

Division of Family Support

OPERATION MANUAL
Volume IVA

OMTL-632

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MS 1010 NON-MAGI MA DEFINITIONS (1)

Terms used in Non-MAGI Medicaid:

ACTUARIALLY SOUND: A term used to determine if the average years of expected life remaining for an individual coincide with the life of a financial instrument, such as an annuity, promissory note, loan, mortgage, or land contract. If the individual is not reasonably expected to live longer than the guaranteed period of the financial instrument, it is not considered actuarially sound as the individual is not expected to receive the Fair Market Value (FMV) of their investment back within their lifetime.

ANTICIPATED INCOME: Income, earned or unearned, which is expected to be received in the future.

ASSESSED VALUE: The value of real estate or personal property as determined by the county Property Valuation Administrator (PVA).

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

BENEFICIARY IDENTIFICATION CODE (BIC): Letters or letter-number combinations at the end of the primary wage earners SSA claim number to identify specific beneficiaries who are eligible for benefits under that number. Note: BIC is at the beginning of the claim number for Railroad Retirement beneficiaries.

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

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

BURIAL RESERVES: Resources which are set aside for the individual's burial expenses. Burial reserves can be cash, life insurance policies designated for burial, prearranged funeral contracts, and any other identifiable fund/resource, or combination of funds/resources, designated as set aside for the individual's burial expense.

BURIAL RESERVE EXCLUSION: An allowable exclusion of up to \$1,500 from liquid resources, including the Cash Surrender Value (CSV) of a life insurance policy, when a client indicates these resources are to be used for burial purposes.

BURIAL SPACES: Burial plots, grave sites, crypts, and mausoleums.

BURIAL SPACE ITEMS: A casket, urn, niche, or other repository that is customarily used for the remains, as well as vaults, headstones, markers or plaques, burial containers, the opening and closing of the grave, and the care and maintenance of the grave site.

BUY-IN: A term used to describe the purchase of Medicare Part B from the Social Security Administration (SSA) for individuals determined to be eligible for the Medicare Savings Program or State Supplementation.

CASH SURRENDER VALUE (CSV): The dollar amount the individual would receive for cashing in a life insurance policy.

COINSURANCE: Money that an individual is required to pay for health related services, after a deductible has been paid. Coinsurance is often specified by a percentage. Both Medicare recipients and individuals with private health insurance may incur an expense for coinsurance.

[**COMMUNITY SPOUSE:** An individual who is legally married to an institutionalized spouse; residing at home in the community; and not living in a medical institution, a nursing facility, or participating in a home and community based services waiver program. The individual is considered the community spouse, unless divorced from the institutionalized spouse. Note: Kentucky does not recognize common-law marriage; however, Kentucky does recognize an individual as the community spouse if the couple is considered to be legally married by a state that recognizes common-law marriage.]

COMMUNITY SPOUSE INCOME ALLOWANCE: An amount for the benefit of the community spouse which is deducted from the income of the institutionalized spouse when calculating patient liability.

COMMUNITY SPOUSE RESOURCE ALLOWANCE: The calculated amount deducted from the combined countable resources of the couple prior to determining resource eligibility for the institutionalized spouse.

CONTINUING INCOME: Income, earned or unearned, which is expected to be received on a regular ongoing basis.

COST OF LIVING ADJUSTMENT (COLA): The increase in benefits, such as Social Security, Railroad Retirement, Black Lung, etc. to offset the effects of inflation on fixed incomes.

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

DEPENDENT CHILD: A biological child, stepchild, or adopted child who lives with the community spouse and is claimed as a dependent by either parent for tax purposes under the Internal Revenue Service (IRS) Code.

DEPENDENT PARENT: A parent of either spouse who resides with the community spouse and is claimed as a dependent by either spouse for tax purposes under the IRS Code.

DEPENDENT SIBLING: 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 is claimed by either spouse for tax purposes under the IRS Code.

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

EARNED INCOME: Income received due to 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 received as part of the individual's federal income tax refund.

ELECTRONIC INCOME VERIFICATION (EIV): A method of obtaining verification of a client's earned income online, i.e. The Work Number.

ELIGIBLE SPOUSE: The spouse of an applicant or recipient who meets the aged, blind, or disabled technical eligibility requirement.

ELIGIBILITY DETERMINATION GROUP (EDG): A method of forming groups for each individual to establish which individuals are included in the household size and what income and resources will be considered when determining eligibility.

EPSDT LONG TERM CARE (LTC) CHILD: A child with special health care needs who receives treatment in an Early and Periodic Screening Diagnosis and Treatment (EPSDT) LTC facility, in or out-of-state, that has been certified by the Department for Medicaid Services (DMS), EPSDT program.

EQUITY VALUE: The value of an asset minus any verified debt.

FACE VALUE (FV): The basic death benefit or maturity amount specified by the life insurance policy.

FAIR MARKET VALUE (FMV): The value of an asset if sold at the prevailing price at the time it was actually transferred.

FAMILY INCOME ALLOWANCE: An amount for the benefit of the minor or dependent child, dependent parent, or dependent sibling which is deducted from the income of the institutionalized spouse when calculating patient liability.

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

HOMESTEAD: The applicant's or recipient's principal place of residence, whether occupied or unoccupied. A homestead can be the shelter, the shelter and land, or the land only.

INCOME: Earned or unearned money received from any source such as statutory benefits, child or spousal support, labor or services, rental property, investments, business operations, trusts, annuities, or retirement accounts, including non-recurring lump sums.

[**INSTITUTIONALIZED SPOUSE:** An individual in an LTC facility legally married to a spouse who is not in a medical institution, a nursing facility, or participating in a home and community based services waiver program. Individuals receiving waiver services and non-institutionalized Hospice are considered institutionalized spouses if married to and living in the home with a spouse not receiving those services. An individual in a Personal Care Home (PCH), a Family Care Home (FCH), or an assisted living facility is not considered an institutionalized spouse.]

LAND CONTRACT: A contract between a seller and buyer of real property in which the seller provides financing to the buyer to purchase the property for an agreed-upon purchase price and the buyer repays the loan in installments.

LEGAL GUARDIAN: A person appointed through the state district courts to care for the personal and financial interests of another person.

LEVEL OF CARE (LOC): A record received in Worker Portal as notice that an individual has been assessed and it has been determined that it is medically necessary for them to receive waiver services, Hospice, or have placement in a Nursing Facility.

LIFE ESTATE: When a person has a legal right to use property during their lifetime, but does not own the property outright.

LIQUID ASSETS: Cash on hand or resources which can be readily converted to cash, such as savings accounts, checking accounts, Certificates of Deposit (CD), stocks, bonds, mutual fund shares, etc.

LONG TERM CARE (LTC): A range of services and supports an individual may need in order to meet their health and/or personal care needs during a short or long period of time. Long term care may be provided at home, in the community, or in a nursing facility.

