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Cabinet for Health and Family Services
Department for Community Based Services

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Medicaid (MA) and State Supplementation

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MS 1000 PROVIDING MEDICAID

Medicaid is provided to aged, blind, or disabled individuals who are categorically or medically needy. The program is administered in compliance with Title XIX of the Social Security Act and provides a wide scope of medical services.

MS 1010 DEFINITIONS

Terms used in this manual are as follows:

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

ANCILLARY SERVICES. Services for which a separate charge is customarily made and designated for the vendor payment system limited to legend and non-legend drugs including catheters, irrigation supplies and solutions, physical, occupational and speech therapy, and laboratory procedures.

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

ASSESSED VALUE. Value as shown on records in the county property valuation office.

BASELINE DATE. The baseline date is the date an individual is both institutionalized and applies for MA coverage. This determination is applicable to case actions completed on or after 8/1/95. For individuals with multiple periods of institutionalization or multiple applications, whether or not they are approved, the baseline date is the FIRST DATE the individual has both applied for MA and is also institutionalized. EXAMPLE: The individual was institutionalized 8/1/95 and application for MA was made on 8/1/95. The baseline date is 8/1/95 because that is the date the individual was both institutionalized and applied for MA.

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

BURIAL RESERVES. Life insurance policies designated for burial, annuities designated for burial, burial trust funds, prepaid and/or prearranged funeral contracts, and any other identifiable fund or resource designated as set aside for the individual's burial expense.

BURIAL SPACES. Conventional grave sites, crypts, mausoleums, urns, vaults, caskets, headstones, and opening and closing of the grave.

BUY-IN. The purchase of SMI coverage by Medicaid for all eligible individuals.

CASH SURRENDER VALUE (CSV) OF LIFE INSURANCE. The dollar amount the individual would receive for cashing in a life insurance policy. This is the cash value less indebtedness.

COINSURANCE. Partial payments for continuing services chargeable to individuals under Medicare. Long term care Medicaid vendor payments are made for Medicare recipients, after deductions from income are made for the 21st through the 100th day of LTC or when Medicare benefits are exhausted, whichever comes first.

COMMUNITY SPOUSE. An individual who is legally married, or is considered legally married by a state that recognizes common-law marriage to an institutionalized spouse, and who resides at home in the community. The individual is still considered the Community Spouse even if separated from institutionalized spouse. The institutionalized spouse is only viewed as single once divorced. Community spouse includes an individual living at home, including a family care home or personal care home, who has a spouse in an LTC facility, including mental hospitals, Institutions for Mental Diseases, and institutionalized Hospice, a non-HCBS individual at home with an HCBS spouse, a non-SCL individual at home with an SCL spouse and a non-Hospice individual at home with a Hospice spouse.

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

COMMUNITY SPOUSE RESOURCE ALLOWANCE. A designated amount deducted from the combined countable resources of the institutionalized spouse and community spouse prior to determining resource eligibility of the institutionalized spouse. Do not use the allowance in determining resource eligibility of the community spouse.

CONTINUING INCOME. Payment received on a regular ongoing basis.

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

COUNTABLE EARNED INCOME. Total earned income minus deductions.

COUNTABLE UNEARNED INCOME. Total unearned income minus deductions.

COURT ORDERED SUPPORT FOR COMMUNITY SPOUSE. An amount court ordered against an institutionalized spouse for monthly support for the community spouse.

DEDUCTIBLES. Initial payments chargeable to Medicare recipients.

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

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

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

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

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

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

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

EPSDT INSTITUTIONAL CARE CHILD. A child with special health care needs who receives treatment in an EPSDT institutional care facility in or out-of-state, certified by the EPSDT program of the Department for Medicaid Services.

EQUITY VALUE. Assessed value, minus indebtedness.

ESSENTIAL PERSON (EP). An individual who is not SSI eligible in their own right, but who is considered by SSI as a person essential to the SSI recipient's care.

EXCLUDED INCOME. Money received but not counted in determining eligibility.

EXCLUDED RESOURCE. Money, real property, personal property or other assets not counted in determining eligibility.

EXTENDED CARE FACILITY (ECF). A licensed skilled care facility connected to an acute care hospital.

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

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

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

GENERAL EXCLUSION. The $20 income deduction allowed for all Medicaid recipients with the exception of SSP recipients.

GRANDFATHERED DISABLED CHILD (GDC). A child who lost SSI benefits due to the Personal Responsibility and Work Opportunity Act (PRWOA) of 1996 change in definition of childhood disability. These children remain Medicaid eligible until age 19 or otherwise ineligible.

GROSS INCOME. Sum of income that is not excluded, both unearned and earned, prior to deductions.

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

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

INCOME. The money received from statutory benefits, labor or services, rental property, investments, business operations, nonrecurring lump sum income, etc. Income may be unearned or earned.

INCREASED PERSONAL NEEDS ALLOWANCE. Deductions allowed from resources (PASS only) or earned/unearned income for individuals in vendor payment cases and who are aged, blind or disabled. These deductions are not allowed to the community spouse.

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

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

C. Mandatory Withholdings. An amount deducted from earned and unearned income of an LTC recipient for mandatory withholdings, e.g.,

mandatory payroll deductions that are a condition of employment and/or Federal, state and local taxes that the government requires the payer to deduct before payment is made to the payee. Do not allow deductions for withholdings resulting from recipient-induced actions such as voluntary income tax withholdings and court ordered deductions for child support or other garnishments resulting from recipient-induced indebtedness or financial obligations.

D. Plan for Achieving Self-Support (PASS). An income and/or resource exclusion that allows a blind or disabled individual to set aside income/resources for a work goal such as education or starting a business.

INCURRED MEDICAL EXPENSE. A medical expense actually owed or paid.

IN-KIND INCOME. Any gain or benefit not in the form of money payable directly to the household, such as meals, clothing, free rent or produce from a garden.

INSTITUTION. An establishment which furnishes food, shelter, and some treatment or services to 4 or more persons unrelated to the owner. This definition includes personal care homes and LTC facilities.

INSTITUTIONALIZED SPOUSE. An individual who is in an LTC facility, including mental hospitals, Institutions for Mental Diseases and institutionalized Hospice, and is legally married, or considered legally married by a state that recognizes common-law marriages, to a spouse who is not in an LTC facility. Home and Community Based Services (HCBS), Supports for Community Living (SCL), and noninstitutionalized Hospice recipients are considered institutionalized spouses if married to and living in the home with a non-HCBS/non-SCL/non-Hospice spouse. An individual in a personal care home or family care home with a spouse remaining at home is not considered an institutionalized spouse.

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

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

LEGAL GUARDIAN. An individual appointed through the State district courts, pursuant to an application for appointment filed under KRS 387.025, to be in charge of the affairs and finances of a minor or for those age 21 or above declared incompetent by a court of law. Additionally, the individual is usually required to be bonded upon appointment and to file periodic financial settlements with the district court on behalf of their ward.

LEGEND DRUG. Drug or medical supply which requires a prescription.

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

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

LIVING APART. Not sharing a common household due to estrangement, disability, institutionalization, or illness.

LIVING TOGETHER. Sharing a common living arrangement in a household.

LOCK-IN. Utilization control mechanism applicable to individuals identified as over-utilizers of Medicaid program benefits.

LONG TERM CARE FACILITIES (LTC). Licensed Nursing Facilities (NF) and Mental Hospitals (MH) approved for participation in Title XVIII and licensed Intermediate Care Facilities for the Mentally Retarded or Developmentally Disabled (ICF/MR/DD).

LOOK BACK PERIOD. Look back period for the transfer of resources, other than a trust, is 36 months from the baseline date. For trusts established ON OR BEFORE 8/10/93 and a transfer of resources occurs into the trust after 8/10/93, the look back period is 36 months from the baseline date. For trusts established AFTER 8/10/93, the look back period is 60 months from the baseline date.

MA FAMILY. Individuals whose income and resources are used to determine eligibility of the assistance group.

MEDICAID (MA). Medicaid benefits provided to eligible individuals in compliance with Title XIX of the Social Security Act as administered by DCBS under contract to the Department for Medicaid Services (DMS).

MEDICAID QUALIFYING TRUST. A trust or similar legal device established on or before August 10, 1993 by an individual or the individual's spouse, other by than by a will, under which the individual is the beneficiary of all or part of the income from the trust. A trust or similar legal device established by an individual's guardian or legal representative, acting on the individual's behalf, is also a Medicaid Qualifying Trust. The trustee has discretion over payments from the trust.

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

MINOR CHILD OF INSTITUTIONALIZED/COMMUNITY SPOUSE. Couple's child under age 21 who lives with the community spouse and is claimed as a dependent by either spouse for tax purposes under the IRS Code.

MODEL II WAIVER. Provides up to 16 hours a day for nursing services, as approved by DMS.

MONTHLY RATE FOR A MEDICAID RECIPIENT. Per diem or daily rate of the facility multiplied by 7 and the result by 4 1/3 to establish a monthly rate. Per diem or daily rate is the charge for routine services, such as, cost of the regular room, dietary, medical social services, nursing services, the use of equipment and facilities and minor medical and surgical supplies such as gauze, tape, band-aids, cotton swabs, etc.

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

NATURAL ASSETS. Rights to oil, gas, coal, timber, etc., on land not owned by the individual.

NET WAGES. Wages minus work expense deduction if appropriate.

NONHOME. Property, other than a home, owned by an individual.

NONLEGEND DRUGS. Drugs or medical supplies which do not require a prescription.

NONPARTICIPATING NF. A licensed nursing facility (NF) that has not been certified by DMS to participate in KMP. These facilities are nonparticipating by their decision.

NONRECURRING LUMP SUM INCOME. A total amount of income received at one time and not expected to continue.

NONTRUST PROPERTY. Any property that has not been placed in a trust.

NURSING FACILITY (NF). A licensed facility in which individuals are eligible for vendor payment. These facilities meet all requirements for participation in KMP.

PARTICIPATING ICF/MR/DD. A licensed ICF for the treatment of the mentally retarded or developmentally disabled which has a valid provider contract with DMS.

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

PASS THROUGH. The disregard of RSDI cost-of-living increases which resulted in discontinuance of eligibility for SSI or SSP.

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

PEER REVIEW ORGANIZATION (PRO). The organization responsible for conducting patient status determinations for recipients in need of NF, ICF/MR/DD and psychiatric care.

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

PERSONAL EFFECTS. Clothing, jewelry, items of personal care, etc.

PERSONAL NEEDS ALLOWANCE. A basic maintenance deducted from the gross income of recipients in NF, noninstitutionalized Hospice, HCBS and SCL.

PERSONAL PROPERTY. Any property which is movable, other than real property.

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

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

PROMISSORY NOTE. A written promise to pay on demand, or on a specified date, a certain sum of money to a certain seller or lender.

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

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

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

RESOURCES. Money, property or other assets.

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

RSDI. The social security benefit payable under Title II of the Social Security Act to retirees, survivors or disabled individuals.

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

SPEND DOWN. Utilization of excess income for recognized medical services.

SSI. Supplemental Security Income (SSI) is a federally funded program that makes monthly payments to individuals who have limited income and resources if they are 65 years of age or older or if they are blind or have another disability. Being eligible for SSI means an individual receives a monthly SSI payment and Medicaid.

SSI ALERT. An institutionalized individual receiving SSI whose other income is $50 or more.

STATE SUPPLEMENTATION PAYMENT (SSP). The payment made to an aged, blind or disabled individual to meet certain special needs.

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

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

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

1. Performed for pay or profit; or
2. Generally performed for pay or profit; or
3. Intended for profit, whether or not a profit is realized.]

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

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

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

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

UNDUE HARDSHIP. Undue hardship is a situation in which the application of transfer of resources penalties or consideration of funds placed in a trust deprive an individual of medical care such that the individual's health and life would be endangered. Undue hardship also exists when application of the transfer of resources or trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

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

MS 1015 ABBREVIATIONS

There are a number of abbreviations commonly used in this volume.

A. Abbreviations that require definition are included in MS 1010.

B. The remaining abbreviations are listed below.

1. [DCBS - Department for Community Based Services
2. DFS - Division of Family Support
3. DPD - Division of Policy Development
4. DPP - Division of Permanency and Protection]
5. DMS - Department for Medicaid Services
6. [EPSDT – Early and Periodic Screening, Diagnosis and Treatment]

[7. K-TAP - Kentucky Transitional Assistance Program
8.] HCBS - Home and Community Based Services
[9.] IMD - Institution for Mental Diseases
[10.] IRS - Internal Revenue Service
[11.] LTC - Long Term Care
[12.] MRT - Medical Review Team
[13. MSBB - Medical Support and Benefits Branch
14.] NEMT - Nonemergency Medical Transportation
[15.] PRO - Peer Review Organization
[16.] PRTF - Psychiatric Residential Treatment Facility
[17.] QDWI - Qualified Disabled Working Individual
[18.] QMB - Qualified Medicare Beneficiaries
[19. SCL - Support for Community Living
20.] SLMB - Specified Low-Income Medicare Beneficiaries
[21.] SSA - Social Security Administration

MS 1020 AGENCY RESPONSIBILITY

DMS is the single state agency with designated responsibility for the administration of Medicaid in compliance with Title XIX of the Social Security Act.

A. DETERMINATION OF INITIAL AND CONTINUING ELIGIBILITY for medical services of aged, blind or disabled persons receiving SSI is performed by SSA. [Issuance of MAID Cards to SSI eligible individuals is the responsibility of DCBS.

Eligibility determination for all other aged, blind, or disabled persons including those persons losing SSI eligibility, is the responsibility of DCBS field staff.]

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

MS 1030 CLASSIFICATION OF ELIGIBLE GROUPS

Classifications and codes used to identify eligible aged, blind, and disabled groups are as follows:

A, B, D/AP, BP, DP: Aged, blind, or disabled persons who receive SSI. These individuals may also receive SSP.

F, G, H/FP, GP, HP: Aged, blind, or disabled persons who do not receive SSI but may receive SSP and are considered categorically needy.

J, K, M: Aged, blind, or disabled persons who do not receive SSI or SSP. These individuals meet the same technical eligibility factors as A, B, D persons but:

1. Have income and/or resources in excess of the SSI limitations;
2. Have excess income utilized either through allocation to dependents and/or spend down; or
3. Are deceased and application has been made by an interested party.

[The categories for “Medicaid Works” are “K” (blind) and “M” (disabled).]

Z: Aged, blind, or disabled persons who are eligible for limited Medicaid coverage.

1. QMB - These persons receive payment of Medicare deductibles, co-insurance, and Buy-In.
2. QDWI - These persons receive only Buy-In of the Medicare, Part A premium.
3. SLMB - These persons only receive the Buy-In of the Medicare Part B premium.
4. QI1 - These persons receive only Buy-In of the Medicare Part B premium IF the limited annual funding is still available.

MS 1040 ONE CATEGORY OF ASSISTANCE

An individual may receive regular MA in one category only but may receive both regular MA, QMB, or SLMB benefits simultaneously as a dual eligibility case. [However, an individual may NOT receive MA, QDWI or QI1 benefits simultaneously as a dual eligibility case.] Money payment recipients, including SSI recipients, receive MA under the money payment program code.

MS 1050* INTRODUCTION

Medical services available to MA eligible individuals are specific and limited.

MS 1060 MEDICARE/MEDICAID RECIPIENTS

Medicaid benefits available to Medicare covered individuals are limited to:

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

B. JKM individuals in LTC who are allowed an income deduction to cover SMI charges. Other Medicare covered individuals who are allowed the deduction as a spend down item;

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

D. Inpatient hospital deductible; and

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

MS 1065 CO-PAY FOR MEDICAID RECIPIENTS

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

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

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

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

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

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

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

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

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

1. A co-payment of $3 is charged at the time of service for an emergency room visit that Medicaid deems a non-emergency, such as for allergies or a sore throat.
2. A co-payment of $2 is required at the time of rendered services by the following providers:

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

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

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

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

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

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

1. Children under age 18:

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

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

3. Recipients who reside in Personal Care Homes (PCH) and Family Care Homes (FCH);

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

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

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

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

9. Recipients covered by the Passport Health Plan, except for prescriptions not covered by Passport, such as those written by psychiatrists; and

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

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

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

MS 1070* ALTERNATE BIRTH CENTERS

Alternate birth center services provided by a participating, licensed birth center are:

A. Prenatal visits;

B. Standby services with a medical professional physically present during labor;

C. Delivery, necessary supplies, and post delivery examination; and

D. Postnatal visits.

MS 1080 AMBULANCE TRANSPORTATION

Ambulance transportation is available for emergency or nonemergency trips if the following conditions are met:

A. [Emergency ambulance service is provided to the nearest emergency room of a hospital. If the nearest facility is other than a hospital emergency room, the service may be covered if medically indicated.

B. All nonemergency ambulance runs are considered stretcher service as required by the NEMT program and require a statement from a physician that it is medically necessary for the patient to travel by ambulance. See MS 3970.]

MS 1090 AMBULATORY SURGICAL CENTERS

Benefits available in Ambulatory Surgical Centers are:

A. Radiology and laboratory services;

B. Surgical supplies;

C. Anesthesia and anesthesia administration;

D. Blood and blood administration;

E. Operating and recovery/holding room;

F. Professional component of hospital-based physicians;

G. Under specific conditions, induced abortions, miscarriages or premature births; and

H. Sterilizations according to Federal regulations.

MS 1100 AUDIOLOGY SERVICES

Audiology services for the individual under age 21 are:

A. Complete hearing evaluation;

B. Hearing aid evaluation and limited follow-up visits; and

C. Monaural hearing aid on a preauthorized basis.

MS 1105* CHIROPRACTIC SERVICES

Chiropractic services are available to all Medicaid recipients.

MS 1110 DENTAL SERVICES

Dental services are available to individuals:

A. Under age 21 and include but are not limited to extractions, cleaning, including 1 stannous fluoride treatment a year and x-rays; and

B. Over age 21 and include but are not limited to extractions, fillings and emergency treatment for pain, infection and hemorrhage.

MS 1120 DIALYSIS

Renal dialysis benefits are:

A. Physician and laboratory services;

B. Hemodialysis; and

C. Home supplies and expenses recognized by Medicare or home dialysis.

MS 1130 FAMILY PLANNING SERVICES

Family planning services, available for all recipients of child bearing age, including sexually active teenagers, are:

A. Counseling and referral;

B. Physical examination;

C. Specified laboratory and clinical tests;

D. Information and education regarding contraceptive methods;

E. Prescription and provision of contraceptive methods, including continuing counseling, treatment and supplies; and

F. Infertility services.

MS 1140* HOSPITAL BENEFITS

Medicaid recipients may receive the following hospital benefits:

A. Inpatient services.

1. Maximum of 14 days coverage per admission.

2. Services are limited to treatment for acute or chronic illness, injury or impairment and maternity care when they cannot be rendered on an outpatient basis.

3. Some surgical procedures are not covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for the admission or the physician certifies a medical necessity requiring admission to the hospital.

B. Outpatient services.

1. Services must be furnished by or under the supervision of licensed physicians or dentists.

2. Services are limited to diagnostic, therapeutic or emergency room.

C. Abortion services. Services are covered under inpatient and outpatient services when the service is necessary for the preservation of the life of the woman seeking treatment.

MS 1150* LABORATORY AND X-RAY

Independent laboratory and radiology services are procedures listed on the benefit schedule.

MS 1160 LONG TERM CARE

Long term care benefits are:

A. Tuberculosis hospitals for clients age 65 and over as long as medically necessary.

B. Joint Commission on Accreditation of Hospitals (JCAH) approved psychiatric hospitals or programs providing inpatient care for individuals age 65 and over or under 18 as a "U" case, except payment can continue to age 22 if admission was before the 21st birthday and eligibility as a disabled individual is determined.

C. NF or ICF/MR/DD public or private facilities for as long as patient status is met.

MS 1170 MENTAL HEALTH

[A. Mental health benefits are covered when provided by:

1. Independent psychiatrist's office;

2. Mental hospital;

3. Acute care hospital with a psychiatric unit;

4. Community mental health center; or

5. Physician's office.

B. Services covered at these locations are:

1. Psychiatrist's office - Therapy.

2. Mental hospital - Inpatient/outpatient services.

3. Acute Care Hospital:

a. Inpatient services (psychiatric unit); and

b. Detoxification services.

4. Community mental health center:

a. Outpatient services, regardless of type of clinician, such as group, individual, family, collateral therapies, therapeutic rehabilitation (formerly partial hospitalization), in-home services;

b. Inpatient hospital visits, regardless of type of hospital;

c. Emergency services; and

d. Psychological/psychiatric testing when followed with therapy.

5. Physician's office - Limitations listed in MS 1210 apply.]

MS 1180 NURSE-MIDWIFE SERVICES

Nurse-midwife services are covered if certification and/or licensure requirements are met according to state law.

MS 1190 OPTIONAL SERVICES

At the direction or according to the plan of the attending physician, the following services may be provided:

A. Intermittent skilled nursing care by a registered nurse, licensed practical nurse or physical therapist;

B. Home health aide services if person is medically homebound;

C. Disposable medical supplies; and

D. Durable medical equipment, braces and prostheses when preauthorized.

MS 1200 PHARMACY BENEFITS

Pharmacy benefits are:

A. [Drugs listed on the KMP drug list and prescribed by either a licensed physician, osteopath or dentist;]

B. Drugs necessary to prevent hospitalization but not on the drug list can be covered if preauthorized. The physician requests preauthorization by calling 1-800-807-1273.

MS 1210 PHYSICIAN SERVICES

Physician services and limitations:

A. [Covered services are office visits, including visits for allergy shots, home visits, hospital, NF or elsewhere.]

B. Payment is made for:

1. Only 1 initial, extensive physician visit per patient in a calendar year;
2. 4 services per patient per physician in a calendar year when an outpatient psychiatric service is provided by other than a psychiatrist;
3. Services by a Lock-In provider when the individual is in the Lock-In program unless there is an emergency or referral; and
4. Laboratory procedures listed on benefit schedule.

MS 1220 [PRIMARY CARE CENTER/RURAL HEALTH CLINIC

Primary Care Center/Rural Health Clinic benefits are:]

A. Physician services;

B. Nurse practitioner services; and

C. Other ambulatory services covered under the MA program.

MS 1230 VISION CARE

Vision care services are available as follows:

A. Diagnostic services of an optometrist or ophthalmologist are covered for all age groups.

1. An individual under age 21 may receive no more than 2 pairs of eyeglasses a year.

2. An individual over age 21 may receive treatment for eye diseases, if treated by an ophthalmologist.

B. Preauthorization is necessary for all services other than examinations or diagnostic procedures.

MS 1250 DCBS RESPONSIBILITIES

Responsibilities of the Department, established by Federal regulations regarding use of medical services, are:

A. To notify all recipients of available medical services including 2 special areas:

1. Early and periodic screening, diagnosis and treatment services (EPSDT) for individuals under age 21; and
2. Family planning services for all persons of child-bearing age, a medical and social service, is provided through counseling and referral to available services by:

a. [Notifying K-TAP and MA recipients by KAMES generated notice, as appropriate, of the availability of family planning services.]
b. If requested, providing an MA recipient an explanation of services available and referral to family planning vendors or other appropriate resources.

B. To control overutilization of medical services through the development of review procedures and effective controls. This is accomplished:

1. For hospital services by:
   a. Limiting number of days payment is made in relation to diagnosis.
   b. NF need is established by patient status process.
2. For physician and pharmacy services by using a control system called Lock-In.

MS 1260 LOCK-IN

A. Lock-In is a system to control a recipient's inappropriate use of:

1. Physician services; and
2. Pharmacy services.

[Lock-In is not appropriate for Qualified Medicare Beneficiaries MA cases.]

B. The purpose of Lock-In is to:

1. Educate MA recipients with regard to their health care needs;
2. Reduce inappropriate use of medical services;
3. Identify reason for over-use; and
4. Foster an effective utilization of health care services and improve quality of care by developing a stable patient-physician relationship.

MS 1270 OVER-USE IDENTIFICATION

A. Identify recipient over-use of medical services as follows:

1. [Worker, pharmacy, and/or physician, with knowledge of irregularities in recipient's use of nonemergency medical transportation, sends information to DMS for review.

2. Computer generated profiles regarding frequent DMS provider changes and excessive number of drugs, are sent to DMS who:]

a. Contacts all physicians of the recipient; and
b. Sends physicians a copy of the recipient's computer generated use pattern to determine if the recipient should be placed in Lock-In.

B. Lock-In placement is then based on:

1. Advice of one or more of the recipient's physicians; and
2. Request of Medicaid Physician Consultant.

MS 1280 LOCK-IN RESTRICTIONS

Coverage/restrictions while in Lock-In.

A. MA will pay for necessary covered medical services rendered by other providers, for example, dentists, EPSDT, etc.

B. Transportation is approved if the Lock-In physician meets requirements of nonemergency medical transportation.

C. A specialist/attending physician referred/recommended by the Lock-In physician can be paid but requires prior notification to expedite payment.

D. [When one MA eligible household member is required to participate in the Lock-In program, that individual only is subject to Lock-In requirements. The remaining MA eligible household members are not subject to Lock-In procedures.]

MS 1290 LOCK-IN PROCEDURES

Place a recipient on Lock-In as follows:

A. DMS sends the recipient form Lock-In 2, Notification Letter Regarding Lock-In. [The Family Support Supervisor (FSS) is sent a copy of the notice.]

B. DMS sends the FSS form Lock-In 3, advising the DCBS Office of the Lock-In Placement. This is accompanied by a copy of form Lock-In 2 sent to the recipient.

C. Within ten days of receipt of form Lock-in 3, send form PAFS-2 to the recipient scheduling an appointment for the recipient to select a Lock-in provider.

D. Contact the Lock-In physician and pharmacy to:
   1. Explain terms of Lock-In;
   2. Verify providers will accept the recipient; and
   3. Obtain physician and/or pharmacy provider number(s).

E. Complete form MAP-520A.1, Notice of Lock-In Selection or Failure to Make Selection, in the local office, listing the recipient's selection of:
   1. Either a General Practitioner or a Family Practice physician; and
   2. A pharmacist.

F. If a recipient fails to select a physician and/or pharmacy:
   1. [Notify DMS, the Division of Medical Management and Quality Assurance, 6E-C, 275 E. Main Street, Frankfort, Kentucky 40621-0001, Attn: Lock-In.]
      a. Complete and send form MAP-520A.1 notifying DMS of recipient's failure to make selection(s);
      b. Retain copy for case record; and
      c. Assist DMS as needed, in determining the office location of all providers of the recipient in relation to the recipient's address.

   2. DMS assigns a physician and/or pharmacy.
      a. DMS sends the recipient a notice of the assignment;
      b. DMS returns original form MAP-520A.1 to the local office with the physician and/or pharmacy name and address, in addition to a copy of the notice of the assignment; and
      c. File form MAP-520A.1 and the copy of the notice of the assignment in the case record.

MS 1300 LOCK-IN CHANGE

If a recipient requests a change of physician and/or pharmacist:

A. [Notify DMS, the Division of Medical Management and Quality Assurance, 6C-C, 275 E. Main St., Frankfort, Kentucky 40621-0001, Attn: Lock-In.]

1. Send change form MAP-520A.1;
2. Send copy of initial form MAP-520A.1;
3. Attach memorandum explaining reason for request; and
4. Retain copies for case record.

B. DMS approves or denies the request for change.

1. When a request for change is denied a notice is sent by DMS, Division of Member and Provider Services to the Lock-In recipient to choose another Lock-In physician and/or pharmacist.

2. Reasons for denial may be either:
   a. A pattern of frequent provider changes;
   b. Excessive number of drugs; or
   c. Doctor shopping.

C. [If a Lock-In pharmacy or physician requests the recipient be removed from their care, advise the Lock-In provider to contact the Division of Medical Management and Quality Assurance at 502-564-2393.]

D. If a Lock-In recipient is discontinued and reapproved with no lapse in Medicaid coverage, reassign the Lock-In recipient to the same previously assigned Lock-In provider. [If a Lock-In recipient is discontinued and reapproved with a lapse in Medicaid coverage, contact DMS at the telephone number shown above in item C.]

MS 1310 [DMS RESPONSIBILITIES

DMS responsibilities are:]

A. Mandatorily assign providers to recipients failing to voluntarily select providers;

B. With providers, closely monitor recipient's health status and use patterns;

C. Evaluate Lock-In status of recipient after 12 months;

D. Remove recipient from Lock-In prior to the end of the 12 month period, if recommended by recipient's physician;

E. Continue to monitor recipient to ensure appropriate use patterns are established;

F. [Send notice of removal from Lock-In to Lock-In providers and DCBS;] and

G. Provide assistance to Lock-In providers.

MS 1320 REMOVING LOCK-IN

Worker activity when a recipient is removed from Lock-In.

A. [For case changes, notify the DMS of changes by memorandum.]

B. If a recipient is removed from Lock-In and is on PA-62, notify the recipient by form MA-105.

MS 1330 LOCK-IN RIGHTS

Rights of Lock-In recipients.

A. When a fair hearing request is received within 10 days of receipt of form Lock-In 2, Notification Letter Regarding Lock-In:

1. Send form PAFS-78, Request for Hearing, Appeal and/or Withdrawal;
2. [Send a copy of the PAFS-78 to DMS, the Division of Medical Management and Quality Assurance, 275 East Main Street, 6C-C, Frankfort, Kentucky 40621]; and
3. Provide full medical coverage until a hearing decision is rendered.

B. If a recipient has been in Lock-In status for 1 year or if Lock-In is extended to a 2nd year, the recipient has the right to a fair hearing.

MS 1350 APPLICATION FOR ENTITLED BENEFITS

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

A. K-TAP or SSP, SSI benefits, VA Aid and Attendance or welfare program cash benefits of a similar nature are NOT considered entitled benefits.

B. Use form PA-5.1 to refer an individual, who wishes to apply for SSI or RSDI benefits, to SSA. Complete form PA-5.1 according to procedural instructions.

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

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

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

[F.] Spot check each month to verify receipt and amount of benefit or denial of benefit.

MS 1353 ELIGIBILITY FOR ENTITLED BENEFITS

Use the following guidelines to determine if an individual meets the general requirements for these common entitled benefits.

A. Worker's Compensation.

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

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

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

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

2. Applications are available in the local UMWA office.

C. RSDI

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

2. Eligible individuals include:
   a. Retired person, age 62 or older;
   b. Disabled person with the minimum employment quarters;
   c. Dependent spouse, age 62 or older;
   d. [Spouse with dependent child under age 16];
   e. [Unmarried children to age 18, up to age 19 if attending high school full-time.]; and
   f. Certain surviving family members.

3. Apply at the SSA office serving the county of residence.

D. Black Lung Benefits.

1. Persons eligible for benefits based on disability or death due to Black Lung related to employment in the coal mines include:
   a. Miners totally disabled due to Black Lung;
   b. That person's spouse;
   c. Dependent child under age 18, or if disabled before age 22; and
   d. Certain surviving family members.

2. Apply at the SSA office serving the county of residence.

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

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

2. Eligible individuals include:
   a. Veterans
   b. Widows
   c. Unmarried children under age 18
   d. Certain helpless children
   e. Certain parents if servicemen or veterans who died from service-connected injury or disease.

3. Apply with field representative serving the county in which the applicant lives.

F. Veteran's benefits (VA) Pension payments.

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

2. Eligible individuals include;
   a. Veterans
   b. If there are dependents, payments will be increased.

3. Apply with field representative serving the county in which the applicant lives.

G. Railroad Retirement

1. Benefits are based on wages from railroad employment

2. Information regarding retirement, disability and death benefits is available from the Railroad Retirement Board, Room 377A, Federal Building, P.O. Box 3705, 600 Federal Place, Louisville, Kentucky 40202.

H. Medicare Hospital Insurance Benefits (HIB) and Supplementary Medical Insurance (SMI)

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

2. Eligible individuals include:
   a. Persons at lease age sixty-five and entitled to RSDI benefits.
   b. Persons receiving RSDI benefits for 2 years or more, as a disabled worker, disabled child, or disabled widow.

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

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

payments provide for certain medical costs in addition to those covered by HIB.

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

6. Apply at the SSA office serving the county of residence.

MS 1360 APPLICATION AFTER DENIAL OF SSI BENEFITS

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

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

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

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

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

MS 1370 APPLICATION PROCESS FOR MEDICAID

[A separate MA application is not required for persons receiving K-TAP or SSP. Complete an application according to procedural instructions. Process all applications within 30 days of the application date.

A. The application is signed by either: the applicant, the applicant's statutory benefit payee, committee or guardian, an interested party; or the statutory benefit payee for persons receiving SSI or statutory benefits if different from the applicant.

1. If the statutory benefit payee, committee or guardian does not live in Kentucky:
   a. Register the application on the date assistance is requested;
   b. Send the application and a cover letter to the statutory benefit payee, committee or guardian for completion and signature; and
   c. Carry the case in the county where the applicant is located.

B. If the application is signed by a mark (X), one other person as witness, either related or unrelated, must sign the application. Use the applicant's name for the case name even if the application is signed by someone other than the applicant.

C. If the individual or the individual's statutory benefit payee, committee, guardian, power of attorney, interested party or other representative is applying in a county other than the county of residence, including applications made for a hospitalized individual, refer to Volume IV, MS 1330.

D. Case responsibility for a Medicaid eligible child, in the custody of the Department of Juvenile Justice, is the county where the DJJ worker applies for the child.]

MS 1371 AUTHORIZED REPRESENTATIVE (AR)

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

A. Form MAP-14, Kentucky Medicaid Authorized Representative, MUST be used as the written consent and must be presented at the time of application. The MAP-14 is available on the DMS web site at: http://chfsnet.ky.gov/dms/. Workers may access the form electronically at: http://chfsnet.ky.gov/dcbs/dfs/forms/. The MAP-14 also authorizes the AR and/or the company representing the client to inquire about the Medicaid applicant's case, including forms completed by the recipient, worksheets, correspondence to or from the recipient, MRT decisions and non-confidential records.

Example: Ivan from Company X has come in to apply on behalf of Mr. Jim. Ivan has a completed and current MAP-14 and is able to apply. Ivan goes back to his job but he finds out he has been assigned to another client. Now, Betty, also from Company X, has taken over Mr. Jim's case. Although Ivan made the application, and it was he that brought in the signed MAP-14, Betty is able to inquire about Mr. Jim's case as the MAP-14 names Company X, not the individual who brought the signed form, as the AR.

B. Form MAP-14 is <u>not</u> necessary if the person applying is:

1. The payee of the applicant;

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

3. The parent or legal guardian of a dependent child;

4. The Power of Attorney (with documentation);

5. The representative of a ICF/MR/DD facility; or

6. A nursing facility resident incapable of declaring intent. Contact the nursing facility for verification.

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

Note: A signed MAP-14 is only valid for 90 days from the date of signature.

D. If a MAP-14 is <u>NOT</u> presented or if the date of signature is beyond the 90 days, complete the following:

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

2. Give the AR a new MAP-14. Advise the AR that the MAP-14 must be

completed and that it must be current, before the application interview can continue with the individual as the applicant's AR.

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

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

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

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

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

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

F. After the interview with the AR, workers are to confirm the information given by the AR with the applicant/recipient.

1 . Confirmation of information with the applicant can be obtained by telephone.

2. If unable to reach the applicant by telephone, send a PAFS-2 to the applicant requesting that he/she contact the local DCBS office.

3. If confirmation cannot be determined, the application is to be denied.

G. The applicant/recipient is the primary source of information in furnishing verification of financial and technical eligibility. However, the AR may inquire about the Medicaid applicant's case, beyond the application interview, provided that a current MAP-14 is on file. The date of signature on the MAP-14 cannot be older than 90 days.

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

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

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

1. The specific information to be released;
2. A specific time frame;
3. An original signature (no photocopies); and
4. To whom the information can be released.

For more on HIPAA requirements refer to Volume I, MS 0127.]

MS 1372 APPLICATION INTERVIEW

Except in unusual circumstances complete the MA application during a face-to-face interview. The following procedures are to be followed when conducting the interview:

A. Inform all individuals of their rights and responsibilities at the time of application and recertification.

1. Provide the individual with informational pamphlets such as; Hearings, Civil Rights, Medicaid, EPSDT, WIC, child and spousal support, etc. and complete form PAFS-203, Checklist of Factual Information Provided;

2. Explain services available related to child care, medical, WIC, etc.;

3. Advise the individual that all changes must be reported within 10 days of the date of change, as well as any changes which occur prior to processing the application and provide form PAFS-14 for signature;

4. Advise the individual of the right to appeal any adverse decision in compliance with the Civil Rights Act;

5. Advise the individual of the availability of the Child Care Assistance Program (CCAP). See MS 1125;

6. Explain the immunization requirements for children and provide form PAFS-252, Immunization Fact Sheet. Form PAFS-252 may also be used by the recipient for tracking each child's immunizations. Provide additional forms as needed for each child in the household.

7. If a member of the benefit group age 18 or over is present at the time of the interview and not registered to vote or not registered to vote at his/her current address, complete form PAFS-706, Voter Registration Rights and Declination, and explain the voter registration process. See MS 1230.

B. During the face-to-face interview for MA:

1. Explain the use of the KYHealth card. Emphasize that each eligible individual will receive a separate KYHealth card which will cover all periods of eligibility. The KYHealth card is issued to each recipient in the county of residence on approval of the application;

2. Advise the applicant that the KYHealth card is a one-time only plastic card which is intended to be permanent. Instruct the applicant not to

throw away the card, even if the case is discontinued or the household moves to another county.

3. Explain retroactive MA coverage and how eligibility is determined;

4. Explain medical services available including EPSDT and WIC programs. Review form PA-3 and explain how to access EPSDT services. Give a copy of form PA-3 to the applicant;

5. Explain that Medicaid is the payer of last resort. Any other health or hospital insurance is billed before Medicaid. Additionally, explain to recipients of Family MA the requirement to assign their rights to third party payments to the Cabinet for Health and Family Services. Explain the Kentucky Health Insurance Premium Payment (KHIPP) Program. Complete form PA-40, Third Party Liability Health Insurance, and form PA-41, Employer Health Insurance Letter, as appropriate;

6. Explain the KenPAC or managed care program including grievance and hearing rights;

7. If a member of the assistance unit appears to have a disabling health condition, such as quadriplegia or head injury, refer the individual to the SSA utilizing form PAFS-5.1, Report or Referral to the District Social Security Office, to apply for SSI and Social Security benefits. Do NOT delay the individual's application for assistance pending a determination of MRT, Social Security or SSI entitlement.

8. Explain MA IPV policy and penalties according to MS 1750 through MS 1795.

9. [Explain responsibilities for co-pays for prescription drugs and specialty providers per Volume I MS 0460.]

MS 1374 APPLICATIONS FOR THE DECEASED

Applications for the deceased are accepted but additional requirements apply depending on the nature of the deceased circumstances.

A. Accept and process MA applications made after the applicant's death in a non-managed care county if:

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

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

B. Accept and process MA applications made after the applicant's death in a managed care county only if application is made in the month of death.

C. Accept an application for an SSI applicant who dies before SSI entitlement is established, or before a hearing can be requested or held. See Volume IVA, MS 4662.

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

E. If an individual is determined eligible for Medicaid and dies prior to case approval, a MAID card for the individual is authorized by a special circumstance transaction. Process the application for remaining members, based on the current situation.

F. For any MA case where a parent dies prior to approval, explore K-TAP eligibility based on death of a parent.

MS 1376 OUT-OF-STATE APPLICANTS

MA can be requested by or for a Kentucky resident who is temporarily out-of-state. The individual, an interested party or an out-of-state agency may request assistance by letter or telephone.

A. To request assistance by letter or telephone the following conditions MUST exist:

1. An emergency situation arises;

2. Care and services are needed immediately; and

3. Health would be endangered if the individual attempted to return to Kentucky.

B. Send an application dated the day the request is received, to the requesting person. When the form is returned, treat the application as an emergency and complete necessary forms according to usual procedures.

MS 1420 SCOPE OF INVESTIGATION

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

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

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

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

1. If medical services were received, determine financial and technical eligibility for each of the 3 prior months.
2. If medical services were not received during any of the 3 months prior to application, retroactive eligibility does not exist.

D. [When an application is made by an interested party for an applicant, contact the applicant to confirm all information. If the applicant is unable to provide the information, contact those familiar with the circumstances of the applicant, e.g., children, spouse, estate executors, etc.]

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

MS 1430 AUTHORIZING BENEFITS

A. Authorize denials, withdrawals, or approvals:

1. Complete form PA-62 when using the PA-62 system and mail form MA-105 according to procedural instructions when action is taken; or
2. Complete and process through KAMES screens when using the KAMES system. The system sends appropriate notices.

B. When an application for assistance is denied, investigate MA eligibility for the three months prior to application. If the case is determined MA eligible for one or more of the prior three months do the following:

1. PA-62 cases:

a. [Approve Medicaid coverage and issue a KYHealth card as needed for the appropriate month according to procedures for Special Circumstance Transactions in the Computer Manual;]
b. Send form MA-105 to indicate approval or denial; or
c. Enter specific dates of time limited coverage on form MA-105, if approved.
[d. Spend Down approvals cannot be processed on the PA-62 system.]

2. [KAMES approves Medicaid coverage, issues a KYHealth card as appropriate, and sends the necessary notices.]

C. For the three-month period prior to the application month:

1. Authorize regular MA coverage in any month technical and financial eligibility is met and medical expenses are incurred; and
2. [Authorize Spend Down MA coverage on KAMES where technical and resource eligibility are met but income exceeds permitted limits.]

D. Requests for authorization of MA coverage in which the provider is billing for a service which exceeds 12 months are not processed on the PA-62 system or on KAMES. Medical providers must request payment for services within 12 months from the date of the service or within 12 months from the date of issuance of the MA coverage for the date of service. Advise the provider who is inquiring payment for services after 12 month period has ended to call Medicaid Customer Service at 1-800-635-2570.

MS 1435* SPECIAL CIRCUMSTANCE PROCESSING

Effective 2/1/04, the following changes are in effect for processing Special Circumstance actions on KAMES. It is important that you note how the terms supervisor and principal, as listed below, apply to individuals coded with KAMES security clearance type 02 (supervisors) and type 24 (principals). These are the people with clearance to sign off on an action. It does not refer to an individual's personnel classification.

A. All special circumstance actions will pend for supervisory approval.

1. When an individual initiates a special circumstance action the message, "Action pending – take case to supervisor" appears. This includes actions initiated by principals. A principal worker is not able to sign off on his/her own special circumstance action.

2. The case file must be taken to the principal, supervisor, or designated individual, as appropriate, for a separate sign off. In order to successfully sign off on a case, the supervisor, principal, or designated individual must be logged on to KAMES in his/her own "HRII" code.

3. If the special circumstance action is not signed off on appropriately on the same date the action is initiated, the worker and supervisor will receive a DCSR message, "Awaiting Aprvl – Spec Circum" the next work day as a reminder that the action has pended.

4. Supervisors can not update or change any data on a pending special circumstance transaction. Any needed changes must be given back to the worker initiating the action for corrections before the action is approved.

B. Supervisors can not initiate a special circumstance transaction. If a supervisor attempts to enter, "Y" to the, "Do you wish to add a selection not listed above?" on the special circumstance (HRKIPDIE) screen, the error message, "Entry not allowed" will be posted.

C. Supervisors and principals have an option on the KAMES Daily Case Status Report Menu (HRKIMU57) screen. The option is, "O – Special Circumstance Approved". The system takes the worker to this screen when paging through the DCSR screens at sign on, or the worker can manually select option, "O" to view at any time. When viewed, this listing will provide information on all special circumstance actions approved using that individual's HRII code and password.

1. The actions will remain on the listing for 14 calendar days from the approval date and cannot be deleted or removed.

2. The listing indicates the type of special circumstance transaction completed as follows:

a. Education bonus;
b. Money payments;
c. Medical cards.

Supervisory, principal, and designated workers are advised to view the listing on a daily basis for any discrepancies. If any payments on the listing were not authorized by the individual indicated, report the information immediately to the appropriate regional staff for investigation.

MS 1440 CASE RECORD

Case records are maintained for aged, blind, or disabled individuals, except SSI only individuals, and contain:

A. Form PAFS-116;
B. Application;
C. All other related forms according to type of application filed and documentation required; and
D. All required verification.

File form PA-31, Eligibility Worker Card, if maintained in your county, in the card box according to the date of the next recertification.

MS 1450 EFFECTIVE DATES FOR RETROACTIVE MEDICAID

A separate determination of retroactive MA eligibility is made independently of the ongoing SSI determination.

A. Individuals approved for SSI are eligible for retroactive MA based on the application filing date.

1. SSI applications filed prior to 1/1/98 can be determined eligible for retroactive MA for the 3 months prior to the application if resource and income eligibility existed.
2. SSI applications filed as of 1/1/98 are eligible as follows:
   [a.] In a non-managed care county the SSI application month and the two months prior to the SSI application month; or
   [b. In a managed care county the first day of the SSI application month forward.]
3. For additional information on MA effective dates for SSI recipients, see MS 4720.

B. [All other MA recipients are eligible for retroactive MA as follows unless they reside in a managed care county:]

1. To be eligible for retroactive MA coverage, medical services must have been received during any 1 of the 3 months prior to application.
   [a. If the applicant states medical services were not received:
      (1) Document applicant's statement; and
      (2) DO NOT authorize retroactive coverage.
   b.] If medical services were received, determine if technical, resource, and income eligibility exists for each of the 3 months prior to application.
      (1) If technical, resource, and income eligibility exists in each of the 3 prior months, authorize coverage effective the 1st day of the 3rd month prior to the month of application.
      (2) If technical, resource, and income eligibility exists only in 1 or 2 of the months, authorize coverage only for the months medical services were received.
      (3) If technical and resource eligibility exists in months medical services were received but income ineligibility exists, determine spend down status for any month medical services were received. [Refer to MS 2650-2740 for spend down criteria.]
2. Do not authorize retroactive MA coverage for months technical and resource eligibility does not exist.

C. [All other managed care MA recipients are not eligible for retroactive MA benefits. If the individual has medical expenses in any of the three months prior to the application month and income exceeds program standards in those months, a spend down determination can be made.

D.] Document the case record to indicate the method used to establish month of coverage. Also document that the applicant was given an explanation of retroactive MA coverage.

MS 1460 EFFECTIVE DATE FOR ONGOING MEDICAID

The effective date of ongoing MA eligibility is:

A. For Adult or Family MA recipients, the 1st day of the month of application.

B. [For Medicaid Works recipients, coverage begins effective the date of application as some applicants may be subject to premium payments. There is no retroactive coverage.

C.] For SSI recipients in non-managed care counties, the first day of the month following the application month;

[D.] For SSI recipients in managed care counties, the first day of the application month coded "N02"; or

[E.] For spend down recipients, the specific day excess income is obligated.

MS 1470 STANDARDS OF PROMPTNESS

See Policy Clarification

A. Process all applications within 30 days except for a disability determination which must be processed within 90 days. [Refer to Volume I, MS 0151, for cases pending over 30 days with good cause.]

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 are:

1. Delay in receiving the examining physician documentation; and
2. Delay in receiving the Medicare Explanation of Benefits (EOB) for spend down cases.

MS 1480 RECERTIFICATION PROCESS

Determine continuing MA eligibility for all non-SSI beneficiaries as follows.

A. For REGULAR MA, QMB, QDWI, SLMB, AND PASS THROUGH CASES:

1. [Process a complete recertification every 12 months. The 12-month period begins with the application/recert month; and]
2. Verify and document amount of income and resources according to procedures for the appropriate program.

B. For non-SSI LTC, HCBS, SCL and HOSPICE CASES:

1. Complete a recertification every 12 months. [The 12-month period begins with the application/recert month.] Do not change the recertification date as the result of an interim change transaction; and
2. Verify and document income and resources according to procedures for the appropriate program.

C. For spend down cases, verify and document amount of income, resources, and medical expenses according to the regular procedures.

D. For approvals, the certification begins with the month of application.

E. For QI1 cases:

1. Complete a recertification each December; and
2. Verify and document income and resources according to procedures for the program.

MS 1490 INTERIMS

Process as an interim case change the results of spot checks or reported changes occurring between complete recertifications. Take action on reported changes within 10 days.

MS 1500 RECERTIFICATION PROCEDURES

Thoroughly cover all technical and financial requirements to ensure the recipient continues to be eligible. Do not re-determine disability unless form PA-610 indicates the need for reexamination or an improvement in the condition of the recipient is noted. Require a face-to-face interview for all recertifications except for cases of institutionalized individuals in a nursing facility and recipients in the "Z" categories. [Use of a telephone interview is the option of the representative of the individual institutionalized in a nursing facility. Recipients in "Z" cases recertify by mail-in forms.]

A. Refer individuals who have reached 64 years, 9 months of age to the District Social Security Office for a determination of eligibility for HIB, SMI, and other benefits.

B. [For QMB, SLMB, QI1 and QDWI cases, recertifications are processed by means of the automated forms KIP-2Q, Renewal Form for the Medicare Savings Plan, and KIP-2QA, Renewal Form for the Medicare Savings Plan – Final Notice. Workers may conduct a telephone recertification interview at the request of the client or authorized representative (AR), but the option of scheduling either a telephone or face-to-face interview for these cases is not available on KAMES. For detailed recertification procedures, see MS 4530. For more information on an AR see MS 1371.]

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

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

2. On the 9th work day of the month, your list of Cases Requiring Recertification appears on your DCSR. Print the list and proceed to schedule your recertification appointments as follows:

a. On the Main Menu select "D", Appointment Scheduling, press enter, and the Appointment Calendar screen appears.
b. Enter the date as MMDDYYYY, press enter, and the Appointment Calendar appears.
c. Enter the "case number" and type "RC" to schedule an appointment and generate an appointment letter. The system permits you to schedule appointments 7 days a week, including weekends and holidays, from 7:00 a.m. to 6:30 p.m., if you wish to do so.
d. If an FS case and IM case with the same head of household are scheduled on the same day in adjacent time slots, a joint appointment notice is sent.

1) List both appointments on the calendar before pressing enter.
2) The appointment time listed on the notice will be that of the earlier appointment.

e. PAFS appointments are automatically scheduled a one hour time slot.

f. ONLY institutionalized individuals in a nursing facility have the option to waive the face-to-face interview with the recipient's representative.

g. Reschedule a recertification appointment using interview type "HR". If rescheduled before the 18th, only the rescheduled appointment generates a notice. If rescheduled after the 18th, KAMES does not send a new notice.

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

a. Reassignments between the 9th work day and the 17th calendar day will appear on the new worker's DCSR the day following the reassignment. The new caseworker must schedule the appointment for recertification. If the previous worker has already scheduled an "RC" appointment, you must use "HR" to schedule your appointment.

b. Reassignments on the 18th calendar day will have the appointment scheduled to the caseworker with responsibility prior to reassignment.

MS 1510* NOTICE OF ADVERSE ACTION

The following SITUATIONS DO NOT REQUIRE TIMELY NOTICE, although notice of action taken is sent.

A. Death of aged, blind or disabled recipient has been verified.

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

C. Assistance has been approved in another state.

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

E. A recipient requests discontinuance by a signed statement.

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

G. An SSP recipient has entered a long term care facility resulting in vendor payment status.

MS 1530 REASONS FOR NEGATIVE ACTION

Denials and discontinuances result from failure to meet technical or financial eligibility requirements, failure to comply with technical requirements, failure to meet patient status or for other reasons. Negative actions also occur if income increases or medical expenses decrease. For the cases on the PA-62 system prepare form MA-105 according to instructions. For cases on KAMES, the appropriate notice will be system generated. Refer to one of the following reasons for negative action:

A. 5095.1 FINANCIAL REASON:

1. Income or resources exceed MA standard;
2. Income has increased;
3. Medical expenses decrease;
4. Ineligibility period is still in effect;
5. Ineligible due to transfer of resources; or
6. Income or resources within SSI standard.

B. 5095.2 TECHNICAL ELIGIBILITY does not exist:

1. The individual is not age 65, disabled or blind;
2. [The individual is not under age 21 and an inpatient of a psychiatric hospital;]
3. Other technical reason, such as individual living in a public institution;
4. Citizenship requirements are not met; or
5. Individual receives, has applied for or has reconsideration rights for Supplemental Security Income (SSI).

C. 5095.3 FAILURE TO COMPLY WITH TECHNICAL REQUIREMENT:

1. Failure to fully complete or return application forms;
2. Failure to keep an appointment for an interview; including an OIG interview;
3. Failure to provide sufficient information or clarify conflicting information so that a determination of eligibility could be made;
4. Failure to provide birth verification; or
5. [Failure to explore eligibility for entitled benefits, e.g., Veterans Benefits, Railroad Retirement Benefits, pensions, IRA distributions, Black Lung Benefits, Social Security Benefits, etc.;] or
6. Disqualified, no extraordinary circumstance.

D. 5095.4 FAILURE TO MEET PATIENT STATUS.

E. 5095.5 OTHER REASONS, including:

1. Request of individual or formal withdrawal;
2. Inability to locate;
3. Change of agency policy; or

4. Individual is not a resident of Kentucky.

In addition to the section number, give a brief but thorough, easily understood explanation of the reason for the action.

MS 1540 MISREPRESENTATION AND FRAUD

A. If you learn a recipient or responsible party withheld information in order to receive MA, follow MA IPV procedures. See Volume I, MS 1760.

B. [If situations of suspected provider fraud or abuse are reported, send a memorandum with a summary of the situation to:]

Office of Inspector General (OIG)
Division of Special Investigations
[275 E. Main Street, 5E-D]
Frankfort, Kentucky 40621-0001

C. Attach a copy of any available documentation with the OIG memorandum. Keep any original documentation in the local office.

MS 1550 INTRODUCTION

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

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

MS 1560 ENUMERATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS 1580 INTRODUCTION

Receipt of MA is limited to residents of the state.

A. Institutionalized individuals, including SSI recipients must meet residency requirements.

B. Noninstitutionalized individuals are considered residents if:

1. Living in Kentucky with the intention to remain permanently or for an indefinite period;

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

3. Living in Kentucky; and

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

[C. Individuals who are residing in the state on a temporary basis DO NOT meet residency requirements for Medicaid eligibility. Persons residing in the state on a temporary basis include, but are not limited to, students, Job Corps participants whose caretaker relative resides out-of-state, visitors, tourists and certain aliens who enter the U.S. on a temporary basis.

1. If there is reason to believe that an applicant is residing in the state on a temporary basis, the worker is to thoroughly question the individual and document the case record regarding the individual's statements of residency.

a. Individuals who state they are residing in Kentucky for a limited period do not meet residency requirements. For example, students who state they will return to their home state at the end of the school year.
b. Individuals age 21 and over, and those under 21 who are capable of indicating intent, who enter the state and indicate intent to remain in the state permanently or for an indefinite period of time, may meet residency requirements.

2. Non-qualified aliens may be eligible for time-limited Medicaid coverage for emergency medical conditions if all financial and technical eligibility requirements, <u>including residency</u>, are met.

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

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

The following list defines the specific letter codes:

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

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

MS 1590* PLACEMENT BY ANOTHER STATE

Placements by a state or an entity recognized under state law as acting on behalf of the state are considered placements by that state. The state arranging or actually making the placement is considered as the placed individual's state of residence.

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

When a competent individual leaves the facility in which they were placed by a state, the individual becomes a resident of the state in which they are physically located.

MS 1600* PUBLIC INSTITUTIONS

A. AN INMATE OF A PUBLIC INSTITUTION, such as, prison, state-operated hospital for mental illness, or similar facility, is not eligible for benefits.

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

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

MS 1610 INTERRUPTION OF PUBLIC INSTITUTIONAL STATUS

[Contact MSBB for Medicaid approval on the following:]

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

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

MS 1615* HOME INCARCERATION

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

MS 1620 SPOUSE ABUSE CENTER

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

MS 1630 EMERGENCY SHELTER

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

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

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

1. [The individual or family group are residents of emergency shelters no more than 3 months in any 12 month period; and]

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

C. Spot check MA recipients residing in emergency shelters each month to:

1. Ensure they are not a resident of the shelter for more than 3 months in a 12 month period; and

2. Take appropriate case action when they leave the shelter.

MS 1640* SPECIFIC PROHIBITIONS

Do NOT deny MA because the individual:

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

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

C. Does not maintain a fixed or permanent address.

MS 1650* DISPUTED RESIDENCY

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

MS 1660 INTRODUCTION

As a condition of eligibility for MA, including MA based on entitlement to SSI, federal law requires cooperation with the Agency in identifying and providing information to assist the Agency in pursuing any third party who may be liable to pay for care or services available under Medicaid.

A determination for the appropriateness of the Kentucky Health Insurance Premium Payment (KHIPP) program must be made if a parent responsible for the MA child or spouse of the MA individual is employed. For TPL procedures and examples, see Volume IV, MS 2110.

MS 1670 THIRD PARTY ASSIGNMENT

Advise the individual during the application/recertification interview of TPL requirements for MA eligibility. [A statement assigning third party payments to the Cabinet for Health and Family Services, Department for Community Based Services is included on the application form and on form PA-40, Third Party Liability Health Insurance.] If an applicant has any health insurance coverage, including Medicare, complete form PA-40 or the appropriate KAMES screen.

If the individual refuses without good cause to assign third party payments to the Agency, the case is ineligible. For good cause criteria, see Volume IV, MS 2120.

MS 1680 TPL AND SSI

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

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

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

1. Gathers the TPL information at that time;

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

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

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

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

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

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

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

D. When this individual comes into the local office:

1. Discuss TPL requirements with the individual;

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

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

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

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

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

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

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

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

MS 1690* KHIPP OVERVIEW

Medicaid requires review of group health insurance plans which are available through the employer to:

A. An employed case member;

B. An employed parent responsible for a non-SSI MA child;

C. An employed spouse of an MA individual, residing with the assistance unit but not on the case, such as sanctioned parent or stepparent;

D. An employed blind or disabled child;

E. An employed JKM individual; or

F. A retired aged, blind, or disabled MA individual drawing a pension from a former employer.

DMS determines whether the payment of the premiums by MA would be cost-effective. The payment of premiums is made through the KHIPP program. See Volume IV, MS 2150.

MS 1700* AGED

To receive assistance as aged:

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

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

MS 1710* BLIND

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

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

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

MS 1720 DISABLED

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

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

A. [WHEN A FIELD DETERMINATION CAN BE MADE]

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

2. Deny the application if resource ineligible.

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

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

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

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

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

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

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

C. SPECIAL EXAMINATION:

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

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

3. Assist the individual in making any needed arrangements;

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

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

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

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

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

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

MS 1750 INTRODUCTION TO FINANCIAL ELIGIBILITY

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

Depending on the assistance requested, certain ALLOCATIONS, ALLOWANCES and STANDARDS are used to determine eligibility for Aged, Blind or Disabled MA.

A. [SUPPORTS FOR COMMUNITY LIVING (SCL) WAIVER STANDARD is $4,006, effective 1/1/09.

B. COMMUNITY SPOUSE RESOURCE ALLOWANCE MINIMUM is $21,912, effective 1/1/09; MAXIMUM is $109,560, effective 1/1/09.

C. COMMUNITY SPOUSE INCOME ALLOWANCE MINIMUM is $1,750, effective 1/1/09; MAXIMUM is $2,739, effective 1/1/09.

D. COMMUNITY SPOUSE MINIMUM SHELTER ALLOWANCE is $525, effective 7/1/08.]

E. FAMILY MEMBER INCOME ALLOWANCE STANDARD is $1,750, effective 7/1/08.

F. PERSONAL NEEDS ALLOWANCE for basic maintenance in a licensed nursing facility is $40 (this amount does not change).

G. [PERSONAL NEEDS ALLOWANCE for Non-institutionalized Hospice, Home and Community Based Services (HCBS), Acquired Brain Injury (ABI), and Supports for Community Living (SCL) Waiver is $694 (SSI Standard $674 plus SSI general exclusion $20), effective 1/1/09.

H. SPECIAL INCOME STANDARD for long term care (LTC) and waiver cases is $2,022, effective 1/1/09.

I. BLIND OR DISABLED CHILD ALLOCATIONS, effective 1/1/09.

1. Ineligible sibling allocation is $337;

2. Parent allocation for unearned income is $714 for one parent in the home or $1051 for two parents in the home; and

3. Parent allocation for earned income is $1,473 for one parent in the home or $2,147 for two parents in the home.]

J. Medicaid Works standards are effective 11/1/07. These amounts are found on KAMES inquiry. Select option “B” from the KAMES Main Menu. Then select option “E” Eligibility Tables, from the KAMES Inquiry Menu. Then select option “C” Medical Assistance Eligibility Table.

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

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

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

4. [The unearned income limit is the SSI Standard of $674 plus the SSI $20 general exclusion, effective 1/1/009.]

MS 1770 APPLICANT LIVING WITH SPOUSE

A. Spouses living together. Consider income according to MS 2610, 2620, and 2630. Consider resources as available to each other, whether they are actually contributed.

B. Spouses living apart. If both spouses apply or are technically eligible as aged, blind, or disabled, consider their income and resources as follows.

1. Living apart due to institutionalization of 1 spouse.

a. Institutionalized spouse applies:
(1) Consider only the income of the institutionalized spouse beginning with the month of separation. EXCEPTION: If at the time the application is processed it is determined that the institutionalized spouse did not reside in a nursing facility for 30 consecutive days, consider the income of the community spouse available to the institutionalized spouse.
(2) For individuals institutionalized prior to 9/30/89, consider resources of the couple as available to each other for the month of separation. Beginning the month after the month of separation, consider resources of the spouse which are contributed to the institutionalized individual.
(3) For individuals institutionalized on or after 9/30/89, consider resources of the couple to determine eligibility of the institutionalized spouse according to MS 2120.

b. Community spouse applies:
(1) Consider income of the couple as available to the community spouse through the month of separation.
(2) Consider income of the community spouse plus any income of the institutionalized spouse actually made available to the community spouse, beginning the month after the month of separation.
(3) Consider resources of the couple available to the community spouse through the month of separation. The month after the month of separation, consider only the resources of the institutionalized spouse actually made available to the community spouse.

2. Living apart due to reason other than institutionalization:

a. Consider income and resources of the couple in the month of separation.
b. Consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse, beginning the month after the month of separation.

MS 1780* COUPLES IN LTC

A. Living apart due to institutionalization policy applies whether the couple is residing in the same room, the same LTC facility or in separate facilities. Treat the institutionalized couple as a couple during the month of separation even though they are not residing in a household. Beginning the month after the month of separation, treat the couple as individuals. The couple is considered as living apart during the month of separation when one spouse is institutionalized in LTC and the other spouse is in a personal care home or family care home.

B. To be considered an eligible couple, both spouses must be aged, blind or disabled, income and resource eligible as a couple, and both must apply, although application need not be made at the same time.

Refer to MS 3550 to determine MA eligibility and patient liability for the institutionalized couple.

MS 1790 APPLICANT LIVING WITH DEPENDENT CHILD

A. Living together.

1. Consider resources and income of MA family.
2. Compare to resources and income limits for MA family size.

B. Living apart due to reasons other than institutionalization of one spouse, both applying for or receiving MA.

1. [For the Family Related MA case, during the month of separation, consider the income and resources of the parent and dependents included in the case and income and resources of the aged, blind or disabled parent.] The month after the month of separation, consider only the income and resources actually made available to the family by the aged, blind or disabled parent.
2. [For the aged, blind or disabled parent, consider income and resources of the aged, blind or disabled parent and the income of the Family Related MA parent for the month of separation.] The month after the month of separation, consider only the income and resources of the aged, blind or disabled parent.

C. Living apart from spouse due to reasons other than institutionalization, spouse not receiving MA.

1. For the month of separation, consider and compare resources and income in relation to family size, including the parent living apart.
2. After the month of separation, consider and compare resources and income in relation to family size, excluding the parent living apart.

D. Living apart due to institutionalization of one spouse with dependents.

1. In determining MA eligibility for the community spouse and the dependents, consider the gross income of the couple and dependents through the month of separation. Beginning the month after the month of separation, consider the community spouse's gross income, the dependent's gross income plus the verified amount the institutionalized spouse actually contributes to the community spouse and dependents. Include the institutionalized spouse in the MA Family Size for the month of separation but exclude the institutionalized spouse the month after the month of separation. Consider resources of the couple available to the community spouse for the month of separation.
2. For resource consideration of the institutionalized spouse, see MS 2120-2170. To determine the patient liability for the institutionalized individual and the community spouse income and family income allowances refer to MS 3500-3610.

MS 1800 [K-TAP AND FAMILY RELATED MA RECIPIENT WHO ENTERS LTC

A. Consider resources and income as in K-TAP and Family Related MA case for up to 1 year.] Immediately refer the nursing facility recipient to SSA to apply for SSI benefits if the recipient's medical condition appears to be disabling, such as, head injury, quadriplegic, etc.

B. Consider resources and income on basis of living apart when it becomes apparent separation will last more than 1 year. Determine technical eligibility for aged, blind or disabled individual. Establish a separate J, K or M case for the aged, blind or disabled parent/child.

C. [When separate cases are established remove the J, K or M parent/child from the K-TAP or Family Related MA case.]

MS 1810* BLIND OR DISABLED CHILD LIVING WITH PARENTS

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

A. Consider total resources and income of the parent.

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

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

1. Deem parental income, as needed to raise the sibling's income to the maximum ineligible sibling allocation. Allow an ineligible sibling allocation for each ineligible sibling under age 18 living in the home of the blind or disabled child;
2. Deduct from unearned parental income, up to the maximum parent allocation for unearned income only or a combination of unearned and earned income;
3. Deduct from earned parental income up to the maximum parent allocation for earned income only;
4. If there are two parents in the home, use the parent allocation for two, even if only one has the income;
5. See MS 1760 for parental and sibling allocation maximums.

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

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

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

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

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

MS 1820* BLIND OR DISABLED CHILD LIVING APART FROM FAMILY

DETERMINE FINANCIAL ELIGIBILITY FOR A BLIND OR DISABLED CHILD, LIVING APART FROM FAMILY DUE TO INSTITUTIONALIZATION (LTC) OR HOSPITALIZATION IN AN ACUTE CARE HOSPITAL AS FOLLOWS:

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

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

2. Deduct from income of the parent:
   a. Income as needed to raise the siblings income to the maximum ineligible sibling allocation. Allow a separate deduction for each ineligible sibling under age 18 living in the home. If application is made for more than one blind or disabled child in the same family, hospitalized or institutionalized, allow allocation of parental income to the ineligible siblings living in the home in each case.
   b. The maximum parent allocation for unearned income only, or a combination of unearned income and earned income;
   c. Up to the maximum parent allocation for earned income only;
   d. If there are two parents in the home, use the parent allocation for two, even if only one of the parents has the earned or unearned income; and
   e. See MS 1760 for parental and sibling allocation maximums.

B. Consider total resources and income of the child.

1. Allow appropriate income deductions from the income of the child according to MS 2480;
2. Combine the deemed income of the parent and the countable income of the child;
3. Allow verified incurred medical expenses of the parent, sibling, and the child; and
4. Use the MA Scale for one in the eligibility determination.

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

MS 1850 OVERVIEW OF RESOURCES

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

See MS 2050-2110 for transfer of resources policy.]

