special discounts.

Eligibility for a CSR is determined at the same time as 2016 coverage year APTC eligibility using the same time standards and verification criteria. An individual can receive both APTC and CSR for the 2016 coverage year.

Note: Beginning with the 2017 coverage year, all CSR eligibility will occur through the Federally Facilitated Marketplace (FFM).

- A. The technical requirements are the same for 2016 coverage year CSR as for 2016 coverage year APTC:
 - 1. Citizenship or Lawful Presence;
 - 2. Residency; and
 - 3. Non-Incarceration.
- B. In addition to the technical requirements, the individual must also:
 - 1. Be eligible to enroll in a 2016 coverage year QHP;
 - 2. Be eligible to receive APTC for the 2016 coverage year; and
 - 3. Purchase a Silver level plan through the Exchange. The individual is not eligible for 2016 coverage year CSR if they purchase another metal level plan such as Bronze, Gold, or Platinum.
- C. To be eligible for 2016 coverage year CSR an individual must be at or below the 250% FPL. The amount of CSR an individual can receive is based on income and is divided into three categories.

The table below indicates the maximum out-of-pocket expenses for an individual who qualifies for 2016 coverage year CSR based on the income level.

Income	Out-of-Pocket Maximum for Silver QHPs (individual/family)
100 – 150% FPL	\$2,250/individual; \$4,500/family
150 – 200% FPL	\$2,250/individual; \$4,500/family

200 – 250% FPL	\$5,200/individual; \$10,400/family
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D. American Indians/Alaskan Natives (AIAN) are eligible for 2016 coverage year CSR if they purchase ANY LEVEL QHP for the 2016 coverage year and they meet the following criteria:

1. Connected to a federally recognized tribe;
2. Is eligible to receive APTC for the 2016 coverage year; AND
3. Their income is at or below 300% FPL.

Note: Individuals are required to provide verification of AIAN status.]

This is a general glossary of commonly used acronyms that may be found within the MAGI Manual and associated with the Kentucky Health Benefit Exchange (KHBE). Detailed definitions of the more commonly used terms can be found in MAGI Medicaid Definitions.

Acronym	Definition
ACA	Affordable Care Act
AGI	Adjusted Gross Income
AIAN	American Indian/Alaskan Native
APTC	Advance Premium Tax Credit
ATIN	Adoption Taxpayer Identification Number
CHIP	Children's Health Insurance Program
CIS	Citizenship and Immigration Services
CMS	Centers for Medicare & Medicaid Services
COLA	Cost of Living Adjustment
CSE	Child Support Enforcement
CSR	Cost Sharing Reductions
DAC	Disabled Adult Child
DHS	Department for Homeland Security
DMS	Department for Medicaid Services
E&E	Eligibility & Enrollment
EDG	Eligibility Determination Group
EIN	Employer Identification Number
ESI	Employer Sponsored Insurance
FDSH	Federal Data Services Hub
FPL	Federal Poverty Level
HIPAA	Health Insurance Portability and Accountability Act
HMO	Healthcare Maintenance Organization
KCHIP	Kentucky Children's Health Insurance Program
KHBE	Kentucky Health Benefits Exchange
KOG	Kentucky Online Gateway
LPR	Lawful Permanent Resident
MAGI	Modified Adjusted Gross Income
MCI	Master Client Index
MEC	Minimum Essential Coverage
NON-MAGI	Non-Modified Adjusted Gross Income
PE	Presumptive Eligibility
PRTF	Psychiatric Residential Treatment Facility
PTC	Premium Tax Credit
QHP	Qualified Health Plan