LONG TERM CARE FACILITIES (LTC): Licensed Nursing Facilities, and Mental Hospitals (MH), and licensed Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF IID).

LOOK BACK PERIOD: During a property and asset check, this is the time period reviewed for a prohibited transfer of resources. The look back period for a transfer of resources is 60 months from the application date.

MEDICAID: Benefits provided to individuals who are categorically or medically needy. The Medicaid program is in compliance with Title XIX of the Social Security Act as administered by DMS. Kentucky's Medicaid program is a health insurance program for low-income and needy individuals, which is jointly funded by Federal and State funds.

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) for eligible individuals.

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

MINOR CHILD: Child age 21 or younger who lives with the community spouse and is claimed as a dependent by either member of the couple for tax purposes under the IRS Code.

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

MODIFIED ADJUSTED GROSS INCOME (MAGI): Income eligibility for Medicaid is determined using the MAGI methodology that uses taxable income minus specific

deductions, such as but not limited to, student loan interest, educator expenses, and alimony (if the separation or divorce agreement is finalized on or after 12/31/18). MAGI methodology is used to determine eligibility for children, pregnant women, parent/caretaker relatives, and low income adults between the ages 19-64.

MORTGAGE: A legal agreement that conveys the conditional right of ownership on an asset or property by its owner (the mortgagor) to a lender (the mortgagee) as security for a loan.

NON-HOME PROPERTY: Real property other than homestead property, such as rental property, business property, homestead property after 6 months of institutionalization, etc.

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

NURSING FACILITY (NF): A licensed facility which provides residential care for people who require long term care above room and board, such as skilled nursing due to a mental or physical condition or rehabilitation due to injury, disability, or illness.

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

[**PATIENT LIABILITY:** The amount a Long Term Care Medicaid recipient must pay toward their cost of care. This amount is based on their income and is paid to the provider.]

PEER REVIEW ORGANIZATION (PRO): The organization responsible for conducting level of care (LOC) determinations for recipients in need of NF or waiver services.

PERSONAL NEEDS ALLOWANCE (PNA): A basic amount for maintenance deducted from the gross income when determining the patient liability of recipients in NF, waiver services, or Hospice.

PERSONAL PROPERTY: Property of a personal nature, such as jewelry, clothing, or furniture.

PREARRANGED FUNERAL CONTRACT: A contractual agreement between an individual and funeral home to preselect goods and services for an individual's funeral.

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

QUALIFYING INCOME TRUST (QIT): A means of excluding income in order to establish Medicaid eligibility for individuals who are receiving LTC services and have income exceeding the special income standard.

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

REASONABLE COMPATIBILITY: For Non-MAGI Medicaid, reasonable compatibility determines whether or not additional verification is needed for liquid assets. The

client stated amount of liquid assets are verified by Eligibility Advisor and Worker Portal adds this value to other client stated resources to determine if they are below the resource limit. This determines if additional verification is required for liquid assets.

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, whether or not a Medicaid application is completed.

RESOURCES: Assets which can be used, to meet basic needs of food, clothing, and shelter, including liquid assets, property, vehicles, etc.

RETIREMENT, SURVIVORS, DISABILITY INSURANCE (RSDI): Social Security benefits payable under Title II of the Social Security Act. RSDI refers to the three types of benefits that the SSA pays. These payments are made to individuals who are at full retirement age (62-67), survivors (children, widows, widowers), or to individuals (and qualified dependents) who are now disabled.

SELF SERVICE PORTAL (SSP): Online platform that allows individuals access to apply for and receive information about public assistance benefits (SNAP, TANF, Medicaid, and Child Care). Kentucky's SSP is called kynect benefits.

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

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

STABLE ACCOUNT: Tax-advantaged savings accounts for individuals with disabilities.

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

SUBSTANTIAL GAINFUL ACTIVITY (SGA): A term used by the SSA to describe a level of work and earnings. It is considered in situations involving disabled or blind individuals. Work can be classified as "substantial" if it involves physical or mental activity or a combination of both. Full or part-time work can be classified as substantial.

SUPPLEMENTAL SECURITY INCOME (SSI): A federally funded program that makes monthly payments to individuals who have limited income and resources if they are aged, blind, or disabled.

TERM LIFE INSURANCE: Life insurance that covers a specified period of time during which premiums are paid. 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.

TRANSFER OF RESOURCES: Any cash, liquid asset, or property which is voluntarily transferred, sold, given away or otherwise disposed of at less than fair market value.

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

UNDUE HARDSHIP: When the denial of Medicaid, due to a transfer of resources penalty or consideration of funds placed in a trust, deprives an individual of medical care to the extent the individual's health and life would be endangered or the individual would be deprived of food, clothing, shelter, or other necessities of life.

WHOLE LIFE INSURANCE: Life insurance that pays a benefit on the death of the insured and also accumulates a cash value.

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

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

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

MS 1020

AGENCY RESPONSIBILITY

(1)

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

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

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

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

MS 1030 TYPE OF ASSISTANCE (TOA) (1)

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

<u>TOA</u>	<u>Program Name</u>	<u>Description</u>
ABDM	Non-SSI Regular MA	Aged, blind, or disabled individuals with income at or below the MA scale who are not receiving SSI or State Supplementation.
EMCA	[Time-Limited MA for Aged, Blind, or Disabled immigrants.	Time-Limited MA for an aged, blind, or disabled immigrant with an emergency medical condition who does not meet qualified immigrant requirements for ongoing MA.]
EXPT	Exparte	Two months MA for individuals who lost SSI due to excess income or resources, living arrangement, or refusal to obtain drug/alcohol treatment.
LTCM	LTC MA	Vendor payment MA to categorically needy individuals. These individuals use the special income standard.
MAWR	Medicaid Works	Disabled individuals age 16 through 64 who have earned income (i.e. working individuals) and are unable to engage in Substantial Gainful Activity (SGA) but are working and are financially eligible for regular MA.
PTCC	Pass Through – Correct and Concurrent	Individuals who previously received SSI/State Supplementation and Retirement, Survivor's, Disability Insurance (RSDI) correctly and concurrently (in the same month) and lost SSI/State Supplementation due to an increase in income.
PTDC	Pass Through – Disabled Adult Children	Blind or disabled individuals, age 18 and older, who lose SSI as a result of an entitlement to or increase in RSDI Disabled Adult Child (DAC) benefits.
PTEW	Pass Through – Disabled Early Widow(er)s or Disabled Surviving Divorced Spouses	Individuals, age 60 through 64, who lost SSI/State Supplementation as a result of entitlement to RSDI early widow's or widower's benefits, and who are not yet entitled to Medicare Part A. Individuals age 50 through 59 who received SSI/State Supplementation and who lost SSI/State Supplementation as a result of entitlement to RSDI disabled widow's or widower's or disabled surviving divorced spouse's benefits and not yet entitled to Medicare Part A.