MS 1860 RESOURCE LIMITS

A. Aged, Blind, or Disabled Individuals.

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

[B Blind or Disabled Medicaid Works Individuals.

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

C.] Blind or Disabled Child.

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

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

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

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

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

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

E.] Do not count the current month's income as both income and a resource. EXAMPLE: If income for the current month is deposited in a bank account, deduct that amount from the account balance to determine actual resources.

[F.] If resources exceed limits, reduce the countable resources by any verified liability against them, such as, outstanding checks drawn against an account.

[G.] The case is resource eligible for that month if total countable resources are equal to or less than the limits when an application or recertification is processed.

[H.] The case is resource ineligible if total countable resources exceed limits when an application or recertification is processed. In this situation, deny the application or send timely notice to discontinue an active case.

[I.] The case is resource eligible for the month of discontinuance or denial, if reapplication is made and resources are reduced at or below the resource limit during the month without transfer of resources to establish eligibility.

MS 1870 VERIFICATION AND DOCUMENTATION

VERIFY AND DOCUMENT RESOURCES IN CASE RECORD:

A. At initial eligibility determination and for 3 months prior to application month. [Refer to Volume I, MS 0151, for cases pending over 30 days with good cause];

B. At renewal, verification of resources is required for the prior month only to assure resources are within limits;

C. Any time holdings are near resource limits at approval or renewal, set up a monthly spot check for at least 3 months; and

D. When there is indication of receipt or transfer of resources.

MS 1880 EXCLUDED RESOURCES

Excluded resources are available money, real property, personal property or other assets not counted in determining eligibility. When an excluded resource is sold, such as a vehicle equipped for the disabled, compare proceeds to the limits for liquid assets. The proceeds are not considered income, but a change in the type of resource.

A. Home. Exclude proceeds from the sale of a home or insurance payments from the loss of a home for 3 months from the date of receipt of proceeds, if the intent is to use them to purchase another home. Transfer of the home for less than fair market value (FMV) as of 8/1/95, is a prohibited transfer unless it is made to specified individuals. See MS 2070A, regarding transfer of the home. For consideration of homestead property after 6 continuous months of institutionalization, see MS 1975.

[B. Household equipment and personal effects.

C. Homestead property becomes non-home real property after six months of institutionalization. Non-home real property may be excluded if:

1. It can be demonstrated that there is a reasonable effort being made to sell the property at FMV. The individual must publicly make known the intention of selling the property at FMV through a newspaper ad, by contract with realtor, correspondence with a financial institution, etc. The exclusion for effort to sale may be extended after the initial six month exclusion on a case-by-case basis.

   This extension requires approval by Department for Medicaid Services (DMS). Send all pertaining information to the Medical Support and Benefits Branch (MSBB) for DMS review.

2. The member signs a letter stating an intention to return home.

   Review the situation at each recertification/reapplication and require verification of the ongoing reasonable effort to sell the property at FMV or a new statement of intention to return home.

D. Property sold on a land contract being purchased by an applicant/recipient. The contract must be actuarially sound, without balloon payments and without forgiveness of debt in the event of termination of sale. These land contracts must be reviewed by DMS. Send all pertinent information to MSBB for DMS review.

E. Life estate interest in real estate property or other property, e.g., oil lease. If an individual is in a vendor payment case (LTC, ICF/MR/DD, SCL, ABI, HCBS, Michelle P, ABI LTC) and/or the individual's community spouse transfers property to establish the life estate, see transfer of resource policy outlined in MS 2050 - MS 2110.

F. Non-home property (other than previously considered homestead property). Exclude the first $6,000 of equity value of non-home, income producing property NOT used in a trade or business. Totally exclude the value of property that is essential for self-support of the individual, spouse or family group AND which is used in a trade or business, i.e. a vehicle. For the purposes of this exclusion, rental property is not considered a trade or business.

G. Equity value of all equipment (including tools, machinery, etc.), livestock, or other inventory used in a farming or self-employment enterprise.

H. Relocation Assistance. Relocation assistance provided by a state or local government comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, which is subject to the treatment required by Section 216 of such Act.

I. Vehicles.] One vehicle regardless of value if used as an owner occupied home. One vehicle regardless of value if used by a member of the household for self-employment. In addition, one vehicle regardless of value if used for employment, to obtain medical treatment, or if specially equipped for the disabled. For the Medicaid eligibility determination and resource assessment of an institutionalized spouse with a community spouse, exclude one vehicle, regardless of value or intended use, if it is used by the community spouse. If a household has four vehicles that meet each of the above exceptions, then a total of four vehicles could be excluded. Exclude $4500 from the total equity value of all nonexcluded vehicles.

[NOTE: If at the time of admission, an institutionalized individual did not own a vehicle, and has resources that the individual wishes to use to purchase a vehicle, DMS has clarified that this vehicle cannot be excluded unless there is medical evidence that the client can utilize the form of transportation being purchased. Example: client purchases specially equipped van. However, in this situation, client is physically limited to stretcher transportation. This vehicle could not be excluded.]

[J. All resources of an SSI individual. All resources of an SSI essential person or spouse whose MA eligibility is based on inclusion in the SSI case.

K. Burial space items such as conventional gravesites, crypts, mausoleums, urns, vaults, caskets, headstones, and opening and closing of the grave.

L. Term and burial insurance policies.

M. Value of a prearranged funeral contract funded by a life insurance policy with: 1) an irrevocable assignment of ownership to the funeral home, 2) irrevocable assignment of beneficiary (the funeral home is the beneficiary) or 3) just an irrevocable assignment to the funeral home of the life insurance policy. If over $10,000 and a vendor payment case, the prearranged funeral contract must be sent to MSBB along with a cover sheet for DMS review.

N. The value of prearranged funeral contracts (purchased with cash) that has an irrevocable funeral trust agreement signed within 30 days of the application. If over $10,000 and a vendor payment case, the prearranged funeral contract must be sent to MSBB along with a cover sheet for DMS review.

O. Allow a $1500 exclusion from burial reserves for each member of the assistance group for the following:

1. Whole life insurance policies;

2. Burial funds;

3. Cash set aside for burial purposes; and

4. Prearranged funeral contracts <u>without</u> an irrevocable assignment.

P. Interest on burial reserves, if allowed to accrue.

Q. Cash received to repair or replace a damaged, lost or stolen excluded resource, including interest accruing from cash, or in kind item. Allow 9 months for the repair or replacement of the excluded item and an additional 9 months when the individual shows good cause.

R. Retirement plans. IRAs, KEOGH plans, deferred compensation, tax deferred retirement plans and other tax deferred assets. Consider amounts withdrawn as nonrecurring lump sums. Regular disbursements are considered to be other unearned income.

S. Medicaid Qualifying Trust. Principal and accrued interest of a Medicaid Qualifying Trust established on or before 8/10/93, if the trustee has limited authority to access and distribute the trust funds to the beneficiary. All trusts must be reviewed by DMS.

T. Lump sum backpayments. Lump sum backpayment from SSI and/or RSDI for the first 6 months following the month of receipt. Deduct current month's benefits from the backpayment prior to determining the excluded resource amount. Set up a spot check for the end of the 6-month period. Consider any remaining amount as a countable resource.

U. Reimbursement for a medical or social service. Consider as excluded resources in the month of receipt and in the calendar month following receipt any cash payments received for medical or social services. However, the cash payment is considered a resource if still held the second month following receipt.

Determine the purpose of the contribution:

1. Paying for a medical expense not covered by insurance or MA;

2. Paying for a social service expense, such as drug counseling;

3. Paying for any amount of reimbursement for a medical or social service bill the individual has already paid.

V. Exclude Earned Income Credit (EIC) payments as a resource in the month of receipt and the following month.

W. Aleutian payments. Up to $12,000 to Aleutians and up to $20,000 to individuals of Japanese ancestry for payments made by the federal government to compensate for hardships experienced during World War II. All recipients of these payments are provided with written verification by the federal government.

X. Agent Orange Settlement. Payments made from the Agent Orange Settlement Fund issued by Aetna Life and Casualty to veterans or their survivors in accordance with Public Law 101-201 and retroactive to January 1, 1989.

Y. Victims Compensation payments. Exclude completely for nine months payments received for losses and incurred expenses, such as lost wages or property, medical treatment, etc. Victim compensation payments received from a fund established by a state to aid victims of crime, to the extent that the individual can verify that the amount was paid as compensation for pain and suffering purposes, for expenses incurred, or losses suffered as a result of a crime.

Z. Austrian payments. Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

AA. Nazi Persecution Victims. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.

BB Hemophiliacs. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using the SSI standards. This resource is NOT excluded by SSA, so these recipients should not be SSI eligible. Enter these applications on KAMES as usual. If the hemophiliac is resource ineligible for some other reason, pend the application and contact the Medical Support and Benefits Branch through your Regional Program Specialist for further instructions.

CC. Susan Walker class action suit. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.

DD. Exempt resources which are inaccessible for 30 days or more in the resource eligibility determination until these resources are accessible. This policy applies in case situations when the applicant/recipient is attempting to liquidate excess resources. (Life insurance policies are not included in this exemption.)

1. Require written verification of inaccessibility of the resource from the institution holding the resource.

2. Set up a monthly spot check to track the inaccessibility of the resource as accessing the resource can make the individual ineligible for MA in the future.

EE. Resources included in a Plan for Achieving Self-Support (PASS).

FF. Tax rebate checks are excluded in the month of receipt and the following two months. Any proceeds from the rebate retained after the third month are considered a countable resource.

MS 1890 ANNUITIES

[An annuity is an investment from which an individual receives fixed payments for a lifetime or for a specified number of years. On 9/1/03, the Department for Medicaid Services (DMS) began reviewing all annuities for the determination of Medicaid eligibility at applications, recertifications and resource assessments. On February 8, 2006, the Federal Deficit Reduction Act of 2005 (DRA), signed into law new requirements for the Medicaid statute in the treatment of annuities (DMS began reviewing for this change effective September 2006).

A. For annuities signed on or after February 8, 2006, the DRA requires that DMS be named as a beneficiary, after a spouse or minor/disabled child. The change in annuities also applies to those annuities owned by the applicant and the community spouse. For annuities owned by the community spouse, DMS is to be named before the institutionalized spouse. This also applies in situations where both spouses are institutionalized. For individuals who have an annuity that was signed and dated prior to February 8, 2006, or who do not have any annuities, the institutionalized or community spouse or power of attorney (POA) initials the first statement on form MA-34, and signs and dates the form. The following two questions are in place for KAMES to capture annuity information.

1. "Individual/Spouse has annuity?"; and
2. "Reviewed by DMS? Ver Scr: Date:"

These are answered "Y" or "N" and the verification source can be either written statement ("WS") or original record ("OR"). Document in case comments who has ownership of the annuity, either the applicant or the spouse.

Also effective February 8, 2006, form MA-34, Declaration of Annuities, MUST be completed for all Long Term Care (LTC) or waiver resource assessments, applications and recertifications, whether or not the individual has an annuity.

B. The types of cases requiring form MA-34 are as follows:

1. NURSING FACILITY;
2. HCBS;
3. SCL;
4. MODEL WAIVER II;
5. ICF/MR/DD;
6. MENTAL HEALTH/PSYCHIATRIC FACILITY (FOR AGE 65 OR OLDER);
7. ADULT DAY CARE;
8. IMD; or
9. ABI.

C. DMS will advise how the annuities are to be considered. Use the following procedures when forwarding an annuity for applications or resource assessments:

1. Review community spouse annuities. If an annuity is payable to the community spouse and the value of the annuity is greater than $22,328, the minimum community spouse resource allowance plus the institutionalized spouse resource limit of $2,000, the applicant must provide documentation of the fair market value (FMV) of the annuity. Because an annuity can be sold even though it is considered to be actuarially sound, the FMV is to be considered a countable resource for resource assessments and applications.

2. Review the applicant's annuity to see if the annuity was set up with the individual's money and if it was signed and dated on or after February 8, 2006. The applicant must be receiving disbursements on a regular basis. If the annuity meets these criteria, advise the applicant that DMS will need to be added as a beneficiary and that form MA-34, Declaration of Annuities, is to be signed. Do not forward the annuity until this change is completed.

3. Advise the applicant of DMS' position in the order of beneficiary assignment in relation to who is currently listed on the annuity. For example: DMS would be the second beneficiary if there is a community spouse <u>or</u> minor/disabled child, third beneficiary if there is a community spouse <u>and</u> a minor/disabled child. If there is neither a community spouse nor a minor/disabled child, then DMS is to be named as the first beneficiary.

4. Once the annuity is received with the change of DMS beneficiary position, make two copies of the annuity document(s). Forward one copy to the Medical Support and Benefits Branch (MSBB) and <u>retain a copy of the annuity for the case record</u>.

   Note: For recertifications, do not forward an annuity that has been previously reviewed by DMS unless changes have been made to the annuity.

5. Attach the annuity to be reviewed to form MAP-4104, Annuity Transmittal. Follow the procedural instructions for this electronic form.

6. Ensure that any attachments listed in the annuity have been provided. If any part of the annuity or attachments is missing, request the missing information from the client and submit the annuity when everything is in order.

7. To ensure that processing timeframes are met, mail or fax complete copies of annuities that needs to be reviewed, along with Form MAP-4104, Annuity Transmittal, on a daily basis to MSBB. The case is to remain pending until a response is received from DMS. DMS will give priority to annuity reviews for applications. Refer to <u>Volume I, MS 0151</u>, for cases pending over 30 days with good cause.

8. MSBB forwards the copy of the annuity to DMS for review. MSBB maintains a log of the documents received for tracking and response purposes.

9. Following completion of the review, DMS notifies MSBB staff regarding consideration of the annuity. MSBB staff will send a memo containing this information to the worker with a copy to the Program Specialist. The copy of the annuity will not be returned.

Note: For individuals/community spouses who do not comply with the change in policy in effect February 6, 2006, the annuity will be considered a transfer of resources for less than FMV. This may result in an ineligibility period. The transfer of resource penalty must be served out unless a hardship determination is requested and approved by DMS. Refer to MS 2070H regarding hardship determination requests.

D. For recertifications, do not hold a recertification pending for receipt of the annuity review response. Complete any case action necessary as a result of the review response within the next administratively feasible month.

E. For reapplications in which an annuity has been previously reviewed and approved by DMS, the worker must check the date on the annuity. If dated within the new guidelines, inform the applicant that DMS is to be added as beneficiary, and what position. Complete form MA-34 and after changes are completed, forward to MSBB for review. The case is to remain pending until changes are completed.

F. If the recipient has access to the principal of the annuity, regardless of penalty for early withdrawal, the principal is a countable resource.

G. Annuities that provide a minimal payment throughout the life of the annuity, but have a large balloon payment in the final month, are considered a transfer of resources and subject to transfer of resource penalties.

H. Questions concerning the status of an annuity review are to be directed to the Medicaid Program Assistance Section (MPAS) supervisor.

I. The Office of Inspector General (OIG) will track the annuities for changes and the death of the applicant.]

MS 1900 [LIFE EXPECTANCY TABLE]

Period Life Table, 2004						
	Male			Female		
Exact age	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
0	0.007474	100,000	74.83	0.006091	100,000	79.96
1	0.000513	99,253	74.40	0.000461	99,391	79.45
2	0.000328	99,202	73.43	0.000268	99,345	78.49
3	0.000247	99,169	72.46	0.000195	99,318	77.51
4	0.000205	99,145	71.47	0.000166	99,299	76.52
5	0.000189	99,124	70.49	0.000148	99,283	75.54
6	0.000182	99,106	69.50	0.000138	99,268	74.55
7	0.000172	99,088	68.52	0.000130	99,254	73.56
8	0.000153	99,071	67.53	0.000122	99,241	72.57
9	0.000126	99,055	66.54	0.000113	99,229	71.58
10	0.000102	99,043	65.55	0.000107	99,218	70.58
11	0.000104	99,033	64.55	0.000110	99,207	69.59
12	0.000156	99,022	63.56	0.000133	99,196	68.60
13	0.000273	99,007	62.57	0.000178	99,183	67.61
14	0.000435	98,980	61.59	0.000238	99,166	66.62
15	0.000613	98,937	60.61	0.000308	99,142	65.64
16	0.000782	98,876	59.65	0.000372	99,111	64.66
17	0.000935	98,799	58.70	0.000421	99,075	63.68
18	0.001061	98,707	57.75	0.000445	99,033	62.71
19	0.001162	98,602	56.81	0.000451	98,989	61.74
20	0.001264	98,487	55.88	0.000454	98,944	60.76
21	0.001361	98,363	54.95	0.000462	98,899	59.79
22	0.001422	98,229	54.02	0.000469	98,854	58.82
23	0.001438	98,089	53.10	0.000480	98,807	57.84
24	0.001420	97,948	52.17	0.000493	98,760	56.87
25	0.001392	97,809	51.25	0.000507	98,711	55.90
26	0.001368	97,673	50.32	0.000523	98,661	54.93
27	0.001349	97,539	49.38	0.000542	98,609	53.96
28	0.001341	97,408	48.45	0.000564	98,556	52.99
29	0.001344	97,277	47.52	0.000590	98,500	52.02
30	0.001352	97,146	46.58	0.000621	98,442	51.05
31	0.001367	97,015	45.64	0.000659	98,381	50.08
32	0.001404	96,882	44.70	0.000705	98,316	49.11
33	0.001467	96,746	43.76	0.000761	98,247	48.14
34	0.001555	96,604	42.83	0.000825	98,172	47.18

Period Life Table, 2004						
	Male			Female		
Exact age	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
35	0.001662	96,454	41.89	0.000898	98,091	46.22
36	0.001782	96,294	40.96	0.000979	98,003	45.26
37	0.001918	96,122	40.04	0.001074	97,907	44.30
38	0.002068	95,938	39.11	0.001183	97,802	43.35
39	0.002235	95,740	38.19	0.001306	97,686	42.40
40	0.002420	95,526	37.28	0.001439	97,559	41.46
41	0.002629	95,294	36.36	0.001581	97,418	40.52
42	0.002863	95,044	35.46	0.001732	97,264	39.58
43	0.003127	94,772	34.56	0.001891	97,096	38.65
44	0.003418	94,475	33.67	0.002059	96,912	37.72
45	0.003732	94,153	32.78	0.002244	96,713	36.80
46	0.004067	93,801	31.90	0.002441	96,496	35.88
47	0.004424	93,420	31.03	0.002634	96,260	34.96
48	0.004805	93,006	30.17	0.002815	96,007	34.06
49	0.005208	92,560	29.31	0.002997	95,736	33.15
50	0.005657	92,077	28.46	0.003198	95,449	32.25
51	0.006134	91,557	27.62	0.003431	95,144	31.35
52	0.006595	90,995	26.79	0.003696	94,818	30.46
53	0.007027	90,395	25.96	0.003998	94,467	29.57
54	0.007457	89,760	25.14	0.004341	94,090	28.68
55	0.007921	89,090	24.33	0.004722	93,681	27.81
56	0.008467	88,385	23.52	0.005148	93,239	26.94
57	0.009121	87,636	22.71	0.005627	92,759	26.07
58	0.009912	86,837	21.92	0.006166	92,237	25.22
59	0.010827	85,976	21.13	0.006765	91,668	24.37
60	0.011858	85,045	20.36	0.007445	91,048	23.53
61	0.012966	84,037	19.60	0.008187	90,370	22.71
62	0.014123	82,947	18.85	0.008959	89,630	21.89
63	0.015312	81,776	18.11	0.009747	88,827	21.08
64	0.016567	80,524	17.38	0.010582	87,962	20.29
65	0.017976	79,190	16.67	0.011511	87,031	19.50
66	0.019564	77,766	15.96	0.012572	86,029	18.72
67	0.021291	76,245	15.27	0.013772	84,947	17.95
68	0.023162	74,621	14.59	0.015130	83,777	17.19
69	0.025217	72,893	13.93	0.016651	82,510	16.45
70	0.027533	71,055	13.27	0.018406	81,136	15.72
71	0.030131	69,098	12.64	0.020342	79,643	15.01
72	0.032978	67,016	12.01	0.022346	78,023	14.31
73	0.036086	64,806	11.41	0.024382	76,279	13.62

Period Life Table, 2004						
	Male			Female		
Exact age	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
74	0.039506	62,468	10.81	0.026551	74,419	12.95
75	0.043415	60,000	10.24	0.029073	72,443	12.29
76	0.047789	57,395	9.68	0.032023	70,337	11.64
77	0.052464	54,652	9.14	0.035307	68,085	11.01
78	0.057413	51,785	8.62	0.038949	65,681	10.40
79	0.062789	48,812	8.11	0.043047	63,123	9.80
80	0.068836	45,747	7.62	0.047769	60,405	9.22
81	0.075724	42,598	7.15	0.053190	57,520	8.65
82	0.083466	39,372	6.70	0.059279	54,460	8.11
83	0.092144	36,086	6.26	0.066080	51,232	7.59
84	0.101803	32,761	5.84	0.073685	47,847	7.09
85	0.112468	29,426	5.45	0.082199	44,321	6.62
86	0.124164	26,116	5.08	0.091712	40,678	6.17
87	0.136917	22,874	4.73	0.102294	36,947	5.74
88	0.150754	19,742	4.40	0.113990	33,168	5.33
89	0.165704	16,766	4.09	0.126820	29,387	4.96
90	0.181789	13,988	3.80	0.140793	25,660	4.60
91	0.199019	11,445	3.54	0.155906	22,047	4.28
92	0.217396	9,167	3.29	0.172147	18,610	3.97
93	0.236906	7,174	3.06	0.189496	15,406	3.70
94	0.257525	5,475	2.86	0.207925	12,487	3.44
95	0.278031	4,065	2.68	0.226597	9,891	3.22
96	0.298111	2,935	2.52	0.245258	7,649	3.01
97	0.317432	2,060	2.38	0.263628	5,773	2.83
98	0.335655	1,406	2.25	0.281410	4,251	2.66
99	0.352438	934	2.13	0.298294	3,055	2.50
100	0.370060	605	2.02	0.316192	2,144	2.36
101	0.388563	381	1.91	0.335163	1,466	2.22
102	0.407991	233	1.81	0.355273	975	2.08
103	0.428390	138	1.71	0.376590	628	1.95
104	0.449810	79	1.61	0.399185	392	1.83
105	0.472300	43	1.52	0.423136	235	1.71
106	0.495915	23	1.43	0.448524	136	1.60
107	0.520711	12	1.35	0.475436	75	1.49
108	0.546747	6	1.26	0.503962	39	1.39
109	0.574084	3	1.19	0.534199	19	1.29
110	0.602788	1	1.11	0.566251	9	1.20
111	0.632928	0	1.04	0.600226	4	1.11
112	0.664574	0	0.97	0.636240	2	1.03

Period Life Table, 2004						
	Male			Female		
Exact age	Death probability [a]	Number of lives [b]	Life expectancy	Death probability [a]	Number of lives [b]	Life expectancy
113	0.697803	0	0.91	0.674414	1	0.95
114	0.732693	0	0.84	0.714879	0	0.87
115	0.769327	0	0.78	0.757772	0	0.80
116	0.807794	0	0.72	0.803238	0	0.73
117	0.848183	0	0.67	0.848183	0	0.67
118	0.890592	0	0.62	0.890592	0	0.62
119	0.935122	0	0.57	0.935122	0	0.57

[a] Probability of dying within one year.
[b] Number of survivors out of 100,000 born alive.

Note: The period life expectancy at a given age for 2004 represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for 2004 over the course of their remaining life.

MS 1920* EARNED INCOME TAX CREDIT

EARNED INCOME TAX CREDIT (EITC). Consider the remainder of EITC payments as a resource beginning the second month after the receipt month.

MS 1930* HOME EQUITY PLANS

HOME EQUITY PLANS (HEP) allow elderly homeowners to convert the equity value of their homes into cash without being forced to leave their homes. The following HEP are currently available.

A. DEFERRED PAYMENT LOANS (DPL) are one-time lump sum loans used to repair or improve a home or to pay property taxes. They are usually offered by local government housing or community development departments with no repayment due until the homeowner dies, sells the home or moves.

B. REVERSE MORTGAGES allow a homeowner to borrow, via a mortgage contract, some percentage of the appraised value of their home. The homeowner can receive periodic payments and/or a line of credit to draw against. Some reverse mortgages involve the purchase of an annuity and are called Reverse Annuity Mortgages (RAM). In most reverse mortgages the loan to the homeowner is not repaid until the homeowner dies, sells the home or moves.

C. SALE-LEASEBACK allows the homeowner to transfer title of the home to a buyer in exchange for an installment note satisfied by regular payments. The installment note may bear interest. The buyer then allows the former homeowner to remain in the home in exchange for rent. Because the rent is a lesser amount than the former homeowner receives from the installment note, they are provided with needed proceeds. Some sale-leaseback arrangements involve the purchase of an annuity.

D. TIME SALE allows the homeowner to sign a contract to sell their home at death but maintain title to and continue to live in the home. The buyer of the contract makes regular payments to the homeowner. The contract may provide for payment of interest and/or the purchase of an annuity.

E. VERIFICATION. Copy of the HEP such as a reverse mortgage, time sale, sale-leaseback or loan.

F. CONSIDERATION. Carefully review the HEP to determine the type of compensation the homeowner is to receive, frequency, schedule of receipt, amounts, etc.

1. If the money from the mortgage establishes a line of credit, consider the entire amount of the line of credit as a countable resource effective the month the line of credit becomes available.
2. If the money from the mortgage is paid to the MA applicant/recipient as a lump sum payment and/or a down payment, consider the amount paid as a countable resource in the month the lump sum and/or down payment is received.

3. Proceeds other than a line of credit, lump sum payment and/or a down payment, such as annuity, including reverse annuity mortgages, other than reverse equity arrangements, are not considered to meet the definition of a converted resource, but are considered as unearned income, according to MS 2260.

MS 1940 JOINTLY HELD RESOURCES

JOINTLY HELD RESOURCES are resources owned or held by more than 1 person. Allow individuals the opportunity to rebut the ownership if they state that they do not contribute to or withdraw from a jointly held resource, such as checking, savings, CD, or savings bonds, etc.

A. VERIFICATION OF JOINTLY HELD RESOURCES. Document in case record the amount of the resource and type of verification used.

B. [CONSIDERATION OF JOINTLY HELD RESOURCES. For transfer of resources consideration of jointly held resources transferred after 8/10/93 for HCBS, HCBS Model Waiver 2, ICF/MR/DD, SCL and LTC cases, see MS 2050.]

1. Do not consider the placement of another's name on an account or asset as a joint owner set up as "or" to be a transfer of assets until:

   a. Action is taken to withdraw funds from the account; or

   b. Action is taken to remove the asset from the control of one of the joint owners.

   [For jointly held resources, the 36 month look back period for the transfer of resources policy applies to LTC, ICF/MR/DD, SCL, HCBS Model Waiver 2 and HCBS cases when any action is taken after 8/10/93 by the individual or any other party to reduce or eliminate the individual's ownership or control of the resources. Effective February 9, 2009 the look back period will progressively expand from 36 months to 60 months. At this point the look back period will increase daily until February 8, 2011, at which point the look back period will have reached 60 months.]

   Note: There is no change in the look back period for resources transferred into a trust or used to establish a trust. The look-back period remains 60 months.

2. Total amount of joint checking/savings account is available to the individual when only one signature is required to withdraw funds.

3. When more than 1 signature is required to withdraw funds from joint checking/savings account, only the individual's share is available. Establish shares by a signed statement from other parties as to the division. If the other owner refuses to co-sign to make the resource available, do not count the resource. Obtain verification of the other owner's refusal to sign.

4. If more than one of the account holders is an eligible individual, divide the funds equally among the eligible individuals when determining resources. Use this policy even if all the funds in the

account were deposited by an ineligible individual and the eligible individuals have never made a withdrawal from the account.

5. If there is no predetermined allocation of shares from a business enterprise, determine individual's available share by dividing the value of the business enterprise by the number of owners.

6. If resources are held jointly, other than checking/savings accounts and business enterprises, determine recipient's share by dividing value of the jointly held resource by the number of owners, or if otherwise specified, by percentages. A parent's share is available to the children for whom assistance is requested, regardless of whether the parent is included.

7. Consider no resources available when any of the parties of the jointly held resource are not willing to release their portion of the resource or one party cannot be contacted for a release of their portion. It must be verified that litigation would be required or is pending, such as divorce settlement, probate of will, etc., to determine to whom a resource belongs. Spot check monthly or in the month the litigation is expected to be completed.

C. VERIFICATION OF REBUTTAL OF JOINTLY HELD RESOURCES. In order for the individual to rebut the ownership of jointly held resources, the individual must provide:

1. A written statement from the individual regarding ownership, who deposits and withdraws;

2. A written statement from each of the other account holders which corroborates the individual's statement, unless the account holder is a minor or is incompetent; and

3. Verification that the individual's name has been removed from the joint account.

   Do not consider the resource available the month the individual's name is removed from the account.

MS 1960 LIFETIME CARE AGREEMENT

LIFETIME CARE AGREEMENTS are entered into with another individual or organization for lifetime care of an individual or family, in exchange for resources of the individual or family.

A. VERIFICATION OF LIFETIME CARE AGREEMENT. Copy of agreement or statement from organization or individual providing care.

B. CONSIDERATION OF LIFETIME CARE AGREEMENT.

1. If resources are still available to the individual or organization with whom the agreement is made, the case is ineligible.

2. If individual or organization holding an agreement provides a written statement that the resources have been exhausted or reduced, compute current resources to determine if within the resource limit.

MS 1970 LIQUID ASSETS

[Liquid assets are reserves that can be easily converted into cash for immediate use; these include but are not limited to:

1. Cash, checking accounts;
2. Savings accounts, certificates of deposit;
3. Stocks, mutual fund shares, bonds;
4. Promissory notes, mortgages, land contracts; and
5. Any other item readily convertible to cash.

A. CONSIDERATION OF LIQUID ASSETS

1. Resources in excess of the maximum when the case is processed result in denial/discontinuance of the case.

2. The proceeds from the conversion or sale of any resource are not income but a change in the type of resource.

3. The value of stocks, mutual fund shares, and bonds is based on market value on day verified.

4. If negotiable or salable, promissory notes, loans, mortgages, and land contracts are considered resources, see MS 2330.

5. Consider the portion of interest from interest bearing checking and savings accounts, remaining after the month of receipt, as a resource beginning the month after the receipt month.

6. Consider as a countable resource the total value of a certificate of deposit (CD), including the interest which is posted to the CD and not paid directly to the individual owner of the CD.

   If interest posted to the CD is paid directly to the individual owner of the CD, consider as a countable resource the total amount remaining in the CD.

7. Certain cash payments received for medical or social services are considered to be a resource, if still held the second month following receipt.

   These cash payments are money (cash, check, specified fund) contributed to an individual from either an agency or interested party, for the specific purpose of paying for a medical expense not covered by insurance or MA, or a social services expense. A social services expense may include but is not limited to drug counseling through a church organization or social service agency.

   Consider as a countable resource reimbursements for medical or social service bills already paid by the individual.

8. Resources which are inaccessible for 30 days or more are exempt in the resource eligibility determination until these resources are accessible. This policy applies in case situations when the applicant/recipient is attempting to liquidate excess resources. Require written verification from the institution holding the resource of the inaccessibility of the resource to the applicant/recipient. Set up a monthly spot check to track the inaccessibility of the resource as accessing the resource may make the individual ineligible for MA in the future. This exclusion DOES NOT apply to life insurance policies.

   EXAMPLE: An applicant has excess resources in the form of non-homestead property. This property is listed for sale, however there have been no offers made. Consider the resource to be inaccessible.]

B. Verification

1. If resources are declared, the applicant must make available the appropriate documents, such as:

   a. Statements from banks or other financial institutions;
   b. Checking account statements;
   c. Savings account statements;
   d. Stocks, bonds, or certificates of deposit;
   e. Financial instrument;
   f. Land contracts, promissory notes or mortgages; or
   g. Other sources of documentation.

2. Before LTC vendor payment is authorized, use form PAFS-18, Liquid Asset Verification and Invoice for Payment, and check for declared or undeclared resources in at least 2 banks in the vicinity in which the individual lives or lived prior to entering LTC. The individual and spouse, if appropriate, or committee or Power of Attorney must sign form CFS-1, Informed Consent and Release of Information and Records. [Document the case record if unable to check 2 banks for reasons such as; only 1 bank is in the community.]

   All IM vendor payment cases subject to transfer of resource penalties will pend on KAMES for a resource check refer to MS 2050. The question, “Has bank and courthouse asset check been done?” must be answered “Y” or “N”, with verification code “OR” or “WS” entered, before the system will process the vendor payment approval.

   The following types of care are excluded from the resource check:

   - Hospice Non-Institutional;
   - Hospice NF;
   - Mental Health/Psychiatric Facility;
   - PRTF; and
   - EPSDT.

If the county of residence prior to entering LTC is out-of-state and no resources are declared, accept the statement of the LTC individual as verification. No further verification is required.

MS 1975 [RECOGNITION OF AN INSTITUTIONALIZED INDIVIDUAL'S HOMESTEAD RESOURCES

A Medicaid recipient is considered permanently institutionalized after 6 consecutive months in a long-term care facility. After the 6th consecutive month, the homestead property is no longer the individual's residence and is considered non-home property. The Federal Deficit Reduction Act of 2005 (DRA), signed into law February 8, 2006, stated that individuals with an equity interest in their home greater than $500,000.00 are ineligible for Medicaid coverage for Nursing Facility or waiver services. Waiver services are: HCBS, SCL, MODEL WAIVER II, ICF/MR/DD, MENTAL HEALTH/PYCHIATRIC FACILITY FOR AGE 65 OR OLDER, ADULT DAY CARE, IMD, ABI, AND CDO.

A. WHEN HOMESTEAD PROPERTY IS EXCLUDED:

1. WHEN A DEPENDENT FAMILY MEMBER LIVES IN THE HOME.
Homestead property with an equity value less than or greater than $500,000 is exempted only when a community spouse or other dependent family member resides in the home. A dependent family member is a child, stepchild or grandchild; parent, stepparent or grandparent; aunt, uncle, niece or nephew; brother or sister, stepbrother or stepsister, half-brother or half-sister; cousin; or in-law. A dependent is defined as an individual who received more than one-half of their annual financial support from the institutionalized recipient.

2. During the first 6 months of institutionalization.

3. When there is a verified continuing effort to sell (second 6 months). The non-home property may be excluded for an additional six months if there is a verified continuing effort to sell it at fair market value.

Note: Equity value of the home is determined by the current market value minus any encumbrance on the home. Current market value is the going price of the home, or the amount for which it can reasonably be expected to sell on the open market in a particular geographic area. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan or other debt that is secured by the home. To verify current market value, workers are to obtain verification from the Property Value Assessment (PVA) office. Add any outstanding debts or liens against the property minus the debts from the fair market value to obtain the equity value of the home. The PVA assessment or tax notice, without any homestead or other exemptions, can be used to verify fair market value. Some tax bills list the fair market value as the fair cash value.

4. When approved by the Department for Medicaid Services (additional 6 months). The exclusion for "effort to sell" may be extended past the additional 6-month exclusion on a case-by-case basis. This extension requires approval by the Department for Medicaid Services (DMS).

Verification for the extension request is sent to the Medical Support and Benefits Branch through the regional Program Specialist. Request for extensions must include an explanation of previous effort to sell and reason for the extension request.

Note: If DMS denies the extension, the equity value of the property is considered a countable resource. If the resources exceed the allowable limits, allows the case to discontinue. If a reapplication is taken, the applicant/representative will need to provide verification that an attempt is being made to sell the property at FMV. If the recipient has been discharged from the facility and the case has been inactive for more than 30 days, allow a 6-month exclusion before requesting an extension for attempt to sell from DMS. During the period of discontinuance they are resource ineligible for Medicaid.

5. When the individual states intent to return home. An individual's homestead may be exempt after six months of institutionalization if the individual states intent to return home. The individual must provide a written statement indicating the intent to return to the home by an estimated time (as in the number of months). The statement must be signed by the recipient. If the recipient is unable to sign, the statement must be signed by the Power-of-Attorney (POA). If there is no POA, the statement must be signed by the representative. Do not spot-check the case for the expiration of the time period designated in the statement unless the time period designated will expire prior to the next recertification. Reinvestigate the matter and require a new written statement at each recertification.

B. WHEN HOMESTEAD PROPERTY IS NOT EXCLUDED:

1. When there are no exemptions as outlined above and the six months of continuous institutionalization has expired.

2. When the equity interest in the home is greater than $500,000.00, the case is denied for LTC or waiver services. A screen on KAMES is available to capture information regarding home property with an equity value greater than $500,000.00. Cases with applicants who are denied or disqualified for being over the resource limit due to the equity value of their homestead property. KAMES will automatically apply a 468 disqualification code to the case. This disqualification can only be removed by a supervisor.

C. HOW TO PROCESS A CASE WITH HOMESTEAD PROPERTY

At the time of the application interview:

1. Explain that the homestead property is considered a countable resource after six months of institutionalization, if not otherwise exempt.

2. Explain that if the property is not exempt and the equity value of the home is greater than $500,000, the application will deny due to excess resources.

3. Advise the applicant that the sale of the home must be reported within 10 days.

4. Advise the applicant of the exemption if there is a spouse or dependent family member living in the home.
   a. Verification is needed that a family member, other than a spouse, lives in the home and is a dependent.
   b. The dependent family member must have been living with the institutionalized individual prior to admission to an LTC facility.

5. Advise the applicant of the exemption for intent to return home

D. NEW ADMISSIONS OF 6 MONTHS OR LESS

For applications with a new admission of 6 months or less to a LTC facility, enter a spot check to send a "request for information" (RFI) to the recipient after six months of institutionalization. The six-month count starts with the month of institutionalization of the individual rather than with Medicaid eligibility. REMINDER: After six months of institutionalization, the homestead property becomes non-home property.

If the non-home property is considered a countable resource complete the following:

1. Allow the recipient 10 days to respond with verification of the sale or the effort to sell the non-home property, or to provide a statement of intent to return home.

2. If the verification is not returned, enter the value of the property on the non-home real property screen. If the equity value causes ineligibility, the case will discontinue for excess resources and KAMES will send the appropriate notice.

3. Upon receipt of verification for "effort to sell", allow the recipient 6 months and enter a spot check to send a request for information (RFI) at the end of that period. For criteria for reasonable effort to sell see section F.

4. Once the property is sold, obtain a copy of the closing statement and consider the proceeds a resource. Enter the amount received on the sale of the property resource screen and answer "N" to "is this homestead property?" KAMES will send the appropriate notice of discontinuance if resources exceed limits.

E. WHEN THE INDIVIDUAL HAS BEEN INSTITUTIONALIZED FOR 6 MONTHS OR MORE PRIOR TO THE APPLICATION.

The individual must provide verification of the sale or "effort to sell" the non-home property, or a statement of intent to return home, before the application is processed. Once this is complete:

1. Approve the case for individuals who provide verification of “effort to sell” or a statement of the intent to return home. Spot-check the case for 6 months from approval to send a RFI for additional information on the sale of the non-home property.

2. Once the property is sold, follow procedures in section B.

3. At the 6-month spot check, if no exemptions apply, obtain verification of an effort to sell at FMV.

F. REASONABLE EFFORT TO SELL

A reasonable effort to sell the property shall consist of:

1. Listing the property with a real estate agent. Obtain a copy of the sale agreement (the sales contract) for verification purposes.

2. If the individual is trying to sell the property privately a combination of at least two of the following actions must occur:

   a. Advertising the property in the local newspaper or on television or radio stations;

   b. Placing a “For Sale” sign on the property which is clearly visible from the nearest public road;

   c. Distributing fliers advertising the property for sale;

   d. Posting notices regarding availability of the property on community bulletin boards; or

   e. Showing the property to interested parties on a continuing basis.]

MS 1980 NONHOME REAL PROPERTY

NONHOME REAL PROPERTY is property owned by an individual other than a home. Consider only the equity value as a countable resource. Equity is determined by value minus debt.

EXAMPLE: Applicant owns her home and adjoining property out in the county. She also owns a one-acre tract with a small house in town. The one-acre tract with the small house is non-home real property. The Fair Market Value (FMV) of the property is $30,000. The applicant has verified that she owes $10,000 on it. The countable value of the property is $20,000 ($30,000 - $10,000).

When entering non-home real property on KAMES, enter both the FMV and any amount owed. KAMES automatically calculates the countable/equity value.

A. VERIFICATION FOR ALL CASES DECLARING NONHOME REAL PROPERTY

1. Determine the fair market value by records in the county property valuation office;

2. Determine fair market value in relationship to sales of comparable property in the vicinity if assessed value is unavailable;

3. Document the amount of resource and type of verification used:

   a. Current tax statement;
   b. Statement regarding indebtedness of resource; or
   c. For fair market value, contact 3 sources and average.

B. SPECIAL VERIFICATION PROCEDURES FOR ALL NON-SSI LTC CASES. Follow these procedures only for LTC approvals and active LTC cases transferred to another county.

1. The property check must be completed within 90 days of the LTC approval.
2. When an active LTC case is transferred to another county, complete the verification procedures at the next recertification.
3. Determine county of residence. If necessary, contact responsible relatives, interested parties, or the facility to determine county of residence.

   a. If the county of residence prior to entering LTC is the same county in which the facility is located:

      (1) Check property transfer and mortgage records in the county court clerk's office to determine if property in the name of the individual and/or spouse is owned or has been bought or sold.

(2) Check records in the county property valuation office to determine if property is listed in the name of the individual and/or spouse.

b. If the county of residence prior to entering LTC is different from the county in which the facility is located:

(1) Send a memorandum or form PA-16, Real Property Verification Request, to the Family Support Supervisor in the county shown as the individual's residence; and
(2) Request records be checked to determine property ownership.

4. [All IM vendor payment cases subject to transfer of resource penalties will pend on KAMES for a resource check. The question, “Has bank and courthouse asset check been done?” must be answered, with verification code “OR” or “WS” entered, before the system will process the vendor payment approval.

The following types of care are excluded from the resource check:

- Hospice Non-Institutional;
- Hospice NF;
- Mental Health/Psychiatric Facility;
- PRTF; and
- EPSDT.

5.] If the county of residence prior to entering LTC is out-of-state accept the individual and/or spouse's statement unless questionable.

[6.] Document the case record regarding ownership of real property and indicate method of verification.

C. CONSIDERATION OF NONHOME REAL PROPERTY. If nonhome real property is not income producing, combine the equity with other countable resources and compare to resource limits.

D. EXCLUSION OF PROPERTY DUE TO INABILITY TO SELL. Real property or non-real property may be excluded as a resource for a reasonable effort to sell. This exclusion is not permanent. At each recertification/reapplication, it must be reviewed and verified that there has been and continues to be a reasonable effort to sell the property at Fair Market Value. The individual must make known publicly, their intention of selling the property at FMV through a newspaper ad, correspondence with a financial institution, etc. For non-homestead property after six months of institutionalization, see MS 1975.

MS 1990* NONRECURRING LUMP SUM

NONRECURRING LUMP SUM FROM ACCUMULATED BACKPAYMENT OF STATUTORY BENEFITS OTHER THAN RSDI/SSI. Consider any amount remaining from the lump sum back payment as a resource beginning the month after the receipt month.

MS 2000* SSI ESSENTIAL PERSON RESOURCES

A. VERIFICATION. Document in case record the amount of the resource and type of verification used.

B. CONSIDERATION. Consider resources of SSI essential person, whose MA eligibility is not based on inclusion in the SSI case.

MS 2010 TRUSTS

The Department for Medicaid Services (DMS) reviews all trusts, other than funeral trusts under $10,000, pertaining to the determination of Medicaid eligibility. DMS will advise how the trust should be considered in each eligibility determination. The procedure is as follows:

1. For applications, case changes and recertifications that include a trust, field staff are to make two copies of the trust document. Retain a copy of the trust for the case record. Annotate on the front page of the copy, "application", "case change" or "recertification" as appropriate. Additionally, attach a note containing the worker's name and county of location, case name and number for response purposes and forward this copy to the Medical Support and Benefits Branch (MSBB), CHR Building, 275 East Main Street, 3E-I, Frankfort, Kentucky 40621.

   Workers are to review the trust to ensure all attachments listed in the trust have been provided. If any parts of the trust or attachments are missing, request the missing information from the client and DO NOT submit the trust until everything has been provided.

   Note: For recertifications, do not send a trust that has been previously reviewed by DMS or Quality Central staff unless changes in the trust have occurred.

2. Forward the copy to MSBB in Quality Central. Mail copies daily, if possible, to assure processing timeframes are met.

3. MSBB is responsible for forwarding the copy of the trust to DMS for review. MSBB maintains a log of the trusts received for tracking and response purposes.

4. Following completion of the review, DMS notifies MSBB staff regarding consideration of the trust. MSBB staff will send this information in writing to the worker and the Service Region Program Specialist. The copy of the trust will not be returned.

5. For application, hold the application pending until a response from DMS is received. DMS will give priority to trust reviews for application. [Refer to Volume I, MS 0151, for cases pending over 30 days with good cause.]

6. For recertifications, do not hold a recertification pending for receipt of the trust review response. Complete any case action necessary as a result of the review response with the next administrative feasible month following receipt of the response.

7. In some situations, DMS may need additional information to complete their review. The worker should promptly request the additional information upon notification from MSBB.

8. Workers who have questions concerning the status of a trust review are directed to contact MSBB through their Regional Program Specialist.

9. For recipients, representatives or attorneys who have questions about the regulations in establishing a trust, refer them to the following websites:

   a. The Center for Medicare and Medicaid Services Medicaid Manual refer to http://www.cms.hhs.gov/medicaid/ for section 3259 the "Treatment of Trust";
   b. Kentucky Administrative Regulations refer to: http://www.lrc.ky.gov for title 907 KAR "Cabinet for Health Services, the Department for Medicaid Services"; and
   c. Department for Medicaid Member Services at 1-800-635-2570.

MS 2011* CONSIDERATION OF INCOME FROM A MEDICAID QUALIFYING TRUST ESTABLISHED ON OR BEFORE 8/10/93

The Department for Medicaid Services (DMS) reviews all trusts for Medicaid eligibility determinations. DMS will advise how the trust is to be considered in their response once the trust has been reviewed. Based on DMS determination on how the funds are to be considered in the case the applicant/recipient could be considered for an undue hardship determination.

For Medicaid Qualifying Trusts established on or before 8/10/93, if DMS finds that there is a set monthly payment, that payment amount would be considered unearned income whether or not the individual actually receives the full payment amount.

If the individual alleges consideration of the full payment amount causes an undue hardship, the individual may request exemption from this requirement. An undue hardship is considered to exist if the trustee is legally unable to pay the maximum monthly payment allowed by the trust; for example, if the individual is obligated to pay court ordered child support or alimony.

Submit a memorandum to CHFS/DCBS Supervisor, MSBB, 275 East Main Street, 3E-I, Frankfort, Kentucky 40621, requesting an undue hardship determination for a Medicaid Qualifying Trust. Include in the memorandum the reason(s) the individual is alleging an undue hardship due to consideration of the total income from the Medicaid Qualifying Trust. Attach copies of verification of the reason(s) furnished by the individual.

MS 2030 VEHICLES

For nonexcluded vehicles, consider any excess above $4500 of total equity value as a countable resource.

[The total equity value of recreational vehicles, boats, canoes, etc. is a countable resource.]

MS 2031 OVERVIEW OF BURIAL RESERVES

Burial Reserves are resources that are set aside or designated by the recipient to pay for funeral expenses. Burial reserves may be in the form of:

A. Prearranged funeral contracts;

B. Life insurance policies;

C. Burial funds; or

D. Cash set aside for burial purposes.

Each individual is allowed a $1,500 exclusion for burial reserves in addition to the normal $2,000 resource allowance. The $1,500 exclusion can be applied to a combination of any of the above by the signing of form MA-36, Burial Designation. If form MA-36 is signed at application it also covers the designated burial reserve for the retroactive three months. For example, a MA-36 is signed for a life insurance policy at application on June 4th. The client was admitted to a nursing facility on March 4th, and level of care was met on March 4th. The signed MA-36 is good for March, April, and May and ongoing. If the MA-36 is not signed, the entire resource is countable.

At application, burial reserves may be commingled with other resources, but must be separated in order to be excluded. When burial reserves are mixed with other resources, consider the difference between the account balance and the designated amount for burial a liquid asset (account balance minus burial reserve equals liquid asset). After the case is approved, burial reserves must be separated from other resources within 30 days.

For vendor payment cases, if the amount of the burial reserve is over $10,000 ($10,001 or more), the related documentation such as itemized statement and copies of all life insurance policies, etc. must be forwarded to MSBB for DMS approval.

MS 2032 BURIAL RESERVE DEFINITIONS

BURIAL FUND – Monies deposited in a financial institution with a contractual agreement which designates that the funds deposited are for burial purposes only.

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

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

BURIAL RESERVE EXCLUSION – An allowable $1,500 exclusion from liquid resources when a client indicates these resources are to be used for burial purposes. Form MA-36, Burial Designation, must be signed in order for the $1,500 exclusion to be allowed.

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

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

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

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

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

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

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

PREARRANGED FUNERAL CONTRACT – A contractual agreement between the client and funeral home that itemizes the selection of goods and services. If it is a vendor case application and the contract is over $10,000 ($10,001 or more), forward to MSBB for DMS review with the completed cover sheet attached. Applications must remain pending until the approval or denial letter is received from MSBB. This contract can be funded by multiple sources such as life insurance and cash. The funding source must have one or more of the following:

A. An acknowledged change of ownership of the insurance policy;

B. Irrevocable assignment to the funeral home that guarantees that the funeral home receives the funds of the life insurance; or

C. Irrevocable assignment of beneficiary of the life insurance to the funeral home; or

D. Irrevocable trust agreement if funded by cash.

E. All prearranged funeral contracts must have an itemized statement of goods and services selected.

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

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

MS 2033 EXCLUDED BURIAL ITEMS

The following burial items are considered as excluded resources:

A. Burial space items including conventional gravesites, crypts, mausoleums, urns, vaults, caskets, headstones, and opening and closing of the grave. Each household member is allowed one burial container and location, one headstone and opening of closing of grave or other repository;

B. Burial insurance policies that are payable only for the disposal of the remains of the deceased;

C. Value of a prearranged funeral contract funded by the purchase of life insurance policy with an irrevocable assignment or irrevocable of ownership/beneficiary of the life insurance policy to the funeral home;

D. The value of a prearranged funeral contract with an Irrevocable Funeral Trust Agreement;

E. Allow a $1500 exclusion from burial reserves by completion of form MA-36, Burial Designation, for each member of the assistance group when the client indicates that the burial reserve is to be used for burial and no other burial arrangements have been made; or

F. Term insurance policies with no cash surrender value (CSV).

Consider any reserves withdrawn from a resource that has been excluded as a burial reserve a countable resource during the first possible month after the Agency becomes aware of the withdrawal. Consider reserves remaining in the burial reserve as excluded resources.

MS 2034 BURIAL FUNDS

Burial funds are resources held in an account at a financial institution (i.e. a bank) to be disbursed for burial expenses only for the account holder. The funds are not accessible by the Medicaid recipient or any other individual and can only be disbursed for burial expenses at the time of the recipient's death. Naming the funeral home as the beneficiary on the account is not necessary. The funeral home can be chosen at the time of need. All documentation from the financial institution must be forwarded with a completed cover sheet to Medical Support and Benefits Branch (MSBB) for Department for Medicaid Services (DMS) review. Applications cannot be processed and must be held pending until receipt of DMS review of the burial fund.

A. VERIFICATION:

The following must be verified and documented:

1. Verify burial funds by copies of the contractual agreement from the financial institution.

2. Verify that the monies contained in the burial fund are inaccessible and can only be released at the recipient's death.

B. CONSIDERATION:

Field staff will be advised on how to consider the burial fund when response from the DMS review is received. MSBB will forward a memo detailing how the fund is to be considered.

C. SYSTEM ENTRY:

Burial funds are entered on the KAMES system on the RESOURCES (KIMA31) screen by:

1. Answering yes to "Does He/She Have Any Money Set Aside for Burial Other than Life/Burial Insurance Policy or a Prearranged Funeral Contract?"

2. Follow the instructions that will be given in the memo from MSBB on system entry of the burial fund.

MS 2035 CASH SET ASIDE FOR BURIAL PURPOSES

An individual can set aside up to $1,500 to designate for burial purposes. This can be in the form of a bank account, a Certificate of Deposit (CD), a savings account, or money stored under the mattress, in the cookie jar, lingerie drawer, etc.

If funds are commingled at the time of application, the burial reserves must be separated within 30 days of the case approval in order to allow the $1,500 exclusion.

A. VERIFICATION:

The following must be verified and documented.

1. Bank accounts - verified by a copy of the bank statement;

2. CD's – verified by a copy of the CD;

3. Savings Accounts – verified by a copy of the savings passbook; or

4. Hidden money – verified by a written statement of the money stored in the home from the client.

B. CONSIDERATION:

Form MA-36, Burial Designation, must be signed in order to allow a $1,500 exclusion from the cash set aside.

C. SYSTEM ENTRY:

Money set aside for burial is entered on the KAMES system on the RESOURCES (KIMA31) screen by:

1. Answering yes to "Does He/She Have Any Money Set Aside for Burial Other than Life/Burial Insurance Policy or a Prearranged Funeral Contract?"

2. Entering the total amount of this money after "If Yes, Amount:"

3. Answering "Y" to "Are These Funds Clearly Designated As Set Aside for Burial?"

4. Entering OR as your verification source after the appropriate verification is received. This will allow the $1,500 exclusion.

D. EXAMPLE:

Individual states they have $1,600 in their cookie jar. This money is to be used for their burial expenses.

$1,600 in cookie jar
-1,500 Burial exclusion
$ 100 Countable Resource

The $1,500 must be separated from the $100 within 30 days of the case approval. The individual agrees to this action by signing the MA-36.

MS 2036 LIFE INSURANCE POLICIES

Life insurance is a means to set aside money to be used at the time of the individual's death. Policy holders buy insurance from an insurance company and pay specific periodic amounts (premiums) for the duration of the policy (either a set period of time or for a lifetime).

A client can designate a life insurance policy for burial purposes. This will allow a $1,500 exclusion from the cash surrender value (CSV) of the policy. This can be done by completing and signing Form MA-36, Burial Designation. There is no limit to the number of insurance policies that may be designated for burial. If the total combined CSV of the policies exceed $1,500, any amount in excess of $1,500 is a countable resource.

There are three distinct types of insurance policies: term life, burial insurance and whole life insurance. While the verification requirements are identical, each type of life insurance policy is considered individually.

A. TERM LIFE INSURANCE POLICIES

Term Life Insurance policies are active and payable for a designated period of time. Term Life Insurance policies are those that generally have no cash surrender value or loan value. The benefits for these policies can be accessed at the death of the policyholder. Although these policies are totally excluded from consideration for Medicaid, we are still required to enter these policies on KAMES.

1. VERIFICATION:

The following must be verified and documented:

a. Name of policy owner
b. Name of covered individual
c. Name of company
d. Policy Number
e. Face Value

A copy of the policy must be filed in the case record.

2. CONSIDERATION:

Term Life Insurance policies are an excluded resource. Therefore, an MA-36 is not required for Term Life Insurance policies.

3. SYSTEM ENTRY:

When entering term insurance policies:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;

b. Enter the insurance company's name, policyholder's name and SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 1 – TERM INS;
d. Enter face value, date of policy issuance. The KAMES system will exclude the value of this policy.

Another option for Term Life Insurance policies that has recently appeared on the market are Modified Term Life policies. These can have a cash surrender value and verification is required to determine the amount. If the policy has a cash surrender value, it is to be entered under Option 3, Whole Life Insurance and the verified cash surrender value entered appropriately. Document in case comments the reason this was entered under Whole Life. Do not enter Modified Term Life policies with cash surrender values under Option 1 as the system will not accurately calculate the resources. All Modified Term Life policies must be verified at application and annually at recertification as this benefit may not be in effect for the entire life of the policy. Form MA-36 is required for Modified Term Life Insurance policies in order to exclude $1,500 from consideration.

B. BURIAL INSURANCE POLICIES

A burial insurance is a life insurance policy that can only be used to pay the burial costs for the deceased policyholder. Burial Life Insurance policies are those that have no cash surrender value or loan value. The benefits for these policies are only received at the time of death of the policyholder. Although these policies are totally excluded from consideration for Medicaid, we are still required to enter these policies on KAMES.

1. VERIFICATION:

The following must be verified and documented:
a. Name of policy owner
b. Name of covered individual
c. Name of company
d. Policy Number
e. Face Value

A copy of the policy must be filed in the case record.

2. CONSIDERATION:

Burial Insurance is an excluded resource. Form MA-36 is not required for Burial Insurance policies.

3. SYSTEM ENTRY:

When entering burial insurance policies"

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the insurance company's name, policyholder's name and SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 2 – BURIAL INS;

d. Enter face value, date of policy issuance. The KAMES system will exclude the value of this policy.

C. WHOLE LIFE INSURANCE POLICIES

Whole life insurance builds a Cash Surrender Value (CSV) over time, which the policyholder can withdraw or borrow against. This is considered an available resource. The individual can designate a whole life insurance policy for burial purposes which will allow a $1,500 exclusion from the countable resource by signing Form MA-36.

1. VERIFICATION

The following must be verified and documented:

a. Name of policy owner
b. Name of covered individual
c. Name of company
d. Policy Number
e. Face Value
f. Cash Surrender Value (at application, reapplication and recertification)
g. Loan Balance, if any (at application, reapplication and recertification)

A copy of the policy must be filed in the case record. If the whole life insurance policy does not have a current table of cash surrender values, verification of current values (face and cash surrender/loan value) is required. This typically occurs when the policy is over 20 years old as most policies only have a table for that length of time. It is the responsibility of the individual to request the verification from the insurance company. If the policy was written by a company no longer in business in Kentucky, the Department of Insurance can be contacted to determine what company has taken responsibility for this policy. The current phone number for the Department of Insurance is (800) 595-6053.

2. CONSIDERATION:

Compare the Face Value and the Cash Surrender Value (minus any loan balance) of a whole life insurance policy. The lesser amount of the two is a countable resource. A $1,500 exclusion is only allowed if the individual signs the form MA-36. Any remaining amount is a countable resource. There is no limit to the number of life insurance policies that may be designated for burial purposes. However, only one $1,500 exclusion is allowed. If the form MA-36 is not signed, the $1,500 exclusion is not allowed.

If an individual has more than one form of burial reserve, only one can be excluded.

Example: Client has a prearranged funeral contract for $3,000 that is irrevocably assigned to the funeral home. Client also has two whole life insurance policies with a CSV of $1,400 (no loan value). The entire amount ($3,000) of the prearranged funeral contract is an excluded

resource. Therefore, the $1,500 exclusion cannot be allowed for the two life insurance policies. The total countable resources in this example would be $1,400.

3. SYSTEM ENTRY:

When entering whole life insurance policies:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the insurance company's name, policyholder's name and SSN and account number on the KAMES Burial Reserve screen.;
c. Choose Option 3 – WHOLE LIFE INS
d. Enter face value, date of policy issuance, cash surrender value, and amount of loans (if any).
e. If a MA-36 has been appropriately signed for this policy, answer "Y" to "If Life Insurance Policy, Has the Policy Been Designated for Burial Purposes?"
f. Enter a verification source of WS. KAMES will allow the $1,500 exclusion and calculate the remaining countable resources (if any).

EXAMPLE 1:

An individual has a whole life insurance policy with a CSV of $1,250, which is not designated for burial (no form MA-36 signed). There is a $300 loan against the policy.

$1,250 CSV
- 300 Loan against policy
= 950 Countable resource

EXAMPLE 2:

An individual has a whole life insurance policy with a CSV of $2,000, which has been designated for burial (form MA-36 signed). There is a $600 loan against the policy.

$2,000 CSV
- 600 Loan against policy
$1,400 Remainder
-1,500 Burial exclusion (MA-36 signed)
0 Countable resource

EXAMPLE 3:

An individual has two whole life insurance policies with Silver Life, with a cash surrender value of $600 each. They have two policies with Gold Shield, with a cash surrender value of $1,000 each. There is one policy with Golden Age, with a cash surrender value of $2,000. There are no outstanding loans on any of the policies, and a MA-36 has been signed for each policy to designate for burial.

$ 600 – Silver Life policy
600 – Silver Life policy
1,000 – Gold Shield policy
1,000 – Gold Shield policy
2,000 – Golden Age policy
5,200 – total CSV for all policies

$5,200 – total CSV for all policies
-1,500 – burial exclusion (MA-36's signed)
$3,700 – total countable resource

MS 2037 PREARRANGED FUNERAL CONTRACTS

Prearranged funeral contracts are legal agreements between the recipient and the funeral home. They may be funded by life insurance policies, cash or a combination of both. All prearranged funeral contracts must include an itemization of goods and services selected for the individual and signed by appropriate individuals. The statement required must list each item individually with its value, and cannot be a total package value. Without an itemization of goods and services we can only allow the $1500 exclusion. On vendor payment cases, if the contract exceeds $10,000 ($10,001.00 or more), all documentation from the funeral home must be forwarded with a completed cover sheet to Medical Support and Benefits Branch (MSBB) for Department for Medicaid Services (DMS) review. Applications cannot be processed and must be held pending until receipt of DMS review of the contract over $10,000.

Any interest or dividends that accrue on a prearranged funeral contract after the case is approved is excluded. If over $10,000, once DMS has approved, no further action is needed.

There are five distinct types of prearranged funeral contracts identifiable according to how they are funded:

1. Those funded by a whole life insurance policy with an irrevocable assignment;

2 Those funded by cash with no Irrevocable Funeral Trust Agreement;

3. Those funded by cash with an Irrevocable Funeral Trust Agreement;

4. Those funded by cash with a purchase of an insurance policy through the funeral home: or

5. Those funded by a combination of a whole life insurance policy with an irrevocable assignment and cash with an Irrevocable Funeral Trust Agreement.

A. Prearranged Funeral Contracts funded with Life Insurance with an Irrevocable Assignment. This type of prearranged funeral contact is where the individual already has a life insurance policy and they turn it over to the funeral home. This contract is an excluded resource if the irrevocable assignments have been made by the insurance company. If a vendor payment case, and the contract exceeds $10,000 ($10,001.00 or more), all documentation from the funeral home must be forwarded with a completed cover sheet to Medical Support and Benefits Branch (MSBB) for Department for Medicaid Services (DMS) review. Applications must remain pending until an approval or denial notice is received from MSBB.

1. VERIFICATION:

The following must be verified and documented:

a. Detailed itemized Statement of Goods and Services
b. Verification from the insurance company that the irrevocable change has been made
c. DMS approval if prearranged contract has a value over $10,000 ($10,001 or more). The case must remain pending until a letter of approval or denial is received from MSBB.

2. CONSIDERATION:

When a contract is funded by a whole life insurance policy with an irrevocable assignment, or an irrevocable assignment of beneficiary or ownership to funeral home, the entire value of the prearranged funeral contract is an excluded resource. Form MA-36 is not required for this type of burial reserve.

3. SYSTEM ENTRY:
When entering a prearranged funeral contract funded by a whole life insurance policy irrevocably assigned to the funeral home:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the name of the funeral home, not the life insurance company, the individual's name, SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
d. Enter the face value of the contract minus any accrued interest or dividends, the date issued;
e. Answer "Y" to the "If Prearranged Funeral Contract, is there Irrevocable Assignment or Trust Agreement?";
f. Enter verification source of WS. This will exclude the entire amount of this contract.

EXAMPLE:

An individual has a $4500 funeral contract funded by a Golden Life Whole Life insurance policy. Verification has been received that this policy has been irrevocably assigned to the funeral home. An itemized statement of goods and services was also received. The entire $4500 is excluded.

B. Prearranged funeral contract funded with cash and has no Irrevocable Funeral Trust Agreement. This type of contract with no irrevocable funeral trust agreement, is an available resource with certain considerations.

1. VERIFICATION:

The following must be verified and documented:

a. Detailed itemized Statement of Goods and Services
b Source of cash
2. CONSIDERATION:

When a prearranged funeral contract is purchased with cash, with no irrevocable funeral trust agreement, the value of the prearranged funeral is considered an available resource with the following considerations:

a. Interest or dividends on burial reserves are excluded if allowed to accrue;
b. The value of the burial space items is excluded completely; and
c. $1,500 exclusion if Form MA-36, Burial Designation, is signed.
d. Any remaining value after the above exclusions is a countable resource.

3. SYSTEM ENTRY:

When entering a prearranged funeral contract funded by cash with no irrevocable assignment:

a. Answer "Y" to "Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?" on RESOURCE (KIMA31) screen;
b. Enter the name of the funeral home, the individual's name, SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
d. Enter the face value of the contract (minus interest and dividends that have accrued), the date issued;
e. Answer "Y" to "Is there a Loan Against the Policy or are Exempt Items (Casket, Vault, Etc.) in the Prearranged Funeral Contract?"
f. Enter the amount of the excluded items in space indicated by "If Yes, What is the Total Amount of the Loan/Exempt Items."
g. Answer "Y" to "If Life Insurance policy, Has the Policy Been Designated for Burial Purposes?";
h. Enter verification source of WS. This will exclude $1,.500 if the form MA-36 has been signed.

EXAMPLE:

A $6,000 prearranged funeral contract is purchased with cash. The individual has selected a casket for $2,500, burial plot valued at $1,000, opening and closing of grave for $500, funeral services for $1,000, embalming cost of $500, and clothing valued at $200, limousine at $200, and flowers at $100.

The excluded burial space items are determined by adding: casket at $2,500 plus burial plot valued at $1,000 plus $500 for the opening and closing of the gravesite totaling $4,000. The calculations for the countable resource are as follows:

$6,000 Value of the contract
-4,000 Value of burial space items
2,000 Remainder
-1,500 Burial Reserve Exclusion
$ 500 Countable Resource

C. Prearranged funeral contract funded by cash with an Irrevocable Trust Agreement. This is an excluded resource if the Irrevocable Funeral Trust Agreement is signed within 30 days of the Medicaid application. If a vendor payment case, and the contract exceeds $10,000 ($10,001.00 or more), all documentation from the funeral home must be forwarded with a completed cover sheet to Medical Support and Benefits Branch (MSBB) for Department for Medicaid Services (DMS) review. Applications must remain pending until an approval or denial notice is received from MSBB.

1. VERIFICATION:

The following must be verified and documented:

a. Detailed itemized Statement of Goods and Services;
b. Irrevocable Funeral Trust Agreement signed within 30 days of the Medicaid application.
c. DMS approval if prearranged contract has value over $10,000; and
d. Source of cash.

2. CONSIDERATION:

When a prearranged funeral contract is purchased with cash, with an Irrevocable Funeral Trust Agreement, the value of the prearranged funeral is considered an excluded resource if the following criteria are met:

a. All entries are completed on the Irrevocable Funeral Trust Agreement;
b. The form is signed and dated within 30 days of the date of application; and
c. A detailed itemized Statement of Goods and Services for the amount of the cash is provided;
d. DMS approval if prearranged contract has value over $10,000.

A new irrevocable funeral trust is required if the client leaves vendor payment status for over 30 days.