QDWI	Qualified Disabled Working Individuals (QDWI)	Provides for Buy-In of Medicare Part A.
QI1P	QI1 – Additional Low-Income Medicare Beneficiaries	Provides for payment of Medicare Part B premium for individuals with income above 120% FPL and below 135% FPL.
QMBC	[Qualified Medicare Beneficiaries (QMB)]	Individuals who are conditionally enrolled in Medicare Part A. This TOA is not dually eligible with any other type of Medicaid coverage other than Spend Down.]
QMBP	Qualified Medicare Beneficiaries (QMB)	Provides for payment of Medicare Part A and Medicare Part B premiums, Medicare deductibles, and Medicare coinsurance amounts for individuals with income under 100% of the Federal poverty level (FPL).
SLMB	Specified Low-Income Medicare Beneficiaries (SLMB)	Provides for payment of the Medicare Part B premium only for individuals with income above 100% FPL and below 120% FPL.
SSIP	Potential SSI Recipient	Aged, Blind, or Disabled individual whose income is below the SSI standard.
SSIR	Regular SSI MA	Individuals who receive Supplemental Security Income (SSI).
SSPM	State Supplementation MA	MA for State Supplementation approved individuals who are not SSI recipients, but are aged, blind, or disabled.
SSPP	State Supplementation	State Supplementation payments for aged, blind, or disabled individuals.

MS 1235

DISCLOSURE OF MEDICAID INFORMATION

(1)

[Information concerning Medicaid (MA) may be released to the following entities or individuals listed below, provided they comply with Health Insurance Portability and Accountability Act compliance requirements (HIPAA). For more information about HIPAA, refer to Volume I, [MS 0160](#).]

- A. Public employees including any identified representative of the Department of Health and Human Services (DHHS) in the performance of his/her duties in connection with the administration of the public assistance or child support enforcement programs pursuant to part D of Title IV of the Social Security Act.
- B. Law enforcement agencies and their representatives including county and commonwealth attorneys, district and circuit court judges, and grand juries in discovering and prosecuting cases involving fraud.

[A potential fraud situation in MA may be identified by the Kentucky State Police during the course of other investigations. Form KSP-58, Request for Confidential Information, is utilized by the Kentucky State Police when requesting information concerning fraud or potential fraud investigations, whether identified by the Department for Community Based Services (DCBS) or another source.]

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

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

If the requesting officer indicates he/she wishes to take case record material out of the office, offer to print the necessary documents from the Electronic Case File (ECF).

- C. Members of Congress and the General Assembly, limited to cases of individual constituents who have requested information regarding their application or Medicaid status.
- D. Any representative that has requested a hearing before an agency hearing officer, to the extent necessary for the proper presentation of the case. The release of information under this provision is limited to only that information applicable to the hearing request. In addition, any information or names obtained shall not be used for commercial or political purposes.
- E. Any audit or similar activity; e.g., review of expenditure reports or financial review, conducted in connection with the administration of any federal or federally assisted program. For MA, the audit/activity must be conducted in connection with the administration of the MA program. This is limited to governmental entities authorized by law to conduct such an audit or activity.

- F. Officials administering any title IV-E foster care and adoption assistance programs.
- G. Local law enforcement agency, the Kentucky State Police, Commonwealth or county attorney to report known or suspected instances of child abuse or neglect of a child receiving assistance. The local office cooperates in providing information necessary to verify a suspected or known senior or child abuse situation which has been reported to the proper authorities.
- H. Attorneys, absent parents, etc., who appear in the local office with a COURT ORDER carrying a signature of a judge or an individual with the authority of a judge such as a Domestic Relations Commissioner. If the court ordered information is due within 10 calendar days, the information can be released. If the local office has any questions on whether the court order meets the specified criteria or the local office has in excess of 10 calendar days to provide the information, contact the Medical Support and Benefits Branch (MSBB) through the Regional office. Unless otherwise notified by regional office staff or the court, court orders must be followed. For procedures regarding subpoena requests, refer to Volume I, [MS 0170](#).
- I. Only Board of Elections officials may view forms and/or information utilized directly in the voter registration process. Otherwise, voter registration information remains confidential.

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

MS 1240

KYHEALTH CARD

(1)

[The KYHealth card is issued to all individuals eligible for Medicaid who are exempt from managed care enrollment. It is issued at initial approval for ongoing Medicaid, Spend Down Medicaid, and initial Medicaid eligibility issued by special circumstance. A new card is not issued for subsequent Spend Down approval periods unless the individual no longer has the original card and requests a new one be issued. A KYHealth card is only issued to individuals at reapplication if they have not received Medicaid in the prior three months.

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

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

- A. If an undelivered KYHealth card is received in a DCBS office, take the following action:
 1. Send the KYHealth card to the new address, if available, and assure appropriate action is taken to correct the address in Worker Portal; or
 2. If the new address is unavailable, contact the individual by phone. If the individual provides a change of address, update Worker Portal and send the KYHealth card to the appropriate address. If unable to contact the individual by phone, generate a Request for Information (RFI) requesting that verification of residency be provided within 30 days. If the individual does not respond to the RFI, the case will discontinue.
- B. DCBS offices should maintain a centralized file for KYHealth cards returned by Central Office. If an individual requests a duplicate KYHealth card, the centralized file in the DCBS office is to be checked before issuing a new card.
- C. Do not process requests for duplicate KYHealth cards on new approvals less than 10 days from the case disposition].
- D. Requests for duplicate KYHealth cards for MA individuals are processed by DCBS staff. These cards are issued by selecting MAID Card Request on the Case Summary Screen on Worker Portal.
- E. Requests for duplicate KYHealth cards for Supplemental Security Income (SSI) individuals are processed by DCBS staff on Worker Portal.

MS 1340 INTRODUCTION TO MANAGED CARE (1)

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

- A. The purpose of managed care is to:
 - 1. Assure needed access to care;
 - 2. Provide for continuity of services;
 - 3. Strengthen the patient/physician relationship;
 - 4. Promote the educational and preventive aspects of health care;
 - 5. Prevent unnecessary utilization and cost; and
 - 6. Improve the quality of care received.
- B. Non-exempt individuals are required to enroll with an MCO. Upon disposition of an application, if the worker does not enter the shopping module and assist the individual in making their MCO selection, Worker Portal will trigger the auto assignment process. An MCO will be assigned for the individual using auto assignment rules.
- C. Individuals also have the option of selecting a Primary Care Provider (PCP) in the shopping module after MCO selection. If a PCP is not selected after enrollment, the MCO will assist the individual in selecting one. The individual will receive a handbook and informational materials from the MCO.
- D. The Department for Medicaid Services (DMS) maintains a managed care toll-free telephone number to assist providers and recipients who have specific questions pertaining to managed care. The Medicaid managed care number is 1(855)446-1245, and is available from 8 a.m. to 5 p.m. Eastern Standard Time, Monday through Friday.
- [E. MCO website at <https://chfs.ky.gov/agencies/dms/dpqo/mco-cmb/Pages/mco-options.aspx> may be accessed by workers and recipients to search for information on each MCO, including links to each MCOs website.]

MS 1343

MANAGED CARE ENROLLMENT

(1)

[Managed Care Organizations (MCO) contact enrolled members and issue them Managed Care cards. If a replacement card is needed, the individual should contact their MCO. Refer members with questions regarding services or billing to Managed Care Member Services at 1-855-446-1245, or to their designated MCO. MCO numbers are located on the back of the managed care card. Please note that individuals enrolled in managed care only receive an MCO card and are not issued a KYHealth card.

- A. New Medicaid applicants and members reapplying more than 60 days since the last MCO enrollment have the opportunity to select a new MCO during the application process. If they do not choose an MCO, Worker Portal will automatically enroll them in an MCO during the nightly batch using the auto assignment process.
- B. Individuals not selecting an MCO at application or individuals who are reapproved within 60 days of their last MCO enrollment are subject to the following auto assignment process:
 - 1. New applicants who do not choose an MCO are auto assigned to the MCO with the least member enrollment. These individuals have 90 days from the initial enrollment to change their MCOs.
 - 2. Previous recipients, who do not choose an MCO at application and were not enrolled within the last 60 days, are auto assigned to the MCO with the least member enrollment and have 90 days from initial enrollment to change their MCO.
 - 3. Recipients who were enrolled with an MCO within the last 60 days are assigned to their previous MCO. They may not select a different MCO at reapplication and do not have a 90-day period to change their MCO.
 - 4. Deemed eligible newborns are assigned the same MCO as their mother for the month of birth and the following month.
- C. All members have the opportunity to request an MCO change during the open enrollment period.
- D. DCBS assists with MCO Changes using the MCO Change Request tab on the Case Summary screen for the following individuals:
 - 1. Individuals within the initial 90-day MCO change request period; or
 - 2. Any individual requesting a change during Open Enrollment.
- E. DCBS does not have the ability to make MCO changes outside of Open Enrollment or the 90-day initial enrollment period. Refer individuals requesting MCO changes outside of these times to contact DMS Medicaid Member Services at 1-800-635-2570 for information regarding the Disenrollment for Cause process.

- F. An incarceration suspension is created to suspend MCO enrollment for incarcerated individuals. Once it is reported that the individual has been released, the suspension is ended and the individual is eligible for reenrollment in an MCO beginning the date they were released.]

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

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

- A. The following Medicaid (MA) members are non-exempt and required to enroll in an MCO, if no criteria in section B applies:
1. Individuals receiving MA who are aged, blind, or disabled;
 2. Pass Through recipients;
 3. State Supplementation recipients;
 4. Supplemental Security Income (SSI) recipients;
 5. Children under 21 years of age, in a Psychiatric Residential Treatment Facility (PRTF);
 6. Individuals receiving Non-Institutionalized Hospice waiver services;
 7. Individuals receiving PRTF I/II or Mental Health/Psych services;
 8. Individuals receiving Exparte; and
 9. Individuals in DJJ/Subsidized Adoption/Foster Care.
- B. The following MA members are exempt and not required to enroll in an MCO:
1. Members receiving waiver services except Non-Institutionalized Hospice waiver services;
 2. Members in Long Term Care (LTC) facilities, such as Nursing Facilities, Institutionalized Hospice, and Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);
 3. [Members receiving Medicare Savings Program (MSP) benefits (unless dually eligible for Medicaid as a non-exempt individual)];
 4. Incarcerated individuals requiring care outside of the institution;
 5. Members whose eligibility is time limited, such as Spend Down and Emergency Time-Limited MA
 6. Members in the Medicaid Works Program.
- C. [Individuals who are non-exempt from managed care enrollment but also dually eligible for the Medicare Savings Program are required to enroll in an MCO. However, if the individual meets any of the other exemption reasons listed above in section "B" they will be considered exempt and will not be enrolled in an MCO.

Example: Brandon is a Pass Through recipient and is dually eligible for the Medicare Saving Program in the SLMB type of assistance. As a Pass Through recipient, he is non-exempt and therefore required to enroll in an MCO. Since none of the other exemptions apply, he will continue to receive MSP benefits and will be enrolled with an MCO.

Example: Martha receives Medicaid in the ABDM type of assistance and receives QMBP benefits. She isn't eligible for SSI due to reasons other than income and resources and was determined disabled by the Medical Review Team (MRT). She recently began receiving waiver services. Even though she is dually eligible, she is no longer required to enroll in an MCO because she is exempt.

- D. MCO enrollment is suspended for incarcerated individuals until they are released. Once the incarceration suspension is terminated in Worker Portal, the individual is eligible to be reenrolled into their MCO beginning the date that the suspension is ended.]

MS 1350 APPLICATION FOR ENTITLED BENEFITS (1)

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

- A. KTAP, State Supplementation, Supplemental Security Income (SSI), VA Aid and Attendance or welfare program cash benefits of a similar nature are NOT considered entitled benefits.
- [B. If an individual is potentially eligible for SSI, enter an application on Worker Portal. Form PA-5.1, Report or Referral to the District Social Security Office, will system generate for the individual to apply for SSI.]
- C. If an individual refuses to apply for entitled benefits, eligibility does not exist unless good cause for not applying is established. Good cause includes reasons such as previous denial of benefits with no change in circumstances or inability to prove eligibility. If any type of denial of potential benefits is alleged, require the individual to present written documentation of the denial.
- D. Individuals are required to access IRA funds if they are at least 59 1/2 years of age, and the funds are available. The applicant/recipient must provide verification from the financial institution that the required minimum withdrawal, based upon the individual's age is being made. Individuals receiving disbursements from Roth IRA's must withdraw the same amount as from a traditional IRA. The Department for Medicaid Services (DMS) does not make any distinctions between traditional and Roth IRA's. Failure to comply with these procedures results in ineligibility for Medicaid (MA).

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

- E. Before approval, obtain verification from the appropriate agency of application for the potential entitled benefit; however, do not deny assistance based on projected income.
- [F. Refer individuals who have reached 64 years and 9 months of age to the Social Security Administration (SSA) for a determination of eligibility for Medicare benefits.]

MS 1353 ELIGIBILITY FOR ENTITLED BENEFITS (1)

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

A. Worker's Compensation:

1. Eligibility is based on injury, occupational disease, or death resulting from, and in the course of, employment.
2. The Worker's Compensation Board determines eligibility and benefit amount after applying through the employer.

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

1. Miners, disabled miners, widows of miners, and their families may be eligible for retirement or other benefits.
2. Applications are available in the local UMWA office.

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

1. Benefits are based on wages from employment or earned income from self-employment.
2. Eligible individuals include a:
 - a. Retired person, age 62 or older;
 - b. Disabled person with the minimum employment quarters;
 - c. Dependent spouse, age 62 or older;
 - d. Spouse with a dependent child under age 16;
 - e. Unmarried child to age 18, up to age 19 if attending high school full-time; and
 - f. Surviving family member under certain circumstances.