3. SYSTEM ENTRY:

When entering a prearranged funeral contract funded by cash with an irrevocable funeral trust agreement:

a. Answer “Y” to “Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?” on RESOURCE (KIMA31) screen;
b. Enter the name of the funeral home, the individual’s name, SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
d. Enter the face value of the contract, the date issued;
e. Answer “Y” to “If Prearranged funeral Contract, Is There Irrevocable Assignment or Trust Agreement?”;

f. Enter OR as verification source. This will totally exclude the entire amount of the prearranged funeral contract.

D. Prearranged Funeral Contracts funded by cash with a purchase of an insurance policy through the funeral home. These types of contracts require (1) a copy of the policy showing it is irrevocably assigned or that the funeral home is the owner and (2) a detailed itemized Statement of Goods and Services. These types of policies would be Forethought, Investors Heritage, etc. This is an excluded resource if the policy is assigned to the funeral home and is accessible only at the death of the insured. If a vendor payment case, and the contract exceeds $10,000 ($10,001.00 or more), all documentation from the funeral home must be forwarded with a completed cover sheet to Medical Support and Benefits Branch (MSBB) for Department for Medicaid Services (DMS) review. Applications must remain pending until an approval or denial notice is received from MSBB.

1. VERIFICATION:

   The following must be verified and documented:

   a. Detailed itemized Statement of Goods and Services;
   b. A copy of the insurance policy showing it is irrevocable or that is assigned to the funeral home and can only be accessed at the death of the insured;
   c. DMS approval if prearranged contract has value over $10,000; and
   d. Source of cash.

2. CONSIDERATION:

   When a contract is funded by cash and then a policy is purchased at the funeral home and the policy has an irrevocable assignment, or an irrevocable assignment of beneficiary or ownership to funeral home, the entire value of the prearranged funeral contract is an excluded resource. The Irrevocable Funeral Trust agreement is not required. The MA-36 is also not required.

3. SYSTEM ENTRY:
   When entering a prearranged funeral contract funded by cash with the purchase of an insurance policy at funeral home:

   a. Answer “Y” to “Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?” on RESOURCE (KIMA31) screen;
   b. Enter the name of the funeral home, not the life insurance company, the individual’s name, SSN and account number on the KAMES Burial Reserve screen;
   c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
   d. Enter the face value of the contract minus any accrued interest or dividends, and the date issued;
   e. Answer “Y” to the “If Prearranged Funeral Contract, is there Irrevocable Assignment or Trust Agreement?”;
   f. Enter verification source of WS. This will exclude the entire amount of this contract.

E. Prearranged Funeral Contracts funded by a combination of funding sources. These types of contracts require (1) an irrevocable assignment of the life insurance policy and (2) an Irrevocable Funeral Trust agreement for the cash, signed within 30 days of the Medicaid application. If both are provided along with a detailed itemized Statement of Goods and Services, the entire prearranged funeral contract is excluded. If a vendor payment case, and the contract exceeds $10,000 ($10,001.00 or more), all documentation from the funeral home must be forwarded with a completed cover sheet to Medical Support and Benefits Branch (MSBB) for Department for Medicaid Services (DMS) review. Applications must remain pending until approval or denial notice is received from MSBB.

1. VERIFICATION:

The following must be verified and documented:

a. Verification from the insurance company that the irrevocable change has been made;
b. A detailed itemized Statement of Goods and Services;
c. Irrevocable Funeral Trust Agreement for the cash portion of the contract signed within 30 days of the Medicaid application;
d. DMS approval if prearranged contract has value over $10,000; and
e. Source of cash

2. CONSIDERATION:

When a prearranged funeral contract is purchased with a combination of life insurance and cash, the following applies:

a. An Irrevocable Funeral Trust Agreement with all entries completed for the cash portion of the contract signed within 30 days of application;
b. An irrevocable assignment of beneficiary or ownership to the funeral home for the life insurance portion (verification must be received from the insurance company, not funeral home);
c. A detailed itemized Statement of Goods and Services; and
d. DMS approval if prearranged contract has value over $10,000.

A new irrevocable funeral trust is required if the client leaves vendor payment status for over 30 days.

Form MA-36 is not required.

3. SYSTEM ENTRY:

When entering a prearranged funeral contract funded by cash with an irrevocable funeral trust agreement and a life insurance policy with an irrevocable assignment:

a. Answer “Y” to “Is He/She covered By Life/Burial Insurance Policies/Or A Prearranged Funeral Contract?” on RESOURCE (KIMA31) screen;

b. Enter the name of the funeral home, the individual's name, SSN and account number on the KAMES Burial Reserve screen;
c. Choose Option 4, PREARRANGED FUNERAL CONTRACT;
d. Enter the face value of the contract, the date issued;
e. Answer "Y" to "If Prearranged funeral Contract, Is There Irrevocable Assignment or Trust Agreement?";
f. Enter OR as verification source. This will totally exclude the entire amount of the prearranged funeral contract.

E. General funding rules:

UNDER-FUNDED: An under funded contract means the individual has selected goods and services that total more than the funds allocated by cash or life insurance policy. The individual still has a liability to the funeral home for the remaining balance. If the individual has selected over $10,000 in goods and services but has only provided the funeral home with $5,000 in cash or life insurance, this is an under-funded funeral contract, and does not need to be reviewed by DMS as funding has not exceeded $10,000. The funding provided to the funeral home is the value of the contract and the amount entered into the system.

FULLY FUNDED: A fully funded contract means all goods and services needed for the individual's burial are paid for and the funeral home has guaranteed the price. Guaranteed prices limit inflationary costs of funeral services and merchandise If the individual has a fully-funded prearranged funeral contract, and is not upgrading (such as oak casket exchanged for a cherry casket), they cannot add funds to this prearranged funeral contract.

If the prearranged funeral contract funding exceeds $10,000, it must be forwarded to MSBB for DMS review. In addition, if the individual adds funds with the intention of upgrading their goods and services and the new amount of the contract exceeds $10,000, the contract will need to be reviewed by DMS.

OVER FUNDED: An over funded contract means the individual has provided funds in excess of the selected goods and services. When reviewing an over funded funeral contract, first verify the date the source of funding (cash or life insurance) was assigned (life insurance) or put in a trust (cash).

If the date was beyond our look back period for transfer of resources, the worker is to input the entire amount of the contract on the KAMES system. KAMES will exclude the entire contract as long as all requirements for exclusion are met.

If the date is within our look back period, enter the prearranged funeral contract on the KAMES system and input the amount of itemized goods and services as the funeral value. The remainder of the funding above this amount is to be input on the transferred resource screen using the date of the assignment as the transfer date.

If the prearranged funeral contract funding exceeds $10,000, it must be forwarded to MSBB for DMS review. In addition, if the individual adds funds with the intention of upgrading their goods and services and the new amount

of the contract exceeds $10,000, the contract will need to be reviewed by DMS.

F. General rules that apply to all prearranged funeral contracts:

There can be no clauses in the trust which indicate that any excess funds, after arrangements are paid, may be returned to a designated individual such as the beneficiary. Provisions such as this indicate a potential violation of fair market value requirements and a possible prohibited transfer of resources. If an excess remains after all funeral expenses have been paid, the excess must be designated to the estate of the deceased.

If a recipient makes changes or additions to an existing prearranged funeral contract, obtain a written, detailed explanation from the funeral home as to the purpose and nature of the changes. Obtain verification from the recipient as to the source of the funds added to the contract. If it is verified that these upgrades or services are not included in the original contract, this is allowable. A new contract is not required; a signed addendum can be accepted. If the circumstances are questionable, refer the matter to MSBB for consideration.

If cash, which is paid to a funeral home for a burial contract, is used by the funeral home to purchase an insurance policy, such as Forethought, Investor's Heritage or Kentucky Funeral Director's Life Insurance, it is considered a prearranged funeral contract funded by a life insurance policy.

MS 2050 TRANSFER OF RESOURCES

This policy provides for an unlimited period of restricted MA coverage resulting in ineligibility for vendor payment status for an otherwise eligible institutionalized individual who transfers resources for less than FMV during the prohibited period.

A. Transfer of resources policy and penalties apply to individuals (including SSI recipients, see MS 2110) who apply for or receive Medicaid for LTC, ICF/MR/DD, SCL, HCBS, individuals in Guardianship, and/or the individual's community spouse.

B. Do not apply the transfer of resources policy to transfers made by recipients in an ICF/MR/DD or SCL setting prior to 8/10/93.

EXAMPLE: An SCL recipient became MA eligible in 10/92 with recertification due in 10/94. A transfer of resources occurred in 9/92. Transfer of resources policy effective 8/10/93 does not apply.

[C. Effective February 9, 2009 the look back period will progressively expand from 36 months to 60 months for transfers made on or after February 8, 2006. At this point the look back period will become 37 months and will increase by one month each following month until February 8, 2011, at which point the look back period will have increased to 60 months. For transfers made before February 8, 2006, the previous procedures (3-year look back period) still applies. Refer to MS 2080 for the new look back period for transferred resources and the system changes to impose new "transfer of resources" disqualifications.

There is no change in the look back period for resources transferred into a trust or used to establish a trust. The look-back period remains 60 months.]

D. All IM vendor payment cases subject to transfer of resource penalties will pend on KAMES for a resource check. The question, "Has bank and courthouse asset check been done?" must be answered, with verification code "OR" or "WS" entered, before the system will process the vendor payment approval.

The following types of care are excluded from the resource check:

- Hospice Non-Institutional;
- Hospice NF;
- Mental Health/Psychiatric Facility;
- PRTF; and
- EPSDT.

E. The penalty applies to the institutionalized spouse when the community spouse transfers resources for less than fair market value.

1. If the community spouse transfers assets that result in a penalty period for the institutionalized spouse and the community spouse subsequently becomes institutionalized, any remaining penalty period is apportioned between the spouses (divided in amounts requested by both spouses), if the former community spouse is MA and vendor payment eligible.

2. If one spouse is no longer subject to the penalty, such as, the spouse no longer receives nursing facility services, one spouse dies, etc., the remaining penalty period applicable to both spouses must be served by the remaining spouse.

F. Do not apply transfer of resources policy to funds attached to an irrevocable funeral trust agreement or a prearranged funeral contract with an irrevocable assignment of ownership.

G. Apply transfer of resources policy to assets, such as lump sum payments, not yet considered as a resource. Consider lump sum payments given away in the month of receipt a transfer of resources.

H. Apply transfer of resource policy to property, including homestead property, in which ownership was transferred to another individual while retaining life interest in that property. As actual ownership of the property has passed to another individual, the transfer to life estate interest carries a penalty period. Refer to MS 2055 for these resource calculations. For consideration of homestead property after six months of institutionalization, refer to MS 1975.

I. The placing of homestead property into a trust may be subject to transfer of resources penalties. The Department for Medicaid Services (DMS) is responsible for making the determination. Forward a copy of the homestead trust to the Medical Support and Benefits Branch (MSBB).

MS 2055 CALCULATING LIFE ESTATE TRANSFERS

Under a life estate, a transfer of resources occurs whenever the value of the transferred property is greater than the value of the life estate. Use the following steps to determine the value of a life estate.

A. [Determine the market value at the time of transfer of the transferred property.]

B. Calculate the recipient's age at the time of transfer. Use that age to select the Life Estate Factor from the Life Estate Table in MS 2056.

C. [Multiply the property value by the Life Estate Factor to get the transfer of resource amount.

D. Divide the transfer of resource amount by the number of years of life expectancy determined from the Life Expectancy Table in Vol. IVA, MS 1900 to get the yearly value of property.

E. Multiply the yearly value of property by the number of years remaining in life expectancy since the transfer to get the dollar amount of the current life estate.

Example: Mom, age 79, is in a Nursing Facility. She deeded her $78,000 homestead to her children 2 years ago but retained a life estate interest. Her representative has come in to apply for Medicaid. To calculate the Life Estate Transfer, take the following steps:

1. Value of property at time of transfer	$78,000
Age at time of transfer (79-2)	77
Life Estate Factor (Vol. IVA, MS 2056)	.51258
2. Value of property	$78,000
Life Estate Factor	x.51258
Transfer of resource amount	$39,981.24
3. Transfer of resource amount	$39,981.24
Divided by years of life expectancy	10.83
Yearly value of property	$3,691.71
4. Yearly value of property	$3,691.71
Remaining years of life expectancy	8.83
Amount of current life estate	$32,597.80

F.] The result is the value of the transferred resource. Use this amount when determining the transferred resource penalty period, per MS 2080.

MS 2056* LIFE ESTATE TABLE

Use the following table to identify the Life Estate Factor necessary to determine the value of life estate. Age in this table refers to the individual's age at the time the transfer took place.

Age	Factor	Age	Factor	Age	Factor
0	.02812	37	.06974	74	.46138
1	.01012	38	.07433	75	.47851
2	.00983	39	.07917	76	.49559
3	.00992	40	.08429	77	.51258
4	.01019	41	.08970	78	.52951
5	.01062	42	.09543	79	.54643
6	.01116	43	.10145	80	.56341
7	.01178	44	.10779	81	.58033
8	.01252	45	.11442	82	.59705
9	.01337	46	.12137	83	.61358
10	.01435	47	.12863	84	.63002
11	.01547	48	.13626	85	.64641
12	.01671	49	.14422	86	.66236
13	.01802	50	.15257	87	.67738
14	.01934	51	.16126	88	.69141
15	.02063	52	.17031	89	.70474
16	.02185	53	.17972	90	.71779
17	.02300	54	.18946	91	.73045
18	.02410	55	.19954	92	.74229
19	.02520	56	.20994	93	.75308
20	.02635	57	.22069	94	.76272
21	.02755	58	.23178	95	.77113
22	.02880	59	.24325	96	.77819
23	.03014	60	.25509	97	.78450
24	.03159	61	.26733	98	.79000
25	.03322	62	.27998	99	.79514
26	.03505	63	.29304	100	.80025
27	.03710	64	.30648	101	.80468
28	.03938	65	.32030	102	.80946
29	.04187	66	.33449	103	.81563
30	.04457	67	.34902	104	.82144
31	.04746	68	.36390	105	.83038
32	.05058	69	.37914	106	.84512
33	.05392	70	.39478	107	.86591
34	.05750	71	.41086	108	.89932
35	.06132	72	.42739	109	.95455
36	.06540	73	.44429		

MS 2070 EXCEPTIONS TO TRANSFER OF RESOURCES

Do not restrict MA coverage for transfer of resources if one of the exceptions apply.

A. Transfer of homestead property on or after 8/10/93, to:

1. The spouse;

2. A natural, adopted or step child who is under age 21 or who is blind or disabled;

3. A sibling who has equity interest in the home who lived with the institutionalized individual one year prior to institutionalization; or

4. A natural, adopted or step child, other than above, who resided with the institutionalized individual two years prior to institutionalization and provided care to the individual to prevent institutionalization. Use birth, adoption, and marriage records to establish relationship. Age of the child is not a factor. Require two statements from collateral contacts for verification that the child lived two years with recipient prior to institutionalization and provided care to prevent institutionalization.

Consider transfer of homestead property on or after 8/10/93 to any individual not listed above as a transfer of assets. Transfer of the homestead property into a trust on or after 9/1/03 is considered a transfer of resources. Additionally, adding another individual's name to homestead property on or after 9/1/03 constitutes a transfer of resources, even if the name of the original owner remains on the deed.

B. A resource which would have been exempt from consideration had the transfer not occurred, such as transfer of a vehicle regardless of value if specially equipped for the disabled. This exception DOES NOT APPLY to homestead property, or the transfer of property in which the member retained a life estate interest.

C. The individual presents convincing evidence the transfer was exclusively for a purpose other than establishing MA eligibility. For example:

1. A satisfactory showing is made that the individual intended to dispose of the resources at fair market value.

2. The transfer was for services rendered for care of the individual if the individual can provide a signed, dated, notarized statement verifying that the payment arrangements were in effect when the services were initiated.

3. The transfer was for expenses incurred as a result of a family emergency.

D. The uncompensated equity value of the transferred resource added to other assets does not exceed the appropriate resource limit for the individual or the community spouse. Verification of dispersal of the funds is not required.

E. The resource was transferred to the community spouse, or solely for the benefit of the community spouse.

F. [Any resource, other than homestead property, was transferred for the sole benefit of the individual's child of any age who is blind or permanently and totally disabled. The resource must be placed in a Special Needs Trust. The Special Needs Trust must then be forwarded to the Medical Support and Benefits Branch (MSBB) for Department for Medicaid Services (DMS) review with the completed cover sheet.]

G. A determination is made that the individual had good cause for transferring the resource. To request a good cause determination, submit a memorandum to the Medical Support and Benefits Branch, 3E-I, 275 East Main St., Frankfort, Ky. 40621. Include in the memorandum, circumstances regarding the good cause claim, the amount of good cause expenses and resources remaining.

1. Good cause may be established if one of the following occurs:

   a. A natural disaster, fire, flood, storm, earthquake;

   b. Illness resulting from accident or disease, hospitalization or death of a member of immediate family; or

   c. Civil disorder or other disruption resulting in vandalism, home explosions, or theft of essential household furnishings.

   d. The transfer of resource penalties or consideration of funds placed in a trust deprives an individual of medical care such that the individual’s health or trust provisions would deprive the individual of food, clothing, shelter or other necessities of life.

2. Case action cannot be completed until after a written response to the request for good cause determination is received from MSBB.

MS 2080 CONSIDERATION OF TRANSFERRED RESOURCES

The Deficit Reduction Act of 2005 (DRA), has legislated several changes to the Medicaid vendor payment eligibility determination and the consideration of transfer of resources. The Department for Medicaid Services (DMS) has implemented these changes into policy effective February 1, 2007. These changes only affect new applicants who have transferred resources on or after February 8, 2006, or resource transfers which became known to the agency after February 8, 2006.

A. Effective February 9, 2009 the look back period will progressively expand from 36 months to 60 months for transfers made on or after February 8, 2006. At this point the look back period will increase daily until February 8, 2011, at which point the look back period will have reached 60 months. For transfers made prior to February 8, 2006, the previous procedures (3-year look back period) still applies.

B. If a resource was transferred during the look back period of 36 months (current look-back period for transfer of resources) or 60 months (the current look-back period for resources transferred into a trust) prior to the baseline date and none of the exceptions apply, it is presumed that the transfer was for the purpose of establishing MA eligibility.

1. For transfer of resources made prior to February 8, 2006, other than a trust, the look back period is 36 months.

2. For transfer of resources made on or after February 8, 2006, effective February 9, 2009, the look-back period will increase daily until February 8, 2011, at which point the look-back period will have reached 60 months.

   For example: On February 9, 2009, the look back period will be 36 months and 1 day.

   On March 9, 2009, the look back period will be 37 months and 1 day.

   On February 9, 2010, the look back period will be 48 months and 1 day.

   Note: Effective February 9, 2009, the look-back period will NEVER go back further than February 8, 2006.

3. For transfer of resources from February 8, 2011 forward, the look-back period will be 60 months.

4. For trusts established on or before 8/10/93 and a transfer of resources occurs into the trust after 8/10/93, the look back period is 36 months.

5. For trusts established after 8/10/93, the look back period is 60 months.

Note: The addition of another's name to an asset after 9/1/03 constitutes a transfer of resources even if the name of the original owner remains on the asset as owner. The burden of rebutting this presumption rests with the individual. The opportunity for rebuttal is allowed through the fair hearing process.

C. The start date of the penalty period for prohibited transfers of resources that occurred on or after February 8, 2006, is also changed by the DRA. The day the penalty period starts is now either the first day of a month during which resources have been transferred for less than fair market value (FMV) OR the day the individual is eligible for Medicaid vendor payment. Use whichever date occurs last.

Determine the period of restricted coverage or period of vendor payment ineligibility as appropriate.

1. Once eligibility has been determined and a penalty period has been established, it continues until expiration. The penalty period applies only to payment for long term care services, not to all Medicaid cases.

2. [For ineligibility periods that result in partial months the individual only needs to serve the number of days left in that month. Divide the amount of transferred resources by the current transfer of resource factor $177.05 (effective January 2009) per day. The current daily transfer of resource factor of $177.05 is calculated as follows:

   $5,385.27 (2009 transferred resource divider) x 12 (months in a year divided by 365 days per year) = $177.05.]

3. A denial notice is system generated to all new Medicaid applicants once a penalty period has been imposed. The case will deny due to excess income as the system will not use the special income standard. A KIP-105.13, Disqualification, notice is also issued.

4. A 10-day adverse action notice will be system generated for active cases, with penalty periods imposed on an individual who is already eligible for Medicaid vendor payment. The ineligibility period is effective either the month of the transfer for less than FMV OR the date on which the individual became eligible for Medicaid vendor payment, whichever occurred last.

5. The penalty period cannot begin until the expiration of any other existing ineligibility periods.

6. Once the ineligibility period is imposed, it will not be interrupted or temporarily suspended. The ineligibility period will continue to run even if the individual subsequently stops receiving institutional level of care.

D. At application

1. Determine the uncompensated equity value of the transferred resource;

2. Divide the uncompensated equity value by the transferred resource factor. Use the transferred resource factor for the year in which the transfer was made known to the agency. When calculating the individual's total ineligibility period, round down. The DRA prohibits each state from rounding ineligibility periods down to whole months. Therefore for transfers made on or after February 8, 2006 the transfer of resource factor will be a daily amount, rather than a monthly amount. This amount changes each January. This is effective with ALL ineligibility periods calculated after February 1, 2007.

   EXAMPLE 1:

   An application is taken on 4/16/08. The applicant is income and resource eligible. Applicant was admitted to LTC on 4/16/08. $50,000 was given away on 2/10/07 resulting in a disqualification period for LTC vendor payment. The disqualification period is determined as follows:

   $50,000 divided by 156.14 (current daily transfer of resource factor) = 320.23. The ineligibility period is rounded down to 320 days.

   In this example, the count begins with the day of admission to the LTC facility because the applicant has met all other technical and financial eligibility criteria.
   The disqualification period is April 16, 2008, through March 12, 2009. March 13, 2009, is the first day the client would be eligible for LTC vendor payment.

   EXAMPLE 2:

   An application is taken on 5/16/07. The client was admitted to LTC and met level of care on 5/10/07. The individual has multiple transfers that occurs both prior to and on 2/8/06. Determine the ineligibility period as follows:

   $6,000 was transferred on 2/5/06. (This transfer would follow old policy.)
   $7,000 was transferred on 2/8/06.

   $6,000 divided by 150.71 = 39 .81 days rounded down to 39 days.

   Transfer #1 = 39 days.

   $7,000 divided by 150.71 = 46.45 days rounded down to 46 days.

   Transfer #2 = 46 days.

   Transfer #1 disqualification-from date begins on February 1, 2006, and ends on March 11, 2006. The disqualification period is over prior to the date of application; therefore, no disqualification is imposed for the first transfer. Transfer #2 occurred on 2/8/06, the disqualification period begins with the date level of care is met as client is technically and financially eligible on that date. The disqualification period is for 46 days. The disqualification-from date is May 10, 2007. The

disqualification-through date is June 24, 2007. The first day of LTC eligibility would be June 25, 2007.

E. At Recertification/Interims:

1. If a recipient transfers resources, determine the number of months of vendor payment ineligibility.

2. The month of vendor payment ineligibility begins with the month of transfer.

EXAMPLE 3:

At the recertification appointment on 10/2/07 it is discovered that the client sold property for less than FMV on 9/15/07. The FMV of property was $10,000. Client sold property for $3,000. The money received was used to pay outstanding debt. There are no countable resources to consider from the sale of the property. The transferred resource amount is $7,000. Determine the disqualification period as follows:

$7,000 divided by 156.14 = 44.83 days rounded down to 44 days.

In this situation the date of application was 10/15/2006. The date of transfer occurred after the application date, therefore the count will begin with the date of transfer.

The disqualification from date will be 9/15/07 and continue for 44 days. The disqualification-through date will be October 28, 2007.
Note: If the calculation results in a partial month of vendor payment ineligibility, the individual must serve the number of days in that month.

F. Multiple Transfers

All transfers after February 8, 2006, will be treated as a single transfer, instead of looking at each transfer individually. Rather than applying multiple penalty periods, calculate and impose a single period of ineligibility.

EXAMPLE 4:

Application was made on August 1, 2008. There were multiple transfers that occurred prior to the application. All transfers occurred after February 8, 2006.

$4,000 was given away on 3/1/07.
$2,000 was given away on 5/15/07.
$2,000 was given away on 7/19/07.

Total all transfers together that occurred on or after 2/8/07:
$4,000 + $2,000 + $2,000 = $8,000

Divide the total by the current transfer of resource factor.

$8,000 divided by 156.14 = 51.24 days rounded down to 51 days.

Begin the count for the ineligibility period with the day of application. In this situation, that is August 1, 2008. The ineligibility period is for 51 days. Therefore, the disqualification for transfer of resources would end on September 22, 2008. LTC vendor payment eligibility would begin on September 23, 2008.

Note: If the calculation results in a partial month of vendor payment ineligibility, the individual must serve the number of days in that month.

G. Member Disqualification

1. The KAMES "Member Disqualify – Inquiry" screen displays the ineligibility period as days, not months. A new field is added to read "Number of Days Disqualified". This new field is displayed directly below the "Number of Months Disqualified" field. The disqualification from and through dates can be any day of the month.

2. The text of the KIP-105.13 notice for disqualification reason 414 is changed to read as follows:

   "Section 1917(c)(2)(D) of the Social Security Act states that if you will be discharged from the nursing home or if you will lose your waiver services because you are unable to pay, you can request a Hardship Determination. Contact your worker or long term care provider for more information."

   Follow existing Hardship policy should you receive a request for Hardship Determination.

3. A field for number of days disqualified has been added to be displayed directly below number of months disqualified. There should be a numeric field to the right of the day's field and directly below the number of months disqualified field. The numeric value can be any amount from 0 to 9999. This field will be used only when a 414 disqualification is applied and the disqualification is determined after the new code is entered. All other 414 disqualifications that are determined under the old rules will retain the count for the number of months disqualified. Both fields will be displayed but only one field will be populated depending on the time when the disqualification is added. For disqualification 414 ONLY, the beginning and end dates do not necessarily correspond to the beginning and end of the calendar month(s). The 414 can be imposed to begin any day of the month and to end any day of the month. When adding or changing/updating a record, be sure that the through-date is equal to the from-date plus the number of days or months disqualified.

H. Ongoing MA

Determine ongoing or spend down MA eligibility using the regular MA standard.

4. If the application is approved for ongoing MA eligibility, spot-check the case for the end of the restricted coverage period for reinstatement of vendor payment status.

5. Take appropriate action to initiate vendor payments.

I. Resource transfers that occurred prior to February 8, 2006 are to be processed in the following manner:

When an individual completes multiple or incremental transfers of resources, the ineligibility period accrues and runs consecutively beginning with the month of the initial transfer.

EXAMPLE 1:

An individual transferred $5,000 in March, 2004 into an irrevocable trust established August 11, 1997 and the remaining resources of $25,000 was transferred into the trust in April, 2004. In April, 2004 the individual applied for nursing facility services. An ineligibility period of 1 month is calculated for the March, 2004 transfer and a second ineligibility period of 9 months is calculated for the April, 2004 transfer. The ineligibility periods are added for a total ineligibility period of 10 months. The ineligibility period is established beginning with the month of the transfer. In this example, the individual would not be eligible for a Medicaid vendor payment until January, 2005. The ineligibility periods were computed as follows: $5,000 (transferred resource) divided by $2,614 (transferred resource factor) = an ineligibility period of 1.91 or 1 month. $25,000 divided by $2,614 = 9.56 or 9 months. 1 month + 9 months = 10 months total ineligibility period.

EXAMPLE 2:

In March, 2004 an individual transferred $10,000 to his son,$10,000 to his daughter and $10,000 to his brother. In March, 2004 he applied for HCBS. $10,000 divided by $2,614 = 3.83; or 3 months. An ineligibility period of 3 months is established for each transfer. The three 3-month ineligibility periods are added for a total ineligibility period of 9 months beginning with the month of the initial transfer. In this example, the individual would not be eligible for a Medicaid vendor payment until December, 2004.

EXAMPLE 3:

An individual transferred $5,000 to his daughter in March, 2004. In March, 2004 he applied for nursing facility services. $5,000 divided by $2,614 = 1.91 or 1 month ineligibility period. In this example, the individual would not be eligible for a Medicaid vendor payment until April, 2004. In April, 2004 the individual reapplied for nursing facility services and was approved effective April, 2004. In June, 2004 the individual won $20,000 in the Kentucky Lottery. In June, 2004 the individual transferred the $20,000 to his daughter. $20,000 divided by $2,614 = 7.65 or 7 months. A second ineligibility period of 7 months was established beginning with the month of the transfer (June, 2004). In this example, the individual would not be eligible for a Medicaid vendor payment until January, 2005.

EXAMPLE 4:

In May, 2004, a couple has $100,000 in their joint checking account and the couple transfers $20,000 to their daughter. In May, 2004 the husband is admitted to a nursing facility and his community spouse applies for Medicaid Assistance for Long Term Care (LTC) expenses. At that time the couple had $80,000 in countable resources. $20,000 divided by $2,614 = 7.65 or 7 months. An ineligibility period of 7 months is established. In this example, the institutionalized spouse would not be eligible for Medicaid vendor payment until November, 2004.]

MS 2081* Entering Transfer of Resources Disqualifications

System changes for implementation of the transfer of resource daily factor are in place.

A. Applications

KAMES will automatically determine the disqualification period for new applications with no history on KAMES and no 414 disqualification history, provided all of the transfer of resources information is entered correctly.

B. Re-applications

Depending on the disqualification history on KAMES, when the existing disqualification period ends and whether the case becomes eligible during the application; determines whether KAMES will automatically apply the disqualification period or if the worker has to manually:

1. Update/change the disqualification (option 2);
2. Delete the disqualification (option 3). Delete requires supervisor approval;
3. Change the begin date; or
4. Remove the end date.

Note: You cannot manually add a 414 disqualification.

C. If the number of days is left unchanged, the worker needs to change the start date and KAMES will compute a new end date. If the begin date is left unchanged, the worker is to change the number of days, remove the end date and KAMES will compute a new end date.

D. If once the disqualification period is determined and imposed, the client and/or representative brings verification that the transfer of resource has been cured (value of resource transferred given back to the client), then the disqualification period can be reduced by the appropriate number of days (value divided by daily transfer factor). If a disqualification period is reduced using option 2 (change/update) on the disqualification menu, worker will need to document thoroughly on KAMES what actions were taken and why.

If a case appears to be approving incorrectly, please notify the Help Desk prior to exiting the application.

MS 2100 VERIFICATION OF TRANSFER OF RESOURCES

A. For applications, determine if property/assets were transferred during the 36-month or 60-month period immediately preceding the baseline date. Document reason for transfer.

B. For recertifications, determine if property/assets were transferred since the last recertification. Document reason for transfer.

MS 2105 SPECIAL PROCEDURES FOR TRANSFER OF RESOURCES BY A POWER OF ATTORNEY/LEGAL GUARDIAN

For those cases in which the Agency is aware that the power of attorney or legal guardian transferred resources during the 36-month or 60-month period immediately preceding the application month, apply transfer of resource policy at the next recertification. If it is determined that the transfer was completed to establish MA eligibility, apply the penalty beginning with the month of transfer.

[A hardship determination may be requested when resources that were inappropriately transferred by the POA/Legal Guardian are unavailable to pay the LTC cost of care, and the recipient has received a discharge notice from the facility or waiver provider. For hardship determination procedures, see MS 2160.]

MS 2110 SSI RECIPIENTS AND TRANSFER OF RESOURCES

Transfer of resources policy and penalties also apply to individuals receiving SSI.

A. Federal law requires SSA to identify and provide information to assist the Agency in determining whether the transfers will result in a period of restricted MA coverage.

B. Use the following procedures for SSI cases identified by SSA as transferring resources.

1. A listing titled, "HR PAS Transferred Resources Listing," is available on RMDS to indicate SSI individuals identified by SSA as transferring resources.

   The listing includes: the SSI individual's name; social security number; the date of the resource transfer; the type of resource transfer; estimated value of the resource; individual transferring the resource; and the individual to whom the resource was transferred.

2. Access the listing to determine if currently active SSI individuals applying for or receiving LTC or HCBS services are identified as transferring resources. Thereafter, access the listing for SSI individuals whenever a PA-62 document is completed for vendor payment approval for individuals active on SDX. [These individuals will appear on the RDS report titled, "PRO Certification Not Matched to KAMES". See MS 3650.]

3. If the listing indicates a transfer of resources occurred, send the SSI individual form PAFS-2 scheduling an appointment to discuss the transfer. Verify information provided by SSA on the listing and make a determination regarding the transfer prior to imposing a penalty.

MS 2120 SPECIAL RESOURCE CONSIDERATIONS FOR AN INSTITUTIONALIZED SPOUSE WITH A COMMUNITY SPOUSE

Resources of an institutionalized spouse who has a spouse living at home in the community are treated differently to prevent financial hardship which results when one spouse is institutionalized.

A. Provisions of the policy include an assessment of the institutionalized and community spouse's combined countable resources. [Form PA-22, Resource Assessment, is completed at the request of either spouse or the representative acting on behalf of the couple for most recent continuous period of institutionalization.] This assessment may be completed independent of the MA application.

B. The Resource Assessment provides a prescreening of resource eligibility to assist the couple in financial planning and in their decision to apply for MA. Included in the provisions is a community spouse resource allowance. [This resource allowance is determined by the total combined countable resources of a couple, regardless of the existence of a prenuptial agreement.] The allowance represents the amount of resources necessary for the noninstitutionalized spouse to maintain themselves in the community. [Form PA-1A, Supplement C, Institutionalized Spouse Resource and Income Statement, must be completed prior to approval of the application to substantiate intent to transfer resources to the community spouse.]

C. [By law, the community spouse resource allowance cannot exceed the maximum allowable amount which is subject to an annual change. In giving this allowance as a deduction, the policy requires that the amount of the couple's combined countable resources deducted in the community spouse resource allowance actually be made available to the community spouse for their use. This may involve the legal transfer of resources from the institutionalized spouse to the community spouse without penalty for transfer. Allow 6 months for the transfer of resources to be completed. Spot check the case 6 months after approval and contact the community spouse or representative to verify the resources of the institutionalized spouse.] Resource considerations for the community spouse who applies for or receives MA have not changed.

D. Apply the policy to spouses admitted on or after 9/30/89 to a long term care (LTC) facility, institutionalized Hospice, mental hospital and Institutions for Mental Diseases, or who elect HCBS, Supports for Community Living, or noninstitutionalized Hospice.

E. There is no requirement that the institutionalized individual be receiving a vendor payment or be vendor payment eligible to complete PA-1A, Supplement C and PA-22.

EXAMPLE 1: If an institutionalized spouse is eligible for a vendor payment and declines the vendor payment, the community spouse resource allowance is applied in the institutionalized spouse's case.

EXAMPLE 2: If an institutionalized spouse is vendor payment ineligible for any reason, but eligible for a spend down, the community spouse resource allowance is applied in the institutionalized spouse's case.

F. For spouses institutionalized or receiving HCBS, Supports for Community Living or Hospice before 9/30/89, follow previous policy for consideration of resources. If the spouse leaves the facility, HCBS, Supports for Community Living or Hospice for a 30 consecutive day period and is readmitted, apply current resource policy. If an institutionalized spouse is not likely to be institutionalized for at least 30 consecutive days, DO NOT APPLY the community spouse resource allowance in the institutionalized spouse's case. If a change in circumstance results in a couple no longer having an institutionalized/community spouse situation, i.e., one spouse dies, community spouse is institutionalized, etc., do not apply the special resource considerations the month following the month in which the change occurs.

MS 2130 RESOURCE ASSESSMENT

[An assessment of the combined countable resources of the institutionalized spouse and community spouse is completed at the initial Medicaid Long Term Care eligibility inquiry. The assessment is completed via form PA-22, Resource Assessment. Form PA-22 is NOT completed if the potential applicant is not institutionalized. A continuous period of institutionalization begins when the spouse enters LTC, receives institutionalized hospice or non-institutionalized hospice, or any waiver services and is expected to remain in the facility or receive services for at least 30 consecutive days. LTC facilities, hospice and HCBS and SCL providers are responsible for advising all new admissions of the availability of the resource assessment.]

A. [The resource assessment, which may be completed without applying for MA, involves documenting and verifying all countable resources owned by the couple if institutionalization in LTC, Hospice or waiver, began on or after September 30, 1989.] Compare the combined countable resources to the current MA resource allowances for the institutionalized spouse and the community spouse to determine if the institutionalized spouse meets initial resource eligibility for MA.

B. [When an inquiry regarding eligibility for LTC/waiver is made and there is a community spouse, schedule an interview appointment and advise the individual of the verification necessary for the assessment. Complete form PA-22, Resource Assessment, in its entirety during the face-to-face interview with either spouse, committee or representative. If all verification is furnished, provide each member of the couple, committee or representative with a copy of the assessment.] File the original in a designated file location in the local office. If additional information/verification is required, request the information by form PAFS-2 and advise the individual that if the information is not provided, the assessment cannot be completed. Upon receipt of the requested information, promptly complete the assessment, provide copies to either spouse, committee or representative and file the form as indicated above.

C. The community spouse resource allowance amount is calculated only one time for a continuous period of institutionalization of the institutionalized spouse. If a resources assessment is not requested and completed prior to the application, KAMES calculates the community spouse resource allowance at application.

D. If either member of the couple disagrees with the results of the assessment, advise them that they do not have a right to appeal the determination of the countable resources at the time of the assessment. Opportunity to appeal the assessment is provided if and when an application for MA for the institutionalized spouse is made. This information is stated on form PA-22.

E. The resource assessment must be completed within 45 days of the date of request unless there are delays due to nonreceipt of verification from the requesting party or third party, such as, a bank, insurance company, etc. Do not use the 45 day period as a waiting period to initiate/complete the assessment.

F. When an application for MA is made for the institutionalized spouse, obtain the previously completed form PA-22 from the designated local office file, follow directions for entry on KAMES as per MS 2135, item A.2. and place in the case record. If the assessment was completed in another county, send form PAFS-25 to request the PA-22 assessment form from their file. Compare resources owned by the couple at the time of the assessment to currently owned resources. If resources are no longer owned, explore potential transfer of resource. Verify the amount of the remaining resources plus any resources obtained since the assessment to determine current resource eligibility. [Home equity resources in excess of $500,000 are excluded only when a community spouse, minor/dependent or disabled child(ren) reside in the home. If none of these individuals live in the home, the LTC or waiver application is denied.]

G. When a resource assessment is completed in another state and the MA applicant subsequently moves to Kentucky, and there has been no interruption in institutionalization, contact the appropriate state agency and request a copy of the resource assessment completed by that state. Complete form PA-22 to determine the spousal share. This is accomplished by using the resource amounts/types verified by the previous state's resource assessment, but applying Kentucky's resource policies.

MS 2135* COMMUNITY SPOUSE RESOURCE ALLOWANCE CALCULATION

Effective 6/1/03, the special resource consideration for an institutionalized spouse with a community spouse changed. As of this date, Kentucky no longer uses the maximum community spouse resource allowance to establish Medicaid eligibility. For states that elect to use an allowance that is less than the maximum, federal regulations require calculation of a resource allowance based on the couple's specific circumstances.

A. Resource Assessment

1. Procedures for completion of a resource assessment are as specified in MS 2130, Form PA-22, Resource Assessment, is completed at the request of either spouse or the representative acting on behalf of the couple for each period of continuous institutionalization. A continuous period of institutionalization begins when the spouse enters a long-term care facility or receives waiver services and is expected to remain in the facility or receive services for at least 30 consecutive days. The assessment may be completed without applying for Medicaid or even when there are no immediate plans to file a Medicaid application. Copies of the completed forms PA-22 are maintained in a central file in each local office.

2. If a pre-application resource assessment is completed and the institutionalized spouse applies for Medicaid in the same period of continuous institutionalization, the community spouse resource allowance calculated for the pre-application assessment is used to determine Medicaid resource eligibility. To capture this information, the questions, "Was pre-application resource assessment done? If yes, enter total _____", are on line 18 of the KAMES Application General Information screen. If worker answers "Y" (yes) to the first question, the amount of the couple's combined countable resources from item 9a. on form PA-22 is entered. The entry is up to 8 digits and includes dollars and cents (e.g., $56,455.97 is entered 5645597).

3. If a pre-application resource assessment was not completed prior to the application, KAMES calculates the community spouse resource allowance at application. Form PA-22 is no longer completed during the Medicaid application.

B. Community Spouse Resource Allowance Calculation

1. The calculation makes a comparison to the minimum and maximum community spouse resource allowances established by the Centers for Medicare and Medicaid Services (CMS). As of January 1, 2005, the current minimum allowance is $20,000 and the current maximum allowance is $95,100. These allowances are revised annually by CMS. The community spouse resource allowance cannot be less than the minimum or greater than the maximum.

2. The community spouse resource allowance is equal to one-half of the couple's combined countable resources up to the maximum allowance. If the spousal resource allowance is less than the minimum, the community spouse resource allowance is the minimum allowance.

   Example 1: The combined countable resources of a couple are $198,372. One-half of the couple's resources is $99,186 ($198,372 divided by 2 = $99,186). If the amount is greater than the maximum amount allowable, the community spouse resource allowance is the maximum.

   Example 2: The combined countable resources of a couple are $128,000. The community spouse resource allowance is $64,000. ($128,000 divided by 2 = $64,000)

   Example 3: The combined countable resources of a couple are $21,500. One-half of the couple's resources is $10,750 ($21,500 divided by 2 = $10,750). The community spouse resource allowance is $20,000 as the amount cannot be less than the minimum allowance.

C. The community spouse resource allowance may exceed the calculated amount or the maximum only by court order or a fair hearing decision per MS 2140.

D. Institutionalized Spouse Resource Eligibility Determination

   To determine the resource eligibility for the institutionalized spouse, subtract the community spouse resource allowance from the combined countable resources of the couple. If the remainder is greater than $2,000, the resource limit for the institutionalized spouse, the institutionalized spouse is resource ineligible.

   (Using Example 3 above)

Combined resources of the couple	$21,500
Minus Community Spouse Allowance	-20,000
Remainder	$ 1,500

   Resource eligible – remainder is less than $2,000

   (Using Example 2 above)

Combined resources of the couple	$128,000
Minus Community Spouse Allowance	-64,000
Remainder	$ 64,000

   Resource ineligible – remainder exceeds $2,000.

E. The community spouse resource allowance remains constant for the same continuous period of institutionalization or waiver services. The continuous period ends when there is an absence from institutionalization or waiver services are terminated for 30 consecutive days. If the institutionalized spouse reapplies following a 30-day period of absence from the facility or waiver services, a new community spouse resource allowance is calculated.

F. To identify cases in the same or a new continuous period of institutionalization, the question, “Has an interruption in long term care occurred?” is on line 19 of the KAMES Application General Information screen. This is a required entry for an application, re-application and program transfer. If the worker enters “N” (no), KAMES will use the previously established community spouse resource allowance to determine resource eligibility. If “Y” (yes) is entered, KAMES will calculate a new allowance amount or will use the pre-application resource assessment amount entered by the worker (if a new form PA-22 was completed during the new continuous period of institutionalization).

   Example 1: Institutionalized spouse applies for Medicaid and nursing facility coverage. The application is denied due to excess resources. The institutionalized spouse remains in the facility as a private pay patient. A re-application is filed 4 months later. Because the institutionalized spouse is in the same continuous period of institutionalization as the first application, the worker enters “N” to the above referenced question. KAMES will use the same community spouse resource allowance calculated for the first application.

   Example 2: Worker receives form MAP-24 notifying the agency that the institutionalized spouse had been discharged from the nursing facility and the MA case is closed. Two weeks later the worker receives a Prior Authorization (PA) letter indicating the individual has been approved for HCBS services. Although there was a change in type of care, the interruption in services was less than 30 consecutive days. The worker answers “N” to the question. A new community spouse resource is not calculated.

   Example 3: The institutionalized spouse was approved for Medicaid and nursing facility services in June. In September, the institutionalized spouse is discharged from the facility and returns home. In December, the individual is readmitted to the nursing facility and reapplies for Medicaid. As the individual was out of the facility for more than 30 consecutive days, a new community spouse resource allowance is calculated. The worker will answer “Y” to the question. KAMES will calculate a new community spouse resource allowance or use the community spouse resource allowance from the pre-application resource assessment (if form PA-22 was completed between the readmission date and the application date for the new period of continuous institutionalization).

G. For cases determined resource eligible, completion of form PA-1A, Supplement C, Institutionalized Spouse Resource and Income Statement, is still required to obtain the institutionalized spouse’s declaration of intent to transfer resources in excess of $2,000 to the community spouse.

MS 2140 [RESOURCE ELIGIBILITY DETERMINATION FOR APPLICANTS WITH A COMMUNITY SPOUSE]

Resources of the community spouse are not considered the month after the month in which MA/patient liability is established. Any additional resources, inheritance, lump sum, etc., subsequently received by the community spouse does not affect eligibility of the institutionalized spouse.

A. If neither spouse was institutionalized during the retroactive period, compare the couple's resources and income to the MA Scale/MA Standard for 2 to determine eligibility for each of the 3 retroactive months.

B. If a spouse was institutionalized during the retroactive period, use the following procedures to establish resource eligibility of the institutionalized spouse for the retroactive period and ongoing MA eligibility.

1. Determine the CURRENT combined countable resources of the couple.

2. Complete forms PA-1A, Supplement C, and PA-22, if applicable, verifying resources of the couple.

3. Deduct the community spouse resource allowance. The community spouse resource allowance is the maximum amount of the couple's combined resources which may be retained by the community spouse. The community spouse resource allowance may exceed the maximum only if:

   a. A court order against the institutionalized spouse for the support of the community spouse; or

   b. A fair hearing decision establishes that resources in excess of the allowance are required for the community spouse.

   Either member of the couple, the committee or representative may request the fair hearing. Hearings for this purpose are conducted within 30 days of the hearing request to facilitate timely processing of the application. The hearing officer designates a higher resource allowance, if appropriate, in the fair hearing decision.

4. The remainder is compared to the resource allowance for an individual.

If the remaining resources are equal to or less than the allowance, the institutionalized spouse meets initial eligibility. The institutionalized spouse is resource ineligible if the remaining resources exceed the limit.

MS 2150 PATIENT LIABILITY TRANSFER OF RESOURCES

Once initial resource eligibility is established, determine the amount, if any, of resources belonging solely or jointly to the institutionalized spouse which were attributed to the community spouse allowance in the initial resource eligibility determination.

A. Advise the individual that the resources of the institutionalized spouse above the resource allowance for an individual must actually be made available to the community spouse to meet his/her needs in order to be excluded in determining continued resource eligibility.

1. The institutionalized spouse must indicate intent to legally transfer resources to the community spouse and to complete the transfer within 6 months of the initial MA approval.
2. To indicate intent, the institutionalized spouse must sign form PA-1A, Supplement C, Institutionalized Spouse Resource and Income Statement.
3. If the institutionalized spouse fails or refuses to sign the statement of intent, deny the application due to excess resources.

a. If the institutionalized spouse is incapable of indicating intent due to mental impairment, the community spouse, committee or representative acting on the behalf the institutionalized spouse may indicate intent.
b. Accept the statement of the community spouse, committee or representative regarding mental impairment of the institutionalized individual and document the case record accordingly.

B. [Allow the institutionalized spouse 6 months from the month of MA approval to transfer resources to the community spouse. Form PA-1A, Supplement C, is required to be signed prior to case approval.] Allow additional time if verified court action is involved or there is a delay through no fault of the recipient. Carefully document any delays and set up spot checks for the anticipated completion date. If there are no documented delays, consider all transfers completed within the specified timeframes. Spot check the case for the 6th month following approval to ensure transfers are completed. If resources remain in the institutionalized spouse's name, discontinue the case effective with the first administratively feasible month.

C. If resources were transferred to an individual other than the community spouse, determine if the transfer was a prohibited transfer according to, MS 2050-2110. If the transfer was a prohibited transfer, take appropriate action to restrict MA coverage.

D. If the institutionalized spouse obtains additional resources, such as inheritance, gift, etc., after the initial eligibility determination, exclude these resources if:

1. The new resources combined with current resources do not exceed the resource allowance for one; or
2. The institutionalized spouse indicates intent to transfer the resource to the community spouse who has resources below the community spouse resource allowance at the time the additional resources were received. [Complete form PA-1A, Supplement C for the additional resources.]

MS 2160 ADDITIONAL CONSIDERATIONS

Additional considerations are provided to establish resource eligibility when the institutionalized spouse's countable resources exceed the resource allowance for an individual and the individual maintains that the excess resources are not available to cover the cost of care in the LTC facility, Hospice, HCBS, SCL or ICF/MR/DD. Refer to MS 2130.

This situation occurs when all or a majority of the couple's combined resources are in the name of the community spouse and the community spouse refuses to make the resources available to the institutionalized spouse. [This special consideration applies ONLY to resources which belonged to the community spouse prior to the marriage. Consideration does NOT apply to resources jointly held by both spouses.]

Calculate the combined resources of the couple. Subtract the community spouse resource allowance from the combined resources of the couple.

Do not establish initial resource eligibility if countable resources exceed the resource allowance for an individual.

A. If it is verified that the community spouse refuses to make the excess resources available to the institutionalized spouse, exclude the excess resources if:

1. The institutionalized spouse agrees to assign support rights of the excess resource to the State.

   a. The institutionalized spouse agrees to reimburse the State in the amount of the excess resource for medical care provided, if and when the resource becomes available to the institutionalized spouse.
   b. To assign support rights, the institutionalized spouse must sign form PA-1A, Supplement C.
   c. If the institutionalized spouse is unable to assign support rights to the State due to mental impairment, the community spouse, committee or representative acting on behalf of the institutionalized spouse may assign support rights and sign form PA-1A, Supplement C. Accept the statement of the community spouse, committee or representative regarding mental impairment of the institutionalized spouse.

2. If the institutionalized spouse agrees to assign support rights to the excess resources, exclude these resources in the resource eligibility determination and subsequent recertifications. When the excess resource is determined available to the institutionalized spouse, send a memorandum identifying case information and information regarding availability of the resource along with a copy of the signed agreement to:

Cabinet for Health and Family Services
Department for Medicaid Services
Office of the Inspector General
Division of Program Integrity
275 E. Main St., 6E-B
Frankfort, KY 40621

3. If the institutionalized spouse or community spouse, committee or representative acting on behalf of the institutionalized spouse refuses to assign support rights, request a hardship determination.

B. A hardship determination is appropriate when excess resources cannot be excluded by assignment of support rights and the institutionalized spouse will be discharged from the LTC facility or lose HCBS or SCL services due to inability to pay.

1. To request a hardship determination, send a memorandum to:

Department for Community Based Services
Medical Support and Benefits Branch
3rd Floor, 3E-I
275 E. Main Street
Frankfort, Ky. 40621

Include in the memorandum identifying case information, the amount of excess resource, and the reason for refusal to assign support rights to the State.

2. Complete case action after a written response to the request for a hardship determination is received.

3. If it is determined that hardship criteria is met, exclude the excess resources specified in the hardship determination.

[C. A hardship determination may be requested when resources that were inappropriately transferred are unavailable to the LTC recipient to pay the cost of care, and the LTC recipient has received a discharge notice from the facility or wavier provider. This situation generally occurs when a payee or POA mishandles the recipient's resources. Request the hardship determination according to procedures in section B above.]

MS 2170 RECERTIFICATION/INTERIM

Consider only the resources of the institutionalized spouse in determining ongoing eligibility.

A. Resources of the community spouse and those resources that the institutionalized spouse has indicated intent to transfer to the community spouse within six months from the date of application, are not considered available to the institutionalized spouse, effective the month following the month in which eligibility is established.

B. Compare the institutionalized spouse's resources to the resource allowance for an individual.

1. [The case is resource eligible for that month if total countable resources are equal to or less than the limits when the recertification is processed.
2. The case is resource ineligible if total countable resources exceed limits when the recertification is processed.]
   a. Send timely notice to discontinue an active case.
   b. If resources are reduced to the limit or less during the month of discontinuance without a prohibited transfer of resources to establish eligibility, the case is resource eligible for that month if reapplication has been made.

MS 2180 INTRODUCTION

INCOME is the money received from statutory benefits, rental property, investments, nonrecurring lump sums, or for labor or services. Income may be unearned or earned, and must be verified and documented at each application and reinvestigation.

MS 2190 INCOME LIMITS

Subject to the provisions for relative responsibility, total countable income is compared to the MA Scale.

A. MA Scale:

Size of Family	Annual	Monthly	Individual Share
1	2,600	217	
2	3,200	267	134
3	3,700	308	103
4	4,600	383	96
5	5,400	450	90
6	6,100	508	85
7	6,800	567	81
8	7,520	627	78
9	8,240	687	76
10	8,960	747	75
Each Additional Member	+720	+60	Divide by number of members

B. Do not compute total countable income if gross income is equal to or less than the MA scale. Income eligibility is met.

C. If total countable income is equal to or less than MA Scale, income eligibility is met.

D. Use spend down procedures if total countable income is greater than MA Scale.

E. [The personal needs allowance is an amount of income protected for basic maintenance in a HCBS, Hospice, SCL, or licensed NF facility.]

MS 2200 INCOME ROUNDING

A. DO NOT round unearned income.

B. Determine gross monthly wages. When rounding, 50 cents is rounded to the next dollar.

1. HOURLY - Multiply the number of hours in the work week by the hourly rate and round to the nearest dollar.
2. WEEKLY - Round weekly income to nearest dollar. Combine rounded weekly amounts, average, and round to nearest dollar. Multiply by 13, divide by 3, and round result to nearest dollar.
3. BIWEEKLY - Round to nearest dollar. Combine rounded bi-weekly amounts, average, and round to nearest dollar. Multiply by 13, divide by 6, and round to nearest dollar.
4. SEMIMONTHLY - Round to nearest dollar, average, and round if 2 pay periods are used, and multiply by 2.
5. MONTHLY - Round to nearest dollar.

C. For self-employment income:

1. Use actual dollar and cent amount of gross income.
2. Use actual dollar and cent amount of expenses.
3. Subtract actual expenses from actual income and round the difference to the nearest dollar.

D. Round the total of each type of other earned income to the nearest dollar.

E. Total all types of income.

F. Round the total income to the nearest dollar and compare to the appropriate MA Scale.

MS 2210 UNEARNED INCOME

UNEARNED INCOME is money received which does not involve direct physical or mental activity.

Verify income before authorizing case action on approvals, recertifications or reported changes in income. Explore the possibility of withheld income information. Document amount and type of verification. [Refer to Volume I, MS 0151, for cases pending over 30 days with good cause.]

MS 2220 ANNUITIES

An annuity is an investment from which an individual receives fixed payments for a lifetime or a specified number of years.

A. Payments received are considered unearned income.

B. Payments received less frequently than monthly, are converted to a monthly amount.

MS 2230 CHILD OR SPOUSAL SUPPORT

Child and/or spousal support income is the amount of court ordered or voluntary support regularly received by the recipient. Voluntary payments are those amounts made by a legal, alleged or adjudicated parent when there is no court order for support.

A. VERIFICATION. [Includes court records, checks or statement from Non-Custodial Parent (NCP), KASES, etc. Use the disbursement dates on KASES as dates of receipt.]

B. CONSIDERATION. [Average support received by the recipient during the prior 3 months. Do not round weekly, bi-weekly, semi-monthly or monthly amounts when calculating child support.]

1. Exclude support income received by an aged, blind, or disabled adult for a child in the home.

2. [Exclude one-third of the support payments received from an NCP by or for a blind or disabled child.] Consider the remainder unearned income.

[3. If child support income is not representative of the ongoing support due to a VERIFIED change in circumstances, consider the anticipated child support in the ongoing budget.

C. Enter the calculated monthly child support amount, minus exclusions as “other” unearned income on KAMES. Do not round.

D. If a calculator with tape is used for calculations, include the calculator tape in the case record as documentation.]

MS 2240* CONTRIBUTIONS

CONTRIBUTIONS are cash received from any source, including a parent involuntarily absent from the home.

A. VERIFICATION. Statement from individual providing contribution or copy of checks.

B. CONSIDERATION. To determine the monthly amount of contribution, average amounts received from previous 3 months if contributions are expected to continue.

MS 2250 FARM/BUSINESS

FARM/BUSINESS income is unearned if there is no direct involvement in the farm/business activities. In cases of divided ownership, divide profit between the owners, unless by mutual consent entire proceeds are available to the individual. If SSA considers all farm/business income available to an SSI individual, do not count income from this source. If SSA considers only part of the farm/business income available, consider appropriate shares available.

A. VERIFICATION. Records maintained by the individual, current income tax returns, copy of lease agreement, statement of tenant for rental income or other records.

B. CONSIDERATION. To determine profit, deduct work expenses directly related to producing the goods or services and without which the goods or services could not be produced. If the farming arrangements have changed, use anticipated income from the new arrangement.

ALWAYS annualize farm income. Annualize business income and expenses when Individual Tax Return is filed, otherwise average previous 3 months actual reported income and expenses.

1. Deduct the following:

   a. Wages paid to employees;
   b. Rent or interest on a mortgage and, as appropriate, taxes, but only if the enterprise is carried on from a site other than the home;
   c. Interest payments only on the purchase of capital assets, equipment, etc.;
   d. Cost of stock offered for resale;
   e. Cost of materials and supplies including seed, feed, crop insurance, fertilizer, and utilities required to carry on the enterprise;
   f. Travel expenses directly attributable to the operation of the business enterprise, mileage deduction equivalent to the rate for state employees, if the person uses their private vehicle;
   g. Other non-personal items directly related to producing the goods or services;
   h. [Repairs or maintenance of equipment and property; and
   i. Management fees incurred in managing property, including management fees charged by a relative.]

2. Do not deduct the following:

   a. Personal work or business expenses, such as, taxes, FICA, lunches, personal transportation, entertainment expenses, etc.;
   b. Amounts claimed for depreciation, prior losses, or loss in one business from another;

c. Purchase of capital equipment;
d. Payments on principle for the purchase of property, durable goods, capital assets, equipment, etc.; or
e. Improvements, such as paving drive, new roof, putting up a fence, etc.

3. RENTAL income is unearned if the individual is not actually involved in collecting the rent, making or supervising repairs, etc. Determine net profit by the same method used to determine earned rental income.

MS 2260* HOME EQUITY PLANS

HOME EQUITY PLANS (HEP) are designed to allow elderly homeowners to convert the equity value of their homes into cash without being forced to leave their homes.

A. The following HEP are currently available.

1. REVERSE MORTGAGES allow a homeowner to borrow, via a mortgage contract, some percentage of the appraised value of their home. The homeowner may receive periodic payments and/or a line of credit to draw against. Some reverse mortgages involve the purchase of an annuity and are called Reverse Annuity Mortgages (RAM). In most reverse mortgages the loan to the homeowner is not repaid until the homeowner dies, sells the home or moves.

2. SALE-LEASEBACK allows the homeowner to transfer title of the home to a buyer in exchange for an installment note satisfied by regular payments. The installment note may bear interest. The buyer then allows the former homeowner to remain in the home in exchange for rent. Because the rent is a lesser amount than the former homeowner receives from the installment note, they are provided with needed proceeds. Some sale-leaseback arrangements involve the purchase of an annuity.

3. TIME SALE allows the homeowner to sign a contract to sell their home at death but maintain title to and continue to live in the home. The buyer of the contract makes regular payments to the homeowner. The contract may provide for payment of interest and/or the purchase of an annuity.

4. DEFERRED PAYMENT LOANS (DPL) are one-time lump sum loans used to repair or improve a home or to pay property taxes. They are usually offered by local government housing or community development departments with no repayment due until the home-owner dies, sells the home or moves.

B. VERIFICATION. Copy of specific HEP, such as a reverse mortgage, time sale, sale-leaseback or loan.

C. CONSIDERATION. Carefully review the plan to determine the type of compensation the homeowner is to receive, frequency/schedule of receipt, amounts, etc.

1. Payments made from a plan, such as, annuity, including reverse annuity mortgages or other reverse equity arrangement or regular installment payments, are considered as unearned income in the month received.

2. The interest portion of any installment note or contract payment is considered as unearned income in the month received.

3. Proceeds other than interest, regular installment payments and annuity payments, i.e., lump sum payments and line of credit are not considered to meet the definition of income, but are considered as converted resources, according to MS 1970.

MS 2270* INCOME SUPPLEMENTATION

INCOME SUPPLEMENTATION is money received by the individual from the Bureau for Rehabilitation Services, an income protection plan or hospital confinement policy, etc., not used to reimburse actual costs of care.

A. VERIFICATION.

1. Statement from Bureau for Rehabilitation Services;
2. Copy of income protection plan; or
3. Hospital confinement policy, etc.

B. CONSIDERATION. Consider regular monthly income supplementation in determining initial and ongoing eligibility.

MS 2280 LIFE ESTATE INTEREST

[Verify Life Estate Interest by obtaining a copy of the written agreement. Consider all continuing unearned income regardless of whether the life estate interest is in real estate property, real property or any other asset.]

MS 2290* LOANS

LOANS are amounts of money borrowed which require repayment.

A. VERIFICATION. Form PAFS-73, Verification of Contributions-Loans-Roomer/Boarder Payments, is completed and signed by the lender and borrower when the loan is not from a legal lending institution.

B. CONSIDERATION.

1. Exclude loans verified by form PAFS-73 or from a legal lending institution.

2. If a completed form PAFS-73 is not received, consider this income:

a. A contribution if regularly received; or
b. A nonrecurring lump sum if received once.

MS 2310 NURSING FACILITY INSURANCE

[NURSING FACILITY INSURANCE policies provide a benefit to help individuals pay for nursing facility services while residing in a nursing facility.

A. VERIFICATION. Copy of the nursing facility insurance policy.

B. CONSIDERATION. Carefully review the policy to determine who receives payments.

1. If the payment is made directly to the nursing facility, then it is excluded as the facility will reduce this amount from the amount billed to Medicaid. The patient liability does not change.

2. If payment is made directly to the individual, it is then counted as income and it is utilized in determining the individual's patient liability.]

MS 2320 OTHER UNEARNED INCOME

[Other unearned income includes sources of unearned income such as, but not limited, to miner's benefits, pensions, dividends, oil leases, mineral rights, income received from an income indemnity policy, and trust income actually available, unless from a Medicaid Qualifying Trust.]

A. VERIFICATION.

1. Checks;
2. Award letters;
3. Written verification from company;
4. Contract;
5. Bank and other financial statements; or
6. Trust agreement.

B. CONSIDERATION

1. Consider all continuing unearned income.

2. Compute monthly amount if necessary.

3. If unearned income is received irregularly or in irregular amounts, average the prior 3 months' actual income, even if some of the months had zero income, to arrive at the monthly amount. If the income is averaged, complete a spot check every 3 months for changes. [Sixty dollars per quarter is excluded from the calculation of irregular and infrequent unearned income.]

[4. Income from IRA's. Individuals are required to withdraw funds from an IRA when available. If at least age 59½ and eligible to withdraw funds, failure to apply for withdrawals results in ineligibility for Medicaid. There are no distinctions between traditional and Roth IRA's. Amounts of required withdrawals are determined by the financial institution. If disbursements are not received monthly, then the amount received is prorated over the period of time it is intended to cover. For example, a quarterly payment is divided by 3 and is considered as monthly income.]

MS 2330 [PROMISSORY NOTES, LOANS, MORTGAGES, LAND CONTRACTS

PROMISSORY NOTES, LOANS, MORTGAGES, AND LAND CONTRACTS are written promises, claims or contracts for which payment is received by the recipient over a period of time.]

A. VERIFICATION. Contract or other written agreement.

B. [Promissory Notes, Loans, Mortgages and Land Contracts have to meet the following criteria:

1. The repayment term must be actuarially sound (cannot be set up in terms which exceed the applicant/recipient's life expectancy- see Volume IVA, MS 1900, Life Expectancy Table).
2. Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments; and
3. The promissory note, loan, mortgage or land contract must prohibit the cancellation of the balance upon the death of the lender.

C. CONSIDERATION. If the criteria in B is NOT met, the purchase of the promissory note, loan, land contract or mortgage must be treated as a prohibited transfer of resources. Ineligibility periods must be determined and applied. The ineligibility period is based on the amount of the transfer minus the principal payments received since the date of the transfer.

Example: Daniel transfers a $10,000 motorcycle to his nephew Jon in exchange for a promissory note. Jon makes five $100 payments to Daniel. $90 of each payment goes to the principal and the remaining $10 of each payment goes to interest, making it a total of $450 ($90 x 5) applied to the principal. The ineligibility period is based on the amount of the transfer minus the principal payments received since the date of the transfer. $10,000 - $450 = $9,550. The amount to be considered in calculating the ineligibility period is $9,550.

D. CONSIDERATION. If the criteria in B is met:]

1. Consider the interest portion of continuing payments as unearned income if the principal is considered a resource;
2. Consider both principal and interest of payments received as unearned income, if principal is not considered a resource.
3. Deduct actual payments for mortgages, insurance, and taxes from payments received on a land contract.

MS 2340 STATUTORY BENEFITS

Statutory benefits include RSDI, Railroad Retirement, Black Lung, Veterans pension or compensation, Veterans Administration Improved Pension (VAIP), including Agent Orange payments issued by the Department for Veterans Affairs, according to P.L. 102-4 enacted on February 6, 1991, Worker's Compensation, Unemployment Insurance or other pensions. If an individual is receiving statutory benefits at the time of application, entitlement amount of benefits, SMI charges if appropriate, and amount of check MUST be verified and documented BEFORE approval.

A. VERIFICATION.

1. Current benefit verification letters;
2. Checks if no SMI coverage;
3. SSA verification forms;
4. PA-1610A;
5. Railroad Retirement Board;
6. Any other documentation from the payor of benefits; or
7. IMS program HR 39, NEW BENDEX, etc. NOTE: When accessing IMS Program HR 39, use the amount shown as "NET".

B. REQUIREMENT.

1. Individuals must apply for statutory benefits if potential eligibility exists, unless good cause is established. Good cause includes previous denial with no change in circumstances or inability to prove eligibility.
2. If applying for the VAIP reduces the total annual VA payment, they are not required to apply for the VAIP.
3. Verify application for statutory benefits. Refusal to explore entitlement results in ineligibility of the individual.
4. Do not withhold approval or discontinue an active case during the period entitlement is being determined.
5. Set up a monthly spot check to determine if statutory benefits are received or denied.

C. CONSIDERATION. Count statutory benefits in determining income as follows:

1. DESIGNATED BENEFITS. Income as designated by benefit verification letter, benefit statement, PA-1610A, SSA verification forms, etc. Count statutory benefits of individual included in the MA case. Count statutory benefits of responsible relative(s), if any, according to MS 1770 - 1820.

2. NONDESIGNATED STATUTORY BENEFITS. Income not assigned to a specified individual e.g., VA benefits.
   a. When the only individual covered by the statutory benefit is in the MA case, count entire amount.

b. When all individuals covered by the statutory benefit are not in the MA case, prorate the benefit to establish the amount used to determine eligibility by dividing the total statutory benefit by the number it is intended to cover. Count the individual's prorated share in the case. Count prorated shares of responsible relative if any, according to MS 1770-1820. Subtract prorated shares of all others covered by the benefit.