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

D. Black Lung Benefits:

- [1. Individuals eligible for benefits based on disability or death due to Black Lung related to employment in coal mines include:]
 - a. Miners totally disabled due to Black Lung;
 - b. The individual's spouse;
 - c. A dependent child under age 18, or if disabled before age 22; and
 - d. A surviving family member- under certain circumstances.

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

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

1. Benefits are based on injury or disease incurred in or aggravated by active military service.
 2. Eligible individuals include:
 - a. Veterans;
 - b. Widows;
 - c. Unmarried children under age 18;
 - d. Certain helpless children; and
 - e. Certain parents of a serviceman or veteran who died from service-connected injury or disease.
- [3. Individuals apply with a field representative serving the county in which the individual lives.]

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

1. Benefits are based on injury or disease that is non-service connected.
2. Eligible individuals include;
 - a. Veterans; and
 - b. If there are dependents, payments will be increased.
3. [Individuals apply with a field representative serving the county in which the individual lives.]

G. Railroad Retirement:

1. Benefits are based on wages from railroad employment.
2. Information regarding retirement, disability and death benefits may be obtained from the appropriate District Office serving the county of residence as shown below:

Counties:

Boone, Bracken,
Campbell, Gallatin,
Grant, Kenton,
Mason, Pendleton
and Robertson

Boyd, Carter,
Elliott, Floyd,
Greenup, Johnson,
Lawrence, Lewis,
Martin and Pike

Send to:

Cincinnati District Office
CBLD Center, RM. 201
36 East 7th Street
Cincinnati, Ohio 45202
Telephone: (877) 772-5772

Huntington District Office
New Federal Bldg., RM. 145
640 4TH Ave.
Huntington, WV 25721
Telephone: (877) 772-5772

Henderson and
Union

Indianapolis District Office
The Meridian Centre
50 South Meridian,
Ste. 303
Indianapolis, IN 46204
Telephone: (877) 772-5772

All other counties

Louisville District Office
629 South 4th Street
Suite 301
Louisville, Ky. 40202.
Telephone: (877) 772-5772

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

1. Benefits are based on age, blindness or disability.
2. Eligible individuals include:
 - a. Persons at least age 65 and entitled to RSDI benefits; and
 - b. Persons receiving RSDI benefits for 2 years or more as a disabled worker, disabled child, or disabled widow.
3. HIB is at no cost to enrollees entitled to RSDI benefits. It is available on a premium basis to others. HIB payments, supplemented by benefits of the Kentucky Medical Assistance Program, provide for virtually all services ordinarily furnished by a hospital.
4. SMI is available on a premium basis to eligible individuals who enroll during certain enrollment periods. Any individual who does not enroll for SMI at the first available opportunity has their rate increased by 10% for each 12 month period in which they could have enrolled. SMI payments provide for certain medical costs in addition to those covered by HIB.

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

5. The amounts of premium payments are recomputed annually, effective each January.
- [6. Individuals apply at the SSA office serving the county of residence.]

MS 1371

AUTHORIZED REPRESENTATIVE

(1)

[An Authorized Representative (AR) may act on behalf of an individual if the AR has proper consent. If form MAP-14, Authorized Representative, or other appropriate documentation is not provided at the time of application, an interview may still be completed and the case pended for AR designation. Documentation must be provided to verify an individual is authorized to act on the client's behalf before an application, completed by an AR, may be approved.]

A. The following individuals may act as AR for an applicant or recipient:

1. The spouse, if currently married and there is NO existing divorce decree;
2. The parent of a minor child.

NOTE: If the child is age 18 or older, the parent must meet one of the criteria below or be designated as AR by form, MAP-14, Authorized Representative.

3. The verified statutory benefit payee;
4. The court appointed guardian (with documentation);
5. The Power of Attorney (POA) (with documentation);
6. The representative of an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID) facility; or
7. The representative of a Nursing Facility (NF) resident who is verified to be incapable of declaring intent (this does not include hospitalized individuals).

B. [Individuals who do not meet the authorized representative criteria listed above must be designated to act on the behalf of an applicant or recipient by using form MAP-14, Authorized Representative. Workers can access form MAP-14 on the Department for Medicaid Services (DMS) intranet site at: <https://chfs.ky.gov/agencies/dms/MAPForms/MAP14.pdf>]

1. Form MAP-14 allows the applicant/recipient the ability to choose the level of authority they wish to allow the AR. They can choose one, a combination, or all of the following permissions:
 - a. Submit an application for Medicaid;
 - b. Complete and submit any renewal forms;
 - c. Receive copies of notices and correspondences;
 - d. Act on all other Medicaid matters for the applicant or recipient.

Workers must review form MAP-14 to see what permissions have been granted to the AR prior to discussing the case.

2. If a company's employee is acting as an individual's AR through their employment with that company, such as MedAssist, then any representative of that company may request action on, or inquire about, the individual's MA benefits.

3. [Form MAP-14 is valid from the date of signature until the applicant or AR rescinds the form or the member dies. All AR designation is invalid at the time of the member's death.
 4. At the time of application if the individual wishes to name an AR, form MAP-14 must be provided and case notes entered to reflect action taken. If a completed form MAP-14 is returned, the AR information must be entered in Worker Portal.
- C. Department employees (those who work in Family Support) involved in the certification and/or issuance processes cannot be representatives unless there is specific written approval from the Service Region Administrator (SRA) or designee, and only if a determination is made that no one else is available to serve.]

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

[All individuals have the right to make an application and receive a decision on their eligibility for Medicaid (MA). Individuals may apply in-person, by telephone, on the Self-Service Portal (SSP), by a paper application, or by a home visit, if requested. Individuals are never refused the right to apply even if it appears that they don't meet technical or financial eligibility requirements. An Authorized Representative (AR) may be complete an application and/or recertification. For more information on AR's, refer to [MS 1371](#).

Individuals applying on the SSP or by paper application are not required to complete an interview. If verification is required, a Request for Information (RFI) is issued. If no verification is needed, eligibility is determined without worker intervention.

Individuals may also apply for Medicaid using the mail-in application, form MAP-205, Application for Medicare Savings Programs, KHBE-I10 Application for More Than One Person, or KHBE- I11 Application for One Person. Interviews are not required when paper application is submitted, however workers should contact the applicant or AR to confirm or clarify information on the application.

NOTE: Workers are still required to complete a thorough interview with individuals applying in person or by phone.

Use the following procedures when conducting an interview.