3. Consider entitlement amount of statutory benefits. DO NOT deduct amounts withheld due to an overpayment.

MS 2350* SSI

Supplemental Security Income (SSI) is the federally funded and administered money payment assistance program for needy aged, blind or disabled individuals.

A. VERIFICATION. Verify and document by using any of the following sources:

1. Current benefit verification letters;

2. Copy of check;

3. SSA verification forms; or

4. Computer inquiry.

B. CONSIDERATION. Count SSI benefit received to determine the unearned income of the SSP or LTC recipient. If SSI withholds income due to overpayment, the amount actually received is the amount considered.

MS 2400* EARNED INCOME

Earned income is money derived from direct involvement in a work related activity.

Verify income at application, recertification, and when income is reported to be changed. Explore the possibility of withheld income information. Document type of verification and amount of income in the case record.

MS 2410* CONTRACT EMPLOYMENT

Contract employment is income from jobs in which there is a signed agreement such as, school teachers, bus drivers.

A. VERIFICATION.

1. Contract stating salary and terms.
2. Employer contact to establish salary.
3. Employer statement or contact to verify termination of contract.

B. CONSIDERATION.

1. When the individual has a contract/payment agreement, compute gross monthly wages by dividing contracted agreed upon amount by 12 and round to the nearest dollar, unless the contract/payment agreement states income will be paid for fewer months.

   a. If the contract/payment agreement states the income will be received in fewer than 12 months, divide the contracted agreed upon amount by the number of months in the contract/payment agreement and round to the nearest dollar.
   b. If the contract/payment agreement states the income will be received monthly for 12 months and the individual requests the remainder of their pay in a lump sum prior to the end of the 12 month period, continue using the annualized figure for the remainder of the 12 month period.

2. If contract employment is self-employment, consider as self-employment, such as, contract to paint house, install roof, etc.
3. Prorate other contract employment over the life of the contract.

MS 2420 OCCASIONAL AND COMMISSIONED EMPLOYMENT

Occasional employment is income from working an irregular schedule that is not known in advance. Commissioned employment is income received as a percentage of the money received from sales.

A. VERIFICATION. Pay stubs or employer contact.

B. CONSIDERATION. Compute anticipated monthly income by totaling actual amounts of income received in prior 3 months and divide by 3. [Exclude $30 per quarter.]

MS 2430 OTHER EARNED INCOME

[A. Other earned income may be accumulated annual leave and severance pay, cash benefits directly related to employment or payments with taxes withheld which are received under the Senior Community Service Employment Program (SCSEP) as authorized by Title V of the Older Americans Act, P.L. 100-175.

Organizations that receive Title V funds are:

1. Green Thumb;
2. National Council on Aging;
3. National Council of Senior Citizens;
4. American Association of Retired Persons;
5. U.S. Forest Service;
6. National Association for Spanish Speaking Elderly;
7. National Urban League; and
8. National Council on Black Aging.

B.] VERIFICATION. Check or check stubs, employer statements or contact.

[C.] CONSIDERATION. Consider as continuing income.

MS 2440 SEASONAL EMPLOYMENT

Seasonal employment is income from employment during a limited period each year.

A. VERIFICATION.

1. Pay stubs.

2. Employer contact.

3. Current income tax return.

4. Records maintained by individual.

B. CONSIDERATION.

1. Count anticipated earnings or actual earnings received in the month.

2. If employment has terminated before action can be effective, do not consider this income.

3. Spot check next year before anticipated seasonal employment.

MS 2450 SELF-EMPLOYMENT

Self-employment income is income derived from farming, small business enterprise, rental, roomers/boarders, etc. where taxes are NOT withheld prior to receipt of pay.

A. VERIFICATION. Records maintained by individual, statement from tenant, current income tax return, copy of lease agreement or other records.

B. CONSIDERATION.

1. ALWAYS annualize farm income.

2. Annualize nonfarm self-employment income and expenses if Individual Income Tax Return reports self-employment income.

3. When nonfarm self-employment income is not filed on Individual Income Tax Return, average previous 3 months actual income and expenses.

4. To determine profit, deduct work expenses directly related to producing the goods or services and without which the goods or services could not be produced.

C. FARM/SELF-EMPLOYMENT INCOME is considered earned income if derived from active physical engagement or managerial responsibilities in farming/self-employment. In such instances, it is subject to earnings deductions.

1. If farming/self-employment activity is done by one or more family members, prorate to determine individual family member's share from profit.

2. If farming/self-employment arrangements have changed, use anticipated income from the new arrangement.

3. If the individual has never farmed or been self-employed, base anticipated income on the previous year's crop/self-employment activity for the particular farm/self-employment.

4. If farming/self-employment activities have been discontinued, consider no income.

5. In cases of divided ownership of farm/self-employment, divide profit between the owners, unless by mutual consent entire proceeds are available to the individual.

6. [If SSA considers all farm/self-employment income available to an SSI individual, do not enter income from this source in the MA

case.] If SSA considers only part of the farm/self-employment income available, consider appropriate shares available in the MA case.

7. Allowable deductions are:

   a. Wages paid to employees;
   b. Rent or interest on a mortgage and taxes, as appropriate, but only if the enterprise is carried on from a site other than the home;
   c. Interest payments only on the purchase of capital assets, equipment, etc.;
   d. Cost of stock offered for resale;
   e. Cost of materials and supplies including seeds, feed, crop insurance, fertilizer, and utilities required to carry on the enterprise;
   f. Travel expenses directly attributable to the operation of the business enterprise, mileage deduction equivalent to the rate for state employees, if the person uses their own vehicle;
   g. Other nonpersonal items directly related to producing the goods or services;
   h. Repairs or maintenance of equipment and property; and
   i. Management fees incurred in managing property, including management fees charged by a relative.

8. DO NOT ALLOW the following deductions:

   a. Personal work or business expenses, such as, taxes, FICA, lunches, personal transportation, entertainment expenses, etc.;
   b. Amounts claimed for depreciation, prior losses or loss from one business to another;
   c. Purchase of capital equipment;
   d. Payments on principal for the purchase of property, durable goods, capital assets, equipment, etc.; and
   e. Improvements, such as paving a drive, new roof, putting up a fence, etc.

D. RENTAL/BOARDER income is considered earned income if the individual personally collects the rent, makes or supervises repairs or gives other services in relation to the property. Consider profit from rental of property owned or being purchased by the individual.

1. The total amount of allowable deductions may be either prorated or annualized to offset income. Allow the deduction to the advantage of the individual.

   a. The total amount of expenses may be averaged over a timeframe which is less than or greater than 12 months if necessary to allow the whole deduction.
   b. A spot check is required to ensure the deduction is removed once the total amount of the allowable deduction has been used.

2. From rental income of property, other than a home occupied by the individual, deduct the following:

   a. Property taxes, state and local taxes on rental property;
   b. Interest on mortgages, debts, property improvement loans for rental property;
   c. Insurance on property;
   d. Repairs or maintenance to keep rental property in good operating condition; and
   e. Expenses for managing the property.

   If the home is not occupied and not being rented, do not allow deductions to offset income.

3. For roomer or rental income from renting or subrenting a portion of the home occupied by the individual, determine deductions as follows:

   a. Deduct a fraction of the expenses equal to the fraction of the home rented, e.g., if 2 rooms of a 6 room house are rented, then 1/3 of the expenses are used in calculating rental deductions. Do not use halls, baths, etc., in determining the number of rooms.
   b. Determine the total cost of repairs or maintenance of the home, the home's utilities, property insurance, property taxes and interest on mortgage, if any. Multiply the monthly expenses by the fraction of the home rented to obtain the rental deduction.

      EXAMPLE:

Interest on mortgage	$1,200
Utilities	800
Property Insurance	300
Property Taxes	100
	$2,400 divided by 12 = $200 Monthly Cost

      $200 x 1/3 = $66.67 monthly rental deduction

4. For boarder only, deduct an amount equal to the food stamp allotment for the number of boarders. EXAMPLE: There are 3 boarders, the deduction equals the food stamp allotment of a 3 person household.

5. For roomer/boarder:

   a. Deduct an amount equal to food stamp allotment. If roomer/boarder is a member of the food stamp case, do not allow a food deduction.
   b. Rental deduction is computed the same as for a roomer. Do not compute if the roomer/boarder payment is the same as, or less than, the food stamp allotment.

MS 2460* WAGES

Wages are salaries from full-time or part-time employment where taxes are withheld prior to receipt of pay. Odd jobs, occasional, seasonal or contract employment are included.

A. VERIFICATION.

1. Pay stubs.
2. Employer statement either written or verbal.

Spot check within 1 week of anticipated receipt of first check, not to exceed 6 weeks after recipient reports new employment.

B. CONSIDERATION.

1. To determine the estimated monthly income, verify and use income from all pay periods in the prior month. If the prior month's income does not represent the ongoing situation, due to, sick leave, holiday plant closing, etc., use information available which best indicates the ongoing income.
2. Garnishments on salary ARE NOT deducted.
3. For individuals obtaining employment who have not received a pay check or do not have a full month's pay stubs, consider the anticipated earnings. Compute anticipated earnings based on the hourly rate and the estimated number of hours to be worked during a pay period with appropriate deductions. When the first full month's pay is verified by check stubs provided by individual or employer contact, recompute using actual earnings and appropriate deductions.

MS 2465 NONRECURRING LUMP SUM

A NONRECURRING LUMP SUM is money received at one time which is normally considered as income, such as, accumulated back-payments from UI, Worker's Compensation back-payments, back-pay from employment, EIC portion of a federal tax refund, monies withdrawn from IRAs, KEOGH plans, deferred compensation, tax deferred retirement plans, and other tax deferred assets, etc.

[Income from the sale of property, including initial down payment from a land contract sale, IS NOT a non-recurring lump sum but a change in type of resource.]

A. EXCEPTIONS. If the lump sum is from a federal or state income tax refund, it is a countable resource, not countable income, since it was counted or would have been counted as income in the past. If the lump sum is from accumulated annual leave or severance pay it is considered continuing earned income, not a nonrecurring lump sum, in the first possible month following the month received.

Lump sums from accumulated back-payments of SSI and/or RSDI are excluded as a resource for the first 6 months following the month of receipt. If the back-payment includes current benefits for the month in which the payment is received, deduct that amount prior to determining the excluded resource amount. Set up a spot check for the end of the 6 month period. Consider any remaining amount as a countable resource.

[Tax rebates are considered as excluded in the month of receipt and the following two months. Any proceeds from the rebates after the third month shall be considered a countable resource.]

B. VERIFY the lump sum amount by:

1. Statement from lawyer/trustee;
2. Award letter; or
3. Check.

C. CONSIDERATION. Lump sum payments, other than accumulated back payments of SSI and/or RSDI or tax rebates, are considered as unearned income in the month received, if possible. After the month of receipt, consider any portion remaining as a resource.

Transfer of resources policy also applies to assets, such as lump sum payments, not yet considered as a resource. Consider lump sum payments given away in the month of receipt a transfer of resources for individuals receiving LTC, HCBS, SCL or ICF/MR/DD.

EXAMPLE #1: An active LTC recipient receives and also gives away a lump sum back-payment from VA in May and reports receipt in the

same month. Since MA benefits would already be issued for May, the lump sum cannot be considered as income in the month of receipt. However, any amount remaining as of June would be considered as a resource. Also consider the lump sum payment given away in the month of receipt according to transfer of resources policy, outlined in MS 2050.

EXAMPLE #2: A SCL applicant receives and also gives away a lump sum back-payment from VA in the month of application and reports the lump sum before the case is processed. Consider the lump sum as income in the application month, and any remaining amount as a resource in subsequent months. Any portion of the lump sum amount remaining available to the applicant is considered a resource. Also consider the lump sum payment given away in the month of receipt according to transfer of resources policy, outlined in MS 2050.

MS 2470 EXCLUDED INCOME

Excluded income is income received but not considered in determining financial eligibility.

A. K-TAP payments.

B. SSI benefits and any other income of SSI beneficiaries if the beneficiary is:

1. An individual in a Family Related MA family or

2. The spouse of an individual applying for or receiving LTC, Pass Through or Aged, Blind, or Disabled non-SSP.

C. Non-emergency medical transportation payments.

D. Home Energy Assistance payments.

E. Any payment made for child foster care, adult foster care, subsidized adoptions or personal care assistance.

F. In kind income.

G. Home produce for household consumption.

H. Payments on behalf of or for the benefit of an individual, other than the SSP individual made DIRECTLY to a doctor, pharmacist, landlord, utility company, etc., by another individual.

I. Replacement of income already received. If income is lost, stolen or destroyed and the individual receives a replacement, the replacement is not income.

J. Cash, including interest accruing from cash, or in kind item received to repair or replace a damaged, lost or stolen excluded resource. Allow 9 months to repair or replace the excluded item, and an additional 9 months when the individual shows good cause.

K. Educational grants and scholarships obtained and used under conditions that preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill and educational payments made under the Carl D. Perkins Vocational and Applied Technology Educational Act Amendments of 1990 made available for attendance costs. Attendance costs are described as:

1. Tuition and fees normally assessed a student carrying the same academic workload required of all students in the same course of study as determined by the institution, including cost for rental or purchase of any equipment, materials or supplies; and

2. An allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

L. Principal of loans, including educational loans. Verify the loan by a commercial loan contract, form PAFS-73, Verification of Contributions – Loans – Roomer/Boarder Payments, or form PAFS-124, Student Income Verification Form. When verification is received, exclude the loan amount. If verification is not received, consider the amount as a contribution.

M. 20% RSDI increase received in August, 1972, if the individual was a money payment recipient.

N. For Nursing Facility and Waiver cases, exclude Veterans Administration reduced pension payments of $90 or less. Exclude the first $90 of all other VA pensions.

O. Highway relocation assistance.

P. Urban renewal assistance.

Q. Federal disaster assistance and State disaster grants.

R. One-third of child support payment from absent parent when received by eligible blind or disabled child.

S. The Earned Income Credit (EIC).

T. Payments by credit life or credit disability insurance.

U. Experimental housing allowance program payment made under annual contributions contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended, and HUD Section 8 payments or existing housing under Title 24, Part 882.

V. Reparation payments from the Republic of Germany.

W. Public Law benefits and payments to:

1. Elderly persons under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;

2. Elderly persons receiving unearned income or payments with no taxes withheld under the Senior Community Service Employment Program (SCSEP) as authorized by Title V, of the Older Americans Act P.L. 100-175;

   Organizations that receive Title V funds are:
   a. Green Thumb;
   b. National Council on Aging;
   c. National Council of Senior Citizens;
   d. American Association of Retired Persons;
   e. U.S. Forest Service;

f. National Association for Spanish Speaking Elderly;
g. National Urban League; and
h. National Council on Black Aging.

3. VISTA volunteers under Title I of PL 93-113 pursuant to Section 404(g);

4. Individual volunteers for supportive services or reimbursement of out-of-pocket expenses while serving as foster grandparents, senior health aides, or senior companions and to persons serving in Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE), and any other programs under Titles II and III, pursuant to Section 418 of PL 93-113; and

5. Indian tribe members under PL 92-524, PL 93-134, PL 94-114 pursuant to Section 5 effective October 17, 1975 or PL 94-540.

X. 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.

Y. VA Aid and Attendance Allowance (VA A&A), VA Unreimbursed Medical Expenses (VA UME), and VA Compensated Work Therapy (VA CWT).

Z. Income of the ineligible spouse/parent, if less than or equal to $50, when determining MA or spend down eligibility for the aged, blind or disabled spouse/parent.

AA. Payments made from the Agent Orange Settlement Fund issued by Aetna Life and Casualty to veterans or their survivors in accordance with Public Law 101-201 retroactive to January 1, 1989.

BB. Victim compensation payments received from a fund established by a state to aid victims of crime.

CC. Interest on burial reserves if allowed to accrue.

DD. Income included in a Plan for Achieving Self-Support (PASS).

EE. Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

FF. All student work study income, educational grants and loans to any undergraduate made or insured under any program administered by the U.S. Commissioner of Education or under the Bureau of Indian Affairs student assistance programs.

GG. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.

HH. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using SSI standards. This income is NOT excluded by SSA, so these recipients should not be SSI eligible. Enter these applications on KAMES as usual. If the hemophiliac is income ineligible for some other reason, pend the application and contact MSBB through your Regional Program Specialist for further instructions.

II. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.

JJ. Payments made from the Crime Victims Funds.

KK. Section 401 of the Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-149, provided for certain benefits for individuals with covered birth defects during the Vietnam era. There is no age limit for recipients of these benefits. These individuals will receive the benefits until they die. The amount of these Vietnam Veterans benefits are considered as excluded income and resources.

LL. Thirty dollars per quarter of infrequent/irregular earned income.

MM. Sixty dollars per quarter of infrequent/irregular unearned income.

NN. The earned income of a blind or disabled child who is a student in regular school attendance.

OO. All interest and dividend income of recipients, community spouses and parents of disabled children. This income is excluded in both Medicaid eligibility and LTC vendor payment determinations.

PP. Tobacco settlement monies are excluded for the month of receipt and the following month.

[QQ. For Adult Medical Assistance, military combat pay is excluded.]

MS 2480 DEDUCTIONS

Deductions are subtracted from income to allow for specific expenses or allowances.

A. VERIFICATION. Verify related work expenses by viewing and documenting receipts, checks, etc.

B. CONSIDERATION. Deduct the following items in the following order.

1. The $20 general exclusion, first to unearned income, with the balance, if any, applied to earned income.

2. $65 from earned income.

3. The Impairment Related Work Expense (IRWE) is allowed for individuals who are disabled, for any amount expended for specific items or services which enable an individual to work.

   Deduct the following IRWE items and/or services only if not included in a PASS. Allow deductions in the month incurred, or divide over a 12 month period, beginning with the month of the first payment, whichever is more beneficial to the individual.

   a. Payment for attendant care services such as assistance in traveling to and from work, and assistance with personal functions at home in preparing for work such as eating, personal hygiene, dressing, etc.
   b. Payment for medical devices such as durable medical equipment such as wheelchairs, canes, crutches, inhalators, pacemakers, etc.
   c. Payment for prosthetic devices such as, but not limited to, artificial arm, leg, etc.
   d. Payment for work-related equipment for specialized use such as one-handed typewriter, telecommunication devices for the deaf, etc.
   e. Payment for residential modifications that aid an individual to work such as the installment of a ramp or enlargement of a doorway for a wheelchair.
   f. Payment for nonmedical appliances and equipment essential for the control of a disabling condition that are medically verified as necessary, such as an electric air cleaner for an individual with a respiratory disease, etc.
   g. Payment for drugs and medical services to control an individual's impairment, such as anticonvulsant drugs or anticonvulsant blood test monitoring for epilepsy, medications for mental disorders, immunosuppressive medications, etc.

h. Payment for medical supplies and services which enable a person to work such as incontinence pads, catheters, irrigating kits, physical therapy, speech therapy, etc.

i. Payment for transportation costs associated with vehicle structural or operational modifications and payment for use of driver assistance.

j. Payment for installing, maintaining, and repairing impairment related items.

A blind individual may receive either the Blind Work Expense (BWE) or the Impairment Related Work Expense (IRWE), but can not concurrently receive both.

4. 1/2 the remaining earned income.

5. The Blind Work Expense (BWE) is any expense incurred as the result of working. Deductions for employed blind individuals may include, but are not limited to, transportation, lunches, federal, state and local income taxes, F.I.C.A., union dues, prosthetics, special equipment, job related training, etc. Do not allow usual living expenses, rent, food, etc., and educational expenses which are not job related. The special deductions are applicable to both the individual and responsible relative, only if not included in a PASS.

6. Plan for Achieving Self-Support (PASS). Work-related allowances or expenses included in an approved PASS. See MS 2490.

MS 2490* PLAN FOR ACHIEVING SELF-SUPPORT (PASS)

A PASS is an income and/or resource exclusion that allows a blind or disabled applicant/recipient who does not have the capability for self-support, to set aside income and/or resources for a work goal such as education, vocational training, or starting a business.

Individuals can set aside funds:

A. To pay tuition;

B. To purchase work-related equipment, such as a computer;

C. To pay for transportation; or

D. To pay for certain supported employment services, operated by government agencies, private agencies or employers, where an individual with a disability is:

1. Placed in a job;
2. Receives job coaching for a period of time; and
3. Receives ongoing support to enable the individual to perform the job.

A PASS can enable an individual to maintain or establish SSI eligibility when the individual would otherwise be ineligible due to excess income and/or resources. A PASS may decrease an individual's net income used to determine MA eligibility and vendor payment, when the income considered in the PASS is excluded.

MS 2500* PASS EXCLUSION

Allow PASS exclusions in the MA income and/or resource eligibility determination and in the patient liability determination for a blind or disabled MA applicant/recipient and/or an individual age 65 or older who received MA prior to the month of their 65th birthday.

If a blind and/or disabled MA applicant/recipient expresses an interest in developing a PASS, refer the individual to local vocational rehabilitation agencies, local comprehensive care centers, the Veterans Administration, and United Cerebral Palsy, etc. for assistance in completing a PASS.

MS 2510* PASS REQUIREMENTS

Allow only one PASS per occupational objective. A PASS must be in writing and include the following:

A. MA application date;

B. Beginning date and estimated completion date of the PASS activity;

C. Occupational objective clearly stated;

D. Planned expenditures;

E. Income and/or resources now owned and used to achieve the objective;

F. Brief description of the individual's impairment; and

G. Planned expenditures necessary to achieve the occupational objective, e.g. equipment to establish a business, tuition/books required for a training program, transportation, etc.

MS 2520 PASS DETERMINATION

[Forward a Plan for Achieving Self-Support (PASS) to MSBB for DMS review and subsequent approval/denial of the PASS.] See MS 2500.

A. If the PASS is approved, DMS determines the monthly amount of the PASS exclusion and the effective months the PASS exclusion is allowed.

1. The PASS exclusion is allowed for an initial period of up to 18 months.
2. The PASS may be extended for an additional 18 months, if necessary, to complete the occupational objective of the PASS.
3. For a PASS involving an educational or training program, an additional 12-month extension is allowed.

B. DMS approves a PASS for retroactive month(s) if the individual is already involved in the elements, e.g. saving money, making expenditures etc., which will meet all of the PASS requirements or the individual has an existing PASS approved by SSI previously.

MS 2530 PASS AMENDMENTS

Amendments to an existing PASS must be approved by DMS to be effective. [If a change is required to an existing PASS, submit the existing PASS and the amendment to MSBB for DMS approval/denial.] The following types of changes would require an amendment to an existing PASS.

A. Changes in amounts of income/resources to be designated;

B. Changes in planned expenditures; or

C. A change in scheduled attainment date for the occupation objective.

MS 2540* PASS AT RECERTIFICATION

An approved PASS must be submitted for DMS review at the time of recertification to ensure continued compliance. The following information must be forwarded in addition to the PASS in effect:

A. Documentation of any changes that have occurred since the implementation of the PASS or previous reviews of the PASS, such as, quit job, exhausted resources, etc.;

B. Documentation of the individual's progress towards the occupational objective. This information is to be secured from the agency assisting the individual with the PASS; if unavailable, this information should be obtained from the individual; and

C. Documentation of expenditures under the PASS, last three months' bank statements, cancelled checks to vendors and/or providers, etc.

MS 2550* TERMINATING A PASS

The last effective month for a PASS is the earliest month in which one of the following events occurs.

A. The individual is no longer in substantial compliance with their PASS;

B. The individual voluntarily abandons their PASS;

C. The specified time limit expires and no extension is available; or

D. The occupational objective outlined in the PASS is reached.

MS 2560 TECHNICALLY ELIGIBLE APPLICANT

Do the following to determine the income eligibility of a technically eligible applicant.

A. Determine gross unearned income

B. Deduct $20 general exclusion. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

C. Determine gross earned income.

D. Allow appropriate deductions according to MS 2480.

E. Combine countable earned and unearned income.

F. Deduct the MA Scale for 1.

[G.] If there is no excess, the individual is MA eligible.

[H.] If the countable income exceeds the MA scale, determine spend down eligibility.

MS 2570 TECHNICALLY ELIGIBLE APPLICANT AND SPOUSE

Use the following income computation steps to determine MA eligibility of the aged, blind, or disabled individual with a technically eligible spouse.

A. Combine unearned income of the couple.

B. Deduct one $20 general exclusion. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

C. Combine earned income of the couple.

D. Allow appropriate deductions according to MS 2480.

E. Combine countable unearned and earned income.

F. If total countable income is less than or equal to the MA Scale for 2, both are eligible.

G. If total countable income is more than the MA Scale for 2, multiply the excess by 3 to determine the quarterly excess for spend down eligibility.

MS 2580 TECHNICALLY ELIGIBLE APPLICANT WITH TECHNICALLY INELIGIBLE SPOUSE

If the spouse is technically ineligible, compute the amount of income, if any, to be deemed from the ineligible spouse to the applicant. Additionally, when determining spend down eligibility of the applicant with a technically ineligible spouse, compute two budgets. Use the result of the higher budget to compute the applicant's quarterly excess amount.

A. If the ineligible spouse's gross income is:

1. [Less than or equal to $50, deem no income to the applicant. Follow MS 2480 to determine income eligibility.]

2. More than $50, proceed to item B.

B. Compute the income of the couple as follows:

1. Determine gross unearned income of the applicant.

2. Add gross unearned income of the ineligible spouse.

3. Deduct $20 general exclusion. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

4. Determine gross earned income of the applicant.

5. Add gross earned income of the ineligible spouse.

6. Deduct appropriate deductions according to MS 2480.

7. Add countable unearned and earned income (result of items 3 and 6).

8. Deduct the MA Scale for one.

a. If there is no excess, the individual is MA eligible.

b. If there is excess income, determine spenddown eligibility for the applicant. Use medical expenses of the ineligible spouse to reduce the excess income of the applicant. Follow regular spend down procedures to determine medical expenses used to reduce the excess income of the aged, blind, or disabled individual.

MS 2600 COMPANION CASES INTRODUCTION

COMPANION CASES are those in which more than one member of a family is an applicant for or recipient of MA and relative responsibility exists: husband and wife or parent and child.

For purposes of technical eligibility, case number assignment and authorization, consider companion cases individually.

MS 2610 BOTH INDIVIDUAL AND SPOUSE ARE TECHNICALLY ELIGIBLE

A computation is required to determine the amount of income to be considered when both the applicant and his/her spouse are technically eligible.

A. Combine unearned income of the couple.

B. Deduct one $20 general exclusion.

C. Combine earned income of the couple. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

D. Deduct one $65 and 1/2 the remainder deduction for the couple. Deduct other earned income deductions for each spouse, if applicable.

E. Combine countable unearned and earned income.

F. If total countable income is less than the MA Scale for 2, both are eligible.

G. If total countable income is more than the MA Scale for 2, use spend down procedures.

H. If one of the technically eligible spouses becomes institutionalized during a spend down quarter, the spend down liability for the community spouse remains the same through the remainder of the established quarter. If the community spouse reapplies for a subsequent quarter, consider only the community spouse's gross income plus the amount actually made available to the community spouse from the institutionalized spouse. Compare income to MA family size of 1.

   Compute the institutionalized spouse's eligibility and patient liability using policy in MS 3540.

MS 2620 TECHNICALLY ELIGIBLE INDIVIDUAL WITH TECHNICALLY INELIGIBLE SPOUSE

[A computation is required to determine the amount of income to be deemed from the ineligible spouse to the aged, blind, or disabled spouse.

Two budgets are computed. The result of the higher budget is used for the aged, blind, or disabled spouse's spend down amount.]

A. Step I - Technically ineligible spouse:

1. [If the ineligible spouse's gross income is less than or equal to $50, no income is deemed to the aged, blind, or disabled spouse. Use countable income computed in Step II to determine the aged, blind, or disabled spouse's ongoing MA eligibility or spend down liability.] Do not complete Step III.

2. If the ineligible spouse's income is greater than $50, complete Step II and Step III.

B. Step II - Aged, blind, or disabled technically eligible individual:

1. Determine gross unearned income of the aged, blind, or disabled individual.

2. Deduct $20 general exclusion.

3. Determine gross earned income of the aged, blind, or disabled individual. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

4. Deduct one $65 and 1/2 the remainder and other earned income deductions as appropriate.

5. Combine countable unearned and earned income.

6. Deduct MA Scale for 1.

7. If the result is $0, and there is no spousal income to consider, the aged, blind, or disabled individual is MA eligible. Otherwise proceed to Step III.

C. [Step III - For an aged, blind, or disabled but technically eligible individual and technically ineligible spouse:]

1. Determine gross unearned income of aged, blind, or disabled individual.

2. Add gross unearned income of ineligible spouse.

3. Deduct the $20 general exclusion.
4. Determine gross earned income of aged, blind, or disabled individual.

5. Add gross earned income of ineligible spouse. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.

6. Deduct one $65 and 1/2 the remainder for the couple, as appropriate. Deduct other earned income deductions for each spouse, if applicable.

7. Add the results from items 3 and 6. This is total countable income.

8. Deduct the MA Scale for 1.

9. If the result is $0, in Step II and Step III, the aged, blind, or disabled individual is MA eligible.

   If the result is greater than $0, in Step II or Step III the result reflects a potential spend down amount for the aged, blind, or disabled individual. Proceed to Step IV.

D. Step IV - Spend down comparison:

1. Compare the spend down amount computed in Step II to the spend down amount computed in Step III.

2. Use the greater amount to determine spend down eligibility for the aged, blind, or disabled individual.

3. Follow regular spend down procedures to determine medical expenses used to reduce the excess income of the aged, blind, or disabled individual.

MS 2630 [AGED, BLIND OR DISABLED MA WITH A FAMILY MA OR AFDC RELATED MA COMPANION CASE]

A step-by-step computation is required to determine the amount of income to be deemed from the non-aged, blind or disabled individual to the aged, blind or disabled individual. Use form PA-1B, Companion Cases Work Sheet for computations.

[Determine Family MA or AFDC Related MA eligibility for the entire family using calculations in Step I. If there is excess income, eligibility is determined for the aged, blind, or disabled individual using deeming procedures, Step II thru Step V.]

Two budgets are computed. The result of the higher budget is used for the aged, blind, or disabled individual's spend down amount.

A. DEFINITIONS:

1. A family unit is comprised of children and the individual who is not aged, blind, or disabled.
2. An entire family is comprised of the family unit and the aged, blind, or disabled individual.

B. EXCLUSIONS

Do not include the following in family unit or entire family:

1. SSI recipients; or
2. Technically excluded children.

C. INCOME COMPUTATIONS

1. [Step I – Family MA or AFDC Related MA Case: Determination of Excess for Entire Family;]
   a. Determine earned income of the entire family.
   b. Allow a $90 work expense deduction for each member of the entire family with earnings.
   c. Determine unearned income of the entire family.
   d. Combine countable earned and unearned income of the entire family.
   e. Deduct the appropriate MA scale for the entire family.
   f. If the result is $0, entire family is MA eligible.
   g. If the result is greater than $0, multiply amount by three to determine quarterly excess. Proceed to Step II and determine eligibility for the aged, blind, or disabled individual using the following deeming procedures.

2. Step II - Allocation of Income from Ineligible Spouse to Dependent Child/Consideration of Ineligible Spouse's Income:

a. Determine gross unearned income of ineligible spouse.
b. Deduct the difference between the child's income and 1/2 MA Scale for 1 for each child. Allocate sufficient income from the ineligible spouse to bring each child's countable income up to 1/2 MA Scale for 1. DO NOT allocate income from the ineligible spouse to any child whose countable income exceeds 1/2 MA Scale for 1. If unearned income is less than amount to be allocated to the child, deduct the remainder of the allocation from the earned income.
c. The result is the ineligible spouse's remaining unearned income.
d. Determine gross earned income of ineligible spouse.
e. Deduct the remainder of the child allocation amount, if any, from item b. for each child.
f. The result is the ineligible spouse's remaining earned income.
g. Add the amounts from items c and f. This is the ineligible spouse's total income.

If the ineligible spouse's income is equal to or less than $50, no income is deemed to the aged, blind or disabled individual, proceed to Step IV.

If the ineligible spouse's income is greater than $50, proceed to Step III.

3. Step III - Aged, Blind or Disabled Individual with Ineligible Spouse:
   a. Determine gross unearned income of aged, blind or disabled individual.
   b. Add remaining unearned income of ineligible spouse from Step II, item c.
   c. The result is total countable unearned income.
   d. Deduct the $20.00 general exclusion.
   e. Determine gross earned income of aged, blind or disabled individual.
   f. Add remaining earned income of ineligible spouse from Step II, item f. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.
   g. The result is total earned income.
   h. Deduct one $65 and 1/2 the remainder deduction for the couple. Deduct other earned income deductions for each spouse, if applicable.
   i. The result is total countable earned income.
   j. Add the amounts from items d and i. This is total countable income.
   k. Deduct MA Scale for one.
   l. Compute the result and proceed to Step IV.

4. Step IV - Aged, Blind or Disabled Individual
   a. Determine gross unearned income of aged, blind or disabled individual.
   b. Deduct the $20 general exclusion.

c. The result is total countable unearned income.
d. Determine gross earned income of aged, blind or disabled individual.
e. If unearned income is less than $20, deduct the remainder of the general exclusion from earned income.
f. Deduct $65 and 1/2 the remainder and other earned income deductions as appropriate from earned income.
g. The result is total countable earned income.
h. Add amounts in items c and g. This is the aged, blind or disabled individual's total countable income.
i. Deduct the MA Scale for 1.
j. If the result in Step III and Step IV is $0, the aged, blind or disabled individual is income eligible.
k. If the result is greater than $0, in Step III or Step IV the result is the potential spend down amount for the aged, blind or disabled individual. Proceed to Step V.

5. Step V - Spend Down Comparison - Quarterly Excess
   a. Compare the spend down amount computed in Step III to the spend down amount computed in Step IV.
   b. Use the greater amount to determine spend down eligibility for the aged, blind or disabled individual.
   c. Determine eligibility for the family unit according to regular spend down procedures. Do not remove the aged, blind or disabled individual's income from the family unit's case, even though that individual may not be included in the case.

6. Step VI
   a. Compare the spend down amount computed in Step I to the spend down amount computed in Step V.
   b. Allow the individual to make the decision whether to have combined or separate cases since it is possible that one or more family members may be disadvantaged depending on the family members included in the case.

MS 2650 INTRODUCTION TO SPEND DOWN

Spend down provides time-limited Medicaid to an individual or family who meets all resource and technical requirements of eligibility but has income in excess of the MA Scale for the family size. Eligibility is determined on a quarterly basis using the month of application and two subsequent months or some or all of the three months prior to the month of application. Refer to Vol. VI, MS 4270 for instructions on completing MSE referrals for spend down cases.

A. Spend down Medicaid eligibility begins on the day an individual meets their spend down amount; i.e., the day medical expenses equal or exceed the excess income amount. Workers are to advise recipients that the spend down obligated amount is met with medical bills incurred by any case member during the spend time period. The household's obligated amount is met with the first providers who bill. Medical expenses to be used are those incurred during the quarter or currently owed from a prior time period that were not previously covered by spend down or regular Medicaid.

For example: The spend down obligation amount is $100.00 for the spend-down period of 3/23/07 through 5/31/07. Any bills prior to that date are the responsibility of the household along with $100.00 during the time period listed. If the first bill received by DMS was for services on 4/6/07 for $50.00, the amount of that bill is deducted from the obligated amount of $100.00. The next bill received by DMS is for $25.00 for services on 3/23/07, and a bill submitted the same day to DMS for $25.00 for services on 5/1/07; these are deducted from the obligated amount, and the client has now met the spend down obligated amount. Any bills that are submitted after this would be paid by DMS as long as they are within the spend down period of 3/23/07 through 5/31/07.

B. Notices for spend downs show the case obligation amount rather than the individual's obligation amount. The obligation amount is the amount owed during the spend down time period.

C. When processing J, K, or M spend down for a couple (husband & wife), it is necessary for the worker to enter 1 cent as a bill for a month in which one member of the couple does not have medical expenses.

For example: "J" case spend down for prior 2 months only with application taken in August. Husband has medical bills for May only, and the wife has medical bills for June. KAMES correctly approves a 2-month spend down for the husband, but for the wife's spend down to process correctly, worker will need to enter a 1 cent bill for May.

D. For spend downs processed by special circumstance, enter the household's obligated amount by each member of the case.

For example: Household's spend down obligation amount is $100.00. For each member listed, enter $100.00 for their spend down obligation amount.

Tom	# Jones	xxx xx xxxx	07021989	100.00
Shirley	# Jones	000 00 0000	10101989	100.00
Cutie	# Jones	111 11 1111	06062007	100.00

Workers will receive an error message, “SPD LIAB AMTS MUST BE EQUAL”, if the spend down obligated amount is not entered as listed above.

E. If health insurance coverage exists other than Medicaid, that insurance provider must first determine their payment prior to approving the spend down application. Only the amount the individual is responsible to pay can be considered toward the spend down excess. Because of the time involved in determining the insured's liability from the other insurance, Medicaid may not be approved, in some situations, until the eligible quarter has expired. Inform applicants of this possibility.

F. When quarterly excess income equals verified recognized incurred medical expenses, paid or owed, the application may be approved on a time limited basis. Effective time of coverage is on a specific day to a specific day. See MS 2710.

G. [A spend down application is approved as soon as possible, but not to exceed 30 days from the date of application. If a spend down application cannot be processed within 30 days due to non-receipt of medical bills or if it is the beginning of the spend down quarter and income obligation has not been met, the application is to be held pending receipt of incurred expenses. Refer to Volume I, MS 0151, for cases pending over 30 days with good cause. When the verification is received, the case must be worked WITHIN 5 WORK DAYS from receipt of the required verification.]

H. Workers are to advise recipients that they need to wait until they receive a statement from the provider that DMS has been billed, and the bill was denied as it was used to meet 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

MS 2655 DETERMINING THE FAMILY SIZE

The total month's countable income is compared to the MA Scale for the appropriate family size.

A. Compare the income of families with children who meet spend down requirements to the MA Scale for the family size in Volume IV, MS 3450 to determine the excess income that must be spent before Medicaid will begin to make payment of countable medical bills.

B. Compare the income of families with children and a parent who is aged, blind or disabled to the MA scale according to MS 2660. If the aged, blind or disabled parent becomes institutionalized (LTC or Waiver placement), remove that parent from the household size at the end of the established quarter. Consider income or resources given to the community spouse in the resource and income calculation of the remaining family members, if MA eligibility exists. Vendor payment is not paid in spend down.

C. Compare the income of an individual or a couple to the MA Scale for one, if an individual or their spouse is technically ineligible, and to the MA Scale for two when the spouse is technically eligible. For couples, when one spouse is institutionalized (LTC or Waiver placement), consider the other spouse as a household of one beginning the month after the month of admission to the level of care. Consideration of the couple's income, when in PCH or FCH, is also computed as above.

MS 2660 COMPANION CASE SPEND DOWN

[Use these procedures only when a parent is aged, blind or disabled. An applicant can choose to be in the Family Related MA case or in a separate aged, blind or disabled spend down. If the aged, blind or disabled spend down is chosen, establish a separate Family Related MA case for other family members, if eligible.]

A. One case may be a spend down and the other case may be eligible on a continuing basis.

B. Both cases may have an excess but have different amounts.

C. The family unit's excess may be spent down by the children and both parents.

D. [The excess in the aged, blind or disabled MA case may be spent down by both parents.

E. When the family unit case has been spent down and the child in that case incurs an additional medical expense, not covered by Medicaid, follow regular spend down procedures to determine medical expenses used to reduce the excess in the aged, blind or disabled MA case.

F. When the entire family is included in the Family Related MA case and the aged, blind or disabled spouse becomes institutionalized, or goes into PCH or FCH, the Family Related MA spend down case remains the same through the remainder of the established quarter. If the spouse who is not aged, blind or disabled reapplies for a subsequent quarter for the family unit, consider the community spouse and children's gross income plus the amounts actually made available from the institutionalized spouse's income for the community spouse and family allowance. Exclude the institutionalized spouse when determining the MA family size for the Family Related MA case.] Follow regular spend down procedures to determine medical expenses used to meet the excess on the subsequent quarter.

Compute the institutionalized spouse's eligibility and patient liability using policy in MS 3450-3499.

MS 2670 ESTABLISHING THE QUARTER

Quarters to which medical expenses can be applied are either:

A. Prior Quarter - the three months before the application month.

Spend down approvals for the prior three months may be for one, two or all three months if technically and resource eligible and medical expenses are incurred.

An applicant may elect to have eligibility established for only one or two months, if it is to his or her advantage, even if there are medical bills in the other months.

For the three-month period prior to the application month, regular MA coverage is authorized in any month technical and financial eligibility is met and medical expenses are incurred.

[Residing in Managed Care county does not apply to Spend Downs.]

1. If the applicant meets technical AND financial eligibility in any of the three months prior to the application month, regular MA coverage MUST be approved for those months.

   a. Check each month separately to determine if the applicant is eligible for regular MA in any of the prior three months.
   b. If eligible for regular MA in the first month but not in the second or third, approve as regular MA for the first month and determine spend down for the second and third.
   c. If eligible for regular MA for the third month but not for the first and second, approve as regular MA for the third month and determine spend down for the first and second months.
   d. If eligible for regular MA for the second month but not for the first nor third months, approve for regular MA for the second month and compute the first and third months separately for spend down.

2. If the applicant does NOT meet income eligibility for any of the three months prior to the application month but meets technical and resource eligibility and has incurred medical expenses for one, two or three months, spend down determination is made.

   a. If the applicant meets technical and resource eligibility and has incurred medical expenses for all three months, one, two or all three months may be included in the spend down determination.
   b. If technical and resource eligibility exist and medical expenses were incurred in only one of the three prior months, determine spend down eligibility for that month only considering income/deduction received in that month.

c. If technical and resource eligibility exist and medical expenses were incurred in two consecutive months in the prior quarter, determine spend down eligibility for those two months considering income/deduction received in the two months.

d. If technical and resource eligibility existed for all three of the prior months but medical expenses were incurred in the first and third months only, complete two one month spend downs.

e. If technical and resource eligibility exist only in the first and third months and medical expenses are incurred, compute spend down eligibility for each month separately.

B. Current Quarter - the month of application and the two following months.

If technical and resource eligibility are met in the current quarter, all three months must be considered in determining spend down eligibility.

The applicant must be allowed the entire quarter to meet the spend down amount.

MS 2680* QUARTERS FOR COMPANION CASE SPEND DOWN

A. Quarters for companion cases do not have to be the same for both cases;

B. When a family unit case has a later MA end date than the aged, blind, or disabled case:

1. Include the adult in the family unit case for the remainder of the quarter.

2. Request for inclusion must be made by the client.

3. The request must be no later than 3 months after the MA end date of the family unit's quarter.

MS 2690* SPEND DOWN EXCESS

Determine spend down excess as follows:

A. One-Month Spend Down

1. Compute total countable income for the month.
2. Subtract the MA Scale for the appropriate family size.
3. The result is the spend down amount.

B. Two-Month Spend Down

1. Total the two months countable income.
2. Divide by two to obtain the average one month income.
3. Subtract the MA Scale for the appropriate family size.
4. The result is the monthly excess amount.
5. Multiply the excess by two.
6. The result is the spend down amount.

C. Three-Month Spend Down

1. Total the three months countable income.
2. Divide by three to obtain the average one month income.
3. Subtract the MA Scale for the appropriate family size.
4. The result is the monthly excess.
5. Multiply the excess by three.
6. The result is the spend down amount.

MS 2700 SPEND DOWN MEDICAL EXPENSE VERIFICATION

Use the following to verify medical expenses.

A. Medical bills or statements;

B. Receipts for payment of medical expenses;

C. Medical Explanation of Benefits (EOB) which shows covered/uncovered and paid/unpaid medical expenses;

D. Health insurance statements showing amount paid;

E. Other appropriate means.

MS 2710 SPEND DOWN MEDICAL EXPENSE RESTRICTIONS

A. Do not list any expense to be paid by a third party, such as Medicare, health insurance, insurance settlement, etc.

EXCEPTIONS:

1. DO NOT hold spend down applications pending for verification of payment of medical expenses as a result of an unforeseen accident which may be covered by liability insurance owned by another party. It is the responsibility of DMS to obtain reimbursements from third party liability sources.

This procedure does not apply to health insurance policies, such as, Medicare, Blue Cross/Blue Shield, Humana, etc. and Worker's Compensation. Spend down applications are held pending verification of payment of medical expenses by these third party liability sources.

2. For persons undergoing renal dialysis treatment, do not hold spend down applications pending for Medicare Explanation of Benefits (EOB) statements, if:

a. They have Medicare but no other health insurance; and
b. The renal dialysis clinic provides a statement verifying the date of service, cost of service and the anticipated amount of Medicare reimbursement for each date of service. The difference between the Medicare billed amount and the anticipated Medicare payment amount is allowed as the spend down medical expense.

Use this statement and any other verified medical expenses not subject to Medicare reimbursement, 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 EOB.

These cases are given priority and processed as soon as the spend down liability is met. When EOBs 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 spenddown program.

B. Do not consider medical expenses for which individual is absolved from payment, that is, medical bill written off by provider as uncollectible, etc. If the medical expense is more than 90 days old, OR if the individual's responsibility for payment of the medical expense is questionable, then the appropriate provider MUST be contacted to determine whether or not the individual is liable for payment of the expense.

C. Do not consider medical bills or payment on medical bills used to obligate the liability amount for any previous spend down quarter.

EXAMPLE: During the current quarter, a individual purchased eyeglasses costing $129. The total amount was charged on the 6th day of the 1st month of the current quarter. The total amount is considered on the 6th for spend down. During the next quarter, $25 a month has been paid on the $129 charge. The $25 payments cannot be used as the entire $129 was used in the quarter the expense was incurred.

D. Unpaid medical expenses are allowed as a spend down medical expense unless B or C of this section apply.

E. For the child excluded from an K-TAP grant and for whom a separate spend down case has been established:

1. Combine income and resources of the K-TAP group and the excluded child.
2. Apply verified incurred medical expenses of the excluded child.
3. Apply uncovered verified incurred medical expenses of the responsible relative to the spend down amount.
4. Do not consider medical expenses of the K-TAP children.

F. For a blind or disabled child living at home:

1. Consider income and deductions of the parent and the blind or disabled child according to MS 1810; and

2. Apply uncovered verified incurred medical expenses of the parent, blind, or disabled child and siblings to the spend down amount.

G. All bills, statements, receipts, etc., must show actual date of service and daily charge to determine day on which excess is met.

[H. Deductions for prescription drug expenses incurred during a period of Medicaid eligibility may be allowed ONLY if the recipient verifies that Medicaid denied coverage of the drug at the time, and that a prior authorization request was also denied.]

MS 2720 CONSIDERING MEDICAL EXPENSES IN SPEND DOWN

Spend down medical expenses are expenses incurred by an individual, a spouse or dependent child under 21 in the home or away from home for the purpose of school attendance. Unless already receiving MA, these expenses are allowed regardless of whether or not these family members are included in the case and/or regardless of whether or not their income is considered in the MA eligibility determination.

A. Consider any verified recognized medical expense(s) incurred DURING the established quarter subject to the restrictions listed above. Beginning with the first day of the quarter, list daily charges.

B. Consider the unpaid balance of any verified recognized medical expense incurred PRIOR TO the established quarter subject to the restrictions listed above.

1. Consider the expense as incurred on the first day of the first month of the established quarter.
2. Consider only the portion of the expense needed to obligate the spend down excess.
3. 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, on a sheet of bond paper and attach to form PAFS-116. Review the case record to ensure the expense has not been considered in a previous quarter to establish MA eligibility, and record findings on the sheet of bond paper. This will serve as an effective method of tracking the remaining portion of the expense(s) for future spend down use.

   EXAMPLE: An individual's spend down excess for the current quarter is $1,200. Approximately 2 years ago, the individual incurred a $1,600 hospital bill for which a payment of $100 has been made, leaving an unpaid balance of $1,500. The $1,200 portion of the hospital bill is considered on the first day of the first month of the current quarter for spend down. The remaining $300 of the bill can be used to obligate a future spend down excess.

C. Verified payments on medical bills for services when MA was not received are deducted if paid during the quarter.

EXAMPLE: 2 years ago, an individual purchased an $800 hearing aid and charged the full amount. Each month, $25 has been paid. The individual has now applied for MA as a spend down case. Consider the $25 as a recognized medical expense and record as a spend down expense the day the $25 payment is made.

D. When all verified recognized medical expenses presented by the individual are recorded, determine if, on any day in the quarter, the total amount of expenses for the period is as much as the excess income.

MS 2730 ALLOWABLE SPEND DOWN MEDICAL EXPENSES

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

A. Health insurance premiums including SMI, specified disease policies; that is, 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 actually covered, whichever benefits client.

EXAMPLE: A $90 premium is paid July 15 to cover August, September and October. Allow $30 for August 1, September 1 and October 1 or use the entire $90 on July 15.

B. Insurance policies paying specific benefits per day to an individual while hospitalized or during recuperation. Premiums paid on these policies are considered a medical expense;

C. Nursing facility insurance premiums are an allowable medical expense.

D. Transportation for health care not available free of charge. Costs are deductible for use of the individual's own car at the rate of 12 cents per mile;

E. The actual amount paid for caretaker, FC or PC services if the individual is paying the private pay rate.

[If medical expenses of a spouse are being considered and the spouse is receiving SSP then consider the payment for caretaker services as a medical expense.]

F. In-patient hospital services including services in institutions for tuberculosis, mental disease or other specialty hospitals regardless of age;

G. Laboratory and x-ray services;

H. NF services, including services in institutions for tuberculosis or mental disease, for all individuals regardless of age;

I. Any physician's services;

J. Medical care or any other type of remedial care recognized under State law furnished by licensed practitioners within the scope of their practice as defined by State law;

K. Home health care services, including intermittent or part-time services of a nurse or home health aid according to a physician's plan of treatment;

L. Private duty nursing services by a Licensed Practical Nurse or Registered Nurse only;

M. Clinic services;

N. Dental services, including dentures prescribed by a licensed and practicing dentist;

O. Physical therapy and related services including supplies such as hearing aids, etc.;

P. Drugs prescribed by a licensed physician, osteopath or dentist;

Q. Prosthetic devices, including braces, artificial limbs, etc.;

R. Eye glasses and other aids to vision, prescribed by an ophthalmologist or an optometrist;

S. Ambulance services when medically indicated and/or other transportation costs necessary to secure medical examination or treatment;

T. X-ray, radium and radioactive isotope therapy;

U. Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations, including surgical dressings and related items, used at the direction of a physician for continuing treatment of a health problem;

V. If not available from a Home Health Agency, rental or purchase of durable medical equipment including, but not limited to iron lung, oxygen tents, hospital beds, wheelchairs, crutches, braces and artificial limbs including replacements if required because of change in the patient's condition;

W. Purchase, care and maintenance costs of seeing eye dogs;

X. Consider cost of lodging, which may include the lodging cost of a nurse/attendant, a necessary medical expense if it can be determined lodging was necessary to secure required medical service or treatment.

1. Question the client to determine if circumstances necessitated lodging and annotate case record.
2. If need for lodging cannot be determined, request a physician's statement to verify reported expenses were actually medically necessary.
3. Allowable amount may not exceed commercial lodging costs prevalent in area.

Y. Incurred medical expenses paid by a public program of the State or a political subdivision without federally designated funds. Political subdivisions include city, county, or local governments. These medical

expenses are also allowed as deductions for LTC, waiver and Hospice cases if MA eligibility is determined by exceptional spend down, Step II process.

1. Examples of public programs of the State include;
   a. Hospitals such as, UK Medical Center, Humana University, etc.;
   b. Health departments;
   c. Community Service Centers;
   d. Primary Care Centers operated by local health departments; and
   e. Comprehensive Care Centers.

2. Medical expenses paid by programs of the federal government, including Medicare and VA and bills that have been written off as uncollectible are not allowable as spend down deductions.

3. Obtain a copy of the bill to verify that a medical expense was incurred and that the expense was paid by a State public program or political subdivision without federally designated funds prior to allowing the deduction.

Z. Any item verified by a doctor's statement that is medically necessary for controlling a patient's allergy problem. Items may include:

1. The purchase of electrostatic air filters;
2. Humidifiers;
3. Air conditioning;
4. Central heating systems;
5. Hardwood floors;
6. Payment for carpet/upholstered furniture cleaning; and
7. Carpet removal.

AA. Other items clearly identifiable as medical in nature.

1. This includes:

   a. Aspirin;
   b. Antacids;
   c. Peroxide;
   d. Band-aids;
   e. Nutritional supplements such as Ensure; and
   f. Incontinent care products.

2. Cash register receipts are acceptable verification of the expense. If the receipt does not specify the item, the individual's statement is accepted.

BB. Consider charges from a physician who is not enrolled in the Medicaid program as a medical expense on the date of service in the spend down calculation. While the expenses can be deducted, Medicaid can not make payments to a physician who is not an enrolled provider.

MS 2740 SPEND DOWN CASE DECISION

A. When medical expenses are more than the quarterly excess income:

1. Determine the day the excess amount was used;

2. Approve the application; and

3. The KAMES spend down approval notice containing the case level spend down liability amount is issued to the client. The case level spend down amount is the amount the member is obligated to pay on the date the spend down liability is met. For a family Spend Down case, this amount is the total of member liability amounts if more than one member has a liability amount on the date spend down eligibility is met. For a prior quarter spend down approval, the KAMES notice will display two case level spend down liability amounts and spend down coverage period for split eligibility. Split eligibility can occur when medical expenses are incurred in the first and third months of the prior quarter and two separate spend down calculations are completed.

4. Case Processing
   a. Medical expense type code “14 – PRIOR MEDICAL EXP” on the Application Medical Expense screen and is used to identify allowable unpaid medical expenses incurred prior to the established quarter. When using prior medical expenses to meet the spend down amount, always show the date the expense was incurred as the first day of the spend down quarter. If the spend down amount is met with prior medical expenses only, the member spend down liability will be $0.
   b. Unpaid medical expenses from a prior quarter must be verified as still owed. If the bill has been written off or has been paid by a third party, it cannot be used. If verification cannot be provided that the bill is still owed, it cannot be used to meet the spend down liability. The “SPD LIAB” (spend down liability) field on the third General Member Information Inquiry screen is uploaded with the member’s spend down liability amount.
   c. [A permanent, plastic KYHealth card will be generated for members who have not previously received one, or who state that they need a replacement.]
   d. No notice is sent to the medical providers. [It is the responsibility of recipients to notify their providers when they are approved for spend down coverage and to show their KYHealth card to their providers for Medicaid billing purposes. It is important that this responsibility be explained to the applicant during the application interview.]
   e. If there are multiple bills incurred by an individual on the date the spend down eligibility is met, the member spend

down liability amount is applied to (deducted from) the bills in the order they are received by DMS for payment. The member spend down liability amount is not assigned to a specific provider.

f. If a recipient contacts the Agency regarding an outstanding bill after they have notified the provider of spend down eligibility and have submitted the MAID to the provider, advise the recipient to:
   1. Contact the provider to see if the provider has billed Medicaid for the service.
   2. Determine if the billed amount is the member liability amount for the date of spend down eligibility.
   3. If the individual has other billing questions, refer him/her to Medicaid Member Services at (800) 635-2570 for assistance.

5. Special Circumstance
   a. The worker enters each member's spend down liability amount in the "SPD/LIAB" field on the Special Circumstance - 1 screen. The member spend down liability amount is the amount the member is obligated to pay on the date the spend down eligibility is met.
   b. The Special Circumstance –1 Inquiry screen "SPD/LIAB" field displays the member spend down liability amount.
   [c. Spend Down cases processed by special circumstance action will automatically pend for sign-off by a principal or supervisor. The prompt "Action Pended – Give File to Supv/Prin" will display when the worker hits "enter". In order to sign-off the action, the principal or supervisor must be logged onto KAMES in his/her "HRII" code.
   d.] The special circumstance notice for a spend down approval displays case level spend down liability amount.
   [e. For individuals with active QMB cases, workers are to use the recipient status code "HH". For active SLMB cases use "S2". These recipient status codes will prevent the recipients from losing their QMB/SLMB benefits with the issuance of the Spend Down special circumstance. Individuals eligible for buy-in under the Qualified Individuals Group 1 (QI1) and Qualified Disabled Working Individual (QDWI) programs are not dually eligible and workers will need to give a medical deduction for the SMI premium. QI1 and QDWI recipients are to be advised by the worker that the SMI premium will be recouped for the months that they are eligible for the spend down.]

6. Effective date of medical coverage is established as follows.
   a. Month of application and 2 following months:
      (1) Enter the MA beginning date as the day the excess is used.
      (2) Enter the MA ending date as the 1st day of the month of the following quarter.
   b. 3 months before the month of application:

(1) Enter the MA beginning date as the day the excess was used.
(2) Enter the MA ending date as the 1st day of the application month.

c. If, after a determination has been made, additional medical expense verification is provided by the recipient, a recomputation is completed.
(1) If it is determined that their spend down liability was met earlier in the quarter, complete a Special Circumstance Transaction to authorize Medicaid eligibility for the earlier date.
(2) If the recomputation results in the determination that the applicant met the spend down liability later in the quarter, no action is required.

d. 3 months before the application month, and the application month and 2 following months process as separate case actions for each entitlement period.

e. If a condition of eligibility changes during the quarter, redetermine spend down eligibility based on the change.
(1) The applicant becomes ineligible for 1 or 2 months of the 3 month period; or
(2) The composition of the assistance group changes.

B. Medical expenses for the quarter are less than the quarterly excess income.

1. Deny the application.

2. The general action notice is system generated.

C. Reapplications are processed the same as new applications. Verify and document all required items during the investigation.

MS 2800 [Consumer Directed Option (CDO)

Consumer Directed Option (CDO) applies to Home and Community Based Waiver Services (HCBS), Supports for Community Living (SCL), and Acquired Brain Injury (ABI) waiver members.

I. CDO is not an increase in or expansion of current services. It is an option offered to Medicaid members who receive services through the HCBS, SCL and ABI waiver programs. CDO can be chosen at application or on active cases. CDO providers may include family members, friends, and/or neighbors. By choosing CDO, the individual can have better control over how his/her services are provided along with when and where services are provided.

   Individuals may choose traditional services, CDO or blended services (combination of traditional and CDO), depending on the individual's needs and approved plan. Services may not be duplicated by the traditional provider and the CDO provider.

II. If an individual chooses a CDO provider, a support broker is assigned by the Department for Medicaid Services (DMS) to represent them. The support broker assists the individual with recruiting, hiring, and managing his/her employees and negotiating rates. A financial management agency assigned by DMS is responsible for the payment of services.

   The CDO provider number that is entered on KAMES or on the PA-62 system is the number established for the Department for Aging and Independent Living (DAIL). DAIL's provider number for each waiver is as follows:

   1. HCB/CDO is 4343996164002,
   2. SCL/CDO is 3333001504002; and
   3. ABI/CDO is 1717000878002.

III. CDO for HCBS members – Effective September 30, 2006, DMS implemented CDO for HCBS members. HCBS members can use CDO for respite care, personal care, homemaking and attendant care.

   A. If CDO is chosen, an electronic PRO Certification record is passed to KAMES for the CDO provider number "4343996164002".

   B. The member is not discharged from HCBS. Both HCBS (provider type "42") and the CDO (provider type "43") will be listed as providers on KAMES whether CDO only or blended services are chosen.

      The HCBS provider continues to complete the assessment for the HCBS applicants and is listed as the provider type "42" on KAMES. The CDO provider number listed is always "4343996164002", established for DAIL. Agencies are instructed not to send form MAP-24 to the local DCBS office if CDO is chosen. If the member receives

Adult Day services or Adult Day with HCBS, CDO is still listed as the provider type “43”. Adult Day and CDO are NEVER listed together on KAMES because they are both provider type “43”.

C. For Adult Day recipients whose Adult Day agency completes an assessment for those choosing CDO or blended services, CDO is the provider type “43” entered on KAMES. DCBS staff will use the CDO admit date as the discharge date for the Adult Day provider when processing the provider change. The Adult Day agency continues to submit claims to the Medicaid agency even though KAMES shows the member discharged. Since there is no HCBS (provider type “42”) providing services, only the CDO provider is entered on KAMES.

Advise HCBS members to contact their HCBS provider or their Adult Day Health Care agency with any questions regarding CDO.

IV. CDO for SCL – SCL members can use CDO to provide respite care, community living supports and adult day training. CDO can be chosen by new approvals and existing SCL members. Only members who do not receive residential services through the SCL waiver can participate in CDO.

If CDO or blended services are chosen, the CDO support broker notifies the local DCBS office on form MAP-24C. For existing SCL waiver members, DCBS staff will discharge the member from the traditional SCL provider using the CDO admit date as the discharge date on KAMES and adds the SCL/CDO provider number “3333001504002”.

Advise SCL members to contact their case manager with any questions regarding CDO.

V. CDO for ABI – ABI members can use CDO to provide respite, companion care and personal care. CDO can be chosen by new approvals and existing ABI members. Only members who do not receive residential services through the ABI waiver can participate in CDO.

If CDO or blended services are chosen, the CDO support broker notifies the local DCBS office on form MAP-24C. For existing ABI members, DCBS staff discharges the member from the ABI case manager as well as the ABI provider using the CDO admit date as the discharge date on KAMES. Add the support broker as the case manager using the support broker’s ABI provider number as shown on form MAP-24C and add the ABI/CDO provider number “1717000878002” as the primary provider.

Advise ABI members to contact their case manager with any questions regarding CDO.

VI. All technical and financial criteria for Medicaid and waiver eligibility remain unchanged.]

MS 2810 [SCL WAIVER PROGRAM]

[Supports for Community Living (SCL) provides home and community based services for mentally retarded MA recipients who would otherwise require institutional care in an ICF/MR/DD facility. Intermediate care services for the mentally retarded and developmentally disabled are provided by community mental health centers certified by the Department for Medicaid Services (DMS). SCL is available statewide. Individuals eligible for SCL are eligible to choose theses services to be delivered through the Consumer Directed Option (CDO) or in a combination of SCL and CDO. Refer to MS 2800.]

The following are covered services:

A. Adult Day Habilitation Component - Includes services provided in outpatient settings designed to provide an organized program of training in developmental skills, using age-appropriate methods.

B. Case Management/Recipient Evaluation - Includes case coordination, evaluation, preparation of plan of care, and follow-up assessment.

C. Habilitation Component - Includes behavior management; medical and psychological services; occupational, physical and speech therapy; etc.

D. In-Home Support Component - Includes in-home training, home-maker/home health aide services, and personal care services provided to SCL recipients residing at home.

E. Prevocational Services - Includes services aimed at preparing the SCL recipient for paid or unpaid employment and assists the recipient in acquiring and maintaining basic work and work-related skills.

F. Residential Component Services - Includes training, homemaker, personal care services provided to SCL recipients in alternative living units (ALUs) by ALU staff. The residential component does not include room and board.

G. Respite Component - Includes short term care and supervision of SCL recipient provided for the temporary relief of the family or residential staff, or for the safety and relief of the SCL recipient.

H. Supported Employment - Includes paid work in a variety of work settings in which individuals with mental retardation/developmental disabilities are employed. These services may include development of physical capacities, psychomotor skills, interpersonal and communicative skills, development of appropriate work behavior, work performance skills, and job seeking and job keeping skills.

MS 2815 MICHELLE P. WAIVER

Effective July 14, 2008, a new Medicaid waiver, called the Michelle P. Waiver, has been implemented. The Michelle P. Waiver will offer many of the same services as the Home and Community Based (HCB) waiver and the Supports for Community Living (SCL) waiver. For individuals to qualify for Michelle P. Waiver a person must meet Medicaid financial eligibility and the Level of Care for an Intermediate Care Facility (ICF/MR) or Nursing Facility (NF) established by Medicaid. For an assessment to see if they meet Level of Care the individual is to be referred to the local Community Mental Health Center (CMHC). This level of care is applicable for the following IM program codes: A, B, D, AP, BP, DP, FP, GP, HP, C, W, KC, E, I, J, K, L, M, N, P, T and Y.

The Michelle P. Waiver requires a PRO certification before benefits can be issued. Correct verification entry on KAMES is “PR” for “Document Type”. If any other documentation type is entered, an error message “DOCUMENT TYPE DOES NOT MATCH PROVIDER TYPE” will display.

A new selection for “Type of Care Provider” is added to the LTC/Waiver screen. It is type “17” with institutional status of “MP”. When type “17” is entered, then the first two digits of the provider number must begin with 33, 42 or 43.

The Michelle P. Waiver has the same personal needs allowance that is currently allowed for non-institutionalized individuals receiving waiver services.

Individuals receiving state supplementation, program codes AP, BP, DP, FP, GP and HP in a Family Care Home or Caretaker Services, are eligible to receive services from the Michelle P. Waiver. However, individuals in Personal Care Homes (institution status P1 or P2) are not eligible to receive waiver services from the Michelle P. Waiver or any other waiver program. If the worker tries to add the Michelle P. Waiver at application, recertification, program transfer or case change for state supp recipients in a personal care home setting, a prompt “TYPE OF CARE INAPPROPRIATE – PLEASE REVIEW” will display. If the worker proceeds on past the LTC screen, then at disposition, the waiver services will be denied and the following notice will display “NOT WAIVER ELIG IF PC”.

Recipients eligible for Medicaid under Pass Through are not eligible for the Michelle P. Waiver. These cases are to be transferred to Long Term Care (LTC) program code of J, K or M. If the Michelle P. Waiver is entered on a Pass Through case during an application, recertification, program transfer or case change, at case disposition, deny or discontinue the case and follow standard case processing rules for alternate programming to the J, K or M category. When F, G, or H cases are alternate programmed due to applicant/recipient receiving services from Michelle P. Waiver services, the following message “NOT PASS THRU ELIG” displays. However, if the applicant/recipient is denied eligibility in the J, K, or M category, review case for Pass Through eligibility.

For all other categories of assistance, use the same institution status of “MP” and the facility code of “17”. The provider number must begin with 33, 42 or 43 when adding the Michelle P. Waiver at application, recertification, program transfer or case change.

When issuing Michelle P. Waiver benefits by special circumstance, use the institutional status of “MP” and the facility code of “17”. If the incorrect facility code is entered, an error message “MUST AGREE WITH INST STAT AND FAC CODE” will display. If institutional status code is “MP” and the facility code is “17” but the provider number does not begin with 33, 42 or 43, an error message of “INVALID PROVIDER FOR FACILITY CODE” will display.

Medicaid recipients eligible for Supplemental Security Income (SSI) that qualify for the Michelle P. Waiver are entered on the PAS CASE DATA ENTRY (3U) system. Enter eligibility using the institution status of “MP” for A, B or D cases with a case status of “09” or “GG”. The provider number must begin with 33, 42 or 43. Patient liability is determined the same as other waiver cases with institution status of “M6” or “M8”.

Edits for incorrect documents entered on 3U are as follows:

- Wrong facility for institution status is 379 - current facility invalid for institution status.
- [Admission dates prior to July 14, 2008 is 339 – admission date is invalid.]

MS 2820 TECHNICAL ELIGIBILITY REQUIREMENTS

A. The applicant must meet MA criteria for ICF/MR/DD level of care. The level of care is determined by the Peer Review Organization (PRO) using medical, psychological, and social data. [The Department for Mental Health/Mental Retardation (MH/MR) produces a letter of approval and form MAP-24C, Support for Community Living Admission/Discharge, and sends a copy of the letter of approval to the Support Coordination Agency, to the client and to the local office. This letter shows the level of care met. The Support Coordination Agency sends form MAP-24C to the local office showing the provider name, provider number and date of admission.]

B. The DMR-001 is a placement form used for provider changes and is not required for approvals.

C. The applicant must meet all technical eligibility requirements for MA eligibility including age, blindness, disability, enumeration, third party liability, etc. However, an individual not aged, blind or disabled may be eligible for SCL if MA eligible in another category and KMP criteria is met.

MS 2830 [SCL ELIGIBILITY DETERMINATION PROCEDURES]

A. MEDICAID ELIGIBILITY. [Determine MA eligibility by comparing the individual's gross income to the special income standard and considering the number of days the individual has been receiving SCL.]

1. Determine MA eligibility according to procedures outlined in MS 3500-3610.

2. [Determine MA eligibility in Step II by comparing adjusted income to the SCL Standard.] Determine adjusted income by deducting from gross income the MA Scale for one plus the SSI general exclusion and incurred medical expenses of the individual.

3. Do not redetermine MA eligibility if the individual is MA eligible in another category.

B. [Determine the MA effective date using the first day of the month the individual met KMP criteria for SCL as indicated on the DMS letter of approval.

C. Determine patient liability for SCL recipients, in a manner similar to the determination for individuals in an ICF/MR/DD or NF; however, SCL allows the use of a personal needs allowance, computed as the SSI Standard plus SSI general exclusion of $20, which replaces the personal needs allowance used for institutionalized individuals.]

1. Use the personal needs allowance, SSI Standard plus SSI general exclusion.

2. [Compute patient liability for an SCL recipient with a non-AIS/MR spouse in a manner consistent with computations for institutionalized spouse with a community spouse.] See MS 3550.

3. [If ineligibility exists for the month of application, a redetermination of eligibility is determined for the month after the month of admission to SCL.]

MS 2840 [SCL INDIVIDUAL]

Determine MA and patient liability for the single SCL individual as follows.

Step I - Determining MA Eligibility Using Special Income Standard

1. [Determine gross income of the SCL individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been in SCL for 30 full consecutive days, the individual is MA eligible.] Complete Step III to determine patient liability.

3. [If gross income is greater than the special income standard for an individual OR the individual has been in SCL less than 30 full consecutive days, complete Step II to determine MA eligibility.]

Step II - Determining Medicaid Eligibility

1. [Determining countable income of the SCL individual.] Consider gross income and/or net profit, less $20 general exclusion and work related expenses, if appropriate.

2. Deduct the MA Scale for 1.

3. [Deduct any verified, incurred medical expenses of the SCL individual, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill if not covered by MA.

4. Deduct the SCL standard.]

5. If there is no excess, the individual is MA eligible. Complete Step III to determine patient liability.

If an excess remains, do not complete Step III. The individual is ineligible for a vendor payment. Process as a spend down, using the regular MA Scale.

Step III - Determining Patient Liability

1. [Determine gross income and/or net profit of the SCL individual.]

2. Deduct the personal needs allowance.

3. [Deduct an increased personal needs allowance, if appropriate, from income of the SCL individual.]

4. If the individual has dependents deduct an amount to bring total income of dependents up to the MA Scale for the appropriate family size.

5. [Deduct verified, incurred medical expenses of the SCL individual, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

6. Add any third party payment paid directly to the SCL provider, if appropriate.] Do not use these payments for conservation or other deductions.

7. The result is the individual's patient liability or payment toward cost of care.

MS 2850 [SCL CHILD

Determine MA and patient liability for the SCL child living with parents as follows.

For the month of admission, consider the income of the SCL child and parent, as appropriate.

After the month of SCL admission, recalculate considering only the income of the SCL child. See MS 2880.]

Step I - Determining MA Eligibility Using Special Income Standard

1. [Determine gross income of the SCL child.]

2. Add gross income of parent.

3. [If gross income is equal to or less than the special income standard for an individual AND the child has been in SCL for 30 full consecutive days, the child is MA eligible. Complete Step III to determine patient liability.

4. If gross income is greater than the special income standard for an individual OR the child has been in SCL less than 30 full consecutive days, complete Step II to determine MA eligibility.]

Step II - Determining Medicaid Eligibility

1. [Determine countable parental income of the SCL child.] Consider gross income and/or net profit, less $20 general exclusion and work related expenses, if appropriate.

2. To allocate income for each ineligible sibling under 18 living in the home of the parent consider the remainder of the ineligible sibling allocation minus gross income of each ineligible sibling. See MS 1760 for sibling allocation maximums.

3. Deduct a parent allocation for unearned income only or a combination of unearned income and earned income for one parent or for two parents; or a parent allocation for earned income only for one parent or for two parents. See MS 1760 for parental allocation maximums.

4. [Consider total income of the SCL child.]

[5. Allow appropriate income deductions from income of the SCL child according to MS 3480.

6. Combine the deemed income of the parent and the countable income of the SCL child.

7. Deduct any verified incurred medical expenses of the SCL child, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill if not covered by MA.]

8. Deduct verified, incurred medical expenses of the parent and any sibling.

9. Deduct the MA Scale for one.

10. [Deduct the SCL Standard.]

11. If there is no excess, the child is MA eligible. Complete Step III to determine patient liability.

[If an excess remains for the month of admission or after the month of SCL admission, do not complete Step III.] The child is ineligible for a vendor payment. Process as a spend down, up to three months prior to the month of application, if applicable, using the regular MA Scale.

Step III - Determining Patient Liability

1. [Determine gross income and/or net profit of the SCL child.

2. Add excess income of parent. Gross income/net profit less MA Scale for the appropriate family size, excluding SCL child, if appropriate.]

3. Deduct the personal needs allowance.

4. Deduct an increased personal needs allowance from income of the [SCL child, if appropriate.]

5. If the individual has dependents deduct an amount to bring total income of dependents up to the MA Scale for the appropriate family size.

6. [Deduct verified incurred medical expenses of the SCL child, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.]

7. If income of the parent is considered, deduct verified, incurred medical expenses of the parent.

8. [Add any third party payments paid directly to the SCL provider, if appropriate.] Do not use these payments for conservation or other deductions.

9. The result is the child's patient liability or payment toward cost of care.

MS 2860 [SCL INDIVIDUAL WITH NON-SCL SPOUSE]

Determine MA and patient liability for SCL individual with a non-SCL spouse in the home as follows.

Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the SCL individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been in SCL for 30 full consecutive days, the individual is Medicaid eligibile. Complete Step III to determine patient liability.

3. If gross income is greater than the special income standard for an individual OR the individual has been in SCL less than 30 full consecutive days, complete step II to determine MA eligibility.

Step II - Determining MA Eligibility

1. Determine countable income of the SCL individual. Consider gross income and/or net profit, less $20 general exclusion and work related expenses, if appropriate.

2. Deduct the MA scale for 1.

3. Deduct any verified, incurred medical expenses of the SCL individual, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill if not subject to third party payment or covered by MA.

4. Deduct the SCL standard.

5. If there is no excess, the individual is MA eligible. Complete Step III, IV and V to determine patient liability.

If an excess remains, do not complete Step III, IV, and V. The individual is ineligible for a vendor payment. Process as a spend down, using the regular MA Scale.

Step III - Determining Community Spouse Income Allowance

[Determine community spouse income allowance, not to exceed the community spouse income allowance maximum according to MS 3550.] The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process.

Step IV - Determining Family Income Allowance

Determine family income allowance if there is a minor child or dependent child, dependent parent or dependent sibling of either the community spouse or SCL recipient who is residing with the community spouse. Subtract the dependent member's verified gross income from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income allowance. Compute the family income allowance for EACH dependent member.

Step V - Determining Post Eligibility for SCL recipients

1. Determine gross income and/or net profit of the SCL recipient.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the SCL recipient.

4. Deduct the community spouse income allowance up to the maximum.

5. Deduct family income allowance.

6. Deduct verified, incurred medical expenses of the SCL recipient such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

7. Add any third party payment paid directly to the SCL provider, if appropriate. Do not use these payments for conservation or other deductions.

8. The result is the individual's patient liability or payment toward cost of care.

MS 2870 [SCL COUPLE

Determine MA and patient liability for couple, both receiving SCL as follows.]

Step I - Determining MA Eligibility Using Special Income Standard

1. [Determine gross income for each member of the SCL couple.

2. If gross income of each member of the couple is equal to or less than the special income standard for an individual AND each member of the couple has been receiving SCL for 30 full consecutive days, each member of the couple is MA eligible.] Complete Step III to determine patient liability.

3. If gross income of either member of the couple is greater than the special income standard for an individual OR either member of the couple has received SCL less than 30 full consecutive days, complete Step II, item 1 or 2, as appropriate, to determine MA eligibility.

Step II - Determining MA Eligibility

1. [If one member of a couple has income which exceeds the special income standard or has been receiving SCL less than 30 full consecutive days and the spouse has income less than the special income standard, AND has been receiving SCL for 30 full consecutive days do the following:]

   a. Determine countable gross income and/or net profit of the member with excess income less $20 general exclusion and work related expenses, if appropriate.
   b. Deduct the MA scale for 1.
   c. Deduct any verified medical expenses of the member with excess income, such as monthly SMI charges, prorated health insurance premiums and/or actual payment on prior medical bills if not covered by MA.
   d. [Deduct the SCL Standard for the member with excess income.]
   e. If there is no excess, the member is MA eligible. Complete Step III to determine patient liability.

   If an excess remains, DO NOT complete Step III. The member is ineligible for a vendor payment. Process as a spend down, using the regular MA Scale.

2. [If both members of a couple are ineligible using the special income standard or both have been in SCL less than 30 full consecutive days:]

   a. Determine countable gross income and/or net profit of the couple less one $20 general exclusion and work related expenses, if appropriate.
   b. Deduct the MA scale for 2.

c. Deduct any verified medical expenses of the couple such as monthly SMI charge, prorated health insurance premium and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

d. [Deduct the couple's actual cost of care for SCL from the SCL Standard x 2.]

e. If there is no excess, the couple is MA eligible. Complete Step III to determine patient liability.
If excess remains, DO NOT complete Step III, the couple is ineligible for a vendor payment. Process as a spend down, using the regular MA Scale.

Step III - [Determining Patient Liability for SCL couple]

1. Determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case.

2. Deduct the personal needs allowance in each case.

3. Allow 1/2 of total deductions as an increased personal needs allowance in each case.

4. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA scale for the family size. Deduct 1/2 of the amount in each case.

5. Determine the couple's verified medical expenses and actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case.

6. [Add any third party payment paid directly to the SCL provider, if appropriate.] Do not use these payments for conservation or other deductions. Deduct 1/2 of the amount in each case.

7. The result is the individual's patient liability or payment toward cost of care.

MS 2880 [SCL INCOME AND RESOURCE CONSIDERATION

A. SCL INDIVIDUAL WITH NON-SCL. If an SCL individual has a non-SCL spouse, use the procedures outlined below.

1. Consider only the income of the SCL individual in determining MA eligibility and patient liability beginning the month of SCL admission.]
2. Consider the resources according to MS 2120.

B. [SCL COUPLE. If both members of couple receive SCL, use the following policy.]

1. [Consider income and resources of couple as available to each other during the month of SCL admission.
2. Beginning the month after the month of SCL admission, consider only income and resources of the spouse which are actually contributed to the other spouse.

C. DISABLED OR BLIND SCL CHILD UNDER 18 OR AGE 18 THROUGH 20 IF IN SCHOOL LIVING WITH PARENTS.

1. For the month of admission, consider the income and resources of the SCL child and parent according to Step I or II as appropriate.
2. Consider only the income and resources of the SCL child after the month of SCL admission.

D. [K-TAP/FAMILY RELATED MA PARENT OR CHILD RECEIVING SCL

1. Consider resources and income in the K-TAP/Family MA case for up to one year.]
2. Consider resources and income on basis of living apart when it becomes apparent SCL will be received for more than 1 year. Determine technical eligibility for aged, blind or disabled MA program. [Establish a separate J, K or M case for the SCL recipient.
3. When separate cases are established, remove the SCL recipient from the K-TAP or Family Related MA case.]

MS 2890 SCL CASE ACTION

A. [MH/MR LETTER OF APPROVAL AND FORM MAP-24C, Support for Community Living Admission/Discharge, notifies the local office of an individual's placement in SCL. The Confirmation Notice is provided to the local office for informational purposes only and identifies the level of care that the individual requires. The MH/MR letter of approval notifies the local office of the date level of care is met for SCL. Form MAP-24C shows the provider name, provider number and the date of admission.]

B. Form DMR-001, A Confirmation Notice and the DMS Letter of Approval, is a placement form used for provider changes and is not required for approvals.

C. [INTERRUPTION OF STAY IN SCL WHEN AN SCL RECIPIENT ENTERS A NURSING FACILITY FOR 60 DAYS OR LESS. The SCL provider annotates and forwards form MAP-24C to the local office to verify that patient status continues to be met without a new patient assessment if the recipient has been in a nursing facility for 60 days or less and is reinstated to the same SCL provider. Vendor payment is to be authorized upon receipt of this form.

Form MAP-24C includes an entry for the provider to indicate that the recipient was reinstated to the same SCL provider within 60 days of the nursing facility admission.]

D. MA APPLICANT. If the individual does not currently receive MA, the provider notifies the family or responsible party to apply for MA for the individual. Determine eligibility for SCL. The special income standard does not apply if patient status is not met. [If no application is made, retain a copy of MH/MR letter of approval and form MAP-24C in a central file in the local office.]

E. SSI RECIPIENT. If the individual is an SSI recipient, establish a case record. [Authorize vendor payment upon receipt of MH/MR letter of approval and form MAP-24C.] Send form MA-105 notifying the recipient and SCL provider of vendor payment eligibility.

[If SSI is discontinued, and the recipient subsequently applies for MA and continues to participate in SCL, use the MH/MR letter of approval and form MAP-24C as verification that patient status is met and that the recipient continues to participate in SCL.] If the application is approved, authorize vendor payment. Notify the recipient and SCL Provider of vendor payment eligibility.

F. PASS THROUGH RECIPIENT. [When the MH/MR letter of approval and from MAP-24C are received, authorize vendor payment.] Do not determine MA eligibility since the recipient is MA eligible as Pass Through. Program code is unchanged. KAMES will send notices to the recipient and SCL provider of eligibility.

If the recipient is discharged from SCL, discontinue vendor payment. KAMES will send notices to the recipient and SCL provider of ineligibility. Continue Pass Through eligibility. Program code and case status code are unchanged.

G. STATE SUPPLEMENTATION RECIPIENT (CARETAKER SERVICES ONLY). SCL recipients receiving a State Supplementation Payment (SSP) for caretaker services may continue to receive these benefits if the caretaker services are not provided under SCL.

[When the MH/MR letter of approval and form MAP-24C are received, authorize vendor payment.] Do not determine MA eligibility since the recipient is MA eligible as an SSP recipient. Program code and case status code are unchanged. Notify the recipient and SCL provider of eligibility if the case is carried on the PA-62 system; otherwise KAMES will end notices as required.

If the recipient is discharged from SCL, discontinue vendor payment. Notify the recipient and SCL provider of ineligibility if the case is carried on the PA-62 system; otherwise KAMES will send notices as required. SSP eligibility is continued if caretaker services are received. Program code and case status code are unchanged.

H. STATE SUPPLEMENTATION RECIPIENT (PERSONAL CARE OR FAMILY CARE). Individuals receiving SSP and residing in a personal care home or family care home may receive SCL if patient status for SCL is met.

[When the MH/MR letter of approval and form MAP-24C are received, authorize vendor payment.] Do not determine MA eligibility since the recipient is MA eligible as an SSP recipient. Program code and case status code are unchanged. Notify the recipient and SCL provider of vendor payment eligibility if the case is carried on the PA-62 system; otherwise KAMES will send notices as required.

If the recipient is discharged from SCL, discontinue vendor payment. Notify the recipient and SCL provider of vendor payment ineligibility if the case is carried on the PA-62 system; otherwise KAMES will send notices as required. Program code and case status code are unchanged, SSP eligibility is continued if the recipient continues to reside in a personal care home or family care home.

MS 2895 SCL NOTICE PROCEDURES

A. Complete form MA-105 for cases on PA-62.

1. Complete form MA-105 according to instructions for LTC, as appropriate.
2. When increasing liability for SCL individual, the 10 day advance notice must expire before action is taken on the case.
3. In addition to usual distribution for notices, send a copy of the form to the SCL case manager. [The name and address of the case manager are listed on the MH/MR letter of approval.]

   Send another copy of the form MA-105 to:

   Division of Mental Retardation
   Department of Mental Health, Mental Retardation Services
   SCL
   4E-E
   100 Fair Oaks
   Frankfort, Kentucky 40621

B. Hearings and Additional Information.

1. Accept requests for hearings on patient status/reclassification according to procedures in MS 3690.
2. Inform interested persons of the availability of SCL. Refer interested persons to the local Community Mental Health Center for additional information.

MS 2900 [HCBS Waiver Program]

A. Home and Community Based Services (HCBS) allow MA individuals who would otherwise be institutionalized to receive necessary services at home to prevent institutionalization. HCBS individuals are considered institutionalized for financial eligibility even when they live in their own home. HCBS are provided by home health agencies certified by MA and are available statewide.

[Individuals eligible for HCBS are eligible to choose these services to be delivered through the Consumer Directed Option (CDO) or in a combination of HCBS and CDO. Refer to MS 2800.]

B. The following are HCBS covered services:

1. Adult Day Health Services - Provides health and social services in a licensed and certified Adult Day Health Care Center. Case management services are available to recipients enrolled in Adult Day programs. The Adult Day provider (type “43”) may be the recipient’s sole provider or may be either primary or secondary to the HCBS provider (type “42”).

2. Assessment - An RN or social worker evaluates an individual's mental needs and physical abilities. The PRO determines level of care. If the individual does not meet HCBS criteria, the assessment will not be paid by KMP.

3. Case Management - Arranges for needed services, monitors services provided, etc.

4. Homemaker Services - Performs general household activities, such as meal preparation and routine household chores for the individual.

5. Minor Home Adaptations - Includes adding rails, ramps, etc., to individual's home.

6. Personal Care - Performs medically oriented tasks such as assistance with bathing, dressing, ambulation, medications, etc.

7. Respiratory Therapy Services - Provides a qualified respiratory therapist for ventilator dependent recipients who are also receiving home health services.

8. Respite Care - Provides short term relief for caregiver.

MS 2910 TECHNICAL ELIGIBILITY REQUIREMENTS

A. The individual must meet MA criteria which includes determination of level of care for NF services. The level of care is determined by the PRO using medical, psychological and social data.

1. An automated certification is also sent to the local office if level of care is met and is filed in the case record. See MS 3650. DMS determines program eligibility according to HCBS criteria and, if the individual qualifies, forwards form MAP-4200, or Prior Authorization letter to the local office.

2. An automated certification notifies the local office of the date eligibility for HCBS is met and contains an itemized list of the approved monthly HCBS services which may be provided to the individual and the anticipated monthly cost of these services.

B. The individual must meet all technical eligibility requirements for MA eligibility including age, blindness, disability, enumeration, third party liability, etc. [However, an individual not aged, blind or disabled may be eligible for HCBS if MA eligible in another category and all eligibility criteria are met.]

MS 2920 MEDICAID ELIGIBILITY

Medicaid eligibility is determined by comparing the individual's gross income to the special income standard and considering the number of days the individual has been receiving HCBS.

A. Use procedures found in MS 3500 and 3510.

B. Do not redetermine MA eligibility if the individual is MA eligible in another category.

C. [Determine the MA effective date using the first day of the month the individual met Kentucky Medicaid criteria for HCBS as indicated on form MAP-4200 or Prior Authorization letter.] This can only be 3 months prior to the date of application.

MS 2930 PATIENT LIABILITY

Patient liability for single HCBS recipients and couples both receiving HCBS is determined in a manner similar to the determination used for individuals in an NF or ICF/MR/DD. However, HCBS allows the use of a personal needs allowance which is computed as the SSI standard plus SSI general exclusion.

A. Use the personal needs allowance, for the patient liability determination.

B. Patient liability for an HCBS recipient with a non HCBS spouse is computed in a manner consistent with how patient liability is computed for institutionalized spouse with a community spouse. See MS 3550.

MS 2940 HCBS INDIVIDUAL

Determine MA and patient liability for the single HCBS individual as follows:

A. Step 1 – Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the HCBS individual.

2. [If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving HCBS for 30 full consecutive days, the individual is MA eligible. Complete Step II to determine patient liability.]

3. [If gross income is greater than the special income standard for an individual OR the individual has been receiving HCBS less than 30 full consecutive days, refer to MS 3505.]

[B. Step II - Determining Patient Liability]

1. Determine gross income and/or net profit of the HCBS individual.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the HCBS individual.

4. If the individual has dependents, deduct an amount to bring total income of the dependents up to the MA Scale for the appropriate family size.

5. Deduct verified, incurred medical expenses of the HCBS individual such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

6. Add any third party payment paid directly to the HCBS provider, if appropriate. Do not use these payments for conservation or other deductions.

7. The result is the HCBS individual's patient liability or payment toward cost of care.

MS 2950 HCBS CHILD LIVING WITH PARENT

Determine MA eligibility for the HCBS child living with parent, who is under age 18 or age 18 through 20 and in school as follows:

For the month of admission, consider the income of the HCBS child and parent, as appropriate.

After the month of HCBS admission, recalculate considering only the income of the HCBS child. See MS 2940.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the HCBS child.

2. Add gross income of parent.

3. If gross income is equal to or less than the special income standard for an individual AND the HCBS child has been receiving HCBS for 30 full consecutive days, the HCBS child is MA eligible. Complete Step II to determine patient liability.

4. [If gross income is greater than the special income standard for an individual OR the HCBS child has been receiving HCBS less than 30 full consecutive days, refer to MS 3505.]

[B. Step II - Determining Patient Liability]

1. Determine gross income and/or net profit of the HCBS child.

2. Add excess income of parent. This is determined by considering gross income/net profit, less MA Scale for the appropriate family size, excluding HCBS child, if appropriate.

3. Deduct the personal needs allowance.

4. Deduct an increased personal needs allowance, if appropriate, from income of the HCBS child.

5. Deduct verified, incurred medical expenses of the HCBS child, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA. See MS 3480.

6. If income of the parent is considered, deduct verified, incurred medical expenses of the parent.

7. Add any third party payment paid directly to the HCBS provider, if appropriate. Do not use these payments for conservation or other deductions.

8. The result is the HCBS child's patient liability or payment toward cost of care.

MS 2960 HCBS RECIPIENT WITH NON-HCBS SPOUSE

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the HCBS individual.

2. If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving HCBS for 30 full consecutive days, the individual is MA eligible. Complete Step III to determine patient liability.

3. [If gross income is greater than the special income standard for an individual OR the individual has been receiving HCBS less than 30 full consecutive days, refer to MS 3505.

B. Step II - Determining Community Spouse Income Allowance

Determine a community spouse income allowance, not to exceed the community spouse income allowance according to MS 3550.] The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process.

[C. Step III - Determining Family Income Allowance]

Determine a family income allowance if there is a minor child or dependent child, dependent parent or dependent siblings of either the community or HCBS spouse who is residing with the community spouse. Verify the dependent member's gross income and subtract it from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income. Compute the family income allowance for each dependent member.

[D. Step IV - Determining Patient Liability for HCBS Individual]

1. Determine gross income and/or net profit of the HCBS individual.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the HCBS individual.

4. Deduct the community spouse income allowance up to the maximum.

5. Deduct family income allowance.

6. Deduct verified, incurred medical expenses of the HCBS individual, such as monthly SMI charge, prorated health insurance

premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA. See MS 3480.

7. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.

8. The result is the individual's patient liability or payment toward cost of care.

MS 2970 HCBS RECIPIENT WITH HCBS SPOUSE

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income for each member of the HCBS couple.

2. If gross income of each member of the couple is equal to or less than the special income standard for an individual AND each member of the couple has received HCBS for 30 full consecutive days, each member of the couple is MA eligible. [Complete Step II to determine patient liability.]

3. [If gross income of either member of the couple is greater than the special income standard for an individual OR either member of the couple has received HCBS less than 30 full consecutive days, refer to MS 3505.

B. Step II - Determining Patient Liability for HCBS Couple]

1. For the month of admission only, determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case. After the month of admission, consider each member as an individual.

2. Deduct the personal needs allowance in each case.

3. Allow 1/2 of total of deductions as an increased personal needs allowance in each case, if appropriate.

4. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA Scale for the family size. Deduct 1/2 of the amount in each case.

5. Determine the couple's incurred medical expenses such as monthly SMI charge, prorated health insurance premiums and/or actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case. See MS 3480.

6. Add any third party payment paid directly to the HCBS provider, if appropriate. Do not use these payments for conservation or other deductions. [Consider 1/2 of the amount in each case.]

7. The result is the individual's patient liability or payment toward cost of care.

MS 2980 INCOME AND RESOURCE CONSIDERERATION

A. HCBS Individual with Non-HCBS Spouse. If an HCBS individual has a non-HCBS spouse, use the procedures as outlined below.

1. Consider only the income of the HCBS individual in determining MA eligibility and patient liability during the month of HCBS election/admission.
2. Consider the resources according to MS 1770.

B. HCBS Couple. If both members of a couple are receiving HCBS, use the following policy.

1. Consider resources of couple as available to each other.
2. Consider HCBS couples as individuals beginning with the month after the month of admission to HCBS.

C. Disabled or Blind HCBS Child Under Age 18 or Age 18 Through 20 if in School Living with Parent.

1. For the month of separation and for retroactive eligibility, consider the income and resources of HCBS child and parent.
2. Consider only the income and resources of the HCBS child after the month of HCBS admission.

D. K-TAP, AFDC Related or Family Related MA Parent or Child Receiving HCBS.

1. Consider resources and income in the K-TAP/Family Related MA case for up to one year.
2. Consider resources and income on the basis of living apart when it becomes apparent HCBS will be received for more than 1 year. Determine technical eligibility for Aged, Blind or Disabled MA program. Establish a separate J, K or M case for the HCBS parent/child.
3. When separate cases are established, remove the HCBS parent/child from the K-TAP, AFDC Related or Family Related MA case.

MS 2990 CASE ACTION

A. An automated certification notifies the local office of the date level of care is met for HCBS. See MS 3650.

B. INTERRUPTION OF STAY IN HCBS WHEN AN HCBS RECIPIENT ENTERS A NURSING FACILITY FOR 60 DAYS OR LESS. The HCBS provider annotates and forwards form MAP-24 to the local office to verify that patient status continues to be met, without a new patient assessment, if the recipient has been in a nursing facility for 60 days or less and is reinstated to the same HCBS provider. Vendor payment should be authorized upon receipt of this form.

Form MAP-24 includes an entry for the provider to indicate that the recipient was reinstated to the same HCBS provider within 60 days of the nursing facility admission.

C. MA APPLICANT. If the individual does not currently receive MA, the HCBS provider notifies the family or responsible party to apply for MA for the individual. [The special income standard does not apply if level of care is not met or the automated certification is not received. See MS 3650.]

D. SSI RECIPIENT. If the individual is an SSI recipient, set up a case record. [Authorize vendor payment on the PA-62 system upon receipt of the automated certification. Notify the recipient and HCBS provider of eligibility by form MA-105, Notice of Ineligibility.

If SSI is discontinued, and the recipient subsequently applies for MA and continues to participate in HCBS, use the automated notice as verification that patient status is met and the recipient continues to participate.] If the application is approved, authorize vendor payment. [KAMES will send notices to the recipient and HCBS provider of eligibility.]

E. PASS THROUGH RECIPIENT. [When the automated notice is received, complete case change on KAMES to authorize vendor payment.] Do not determine MA eligibility since the recipient is MA eligible as Pass Through. Program code and case status code are unchanged. [KAMES will send notices to the recipient and HCBS provider of eligibility.]

If the recipient is discharged from HCBS, discontinue vendor payment. The recipient and HCBS provider are notified of vendor payment ineligibility. Continue Pass Through eligibility.

F. STATE SUPPLEMENTATION RECIPIENT (CARETAKER OR FAMILY CARE). Individuals receiving SSP for caretaker services or for family care can receive HCBS if patient status is met and there is no duplication of service by the HCBS or SSP providers. If questionable, contact both providers to obtain information. [For individuals in a family care home,

contact the family care provider to determine if services provided duplicate the services provided by the HCBS provider.

When the automated notice is received, authorize vendor payment.] Do not determine MA eligibility since the individual is MA eligible as an SSP recipient. [KAMES will notify the recipient and HCBS provider of vendor payment eligibility.]

If the recipient is discharged from HCBS, discontinue vendor payment. [KAMES will notify the recipient and HCBS provider of vendor payment ineligibility.] SSP eligibility is continued if the recipient continues to receive caretaker services or to reside in a family care home.

If the case is active on the PA-62 system, send form MA-105 to notify the recipient and provider of vendor payment approval or discontinuance, as appropriate.

G. THE ADVERSE DETERMINATION NOTICE AND THE DMS LETTER OF TERMINATION. The adverse determination notice is used by the PRO to deny or terminate a recipient's level of care and is forwarded to DMS. DMS prepares the DMS letter of termination in response to the adverse determination notice when level of care is not met or is no longer required and forwards the forms to the local office.

The DMS letter of termination is also provided to the local office for other reasons, such as recipient no longer wishes to participate in HCBS, death, institutionalization, etc. Discontinue vendor payment if the DMS letter of termination is received. Redetermine MA eligibility using regular MA policy, if appropriate.

MS 2995 HCBS NOTICE REQUIREMENTS

Complete form MA-105 for cases on the PA-62 system according to procedural instructions for LTC, as appropriate. Provide a copy of pamphlet PAM-MAP-381, "Medicaid In-Home Services" to individuals requesting program information and to all program applicants.

A. When increasing liability for an HCBS individual, the 10 day advance notice must expire before action is taken on form PA-62.

B. Notify the HCBS provider. The name and address of the provider are listed on the DMS letter of approval.

C. Accept requests for hearings on patient status/reclassification according to procedures in MS 3690.

MS 3000 ACQUIRED BRAIN INJURY WAIVER PROGRAM

The Acquired Brain Injury (ABI) Waiver Program allows MA eligible individuals suffering from an injury to the brain after birth, that is not hereditary, congenital or degenerative, to receive necessary services at home to prevent institutionalization.

[Individuals eligible for ABI are eligible to choose these services to be delivered through the Consumer Directed Option (CDO) or in a combination of ABI and CDO. Refer to MS 2800.]

[The individual must meet criteria for the ABI waiver as determined by the Department for Mental Health/Mental Retardation (MHMR) who forwards form MAP-24C to the local DCBS office. At least two providers are listed for each recipient: the primary provider and the case manager. The primary provider collects the patient liability. The case manager and any other providers listed on form MAP-24C are paid by the primary provider.]

MS 3005 [ACQUIRED BRAIN INJURY (ABI)
MEDICAID ELIGIBILITY DETERMINATION

The following information is used to determine eligibility, to outline Consumer Directed Option (CDO) procedures for ABI recipients, and to list ABI covered services.

I.] Medicaid eligibility criteria for ABI waiver services are as follows:

A. The individual must meet ABI level of care criteria;

B. Must currently be 21 to 65 years of age. There is no restriction with regard to the age of the individual at the time of injury;

C. [Must be income eligible for Medicaid or establish a Qualifying Income Trust (QIT) if not income eligible using the special income standard processing determination. See MS 3505.]

D. Resource limits must be within the aged, blind or disabled standards; and

E. Spousal impoverishment rules apply to ABI individuals.

[II. Consumer Directed Option (CDO) procedures and options for ABI recipients are as follows:

A. Effective January 30, 2007, DMS implemented CDO for ABI wavier members. ABI members can use CDO to provide respite, companion care and personal care. CDO can be chosen by new approvals and existing ABI members. Only members who do not receive residential services through the ABI waiver can participate in CDO.

B. If CDO or blended services are chosen, the CDO support broker will notify the local DCBS office on form MAP-24C. For existing ABI members, DCBS staff will discharge the member from the ABI case manager as well as the ABI provider using the CDO admit date as the discharge date on KAMES. Add the support broker as the case manager using the support broker's ABI provider number as shown on the MAP-24C and add the ABI/CDO using provider number "1717000878002" as the primary provider number.

C. Advise ABI members to contact their case manager with any questions regarding CDO.

III.] The following are ABI covered services if not provided during periods of hospitalization or residence in a nursing facility:

A. Case Management services;

B. Personal care, respite care and companion services;

C. Structured day program in a licensed adult day health center or outpatient rehabilitation facility;

D. Pre-vocational and supported employment services;

E. Behavior Programming;

F. Counseling and training;

G. Occupational therapy, speech, hearing, language services;

H. Specialized medical equipment and supplies;

I. Environmental modifications, limited to $1,000 per six month period; and

J. Community residential services as a last resort to remaining in the community.

MS 3010 ABI PATIENT LIABILITY DETERMINATION

A. The approval document, MAP-24B, Brain Injury Waiver Admission/Discharge, notifies the local office of the primary provider and lists the services, costs and providers of the service. A Confirmation Notice is not applicable for ABI waiver services.

B. The individual is eligible for 3 months of retroactive coverage;

C. Individuals determined eligible for the ABI waiver program are excluded from managed care;

D. Make an eligibility determination based on criteria in MS 2940 to 2990; and

E. [Process ABI cases within 30 days of receipt of a complete application.]

MS 3015 ABI INDIVIDUAL

Determine MA and patient liability for the single ABI individual as follows:

A. Step I - Determining MA Eligibility Using Special Income Standard
   1. Determine gross income of the ABI individual.
   2. [If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving ABI for 30 full consecutive days, the individual is MA eligible. Complete Step II to determine patient liability.]
   3. [If gross income is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Patient Liability]
   1. Determine gross income and/or net profit of the ABI individual.
   2. Deduct the personal needs allowance.
   3. Deduct an increased personal needs allowance, if appropriate, from income of the ABI individual.
   4. If the individual has dependents, deduct an amount to bring total income of the dependents up to the MA Scale for the appropriate family size.
   5. Deduct verified, incurred medical expenses of the ABI individual such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.
   6. Add any third party payment paid directly to the ABI provider, if appropriate. Do not use these payments for conservation or other deductions.
   7. The result is the ABI individual's patent liability or payment toward cost of care.

MS 3017 ABI RECIPIENT WITH NON-ABI SPOUSE

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the ABI individual.
2. [If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving ABI for 30 full consecutive days, the individual is MA eligible. Complete Step II to determine patient liability.]
3. [If gross income is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Community Spouse Income Allowance

Determine a community spouse income allowance, not to exceed the maximum community spouse income allowance.] The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process. [Refer to MS 3550.

C. Step III - Determining Family Income Allowance]

Determine a family income allowance if there is a minor child or dependent child, dependent parent or dependent siblings of either the community or ABI spouse who is residing with the community spouse. Verify the dependent member's gross income and subtract it from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income. Compute the family income allowance for each dependent member.

[D. Step IV - Determining Patient Liability for the ABI Individual]

1. Determine gross income and/or net profit of the ABI individual.

2. Deduct the personal needs allowance.

3. Deduct an increased personal needs allowance, if appropriate, from income of the ABI individual.

4. Deduct the community spouse income allowance up to the maximum.

5. Deduct family income allowance.

6. Deduct verified, incurred medical expenses of the ABI individual such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA. See MS 3480.

7. Add any third party payment paid directly to the ABI provider, if appropriate. Do not use these payments for conservation or other deductions.

8. The result is the individual's patient liability or payment toward cost of care.

MS 3020 ABI RECIPIENT WITH ABI SPOUSE

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income for each member of the ABI couple.

2. [If gross income of each member of the couple is equal to or less than the special income standard for an individual AND each member of the couple has received ABI for 30 full consecutive days, each member of the couple is MA eligible. Complete Step II to determine patient liability.]

3. [If gross income of either member of the couple is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Patient Liability for the ABI Couple]

1. Determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case.

2. Deduct the personal needs allowance in each case.

3. Allow 1/2 of total of deductions as an increased personal needs allowance in each case, if appropriate.

4. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA Scale for the family size. Deduct 1/2 of the amount in each case.

5. Determine the couple's incurred medical expenses such as monthly SMI charge, prorated health insurance premiums and/or actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case. See MS 3480.

6. Add any third party payment paid directly to the ABI provider, if appropriate. Do not use these payments for conservation or other deductions. Deduct 1/2 of the amount in each case.

7. The result is the individual's patient liability or payment toward cost of care.

MS 3025 ABI INCOME AND RESOURCE CONSIDERATION

A. ABI INDIVIDUAL WITH NON-ABI SPOUSE. If an ABI individual has a non-ABI spouse, use the procedures as outlined below.

1. Consider only the income of the ABI individual in determining MA eligibility and patient liability during the month of ABI admission.

2. Consider resources according to MS 1770.

B. ABI COUPLE. If both members of a couple are receiving ABI, use the following policy:

1. Consider resources of couple as available to each other. Consider income according to Step I during the month of ABI admission.

2. Consider ABI couples as individuals beginning with the month after the month of admission to ABI.

C. K-TAP, AFDC-RELATED OR FAMILY MA PARENT RECEIVING ABI. Use the following procedures.

1. Consider resources and income in the K-TAP, AFDC-Related or Family MA case for up to one year.

2. Consider resources and income on the basis of living apart when it becomes apparent ABI will be received for more than 1 year. Determine technical eligibility for aged, blind or disabled MA program. Establish a separate J, K or M case for the ABI parent.

3. When separate cases are established, remove the ABI parent from the K-TAP, AFDC-Related or Family MA case.

MS 3030 ABI Long Term Care (LTC) Waiver

The Medicaid Acquired Brain Injury (ABI LTC Waiver) is implemented effective 10/1/08. This waiver is designed for individuals who meet ABI level of care criteria, but require ongoing supportive services beyond the intensive rehabilitation services provided by the traditional ABI Waiver program. In the traditional ABI Waiver program, individuals are expected to achieve recovery.

A. Technical requirements for ABI LTC Waiver:

1. Must meet eligibility criteria in MS 2940 to 2990;

2. Must meet ABI level of care criteria, see MS 3005;

3. Must be age 18 or older.

B. Financial requirements for ABI LTC Waiver:

1. Must be within LTC/Waiver income guidelines for Medicaid or establish a Qualifying Income Trust (QIT) if not income eligible using the special income standard processing determination. See MS 3505.

2. Resource limits must be within the aged, blind or disabled MA standards. Spousal Impoverishment rules apply to ABI LTC Waiver individuals. See MS 3025.

3. The personal needs allowance is the same as currently allowed for non-institutionalized individuals receiving waiver services.

4. ABI LTC Waiver recipients/applicants with earned income are allowed the $65 and ½ the remainder deduction.

5. Therapeutic Wages for ABI LTC Waiver recipients/applicants are entered on the earned income screen on KAMES. The system will apply the $65 and ½ the remainder deduction. Answer “Y” to the question “DOES HE/SHE RECEIVE EARNINGS FROM THERAPEUTIC PLACEMENT?” on the second long term care screen.

C. Program requirements for ABI LTC Waiver:

1. An ABI LTC Waiver recipient may have only one provider.

2. ABI LTC Waiver members are identified by a “provider type of 18” indicator on the PRO CERT.

3. Process the ABI LTC Waiver case within 30 days of receipt of a complete application.

4. Individuals determined eligible for ABI LTC Waiver are exempt from Managed Care, KenPAC and co-payments.

5. The individual is eligible for 3 months of retroactive coverage. However, coverage cannot start prior to the onset date of the program, which is 10/1/08.

6. Consumer Direct Option (CDO) is an option available to ABI LTC Waiver recipients and can be used to provide respite companion care and personal care. CDO recipients, with an "18" type of care on KAMES and "B2" institution status for PA62/LTC cases; will have a provider number with a prefix of 17.

7. Pass Through cases must be transferred to a "J", "K" or "M" category to receive ABI LTC Waiver.

8. State Supplementation (SSP) recipients in a Family Care Home (FCH) or receiving Caretaker Services are eligible to receive ABI LTC Waiver. Workers add the LTC segment to the existing SSP case.

9. Individuals receiving Personal Care Home (PCH) services with an institutional status code of "P1" or "P2" are not eligible to receive ABI LTC Waiver services. If a worker adds ABI LTC Waiver services (type 18) to a SSP case for a recipient in a PCH (INST STAT CODE: "P1" or "P2"), the following error message will display: "PERSONNAL CARE AND WAIVER CANNOT CO-EXIST". At this point the worker must:

   a. Use the "F3" key to back out of the case; or
   b. Continue past the 1st page of the LTC screen and at case disposition deny the application. The following denial reason will display: "NOT WAIVER ELIGIBLE IF PC."

D. System Entry:

1. Entering ABI LTC Waiver cases on KAMES:

   a. This level of care is applicable for any Medicaid recipient age 18 or older.
   b. Enter a provider number that begins with a 17, 33, 42 or 43.
   c. Enter provider type "18" in response to the question "WHAT IS THE TYPE OF CARE PROVIDED?". If Type 18 and provider number does not begin with a 17, 33, 42 or 43, the following message will display: "INVALID PROVIDER FOR FACILITY CODE".
   d. Enter "PR" as the documentation type if anything other than "PR" is entered the following error message will display: "DOCUMENT TYPE DOES NOT MATCH PROVIDER TYPE".
   e. Enter the date for the level of care as 10/1/08 or after. If a level of care date prior to 10/1/08 is entered, the following error message will display: "PROVIDER NUMBER OR ADMISSION DATE INVALID".

2. Entering ABI LTC Waiver cases ("A", "B" or "D") on 3U PA 62 System:

   a. Enter "09" for the case status in field 22.
   b. Enter "B2" for the institutional status in field 23.

c. “V-Print” edit errors for incorrect entries are as follows:

1) If “B2” is entered as the institutional status and the admission date entered is prior to 10/1/08 or the facility number does not begin with a 17, 33, 42, or 43, the “V-Print” will show a 379 error code stating, “CURRENT FACILITY INVALID FOR INSTITUTION STATUS”.
2) If more than one facility is entered for an institution status “B2” code, the “V-Print” will show a 642 error code stating “SECOND PROVIDER NOT ALLOWED FOR B2 INSTITUTION STATUS”.

MS 3050 SCOPE OF PROGRAM

The Hospice program offers specific medical services to terminally ill individuals with a life expectancy of six months or less who are MA eligible. An individual may elect MA Hospice services instead of regular MA services. Noninstitutional Hospice services are provided in an individual's home and Institutional Hospice services are provided in a Nursing Facility (NF).

A. MEDICAID HOSPICE SERVICES. The Hospice program offers a greater variety of medical services to the terminally ill recipient. The following are an array of services offered only to individuals enrolled in a certified Hospice program.

1. Nursing care provided by or under the supervision of a registered nurse.
2. Medical social services provided by a social worker under the direction of a physician.
3. Counseling services, including dietary counseling, provided to the terminally ill individual and the family members or other persons caring for the individual at home.
4. Short term inpatient care, including both respite care and procedures necessary for pain control, acute and chronic symptom management provided in a MA participating hospital or NF.
5. [Long term inpatient care in a NF with the NF as the individual's place of residence.]
6. Continuous home care, full time nursing care, during a period of acute medical crisis, minimum of 8 hours per day.
7. Medical appliances and supplies, including drugs and biologicals.
8. Home health aide services and homemaker services.
9. Physical and occupational therapies and speech/language pathology services.

B. BENEFIT PERIOD. Hospice services consist of 4 benefit periods consisting of 90/90/30 days with unlimited 60 day benefit periods thereafter.

1. The individual may elect at any time to revoke Hospice services without showing cause or may change Hospice providers.
2. DMS tracks the benefit periods.
[3. Forms MAP-374, MAP-375, MAP-376 and MAP-378 are used by the designated Hospice to notify the Department for Community Based Services (DCBS) staff of Hospice elections, revocations, provider changes and terminations. The designated Hospice is responsible for providing these forms to the local DCBS office.

a. Elections: MAP-374, Election of Medicaid Hospice Benefits, notifies DCBS staff of an individual’s choice for Hospice benefit and it verifies medical eligibility requirements (terminally ill, life expectancy of 6 months or less) and identifies admissions into skilled nursing facilities, if appropriate. If an individual revokes

or terminates Hospice benefits, a second form MAP-374 is required to determine eligibility for a second Hospice program. Initiate the application process when form MAP-374 is received. File the form in the case record; or

b. Revocations: MAP-375, Revocation of Medicaid Hospice Benefits, notifies DCBS staff that an individual has chosen to revoke Hospice benefits. Hospice benefits may be revoked at any time and for any reason. Recipients who revoke Hospice may re-elect Hospice at any time in the future. Terminate Hospice benefits and re-determine Medicaid eligibility using regular MA policy when form MAP-375 is received. File the form in the case record; or

c. Hospice Vendor Changes: MAP-376, Change of Hospice Providers, notifies DCBS staff of a change in Hospice providers. Complete the Hospice provider change when form MAP-376 is received. File form MAP-376 in the case record; or

d. Terminations: MAP-378, Termination of Medicaid Hospice Benefits, notifies DCBS staff that Hospice benefits are terminated as a result of death or other reason as indicated on the form. A termination of Hospice benefits is NOT a revocation of benefits. Discontinue Hospice benefits and re-determine Medicaid eligibility using regular MA policy, if appropriate. File the form in the case record; and

e. Hospice Patient Change: MAP-403, Hospice Patient Status Change, notifies DCBS staff that an individual went from a NF to a home setting or other changes. The use of MAP-403 avoids the necessity of doing a new election form. Make the necessary changes and file in case record.]

MS 3060 HOSPICE RATES

The following are DMS Hospice rates by county. The Hospice rates are used to determine spend down eligibility for a non-institutionalized Hospice recipient.

The Hospice rates are established by county and not the service area of the Hospice provider.

The Hospice recipient's county of residence determine the Hospice rate.

A. [Boone, Campbell, Gallatin, Kenton and Pendleton counties' monthly Hospice rate is $3,672.51.]

B. [Boyd, Carter, Christian and Greenup counties' monthly Hospice rate is $3,721.35.]

C. [Bullitt, Jefferson and Oldham counties' monthly Hospice rate is $3,626.44.]

D. [Henderson County's monthly Hospice rate is $3,408.41.]

E. [Bourbon, Clark, Daviess, Fayette, Jessamine, Madison, Scott, and Woodford counties' monthly Hospice rate is $3,477.14.]

F. [Daviess County's monthly Hospice rate is $3,393.56.]

G. [For all other counties the monthly Hospice rate is $3,286.06.]

The Hospice rates change every January. These rates are effective January 1, 2005.]

MS 3070 HOSPICE TECHNICAL ELIGIBILITY REQUIREMENTS

A. The applicant must be enrolled with a DMS certified Hospice provider. Form MAP-374 verifies Hospice election, date of enrollment, and long term inpatient care in a nursing facility, if appropriate. [A person who is receiving Hospice Services in a Nursing Facility is not required to be in a Medicaid certified bed.] The Hospice provider forwards form MAP-374 to the local office.

B. The applicant must meet all technical eligibility requirements for MA eligibility including age, blindness, disability, enumeration, third party liability, etc. However, an individual not aged, blind or disabled may be eligible for Hospice services if MA eligible in another category.

C. If a recipient revokes or terminates Hospice benefits, a second form MAP-374 is forwarded by the Hospice provider to the local office verifying Hospice election for the remaining benefit periods.

MS 3080 HOSPICE NOTICE PROCEDURES

Complete form MA-105 for cases on the PA-62 system according to procedural instructions for LTC, as appropriate.

A. When increasing liability for a Hospice individual, allow the 10-day advance notice to expire before taking action.

B. In addition to usual distribution for form MA-105, send a copy to the Hospice provider.

C. Accept requests for hearings on patient status/reclassification according to procedures in MS 3690.

MS 3100 NONINSTITUTIONAL HOSPICE MEDICAID ELIGIBILITY

Determine MA eligibility by comparing the applicant's gross income to the special income standard for an eligible individual, considering the number of days the applicant has been receiving Hospice.

A. Use the special income standard if:

1. The individual's gross income is equal to or less than the special income standard for an individual AND the individual has been receiving Hospice for 30 full consecutive days. [The 30 full consecutive days is effective the 32nd day and includes days the individual received LTC, HCBS or SCL.]

2. Gross income is equal to or less than the special income standard for an individual AND the Hospice election is less than 30 full consecutive days as a result of death. THIS IS THE ONLY EXCEPTION.

3. MA eligibility is determined by comparing gross income to the special income standard and considering the number of days the individual has been in Hospice. In some situations the individual's gross income may be equal to or less than the special income standard for an individual but more than the actual cost of Hospice. These individuals are ongoing MA eligible, but may be vendor payment ineligible.

B. DO NOT use the special income standard if the applicant's gross income is greater than the special income standard OR if the individual has not been receiving Hospice for 30 full consecutive days.

1. Determine MA eligibility by a quarterly spend down for these individuals.

2. Do not determine MA eligibility if the individual is MA eligible in another category.

MS 3110* NONINSTITUTIONAL HOSPICE MA EFFECTIVE DATE

Determine the MA effective date using the first day of the month the individual elected Hospice as indicated on Form MAP-374.

A. If the individual has been in LTC for 30 full consecutive days at the time of case processing, compare the income to the special income standard for current and retroactive eligibility beginning with the first day of the month in which patient status was met.

B. Use regular MA policy for retroactive months during which patient status was not met.

MS 3120* NONINSTITUTIONAL HOSPICE PATIENT LIABILITY

Patient liability is determined in a manner similar to the determination for individuals in an NF or ICF/MR/DD. The Hospice Program allows the use of a Hospice personal needs allowance of the SSI Standard plus the SSI general exclusion of $20, which replaces the LTC personal needs allowance.

A. Use the Hospice personal needs allowance if gross income is equal to or less than the special income standard for an individual AND the applicant has been receiving Hospice for 30 full consecutive days.

B. Also use the Hospice personal needs allowance if gross income is equal to or less than the special income standard for an individual and the Hospice election is less than 30 full consecutive days as a result of death. THIS IS THE ONLY EXCEPTION.

MS 3130 [NONINSTITUTIONALIZED HOSPICE INDIVIDUAL OR CHILD LIVING WITH PARENTS

Determine MA and patient liability for a single Hospice individual, or a Hospice child under age 18 Or age 18 through 20 if in school living with parents as follows.

Consider the income of the Hospice child and parent the month of Hospice election. After the month of Hospice election, recalculate considering only the child's income. See MS 3160.]

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the Hospice applicant. For a Hospice child, combine parental income and the child's income, and compare to the special income standard for an individual.
2. If gross income is equal to or less than the special income standard for an individual AND the individual has been receiving Hospice services for 30 full consecutive days, the applicant is MA eligible. Complete Step III to determine patient liability.
3. [If gross income is greater than the special income standard for an individual OR the individual has been receiving Hospice services less than 30 full consecutive days, determine quarterly spend down eligibility, using the regular MA Scale.] Do not complete Step II or Step III on form PA-1A.

B. Step III - Determining Patient Liability

1. Determine gross income and/or net profit of the Hospice individual.
2. Add excess income of the Hospice child's parent. Consider gross income/net profit less MA Scale, for the appropriate family size, excluding Hospice individual.
3. Deduct the personal needs allowance.
4. Deduct an increased personal needs allowance, if appropriate, from income of the Hospice individual/child.
5. If dependents have income less than MA Scale, deduct an amount to bring total income of dependents up to the appropriate MA Scale for the family size.
6. Deduct verified, incurred medical expenses of the Hospice individual not subject to third party payment. This may cause a monthly change in the individual's liability.
7. If income of the parent is considered, deduct verified, incurred medical expenses of the spouse/parent.
8. Add any third party payment paid directly to the Hospice provider, if appropriate. Do not use these payments for conservation or other deductions.
9. The result is the individual's patient liability or payment toward cost of care.

MS 3140 [NONINSTITUTIONALIZED HOSPICE COUPLE]

[Determine MA and patient liability for a couple, both receiving Hospice, as follows.

Consider the income of the couple the month of Hospice election. After the month of Hospice election, recalculate considering only the Hospice individual's income and the spouse's income actually contributed to the Hospice individual. See MS 3160.]]

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income for each member of the Hospice couple.
2. If each member's gross income is equal to or less than the special income standard for an individual AND each member of the couple has received Hospice for 30 full consecutive days, both are MA eligible. Complete Step III to determine patient liability.
3. If gross income of either member of the couple is greater than the special income standard for an individual, OR either member of the couple has received Hospice less than 30 full consecutive days, DO NOT complete Step II or Step III on form PA-1A. If there is excess income, the case is processed as a spend down, using the regular MA scale.

B. Step III - Determining Patient Liability for Hospice Couple

1. Spouses using same Hospice provider.

   a. Determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case.
   b. Deduct the personal needs allowance in each case.
   c. Allow 1/2 total of deduction as an increased personal needs allowance in each case.
   d. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA Scale for the family size. Deduct 1/2 of the amount in each case.
   e. Determine the couple's combined, verified, incurred medical expenses such as monthly SMI charge, prorated health insurance premiums and/or actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case. This may cause a monthly change in the individual's patient liability.
   f. Add any third party payment paid directly to the Hospice provider, if appropriate. Do not use these payments for conservation or other deductions. Deduct 1/2 of the amount in each case.
   g. The result is the individual's patient liability or payment toward cost of care.

2. Spouses using different Hospice providers.

   a. Determine gross income and/or net profit of the individual. Do not consider income as a couple.
   b. Deduct the personal needs allowance in each case.
   c. Deduct an increased personal needs allowance for the individual, if appropriate.
   d. If dependents have income less than the MA Scale, determine the amount required to bring the dependent's total income up to the MA Scale for the family size. Deduct the amount in only one case. Apply the deduction to the case which will most advantage the couple, unless the couple chooses otherwise.
   e. Deduct verified, incurred medical expenses of the individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the individual's patient liability.
   f. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.
   g. The result is the individual's patient liability or payment toward cost of care.

MS 3150 NONINSTITUTIONALIZED HOSPICE APPLICANT WITH NON-HOSPICE SPOUSE

Determination of MA and patient liability for noninstitutionalized Hospice applicant with non-Hospice spouse in the home.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the individual.
2. If gross income is equal to or less than the special income standard for an individual AND Hospice has been received for 30 full consecutive days, individual is MA eligible. [Complete Steps II, III, and IV to determine patient liability.]
3. If gross income is greater than the special income standard for an individual OR the individual has been receiving non-institutionalized Hospice less than 30 full consecutive days, determine quarterly spend down eligibility, using the regular MA Scale. Do not complete Steps II, through V on form PA-1A, Supplement B.

B. [Step II - Determining Community Spouse Income Allowance

Determine a community spouse income allowance, not to exceed the community spouse income allowance, according to MS 3550.] The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process.

C. [Step III - Determining Family Income Allowance]

Determine a family income allowance if there is a minor child or dependent child, dependent parent or dependent siblings of either the community spouse or Hospice applicant who is residing with the community spouse. Verify the dependent member's gross income and subtract it from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income allowance. Compute the family income allowance for each dependent member.

D. [Step IV - Determining Patient Liability for Hospice Applicant]

1. Determine gross income and/or net profit of the Hospice applicant.
2. Deduct Hospice personal needs allowance, SSI Standard plus the SSI general exclusion.
3. Deduct an increased personal needs allowance, if appropriate, from income of the Hospice applicant.
4. Deduct community spouse income allowance up to the maximum.
5. Deduct family income allowance.

6. Deduct verified, incurred medical expenses of the Hospice applicant, such as monthly SMI charge, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.
7. Any third party payment paid directly to the facility for Hospice cost, if appropriate. Do not use these payments for conservation or other deductions.
8. The result is the applicant's patient liability or payment toward cost of care.

MS 3160 NONINSTITUTIONAL HOSPICE INCOME AND RESOURCE CONSIDERATION

A. NONINSTITUTIONALIZED HOSPICE INDIVIDUAL WITH NON-HOSPICE SPOUSE

Consider only the income of the individual according to MS 3150. Resources of the couple are considered according to MS 2120.

B. NONINSTITUTIONALIZED HOSPICE COUPLE

1. Eligible Noninstitutionalized Hospice Couples Using the SAME Hospice Provider.

a. During the month of Hospice election:

(1) To determine MA eligibility, consider resources of the couple as available to each other. Consider income according to Step I. EXCEPTION: Do not consider income of an SSI spouse.
(2) Divide the couple's income and medical expenses equally, and consider equal amounts to each spouse to determine patient liability.
(3) If the couple has dependent(s), determine an amount to bring the dependent's income up to the appropriate MA Scale for the family size. Deduct 1/2 of the amount in each case.

b. Beginning the month after the month of Hospice election, consider only income and resources of the spouse which are actually contributed to the individual.

2. Eligible Noninstitutionalized Hospice Couples Using DIFFERENT Hospice Providers.

a. During the separation month:

(1) To determine MA eligibility, consider resources of the couple as available to each other. Consider income according to Step I. EXCEPTION: Do not consider income of an SSI spouse.
(2) Consider income and medical expenses of each individual to determine patient liability. (Do not consider income and medical expenses as a couple.)
(3) If the couple has a dependent(s), determine an amount to bring the dependent's income up to the appropriate MA Scale for the family size. Deduct the income in only one case. Apply the deduction to the case which will most advantage the couple, unless the couple chooses otherwise.

b. Beginning the month after the month of Hospice election, consider only income and resources of the spouse which are actually contributed to the individual.

C. BLIND OR DISABLED NONINSTITUTIONALIZED HOSPICE CHILD (UNDER AGE 18 OR AGE 18 THROUGH 20 IF IN SCHOOL) LIVING WITH PARENTS

1. Consider the income and resources of the Hospice child and parent(s) during the month of Hospice election.
2. Consider only the income and resources of the Hospice child after the month of Hospice election.

D. [K-TAP/FAMILY MA PARENT RECEIVING NONINSTITUTIONAL HOSPICE]

1. Consider resources and income in the K-TAP/Family MA case for up to one year.
2. Consider resources and income on basis of living apart when it becomes apparent Hospice services will be received more than 1 year. Determine technical eligibility for the Aged, Blind or Disabled MA program.

MS 3170 NON-INSTITUTIONAL HOSPICE CASE ACTION

A. FORM MAP-374. Form MAP-374 notifies local staff of the date Hospice is elected and verifies that medical eligibility requirements, terminally ill, life expectancy of six months or less, are met . The Hospice provider forwards form MAP-374 to the local office. When application is received, file form MAP-374 in the case record and take appropriate case action to authorize vendor payment.

B. MA APPLICANT. If the individual does not currently receive MA, the Hospice provider notifies the individual's family or responsible party to apply for MA. [The special income standard does not apply if form MAP-374 is not received.] File form MAP-374 in the case record.

C. SSI RECIPIENT. If the individual is a SSI or a SSI/other income recipient, establish a case record. [Authorize vendor payment upon receipt of form MAP-374 and establish a case on the PA-62 system.]. Consider the SSI or SSI/other income, if received. KAMES will send appropriate notices.

If SSI is discontinued and the individual subsequently applies for MA and continues to participate in the Hospice program, use form MAP-374 as verification that eligibility requirements are met. If the application is approved, authorize vendor payment. [KAMES will send appropriate notices.]

D. PASS THROUGH RECIPIENT. If the individual is a Pass Through recipient, authorize vendor payment upon receipt of form MAP-374. File form MAP-374 in case record. [KAMES will notify the recipient and Hospice provider of eligibility.]

If the recipient revokes or terminates Hospice benefits, discontinue vendor payment. [KAMES will notify the recipient and Hospice provider of ineligibility.] Continue Pass Through eligibility.

E. STATE SUPPLEMENTATION RECIPIENT. If the individual is an SSP recipient, authorize vendor payment upon receipt of form MAP-374.

1. File form MAP-374 in case record.
2. Do not change program code and case status code.
3. [Send form MA-105 notifying the recipient and Hospice provider of eligibility for case on PA-62; for cases on KAMES the appropriate notices will be system generated.]
4. If the recipient revokes or terminates Hospice benefits, discontinue the vendor payment.
   a. [Send form MA-105 notifying the recipient and Hospice provider of ineligibility if on PA-62; for cases on KAMES the appropriate notices will be system generated.]
   b. Continue SSP eligibility.
   c. Do not change program code and case status code.

MS 3180

INSTITUTIONAL HOSPICE
MA ELIGIBILITY DETERMINATION

MA eligibility is determined by comparing the individual's gross income to the special income standard for an eligible individual and considering the number of days the applicant has been receiving Hospice.

A. Follow eligibility determination procedures found in MS 3500.

B. [The 30 full consecutive days is effective the 32nd day and may include days the individual received LTC, HCBS or SCL.]

MS 3190 [INSTITUTIONAL HOSPICE MA EFFECTIVE DATE]

Determine the MA effective date using the first day of the month the applicant elected Hospice as indicated on form MAP-374.

If case is processed prior to 30 full consecutive days of admission, use regular MA policy to determine if the individual is potentially eligible for retroactive MA for the three months prior to the month of application.

If the individual has been in LTC for 30 full consecutive days at the time of case processing, compare the income to the special income standard for current and retroactive eligibility beginning with the first day of the month in which patient status was met. Use regular MA policy for retroactive months during which patient status was not met.

MS 3200 [INSTITUTIONAL HOSPICE PATIENT LIABILITY]

Determine patient liability in the same manner as for individuals in an NF or ICF/MR/DD. The Hospice program allows the use of the personal needs allowance for individuals receiving Hospice services in an LTC facility.

Compute patient liability for an institutionalized Hospice recipient with a community spouse in a manner consistent with patient liability computation for an institutionalized spouse with a community spouse. See MS 3550.

MS 3210 INSTITUTIONALIZED HOSPICE INDIVIDUAL

A. Step I - Determining MA Eligibility Using Special Income Standard

1 Determine gross income of the Hospice individual.

2. [If gross income is equal to or less than the special income standard for an individual AND the individual has been in Hospice for 30 full consecutive days, the individual is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Patient Liability]

1. Determine gross income and/or net profit of the individual.

2. Deduct the personal needs allowance.

3. Deduct, if appropriate, increased personal needs allowance from income of the individual.

4. If dependents have income less than MA Scale, deduct an amount to bring total income of dependents up to the MA Scale for the appropriate family size.

5. Deduct verified, incurred medical expenses of the Hospice individual not subject to third party payment. This may cause a monthly change in the individual's patient liability.

6. Add any third party payment paid directly to the Hospice provider for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.

7. The result is the individual's patient liability or payment toward cost of care.

MS 3220 INSTITUTIONALIZED HOSPICE CHILD

Determine MA and patient liability for the institutionalized Hospice blind or disabled child under age 18 or age 18 through 20 if in school, applicant or recipient, living with parents as follows:

For the month of admission, consider the income of the Hospice child and parent, as appropriate.

After the month of Hospice admission, recalculate considering only the income of the Hospice child. See MS 3210.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the Hospice child.

2. [If gross income is equal to or less than the special income standard for an individual AND the Hospice child has been in Hospice for 30 full consecutive days, the Hospice child is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual, refer to MS 3505.

B. Step II - Determining Patient Liability]

1. Determine gross income and/or net profit of the Hospice child.

2. Add excess income of parent. Consider Gross income/net profit less appropriate MA Scale.

3. Deduct the personal needs allowance.

4. Deduct, if appropriate, increased personal needs allowance from income of the Hospice child.

5. If dependents have income less than MA Scale, deduct an amount to bring total income of dependents up to the MA Scale for the appropriate family size.

6. Deduct verified, incurred medical expenses of the Hospice child not subject to third party payment. This may cause a monthly change in the Hospice child's liability.

7. If income of the parent is considered, deduct verified, incurred medical expenses of the parent.

8. Add any third party payment paid directly to the Hospice provider for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.

9. The result is the Hospice child's patient liability or payment toward cost of care.

MS 3230 INSTITUTIONALIZED HOSPICE INDIVIDUAL WITH NON-HOSPICE SPOUSE

A. Step I – Income Consideration

1. Determine gross income of the Hospice individual.

2. [If gross income is equal to or less than the special income standard for an individual AND the applicant has been receiving Hospice for 30 full consecutive days, the applicant is MA eligible. Complete Step II to determine patient liability.

3. If gross income is greater than the special income standard for an individual refer to MS 3505.

B. Step II - Determining Community Spouse Income Allowance

Determine a community spouse income allowance as per MS 3550.] The community spouse income allowance can only exceed the maximum allowable amount if there is a court order in a greater amount or if a hearing officer establishes need for a higher amount through the fair hearing process.

[C. Step III - Determining Family Income Allowance]

Determine a family income allowance if there is a minor child or dependent child, dependent parent or dependent sibling of either the community or Hospice spouse who is residing with the community spouse. Verify the dependent member's gross income and subtract it from the family income allowance and allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income allowance. Compute the family income allowance for each dependent member.

[D. Step IV - Determining Patient Liability for Hospice Spouse]

1. Determine gross income and/or net profit of the Hospice individual.

2. Deduct the personal needs allowance.

3. Deduct, if appropriate, an increased personal needs allowance from income of the Hospice individual.

4. Deduct community spouse income allowance up to maximum.

5. Deduct family income allowance.

6. Deduct verified incurred medical expenses of the Hospice individual, such as monthly SMI charge, prorated health insurance

premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by MA.

7. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.

8. The result is the individual's patient liability or payment toward cost of care.

MS 3240 INSTITUTIONALIZED HOSPICE COUPLE

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income for each member of the Hospice couple.

2. If each member's gross income is equal to or less than the special income standard for an individual AND each member of the couple has received Hospice for 30 full consecutive days, each member of the couple is MA eligible. [Complete Step II to determine patient liability.

3. If gross income of either member of the couple is greater than the special income standard for an individual refer to MS 3505.

B. Step II - Determining Patient Liability for Hospice Couple]

1. Spouses in same LTC facility.

a. Determine gross income of the couple and divide by 2. Consider 1/2 of the income in each case.
b. Deduct the personal needs allowance in each case.
c. Allow 1/2 total of deduction as an increased personal needs allowance in each case.
d. If the couple has dependents, determine an amount to bring the dependent's total income up to the MA Scale for the family size. Deduct 1/2 of the amount of each case.
e. Determine the couple's combined, verified medical expenses such as monthly SMI charge, prorated health insurance premiums and/or actual payments on a current or prior medical bill not subject to third party payment or covered by MA. Deduct 1/2 of the amount in each case. This may cause a monthly change in the individual's patient liability.
f. Add any third party payment paid directly to the Hospice provider, if appropriate. Do not use these payments for conservation or other deductions. Deduct 1/2 of the amount in each case.
g. The result is the individual's patient liability or payment toward cost of care.