- A. If the individual is physically or mentally disabled, elderly, or has another special need, provide reasonable accommodations to any special needs the individual may have no matter where the interview is conducted. Accommodation to special needs may include but is not limited to:
 1. Interpreter services for hearing impaired individuals. For more information on interpreter services for the hearing impaired, refer to Volume I, [MS 0220](#);
 2. Additional space for the interview to accommodate an individual who uses a wheelchair;
 3. Scheduling appointments when special transportation services are available;
 4. If the individual does not speak English, obtain interpreter services. For more information on interpreter services, refer to Volume I, [MS 0230](#); or
 5. Making a home visit.

NOTE: Individuals may be accompanied by anyone of their choosing during the interview.

- B. Inquire Worker Portal to determine if an individual has previously received MA. If so, review the case(s) thoroughly.
- C. Ask all the questions on Worker Portal as the interview progresses.

- D. Explain retroactive MA coverage and ask if the individual has unpaid medical expenses in any of the prior three months. For information regarding retroactive MA, refer to [MS 1450](#).
- E. Run system checks as appropriate, i.e. BENDEX, SDX, external agency searches, Eligibility Advisor (EA), etc. to review for potential income and resources.
- F. Explain the requirement to cooperate with Third Party Liability (TPL). Enter all health insurance information on Worker Portal. For information regarding TPL, refer to MS 1660.

Note: Medicare Part D is not considered TPL, as Medicaid does not provide prescription coverage for Medicare recipients, and is not required to be entered.

- G. Enter Case Notes on Worker Portal while the applicant/recipient is still present or on the phone.
- H. Inform individuals of their rights and responsibilities:
 - 1. Advise the individual that all changes must be reported within 30 days of the date of the change;
 - 2. Explain form MA-2, Medicaid Penalty Warning. Form MA-2 must be signed by the applicant to verify he/she understands the potential consequences for committing fraud. The form may be signed electronically or hardcopy at face-to-face interviews. For phone interviews, form MA-2 may be signed with voice signature; otherwise, Worker Portal will issue form MA-2 to the individual for signature and the case will pend for its return;
 - 3. Advise the individual of the right to request a hearing to appeal any adverse decision;
 - 4. If the applicant is age 18, or will be 18 before the next election, explain the voter registration process and complete the voter registration question on Worker Portal. Refer to Volume I, [MS 0640](#) and [MS 0650](#) for procedures regarding voter registration; and
 - 5. Provide all mandatory informational forms and/or pamphlets required at application/recertification. Thoroughly explain all forms.
 - a. For face-to-face interviews, forms requiring signature may be signed electronically or hardcopy;
 - b. For phone interviews:
 - i. Inform the applicant of all forms that should be received;
 - ii. Explain the information contained in the forms; and
 - iii. For any forms not signed by voice signature, explain that the forms must be signed and returned.
- I. Explain all Medicaid processes:
 - 1. Explain the Managed Care program if any individuals in the household are required to enroll with a Managed Care Organization (MCO). For information on Managed Care, refer to [MS 1340](#).

2. Explain the KYHealth card for any individuals in the household exempt from managed care enrollment. For information on the KYHealth card, refer to [MS 1240](#).
 3. Advise individuals to contact their MCO or Medicaid Member Services with any questions regarding coverage or billing. The appropriate phone number is listed on the MCO card or the back of the KYHealth card.
- J. The applicant must sign the application. If the interview is face-to-face, either electronic or hardcopy signature is acceptable. If the interview is by phone, the application may be signed by voice signature. Otherwise, Worker Portal will issue the application to the individual for signature and the case will pend for its return.

Note: The application may be signed by the applicant, the applicant's statutory benefit or (SSI) payee, legal guardian, power of attorney (POA), or AR. If the application summary is signed by a mark, such as an X, another person must sign the application as a witness. The witness may be related or unrelated to the applicant.

- K. Explain the difference between mandatory and optional verification.
- L. Explain what is required to process the case timely and that Medicaid will deny or discontinue if mandatory verification is not returned by the due date.

Note: Individuals have 30 days to return requested information before the application denies, unless additional time is requested. For information on individuals requesting additional time, refer to [MS 1470](#).

ALL income and resources MUST BE verified and documented BEFORE eligibility is disposed to ensure the applicant meets technical and financial requirements.

- M. Run eligibility, if additional verification is required, an RFI will generate. Review the RFI to ensure that it is correct.
- N. Review all disposition screens, including financial, income, resources, and patient liability, as appropriate. Any verification provided at the interview must be scanned to the Electronic Case File (ECF) at that time.
- O. If all verification is provided at the time of the interview, dispose eligibility.
- P. Ensure that all of the applicant's questions are answered.
- Q. After the Interview:
1. Scan all verification returned to the DCBS office into ECF upon receipt. All documents pertaining to eligibility for the current certification period must be scanned into ECF.
 2. Explain that verification may be returned by mail or fax to the Centralized Mail Center, by uploading documentation to the SSP, or by returning to any DCBS office.

3. If clarification of policy is required from the Medical Support and Benefits Branch (MSBB), send the request to the regional Program Specialist immediately to prevent delays in processing the case.
- R. When an application for assistance is denied, investigate MA eligibility for the three months prior to application to determine if the individual may be eligible for benefits in the Spend Down program.]

MS 1374

APPLICATIONS FOR THE DECEASED

(1)

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

- A. Accept and process Medicaid (MA) applications made after the applicant's death if:
 - 1. Medical bills were incurred during the 3 months prior to application or in the application month; and
 - 2. The individual was technically and financially eligible at the time services were rendered.
- B. Take an application for a Supplemental Security Income (SSI) applicant who dies before SSI entitlement is established or dies before a hearing can be requested and held. See Volume IVA, [MS 4662](#).
- C. A field determination of disability can be made if MA eligibility is requested only for the month of death.
- D. If an individual is determined eligible for MA and dies prior to case approval, if all technical and financial requirements are met process the application accordingly.

MS 1380

[CASE NOTES]

(1)

Documentation for Non-Modified Adjusted Gross Income (Non-MAGI) Medicaid is necessary in order to capture information that may conflict with system entries or requires explanation beyond data found on Worker Portal. Due to the complexity of Non-MAGI Medicaid casework, comprehensive and thorough case notes are crucial, especially with statewide processing of Medicaid. Documentation is also necessary to address any unusual circumstances regarding an individual's eligibility.

Along with general items found in Volume I, MS 0130, Documentation, the following is a list of additional items that, though not all inclusive, may be required to be addressed in case notes. Management can request added documentation beyond the minimum requirements for areas workers have difficulty applying correct policy.

Worker Portal requires case notes for any information verified through collateral contact. Always document the name of the person contacted along with their phone number and the agency they work for, if applicable.

A. Technical Eligibility:

1. Methods used to verify citizenship/identity.
2. [Level of Care (LOC):
 - a. Admit Date;
 - b. Whether or not the LOC is in Worker Portal;
 - c. The Nursing Facility (NF) that the individual resides in, if applicable; and
 - d. Changes in LOC.]
3. Household composition and reasons for excluding a household member.
4. Residency.
- [5. Disability: When a referral to the Medical Review Team (MRT) is made for a determination of disability or the reason a field determination of disability is made and any verification used.]