2. Spouses in different LTC facilities.

a. Determine gross income and/or net profit of the individual. Do not consider income as a couple.
b. Deduct the personal needs allowance in each case.
c. Deduct an increased personal needs allowance for the individual, if appropriate.
d. If dependents have income less than the MA Scale, determine the amount required to bring the dependent's total income up to the MA Scale for the family size. Deduct the

amount in only one case. Apply the deduction to the case which will most advantage the couple, unless the couple chooses otherwise.

e. Deduct verified, incurred medical expenses of the LTC individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the individual's patient liability.

f. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions

g. The result is the individual's patient liability or payment toward cost of care.

MS 3250 [INSTITUTIONAL HOSPICE INCOME AND RESOURCE CONSIDERATION

A. INSTITUTIONALIZED HOSPICE INDIVIDUAL WITH NON-HOSPICE SPOUSE]

1. If an institutionalized Hospice individual has a non-Hospice spouse, consider only the income of the Hospice individual in determining MA eligibility and patient liability during the month of Hospice election/admission.

2. Consider the resources according to MS 2120.

B. [INSTITUTIONALIZED HOSPICE COUPLE]

1. [Eligible institutionalized Hospice couples in the SAME LTC facility.

a. During the separation month:
1) Consider resources of the couple as available to each other. Consider income according to Step I or Step II, as appropriate. EXCEPTION: Do not consider income of an SSI spouse.
2) To determine patient liability, divide the couple's income and medical expenses equally, and consider equal amounts to each spouse.
3) If the couple has dependents, determine an amount to bring the dependent's income up to the appropriate MA Scale for the family size. Deduct 1/2 of the amount in each case.

b. Beginning the month after the month of Hospice election, consider only income and resources of the ineligible spouse which are actually contributed to the recipient.]

2. Eligible institutionalized Hospice couples in DIFFERENT LTC facilities.

a. [During the separation month:
(1) Consider resources of the couple as available to each other.] Consider income according to Step I or Step II, as appropriate. EXCEPTION: Do not consider income of an SSI spouse.
[(2) To determine patient liability, consider income and medical expenses of each individual. Do not consider income and medical expenses as a couple.
(3)] If the couple has dependents, determine an amount to bring the dependent's income up to the appropriate MA Scale for the family size. [Deduct the amount in only one case.

b. Beginning the month after the month of separation, consider only income and resources of the ineligible spouse which are actually contributed to the eligible applicant.]

C. [BLIND OR DISABLED INSTITUTIONALIZED CHILD UNDER AGE 18 OR AGE 18 THROUGH 20 IF IN SCHOOL

1. Consider the income and resources of the Hospice child and parent according to Step I or Step II, as appropriate, during the month of Hospice election.

2. Consider only the income and resources of the Hospice child after the month of Hospice election.

D. K-TAP/FAMILY RELATED MA PARENT OR CHILD RECEIVING INSTITUTIONAL HOSPICE

1. Consider income and resources in the K-TAP/Family Related MA case for up to one year.

2. Consider income and resources on the basis of living apart when it becomes apparent Hospice will be received more than 1 year.] Determine technical eligibility for the Aged, Blind or Disabled MA program. Establish a separate J, K, or M case for the Hospice parent/child.

3. [When separate cases are established, remove the institutionalized Hospice parent/child from the K-TAP/Family Related MA case.]

MS 3260 INSTITUTIONAL HOSPICE CASE ACTION

A. FORM MAP-374. Form MAP-374 notifies local staff of the date Hospice is elected and verifies that medical eligibility requirements are met, that is terminally ill, life expectancy of six months or less. In addition, form MAP-374 identifies the LTC facility where the individual is residing and includes the level of care received at the LTC facility.

B. MA APPLICANT. If the individual does not currently receive MA, the Hospice provider notifies the individual's family or responsible party to apply for MA. Determine eligibility for Hospice. The special income standard does not apply if form MAP-374 is not received. [File form MAP-374 in the case record once vendor payment is authorized.]

C. SSI RECIPIENT. If the individual is a SSI or a SSI/other income recipient, consider the SSI or SSI/other income, if received. Authorize vendor payment when form MAP-374 is received. [If SSI is discontinued, then the PA-62 case is also automatically discontinued, including the vendor payment information section.] When the case is reapproved as a J, K or M, complete an application using the appropriate notification form as verification that medical eligibility requirements are met.

MS 3300 WHO IS ELIGIBLE FOR LTC VENDOR PAYMENT

A. LTC vendor payment can be made for an individual if:

1. The MAID card is received. If an SSI applicant/recipient refuses to cooperate with TPL requirements AND does not have good cause for refusing to cooperate, then vendor payments ARE NOT appropriate since the SSI applicant/recipient IS NOT MA eligible;

2. [Patient status and level of care needed is established by the Department for Medicaid Services (DMS), the PRO or Medicare];

3. [There is income below the special income standard or the individual has an approved QIT; and]

4. The individual is in an institution such as inpatient hospital NF bed, nursing facility (NF) or Psychiatric Residential Treatment Facility (PRTF) if age 18 to 21, or to age 22 if in uninterrupted treatment beginning prior to age 21, or age 65 or over; or

5. An eligible child receiving EPSDT LTC services; or

6. The individual is in an institution classified as an Institution for Mental Diseases (IMD) and is age 18 to 21, or to age 22, if institutionalized on his/her 21st birthday, or age 65 or over. Facilities currently certified in Kentucky as IMDs for nursing facility level of care are Glasgow State Hospital and Western State Hospital. A Confirmation Notice is required for level of care determination for these IMDs. The remaining three facilities are personal care, and vendor payment for level of care does not apply. The three PC level IMDs are: Caney Creek PCH, Bluegrass PCH located at Eastern State Hospital, and the Center for Rehabilitation located at Central State Hospital.

B. Levels of care are:

1. Nursing Facility;

2. Intermediate Care for the Mentally Retarded/Developmentally Disabled (ICF/MR/DD); and

3. Mental Hospital Care (MH).

C. [If criteria in item A are met, the following individuals are eligible for LTC vendor payments:]

1. Aged, blind or disabled individuals in the A, B or D category;

2. Aged, blind or disabled individuals in the J, K or M category;

3. A specified relative or second parent in an K-TAP assistance group or in a Family Related MA group. For EPSDT institutional care facilities, eligibility must have been established or existed before admission; and

4. Any child in a K-TAP assistance group or a Family Related MA group as long as the parent continues to exercise control over the child or the child remains in foster care status. For EPSDT institutional care facilities, eligibility must have been established or existed before admission.

D. Arrangements for LTC best suited to the needs of the individual are a joint responsibility of:

1. [The PRO or DMS determines the level of care required; and]

2. [DPP, which helps individuals obtain placement in the appropriate level of care.]

MS 3320* SPECIAL PROCEDURES FOR LTC APPLICANTS

A. Individual in LTC has income of less than $50.

1. Explain SSI and refer to SSA if potentially eligible.
2. Complete application.
3. Determine eligibility.

B. Individual receiving time-limited MA enters an LTC facility.

1. Before the end of the MA eligibility period, complete application for vendor payment.
2. Determine technical eligibility.
3. Determine patient liability.
4. Determine case status.

MS 3330* RESIDENCE REQUIREMENTS FOR LTC

An individual in an LTC facility must meet Kentucky residence requirements according to MS 1580-1650 and as follows:

A. INDIVIDUAL UNDER AGE 21 OR INDIVIDUAL BECOMING INCAPABLE OF INDICATING INTENT BEFORE AGE 21, IN AN INSTITUTION OR PCH NEITHER MARRIED NOR EMANCIPATED. State of residence of these individuals is:

1. The state where the parent or legal guardian lives at the time of placement;
2. The state where the parent or legal guardian lives who files the application, if the individual is institutionalized in that state;
3. The state where the person lives who files the application, if the individual has been abandoned by his or her parents, does not have a legal guardian, and is institutionalized in that state; or
4. For the over age 21 institutionalized individual who became incapable of indicating intent prior to age 21, the state of residence may be that of the parent, or guardian when parental rights have been terminated applying for MA on the individual's behalf, if the parents reside in separate states.

B. INSTITUTIONALIZED INDIVIDUAL BECOMING INCAPABLE OF INDICATING INTENT AT OR AFTER AGE 21. For the institutionalized or PCH individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically located, unless another state made the placement.

MS 3350 SSI RECIPIENT IN LTC

Caseload responsibility for an SSI recipient who enters long term care is determined according to Volume I, MS 0175.

Refer to Volume I, MS 0168 for instructions on case transfers.

A. [Immediately authorize vendor payment via PA-62 system, upon receipt of either an automated certification, MAP-374, or MAP-24, Admission Notice/Discharge Notice, received for recipients in NF, PRTF, ICF/MR/DD, IMD or a mental hospital.] See MS 3650.

B. Cases requiring a vendor payment with a statutory benefit payee/committee/guardian are carried in the county in which the statutory benefit payee/committee/guardian resides and are transferred only if the statutory benefit payee/committee/guardian moves or changes. Cases are carried in the county of the power of attorney ONLY if that person is also the designated statutory benefit payee for other forms of assistance such as SSI, RSDI, RR or VA.

Additionally, ensure the case is carried in the requested county of the statutory benefit payee/committee/guardian who requests the case be carried in the county of their employment which is different from their residence.

Cases requiring a vendor payment whose statutory benefit payee/committee/guardian/power of attorney live out-of-state are carried in the county in which the applicant/recipient resides.

2. [Send form PAFS-5.1 to Social Security to report the SSI recipient's move into an LTC facility. For EPSDT long term care children, comment on form PAFS-5.1 that the child placed for medical treatment remains a Kentucky resident. Spot check at the end of 3 months from the date form PAFS-5.1 was sent to determine SSI status.] In some situations, SSI benefits received by these children will not be reduced. If the SSI payment is not reduced by the end of the 3 months, count the full SSI payment and allow the $40 personal needs allowance.

3. As a control mechanism and for counting purposes, prepare form PA-31 if required, using program code A, B or D. Mark "SSI Only" or "SSI Alert" or "SSI/MSE" as appropriate. File in the card box.

B. SSA determines continuing SSI eligibility using a standard of $30.

1. If income other than SSI is $50 or more, SSI will be discontinued. For SSI Alert:

a. [Client will receive form PA-10-SSI.2 notifying them that their SSI benefits have been terminated.
b. Notification is given that for a determination of eligibility for Medicaid to contact the Department for Community Based Services.]

2. If income other than SSI is less than $50, adjust payment to $30 or less with no change in A, B or D program code. Patient liability is zero.

3. If income is SSI only, adjust payment to $30 with no change in A, B or D program code. Patient liability is zero.

4. SSI does not consider all children placed in EPSDT LTC facilities to be institutionalized. For those SSI children continuing to receive full benefits, allow $40 personal needs allowance and consider the remaining SSI as patient liability. See Volume IV, MS 4170.

MS 3360 F, G, OR H INDIVIDUAL IN LTC

For the non-SSI, SSP or Pass Through recipient admitted to LTC, do the following:

A. Remove the money payment and program transfer to J, K, or M as appropriate. Authorize vendor payment upon receipt of form MAP-24 or an automated certification. See MS 3650.
B. Do not take a new application unless a recertification is due.
C. Change program code on form PA-31 if required, to J, K, or M as appropriate.
D. Do not change the month of recertification.

MS 3370 LTC ADMISSION WITHOUT MEDICAID

[When form MAP-24 is received for an individual not currently covered by MA or the member information appears on the "PRO Certifications Not Matched to KAMES" Report, the following applies:]

A. The facility is responsible for referring families or responsible parties to the local office for MA application.
B. Obtain an application in the J, K, or M category as appropriate and determine eligibility.
C. If eligible, authorize vendor payment in response to form MAP-24 for Medicare covered admissions.
D. [Authorize vendor payment based on certification found on the "PRO Certification Not Matched to KAMES" Report. See MS 3650.]

MS 3380 PATIENT STATUS NOT MET

If a non-SSI LTC recipient does not meet patient status, but applies or remains eligible MA in the aged, blind, or disabled MA category, the following applies:

A. Program code is J, K, or M.
B. Determine MA eligibility using noninstitutionalized aged, blind, or disabled MA policy.
C. Since patient status is not met, cost of care cannot be paid by MA; therefore, do not authorize vendor payment. If spend down determination is made, consider verified facility costs as a recognized medical expense.
D. [Authorize vendor payment when an automated certification is received or the member information appears on the "PRO Certifications Not Matched to KAMES" Report. See MS 3650.]

MS 3390 QMB RECIPIENT IN LTC

A. [For the QMB recipient admitted to LTC:

1. Send an appointment letter to the representative/payee to complete a new application.
2. Enter a program transfer to J, K or M when the appointment is kept.]
3. Obtain all verification and information forms which are required for MA and LTC eligibility.
4. [When all verification and information have been received and the applicant has been determined to be eligible for LTC vendor payments for J, K or M cases, approve as an LTC case with dual eligibility status.
5.] If the program transfer denies, the case should continue as a "Z" only.

[B.] Process these cases without loss of QMB benefits by the individual.

MS 3400 [K-TAP AND FAMILY MA RECIPIENT IN LTC

For the individual admitted to LTC who receives K-TAP or Family MA.

A. If an SR or SP included in a K-TAP or Family MA case is admitted to LTC, the patient liability is zero.

B. If a child included in a K-TAP or Family MA case is admitted to LTC, complete the following steps to determine net income of LTC recipient.]

1. Verify gross income of LTC child only.
2. Deduct, if appropriate, medical expenses and private health insurance premium from gross income of LTC child only.
3. If appropriate, deduct as an increased PNA any verified minimum mandatory deductions from income of the LTC child.

C. If two or more children in the same K-TAP or Family MA case are admitted to LTC at the same time, complete the following steps to determine a separate patient liability for each LTC child.

1. Consider separately verified gross income for each LTC child.
2. Deduct as an increased personal needs allowance, if appropriate, verified minimum mandatory deductions from income of the LTC child.
3. Deduct, if appropriate, medical expenses and private health insurance premiums from the gross income of the LTC child who incurs the expenses.
4. Determine net income of each K-TAP child.
   a. Complete a separate vendor payment section for each LTC child.
   b. The $40 PNA deduction is deducted by the system.

D. [For case responsibility for K-TAP or Family MA see Volume I, MS 0155.]]

MS 3410 SSI/SSP RECIPIENT ENTERING LTC

SSI benefits and SSP are continued to certain individuals, who are admitted to a public institution.

A. Uninterrupted SSI/SSP benefits for up to 3 full months are provided to recipients who are temporarily institutionalized for medical care in an LTC facility and who otherwise would receive a reduced benefit or none at all.

1. This allows the recipient to pay some or all of the necessary expenses to maintain their home or living arrangement to which they may return upon discharge from the facility. Do not count the continued SSI/SSP benefits in determining patient liability.

2. In order to qualify for continuation of payments, the following conditions must be met:
   a. The individual must be eligible for SSI or for both SSI and SSP in the month prior to the first month they would be ineligible, or eligible for a reduced amount due to residence in an LTC facility.
   b. The individual must continuously reside throughout the affected month in a LTC facility in which MA pays more than 50 percent of the cost of care.
   c. A physician must verify that the individual is expected to be medically confined for 90 consecutive days or less. The physician statement is provided to the SSA.

B. SSA makes the determination of eligibility for continued payments and sends notification to the SSI recipient.

1. A copy of the notification letter is also sent by SSA to the local office located in the same county as the SSI recipient's mailing address.
2. If the worker responsible for the case is located in another county, the notification letter is forwarded within 2 working days to the appropriate local office.

C. For an SSI recipient temporarily institutionalized for medical care in an LTC facility, take the following action:

1. [If the member information appears on the “PRO Certification Not Matched to KAMES” Report or MAP-24 and the SSA notification letter are received by the local office:]
   a. Set up a case record file using the A, B or D category case number;
   b. Exclude all SSI income;
   c. Complete an interim notation sheet documenting the case situation;

d. Send form MA-105 for PA-62 case to the recipient and facility; and
e. Annotate form PAFS-116, Case History Folder, and form PA-31, Eligibility Worker Card. See MS 3650.

2. [If the member information appears on the "PRO Certification Not Matched to KAMES" Report or MAP-24 is received prior to the SSA notification letter:]
   a. Count the $30 continuing SSI eligibility amount if the recipient has no other income;
   b. If the recipient has other income, treat the case as an SSI Alert; and
   c. [When the SSA notification letter is received, immediately remove the SSI income.] See MS 3650.

3. If the SSA notification letter is received prior to MAP-24, and the member information does not appear on the "PRO Certification Not Matched to KAMES" Report do not take any action until this information is received. When received, follow procedure in item C, 1. See MS 3650.

D. For an SSI and SSP recipient temporarily institutionalized for medical care in an LTC facility, take the following action:

1. If the member information appears on the "PRO Certification Not Matched to KAMES" Report or MAP-24, and the SSA notification letter is received by the local office, complete form P-62 excluding all SSI and SSP income. File a copy of the information and the form in the SSP case record. Complete an interim notation sheet and send form MA-105 to the recipient and the facility. Annotate form PAFS-116, Case History Folder, and form PA-31, Eligibility Worker Card, if used in your county. See MS 3650.

2. If the member information appears on the "PRO Certification Not Matched to KAMES" Report or MAP-24 is received prior to the SSA notification letter, take action to discontinue the SSP. Submit form PA-62 counting the $30 continuing SSI eligibility amount if the recipient has no other income. If the recipient has other income, treat the case as an SSI Alert. When the SSA notification letter is received, immediately reinstate the SSP case with retroactive payment, if appropriate, and submit a change form PA-62 removing the SSI and other income. See MS 3650.

3. If the SSA notification letter is received prior to receipt of form MAP-24 or the member information appearing on the "PRO Certification Not Matched to KAMES" Report, do not take any action until one of these forms is received. Upon receipt of the form, follow procedures in item D, 1. See MS 3650.

E. Set up a spot check for these case for 1, 2, and 3 months from the date of admission. If the individual remains in LTC longer than 3 months,

follow established policy for SSI/SSP individuals admitted to an LTC facility.

MS 3420* MEDICARE RECIPIENT IN LTC

For the individual admitted to LTC with Medicare responsible for payment:

A. Medicare covers 100% of the LTC cost for the first 20 days, and 80% of the LTC cost for the following 80 days.

B. For the latter 80 days, a 20% copayment must be made.

C. If the individual is QMB eligible, QMB must cover this Medicare copayment and the individual will have a $0 patient liability.

MS 3430* MEDICARE AND MEDICAID RECIPIENT IN LTC

For the individual admitted to LTC as Medicare pay and who apply for or are already receiving Medicaid and QMB:

A. Establish the patient liability using regular Medicaid policy.

B. To insure the QMB recipient is aware of the patient liability when Medicare is the primary payor, include a statement on form MA-105 advising the QMB recipient that patient liability will be $0 for any LTC period of Medicare coverage.

C. Since the patient liability will be $0 for some months, the recipient's resources may accumulate in excess of the resource limit. For those cases where there is a potential for accumulation of excess resources, complete a spot check for excess liquid assets during the LTC Medicare payment period. Annotation of form MA-105 and the spot check for potential excess resources are the only actions required.

MS 3450* COST OF CARE

Determine the amount of income an individual pays toward the cost of LTC.

A. The effective date income is available from an individual initially admitted to LTC, Medicare or Medicaid eligible, is determined by the system. Consider an individual readmitted after being out of a facility for more than 30 days an initial admission.

B. The individual admitted to LTC as private pay has income considered available for MA eligibility when the source for private pay is insufficient or exhausted. Private pay sources include Worker's Compensation, VA, private insurance or the individual's own resources.

MS 3460 [COUNTABLE INCOME FOR PATIENT LIABILITY DETERMINATION]

Consider the following types of income when computing the amount of income available to pay cost of care. Do not consider as income any payment made by a relative or other interested party, to obtain a private room, telephone, television services, etc.

A. Earnings from therapeutic placement. The facility must supply a written statement showing employment is for therapeutic and rehabilitative purposes.

B. [Amount of VA pension over $90. The first $90 of VA pensions and VA reduced pensions of $90 or less are excluded.]

1. [For veterans who are approved for VA pension and who receive a lump sum retroactive payment, the $90 exclusion and the $40 personal needs allowance (PNA) must be applied retroactively in the patient liability determination.] Consider any remainder of the payment as a lump sum in the month of receipt, if possible.

[EXAMPLE: A veteran is approved for a $300 VA pension effective January and receives and reports a $1,600 ($300 x 6) lump sum payment in June. Since the first $90 is excluded and the individual is entitled to the $40 PNA, a total of $780 ($90 + $40 = $130 x 6) would be deducted from the lump sum. The remainder, $1,600 - $780 = $820, is considered lump sum income. Since the lump sum was reported in the month of receipt (June), it is not administratively feasible to count the lump sum as income since MA benefits have already been issued for June. Therefore, any remainder of the $820 is considered a resource beginning the month following the month of receipt.]

2. Do not complete a correction transaction for patient liability for the retroactive months. However, complete the computation to determine the lump sum payment amount. Complete a change transaction if it is possible to consider the lump sum income.

C. Consider the RSDI entitlement amount, deduct SMI charges, if appropriate. If accessing IMS Program HR 39, NEW BENDEX, for the RSDI benefit amount, use the amount shown as "NET" in the calculation process.

D. [Accumulated back payments of statutory benefits are considered according to MS 2465.]

E. For the SSI only recipient, count $30 of the SSI payment.

F. If an SSI recipient has other income of less than $50, count $30 of the full SSI payment.

G. [For SSI children in EPSDT LTC who continue to receive full SSI benefits 3 months after form PAFS-5.1 was sent to SSA, allow the personal needs allowance and count the remaining SSI.]

H. SSP payments continuing beyond the month of LTC admission:

1. [If the admission is not temporary, request the check(s) be returned to the Cabinet for Health and Family Services, Department for Community Based Services, DAFM-General Accounting Branch, 275 E. Main St., 3W-C, Frankfort, KY 40621.]
2. If not returned, show the total SSP payment as income the month following the month of admission.

[I.] Consider income available from trust property to each member of a couple in accordance with the specific terms of the trust. When the trust document is not specific as to the couple's ownership interest in income, use the same procedures used to establish ownership interest in nontrust property.

[J.] Nontrust property is property which has not been placed in a trust.

1. Unless a legal document otherwise specifically provides, or the institutionalized spouse establishes that ownership interest of income produced from nontrust property is other than stated below, consider the income from such property in both MA eligibility and posteligibility determination as follows:

   a. Consider income paid solely to the institutionalized spouse or the community spouse available to that person.

   b. Divide income paid in the names of the institutionalized spouse and the community spouse between them.

   c. Consider income paid in the names of the institutionalized spouse, community spouse, and at least one other person, available to each individual on an equal share basis, unless one or more of the persons can verify a different share of ownership exists.

   d. Divide income paid to a couple from nontrust property when there is no legal document establishing ownership between them.

2. Allow the institutionalized spouse to rebut the ownership of income produced from nontrust property. The institutionalized spouse must provide:

   a. A written statement from the applicant regarding ownership of income;

   b. A written statement from each of the other persons receiving income from the nontrust property which corroborates the

applicant's statement, unless the individual is a minor or is incompetent; and

c. Verification the applicant's name has been removed from the nontrust property.

Do not consider the income available the month the applicant's name is removed from the nontrust property.

3. A fair hearing may be requested when the institutionalized spouse disagrees with the Agency's decision on the ownership of this income.

[K.] Nursing facility insurance policies provide for payment for nursing facility services while an individual is residing in a nursing facility. If the payment is made available to the individual or the facility and may be used for the purchase of food, clothing or shelter, it is considered as income in the MA eligibility and patient liability determination.

[L.] Nazi Persecution Victims Eligibility Benefits Act (P. L. 103 286) provide for payments to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required. Consider payments as income in the patient liability determination ONLY.

[M. A change in the Federal law, effective August 1, 2002, mandates that VA Aid and Attendance (A&A) and VA Unreimbursed Medical Expenses (UME) are countable for VA beneficiaries in a state-operated veterans facility that accepts Medicaid. Currently, Kentucky has no state-operated facilities that accept Medicaid. This information is being provided for future reference.]

MS 3470 [EXCLUDED INCOME FOR LTC/WAIVER]

Do not use the following types of income when calculating cost of care.

A. Do not consider as income, any payment made by a relative or other interested party to obtain a private room, telephone, television service, etc.

B. VA beneficiaries in LTC are usually eligible for an Aid and Attendance Allowance and/or Unreimbursed Medical Expenses.

1. Refer individuals to the Regional VA Office to apply for VA Aid and Attendance Allowance (VA A&A) and/or VA Unreimbursement Medical Expenses (VA UME).

a. [Application for VA A&A is NOT a condition of MA eligibility.]
b. Require the individual to apply for VA UME.

2. Spot check to verify receipt of the increase, if application is made.
3. [Exclude the VA A&A and/or VA UME in the MA and patient liability determination.]

C. Exclude the uninterrupted SSI and/or SSP payments for up to 3 full months for recipients who are temporarily institutionalized for medical care in an LTC facility (and who otherwise would receive a reduced benefit or none at all).

D. Exclude the VA A and A and/or VA UME in the MA and patient liability determination.

E. Exclude the entire SSI payment for the SSI recipient whose other income is $50 or more.

F. Exclude nursing facility insurance policy payment which is restricted to the purchase of or reimbursement for medical services.

[G. Exclude the first $90 of VA Pensions received by a veteran or spouse of a veteran. Exclude VA reduced pensions of $90 or less.]

MS 3480 DEDUCTIONS AND ALLOWANCES

A. LTC recipients retain a personal needs allowance for personal and incidental needs, unless their income is lower than the personal needs allowance.

B. Allow a separate amount as an increased personal needs allowance, if appropriate, for the following specific expenses.

1. Verified mandatory withholdings from earned and unearned income of the LTC recipient such as legal, mandatory payroll deductions that are a condition of employment and/or Federal, state and local taxes that the government requires the payer to deduct before payment is made to the payee.

   a. Do not include withholdings that result from recipient decisions and/or actions, such as voluntary income tax withholding's and court-ordered deductions for child support or other garnishments resulting from recipient-induced indebtedness or financial obligations.
   b. Verify withholdings that are mandatory.

2. Plan for Achieving Self-Support (PASS). Work related allowances or expenses included in an approved PASS. See MS 2500.

3. The Blind Work Expenses (BWE) is a work related expense or allowance.

   a. It is applied to aged cases provided that the aged individual received MA coverage prior to his/her 65th birthday.
   b. Allow the BWE for any work expense incurred. The BWE includes, but is not limited to, transportation to and from work, dog guide, lunches, federal, state and local income taxes, F.I.C.A., union dues, prosthetics, special equipment, job related training, etc.
   c. Do not allow usual living expenses, rent, food, etc., and educational expenses which are not job related, in addition to deductions included in a PASS.
   d. Apply the special deductions to both the aged individual and the aged responsible relative, if the work expense is not included in a PASS.

4. Apply the Impairment Related Work Expense (IRWE) to aged cases provided that the aged individual received MA coverage prior to his/her 65th birthday.

   a. The IRWE includes any amount expended for specific items or services which enable an aged or disabled individual to work as long as the specific items or service are not included in a PASS.

b. Allow deductions, if not included in a PASS, in the month incurred, or divide over a 12-month period, beginning with the month of the first payment, whichever is more beneficial to the individual.

(1) Payment for attendant care services such as assistance in traveling to and from work, and assistance with personal functions, that is eating, personal hygiene, dressing, etc., at home in preparing for work.

(2) Payment for medical devices such as durable medical equipment, that is, wheelchairs, canes, crutches, inhalators, pacemakers, etc.

(3) Payment for prosthetic devices such as artificial arms, legs and other parts of the body.

(4) Payment for work related equipment for specialized use such as one-handed typewriter, telecommunication devices for the deaf, etc.

(5) Payment for residential modifications that aid an individual to work, such as the installment of a ramp or enlargement of a doorway for a wheelchair.

(6) Payment for nonmedical appliances and equipment essential for the control of a disabling condition that are medically verified as necessary, such as an electric air cleaner for an individual with a respiratory disease, etc.

(7) Payment for drugs and medical services to control an individual's impairment such as anticonvulsant drugs or anticonvulsant blood test monitoring for epilepsy, medications for mental disorders, immunosuppressive medications, etc.

(8) Payment for medical supplies and services which enable a person to work, such as incontinence pads, catheters, irrigating kits, physical therapy, speech therapy, etc.

(9) Payment for transportation costs associated with vehicle structural or operational modifications and payment for use of driver assistance.

(10) Payment for installing, maintaining and repairing impairment related items.

C. Compute a family income allowance for each dependent family member with income less than the family income allowance, who is claimed by either spouse for tax purposes under the IRS Code.

1. This can include minor children, dependent children, dependent parent or dependent siblings who are residing with the community spouse.

2. Require verification if a dependent is age 18 or over.

3. Subtract the family member's gross income from the family income allowance standard. Divide the remainder by three, round to the nearest dollar and allow that amount as a deduction from patient liability. The deduction can be allowed without proof that the money is made available to the family member.

D. For an institutionalized individual who has a community spouse, consider the amount needed to bring the community spouse's gross monthly income up to the community spouse income allowance as calculated per MS 3550.

1. Allow the community spouse income allowance only if the money is actually given to the community spouse.
2. This amount can be increased only:

a. If a court has entered an order against an institutionalized spouse for monthly support for the community spouse in an amount which exceeds the difference between the community spouse's available income and the community spouse income allowance. Allow the greater amount as a deduction to the institutionalized spouse's income; or

b. An Administrative Hearing officer can establish through the fair hearing process that the community spouse needs income above the level established as the community spouse income allowance. Either spouse may request a hearing at which time evidence may be presented that additional income is needed due to significant financial duress. These hearings must be held within 30 days of the request. If the hearing officer determines that exceptional circumstances exist causing financial duress, the hearing officer grants the increase in the community spouse allowance for a stated period of time. The case is spot checked to remove the increase at the end of the time granted. If the client is dissatisfied at this action, a new hearing may be requested. At recertification, if it is determined that the exceptional circumstances causing financial duress no longer exists, a memorandum outlining the change in circumstances, along with a copy of the hearing decision should be sent to the Commissioner's Office, Department for Community Based Services, 3rd Floor, 3W-A, CHR Bldg., 275 East Main Street, Frankfort, Ky 40621, for administrative review. Retain a copy of the memorandum in the case record. Take no action until notification is received from Central Office.

3. Do not apply the community spouse income allowance, if an institutionalized spouse is not likely to be institutionalized for at least 30 consecutive days.

E. [All members receiving long term care (LTC) waiver services in the following types of care will be allowed a $65 and ½ the remainder disregard from earned income in determining patient liability:

1. Home and Community Based Services (HCBS);
2. Hospice Non-Institutionalized;
3. Supports for Community Living (SCL);
4. Model Waiver II;
5. Adult Day Care;
6. Acquired Brain Injury (ABI); or
7. Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Compute $65 plus ½ the remainder of earnings.

NOTE: If after the $65 plus ½ the remainder deduction is applied, the patient liability is greater than $999.99, KAMES will calculate the amount correctly but it will not be displayed because KAMES cannot display patient liability figures larger than five characters.]

F. All SSI recipients are covered by the State SMI Buy-In. Do not show SMI as a deduction for any recipient with program code of A, B or D.

G. Allow the cost of SMI if the J, K or M recipient verifies coverage.

H. Allow premiums for medical insurance actually incurred and paid by the LTC recipient.

1. Prorate premiums if paid prospectively. Allow as a deduction for month's premium covers. For example, if health insurance of $90 is paid in May to cover June, July and August, allow $30 as an expense in each covered month or allow the entire premium in the month incurred (May).

2. View all medical insurance policies and record identifying information.

3. Complete form PA-40 or the KAMES Health Insurance screen as appropriate.

I. Deduct verified, incurred medical expenses the facility is not required to provide; for example, eyeglasses, hearing aids, dentures, chiropractic services. In no case will a deduction be allowed for a period prior to the month in which the change was reported to the worker.

1. Deduct the cost of a medically necessary attendant if payment for such an attendant is not available from another MA provider at no cost to the individual. Example: A 22-year-old HCBS individual lives in the home with his parents. Both parents work outside the home and must hire a person to take care of the individual, who is

a quadriplegic. The parents requested cost of attendant care be allowed as a deduction in the HCBS case. The parents provide a doctor's statement that it is medically necessary for the individual to have care at all times. Attendant care cannot be provided by a family member.

2. Allow as deductions against current patient liability computations any unpaid, incurred medical expenses from a period of time prior to MA eligibility for which the individual is currently responsible.

   a. If the individual requests the deduction for the purpose of paying the incurred medical expense, it is not necessary to verify that the individual is actually using the amount deducted to pay the incurred medical expense.
   b. The total allowable deduction cannot exceed the amount of the outstanding medical expense. Example: If an outstanding medical expense is $4,000.00 when the deduction is first allowed, the total amount of the allowable deduction cannot exceed $4,000.00.
   c. Allow the deduction to the advantage of the individual. The total amount may be averaged over a time frame selected by the individual.
   d. Post a spot check to ensure the deduction is removed once the total amount of the allowable deduction is used.

3. Do not allow as a medical expense deduction an unpaid cost of NF care incurred during vendor payment ineligibility period due to a transfer of assets penalty.

J. Do not deduct items and/or services the facility is required to provide, such as, wheel chairs, crutches, walkers, incontinent supplies, durable medical equipment, furniture, personal care items, etc.

K. Allow a deduction for co-pays when computing patient liability.

L. Allow a deduction for prescription drug expenses IF the applicant/recipient verifies that the Department for Medicaid Services has denied coverage and that a prior authorization for coverage has also been denied. Obtain a copy of the applicant/recipient's denial letter for documentation.

M. Enter medical expenses for KAMES cases as follows:

1. If a medical expense is one-time only, such as a hospital bill, enter "Y" to "One-time only?".

2. When processing a joint application, expenses to be counted in both cases are entered twice on the Medical Expenses screen.
   a. Answer "IM" for the first entry.
   b. Answer "FS" for the second entry.

3. Enter a current month's date in "Date Paid/Incurred" on the Medical Expenses screen for ongoing medical expenses. For

member add in an IM case, enter past dates as appropriate, for retroactive MA.

[N. Monthly representative payee service fees charged by facilities to their recipients are not allowable medical deductions.]

MS 3500 SPECIAL INCOME STANDARD

Compare gross income to a special income standard for an individual to determine MA eligibility for LTC applicant. Consider the applicant's income and the number of days the applicant has been in LTC when determining MA eligibility.

A. Use the special income standard if the applicant's gross income is equal to or less than the special income standard AND the applicant has been in LTC for 30 full consecutive days or died prior to the 30th day.

1. [The 30 full consecutive days is effective the 30th day of admission and may be spent in different facilities or at different levels of care, including days the applicant received Hospice, HCBS or SCL.

   NOTE: Although the effective day of admission is the 30th day, KAMES will not process the application until the 32nd day. If an applicant is discharged on the 30th or 31st day, allow the case to approve and then complete the discharge as a case change transaction.]

2. Determine MA eligibility by comparing gross income to the special income standard and considering the number of days the applicant has been in LTC.
   a. In some situations the gross income may be equal to or less than the special income standard for an individual but more than the monthly private pay rate or actual cost of care.
   b. These individuals are ongoing MA eligible, but may be vendor payment ineligible.

B. DO NOT use the special income standard if the applicant has not been in LTC for 30 full consecutive days. For these individuals, determine MA eligibility by spend down procedures.

C. For applicants in LTC greater than 30 full consecutive days with income over the special income standard refer to MS 3505.

MS 3505 QUALIFYING INCOME TRUST (QIT)

The Kentucky Medicaid Program allows for the establishing of a Qualifying Income Trust (QIT), also known as a Miller Trust, for those individuals whose income is over the special income standard. Income placed in a QIT is excluded from determination of MA eligibility but is considered in the calculation of patient liability.

The Department for Medicaid Services [(DMS) must approve all QIT's before a case is approved].

A. DMS requires that a QIT meet the following criteria:

1. The QIT must be irrevocable.
2. Income must be put into the QIT to reduce the individual's income below the special income standard.
3. No resources may be put into the QIT. For example: Any money in a savings account cannot be put into the QIT.
4. A separate account must be established. The individual cannot use an existing bank account for the QIT or commingle QIT funds with funds from another account.
5. Upon the death of the individual, DMS receives all monies remaining in the trust up to an amount equal to the total paid on behalf of the individual by Medicaid. Any funds remaining after Medicaid is reimbursed will be the property of the individual's estate.
6. The trustee must consult with Medicaid on payments from the trust before they are made in order to assure that the payments are allowable under Federal and state law.

B. Rules for funds entering and leaving the trust are as follows:

1. All of the individual's countable income over the special income standard must go into the trust.
2. Monies placed in the trust can be disbursed for:
   a. personal needs allowance;
   b. community spouse/family support;
   c. cost of other health insurance; or
   d. patient liability paid to the nursing facility/waiver provider.
3. DMS must approve all other expenditures (e.g. eyeglasses, dentures, hearing aids, attendant care and other expenses not covered by Medicaid or other health insurance.
4. Send a written request for the expenditure to the Medical Support and Benefits Branch through your Program Specialist. The request must include:
   a. Physician's statement as to why the service or item is needed;
   b. Copy or estimate of bill;
   c. Date expense incurred; and
   d. Verification of balance owed.
5. Payments from the trust must be made at regular intervals (monthly or by the end of the month following the month funds were placed in the trust.)

a. At application, if the individual is over the special income standard:

1. Explain that the individual [must set up a QIT to become Medicaid eligible].
2. Provide fact sheet MAP-007, Qualifying Income Trust.
3. If the individual indicates intent to establish a QIT, request that a copy of the QIT be returned in 10 days.
4. [Advise the applicant that the documentation accompanying the QIT must include the name and address of the financial institution and the QIT account name and number.
5.] A question, "Has a DMS approved Qualifying Income Trust?" is on KAMES on the LTC/Waiver screen. Answer "Y" to this question if the individual intends to create a QIT. Leave "VER" source blank.
6. [Once a QIT and accompanying documentation is returned, complete the DMS Review/Cover sheet and forward to]:

   Medical Support and Benefits Branch (MSBB)
   275 E. Main St., 3E-I
   Frankfort, KY 40621
   ATTN: Supervisor, Medicaid Program Assistance Section

7. DMS will review and approve or deny all QIT's.
8. If the QIT is approved by DMS, enter "OR" as verification source.
9. If the QIT is denied by DMS, change the answer to "Has a DMS approved Qualifying Income Trust?" to "N". The case will deny for over income limit.

[D. At recertification and re-application, obtain the QIT bank statements for the prior two months and forward to MSBB along with the DMS Review/Cover sheet to the above address.

1. If the QIT statements are not provided, the case is discontinued for failure to supply information.
2. If the QIT statements are provided, forward to MSBB and process the recertification as usual. Do not hold the recertification pending a response from DMS. If DMS determines that negative action is appropriate, field staff will be notified.]

If an individual with a QIT is discharged from LTC/Waiver services or is no longer eligible to receive Medicaid, the QIT will remain in place until the death of the individual, however the individual will no longer be required to place income in the QIT. DMS is not reimbursed from the QIT until the individual is deceased.

MS 3510 LTC MA EFFECTIVE DATE

[Determine the LTC MA effective date using the first day of the month the applicant met patient status not to exceed 3 months prior to the application. The patient status date is found on the Automated PRO certification or form MAP-24, as appropriate.]

A. If a case is processed prior to 30 full consecutive days of admission, use regular MA policy to determine if the applicant is potentially eligible for the retroactive period.

B. If the applicant has been in LTC for 30 full consecutive days at the time of case processing, compare the income to the special income standard for current and retroactive eligibility beginning with the first day of the month in which patient status was met not to exceed 3 months prior to application. Use regular MA policy for retroactive months during which patient status was not met.

MS 3520 INTERRUPTION OF STAY

A. Redetermine MA eligibility if there is an interruption in the individual's stay in the LTC facility.

B. [Redetermine MA eligibility if the recipient is discharged and admitted to ANOTHER LTC facility, Hospice, HCBS or SCL with no interruption in stay and Step II was used to determine the recipient's prior MA eligibility.] A change in the deduction of the private pay rate or cost of care may affect MA eligibility.

MS 3530 LTC INDIVIDUAL

Do the following to determine MA eligibility and patient liability for the single applicant.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income of the individual.

2. [If gross income is equal to or less than the special income standard AND the applicant has been in LTC for 30 full consecutive days, the applicant is MA eligible. Complete Step II to determine patient liability.]

3. [If gross income is greater than the special income standard refer to MS 3505.

B. Step II - Determining Patient Liability for the LTC single individual.]

1. Determine gross income and/or net profit of the individual.

2. Deduct the personal needs allowance.

3. Deduct increased personal needs allowance, if appropriate, from income of the applicant.

4. If dependents have income less than MA Scale, deduct an amount to bring total income of dependents up to the MA Scale for the family size.

5. Deduct verified, incurred medical expenses of the LTC individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the applicant's liability.

6. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.

7. The result is the individual's patient liability or payment toward cost of care.

MS 3540 LTC COUPLE

Do the following to determine MA and patient liability for LTC individuals when both spouses are in LTC, whether the same or different facilities.

Redetermine MA eligibility and patient liability for both members if the spouse of an institutionalized individual enters the same or a separate LTC facility any time during the month of separation. Coordinate the redetermination with the caseworker responsible for the case of the first spouse who entered LTC, if different.

A. Step I - Determining MA Eligibility Using Special Income Standard

1. Determine gross income for each member of the couple.

2. If gross income of each member of the couple is equal to or less than the special income standard AND each member of the couple has been in LTC for 30 full consecutive days, each member is MA eligible. [Complete Step II to determine patient liability.]

3. [If gross income of either member of the couple is greater than the special income standard refer to MS 3505.

B. Step II - Determining Patient Liability for LTC individual.]

1. Spouse in the same LTC facility

a. Determine the couple's combined income and divide by 2. Consider 1/2 of the couple's income in each spouse's case.
b. Deduct the personal needs allowance in each case.
c. Allow 1/2 of the total deduction as an increased personal needs allowance in each case.
d. If dependents have income less than MA scale, determine the amount required to bring the dependents total income up to the MA Scale for the family size. Deduct 1/2 of the amount in each case.
e. Determine the couple's combined medical expenses and deduct 1/2 of the verified, incurred medical expenses in each case which are not subject to third party payment. Deduct actual payments on a current or prior medical bill not covered by MA. This may cause a monthly change in the recipient's patient liability.
f. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Deduct 1/2 of the amount in each case. Do not use these payments for conservation or other deductions.
g. The result is the individual's patient liability or payment toward cost of care.

2. Spouse in different LTC facility

a. Determine gross income and/or net profit of the applicant. Do not consider income as a couple.
b. Deduct the personal needs allowance in each case.
c. Deduct increased personal needs allowance for each individual if appropriate, from the income of the individual.
d. If dependents have income less than MA Scale, determine the amount required to bring the dependents' total income up to the MA Scale for the family size. Deduct the amount in only one case. Apply the deduction to the case which will most advantage the couple, unless the couple chooses otherwise.
e. Deduct verified, incurred medical expenses of the LTC individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the recipient liability.
f. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Do not use these payments for conservation or other deductions.
g. The result is the applicant's patient liability or payment toward cost of care.

MS 3550 LTC INDIVIDUAL WITH COMMUNITY SPOUSE

Complete the following steps to determine MA eligibility and patient liability for an institutionalized individual with a community spouse. Use form PA-1A, Supplement B, to complete these calculations for cases on the PA-62 system.

A. Step I - Determining MA Eligibility Using the Special Income Standard

1. Determine gross income of the individual.

2. [If gross income is equal to or less than the special income standard ($2,022 effective 01/01/09) AND the applicant has been in LTC for 30 full consecutive days, the applicant is MA eligible.]

3. If gross income is greater than the special income standard, refer to MS 3505.

B. Step II - Determining the Community Spouse Income Allowance

Income of an institutionalized spouse who has a spouse living at home in the community is treated differently to prevent financial hardship which may result when one spouse is institutionalized. Federal regulations require computation of a community spouse income allowance taking into consideration the community spouse's income and shelter expenses.

1. The following allowances and standards are issued by the Centers for Medicare and Medicaid Services (CMS) and are used to calculate the community spouse income allowance:

   a. [$1,750-Minimum Community Spouse Income Allowance. This amount changes effective 1/1/09.
   b. $2,739-Maximum Community Spouse Income Allowance. This amount changes effective 1/1/09.]
   c. $525–Minimum Community Spouse Shelter Allowance. This amount changes effective 7/1/08.

2. KAMES calculates the community spouse income allowance for an institutionalized spouse case. The Non-Member General Information Screen 3 is used to collect and verify the monthly shelter expenses of the community spouse. Shelter expenses include:

   - Rent or mortgage;
   - Property taxes;
   - Home insurance costs;
   - Utility expenses; and
   - Telephone standard of $30, if applicable.

   The telephone standard and acceptable verification of other shelter expenses are the same as for the Food Stamp Program found in OM Vol. II, MS 5470.

PART I

Community Spouse Excess Shelter Expense Computation

a. Add verified shelter expenses and the telephone standard together to arrive at the total monthly shelter expenses for the community spouse.
b. Subtract the community spouse minimum shelter allowance of $525.
c. The remainder is the community spouse excess shelter expense.

Verification of shelter expenses is NOT mandatory and is NOT a reason for case denial or discontinuance. The case may be worked without the shelter expense provided all other technical and financial eligibility have been met.

PART II

a. Add the minimum community spouse income allowance to the excess shelter expense from PART I.
b. [The result is the community spouse income allowance. This amount cannot exceed the community spouse maximum income allowance ($2,739, effective 1/1/09).
c. If the result is greater than the maximum, the community spouse allowance is the maximum ($2,739, effective 1/1/09).]
d. Subtract the community spouse's gross income from the income allowance to determine the amount which may be deemed to the community spouse.

3. The community spouse income allowance may exceed the calculated amount or the maximum ONLY by a court order or fair hearing decision per MS 3480.

4. Policy and procedures for allowing a community spouse an income allowance as a deduction from the patient liability determination is outlined in MS 3480. The deduction is allowed only if the income is actually made available to the community spouse each month. Form PA-1A, Supplement C, Institutionalized Spouse Resource and Income Statement, is completed to confirm that the institutionalized spouse understands this stipulation.

C. Step III - Determining Family Income Allowance

Determine a family income allowance if there is a minor child, dependent child, dependent parent or dependent siblings of either the community or institutionalized spouse, who is residing with the community spouse.

1. Verify the dependent member's gross income;

2. Subtract that income from the family income allowance standard ($1,750 effective);

3. Allow 1/3 of the remainder, rounded to the nearest dollar, as that family member's income allowance; and

4. Compute the family income allowance for each dependent member.

D. Step IV - Determining Patient Liability for LTC Spouse

1. Determine gross income and/or net profit of the institutionalized spouse.

2. Deduct the personal needs allowance ($40).

3. Deduct increased personal needs allowance, if appropriate, from the income of the institutionalized spouse, refer to MS 1750.

4. Deduct community spouse income allowance computed in Step II up to the maximum.

5. Deduct family income allowance computed in Step III.

6. Deduct verified, incurred medical expenses of the institutionalized individual NOT subject to third party payment, including Medicare and/or other health insurance premiums, deductibles, and coinsurance. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in patient liability.

7. Add any third party payment, such as LTC cost paid directly to the facility, if appropriate. Do not use these payments for other deductions.

8. The result is the individual's patient liability or payment toward cost of care to the facility.

MS 3560 LTC BLIND OR DISABLED CHILD

BLIND OR DISABLED CHILD (UNDER AGE 18 OR AGE 18 THROUGH 20 IF IN SCHOOL WHETHER APPLICANT OR RECIPIENT).

[Determine MA and patient liability for a child admitted to LTC and living with parents as follows:

A. For the month of admission and for any retroactive eligibility, consider the income of the child and the parent.]

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

C. Allocate income up to the ineligible sibling allocation for each ineligible sibling under age 18 living in the home of the LTC child. This is the ineligible sibling allocation minus gross income of each ineligible sibling.

1. If more than one blind or disabled child applies for LTC, allocate parental income to the ineligible sibling living in the home when computing deemed income to the LTC child.

2. Deduct a parent allocation for unearned income only or a combination of unearned income and earned income for one parent or for two parents.

3. Deduct a parent allocation for earned income only for one parent or for two parents.

4. If there are two parents in the home, use the parent allocation for two, whether one or both of the parents have the earned or unearned income.

5. See MS 1760 for parental and sibling allocation maximums.

D. Consider total income of the LTC child.

E. Allow appropriate income deductions from the income of the LTC child according to MS 2480.

F. Combine the countable income of the parent and income of the LTC child.

G. Allow verified, incurred medical expenses of the parent, sibling and the child in LTC.

H. Allow the MA Scale for one in the eligibility determination.

I. After the month of separation consider only the child's income, including any continuing contribution, and compare to the MA Scale for 1.

J. Refer the parent to SSA if the child is potentially eligible for SSI. If Family Related MA eligibility exists, see policy in Volume IV, MS 1220.

MS 3570 [LTC FOR K-TAP, AFDC RELATED AND FAMILY RELATED MA]

A. [LTC INDIVIDUAL IS MARRIED, HAS DEPENDENT CHILDREN AND IS A MEMBER OF A K-TAP, AFDC Related or FAMILY RELATED MA GROUP.] LTC INDIVIDUAL REQUIRES LTC FOR UP TO 1 YEAR.

1. The LTC individual remains a member of the assistance group for up to 1 year.

2. If total assistance group income is at or below the MA Scale for the family size, including the LTC individual, apply all income to the assistance group's needs.

3. Do not change the K-TAP money payment.

4. Patient liability will be zero.

B. [LTC INDIVIDUAL IS A K-TAP, AFDC Related or FAMILY RELATED MA CHILD REQUIRING LTC FOR UP TO 1 YEAR.]

1. The LTC individual remains a member of the assistance group for up to 1 year.

2. [In determining patient liability for a child who is a member of a K-TAP, AFDC Related or Family Related MA case, consider only the LTC child's income, excluding any K-TAP payment.]

3. Allow the personal needs allowance for the LTC child.

4. Allow an increased personal needs allowance, if appropriate, for verified minimum mandatory deductions from income of the LTC child.

5. Allow appropriate deductions to income.

6. Apply remaining income to cost of care.

C. [A K-TAP, AFDC RELATED OR FAMILY RELATED MA ADULT WHO IS NOT MARRIED OR K-TAP/FAMILY RELATED MA CHILD REQUIRING LTC FOR MORE THAN 1 YEAR OR DETERMINATION MADE ON ADMISSION TO LTC THE STAY WILL BE LONGER THAN 1 YEAR.]

1. Refer to SSA if the LTC individual is potentially eligible for SSI.

2. [If not potentially eligible, complete a hard copy application using the appropriate J, K or M program code. Complete and submit to MRT, according to procedural instructions, PA-601T, for determination of permanent and total disability.]

3. [Do not remove the LTC individual from the assistance group until a favorable decision is received from MRT on the J, K or M application or SSI is approved.]

D. [A K-TAP, AFDC RELATED, OR FAMILY RELATED MA MARRIED ADULT WHO REQUIRES INSTITUTIONALIZATION FOR MORE THAN 1 YEAR OR A DETERMINATION IS MADE ON ADMISSION TO LTC WITH STAY LONGER THAN 1 YEAR.]

1. Refer to SSA if the LTC individual is potentially eligible for SSI.

2. [If not potentially eligible, complete the hard copy application using the appropriate J, K or M program code. Complete and submit to MRT, according to procedural instructions, the PA-601T for a determination of permanent and total disability.]

3. [Do not remove the LTC individual from the assistance group until a favorable decision is received from MRT on the J, K or M application or SSI is approved.]

4. When the J, K or M application is processed, consider only the institutionalized individual's income in determining MA eligibility and patient liability. Use the special spousal and family member allowance provisions in the income conservation of the institutionalized spouse's income. [This may reduce the institutionalized spouse's patient liability.]

E. [INSTITUTIONALIZED INDIVIDUAL HAS A COMMUNITY SPOUSE AND HAS DEPENDENT CHILDREN WHO RECEIVE K-TAP, AFDC RELATED OR FAMILY RELATED MA.]

1. In determining continuing MA eligibility for the community spouse and dependent children, remove the institutionalized individual's gross income the month after the month of separation. Exclude the institutionalized individual when determining MA family size.

2. Include in the community spouse and dependent children's case all the community spouse and dependent children's income plus the actual amount contributed by the institutionalized individual for the community spouse income allowance and the family member's income allowance for dependent children. Exclude the institutionalized spouse when determining MA family size. If their combined income remains below the MA scale for the appropriate family size, the community spouse and the dependents remain MA eligible. If their income exceeds the appropriate MA scale, explore spend down eligibility.

3. Determine the institutionalized spouse's patient liability as per MS 3550. The institutionalized spouse may choose to contribute an amount less than the amount computed for the community spouse income allowance so that the spouse and dependents may retain K-TAP/Family Related MA eligibility.

F. INSTITUTIONALIZED INDIVIDUAL NOT MARRIED WITH DEPENDENTS WHO RECEIVE MA.

1. Income is below MA Scale for family size including the LTC individual.

2. Conserve income of LTC individual to bring total income of dependents up to the MA Scale for the family size.

3. Conserve as long as income is below MA Scale.

G. [INSTITUTIONALIZED SPOUSE HAS A COMMUNITY SPOUSE AND DEPENDENTS WHO ARE INELIGIBLE FOR OR HAVE NOT APPLIED FOR MA OR K-TAP.]

1. [Conserve income of the institutionalized spouse for community spouse income allowance and family allowance as per MS 3550.]

2. Exclude institutionalized spouse from the MA family size.

3. Conserve as long as one spouse is institutionalized and one remains at home.

H. [INSTITUTIONALIZED INDIVIDUAL HAS DEPENDENTS WHO ARE INELIGIBLE FOR OR HAVE NOT APPLIED FOR K-TAP, AFDC RELATED OR FAMILY RELATED MA.]

1. Conserve income of the LTC individual to bring the total income of the dependents up to the MA Scale for the appropriate family size excluding the LTC individual.

2. Conserve as long as income is below the MA Scale.

I. INSTITUTIONALIZED INDIVIDUAL NOT MARRIED, IN A FAMILY GROUP, APPLIES FOR MA TO COVER COST OF LTC.

1. Conserve income to bring total income of dependents up to MA Scale for the appropriate family size excluding the LTC individual.

2. Apply excess income to LTC costs.

3. Do not deduct the family allowance from the institutionalized spouse's income when there is no community spouse.

MS 3580 SPEND DOWN FOR LTC

[Ineligibility for vendor payment exists if there is income in excess of the special income standard and the individual does not have an approved QIT or is institutionalized less than 30 consecutive days.]

A. [Process as a spend down case, using the regular MA scale, refer to MS 2650.]

B. The time limited MAID card cannot be used for LTC vendor payments.

MS 3590* CHANGE IN STATUS

Changes requiring recomputation of continuing eligibility are as follows:

A. Recipient's income increases or decreases;

B. Recipient's level of care or facility changes;

C. Recipient's medical expenses or health insurance premiums increase or decrease;

D. Recipient's spouse's income is considered or is no longer considered in LTC case;

E. Recipient is discharged from LTC facility; or

F. Recipient dies.

MS 3600* PA-62 NOTIFICATION

A. Use form MA-105 to notify the applicant/recipient, committee or responsible party and the LTC facility of:

1. An approval, denial or discontinuance of LTC/MA application; and

2. Increase or decrease in the amount of the recipient's patient liability and effective date of change.

B. Use form MA-105 to notify an individual admitted to LTC as Medicare pay and who apply for or are already receiving MA and QMB that:

1. Medicare is the primary payor; or

2. Patient liability will be zero for any LTC period of Medicare coverage.

MS 3610 EFFECTIVE DATE OF VENDOR PAYMENT

Determine the effective date for vendor payment changes as follows:

A. When increasing patient liability for any vendor payment apply 10-day adverse action policy. [Patient liability is never increased retroactively.] PA-62 documents submitted and accepted:

1. Before cutoff are effective the current month.

2. After cutoff are effective the first day of the following month.

B. When decreasing patient liability for LTC individuals, waiver programs or Hospice, the effective date of vendor payment is the first day of the month the change is entered on KAMES or the PA-62 document is accepted. [Patient liability may be decreased retroactively if patient liability was incorrectly inflated due to agency error for the period in question.]

MS 3650 PEER REVIEW ORGANIZATIONS

The designated peer review organization (PRO) is responsible for conducting patient status determinations for individuals in a NF, HCBS, ICF/MR/DD and Mental/Psychiatric facilities who:

A. Enter a facility and are not covered by Medicare; or

B. Have been Medicare covered and either:

1. Reach the 100th day of stay; or
2. Exhaust Medicare benefits.

C. The review process involves rendering level of care determinations by matching the individual's care needs with the level of care which meets those needs.

D. [The PRO for LTC facilities is National Health Services, 9200 Shelbyville Road, Suite 215, Louisville, Kentucky 40222. The peer review organization is responsible for notifying the agency with:

1.] Electronic Long Term Care certifications with admission date, level of care and date level of care was met. The automated process includes an SSN matching function which searches KAMES for an active or pending member. If a match is found, the system will post a spot check to the worker's DCSR with the message, "Pending PRO Certifications". The spot check will appear on both the worker's and supervisor's DCSR's if the worker is on probationary status. The spot check will appear on the supervisor's DCSR for a non-probationary worker if no action is taken after 10 days.

Workers are to access the certification files for identified matches from item "P", PRO Certifications, on the KAMES Inquiry Menu. The certification is to be force printed and filed in the case record when appropriate case action is taken.

If no SSN match is found on KAMES, the member name, SSN and facility number will appear on the RDS report titled, "PRO Certifications Not Matched to KAMES". The member information is sorted by county code. This will be the location of the certifications for SSI individuals and individuals that are not active Medicaid recipients on KAMES at the time the file is received. Supervisors are responsible for monitoring this report on a daily basis and assuring that PA-62's are completed for vendor payment approval for individuals active on SDX. Workers are to access the certification of files for identified clients on item "P" of the KAMES Inquiry Menu. The certification is to be force printed and filed in the case record when appropriate case action is taken.

When a worker adds a new LTC segment to KAMES, matching the provider number and member number of a pending PRO Certification, the spot check will disappear when the batch cycle is run. Only the supervisor will have the capability to manually delete the PRO Spot Check. In order for the supervisor to manually delete the PRO Spot Check, select function K, Delete PRO Spot Check from the Daily Case Status Maintenance Menu. The supervisor will enter an X next to the spot check to be deleted and hit enter. The X(s) will be highlighted with a message that states "press enter to confirm deletion". When enter is pressed again the supervisor will receive a message stating "record deletion successful". The listing will remain unchanged until batch is run.

A verification source of "PR" is on the LTC screen of KAMES for the following types of care: 01 (Nursing Facility), 02 (HCBS), 07 (ICF/MR/DD), 08 (Mental Health/Psychiatric), 09 (PRTF), 10 (Adult Day Care) and 12 (IMD).

For cases on the PA-62 system, the code "6-PRO Certification" is appropriate for the following levels of care: Nursing Facility, HCBS, ICF/MR/DD, Mental Health/Psychiatric, PRTF, Adult Day Care and IMD.

[2.] Important Notice – Denial of admission or continuation of stay. Adverse action.

E. The PRO for Mental/Psychiatric Facilities is Mental Health Management of America, Inc., P.O. Box 70219, Nashville, Tennessee 37207. The peer review organization is responsible for notifying the agency with:

[1.] Automated Certification for Psychiatric Facility Placement – Notification of continued stay or additional information regarding the placement or stay in the mental hospital or PRTF.

[2.] L-03, Data Correction Form – is used to correct inaccurate data entered on Form L-02.

[3.] L-05, Inpatient Psychiatric Facility Placement Adverse Determination – is used when patient's admission or continued stay in a mental hospital or PRTF is denied.

[4.] L-06, Acknowledgement of Request for Reconsideration – is sent to inform the patient of the date, time and place for reconsideration.

[5.] L-07, Psychiatric Facility Placement Results of Reconsideration - The form indicates the decision if the patient's stay is to be continued.

MS 3660 PEER REVIEW ORGANIZATION
INITIAL CERTIFICATION

[The admission review is completed by the PRO prior to the individual entering the facility or as soon as possible after the individual is admitted to the facility. A retrospective on site review is conducted within 30 days of the provider's request for certification.]

A. [For LTC level of care determinations, the automated certification notifies the local office of the approvals to or changes in LTC with the admission date, level of care, and date level of care met. See MS 3650.

B. For mental/psychiatric level of care determination, the automated certification notifies the local office of the approval with the admission date. See MS 3650.

C. A continued stay review is completed by PRO during the initial level of care determination. The review is performed by examining the individual's medical records and conducting an on site visit with the individual. When a LTC recipient is certified for a continued stay, no notification is sent to the local office. For mental hospitals, the PRO completes a new automated certification if a patient's stay is continued. See MS 3650.]

MS 3670 PEER REVIEW ORGANIZATION DENIAL

An adverse determination is made by the PRO when an individual does not require the level of care being provided.

A. The adverse determination notice is issued when an applicant's admission or a continued stay review is denied.

B. An adverse determination is effective 10 days from the date an adverse determination notice is issued.

C. The PRO allows a 10 day grace period for an individual receiving an adverse determination notice to find other placement.

D. MA benefits continue during the grace period.

E. If an adverse determination notice is received at the initial admission, no grace period is allowed.

MS 3680 PEER REVIEW ORGANIZATION RECONSIDERATION

A reconsideration may be requested if the individual, physician of record or facility is dissatisfied with an adverse determination.

A. The request for a reconsideration is accepted by the PRO in written form only and must be received within 40 days of a continued stay denial or within 3 days of an admission denial.

   1. If the reconsideration request for continued stay denial is received within the 10 day grace period, MA benefits continue until the reconsideration decision is determined.

   2. A hearing is scheduled by the PRO following the receipt of the reconsideration request and is held within 10 days of a continued stay denial and within 3 working days of an admission denial.

   3. The local office is notified in writing when a hearing decision is rendered.

B. When an adverse determination is reversed by the hearing officer, vendor payments continue uninterrupted or the application process is initiated to start vendor payments. The local office is notified in writing of the reinstatement action and the retroactive time period the individual is certified.

C. If the adverse determination is upheld by the hearing officer, discontinue vendor payments or deny the care being provided.

MS 3690 PEER REVIEW ORGANIZATION APPEAL

An appeal may be filed with the PRO by the individual or the individual's responsible party if the PRO decision on an adverse determination is upheld by the hearing officer. Do not continue MA benefits during the appeal process.

A. Accept the appeal in written form only. The appeal must be received by the PRO within 20 days of the date of the results of the hearing notice received by the individual or responsible party.

1. The appeal must include the name of the individual, facility, and the reason the individual or responsible party disagrees with the hearing officers decision.

2. The appeal is sent to the appropriate PRO.

B. A decision is rendered within 15 days of receipt of the appeal request.

MS 3700 PRIVATELY OWNED/OPERATED FACILITIES

A. PRIVATELY OWNED/OPERATED ICF/MR/DD FACILITIES IN KENTUCKY

1. Cedar Lake Lodge, Oldham County;

[2. Higgins Learning Center, Union County; and

3.] Wendel Foster Center, Daviess County.

B. PLACEMENT SERVICES IN PRIVATELY OWNED/OPERATED FACILITIES

1. If the Confirmation Notice shows the appropriate level of care, placement services are not required.

2. If the Confirmation Notice shows level of care is not appropriate and an alternate level of care is indicated, immediately request placement services.

a. [Send a memorandum to MH/MR.]
b. Give individual's name and case number, name of facility and level of care required.

3. If the Confirmation Notice shows level of care is not appropriate but an alternate level of care is not indicated, immediately:

a. [Send a memorandum to MH/MR.]
b. Give individual's name, case number and name of facility.
c. Request an assessment by the PRO to determine the level of care needed.

C. PLACEMENT IN OR FROM ICF/MR/DD CANNOT BE ACCOMPLISHED WITHIN 30 DAYS OF RECEIVING THE CONFIRMATION NOTICE

1. [MH/MR notifies DCBS field staff by memorandum of efforts to place individual.]

2. [Forward this report to the DMS, Division of Administration and Financial Management.]

3. [MH/MR submits progress reports at 60 day intervals, for forwarding to DMS, until placement is accomplished.]

4. Continuing vendor payment is contingent on DMS receiving progress reports.

D. ACCEPTANCE/REFUSAL OF BEDS

1. Approved bed becomes available.

a. First name on waiting list is expected to accept placement.
b. Do not consider bed available if facility refuses to accept the individual.

2. Available bed refused.

a. [Send form MA-105, if on PA-62 system, to the recipient/committee and a copy to MH/MR.]
b. The vendor payment is discontinued.

E. Appeal Panel Hearing Procedure.

1. ICF/MR/DD hearings on patient status must be conducted by an Appeal Panel.

2. The panel is composed of:

a. [A DCBS hearing officer who chairs the Appeal Panel;]
b. A representative from the facility;
c. A neutral representative from the county in which the facility is located appointed by the County Judge/Executive; and
d. [A DCBS worker, with the case record, who represents the Agency.]

3. Action following the hearing.

a. The chair takes a vote of the panel.
b. The decision is written.
c. The chair notifies the parent/payee/guardian/committee of the decision.

4. Decisions of the Appeal Panel.

a. Decision reversed, vendor payment continues.
b. Decision upheld, may be appealed within 30 days of date of decision to either:
(1) The Circuit Court of the county where the State facility is located;
(2) The Circuit Court of the home county of the parents, guardian, committee or payee; or
(3) The Franklin Circuit Court.

F. Hearings on Patient Status. Recipients in ICF/MR/DD have the same hearing rights as any other recipients.

1. When a hearing is requested:

a. Send the PAFS-78 form to the Hearing Branch.
b. [Attach a copy for MH/MR.]
c. Indicate if the request is timely.
d. If timely, vendor payment continues during hearing process.
e. [Hearing Branch sends a copy of the decision to MH/MR for action regarding vendor payment.]

2. Decisions of Hearing Branch.

   a. Decision reversed, vendor payment continues.
   b. Decision upheld:
      (1) [DMS notifies Service Region Administrator by memorandum that payment continues for 10 days to allow for appropriate placement.]
      (2) [Immediately notify MH/MR of the decision and request placement in the appropriate level of care.]

MS 3710 STATE OWNED/OPERATED FACILITIES

A. State Owned/Operated ICF/MR/DD Facilities in Kentucky.

1. Hazelwood, Jefferson County;

2. Oakwood, Pulaski County;

3. Outwood, Hopkins County; and

4. Central State, Jefferson County.

B. Placement Services in State owned/operated facilities are not the responsibility of DCBS.

C. Reclassification of ICF/MR/DD Recipients. MH/MR is responsible for sending written notice of reclassification to the parent/guardian/payee/committee to advise of hearing rights.