B. Resources:

1. Vehicles: document ownership, whether the vehicles are countable or excluded, and the reason for exclusion.
2. Resources that require a review or approval by the Department for Medicaid Services (DMS) such as undue hardship requests or lifetime care agreements.
3. Resources that require a review or approval by the Office of Legal Services (OLS) such as annuities and trusts.
4. Comment on any liquid assets, property, or transferred resources found when completing the asset check.

5. Life insurance, burial reserves, prepaid burials, pre-arranged funeral contracts, etc. Document how these are considered. If any are excluded, explain how and why they are excluded. Comment on irrevocability or ownership assignment, if applicable.
6. [Property, including homestead property and non-home real property. Document the fair market value (FMV) of the property and how it was verified. Document any verification obtained from the PVA or County Clerk's Office. Document how the property is considered in the eligibility determination. If the homestead is exempt, document the reason for the exemption.
7. If there was a prohibited transfer of resources within the look back period and whether penalties apply and why. Document the reason why a Review Transfer Task is created for MSBB to review.]
8. Inaccessible resources and an explanation of why any resources are not considered.
- [9. Document that Eligibility Advisor was checked and the result.
10. Liquid assets, such as checking accounts, savings accounts, Certificate of Deposit (CD), direct express, etc. and how they are verified.
11. How jointly held resources are considered.]

C. Income:

1. Income computations that conflict with standard procedures.
2. Unusual expenses and deductions given for self-employment, rental, and farm income.
3. When the \$90 disregard is not allowed for VA income such as compensation.
4. Situations where relative responsibility exists.
5. [Types of income, who receives the income, and how verified.
6. If income exceeds the special income standard and a Qualifying Income Trust (QIT) is required. Case Notes must be entered to state what was explained to the individual and their understanding.]

D. Community Spouse:

1. [For Long Term Care (LTC) cases, whether or not there is a community spouse.
2. Resource and income types.
3. Excluded real property, motor vehicles, life insurance, burial reserves, and liquid assets.

4. Shelter expenses.
5. Disregards and excess shelter expenses increased due to a fair hearing order or a court order mandate.
6. Increased community spouse income or resource allowance and how verified.
7. Resource assessment has been completed and how much resource is the community spouse allowed.
8. LTC Resource Transfer Consent Screen and LTC Income Statement reviewed with community spouse.]

E. Medical Expenses:

1. [Retroactive coverage was discussed, months requested, and whether or not it was issued.]
2. Third Party Liability (TPL) was explored and the requirement to report other health insurance was explained.
3. How medical expenses were verified and utilized for Spend Down cases.
4. If the Medicaid effective date for a Spend Down quarter was incorrectly established.
5. Unusual consideration of deductible expenses, such as Home and Community Based Services (HCBS) prescription co-payments.

F. Procedural/Case Record Information:

1. [The type of application and whether interview was completed.
2. Any deviation in normal office operating procedures, such as home visit interview, hard copy application, sign language interpreter used, etc.
3. All previous case notes were reviewed.
4. Rights and Responsibilities were explained and understood.
5. An Authorized Representative (AR) is assigned or acts, and how consent is verified.
6. All required forms were given.
7. The reason a Request for Information (RFI) was issued.
8. Whether the Medicaid effective date was backdated or if the standard of promptness was not met.
9. If a suspected fraud claim referral for Medicaid was completed. Comment on the reason for referral for a fraud investigation and the final determination.

10. Changes in the certification period.
11. Document any special circumstance issuance.
12. Program inquiries/directives from Central office.
13. Reasons for any delays in case processing.
14. The household's voluntary request for a denial or discontinuance.
15. Document that the KI-HIPP program was explained.
16. Document whether or not an MRT is to be completed.
17. How Medicare was verified.
18. Patient Liability Worksheet was completed for LTC cases and scanned into ECF.]

As with ALL programs, DO NOT editorialize, offer personal opinions, or air disagreements in case notes. DO NOT include names of Central Office personnel, regional management, program specialists, or any supervisory staff when specific case mandates are received. Case notes are a part of the official case record, which is subject to review by supervisory staff, Central Office, Quality Control, Management Evaluation staff, the Hearings Branch, Department for Medicaid Services (DMS) staff, individuals, and their legal counsel.

MS 1435

PROCESSING SPECIAL CIRCUMSTANCES

(1)

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

A. Situations when the special circumstance function is used:

1. To authorize a retroactive special payment to correct an administrative error on a denied or discontinued case;
2. To correct MA eligibility for prior months not issued through regular issuance;
3. To issue a vendor payment for an inactive case; and
4. To correct patient liability for an active or an inactive case on Worker Portal.

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

C. Special circumstance actions will pend for supervisory approval.

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

E. Supervisors cannot initiate a special circumstance action.]

MS 1440

[ELECTRONIC CASE FILE

(1)

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

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

1. A signed application for each eligibility period when an electronic or voice signature is not used;
2. Income verification;
3. Resource verification;
4. Documentation and verification of technical and financial eligibility;
5. Hearing information that cannot be found in correspondence;
6. Information regarding overpayments and underpayments;
7. Any additional pertinent information or verification; and
8. Information regarding Quality Control review.]

MS 1450 ONGOING/RETROACTIVE MEDICAID (1)

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

A. ONGOING ELIGIBILITY

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

1. The 1st day of the month;
2. For Medicaid Works recipients, coverage begins effective the date of application. There is no retroactive coverage.
3. The specific day during the 3-month period spend down liability is met.
4. The 1st day of the month the applicant has established permanent residence in Kentucky, if the applicant has moved to Kentucky from another state.

B. RETROACTIVE ELIGIBILITY

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

1. Medical services must be received during the 3 months prior to application. If the applicant states medical services were not received, document in comments and DO NOT authorize retroactive coverage.
2. If medical services were received, determine if technical, resource, and income eligibility exists for each of the 3 months prior to application. If technical, resource, and income eligibility exists:
 - a. In each of the 3 prior months, authorize coverage effective the 1st day of the 3rd month prior to the month of application.
 - b. In months medical services were received but income eligibility does not exist, determine spend down status for the months medical services were received.
 - c. In one or two of the months, authorize coverage only for the months eligibility exists and medical services were received.
- C. Document the case record to indicate the method used to establish months of coverage and that the applicant was given an explanation of retroactive Medicaid coverage.

MS 1470 STANDARD OF PROMPTNESS (1)

[The Department for Medicaid Services (DMS) determines time frames for Medicaid eligibility determinations. The Department for Community Based Services (DCBS) is contracted by DMS to determine eligibility for individuals using the policy and procedures set by DMS. All applications must be processed within 30 days of the date of application.

- A. The 30-day time frame allows the individual time to establish a Qualifying Income Trust (QIT) if required, and return any requested information, including copies of trusts and annuities.