D. Hearings on Patient Status/Reclassification.

1. When a hearing request is received within 30 days of the notice of reclassification, vendor payment continues until the decision is rendered.
2. Local office activity:

a. Accept all hearing requests.
b. Send requests to:

[Cabinet for Health and Family Services
Health Services Administrative Hearings Branch
275 East Main St., HS-1E-A]
Frankfort, KY 40621

3. The Administrative Hearings Branch sends a copy of the acknowledgement of the request to the local office in the county where the facility is located.

MS 3715 Money Follows the Person (MFP)

MFP is a program for individuals who have met level of care for a nursing facility, SCL, or ICF/MR/DD for at least six months and have been eligible for Medicaid at least one month. The program is designed to provide transitional assistance to these individuals to enable them to move back into the community and live more independently. This is not a program individuals can apply for; rather the recipients are identified by DMS MFP Staff.

A. Department for Medicaid Services (DMS) and Department for Community Based Services (DCBS) Responsibilities:

1. Individuals that qualify for MFP are identified by DMS and the services are managed by DMS MFP staff.

2. Once an individual has been identified as participating in MFP:

   a. DMS staff will make a KAMES entry that will set the MFP indicator for KAMES inquiry. A spot check will post to the DCBS case worker's DCSR which notifies the worker that the member is in transition. The spot check will display the program code, the case number, the timely date (10 days from date posted), the reason for the spot check and the worker code. The worker is able to confirm that the case has been identified as MFP by selecting the inquiry function on KAMES under segment "A – General Information". The indicator will show the level of MFP the member is in and a date on screen HRKIMK26 (INQ – Case General Information). If the MFP individual is an SSI recipient the worker can confirm the recipient's placement in MFP on the "SDX Inquiry Page". The indicator will show the level of MFP the member is in on screen HRSDX3B1 (SDX Inquiry Page 1).

   b. Once the member moves from the facility to the home environment the worker will receive form MAP-24M, Initial Admission, Change or Discharge of an Individual in KY Transitions (Money Follows the Person), which indicates the level of care required.

   c. Once an individual has been identified as an MFP, he/she can not lose Medicaid eligibility for any reason during the first 365 days of MFP eligibility. To ensure that the 365 day count is not interrupted, when the DMS MFP worker identifies the change on KAMES to reflect the recipient's move from LTC to a waiver, KAMES will automatically assign a two-year certification period. The 365 days are tracked by DMS MFP staff. The 365 days only apply to days the member remains in the community setting. Should the participant enter a hospital or return to a nursing facility, the 365 MFP participation count stops.

3. If an MFP recipient returns temporarily to a hospital or a nursing facility:

   a. The worker will receive notification of this change through form MAP-24M from DMS MFP staff. If the recipient had a shelter expense while in the community, an increased Personal Needs Allowance (PNA)

deduction is allowed to make it feasible for the recipient to continue to pay the shelter expenses to maintain the dwelling while institutionalized. Upon receipt of form MAP-24M the worker will need to:

1. Enter the PNA deduction amount on screens HRKIPA0C (LTC/WAIVER) or HRKIPD23 (CHANGE LTC/WAIVER). Enter the amount of the shelter deduction on the line in front of the "MFP Shelter Deduction?" question and enter the "Start Date". The amount entered will be reflected on disposition screen HRKIPC05 on the "Increased Personal Needs Allowance" line; and

   Note: If the worker receives an error message while trying to enter the shelter deduction, they are to contact the DMS MFP person listed on line 3 of form MAP-24M.

2. Change the waiver status code on KAMES to indicate the recipient has returned to a nursing facility or a hospital; and

b. The PNA deduction is allowed for 6 months from the date the recipient returns to the nursing facility or enters into a hospital. To remind staff of the expiration status of the PNA deduction on the first day of the 6th month after the MFP shelter deduction start date, a "MFP Shelter Deduct to Expire" spot check will post to the workers DCSR. The spot check will display the program code, case number, case name, timely date (10 days from date posted), the reason and the worker code. Upon the expiration of 6 months the worker will need to:

1. Remove the deduction from screens HRKIPA0C (LTC/WAIVER) or HRKIPD23 (CHANGE LTC/WAIVER); and

2. Process the change according to the instructions on form MAP-24M. The change will be to either place the recipient back into the waiver they were in when they were identified MFP, or to place the recipient back into the LTC category the recipient was in prior to being identified MFP; and

3. Delete the spot check and document in case comments the reflected case change.

B. At the end of the MFP participation, DMS MFP staff will notify the DCBS worker of the ending effective date, by sending form MAP-24M. Upon receipt of form MAP-24M, the worker will need to shorten the certification date to the next applicable month and send the recipient a recertification appointment. At this time the MFP recipient will most likely apply for additional DCBS administered benefits. A DMS MFP staff member assisting with the transition may inquire on the recipient's behalf regarding potential eligibility for additional benefits and amounts.

MS 3720 INTRODUCTION TO ESTATE RECOVERY

Estate recovery results in the State filing a claim against the estate of an individual in order to recoup MA expenditures paid on the individual's behalf.

A. Estate recovery is made against a deceased individual's estate. This includes all assets such as cash, personal possessions, and homestead property.

1. A claim is filed against the estate for the total amount of MA expenditures accruing on and after February 2, 1994.

2. MA expenditures prior to February 2, 1994 are not subject to estate recovery.

B. An estate is subject to estate recovery if the individual is at least 55 years of age AND if at anytime the individual received MA for any of the following:

1. NF, not including institutionalized Hospice;

2. ICF/MR/DD services;

3. SCL; or

4. HCBS.

C. [The estates of individuals under 55 years of age are also subject to estate recovery if the individual has been receiving MA for NF or ICF/MR/DD services for a total of six consecutive months or more at the time of death.]

MS 3730 DCBS RESPONSIBILITIES

[The Department for Community Based Services (DCBS) obtains information for purposes of Estate Recovery from all individuals applying for or receiving services in HCBS, SCL, ICF/MR/DD, Model Waiver II, Mental Health Psychiatric Care Facility (age 65 or over), Adult Day Care, Acquired Brain Injury, or a nursing facility.] These procedures are applicable regardless of the system on which the application or recertification is processed. [Estate Recovery information passes directly from KAMES to MMIS.]

A. The Department for Medicaid Services (DMS) will recover against ALL assets held by the recipient at the time of death. Form MAP-708, Medicaid Estate Recovery Fact Sheet, advises the applicant or recipient that the estate may be subject to recoupment of monies expended on their behalf for services received during periods of institutionalization.

1. [Post form MAP-708, Medicaid Estate Recovery Fact Sheet, in each local office waiting room for anyone requesting estate recovery information. Form MAP-708 is system generated to SSI recipients at vendor payment approval on the PA-62 system.]

2. Advise individuals requesting additional information to write to:

[Electronic Data Systems (EDS)
Third Party Recovery Section
P.O. Box 2107
Frankfort, Kentucky 40602]

3. [Form PA-1A, Supplement E, Estate Recovery Notification and Information Sheet Statement, advises the applicant or recipient that their estate may be subject to recoupment of monies expended on their behalf for services received during periods of institutionalization.] The value of homestead property, the name of the spouse, the names of minor dependent children, the names of blind or disabled children, and the name and address of the executor or administrator of the will are collected on the form. If there is no will, obtain the name and address of the next of kin or interested party. [For SSI recipients, form PA-1A, Supplement E is also system generated at vendor payment approval.]

4. File form PA-1A, Supplement E in the most recent application or recertification packet pulled forward and file in each subsequent recertification packet. Review the form at each recertification to include any reported changes or additional estate recovery information.

[5. Form PA-707, Estate Recovery Notice, which is also system generated to SSI recipients at approval, advises the recipient to review the MAP-708 and PA-1A, Supplement E and to complete,

sign and mail the PA-1A, Supplement E to EDS at the above address.]

B. Cooperation in estate recovery is not a technical eligibility requirement for receipt of MA benefits. Do not deny an application or hold other case action pending the receipt of a completed form.

C. [For SSI only recipients requesting services in HCBS, SCL, ICF/MR/DD or a nursing facility, form PA-1A, Supplement E is system generated at the time the vendor payment is authorized to the SSI recipient or payee along with form PAFS-2, Application Letter or Notice of Expiration, requesting that the form be completed and returned within 10 days. Refer to procedural instructions for the form. Inclusion of the PA-1A, Supplement E in the case record is not an eligibility requirement for SSI recipients.]

D. For SSI recipients receiving services in HCBS, SCL, ICF/MR/DD or a nursing facility prior to 4/1/95, a desk review is not required. Completion of form PA-1A, Supplement E is appropriate at the next contact made by the SSI recipient or payee concerning any required vendor payment reported changes.

E. [Notice of death will be sent electronically to MMIS from both the Vital Statistics death match and KAMES discontinuances due to the death of the recipient via nightly batch match.]

F. [Based on the information received by MMIS, a notice is system generated from the Office of Inspector General (OIG) to the individual designated as the Executor or Administrator at case approval, recertification or case change. This notifies the designated individual of the ability/intent of DMS to recover against assets of the individual for cost of care, unless certain exemptions are met. If the member is inactive at the time of death, OIG will contact the designated individual concerning the estate of the deceased once the date-of-death match is received from Vital Statistics.]

G. Advise individuals requesting additional information about Estate Recovery, to send any questions in writing to the following address:

[EDS
Third Party Recovery Section
P.O. box 2107
Frankfort, KY 40602
Phone (502) 564-4958]

MS 3800 NON-EMERGENCY MEDICAL TRANSPORTATION

[Medicaid recipients are eligible for medical transportation services if non-emergency medical transportation criteria are met. Non-emergency medical transportation services are provided through the Human Services Transportation Delivery (HSTD) system, with the exception of stretcher services. Stretcher services are requested by contacting the stretcher service provider directly. The HSTD system is administrated by the Kentucky Transportation Cabinet. The HSTD toll-free customer service hotline is (888) 941-7433 or recipients can call (502) 564-7433. Recipients may call to report problems in requesting services or complaints with services provided by the transportation brokers.

Long Distance travel beyond the service area covered by regional transportation brokers of the HSTD system is requested by contacting the Department for Medicaid Services (DMS) at 502-564-8196. Reimbursement for lodging and meals is handled directly by DMS and is requested when scheduling the long distance travel.]

MS 3810 Non-Emergency Medical Transportation Brokers

The following list of transportation brokers lists the counties in which they provide Non-emergency Medical Transportation (NEMT) and phone numbers at which they are contacted to request services.

[Region 1
Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Marshall, and McCracken counties LKLP Community Action Council (LKLP)
1-800-245-2826

Region 2
Caldwell, Christian, Crittenden, Hopkins, Livingston, Lyon, Muhlenberg, Todd, and Trigg counties
Pennyrile Allied Community Services (PACS)
1-800-467-4601 or (270) 886-6641

Region 3
Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster counties
Audubon Area Community Service, Inc (GRITS)
1-800-816-3511 or (270)686-1651

Region 4
Breckinridge, Grayson, Hardin, Larue, Marion, Meade, and Nelson counties LKLP Community Action Council (LKLP)
1-800-245-2826

Region 5
Butler, Edmonson, Hart, Logan, Simpson, and Warren counties
GRITS/RTEC, LLC
1-888-781-8312 or (270)782-8312

Region 6
Adair, Allen, Barren, Green, Metcalfe, and Taylor counties
GRITS/RTEC, LLC
1-800-321-7832

Region 7
Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, and Trimble counties
Federated Transportation Services of the Bluegrass (FTSB)
1-888-848-0989

Region 8
Anderson, Boyle, Casey, Franklin, Garrard, Jessamine, Lincoln, Mercer, Scott, Washington, and Woodford counties
Bluegrass Community Action Partnership (BGCAP)
1-800-456-6588 or (502)695-4290

Region 10
Fayette county
Federated Transportation Services of the Bluegrass (FTSB)

1-888-848-0989 or (859)233-0066

Region 12

Bell, Clinton, Cumberland, Knox, Laurel, McCreary, Monroe, Pulaski, Rockcastle, Russell, Wayne, and Whitley counties
Rural Transit Enterprises Coordinated (RTEC)
1-800-321-7832 or (606)256-9835

Region 13

Bath, Boone, Bourbon, Boyd, Bracken, Breathitt, Campbell, Carroll, Carter, Clark, Clay, Elliott, Estill, Fleming, Gallatin, Grant, Greenup, Harlan, Harrison, Jackson, Kenton, Knott, Lawrence, Lee, Leslie, Letcher, Lewis, Madison, Mason, Menifee, Montgomery, Morgan, Nicholas, Owen, Owsley, Pendleton, Perry, Powell, Robertson, Rowan,
and Wolfe counties
LKLP Community Action Council
1-800-245-2826 or (606)439-1362

Region 14

Floyd, Johnson, Magoffin, Martin, and Pike counties Sandy Valley Transportation Services (SVTS) 1-800-444-7433 or (606)886-1936]

MS 3900* MEDICAID WORKS OVERVIEW

The Kentucky Medicaid Works program offers disabled individuals who are unable to engage in Substantial Gainful Activity (SGA), but are working and are not financially eligible for regular MA the opportunity to "buy in" into Medicaid. For an explanation of SGA, refer to MS 3912. Medicaid Works applicants who receive Medicare may also receive Qualified Medicare Beneficiaries (QMB) or Special Low-Income Medicare Beneficiaries (SLMB) if their income is below the income limits for the specific program.

Medicaid Works applicants with spouses must meet an initial income test. The income limit for an ineligible spouse is $3,750 per month. If the ineligible spouse's income exceeds $3,750 per month, the applicant is not eligible. If the income of the ineligible spouse does not exceed $3,750, then apply the remaining appropriate income tests as explained next.

Medicaid Works applicants that have already been determined disabled by a Federal/State entity have to pass two different income limit tests. The first test is the unearned income limit test set by the SSI income standards. The second is the earned income limit set by the 250% Federal Poverty Level (FPL).

Medicaid Works applicants that have NOT been determined disabled have to pass three different income limit tests. The first test is the unearned income limit set by the SSI income standards. The second test is the earned income limit set by the 250% FPL. The third test is the SGA income standards. For an explanation of SGA, refer to MS 3912.

Medicaid Works recipients that stop working can continue to be eligible for up to 6 months as long as they intend to return to work.

MS 3910 MEDICAID WORKS APPLICATION

Applications for Medicaid Works are taken in the "K" (blind) or "M" (disabled) program categories. In order to be technically eligible for Medicaid Works an applicant must be:

1. Between the ages of 16 and 64;

2. Actively employed or actively self-employed;

3. Under the unearned income limit AND the earned 250% Federal Poverty Level income limit;

4. Determined to be totally and permanently disabled;

5. UNABLE to engage in Substantial Gainful Activity (SGA).

   a. [A disabled individual earning $980 per month (effective 1/1/09) or more is considered ABLE to engage in SGA.
   b. A blind individual earning $1,640 per month (effective 1/1/09) or more is considered ABLE to engage in SGA]; and

6. Meet all other technical and financial eligibility requirements for Medicaid.

Applications for Medicaid Works are processed as follows:

A. For applicants already determined disabled see item B.

For applicants who have NOT been determined disabled:

1. Workers make a Medical Review Team (MRT) referral by sending a completed form PA-601T, Referral for Determination of Incapacity or Disability, and signed/witnessed forms MRT-15 (with a revision date of 5/01 or after), Authorization for Information/Release of Information. Refer to MS 1720. In the nature of illness section, workers note it is a Medicaid Works application.

2. Prior to sending the MRT, workers determine if the Medicaid Works applicant is able to engage in SGA. Refer to MS 3912. If a Medicaid Works applicant is able to engage in SGA, then he/she is NOT eligible for a disability determination and an MRT referral is not appropriate. If the applicant is unable to engage in SGA, see instructions in MS 3912. The worker is to annotate on the top of the PA-601T that applicant is not engaged in SGA.

B. Coverage is effective the date of application. There is no premium for the first/partial month's coverage. Explain to the applicants that the effective date of medical assistance is the date of application, not the 1st day of the month of application. Correctly enter the date of application as well as all other information on KAMES. There is no retroactive coverage. Cases

will alternate program to “K” or “M” spend down for applicants whose income is over the limit.

C. If an applicant has medical expenses prior to the date of application, up to the 3 prior calendar months, explore eligibility for spend down coverage. A spend down is not to be processed for the same month in which a member has been approved for coverage, as some members are subject to premium payments. The client may elect to wait until the first of the following month to apply for on-going benefits if they need to apply for spend down for the current month. It is the decision of the client; however, the worker needs to make sure the client understands that no coverage will exist prior to the date of application in the application month.

If spend down coverage is requested for any portion of the prior quarter, complete the spend down as a special circumstance transaction, provided all verification has been received. Document the case record accordingly. Refer to OMPU 03-20, MS 99627, Spend Down Changes, 5/1/03, item H, for the instructions for processing spend downs by special circumstance on KAMES.

MS 3912 MEDICAID WORKS SUBSTANTIAL GAINFUL ACTIVITY (SGA)

Substantial Gainful Activity (SGA) is a term used by the Social Security Administration (SSA) to describe a level of work activity and earnings. It is considered in situations involving disabled or blind individuals. Individuals determined to be engaged in SGA are not eligible for Medicaid Works.

HOW TO DETERMINE SUBSTANTIAL GAINFUL ACTIVITY

For applicants who have not been determined disabled, workers are to establish if the applicant meets the criteria to have MRT complete a review by determining if the applicant is engaged in SGA.

To determine if an applicant is engaged in SGA workers are to compare the applicant's actual income received for the prior month to the SGA income limits set by SSA annually. The current SGA monthly income limit is:

SGA for Disabled Individual	SGA for Blind Individual
$980	$1,640

Effective 1/1/09

NOTE: If the income for the prior month is not representative of ongoing, then compute the income by totaling actual amounts of income received in the prior 3 months and divide by 3. If the applicant claims his/her income will change, but is over the SGA standard for the current month, the application is denied for the current month and the individual is advised to reapply in the next month.

At application the worker completes an MRT referral, but prior to sending for review workers determine if the applicant meets the definition of disability. If the applicant's income is more than the SGA standards, the applicant is considered to be engaged in SGA and therefore, does NOT meet the definition of disability, the referral to the MRT is not sent for review. However, if the applicant earns less then the SGA standards, then the worker sends the MRT for review.

> Example 1: Disabled Dan (under the age of 65) works and earns $1,000 and receives $300 in RSDI monthly.
>
> Disabled Dan passed the unearned income test because the $300 in RSDI is under the SSI income standards. Disabled Dan also passed the second income test as his total combined income ($1,300/mo.) is less then the 250% Federal Poverty Level for one. However, disabled Dan's verified earned income is above the SGA income limit. Therefore, he is considered to be engaged in SGA and does not meet the definition of disability.

The MRT referral is NOT sent for review and the worker is to:

1. Annotate the top of form 601-T indicating the applicant does not meet the requirements for a disability determination and is engaged in SGA.

2. Due to system limitations, at this time, applicants will not receive a notice informing them that they do not qualify due to being engaged in SGA. Send form MA-105, Eligibility Notice, to the applicants informing them that income exceeds the SGA income guidelines set by the federal government for an individual to be eligible for Medicaid Works;

3. File the annotated form 601-T in the case record; and

4. Document in comments why the MRT referral was not sent for review.

Example 2: Dan's co-worker Jimmy (also disabled and under age 65) earns $979and receives $200 in VA benefits monthly.

Jimmy has passed the unearned income test and his VA benefit is under the SSI standards. Jimmy has also passed the second income test as his total combined income ($1,139) is less than the 250% Federal Poverty Level for one. Additionally, Jimmy's verified earned income is below the SGA income limit. Therefore he is considered to NOT be engaged in SGA and DOES meet the definition for disability.

At this point, the MRT referral is sent for review and the worker:

1. Complete form PA-601T, Referral for Determination of Incapacity or Disability, and signed/witnessed forms, MRT-15 (with a revision date of 5/01 or after), Authorization for Information/Release of information. Refer to MS 1720. In the nature of illness section, to note that this is a Medicaid Works application.

2. Annotates the top of form 601-T indicating an SGA review has been completed and that the client meets the requirement for a disability determination;

3. Sends the annotated form 601-T along with the MRT-15's for review; and

4. Documents in comments that the applicant meets the requirement for a disability determination and the MRT referral has been sent for review.

MS 3920 MEDICAID WORKS FINANCIAL ELIGIBILITY

Resource and income limits are as follows:

A. The resource limits are:

1. $5,000 for a single individual; and
2. $10,000 for a couple.

B. The income limits are:

1. The income limit (gross earned and unearned) for applicants is 250% of the Federal Poverty Level (FPL);

2. [The income limit for an ineligible spouse is $3,750 per month. If the ineligible spouse's gross income is over $3,750 per month, the applicant is not eligible;

3. The unearned income limit is $694 (SSI standard plus $20).

Note: The SSI standard changes in January of each year.]

Calculate income as follows:

1. For a technically eligible applicant, refer to Volume IVA, MS 2560.

2. For a technically eligible applicant and spouse, refer to Volume IVA, MS 2570.

3. For a technically eligible applicant with a technically ineligible spouse, refer to Volume IVA, MS 2580.

For financial eligibility and verification of employment, refer to Volume IVA, MS 2480 for allowable income deductions. Refer to Volume IVA, MS 2470 for a list of excluded income. Cases will alternate program to "K" or "M" spend down for applicants with income is over the limit.

Applicants who receive Medicare and whose income is under the 100% FPL scale are also eligible for QMB. They are eligible for SLMB if income falls under the 150% FPL scale.

Income Scale for 2008

Family Size	100% FPL (+QMB)	150% FPL (+SLMB)	250% FPL
1	$ 867	$1,300	$2,167
2	$1,167	$1,750	$2,917

Note: These amounts change effective April 1 of each year for Adult MA categories.

MS 3930* MEDICAID WORKS PREMIUM PAYMENTS

Some Medicaid Works cases are required to make premium payments and these cases are conditionally approved. These cases will pend for payment of premium due and be shown on the worker's DCSR as "Pending for premium payment". The worker can access any case that is pending for premium payment. If the case is pended for supervisor approval or supervisor override, no record is sent to the Premium Payment Center (PPC) until the case has been disposed. The PPC cannot contact the client for premium payment until the case is disposed. Supervisory staff should expedite all supervisor approvals and override transactions so as not to disadvantage the applicants. Once a case is pending for Premium Payment only, do NOT make any changes which would cause the case to pend for any other reason.

A. Once the case has been disposed:

1. The case will pend for premium payment for a maximum of 60 days from the date of application;
2. If the individual pays the premium by the due date, the case is updated and the MA card will be issued;
3. If an individual is conditionally approved, but premiums are not paid, the case will deny;
4. No disqualification is imposed for an individual who was eligible but failed to make the premium payment;
5. If the applicant fails to pay the premium due for an application, the system denies the case and the worker receives the spot check "Case Den. Did Not Pay Premium".

B. Premium payment amounts are as follows:

*Recipient Status Code	Income	Monthly Premium Amount
W1	0% - 100% FPL	$ 0
W2	0% - 100% FPL w/QMB	$ 0
W3	100% - 150% FPL	$35
W4	100% - 150% FPL w/SLMB	$35
W5	150% - 200% FPL	$45
W6	200% - 250% FPL	$55

*Recipient status codes are system-applied.

C. WHO IS RESPONSIBLE FOR BILLING?

A third party administrator is responsible for the billing and collection of premiums due. If an individual contacts the local office regarding payment of

premiums, direct the individual to contact the PPC. It is the responsibility of the client to resolve premium payment issues. The mailing address for the PPC is:

Premium Payment Center
P. O. Box 14656
Lexington, KY 40512-4656

The telephone number for the PPC's Customer Service Department is (866) 959-2447. This phone number is for client use only. The PPC office is staffed from 8 A.M. to 7 P.M., Monday through Friday, and 9 A.M. to 1 P.M. on Saturdays, Eastern Standard Time.

The PPC notifies KAMES within 2 business days of receipt of premium payment. Once KAMES receives notification that payment has been made, the case will dispose and a medical card will be issued for the individual.

D. OVERPAYMENT OF PREMIUMS

If an individual contacts the local office concerning a request for refund of premiums paid, instruct the individual to contact the PPC Customer Service at (866) 959-2447.

MS 3940*

DENIAL/DISCONTINUANCE CODES FOR MEDICAID WORKS

The following are denial/discontinuance codes for Medicaid Works cases:

1. Code 261 – Case denied - “Failure to Pay Premium”;
2. Code 661 – Case discontinued – “Did Not Pay Premiums”;
3. Code 270 – Case denied – “Working Disabled Recipient Not Working” (member code 870);
4. Code 670 – Case discontinued – “Working Disabled Recipient Not Working” (member code 870);
5. Code 271 – Case denied – “Does Not Meet Age Requirements of 16 – 64” (member code 871);
6. Code 671 – Case discontinued – “Does Not Meet Age Requirements of 16 – 64” (member code 871);
7. Code 272 – Case denied – “Spouse’s Income Over the Income Limit” (member code 872); and
8. Code 672 – Case discontinued – “Spouse’s Income Over the Income Limit” (member code 872).

MS 3950* MEDICAID WORKS DISQUALIFICATIONS

Medicaid Works individuals will receive notice of a premium due in the month prior to the month that the premium is due. If the Medicaid Works recipient has failed to pay the monthly premiums due, KAMES will disqualify the member and discontinue the case. If the case is in pending recert status, at cut-off, eligibility will issue for the coming month.

EXAMPLE: A notice is sent in October with payment due by November 5th for December coverage. If the Premium Payment Center (PPC) does not receive the payment by the 15th, another notice will be generated at cut-off and the individual will receive a bill for 2 months' premiums due.

A. Once a case has been approved and two premium payments are subsequently missed, the PPC will notify KAMES.

1. KAMES will discontinue the case and impose a disqualification;
2. A spot check will be posted to the worker's DCSR, "Case Disc Did Not Pay Premium";
3. If the individual contacts the worker concerning eligibility, advise the client to contact the PPC;
4. Once PPC contacts KAMES with notice of premiums paid, the member disqualification is removed and a new application can be processed;
5. Forward requests to delete disqualifications to the Medical Support and Benefits Branch (MSBB);
6. MSBB will forward the request to the Department for Medicaid Services (DMS) for approval;
7. Disqualifications cannot be deleted until DMS approval has been received;
8. Only supervisors can delete disqualifications once approval is received from DMS.

Do <u>not</u> deny an applicant the right to apply because of outstanding premiums due. However, there is no coverage for lapsed months. If medical expenses are incurred for months of non-receipt of benefits (up to 3 months prior to application), explore spend down Medicaid eligibility.

The disqualification for non-payment of premium will stand for a one-year period or until the disqualification has been cured by payment of premium(s) due or change in circumstances.

B. REMOVAL OF AN ERRONEOUS MEMBER DISQUALIFICATION

If a change in income results in a disqualified individual becoming eligible for regular Medicaid or if a disqualification is applied in error, the Family Support supervisor (FSSV) can remove the disqualification using the following procedure:

1. The FSSV contacts the KCHIP Branch (which handles all premium payment issues) at (502) 564-6890; and
2. The FSSV supplies the following information concerning the removal of the disqualification:
   a. Case name;
   b. Case number;
   c. Individual's name for whom the disqualification is being removed;
   d. The SSN of the individual; and
   e. The reason for the removal of the disqualification.

C. REAPPLICATION WITH DISQUALIFICATION

If the individual is no longer subject to premium payments because of a change in income, the member disqualification for failure to pay premiums (disqualification code 461) is deleted and the reapplication is processed. DMS approval is not required if the re-applicant is no longer subject to premium payment. Reapplications subject to premium payment are processed following procedures in MS 3930.

1. If, at reapplication, there are no changes in countable income or circumstances, the reapplication will deny for "no eligible members". Provide the individual with the telephone number for the PPC and advise that the PPC be contacted at (866) 959-2447 for instructions for paying the owed premium. Advise the client at the time of reapplication that if countable income remains in the 250% Federal Poverty Level (FPL) range, the case cannot be approved as long as the disqualification for non-payment is in effect. The local office supervisor is not to delete disqualifications unless instructed to do so by DMS or Central Office.

2. For reapplications in which the individual states that a change in income has occurred, force the case to pend by answering "Y" to the "Pend Over 10 Days" question after the case has gone through the disposition screens and the comments screen.

   a. The case will then pend for needed information/verification and a Request for Information (RFI) is generated;
   b. Once the needed verification is provided, manually compute the countable monthly income and compare it to the

appropriate income scale. If income is under the 100% FPL scale where no premium would be due, have the supervisor delete the disqualification and allow the case to approve;

c. If the manual computation shows that the individual remains in a category where a premium is due, allow the case to deny for no eligible members. Do not delete the disqualification. Advise the individual to contact the PPC as stated in Section A above.

MS 3951* MEDICAID WORKS RECERTIFICATIONS/INTERIM CHANGES/UNTIMELY CHANGES

Determine continuing MA eligibility for Medicaid works cases as follows.

A. FOR RECERTIFICATIONS:

1. Process a recertification every 12 months.
2. Verify and document continued resource and income eligibility.
3. If, during the recertification month, the member has failed to pay the monthly premium by the due date, KAMES will discontinue the case. If the recertification is pending at cut-off, eligibility is issued for the coming month.
4. Individuals who are recertified and are in good standing with the Premium Payment Center (PPC) will continue to receive medical assistance.

B. FOR INTERIM CHANGES

1. Process as interims, the results of spot checks or recipient reported changes considered to be a change in circumstances that require a re-computation of countable income.
2. Once a case is pending for Premium Payment only, do NOT make any changes which would cause the case to pend for any other reason. If the client reports a change for which verification is required, the worker is to manually mail a PAFS-2 to the client requesting that needed verification be returned within 10 days.
3. Upon receipt of verification, act upon the change.
4. Recipients who report that they have stopped working may remain eligible for up to six months provided they intend to return to work. The question, “DOES WORKING DISABLED RECIPIENT INTEND TO RETURN TO WORK?” appears on the disposition screen HRKIPC23 for cases in which no earned income is entered/removed. Appropriate responses are “Y” or “N”. If, at the end of the six-month period, the recipient has not returned to work, the case will automatically discontinue as no earned income has been entered.

C. FOR UNTIMELY CHANGES

For verified changes that miss cut-off, due to no fault of the client, and the completed change results in approval in a category that does not require a premium payment, the supervisor is to contact the KCHIP Branch with the following information:

1. Case name;

2. Case number;
3. Reason for the change (decreased income);
4. Reason the change was not processed timely (worker on leave, system not available, etc.); and
5. Month(s) in question.

The KCHIP Branch will advise the PPC of the change to a non-premium payment category and the PPC will refund any premium overpayments.

MS 4150 [PASS THROUGH OVERVIEW

Federal law protects MA eligibility for certain RSDI beneficiaries. The MA category for such individuals is called Pass Through. These beneficiaries previously received MA as a Supplemental Security Income (SSI) or State Supplementation (SSP) recipient, and lost the SSI or SSP benefit due to an increase in, entitlement to, or recomputation of RSDI benefits. Increases in RSDI benefits may be the result of a cost of living adjustment (COLA).

There are three Pass Through groups:

A. Those who previously received SSI/SSP and RSDI correctly and concurrently (in the same month). Applicants in this group can receive in the “F”, “G”, or “H” category based on age or disability.

B. Those who lost SSI/SSP benefits due to an entitlement to or increase in RSDI Disabled Adult Child (DAC) benefits. Applicants in this group can receive in the “F”, “G”, or “H” category based on age or disability. If approved in “G” or “H”, change category to “F” once age appropriate.

C. Disabled or early widows/widowers or disabled surviving divorced spouses who are not yet eligible for Medicare Part A. Applicants in this group can receive in the “G” or “H” category only.

These individuals may be technically eligible in more than one category. Case workers are to first apply DAC or widows eligibility before applying correct and concurrent receipt. Limit retroactive eligibility to 3 months for non-managed care counties. There is no retroactive eligibility in managed care counties.

Technical eligibility for Pass Through is verified, for SSI recipients, by the Social Security Administration (SSA). Send form PA-9, Pass Through Eligibility Letter, to the Frankfort SSA office at the address on the first page of the form. The SSA office will complete the form and return it to the local office. The PA-9 is not to be used for applicants who are no longer eligible for SSP.]

MS 4155* ACRONYMS AND DEFINITIONS

The following acronyms and terms are used in Pass Through and Medicaid policy.

BIC – Beneficiary Identification Code – A code used by the SSA to identify each type of beneficiary. These codes are letters which are at the end of SSA claim numbers.

COLA – Cost of Living Adjustment -Annual increases in Social Security benefits to offset the effects of inflation on fixed incomes.

COUNTABLE INCOME – Total income minus deductions, allowances and general exclusions.

DAC – Disabled Adult Child – A person, age 18 or older, who receives RSDI benefits based on disability which was determined prior to age 22.

MA – Medical Assistance – Kentucky's Medicaid program, which is a jointly funded, Federal-State health insurance program for low-income and needy people. It covers children, the aged, blind, and/or disabled, those who receive SSI/SSP or Kentucky Transitional Assistance Program (K-TAP) benefits.

PA-1A, Supplement A – Pass Through Computation Sheet – Worker completed form used in conjunction with the PA-9 to determine financial eligibility for Pass Through applicants.

PA-9 – Pass Through Verification Letter, is sent to SSA for completion in order to determine technical eligibility and for RSDI amounts needed to compute the Pass Through amount.

RSDI – Retirement, Survivors, and Disability Insurance – Payments made to workers who are at full retirement age (65-67); survivors of workers (children, widows, widowers); or to workers (and qualified dependents) who are now disabled and have a certain number of Social Security credits which are earned by working.

SSA – Social Security Administration – A Federal agency that administers Social Security programs.

SSD – Social Security Disability – Payments to people who are determined to be disabled and have earned a required number of Social Security credits.

SSI – Supplemental Security Income – Financial assistance for people who are aged 65 or older, or are blind or disabled and have limited income and resources.

SSP – State Supplementation Program-Payments from state funds to aged, blind or disabled individuals who have insufficient income to meet special needs for care in a licensed personal care home (PCH), licensed family care home (FCH) or to purchase caretaker services (CS) to prevent institutionalization.

MS 4160 CONCURRENT SSI/SSP

[Current RSDI recipients who, after April 1977, previously received SSI or SSP and RSDI correctly and concurrently (in the same month) and lost SSI or SSP may be eligible in this category of Pass Through. Concurrent receipt must also be correct receipt. Concurrent receipt is considered correct if any portion of an RSDI lump sum payment is awarded for the month of SSI receipt.

There are three types of individuals who may fall into the Concurrent SSI/SSP grouping:

A. Those individuals who would still be eligible for SSI/SSP benefits if all RSDI cost-of-living adjustments (COLA) since last receiving SSI/SSP were deducted from countable income. It is not necessary to wait for another COLA to pass before applying. For example: An individual loses SSI due to COLA effective December 2007. He will meet the Pass Through requirement without having to wait for another COLA.

   1. If the individual has a spouse and the spouse receives RSDI, deduct the spouse's COLA's from the individual's countable income in determining the individual's Pass Through eligibility.

   2. If the individual is a child, and the child's responsible relative receives RSDI, deduct the responsible relative's COLA's from the child's countable income in determining the child's Pass Through eligibility.

   3. The individual's claim number will end in an A, B, C, D or W.

   4. Eligibility in this category is not affected by receipt of Medicare Part A.

   5. If SSI is discontinued due to a RSDI COLA increase, the old amount of RSDI (smaller amount) is used to calculate the Pass Through amount. This RSDI amount can be found on the PA-9, Part II, A2. This is the RSDI amount to be entered on the Pass Through screen on KAMES.

   6. For those individuals who lost SSI/SSP as a result of a COLA, the Pass Through amount is the sum of all COLA increases received since the termination of the SSI/SSP payment.

B. Those individuals who lost SSI/SSP due to a recomputation of RSDI or to a new RSDI entitlement. At least one COLA must have been received since termination of SSI/SSP for the Pass Through requirement to be met.

   1. The loss of SSI/SSP must be the individual's, not the spouse's.

   2. The individual's claim number will end in an A, B, C, D or W.

   3. If SSI/SSP is discontinued due to a <u>recomputation</u> of RSDI, the amount of RSDI (larger amount) which caused the SSI/SSP to discontinue is used. This RSDI amount can be found on the PA-9, Part

II, A4. This is the RSDI amount to be entered on the Pass Through screen on KAMES.

4. Eligibility in this category is not affected by receipt of Medicare Part A.

5. These individuals may be technically eligible in this category, but not financially eligible.

C. Those individuals who lost SSI/SSP due to an increase in income other than RSDI. This refers to only the Pass Through applicant's income, not any other household member's income. At least one COLA must have been received since termination of SSI/SSP for the Pass Through requirement to be met. In many instances, these individuals may not be financially eligible even though technical eligibility is met.

1. Eligibility in this category is not affected by receipt of Medicare Part A.

2. The individual's claim number will end in an A, B, C, D or W.

3. If SSI/SSP is discontinued due to an increase in income other than RSDI, the RSDI amount to be used on the Pass Through screen can be found on the PA-9, Part II, A4. This is the RSDI amount to be entered on the Pass Through screen on KAMES. This RSDI amount should match the amount found on the PA-9, Part II, A2. This is the RSDI amount to be entered on the Pass Through screen on KAMES. You will find the amount of the other income that caused the loss of the SSI on Part I B, sixth line of the PA-9 in this category.

4. In this group only, when completing the PA-1A Supp A, Part II, A or B, you will need to add the other income that caused the loss of the SSI/SSP to the RSDI to get the total income. Therefore, workers will need to request verification of the other income from the individual.

5. These individuals may be technically, but not financially eligible in this category.]

MS 4180 DISABLED ADULT CHILD

[Continued MA coverage is provided to certain blind or disabled individuals, age 18 and older, who lose SSI as a result of an entitlement to or increase in RSDI Disabled Adult Child (DAC) benefits. Neither concurrent receipt of RSDI and SSI or receipt of an RSDI COLA is a technical eligibility requirement for this group of Pass Through applicants/recipients. Once an individual is technically qualified as a DAC, he/she is always a DAC. However, the individual could become financially ineligible for Pass Through.

A. To be classified as a DAC, an individual would have to be determined to be disabled by the Social Security Administration (SSA) before age 22.

B. These individuals previously received SSI and lost SSI on or after July 1, 1987 due to:

   1. An entitlement to RSDI DAC benefits; or
   2. Previously received RSDI DAC benefits concurrently with SSI and lost SSI due to an increase in RSDI DAC benefits.

C. These individuals would still be eligible for SSI if all COLAs and the amount of the RSDI DAC entitlement or increase were deducted from countable income.

D. The RSDI claim number for a DAC is the social security number of the parent the individual is receiving on followed by the letter “C”.

E. Eligibility in this category is not affected by receipt of Medicare Part A.

F. A listing of potential applicants is on RDS report HRSDXRDA, Disabled Children Report. This report is released on a quarterly basis.

G. For individuals who received SSI and RSDI and lost SSI due to a new entitlement or increase in RSDI DAC benefits, the Pass Through amount is the amount of the RSDI DAC benefits which resulted in the SSI discontinuance plus all subsequent COLA’s received since SSI was lost. Calculate the Pass Through amount using the RSDI amount found on the PA-9, Part II, B2. This is the RSDI amount to be entered on the Pass Through screens.

H. For individuals who received SSI only and who lost SSI due to a new entitlement to RSDI DAC benefits, the RSDI amount to be used on the Pass Through screen is zero and may be found on the PA-9, Part II, B2. This is the RSDI amount to be entered on the Pass Through screens.

I. To receive benefits in the Pass Through category as a DAC, an individual must be at least 18 years of age. For applications and program transfers, the age will be determined by the age of the individual on the first day of the application/program transfer month.

Example: An application is taken on 2/6/06. The birthday of the applicant is 3/6/88. The individual is 17 years of age. An "N" will be uploaded for the question, "Did he/she lose SSI/SSP due to entitlement/increase in Disabled Adult child Benefits (DAC)?". This field will be protected to prevent the worker from answering "Y" to the question.

KAMES has an edit in place which prevents an applicant under 18 years of age from receiving benefits in the "G" or "H" category as a DAC.]

MS 4190 DISABLED EARLY WIDOWS AND WIDOWERS OR DISABLED SURVIVING DIVORCED SPOUSES WITH NO MEDICARE PART A

The following individuals are to be considered for Pass Through eligibility:

[A. Individuals, ages 60 through 64, who lost SSI or SSP as a result of entitlement to RSDI early widow's or widower's benefits, and who are not yet entitled to Medicare Part A.] The RSDI claim number will end with a “D” or “W”.

[B. Individuals, ages 50 through 59, who received SSI or SSP and who lost SSI or SSP as a result of entitlement to RSDI disabled widow's or widower's or disabled surviving divorced spouse's benefits, and are not yet entitled to Medicare Part A.] The RSDI claim number will end with a “D” or “W”.

The following criteria apply to both A and B individuals listed above:

[1. Concurrent receipt of SSI/SSP and RSDI is not a requirement.
2. Once an individual’s entitlement to Medicare Part A is established, Pass Through eligibility terminates in this category. Explore eligibility in the concurrent receipt category.] When Pass Through terminates, explore eligibility for QMB, SLMB, QDWI, or QI1.
3. Set up a spot check for those individuals who will reach age 65 or become entitled to Medicare Part A prior to the next case recertification.
4. Terminate Pass Through when entitlement to Medicare Part A is established, even if the individual fails to enroll.
5. This category of Pass Through does not require that a COLA occur prior to determining eligibility.
6. [For individuals who received SSI/SSP and RSDI and lose SSI/SSP due to a new entitlement or increase in RSDI, the Pass Through amount is calculated using the amount of the RSDI benefit which resulted in the SSI/SSP discontinuance plus all COLA increases received since SSI/SSP was lost. The RSDI amount is found on the PA-9, Part II, C2. This is the RSDI amount to be entered on the Pass Through screen on KAMES.
7. For an individual who received SSI/SSP only and who lost SSI/SSP due to a new entitlement to RSDI, the Pass Through amount is calculated using the RSDI benefit amount of 0. This is the RSDI amount to be entered on the Pass Through screen on KAMES.
8. If the individual reaches age 65 or becomes entitled to Medicare Part A and receipt was correct and concurrent, the RSDI amount to be used to calculate the Pass Through amount can be found on the PA-9, Part II, C4. This is the RSDI amount to be entered on the Pass Through screen on KAMES.]

MS 4220 RESOURCES

A. [LIMITS - The total countable resources allowed individuals or couples for Pass Through are as follows:

1. Individual $2000
2. Couple $3000]

B. VERIFICATION - Verify countable resources according to procedures in MS 1810 and 1820.

C. [CONSIDERATION - Consider resources according to policies in MS 1810 and 1820.]

1. If resources exceed limits, the case is ineligible.

2. If the individual is married and living with spouse, and resources exceed the $3000 couple standard, explore eligibility in LTC Aged, Blind, or Disabled MA category which has a higher couple resource standard.

MS 4230 INCOME CALCULATION

A. [Determine countable income according to policies stated for Aged, Blind, or Disabled MA Program. These policies can be found in MS 2180 – MS 2480 of this volume.]

B. [Workers are required to manually compute income eligibility of the Pass Through individual on form PA-1A, Sup. A, Pass Through Computation Sheet and file in case record. KAMES makes these calculations internally.]

C. [Income eligibility is determined by comparing the individual's countable income minus the Pass Through amount to the current SSI or SSP standard for one as appropriate. If the remainder is equal to or less than the standard, income eligibility exists.]

D. [To obtain the amount of RSDI the individual received at the time of SSI discontinuance, send form PA-9, Pass Through Verification Letter, to SSA according to procedural instructions for the form. Do not send a PA-9 for an SSP discontinuance.

1. Send the current form to the Frankfort SSA office immediately upon receipt of a Pass Through application to ensure timely processing.]
2. [As the amount of RSDI benefits verified by SSA on form PA-9 will not change, it is not necessary to obtain a new form PA-9 for a recertification or subsequent reapplication. Pull the original form PA-9 forward with each recertification or reapplication packet. The case record must contain a PA-9 with a revision date no earlier than 6/06.
3. If the information on the PA-9 is questionable, the worker is to review with supervisor and/or program specialist. If the issue cannot be resolved, forward through the program specialist to MSBB for contact with Frankfort SSA office.]

MS 4235* APPLICANT WITH ELIGIBLE SPOUSE

A. For an individual or couple who received SSI, and who lost SSI, compare countable income to the current SSI standard for an individual or couple, as appropriate.

   1. If a couple received SSI and lost SSI and both are applying, a PA-9 is required for the individual and spouse to determine Pass Through for each.
   2. For a couple where only one wants to apply for Pass Through, use the information on the individual's PA-9, Part III, for spouse's information.

B. For a couple, who both received SSP caretaker services and lost SSP, compare the couple's countable income to the current SSP caretaker services standard for a couple, both eligible.

MS 4240 APPLICANT WITH INELIGIBLE SPOUSE

For a couple, when one loses SSI or SSP and the other spouse is technically or financially ineligible for SSI or SSP:

A. [If a technically or financially ineligible spouse's income EXCEEDS the difference between the SSI or SSP standard for an individual and the SSI or SSP standard for a couple, only one requiring care, add the ineligible spouse's income to the applicant's income.

Subtract one $20 general exclusion, earned income deductions, if applicable, and the total Pass Through amount. Compare the remaining income to the SSI standard for an individual or the SSP standard for an eligible individual with an ineligible spouse.

If the remaining income is LESS THAN OR EQUAL TO the SSI or SSP standard, the applicant is income eligible for Pass Through. If the remaining income is OVER the standard, the applicant is not eligible. On PA-1A Sup A this calculation would be completed on Part III, B1.

B. If a technically or financially ineligible spouse's income is EQUAL TO OR LESS THAN the difference between the SSI or SSP standard for an individual and the SSI or SSP standard for a couple, only one requiring care, DO NOT consider that spouse's income in the calculation.

After subtracting one $20 general exclusion, earned income deductions, if applicable, and total Pass Through amount. Compare the applicant's remaining income to the current SSI or SSP standard for an individual.

If the applicant’s remaining income is LESS THAN OR EQUAL TO the SSI or SSP standard, the applicant is income eligible for Pass Through.

If the applicant’s remaining income is OVER the standard, the applicant is not eligible. On the PA-1A, Sup. A, this calculation would be completed on Part III, B2.]

MS 4245* PASS THROUGH FOR INDIVIDUAL LOSING SSP

For those individuals who received SSP and lost SSP, compare the individual's countable income to the appropriate current SSP standard. Refer to MS 4910.

An individual with a spouse who is approved for Long Term Care (LTC) vendor payment is considered an individual the month following the month of separation. This individual's countable income is also compared to the appropriate current SSP standard.

MS 4250 [APPLICATION PROCESS

A. The application is signed by:

1. The applicant.

2. The applicant's statutory benefit payee, committee or guardian.

3. An interested party with a signed form MAP-14.

4. The statutory benefit payee for persons receiving SSI or statutory benefits, if different from the applicant. If the payee does not live in Kentucky:

a. A phone interview may be permitted if it will be a hardship for the payee to come to the local office.
b. Register the application on the date assistance is requested.
c. Carry the case in the county where the applicant is living.]

5. One other person as witness, either related or unrelated, if the application is signed by mark (X).

B. PROGRAM CODE. Use appropriate program code for aged (F), blind (G), or disabled (H) individuals.

C. CASE NUMBER. Use the SSN of the applicant as the case number.

[D. CASE NAME. Use applicant's name for case name even if the application is filed by someone other than the applicant. Use client's full legal name.]

E. APPROVAL. [If countable income, minus Pass Through amount, is equal to or less than the current SSI standard or current SSP standard for one, income eligibility is established. If all other eligibility criteria are met, approve the case.

Establish the effective date as the first day of the month, up to 3 months prior to the month of application in non-managed care counties.]

F. CONTINUING ELIGIBILITY. Complete a recertification every 12 months.

G. CASE RECORD. The case record must contain:

[1. Form PA-9, Pass Through Verification Letter with a revision date no earlier than 6/06 (except in cases where SSP had been received);
2. Form PA-1A, Sup. A, Pass Through Computation Sheet. A new PA-1A Sup A must be completed at each recertification.]

H. Refer to Volume I, MS 0095 for further information on the application process.

MS 4260 DISCONTINUANCES

Discontinue a Pass Through case when:

[A. RSDI less Pass Through amount(s) plus other income exceeds the current appropriate SSI/SSP standard for one;]

B. Resources exceed limits;

C. Recipient dies;

D. Recipient leaves the state; or

E. Recipient address is unknown and mail directed to the individual has been returned. Such cases are reinstated if the recipient is located and no other reason for discontinuance is valid. Restore the original recertification month if the reinstatement is within the certification period.

[F. A Disabled or Early Widow/Widower or Disabled Surviving Divorced Spouse becomes entitled to Medicare Part A and no other Pass Through category applies. Explore eligibility in other MA categories of assistance.]

MS 4270 [PASS THROUGH INDIVIDUAL MOVING TO A NURSING FACILITY OR INSTITUTIONAL HOSPICE]

[When a PRO Certification, MAP-24, or MAP-374 is received, for a Pass Through recipient, do not complete a new application unless a recertification is due. If a recertification is not due, do an interim change.]

A. Answer "Y" to "HAS HE/SHE ENTERED A NURSING FACILTY?" on the Pass Through screen on KAMES. Enter the appropriate information on the "LL", LTC/Waiver screen. Allow the case to alternate program to J, K, or M. Income will be calculated per MS 3530-3570. Do not change the recertification date.

B. Complete necessary forms, including form PA-16, Real Property Verification Request, and form PAFS-18, Liquid Asset Verification and Invoice for Payment. These forms may be accessed online at http://chfsnet.ky.gov/cfs/dcbs/dfs/forms.

[C. If the recipient is discharged from Long Term Care, complete a new Pass Through application. A face-to-face interview is required. Use the previously received PA-9, with a revision date no earlier than 6/06, to calculate the Pass Through amount that was used in the prior Pass Through case.]

MS 4280 [PASS THROUGH INDIVIDUALS IN RECEIPT OF WAIVER OR HOSPICE SERVICES]

[When a PRO Certification, MAP-24C, or form MAP-374 is received for a Pass Through recipient who is in receipt of Waiver on Non-Institutional Hospice, do not complete a new application unless a recertification is due. If a recertification is not due, do an interim change.

A. Enter the appropriate information on the "LL" LTC/Waiver screen on KAMES. Income and patient liability will be calculated according to MS 2800-3260, depending on the type of waiver.

B. If ineligible, notify the recipient of vendor payment ineligibility, and continue Pass Through eligibility.

C. If the recipient is discharged from Waiver or Hospice, notify the recipient of vendor payment ineligibility. Do not change the program code. Continue Pass Through eligibility.

A Pro Certification is used to verify the individual has met level of care Home and Community Based Services (HCBS) Model II Waiver and Consumer Directed Options (CDO).

The MAP-24C verifies admission, changes, and discharges for supports for Community Living (SCL) and Acquired Brain Injury Waiver (ABI).

The MAP-374 verifies admission to Non-Institutional Hospice.]

MS 4300* INTRODUCTION

Qualified Disabled Working Individuals (QDWI) are individuals who lose RSDI benefits due to earnings, but who continue to be eligible for or eligible to enroll in Medicare. QDWI recipients are eligible ONLY for Buy-In of Medicare Part A. Medicare deductibles and co-insurance are not paid. As Buy-In is the only benefit of the QDWI program, Medicaid Identification Cards are not issued to QDWI recipients. Additionally, QDWI individuals may not receive QDWI and regular MA as a dual eligibility case, nor may QDWI eligibility exceed 48 months from the date of eligibility notification by the SSA.

MS 4310 GENERAL INFORMATION

[Take applications for Qualified Disabled Working Individuals (QDWI) individuals and process in the same manner as QMB applications using program code "Z".]

Since the QDWI recipients are working individuals, they do not meet the disabled criteria for MA eligibility. However, discontinue if a QDWI recipient chooses to be included in a case with a dependent child. Since these individuals are not entitled to dual benefits, do not include the QDWI individual in the case for any month in which they received QDWI benefits.

[QDWI recipients are not dually eligible for any other category of Medicaid. QDWI recipients approved for Spend Down lose their buy-in for the months of Spend Down coverage. Workers are to allow a medical deduction for the SMI premium for each Spend Down month, and are to advise recipients that the SMI premium for those months may be recouped by the Centers for Medicare and Medicaid Services (CMS).]

MS 4320 TECHNICAL ELIGIBILITY

A. To be eligible for QDWI, the individual must meet the following criteria:

1. Has not attained age 65;
2. Has been entitled to RSDI based on disability;
3. Has lost RSDI due to earnings exceeding the Substantial Gainful Activity (SGA) level; [See MS 3912.]
4. Continues to have a disabling physical or mental condition;
5. Has or is entitled to enroll in Medicare Part A;
6. Is not eligible for MA; and
7. Has not received QDWI benefits for more than 48 months.

B. The SSA sends notice to the individual at the time RSDI entitlement ends advising them of QDWI.

1. The individual has seven months in which to enroll in Medicare Part A if Medicare has been terminated.
2. After that period of time, the individual may enroll for Medicare Part A only during the general enrollment period, January, February and March of each year.
3. The SSA notification letter may be used to verify that the individual meets QDWI requirements. Otherwise, verification must be obtained from SSA.

C. All other technical eligibility requirements for Aged, Blind, or Disabled MA, except Third Party Liability, must be met.

MS 4330 FINANCIAL ELIGIBILITY

Total resource limit and consideration of resources for a QDWI individual is the same as for a QMB individual with the exception that the prior 3 months resources must be verified to receive retroactive coverage.

Consideration of income for a QDWI individual is the same as consideration for a QMB individual with the exception that the QDWI Scale is used.

Compare total countable income to the following QDWI Income Scale

[200% of Poverty Level MA Scale

Family Size	Income Limit
1	[$1,805
2	$2,429

(Effective 4/1/09)]

If countable income is equal to or less than the appropriate QDWI Scale, income eligibility is met.

MS 4340*

QDWI EFFECTIVE DATES

Effective date of eligibility can be retroactive to 3 months prior to month of application, if all eligibility criteria were met during the 3 month period. QDWI eligibility cannot exceed 48 months.

MS 4350 INTERIMS/RECERTIFICATIONS

[Complete interims/recertifications for QDWI individuals in the same manner as interims/recertification for QMB individuals per MS 4530.]

Benefits for QDWI individuals end when:

A. A disabling condition no longer exist;
B. Recipient requests voluntary termination of coverage;
C. Recipient becomes eligible for Medicare under some other provision, i.e., premium-free Medicare; or
D. 48 months of eligibility have expired. Spot check the case for the expiration of the 48 month period of eligibility.

MS 4400 QMB OVERVIEW

Qualified Medicare Beneficiaries (QMB) recipients are eligible for limited MA and for Buy-In. Individuals may receive benefits in this category in addition to regular MA benefits in another category. This is called dual eligibility.

A. [The QMB individual must meet all technical eligibility requirements for Aged, Blind or Disabled MA.]

[B.] Coverage for QMB individuals provides for payment of Medicare Part A and Medicare Part B premiums, Medicare deductibles, and Medicare coinsurance amounts.

1. QMB does not cover Medicare deductibles and coinsurance for individuals age 21, or age 22 if uninterrupted treatment began prior to age 21, through 64 in a psychiatric hospital.
2. Due to payment of coinsurance amounts, QMB coverage is extended to all Medicare services or items outside the scope of MA coverage.

[C.] Limit coverage for individuals eligible only for QMB to the above. Other MA covered services such as prescription drugs and medical transportation are not covered.

[D.] Individuals with dual eligibility as QMB and MA in another category receive the above benefits in addition to regular MA coverage.

[E.] For individuals whose countable income is in excess of the QMB Standard, determine eligibility for SLMB. See MS 4550.

[F.] For services requiring co-payments refer to MS 1060.

MS 4410 QMB APPLICATIONS

A. [Make application for QMB benefits on KAMES or on form PA-1A for ex-parte individuals.]

1. For QMB only applications, complete items 1 through 12, if form PA-1A is required.
2. Indicate on the form in red ink in the upper right corner "QMB Only" or "Dual Eligibility" as appropriate.
3. Use form PA-1Q to compute QMB eligibility and staple to the back of form PA-1A.
4. [For individuals applying for QMB and K-TAP, Family Related MA or AFDC Related MA, application is made on KAMES.]

B. Maintain a single case record for a case with dual eligibility.

C. [For applications taken on form PA-1A, a separate form PAFS-43, Multi-Program Application Register, is maintained for the QMB program.] Applications for dual eligibility are entered on both the QMB register and the appropriate MA category register. The disposition date entered on the forms PAFS-43 for dual applications may be different depending on whether eligibility for both programs is determined on the same or different dates.

D. All SSI only recipients with Medicare Part A are automatically converted to dual eligibility by SDX. QMB eligibility is designated by a "QMB on/off date" on the SDX file.

MS 4430 MEDICARE PART A

The QMB individual must receive Medicare Part A. Verify receipt by making a copy of the Medicare card, written verification from SSA or a printout of the IMS Bendex file, Program 39.

A. Open enrollment for Medicare Part A is January, February, and March of each year. Individuals who enroll in Medicare Part A during the annual open enrollment period do not become eligible for receipt of Part A until July.

1. [If these individuals request QMB benefits prior to becoming eligible for Medicare Part A, complete an Inquiry/Update PAFS-97, on KAMES. Specify on the KAMES PAFS-97 that the applicant has been advised to return to the local office in May or June to make application to determine QMB eligibility.]

2. Process the QMB application no later than the end of June to coincide with the first month of Medicare Part A receipt in July.

B. Individuals who miss the open enrollment period in the current year cannot enroll in Medicare Part A until the open enrollment period in the following year.

MS 4440* CONDITIONAL ENROLLMENT

Some individuals enroll in Medicare Part A with the condition that they are eligible for QMB benefits so that the incurred premium will be paid under the QMB program.

A. SSA provides the names of conditional enrollees to the Agency and verifies eligibility for and the effective date of Medicare Part A.

1. Send appointment letters to each individual to schedule a QMB application appointment.

2. Schedule the appointment in a timely manner to allow the QMB application to be processed with a QMB effective date to coincide with the Medicare Part A effective date.

3. Appointment letters for individuals who fail to keep a scheduled appointment are to be kept in a designated local office file for a period of 1 year.

B. These individuals must meet all technical and financial eligibility requirements for the QMB program. As these individuals do not have Medicare cards, document the case record regarding conditional enrollment and verification of Medicare Part A eligibility by SSA.

MS 4450 RESOURCES

Use regular Aged, Blind, or Disabled MA policy for relative responsibility, resource verification and consideration to determine resource eligibility with the following exceptions.

A. Resources of a child are not considered in determining QMB eligibility of a parent.
B. [For individuals dually eligible for QMB, HCBS, SCL, or non-institutionalized Hospice, continue to consider spousal resources following the first month after election to HCBS, SCL, or non-institutionalized Hospice for the QMB eligibility determination.]
C. Verification of resources for 3 months prior to the application month is not required.
D. Consider the ineligible spouse's resources even if their income is not being counted.

MS 4455

QMB RESOURCE LIMITS

Total countable resources are compared to the following limits:

Family Size	Limit
1	$4000
2 or more	$6000

MS 4460 INCOME

For an individual or a couple living together or apart, use regular Aged, Blind or Disabled MA policy for relative responsibility, income verification and consideration to determine financial eligibility with the following exceptions.

A. If there is an ineligible spouse and no dependent children, compare the ineligible spouse's gross income to the difference between the QMB Scale for an individual and the QMB Scale for a couple.

1. If the result is equal to or less than the difference between the QMB Scale for an individual and the QMB Scale for a couple, DO NOT consider any of the ineligible spouse's gross income to the QMB individual.
2. If greater than the difference between the QMB Scale for an individual and the QMB Scale for a couple, consider the gross income as being available to the QMB individual.
3. Compare the countable income of the individual to the QMB Scale for one, regardless of whether there is deemed spousal income.

B. If there is an ineligible spouse and dependent children, determine the amount of income to be allocated from the ineligible spouse to bring each child's gross income to 1/2 the QMB Scale for one.

1. Do not allocate income from the ineligible spouse to any child whose countable income exceeds 1/2 the QMB Scale for one.
2. Use the remaining income to calculate QMB eligibility as described in item A of this section.
3. Compare countable income of the QMB individual to the QMB Scale for one, regardless of whether there is deemed spousal income.

C. For individuals dually eligible for QMB and HCBS, SCL or noninstitutional Hospice, continue to consider, if living in the home, the eligible spouse's income or the ineligible spouse's income, if greater than the difference between the QMB Scale for an individual and the QMB Scale for a couple. Consider this income during the month of election and for the months after election to HCBS, SCL or noninstitutional Hospice for the QMB eligibility determination. If there is an ineligible spouse living in the home, compare the countable income of the QMB Scale for an individual. If there is an eligible spouse living in the home, compare the countable income to the QMB Scale for a couple.

D. If QMB eligibility is determined for the institutionalized spouse, compute the countable income, including the community spouse income allowance, minus appropriate deductions. See MS 4480. Compare to the QMB Scale for one.

E. In determining QMB eligibility for the community spouse, consider the community spouse's countable income after appropriate deductions,

including the verified amount of the community spouse income allowance the institutionalized spouse actually contributes to the community spouse, and compare to the QMB Scale for one. [If an SCL, HCBS or noninstitutional Hospice individual lives with an eligible spouse, the couple's income is compared to the QMB Scale for a couple.

When both members of the couple live in the home and one member is receiving HCBS, SCL or noninstitutional Hospice, the couple's income is used to determine QMB eligibility.

F. [The SSI technically eligible spouse is considered in the family size but the SSI income is excluded.]

MS 4470 QMB INCOME SCALE

Total countable income is compared to the following QMB Income Scale.

[100% of Poverty Level MA Scale

Family Size	Limit
1	$ 903
2	$1,215

(Effective 04/1/09)]

If countable income is equal to or less than the appropriate QMB Scale, income eligibility is met. QMB eligibility cannot be met through spend down.

MS 4480 DEDUCTIONS

A. Deduct the $20 general exclusion first from the unearned income. Deduct the balance, if any, from the earned income. If spousal income is considered, apply the exclusion to the combined unearned and earned income of the QMB individual and spouse.

B. Deduct $65 and 1/2 the remainder from the QMB individual's earned income. If spousal income is considered, combine the earned income of the QMB individual and spouse and allow only one $65 and 1/2 the remainder deduction. Allow other work related deductions, if appropriate.

MS 4490 QMB EFFECTIVE DATE

Do not establish QMB eligibility retroactively.

A. [For individuals determined QMB eligible, the QMB effective date is the first day of the month after the month of approval.]

B. For SSI individuals automatically eligible for QMB benefits, the QMB effective date is the month after the system takes action.

[C. Buy-In Accretes, Deletes and Restorations

Buy-In is the purchase of Medicare coverage by the Department for Medicaid Services (DMS) for all eligible individuals. There is a standard 120-day processing time period for cases that have been approved for Buy-In. The transmittal of information for a Buy-In approval passes from the KAMES and PA-62 systems, to DMS, to the Centers for Medicare and Medicaid Services (CMS), and then back from CMS, to DMS, and finally to the recipient. CMS passes the information on to the Social Security Administration (SSA).

The lack or delay of any changes occurring in a recipient's case after 120 days indicates the possible absence or break in the transmittal of information. When this occurs, the local offices respond to recipient inquiries concerning the status of their Buy-In benefits. These Buy-In inquiry requests are forwarded to the Medical Support and Benefits Branch (MSBB) by form PA-1Q, Sup. A, Accretes/Deletes/Restorations, as per the form instructions.

1. Accretion is when buy-in eligibility is added to Medicaid's system (MMIS). A request for an accrete indicates that the SMI premium continues to be deducted from the Beneficiary's entitlement.

   a. The 1st accrete request should be submitted <u>only</u> once 120 days have elapsed from date of approval.
   b. Once Medicaid has added eligibility for Buy-In based on the first request, a period of at least another 120 days must pass before another accrete request is submitted.

2. A delete is a request to terminate buy-in eligibility. This request indicates that the purchase of SMI coverage by Medicaid continues to exist when the recipient is no longer eligible for Buy-In benefits. This may occur when:

   a. An individual no longer meets income eligibility; or
   b. An individual requests that their case be discontinued.

3. Restorations are requests for months of eligibility that were not issued and are the result of administrative errors. Examples include:

a. If an application approval is completed untimely causing eligibility to be effective in a proceeding month; or
b. If retroactive coverage for prior months is not completed for SLMB, QI-1, or QDWI cases.

4. Before sending a Buy-In request for an Accrete, Delete or Restoration, check case for accuracy. Review the case record and KAMES checking for the following discrepancies:

   a. Has it been 120 days since the case was approved or since the last request was sent?
      1. If it has not been 120 days, do not forward the request.
      2. If it has been 120 days, review and check the material for discrepancies before forwarding the request.

   b. If dually eligible, is the case status correct?
      1. If correct, annotate effective date of eligibility on request.
      2. If incorrect, make the necessary corrections.

   c. Is the Medicare claim number correct? The Medicare card can be used if recently received but if not, the number needs to be verified through Social Security. There are many circumstances that can change an individual's Medicare account, especially for women.
      1. If correct, include a copy of the Medicare card with the request.
      2. If incorrect, make the necessary corrections.

   d. Are the Medicare questions answered correctly in the case record and on the system?
      1. If the questions are found to be answered correctly, forward the appropriate request to the Medical Support and Benefits Branch.
      2. If the questions are incorrectly answered, make the necessary changes to correct the information and then forward the appropriate requests to the Medical Support and Benefits Branch.

Once reviewed for discrepancies, if no corrections are required, submit a request by using the form PA-1Q, Supp. A, Buy-in Accrete/Delete/Restoration Request. A copy of the recipient's <u>current</u> Medicare card must be attached to the request form before forwarding to MSBB. All requests are to be submitted and tracked by the Regional MA Program Specialist. If discrepancies are found and corrections are made to the case, staff are to wait 120 days from the date correction is made before forwarding a request.

D. Exparte to Buy-In

SSI cases with dual eligibility carry over their Buy-In coverage during periods when SSI cases are Exparte. Unnecessary interruption of Buy-In eligibility creates difficulties for recipients, possible insurance coverage

delays, and additional work for field staff. Buy-In coverage without interruption conserves a streamlined process for the benefit of the recipient, medical provider and caseworker.

1. Individuals discontinued from receipt of Supplemental Security Income (SSI) receive a notice, form PA-10-SSI.2, that instructs them to contact the local DCBS office to apply for Medicaid benefits.

   a. Exparte cases are individuals discontinued due to excess income payment status, living arrangement, and/or excess resources.
      1. Cases are coded NO1, EO1 or NO4 on SDX.
      2. Cases are uploaded on the PA-62 system as active, for continuation of MA and Buy-In benefits pending the MA redetermination.
      3. Workers are notified monthly by the PA-10-SSI.2 listing.

   b. The form, PA-10-SSI.2, is the notice that advises the individual that due to the discontinuance of SSI, a redetermination of MA eligibility is necessary and additional information is required to complete the redetermination.
      1. The individual/representative has 20 calendar days from the date listed on form PA-10-SSI.2 to contact the local office.
      2. Schedule an appointment interview within 11 calendar days after contact is made with the local office. Complete a telephone interview if the individual/representative contacts the local office and is unable to come into the office, or if a home visit cannot be made.
      3. At the appointment interview, explore all categories of assistance, with special attention addressed to QMB, SLMB, QDWI, and QI-1.
      4. Establish a case record for those individuals who are determined eligible for ongoing benefits.
      5. If it is determined that the individual is ineligible for ongoing assistance in any other category, complete form PAFS-97 and attach to a copy of the MA-105.

E. For Exparte cases that are determined ongoing MA eligible with Buy-In, or QMB, SLMB, and QI-1, after the discontinuance of the Exparte case, reapprove the application onto the PA-62 system to avoid a break or lapse in Buy-In coverage. These cases are to be converted onto KAMES within 30 days of approval onto the PA-62 system.]

MS 4500 APPROVALS

QMB coverage cannot be issued retroactively or met through spend down. Therefore, give QMB eligibility determinations priority. For dual applications, QMB eligibility may be approved prior to the ongoing or spend down MA eligibility.

A. For QMB recipients who subsequently apply for MA in J, K, or M category and who are eligible only as a spend down;

1. Use a special circumstance transaction to approve the spend down. [Use recipient status code “HH” to prevent interruption or discontinuance of the QMB benefit. For detailed procedures, see MS 2740.]

2. Do not consider Medicare premiums for Part A or Part B, Medicare hospital or physician deductibles or any Medicare coinsurance amounts paid by QMB benefits to obligate the quarterly excess.

B. For active QMB individuals who are MA vendor payment eligible, complete a new application and program transfer to J, K, or M.

C. For a QMB recipient whose case is discontinued and who subsequently becomes eligible for MA in another category, submit a reinstatement with a dual eligibility code within 10 days of the QMB discontinuance. This is the only instance in which a case is approved into dual eligibility status.

D. Individuals who elect to receive Medicare Part A benefits and who have not worked enough quarters to be eligible for free benefits are required to pay a premium each month for their Medicare Part A coverage. Use an insurance code of "R" or "S" to identify these individuals for state Buy-In of the Medicare Part A premium.

MS 4510* PA-62 PROCESSING

A. Do not approve dual eligibility applications determined eligible for ongoing MA and QMB benefits on the same date. Submit an approval PA-62 document with the appropriate case status code and allow the SMI premium deduction, if appropriate. When the document clears, submit a second PA-62 changing the case status code to reflect dual eligibility, and remove the deduction for SMI, if appropriate. For situations in which QMB eligibility would be delayed by this process, approve the QMB case, then discontinue and approve as MA with the SMI premium deduction allowed for non-QMB months. When the PA-62 clears, change the case status code to reflect dual eligibility, and remove the SMI premium deduction, if appropriate.

B. New approvals for cases dually eligible as a J, K, or M spend down and as a QMB, require two separate determinations and two forms PA-62. Determine spend down eligibility and complete form PA-62 using the appropriate program code and regular MA case status. Submit another form PA-62 using program code Z with the appropriate QMB only case status code after the first document clears. QMB eligibility may be determined prior to spend down eligibility. In this case, follow procedure in item C.

C. For QMB recipients who subsequently apply for non-vendor payment MA in any category and who are determined ongoing MA eligible, submit form PA-62 to discontinue the QMB case. After the document clears, submit an approval document using the appropriate MA program code, numerical case status code and allow the SMI premium deduction, if appropriate. After the approval document clears, submit form PA-62 changing the case status code to dual eligibility, and remove the SMI premium deduction, if appropriate.

D. For aged, blind or disabled cases that are being discontinued but remain QMB eligible, submit form PA-62 to discontinue the case. After the document clears, complete a program code Z approval transaction.

E. For QMB recipients who are subsequently approved for SSI, the QMB case is discontinued by the system when the SSI case is converted to dual eligibility.

F. For the case situations listed in items C and D, timely notice for discontinuance of the QMB case is not required as QMB case is not required as QMB eligibility will continue. However, annotate the case record thoroughly. Use the following wording.

"The individual is dually eligible for QMB and regular MA benefits effective _____(date)_____. Due to system limitations, a computer transaction document was entered to close the QMB case in order to begin dual eligibility. There is no lapse in QMB coverage."

G. When approving a QMB eligible individual with a companion food stamp case, send form PAFS-628 to the food stamp caseworker to determine if QMB eligibility affects the amount of medical deductions currently allowed in the food stamp case.

MS 4530 INTERIMS/RECERTIFICATIONS

Recertify QMB cases annually.

A. For regular MA cases with dual eligibility only redetermine QMB eligibility once a year.

B. When completing a recertification or interim and the MA case becomes ineligible, determine ongoing QMB eligibility.

C. [Recertifications for QMB only cases are processed using the automated KIP-2Q, Renewal Form for the Medicare Savings Plan, and KIP-2QA, Renewal Form for the Medicare Savings Plan – Final Notice, and do not require a face-to-face interview.

Mail-In Recertification Procedures

A. "Z" cases coming due for recertification are identified on the coming due list with the message "Mail-In Recert Due". No action will be necessary on the part of the worker. Because Federal regulations prohibit the requirement of a face-to-face interview for recertification of Medicare Savings Plan cases, workers do not have the option of scheduling these cases on KAMES.

B. Form KIP-2Q is generated on the 15th of the month prior to the recertification month. If the 15th falls on a weekend or holiday, the form is created on the last workday prior to the 15th.

C. The completed form KIP-2Q is due in the local office on the 3rd workday from the end of the month prior to the renewal month (e.g., the form due date for February renewals is January 28th).

D. The form KIP-2Q due date is used to encourage recipients to return their forms prior to the actual due date of the 1st day of the recertification month.

1. Enter all forms KIP-2Q on KAMES that are received prior to close of business on the 1st workday of the recertification month, regardless of whether verification is provided with the form.

2. If needed verification is not provided with form KIP-2Q, allow the case to pend for request of information and mail form KIP-2.1, Request for Information (RFI), to the client, allowing 10 calendar days for the information to be returned. The system will not mail the RFI to the client as it does with the case change process.

3. If form KIP-2Q is received completed with all needed verification, and the recertification is entered prior to the 1st work day of the recertification month, force pend the case until at least the 1st work day of the recertification month to avoid shortening the original 12-month certification period by one month.

E. If the recipient fails to return form KIP-2Q by close of business on the 1st workday of the month, form KIP-2QA is system-generated and sent to the recipient. Form KIP-2QA provides timely notice of negative action for failure to renew benefits. Form KIP-2QA notifies recipients that they must complete the form and provide all required verification by the 10th of the recertification month or benefits will be discontinued. If the 10th falls on a weekend or holiday, the due date will be the next workday. The specific due date is printed on the form.

F. If form KIP-2QA is received complete and correct after the specified date (10th), but before the close of business on monthly cutoff, the recertification is to be entered on KAMES as long as it is entered by close of business on monthly cutoff and does not pend after cutoff.

G. Forms KIP-2QA which are received complete and correct with all verification by the specified due date can be entered on KAMES up to close of business on the monthly cutoff date. If the worker fails to enter the completed form by cutoff, the case will incorrectly discontinue. An incorrect case discontinuance can create a hardship for the recipient. Even if the case is reinstated, there may be a delay in reinstating the buy-in process.

H. A system discontinuance reason code of 705 is displayed on KAMES case inquiry for cases discontinued for failing to return the mail-in renewal form.

I. Existing recertification procedures that allow the worker to schedule a telephone interview appointment, a face-to-face interview or to schedule a joint Food Stamp and “Z” recertification are changed. Recertification interviews cannot be scheduled for Medicare Savings Plan cases. However, KAMES processing for joint “Z” cases and Food Stamp recertifications is unchanged.

J. Reapplication for cases that discontinue for any reason other than agency error will require a face-to-face interview with either the client or the interested party. Telephone interviews for applications/reapplications are not permitted except in unusual circumstances (i.e., payee lives in another state).]

MS 4550 SCOPE OF PROGRAM

Specified Low-Income Medicare Beneficiaries (SLMB) meet all of the technical requirements for QMB benefits, except for having income in excess of the QMB standard but less than or equal to the SLMB Scale maximum limit.

A. Coverage for SLMB individuals provides for payment of the Medicare Part B premium only and may be effective three months prior to the SLMB application month.
B. KYHealth cards are not issued for SLMB only cases.
C. SLMB eligibility cannot be met through spend down.
D. Individuals may receive SLMB benefits in addition to MA benefits (dual eligibility).

MS 4560 APPLICATIONS

[Take and process applications on KAMES for SLMB individuals in the same manner as QMB applications, using program code "Z".**]**

MS 4565 TECHNICAL ELIGIBILITY

A. The individual must receive both Medicare Part A and B. Verify receipt by making a copy of the Medicare card, written verification from the SSA or a print-out of the IMS Bendex file (Program 39).

B. The individual must meet all technical eligibility requirements for Aged, Blind, or Disabled MA, except Third Party Liability.

MS 4570 SLMB RESOURCES

Total resource limit and consideration of resources for a SLMB individual is the same as the resource limit and consideration of resources for a QMB individual with the exception that the prior 3 months resources must be verified for consideration of retroactive coverage.

Total countable resources are compared to the following limits:

Family Size	Limit
1	$4000
2 or more	$6000

MS 4575 SLMB INCOME

For an individual or couple living together or apart, use regular Aged, Blind or Disabled MA policy for relative responsibility, income verification and consideration to determine financial eligibility with the following exceptions.

A. If there is an ineligible spouse and dependent children:

1. Determine amount of income to be allocated from the ineligible spouse to bring each child's gross income to 1/2 the SLMB Scale maximum limit for one;

2. Do not allocate income from the ineligible spouse to any child whose countable income exceeds 1/2 the SLMB Scale maximum limit for one;

3. Compare the ineligible spouse's remaining income to the difference between the SLMB Scale maximum limit for one and the SLMB Scale maximum limit for two;

4. If the result is equal to or less than the difference between the SLMB Scale maximum limit for one and the SLMB Scale maximum limit for two, DO NOT consider any of the ineligible spouse's income to the SLMB individual; and

5. If the ineligible spouse's remaining income is greater than the difference between the SLMB Scale maximum limit for one and the SLMB Scale maximum limit for two, consider the remaining amount available to the SLMB individual.

6. Countable income of the SLMB individual is compared to the SLMB Scale Maximum limit for one, even if there is deemed spousal income.

B. If there is an ineligible spouse and no dependent children:

1. Compare the ineligible spouse's gross income to the difference between the SLMB Scale maximum limit for one and the SLMB Scale maximum limit for two;

2. If the result is equal to or less than the difference between the SLMB Scale maximum limit for one and the SLMB Scale maximum limit for two, DO NOT consider any of the ineligible spouse's gross income to the SLMB individual; and

3. If the ineligible spouse's income is greater than the difference between the SLMB Scale maximum limit for one and the SLMB Scale maximum limit for two, consider the gross income as being available to the SLMB individual.

4. Countable income of the SLMB individual is compared to the SLMB Scale maximum limit for one, even if there is deemed spousal income.

C. For individuals dually eligible for SLMB and HCBS, SCL, SSP, Pass Through or non-institutional Hospice, continue to consider if living in the home, the eligible spouse's income or the ineligible spouse's income if greater than the difference between the SLMB Scale maximum limit for one and the SLMB Scale maximum limit for two. Consider this income during the month of election and for the months after election to HCBS, SCL, SSP, Pass Through or non-institutional Hospice for the SLMB eligibility determination. If there is an ineligible spouse living in the home, compare the countable income to the SLMB Scale for an individual. If there is an eligible spouse living in the home, compare the countable income to the SLMB Scale for a couple.

D. Compare total countable income to the following SLMB Income Scale.

[120% of Poverty level MA Scale

Family Size	Minimum Limit	Maximum Limit
1	$ 904	$1,083
2	$1,215	$1,457

(Effective 04/1/09)]

If countable income is equal to or greater than the minimum limit, and equal to or less than the maximum limit, income eligibility is met. If countable income is less than the minimum limit, explore potential QMB eligibility.

MS 4580 SLMB DEDUCTIONS

To determine the countable income to be compared to the minimum and maximum limits:

A. Deduct the $20 general exclusion:
   1. From the unearned income;
   2. Deduct the balance, if any, from the earned income; and
   3. If spousal income is considered, apply the exclusion to the combined unearned and earned income of the SLMB individual and spouse.

B. Deduct $65 and 1/2 the remainder from the SLMB individual's earned income:
   1. If spousal income is considered, combine the earned income of the SLMB individual and spouse and allow only one $65 and 1/2 the remainder deduction; and
   2. Allow other work related deductions, if appropriate.

MS 4585 SLMB EFFECTIVE DATES

For a SLMB ONLY case the effective date of eligibility can be retroactive to 3 months prior to month of application, if all eligibility criteria were met.

For active MA cases who become SLMB dual eligible, the SLMB effective date is the month following the action month approving SLMB.

For MA/SLMB dual eligible cases where both MA and SLMB are being approved at the same time, the SLMB effective date can be retroactive to 3 months prior to the month of application.

[For buy-in accretes, deletes and restorations refer to MS 4490.]

MS 4590 INTERIMS/RECERTIFICATIONS

[Complete interims/recertifications for SLMB individuals in the same manner as for QMB individuals per MS 4530.]

MS 4595 CASE PROCESSING

A. All SLMB cases, including dual eligible cases, are processed on KAMES at application, recertification or interim change. [Recertifications are processed using the automated KIP-2Q, Renewal Form for the Medicare Savings Plan, and KIP-2QA, Renewal Form for the Medicare Savings Plan – Final Notice, forms. For detailed procedures, see MS 4530.]

The case will alternate program from any program code to the Z code and is not limited to cases losing eligibility in the J, K or M category. Additionally, a case can be program transferred from a Z case to a J, K or M or to any other allowable program code.

B. For determination of SLMB retroactive eligibility, enter the earliest SMI premium on the medical expense screen. KAMES determines the SLMB eligibility date based on the date the SMI expense is incurred, if all eligibility requirements are met.

C. If a SLMB recipient subsequently applies for spend down in the J, K or M category:

1. Manually calculate the Spend-Down
2. Process through special circumstance on KAMES. [Use recipient status code “S2” to prevent interruption or discontinuance of the SLMB benefits. For detailed procedures, see MS 2740.]

SLMB eligibility can be determined prior to spend down eligibility. Do not consider the Medicare SMI premium for Part B to obligate the quarterly excess.

D. When approving a SLMB eligible individual with a companion food stamp case, a spot check is generated to the food stamp case worker to determine if SLMB eligibility affects the amount of medical deductions currently allowed in the food stamp case.

MS 4600 MEDICARE QUALIFIED INDIVIDUALS GROUP 1 (QI1)

Individuals who receive Medicare Parts A and B can be eligible for payment of the buy-in for their Part B payment (QI1). Individuals ineligible for SLMB must be evaluated to see if eligibility for QI1 exists. Because the QI1 program has limited annual funding, applications can only be approved until funds are exhausted. DMS will advise when funding has been exhausted.

A. Resource Limit:

Family Size	Limit
1	$4,000
2	$6,000

B. [Income Scale: Qualified Individuals Group 1 (QI1)
135% of Poverty Level MA Scale

Family Size	Minimum Limit	Maximum Limit
1	$1,084	$1,219
2	$1,458	$1,640]

C. Retroactive benefits are only available for the federal fiscal year (October 1st through September 30th) of application for QI1 cases. If someone applies in November, retroactive benefits can only go back to October 1st. QI1 recipients are not dually eligible for any other category of Medicaid. QI1 recipients approved for Spend Down lose their buy-in for the months of Spend Down coverage. Workers are to allow a medical deduction for the SMI premium for each Spend Down month, and are to advise recipients that the SMI premium for those months may be recouped by the Centers for Medicare and Medicaid Services (CMS). There is no dual eligibility for these categories.

D. The certification period ends for QI-1 cases on 9/30 of each current year. All QI1 cases must be recertified each September to receive ongoing benefits for the coming year.

E. For buy-in accretes, deletes and restorations refer to MS 4490.

F. See MS 4530 for detailed procedures in using the automated KIP-2Q and KIP-2QA for recertification.

MS 4650 DUPLICATE APPLICATIONS

An application for SSI pending with the SSA is also an application for Aged, Blind, or Disabled MA. Deny any duplicate application for Aged, Blind, or Disabled MA made with DCBS.

MS 4655 ENTITLEMENT

Entitlement to SSI and the amount of payment made are determined by the SSA, following application made at the Social Security Office serving the county in which the applicant lives. Application may also be made by telephone.

MS 4660 POTENTIAL SSI APPLICATIONS

Individuals eligible for but not receiving SSI benefits are not eligible to receive MA in the Aged, Blind, or Disabled category.

A. These individuals must apply for and receive SSI benefits in order to receive MA.
   1. If the individual applies, accept and deny the application.
   2. [If the individual or interested party chooses not to apply for MA, complete form PAFS-97, Assistance Program Inquiry, and form PAFS-5.1, Report of Referral to the District Social Security Office.]
   3. Do not discourage or refuse an MA application.
   4. Process all applications for SSP as emergencies.
B. Obtain a determination of disability through the MRT, for any individual who applies for SSP as a disabled adult and whose income and resources are within the SSI standards.
   1. Prior to approval, verify that application for SSI has been filed.
   2. Process the application once the MRT disability determination has been made.
   3. Do not wait for the SSI determination.
   4. Spot-check for the SSI determination and for possible changes in income.

MS 4662 MA ELIGIBILITY FOR DECEASED APPLICANTS

[The Department for Community Based Services (DCBS) is responsible for determining MA eligibility for an individual who has no spouse or parent in the household and who dies during the application or appeal phase of an SSI request, prior to a determination being made.] Application can be made by any individual on behalf of the deceased individual. The application date is the date the SSI application was filed. Take an application and send a completed PA-601T, Referral for Determination of Incapacity or Disability, and signed/witnessed MRT-15 (with a revision date of 5/01 or after) forms, Authorization for Information/Release of Information, to MRT for determination of disability. File any hearings on these actions through the local office. The MRT-15 may be signed by the next of kin, such as a spouse, child, sibling or parent. [If there is no next of kin, the individual's attorney, executor of the estate or other interested party may sign the form.] See also Volume IVA, MS 1374.

MS 4670 SSI FINANCIAL STANDARDS

[SSI income and resource policies are more restrictive than Medicaid policies which may result in an inappropriate SSI referral.] If an individual, who was denied MA or for whom an inquiry was completed due to potential SSI eligibility, is denied SSI for a financial reason and that individual reapplies for MA within 60 days of the SSI denial date, use the date of the original MA application or form PAFS-97 as the application date.

For individuals who wish to apply for Aged, Blind, or Disabled MA, determine if countable income and resources are within SSI standards as follows:

A. Determine countable income according to MS 1770 through MS 1820.

1. Compare countable income to the SSI income standards.

2. SSI income standards are:

SSI ONLY
[Individual $674
Couple $1,011

(Effective 1/1/2009)]

B. Determine countable resources according to MS 1770 through MS 1820 and MS 1850 through MS 2030.

1. An exception in resource consideration is that SSI resource policy considers some items that are excluded by Medicaid. Examples are personal belongings, jewelry, household items, etc.

2. Compare countable resources to the SSI resource standard.

3. The current SSI resource standards are:

Individual $2,000
Couple $3,000

The SSI resource standard for a couple is less than the MA resource standard of $4,000 for a couple.

4. If resources are equal to or less than the standard, determine income eligibility.

MS 4680 SSI FINANCIAL ELIGIBILITY

A. If income and resources are within SSI standards, potential SSI eligibility exists. [Deny the MA application and complete form PAFS-97, Assistance Program Inquiry, and form PAFS-5.1, Report of Referral to the District Social Security Office.]

B. If the individual exceeds the SSI income standard but meets the SSI resource standard, process an Aged, Blind, or Disabled MA application using the MA Scale for spend down eligibility or eligibility under the special income standard.

C. If income and resources exceed the SSI standards, access the SDX file prior to requesting medical information for an MRT determination.

1. If the SDX file indicates an SSI denial based on nondisability within the prior 12 months, deny the application. Denial date and case processing date are on SDX.
2. If the SDX file does not indicate an SSI denial due to nondisability, request an MRT determination and process the application accordingly.
3. To ensure that SSA disability determinations are utilized, the SDX file is matched on a monthly basis to the PA-62 database.

   a. PA-62 automatically discontinues a disability MA case if the SDX file shows a denial based on nondisability.
   b. An automated form PA-105.7 is system generated for each case being discontinued.
   c. The notice specifies the reason for discontinuance as the SSA disability determination, and that the State Agency is bound by federal regulation to follow the SSA determination.
   d. If a fair hearing is requested, follow usual hearing request procedures.

MS 4690 INSTITUTIONALIZED APPLICANTS

[Institutionalized individuals are not eligible for SSI if other monthly income is $50 or more.] Do not deny these MA applications or refer these individuals to SSA.

MS 4700 SSI ESSENTIAL PERSON

There are two types of SSI Essential Person.

A. A spouse Essential Person (EP) is an individual who was included as the EP of an SSI recipient in December, 1973.

1. The EP spouse receives MA along with the SSI individual by being "grandfathered" into the SSI program on January 1, 1974.
2. If there is no interruption in the EP spouse status, the EP spouse receives MA as long as the SSI individual remains eligible.
3. If the EP spouse is removed as the SSI EP or if the SSI recipient loses eligibility, do not reestablish eligibility for MA as an EP spouse.
4. When notified of the death of an SSI recipient who has an EP spouse, immediately discontinue the medical card of the EP spouse according to form PA-5.2 instructions.

B. A NONSPOUSE ESSENTIAL PERSON whose needs are recognized in the SSI payment DOES NOT receive MA along with the SSI individual.

1. To qualify for MA, the nonspouse EP must be technically eligible for MA in another category.
2. If eligible for MA, these persons retain SSI EP status.

MS 4710* RESIDENCY

The STATE OF RESIDENCE of an SSI recipient moving into Kentucky is determined by the SSA.

A. If the recipient is determined a Kentucky resident, the individual is eligible for MA. The MAID card shows coverage effective the month of transfer. In some situations, SSA issues form PA-527 allowing medical coverage to be provided more quickly.

B. If an SSI recipient moves out-of-state, the new state of residence may require verification of the date of discontinuance of Kentucky MA.

[If such requests are received, forward the inquiry by memorandum to the Department for Medicaid Services, who advises the requesting state of the correct date of MA discontinuance.**]**

C. For LTC cases, see residency policy in MS 3330.

MS 4720 MA ELIGIBILITY FOR SSI RECIPIENTS

Ongoing MA eligibility for SSI recipients is determined by receipt of SSA.

A. SSI Recipients Meeting All Eligibility Requirements.

SSI recipients who meet all eligibility factors are approved by SSA effective the month after their application month. Because SSA no longer issues partial month payments, no SSI payment is received for the month of application; however, the SSI recipient may be MA eligible for that month. [If the SSI recipient is determined MA eligible the Medical Support and Benefits Branch (MSBB) issues the MA coverage.] Retroactive MA eligibility will include the month of application and the two months prior to the application month if made in a non-managed care county. [If in a managed care county and the individual is exempt from managed care coverage, eligibility is determined the same as for individuals in a non-managed care county.]

B. SSI Recipients Not Meeting Eligibility Requirements For One or More Months Prior to SSI Approval.

SSI recipients who have been approved for SSI benefits effective a month or more after their application month must have MA eligibility determined for the period of time between SSI application and approval. Since MA income and resource policy is more liberal than policy used to determine SSI eligibility, these individuals may be eligible for regular MA or spend down benefits if SSI was denied due to excess income or resources.

1. All SSI approvals, other than those identified in Item A of this section, in which the SSI eligible month is later than the application month are identified on a monthly basis through a system match.
   a. These individuals are issued either form PA-SSI-3 or PA-SSI-4, advising them to contact their local office to apply for MA.
   b. A listing of all individuals receiving either form is on RMDS.
2. The notice specifies the exact month for which the SSI recipient may apply.
   a. Determine MA eligibility for each specific month.
   b. The notice also advises the individual that application must be filed within 60 days from the date of the notice and what specific verification is required.
3. These applications ensure an MA eligibility determination for the period of time between SSI application and approval. This is in addition to the procedure for determining eligibility for the application month and the two months prior to the SSI application month. Form PA-11 will continue to be generated for eligibility determination for that time period in non-managed care counties.

4. Recipients approved in a month following the application month but who are not considered disabled prior to the approval month will not receive notices. For example, if an SSI application is made in January but approved in March due to a determination that no disability exists prior to March, forms PA-SSI-3 or PA-SSI-4 will not be issued.

C. SSI Recipients Eligible for Retroactive MA.

[Retroactive MA coverage is available for individuals with medical bills during the application month and two months prior to the SSI application, if approved, provided they live in a non-managed care county, or if living in a managed care county, are exempt from managed care requirements and have filed a claim for SSI on or after January 1, 1998.] Any SSI approvals with an application date prior to January 1, 1998, are potentially eligible for three months of medical coverage prior to the application month.

1. CENTRAL OFFICE sends form PA-11, a computer generated application form and form PA-11 SSI, an insert explaining Hearing Rights, to the SSI individual.
   a. Form PA-11 is completed by the individual and returned to MSBB within the time frames specified on the form for the determination of eligibility for retroactive MA coverage.
   b. If the recipient reports nonreceipt of form PA-11, contact MSBB through your Regional Office to verify if the form has/has not been generated.
   c. Form MA-105 is used to notify individuals of eligibility determinations.
2. If an individual contacts the local office following denial of retroactive coverage due to excess income, the local office determines financial eligibility for spend down status. The MA application date is the date of application for SSI.
3. When the SSI individual contacts the local office to request a hearing on retroactive MA coverage, complete form PAFS-78.
   a. Forward the original and one copy to MSBB.
   b. Case material relative to the hearing issue will be sent to the local office where the hearing will be held.

D. Receipt of UNEARNED FARM INCOME may cause ineligibility of an SSI individual. This will trigger the ex-parte process. The case will automatically discontinue after the two months of ex-parte MA coverage ends. These individuals may apply for MA under codes F, G, H, J, K, M or Z if they remain ineligible for SSI.

E. SSI individuals in LTC whose SSI is terminated because of admission to a nursing facility are approved under the J, K or M program code effective the month of SSI termination. If all eligibility criteria are met, there should be no interruption in eligibility between SSI termination and MA approval. Follow procedures in MS 3350.

Additionally, to ensure QMB eligibility is not lost, follow policy in MS 3390 and 4510.

MS 4750 MEDICAID ELIGIBILITY REDETERMINATION

A redetermination of MA eligibility is required for certain individuals who are discontinued from SSI.

The State buys-in or pays the SMI premium for SSI recipients enrolled in Medicare. [Individuals discontinued from SSI due to excess income or resources are not deleted from buy-in until MA eligibility through the ex-parte program has ended. Timely notice of termination of MA eligibility is system generated to the individual advising the individual to contact the local DCBS office for redetermination.]

Since the SSI standard is greater than the MA Scale, the majority of individuals discontinued from SSI due to excess income are eligible for QMB or SLMB benefits only. However, some individuals may be Pass Through eligible. [Individuals with dependent children may be eligible in the K-TAP or AFDC Related MA categories.]

Individuals discontinued from SSI due to excess resources may be eligible for ongoing MA due to the difference in the resource standard for a couple and the difference in resource considerations between the SSI and MA programs.

MS 4752 GRANDFATHERED DISABLED CHILDREN

The Personal Responsibility and Work Opportunity Act of 1996 (PRWORA) changed the SSI definition of childhood disability, costing many Kentucky children their SSI benefits. The Balanced Budget Act of 1997 responded by requiring States to continue Medicaid (MA) coverage for any child who lost SSI due to PRWORA. [Grandfathered Disabled Children (GDC) are categorically eligible and must be clearly identified as such and will receive MA until their 19th birthday or until a disability redetermination finds them no longer disabled under the pre-PRWORA disability rules or they became financially ineligible.

A. GDC can be divided into four groups, based on their current MA status.] These are:
   1. SSI recipients. These children have already been reapproved for SSI and require no action at this time.
   2. Not receiving SSI, but still getting MA based on an SSI appeal status.
      a. [An SDX indicator of "DC/CMA" will flag them as GDC.
   3. K-TAP/MA recipients.
      a. Removing the child from a K-TAP/MA case would disadvantage the household, so these children will be left on KAMES.
      b. If the K-TAP/MA case is ever discontinued or the child loses K-TAP/MA eligibility, the grandfathered disabled child must be moved to the PA-62 system for continued MA coverage.
      c. "Did he/she lose SSI due to PRWORA change in disability?" and "Lost SSI due to PRWORA?" are added to the KAMES member screens, to identify these children.
         (1) Answer "Y" for any K-TAP/MA child identified as a member of this group. Verification is required and may include listings or other documentation of grandfathered disabled child status.
         (2) When the K-TAP/MA case discontinues or the identified child becomes K-TAP/MA ineligible, a spot check "Does PRWORA child need PA-62 coverage?" appears on the worker's DCSR the following day.
         (3) The child must be approved for continuing MA on PA-62.
      d. K-TAP/MA GDC do not require an MRT redetermination.

B. When B or D cases (case status "07") were automatically created on PA-62 for the children described in items A, 2 and A, 3:**]**
   1. The MA effective date matches the SDX MA end date, so that no MA coverage is lost;
   2. Recertification corresponds with the child's birth month; and

C. **[**The PA-62 system continues to match against SDX. If the SDX record indicates that SSI is approved again, the PA-62 B or D case automatically discontinues with reason code 310.**]**

D. MA financial eligibility for grandfathered, disabled children is based on SSI standards. If a grandfathered, disabled child becomes income ineligible for MA, review the case for potential eligibility in the I category.

MS 4753 [GRANDFATHERED DISABLED CHILD (GDC) RECERTIFICATION]

In order for GDC to continue receiving MA, they must meet SSI income and resource standards and pass a disability redetermination. The disability review will be made by the same staff who decide SSI disability claims and requires some special forms to collect information.

A. Do the following to recertify grandfathered disabled children.

1. Use form PAFS-2, Application Letter/Notice of Expiration, to schedule a recertification interview.
2. Use form PA-1A, Medical Assistance/Supplementation Application/Eligibility Determination, Aged, Blind, and Disabled, to collect the necessary information on the child, parents, and siblings. If the child is 17 1/2 years old or older, disability redetermination is not required. The child will remain disabled until age 18.

3. Collect current disability information by completing:
   a. Form PA-601T, Referral for Determination of Incapacity or Disability. Write "Grandfathered Disabled Child" on the top of the form;
   b. Form SSA-3881-BK, Questionnaire for Children Claiming SSI Benefits;
   c. [Enough forms MRT-15, Authorization for Information/Release of Information, to contact each medical source listed, plus two extra forms; and]
   d. [Enough forms CFS-1A, Informed Consent and Release of Information and Records Supplement, to contact each school listed, plus two extra forms.]

4. Determine financial eligibility, according to MS 1810, and using form PA-1A, Supplement D, Disabled Child Income Computation Worksheet. Use the current SSI scale for one person on line 14 in place of the MA scale.

   a. If the child is income or resource ineligible, discontinue the case. Document thoroughly. File the disability forms in the case record and do NOT send them to MRT.
   b. If the child remains income and resource eligible proceed to item B.

5. If the recipient's representative fails to comply with the recertification process, discontinue the PA-62 case and document thoroughly.

B. Complete a disability determination for each financially eligible GDC:

1. Submit the completed forms listed in item A,3 to the following address:

Medical Review Team
P.O. Box 2190
Frankfort, KY 40602-2190

2. MRT redetermines the child's disability using pre-PRWORA standards and notifies the worker of the results.
   a. If the child is no longer disabled or fails to cooperate with MRT, discontinue the PA-62 case and document thoroughly.
   b. If the child remains disabled, file the notice in the case record. The notice will also indicate if and when the next review is required.

C. Maintain a special file for discontinued GDC case records.

D. Hearings for GDC will be handled by different agencies, based on the hearing issue. If the hearing is related to:

   1. The eligibility determination, DCBS conducts the hearing; or
   2. Medicaid covered services or medical necessity, DMS conducts the hearing.

MS 4755 [SSI DISCONTINUANCE

Individuals whose SSI is discontinued and who request a hearing may continue to receive Medicaid during the hearing process, if they continue to receive the SSI payment.

A. Individuals who contact the local office must be referred to the Social Security Administration (SSA) to appeal the termination of their SSI benefits. Individuals requesting a continuation of Medicaid benefits must make that request with the SSA agency.

B. Individuals approved by SSA for a continuation of benefits while they are in the appeal process will receive MA coverage automatically and they will have a payment status code of C01, M01, or M02.]

MS 4770 SSI DISCONTINUANCE AND SYSTEM ACTIVITY

A. The SDX (SSI file) monthly cutoff date is nine workdays from the end of the month. Individuals discontinued due to excess income payment status code N01 or E01 and/or excess resources, payment status code N04, are uploaded on the PA-62 system as an active case for continuation of MA and buy-in benefits pending the MA redetermination. [These cases have a program code on the PA-62 system of A, B, or D and are referred to as Exparte cases.] These cases will also have an MA on-date of the first day of the following month and a recertification date of the month following the MA on-date, the end of the timely redetermination period. EXAMPLE: An SSI discontinuance identified in March has an MA on-date of April, and recertification date of May. All cases have an unassigned caseworker code of the county number and "099".

B. The A, B and D category cases, with a case status 05 or EE, uploaded to the PA-62 system and identified on the monthly listing, “PA10 SSI.2, Discontinuances for (month and year)”, have an MA end date. The MA end date is the last day of the two-month period of extended Medicaid coverage allowed for the Medicaid eligibility determination. The MA end date will cause the case to automatically discontinue if the individual fails to contact the agency to reapply for Medicaid benefits in another category. [The worker does not need to manually discontinue these cases at the end of the two-month period: A conversion recertification to KAMES may be completed to convert A, B or D Exparte cases on the PA-62 system to J, K, M, F, G, H or Z cases.]

C. Include SSI only, SSI alert cases, and Medical Support Enforcement cases discontinued with a payment status code of N01, N04 or E01 in this process. For SSI only and SSI alert cases, vendor payment eligibility continues through the last day of the two-month period of extended Medicaid or until the determination of eligibility in another category of assistance is completed. Vendor payment information displays with the A, B, or D case information.

[D. In order to avoid loss of Buy-In eligibility, workers are to complete a conversion recertification at application interview to convert A, B or D Exparte cases on the PA-62 system to J, K, M, F, G, H or Z cases on KAMES.

Example: Client has an Exparte case on the PA-62 system and comes into the local office to apply for MA due to receipt of HCBS Waiver Services.

1. From the KAMES menu, select function “A”.
2. Then select option 9, “Conversion recertification”, on the KAMES Application/Recertification Menu.

3. The program code field on the next screen will be unprotected. Enter J, K, M, F, G, H or Z program codes only. KAMES will not allow any other code to be entered.
4. KAMES will determine eligibility for the program code entered.]

MS 4780 SSI DISCONTINUANCE LISTINGS

A, B, or D cases uploaded to the PA-62 system are matched to the system database and a listing is produced each month. This listing is produced nine workdays from the end of the month.

The listing, "SSI Discontinuances For (Month) County (number) Receiving PA-10SSI.2," is sent to the local office. Names identified on this listing, "HR SSI Discontinuances, display on RMDS for informational purposes in the event an individual receives notification and contacts the local office prior to receipt of the hardcopy listing.

A. The listing contains the preprinted name, address, SSN, and the food stamp case name/number, if appropriate.
B. Space is also provided on the listing for tracking by the local office of the following:

1. The date the individual/representative contacted the agency;

2. The appointment date given to the individual/representative;

3. The date form PAFS-2 is provided to the individual/representative if further information is requested;
4. The date form MA-105 is sent to the individual/representative;

5. The date of disposition;

6. Whether the case continues to be eligible or is discontinued; and

7. A section for comments.

C. Retain the annotated listing for one year following receipt.

MS 4790 SSI DISCONTINUANCE NOTICES

Individuals on the local office's listing receive form PA-10SSI.2. This notice advises the individual that due to the discontinuance of SSI, a redetermination of MA eligibility is necessary and additional information required to complete the redetermination. The individual is instructed to contact the local office within 20 calendar days of the date of the notice to schedule an appointment. Form PA-10SSI.2 includes timely notice of negative action for failure to contact the local office to schedule an interview appointment for redetermination of MA eligibility. It is not necessary to issue form MA-105, Notice of Eligibility or Ineligibility, prior to discontinuing the case for failure to contact the Agency. The timely notice on form PA-10SSI.2 applies only to failure to contact the Agency. Form MA-105 is required for timely notice of discontinuance if the recipient contacts the Agency and schedules an appointment, but subsequently fails to keep the appointment.

MS 4800 ASSIGNMENT OF SSI DISCONTINUANCE

Caseworker assignment is determined by each local office.

A. The method used must ensure that each case is assigned to a caseworker for processing and that each case is tracked. The individual must receive an appointment from the caseworker within 11 calendar days of the date of the telephone contact.

B. These cases appear on monthly management reports for caseworker code "099".

MS 4810* PROCESSING TIME FRAMES

A. The individual/representative has 20 calendar days from the date of form PA-10SSI.2 to contact the local office;

B. Schedule an appointment interview within 11 calendar days after contact is made with the local office. It is not necessary to send form PAFS-2 to confirm the scheduled appointment; and

C. Within 20 additional calendar days redetermine eligibility.

MS 4820 CASE DECISION

[Establish a case record for those individuals who are determined eligible for ongoing benefits in the category of assistance. All forms necessary for an application in the category of ongoing assistance are completed during the interview and maintained in the case record.]

A. Caseworkers are notified by a listing "Cases Re-approved for SSI Prior to Completion of Exparte Determination," when an individual is re-approved for SSI benefits during the MA re-determination period.

B. [If it is determined the individual is ineligible for ongoing assistance in another category, complete an “Inquiry/Update PAFS-97” on KAMES. Once form PAFS-97 is completed, it is automatically printed. The worker has the client sign the form, makes a copy for the file and gives the original to the client.]

C. If the individual/representative fails to contact the Agency to schedule an appointment, the case will automatically discontinue. All case transactions on the PA-62 system, other than a discontinuance transaction are prohibited for Exparte A, B or D cases. EXAMPLE: Vendor payment cannot be authorized for an A, B or D case if a Confirmation Notice is received notifying the Agency the individual has been admitted to a nursing facility or waiver program while the case is in Exparte status.

D. Complete a telephone interview if the representative/payee contacts the Agency and is unable to come into the local office due to unusual circumstances (for example: payee lives in another state), there is no representative, and a home visit can not be made.

1. Complete applicable forms and mail to the individual for signature along with the request for needed verification if eligible in another category.

2. [Complete an “Inquiry/Update PAFS-97” on KAMES and indicate "telephone contact" for individual signature if the individual is not eligible. Send a copy of the printed PAFS-97 to the individual.]

E. At the appointment interview, explore with the individual/representative all categories of assistance.

1. It is not necessary to obtain form PA-9 from SSA for Pass Through applications immediately following receipt of a COLA increase. Income verification necessary to compute the pass through amount is obtained from the SDX and BENDEX files.

2. Workers are able to complete a conversion recertification to convert A, B or D Exparte cases on the PA-62 system to J, K, M, F, G, H or Z cases on KAMES.

Example: Client has an Exparte case on the PA-62 system and comes into the local office to apply for MA based upon receipt of HCBS Waiver Services.

1. From the KAMES menu, select function “A”.

2. Then select option “9” on the KAMES Application/Recertification Menu.

3. The program code field on the next screen will be unprotected. Enter J, K, M, F, G, or H program codes only. KAMES will not allow any other code to be entered.

4. KAMES will determine eligibility for the program code entered.

F. Complete and submit form PAFS-78 according to regular policy and procedures if the individual/representative requests a fair hearing. If continuation of benefits is requested and a timely request was made by the individual, the A, B or D case remains active, pending the hearing decision. If the case has already been discontinued when the timely request is received, reinstate benefits.

MS 4900 SSP OVERVIEW

STATE SUPPLEMENTATION PAYMENT (SSP) is permitted by federal regulation. Payments from state funds are available to aged, blind or disabled individuals who have insufficient income to meet special needs for care in a licensed personal care home (PCH), licensed family care home (FCH), or to purchase caretaker services (CS) to prevent institutionalization. Technical requirements of the SSI program for individuals who are aged, blind, or disabled must be met. If potentially eligible, application for SSI must be made and the application verified prior to SSP approval. [Medicaid pays the SMI premium for all SSP recipients with Medicare Part B.]

MS 4910 SSP STANDARDS

A. CLASSIFICATIONS AND STANDARDS FOR STATE SUPPLEMENTATION:

1. Personal Care Home [$1,194]

2. Family Care Home [$ 846]

3. Caretaker Services:

a. Single individual in own home or receiving room, board and care [$ 736]
b. Eligible (aged, blind or disabled)individual with ineligible (neither aged, blind nor disabled) spouse [$ 736]
c. Couple, both eligible (both aged, blind or disabled) but only 1 requiring care [$1,072]
d. Couple, both eligible (both aged, blind or disabled) and both requiring care [$1,126]

B. PERSONAL NEEDS ALLOWANCE included in Personal

Care Home payments .. $ 60

C. PERSONAL NEEDS ALLOWANCE included in Family

Care Home payments .... $ 40

MS 4930 [APPLICATION PROCESS FOR STATE SUPPLEMENTATION

Complete an application for State Supplementation (SSP) according to procedural instructions as outlined below. All applications for SSP must be processed within 30 days of the application date.

A. Complete an application for each member of a couple, when one or both require care, and BOTH are aged, blind, or disabled.

B. The application is signed by either:

1. The applicant;

2. The applicant's statutory benefit payee, committee or guardian;

3. An interested party; or

4. The statutory benefit payee for persons receiving SSI or statutory benefits if different from the applicant. If the statutory benefit payee, committee or guardian does not live in Kentucky:

a. Register the application on the date assistance is requested;
b. Send the application and a cover letter to the statutory benefit payee, committee or guardian for completion and signature; and
c. Carry the case in the county where the applicant is located.

5. One other person as witness, either related or unrelated, if the application is signed by a mark (X).

C. Determine program code for KAMES as follows:

1. SSI recipients:

a. AP - Aged;
b. BP - Blind;
c. DP - Disabled

2. Non-SSI Recipients:

a. FP - Aged;
b. GP - Blind;
c. HP – Disabled]

D. Use the applicant's SSN for the case number.

E. Use the applicant's name for the case name even if the application is signed by someone other than the applicant.

F. Issue SSP payments in the name of the applicant, statutory benefit payee, committee or guardian. This policy is also outlined in Volume I, MS 0300.

G. Use KAMES to process FP, GP, or HP SSP cases that DO NOT contain SSI. Use KAMES to process AP, BP, or DP SSP cases that DO contain SSI.

H. If the applicant age 18 or over is present at the time of the interview and not registered to vote or not registered to vote at his/her current address, complete form PAFS-706, Voter Registration Rights and Declination, and explain the voter registration process. See Volume I, MS 1230.

I. A recipient of SSP shall have the SSP benefits continued without interruption for any of the first three months of medical confinement if admitted to a hospital, a psychiatric hospital or a nursing facility. See MS 3410 and MS 5070.

J. Approve the case if all eligibility factors are met. The effective month of payment for AP, BP, DP, FP, GP, and HP cases is the month of application. The effective date of MA is either;

1. 1st day of the month of application; or

2. Up to 3 months prior to the application month, if all eligibility requirements were met and medical services were received.

K. Deny the SSP application if all eligibility factors are not met and explore eligibility for Aged, Blind or Disabled MA.

L. CONTINUING ELIGIBILITY. After recertification/review, spot check, or case change the case; authorize continuing eligibility if all eligibility factors are met.

M. KAMES automatically issues appropriate notification.

MS 4940 RECERTIFICATION/REVIEW PROCESS & DISCONTINUANCES

Review all State Supplementation (SSP) cases every 12 months. The 12-month count begins with the month of application for approvals or program transfers.

RECERTIFICATION/REVIEW PROCESS

A. [AP, BP or DP CASES. After the initial application, verify living situation and income every 12 months. Enter findings or comments on KAMES case comments and adjust payment, if appropriate.

Note: As long as an SSI recipient's state supp case is active on KAMES, the medical card is issued from KAMES. This MA issuance may be inquired by selecting option "P" on the KAMES main menu.]

B. FP, GP or HP CASES. Complete a recertification every 24 months. The 24-month certification period begins with the month of application for approvals or program transfers. Every 12 months, review items subject to change such as living situation and income. Enter findings or comments on KAMES and adjust payment, if appropriate.

C. SPOT CHECK. If changes are anticipated before the next review or recertification, set up a spot check for the appropriate month of anticipated change.

DISCONTINUANCES

A. Discontinuing AP, BP or DP SSP payments does not automatically discontinue MA coverage, as MA eligibility is issued from the State Data Exchange (SDX) System.

Note: If the state supp case is discontinued for any reason, the medical card will revert back to being issued by the SDX system.

B. Discontinuing SSI due to income does NOT discontinue an SSP payment but DOES require:

1. Program transfer to an FP, GP or HP; and
2. Adjustment of payment if eligibility continues.

C. Discontinuing FP, GP or HP discontinues BOTH the SSP payment and MA. If an FP, GP or HP case is discontinued due to continuing income in excess of program standards, explore eligibility for aged, Blind or Disabled MA as a spend down case.

D. Discontinue the case if all eligibility factors are not met and explore eligibility for Aged, Blind or Disabled MA.

E. KAMES automatically issues appropriate notification.

MS 4950* SSI RECIPIENTS

SSA has determined the individual is either Aged, Blind, Disabled and without sufficient income from other sources to equal the SSI Standard.

MS 4960 NON-SSI INDIVIDUALS

Individuals who are not SSI recipients must meet the SSI technical eligibility criteria for age, blindness or disability.

A. AGE - The individual must be age 65 or older.

1. If there is reason to doubt the individual meets the age requirement, request verification of age.

2. Verification includes:

a. SSA verification forms;
b. Medicare card;
c. Birth registration or certificate;
d. Religious, school, or census records;
e. Insurance policies;
f. Marriage records;
g. Licenses at least 5 years old; or
h. Other acceptable documents.

B. BLINDNESS OR DISABILITY – The individual must be unable "to engage in any substantial gainful activity (SGA) by reason of a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." [See MS 3912]

1. Verification of disability is established if the individual provides proof of the following:

a. Receipt of RSDI or Railroad Retirement Benefits based on disability.
b. SSA has established disability but entitlement is pending due to the five month durational requirement on some disabilities. View notification establishing entitlement.
c. A copy of the favorable decision from SSA, Bureau of Hearings and Appeals, is presented. If benefits are not being received, complete a monthly spot check to establish receipt of benefits. If a check is not received within 6 months, send medical information to MRT.
d. SSI was received during any portion of the 12 months preceding application with the Agency, provided the SSI discontinuance was due to income or resources and not an improvement in condition. Send medical information to the MRT before the next reinvestigation unless the SSI decision stated no reexamination was necessary. If reexamination status cannot be determined, send a memorandum to the MRT asking if a redetermination is necessary. Include in the memorandum, the name and SSN of the individual and date the individual first received SSI.

e. Disability has previously been determined by the Medical Review Team, Hearing Officer, Appeal Board, or Circuit Court and the decision states no reexamination is necessary and there is no visible improvement in condition. Reference the previous decision as documentation.

2. MEDICAL REVIEW TEAM (MRT) – When submitting a request to MRT , write " State Supp. Application" on the front page of the completed form PA-601T in red ink. Submit the PA-601T with MRT-15 forms (1 per service provider + 2) in the following situations:

   a. Disability is not established by any of the above methods;
   b. A situation where an individual applies for SSP benefits, based on disability, and a concurrent application for SSI has been filed but no determination of disability has been received; or
   c. Eligibility is based on receipt of statutory benefits, and benefits are discontinued because the individual is no longer disabled.

MS 4970 ENUMERATION

Everyone applying for or receiving SSP is required to furnish an SSN or apply for a number if one has not been issued. For enumeration procedures for SSP cases, see MS 1560.

MS 5000 THIRD PARTY LIABILITY (TPL) ASSIGNMENT

[Federal law requires cooperation in the assignment of rights for third party payments to DMS for care or services available under MA as a condition of eligibility for SSP.]

MS 5010 KHIPP REQUIREMENTS

[DMS is required to review group health insurance plans which are available through the employer to an employed case member or an employed parent responsible for a non-SSI SSP child, or an employed spouse of an SSP individual and determine whether the payment of the premiums by DMS would be cost-effective. Included in this group are an employed blind or disabled child and an employed FP, GP or HP individual.]

This requirement can apply to the Aged, Blind, or Disabled MA case as an employer group health insurance can be available to a retired individual drawing a pension from a former employer. The payment of premiums is made through the KHIPP Program. [See Volume IV, MS 2150 and Volume IVA, MS 1690 .]

MS 5020 GENERAL REQUIREMENTS

An individual must be a Kentucky resident to receive SSP payments.

A. Individuals receiving SSP as aged, blind or disabled are residents of the State making the payment.

B. [Accept client's statement as proof of residency, unless questionable. Request verification if client's statement is questionable.]

MS 5050 PCH AND FCH

PERSONAL CARE HOMES AND FAMILY CARE HOMES must be licensed by the Certificate of Need and Licensure Board. [A directory of PCH's and FCH's can be found on the Office of Inspector General's (OIG) website: http://chfs.ky.gov/oig.]

MS 5060 CARETAKER SERVICES

Policy Clarification

CARETAKER SUPPLEMENTATION eligibility is determined as follows.

A. Services provided by a caretaker must:

1. [Enable an ill or infirm individual to remain safely and adequately at home, in some other family setting or room and board situation;]

2. Prevent institutionalization; and

3. Be provided at regular intervals.

B. Services may be provided by either:

1. A live-in attendant; or

2. One or more persons hired to come to the home.

C. Caretaker payments are not made if:

1. The individual is taken daily or periodically to the home of the caretaker, that is, a sitter type arrangement; or

2. [The caretaker is the individual's spouse, parent or adult child if those relatives live together.]

Exception: Authorize payment if the individual's spouse, parent, or child does not live with the individual but comes to the home to provide care and all other factors are met.

Example: An individual requiring caretaker services lives with his son and daughter-in-law. The son cannot be the caretaker, but the daughter-in-law may be as she is not the spouse, parent or child of the individual.

D. Contact the caretaker to establish:

1. Service prevents institutionalization;

2. How often service is provided; and

3. Payment made for service.

)

MS 5070* TEMPORARY STAY IN A MEDICAL INSTITUTION FOR NON-SSI RECIPIENTS

A. Effective January 1, 2005, a non-SSI recipient who receives state supplementation shall have continuation of state supplementation benefits without interruption for the first three full months of medical care in a health care facility if:

1. The recipient maintains his/her home or other living arrangement during a temporary admission to a health care facility;

2. A physician certifies in writing that the non-SSI recipient is unlikely to be confined for longer than ninety full consecutive days; then

3. A guardian, other payee, personal care home or family care home receiving a state supplementation check for the recipient, provides the local DCBS office with:

   a. Notification of the temporary admission; and
   b. The physician statement specified in item A.2.

B. A temporary admission shall be limited to the following health care facilities:

1. Hospital;
2. Psychiatric hospital; or
3. Nursing facility.

If a state supplementation recipient is discharged in the month following the last month of continued benefits, the temporary absence shall continue through the date of discharge. The 3-month count begins the first day of the month following the month of admission to the health care facility.

C. Upon receipt of the Confirmation Notice or MAP-24 from the health care facility, workers are to contact recipient's representative to determine if the nursing facility stay is temporary.

1. If the stay is temporary:

   a. Send a PAFS-2 to the representative requesting the physician's statement be provided within 10 days;
   b. Upon receipt of the physician's statement verifying a temporary stay, add the LTC segment to the State Supplementation case;
   c. Add a spot check to the case to follow-up at the end of the three-month period; and
   d. Consider the cost of Personal Care payment as a medical deduction in the patient liability calculation. A deduction for the cost of the family care payment or caretaker services is not an allowable expense.

2. If the stay is not temporary, follow procedures outlined in Volume IVA, MS 3360.

D. If the individual is not discharged until the 4th month, benefits will continue through the date of discharge.

E. For SSI recipients, see MS 3410.

MS 5100 RESOURCES

Resources are assets an individual or couple own and can apply, either directly or by sale or conversion to meet basic needs of food, clothing and shelter.

A. LIMITS. The total countable resources an individual or couple may have to be considered financially eligible for SSP are:

1. Aged, Blind or Disabled Individuals.

INDIVIDUAL	$2,000
COUPLE	$3,000

2. Blind or Disabled Child.

Parent/Child	Allowance
1 Parent	$2000
2 Parents	$3000
1 Child	$2000

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

a. Consider as surplus, any parental resources greater than $2000 or $3000, as appropriate.
b. Determine the parent's surplus resources by comparing the parent's total countable resources to the appropriate resource limit for 1 or 2 parents with any excess considered as parent's surplus.
c. Add the parent's surplus to the child's resources and compare to the child's resource limit of $2000.

B. CONSIDERATION AND VERIFICATION. [Consider and verify resources of the applicant or SSP recipient according to MS 1860 and MS 1870.]

MS 5110 INTRODUCTION TO INCOME

Income is any money received from entitled benefits, rental property, investments, nonrecurring lump sums, etc., or for labor or services. Income is either unearned or earned and must be verified and documented at each application, recertification, and any reported income change.

A. LIMITS. Countable income is compared to the standard for the appropriate classification of SSP.

B. CONSIDERATION AND VERIFICATION. [Consider and verify amount of earned and unearned income, of the applicant or recipient as appropriate, according to MS 1810.]

1. Consider payments made to a third party on behalf of a applicant/recipient, other than payments for medical insurance or medical care and services, as unearned income. EXAMPLE: The amount of rent paid to a landlord by a relative is unearned income.

2. SSP regulations specify that the PCH or FCH standard, for the appropriate level of care minus the $40 personal needs allowance, is payment in full for a recipient's cost of care in a PCH or FCH. Consider any third party payment to a PCH, FCH or caretaker, on behalf of a recipient, as income to the recipient.

3. When receipt of income causes SSI discontinuance for a person in SSP, immediately determine if eligible in F, G, or H category.

MS 5120 DEDUCTIONS/EXCLUSIONS

A. DO NOT deduct the $20 general exclusion.

B. [Allow earned income deductions according to MS 2480.]

MS 5130* COUPLES LIVING TOGETHER

Calculate income for couples living together according to the following:

A. Caretaker Services, with both members determined to be aged, blind, or disabled:

1. DO NOT conserve income of the eligible couple for minor dependent children.

2. If an eligible spouse has income:

a. Combine this income with that of the spouse requiring care; and
b. Apply to standard of couple, both eligible, but only 1 requiring care.

B. Caretaker Services, with spouse ineligible:

1. DO NOT conserve income of the eligible individual for the ineligible spouse and/or minor children.

2. DO NOT deem income to the eligible spouse if the technically ineligible spouse's gross income is less than or equal to the difference between the SSI payment standard for an individual and the SSI payment standard for a couple.

3. Determine the amount of income available to eligible spouse if an ineligible spouse has gross income greater than the difference between the SSI payment standard for an individual and the SSI payment standard for a couple, as follows:

a. Determine income of ineligible spouse.
b. Deduct the following:
(1) For the ineligible spouse, deduct 1/2 the SSI payment standard;
(2) For each minor child without income, deduct 1/2 the SSI payment standard;
(3) For each minor child with income greater than 1/2 the SSI payment standard, make no deduction; or
(4) For each minor child with income less than 1/2 the SSI payment standard, deduct the difference between 1/2 the SSI payment standard and the child's income.
c. Consider remaining amount of ineligible spouse's income, if any, available to the eligible individual.
d. Apply to the Caretaker Services standard for a couple, eligible individual with ineligible spouse.

MS 5140 COUPLES LIVING APART

A. COUPLES IN SAME PCH OR FCH.

1. Couples residing in the same PCH or FCH or residing in the same room in a PCH or FCH are considered as living apart for relative responsibility purposes. Living apart means no longer living together in a household.

2. For the month the couple cease living together in a household, combine income of the couple and consider 1/2 available to each.

3. Consider each member of the couple as an individual the month following the month the couple cease living together in a household.

4. If consideration as an individual results in ineligibility of either spouse at any time, compute income as a couple, counting 1/2 their combined income available to each.

B. COUPLES IN DIFFERENT PCH OR FCH, BOTH APPLYING FOR OR RECEIVING PCH or FCH.

1. For the month the couple cease living together in a household, combine the income of the couple and consider 1/2 available to each.

2. Consider only income of the individual as available beginning the month after the month of separation.

3. If consideration as an individual results in ineligibility of either spouse, the ineligible spouse's SSP payment is discontinued. Consider separate spend down eligibility for the ineligible spouse.

C. COUPLES, ONE APPLYING FOR OR RECEIVING CARETAKER SERVICES, PCH OR FCH, AND THE OTHER SPOUSE IS NOT RECEIVING SSP.

1. For the month of separation.

a. Deem no income to the applicant if the spouse's gross income is less than or equal to the difference between the SSI payment standard for an individual and the SSI payment standard for a couple.
b. Determine the amount of income available to the applicant if the spouse has gross income greater than the difference between the SSI payment standard for an individual and the SSI payment standard for a couple, as follows:
(1) Determine income of the spouse.
(2) Deduct the following:

(a) For the ineligible spouse, deduct 1/2 the SSI payment standard;

(b) For each minor child without income, deduct 1/2 the SSI payment standard;

(c) For each minor child with income less than 1/2 the SSI payment standard, deduct the difference between 1/2 the SSI payment standard and the child's income; and

(d) For each minor child with income greater than 1/2 the SSI payment standard, make no deduction.

(3) Consider remaining amount of the spouse's income, if any, available to the applicant.

2. Beginning the month after the month of separation, consider income of the spouse actually contributed to the applicant.

[D. COUPLES, ONE APPLYING FOR OR RECEIVING SSP AND THE OTHER SPOUSE INSTITUTIONALIZED.

If one member of the couple is institutionalized and the other spouse maintains a home, income in the amount of the SSI program standard for one is conserved for the spouse at home.]

MS 5145* ELDER SHELTER NETWORK

The Elder Shelter Network is a non-profit organization that provides temporary housing to seniors in Jefferson County who have been abused, neglected or financially exploited.

There are special income considerations for individuals in Elder Shelters:

A. Income and resources of the spouse are disregarded for the month of separation.

B. Any payments made on behalf of an applicant by the Elder Shelter Network are disregarded for 90 days from the date of admission into the program.

MS 5150 COMPUTATION

A. PCH/FCH. In licensed home cases, the payment is the amount of the difference between the standard and countable income.

B. CARETAKER. Payment is the difference between the standard and countable income of a single individual or an eligible individual with an ineligible spouse requiring care.

In caretaker cases of couples, both aged, blind, or disabled, 1 OR BOTH requiring care in their own home, payment is the difference between the standard and countable income with each receiving 1/2 of the difference.

MS 5165 CHANGE FROM ONE PC HOME TO ANOTHER PC HOME

See OM Upd. No. 08-01, MS 99777, 1/1/08

State Supplementation recipients may move from one PC home to another within the month. The State Supplementation check can be prorated between the two PC homes. It is the responsibility of the recipient or representative to request a prorated refund from the former PC home when the individual moves from one PCH to another within the same month.

MS 5170 DISCONTINUANCES

See OM Upd. No. 07-08, MS 99757, 4/1/07

Discontinuances have the following affects:

A. Discontinuing A, B or D SSP payment does NOT automatically discontinue MA.

B. Discontinuing SSI due to income does NOT discontinue an SSP payment, but DOES require:

1. Completion of an application;
2. [Program transfer to FP, GP or HP; and]
3. Adjustment of payment if eligibility continues.

C. [Discontinuing FP, GP or HP discontinues BOTH the SSP payment and MA. If an FP, GP or HP case is discontinued due to continuing income in excess of program standards, determine eligibility for Aged, Blind or Disabled MA as a spend down case.]

D. Discontinue the case if all eligibility factors are not met and determine eligibility for Aged, Blind or Disabled MA.

MS 5180 CATEGORY CHANGE

[State Supplementation (SSP) recipients who are admitted into a nursing facility or approved for waiver services are to be approved in the appropriate program category.

A. To transfer an “AP”, “BP”, or “DP” to an “A”, “B”, or “D” consider the following:

1. The “AP”, “BP” or “DP” case must be discontinued on KAMES.

   Note: An SSP recipient may have the SSP benefits continued without interruption for any of the first three months of institutionalization if admitted to a hospital, a psychiatric hospital or a nursing facility on a temporary basis. This allows the recipient to pay some or all of the necessary expenses to maintain their home or living arrangement to which they may return upon discharge from the facility. In order to qualify for continuation of payments refer to MS 3410 and MS 5070.

2. Enter the application on the PA-62 system in an “A”, “B” or “D” program code within 24 hours.

   Note: The recipient is not required to come into the office for the new application on the PA-62 system. Inquire the PRO cert file on segment “P” of the KAMES inquiry menu and enter the information on the PA62/3U system.

B. To transfer an “FP”, “GP”, or “HP” to a “J”, “K” or “M” consider the following;

1. Do not complete a new application if the application was signed within 12 months.

2. If the recertification month is 12 months or less, do not shorten the recertification month. Record the information on the comments screen on KAMES or on bond paper.

3. If the recertification month is between the 12th and 24th month, because “J”, “K”, or “M” cases only have a 12 month certification period, shorten the recertification month to the month following the program transfer.

   Example: An “FP” application was entered in January 2007. In March 2008 (the 14th month of MA coverage in the “FP” category) the case is program alternated to a “J” program code. In order for the “J” case to have a certification period of 12 months it must be reviewed the next feasible month which is May 2008.

4. When an individual enters LTC, discontinue the SSP payment and alternate program the KAMES case to a J, K or M case.

Note: As mentioned above in the note in A1, the SSP recipients may qualify for continuation of payments for any of the first three months of institutionalization. See MS 3410 and MS 5070.

C. J, K, M or F, G, H (Pass Through) to FP, GP, or HP (SSP) requires an application interview and completion of a program transfer for a case on KAMES.

D. SSP recipients may move from one PC home to another within the month. The SSP check can be prorated between the two PC homes. It is the responsibility of the recipient or representative to request a prorated refund from the former PC home when the individual moves from one PCH to another within the same month.]

MS 5190 PAYMENT AUTHORIZATION

See OM Upd. No. 07-08, MS 99757, 4/1/07

A. Use the PA-62 system to process SSP for an SSI recipient; A, B or D.

B. [Use KAMES to process SSP cases that do not contain SSI; FP, GP or HP.]

MS 5200 NOTIFICATION

See OM Upd. No. 07-08, MS 99757, 4/1/07

A. [For cases on the PA-62 system, complete form MA-105 manually to notify the individual or the individual's payee, if appropriate, of:]

1. Approval/denial;
2. Discontinuance;
3. Change; and
4. Result of recertification.

B. KAMES issues appropriate notification automatically.

MS 5210 INTRODUCTION

[There are 3 types of erroneous payment: administrative errors, misrepresentation and fraud.] Take prompt action to correct the current assistance payment when either type of error is found.

MS 5220 ADMINISTRATIVE ERRORS

A. DEFINITION. Administrative errors are either overpayments or underpayments, that result solely from:

1. Misapplication of policy;

2. Computation errors in determining the assistance payment;

3. Failure to act on a change in the recipient's living situation that was reported timely;

4. Failure to submit a correctly completed authorization form that results in untimely processing; or

5. Failure of the worker to confirm or clarify information pertaining to eligibility.

Erroneous payments resulting from an administrative deadline ARE NOT administrative errors if the Agency acted promptly on available information and correctly completed action. Delay in completing a recertification does not constitute an administrative error even though the recertification results in an increased payment.

B. OVERPAYMENT. If the administrative error results in an overpayment, take prompt action to correct the case.

C. UNDERPAYMENT. If the administrative error results in an underpayment, promptly submit:

1. An authorization to correct the current assistance payment; and

2. An authorization for a special payment.

a. The amount of the special payment is the difference between the amount the individual actually received and the amount the individual should have received.
b. This special payment is limited to the 12 months prior to the effective date of the correction.
c. Enter the special payment on the PAFS-116, Case History Sheet, the date of authorization, the amount of the special payment, and the word "Underpayment" under "Reason."

D. CASE ACTION

1. DISCONTINUANCE. If review of a case reveals that an administrative error resulted in the discontinuance of that case, the case is reinstated with the effective date of the ongoing payment entered as the month of action and a special payment(s)

authorized retroactively to the effective month of the discontinuance, not to exceed 24 months.

2. DENIAL. If review of a case reveals that an administrative error resulted in the denial of an application, take another application with the effective date of the original date of application, not to exceed 24 months. Determine eligibility and the amount of assistance for each month the individual was denied benefits, not to exceed 24 months.

MS 5230 REINSTATEMENT PROCEDURE

A. If reinstatement is accomplished within 30 days of the date the discontinuance action was taken, no new application is required. Supervisory approval is required.

B. If reinstatement occurs more than 30 days following the discontinuance action date, a new application is required.

MS 5235 RETURN OF SSP CHECKS

A. State Supplementation (SSP) checks are to be returned by the recipient, recipient's legal guardian or the recipient's payee to the Kentucky State Treasurer the month after the month of:

1. Discharge to:

   a. Nursing Facility, unless the individual's anticipated stay is 90 days or less refer to MS 3470 and MS 5070;
   b. Another PCH or FCH; or
   c. Residence.

   [Note: If the mailing address of the SSP payment is the PCH or the FCH facility's mailing address that PCH or FCH facility is to return the payment to the Kentucky State Treasurer.]

2. Death of the SSP recipient; or

3. Voluntary relinquishment of PCH or FCH license to the Cabinet for Health and Family Services.

B. The SSP checks are to be mailed to:

[Division of Administration and Financial Management (DAFM)
Cabinet for Health and Family Service
275 E. Main St., 3W-C
Frankfort, KY 40621]

1. The PCH, FCH, guardian or payee may send the check directly to DAFM.

2. If the PCH, FCH, legal guardian or payee returns an SSP check to the local office, the worker is to send the check, along with a PAFS-61 to DAFM.

3. [If the SSP check is direct deposited, the PCH legal guardian or payee must provide a certified check or money order for the grant payment. The certified check or money order is made payable to the Kentucky State Treasurer. See B1 if the check is returned directly to DAFM or B2 if the payment is returned to the local office.]

C. A PCH or FCH is to notify the local DCBS office within 5 working days of the death or discharge of a recipient or of the relinquishment of a license.

MS 5240 MISREPRESENTATION AND FRAUD

A. If you learn a recipient or responsible party withheld information in order to receive MA, follow MA IPV procedures. See Volume I, MS 1760.

B. If situations of suspected provider fraud or abuse are reported, send a memorandum with a summary of the situation to:

Office of Inspector General (OIG)
Division of Special Investigations
[275 E. Main Street, 5E-D]
Frankfort, Ky. 40621-0001

C. Attach a copy of any available documentation with the OIG memorandum. Keep original documentation in the local office.

END OF VOLUME IVA