All applications or reapplications must be acted upon promptly. Verification must be processed by the task due date. No more than 30 days should elapse between the application date and the approval or denial action date.

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

1. Delays in receiving the Level of Care (LOC). Worker Portal will pend up to 90 days for the LOC if all other verification is provided.
2. Waiting for an annuity or trust review to be completed by the Office of Legal Services (OLS);
3. Delays in receiving disability determinations from the Medical Review Team (MRT);
4. The individual, or Authorized Representative (AR), requests more time to provide mandatory verification that they are having difficulty obtaining.
 - a. When additional time is requested, ask how much additional time is needed. Extensions cannot be allowed for more than 15 days per request and may not exceed more than 30 days total. A case cannot pend for longer than 60 days from the application date. The individual must explain what action they have taken to obtain the mandatory verification. Document thoroughly in Case Notes.

Example: The AR returns all requested verification except the life insurance policy. He calls on the 23rd day and states that he requested the policy 2 weeks ago but hasn't received anything yet. He contacted the insurance company today and they assured him that it should be going out soon. He asks if he can have an additional 10 days to turn it in.

- b. Do not allow an extension if all other verification has not been returned and/or additional time is requested less than 5 calendar days before the Request for Information (RFI) due date. Requests for additional time cannot be made at application, however workers should explain

at application that if additional time is required, it must be requested 5 days prior to the RFI due date.

- c. If an extension is allowed, change the RFI Due Date in Worker Portal so an RFI will be issued with the new due date.
- d. Allow the case to deny if:
 - 1) An extension is not requested timely, OR
 - 2) The individual did not take action to get the verification timely, OR
 - 3) The maximum extension has been allowed.

- 5. Delay in receiving the Medicare Explanation of Benefits (EOB) for Spend Down cases;
- 6. Income, resources, or other information requiring clarification or verification is discovered when processing the case. Enter the information in Worker Portal to generate a new RFI. Ensure the individual has at least 10 days to return the requested information.

Example: Bank statements are provided to verify an individual's checking account. It is discovered when reviewing the bank statements that the individual has paid for a life insurance policy. Verification of the life insurance should be requested and an RFI should be generated.

- 7. A program inquiry was requested timely but a timely response is not received from the Medical Support and Benefits Branch (MSBB) (document in Case Notes).

To ensure that processing timeframes are met, send program inquiry requests to MSBB on a daily basis through the regional chain of command and respond to all follow up questions or requests from MSBB as soon as possible.

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

- 1. If all verification is received before the 30th day, the case must be processed prior to the 30th day.
- 2. If verification is not received before the 30th day, and the individual has not requested additional time, Worker Portal will deny the case on the 30th day or the first workday following the weekend or holiday.

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

MS 1500

[PASSIVE AND ACTIVE RENEWALS

(1)

All Medicaid cases must be recertified every 12 months to ensure that the recipient continues to meet technical and financial eligibility requirements. The renewal process begins on the 1st day of the month prior to the renewal month and is completed through either the passive or active renewal process. For example, the renewal process will begin July 1st for Medicaid cases with a certification end date of August 31st.

Worker Portal will determine if Medicaid cases meet the criteria to be passively renewed. A passive renewal does not require an individual to take any action, including completing an interview or form, to initiate the renewal of their Medicaid benefits. If a case does not meet the criteria, the case must be actively renewed and Worker Portal will issue form EDB-087, Renewal for Medical Coverage, to initiate the active renewal process. Interviews are not required for passive or active renewals. This applies to all Non-MAGI Medicaid, including Medicare Savings Program.

If the case must be actively renewed, the individual has the option to complete the Medicaid renewal in-person, by phone, or by logging into the Self-Service Portal (SSP). An interview is not required for passive/active renewals or for a renewal completed on SSP. However, an interview is required if the renewal is initiated or completed in-person or by phone.

A. Medicaid cases will be passively renewed if:

1. The head of household has not opted-out of ongoing data checks;
2. All income and resources in the case meet the reverification requirements for passive renewal (see D below);
3. Everyone in the case can be passively renewed. If any individual does not meet passive renewal criteria, the entire case must be actively renewed;
4. The case is not a three month Pass Through renewal; and
5. The case is not in change, intake, or reinstate mode.

B. Passive Renewal Process:

1. Worker Portal interfaces with Eligibility Advisor (EA) to verify liquid resources. If successful, the case is disposed and the renewal is completed without worker or client intervention. If resources require verification, a Request for Information (RFI) is issued giving the individual until the end of the renewal month to provide the required verification. Medicaid benefits will discontinue at the end of the renewal month if verification is not provided.
2. Passive renewals will not be completed if the passive renewal process is interrupted. An interruption to the passive renewal process may occur if a change is completed during the renewal period, or if the member attempts to initiate the renewal via SSP. If the process is interrupted the renewal will not revert to an active renewal as cases eligible for active renewal must be identified in the month before the renewal month. Workers should take care not to interrupt the renewal process. However, if a renewal is interrupted they must contact the member and complete an interview.

Example: Mark reports to DCBS that he has a savings account. A case change is initiated; however, his case is being passively renewed. Since the change interrupted the passive renewal process, the case will not renew. The worker must contact him for a phone interview so that the renewal can be completed.

3. The passive renewal process is completed within 7 days. The completion of the process is indicated by a change in the certification dates with issuance of an approval notice or by the generation of an RFI.

C. Active Renewal Process:

If a case cannot be passively renewed, Worker Portal issues form EDB-087 on the 1st day of the month prior to the renewal month. The completed form EDB-087 is due the last workday of the renewal month. When the renewal form is uploaded to the Electronic Case File (ECF), a document processing task is generated. Any forms received on or before the 15th of the renewal month must be entered by the 15th. If a renewal is not initiated on Worker Portal by the 15th of the renewal month, form EDB-088, Renewal Reminder Form for Medical Coverage, will be issued.

1. If any information entered on the renewal form is missing, unclear, or if the form has not been signed, the renewal must still be entered on Worker Portal. The individual must be contacted to clarify any unclear information. If the individual cannot be reached, or if verification is required, pend the case and issue an RFI ensuring that all required information is requested.
2. If all verification is provided, run eligibility and dispose the case. Worker Portal will automatically update the certification period.
3. If the renewal is initiated on or before the 15th of the renewal month, and verification is not provided with the renewal form an RFI is system generated giving the individual until the last day of the renewal month to provide the required verification. Medicaid benefits will automatically discontinue at the end of the renewal month if verification is not provided.
4. If the renewal is initiated after the 15th of the renewal month, the RFI due date will be 30 days from the date initiated. Although the case will pend beyond the renewal month, Medicaid will not be issued for the following month until the renewal is completed.

Example: Terri's renewal month is July and she returns form EDB-087 on July 20th. Verification of resources is required to determine ongoing eligibility and an RFI is generated with a due date of August 19th. The case remains pending and in Renewal Mode, but no Medicaid coverage is issued for August until verification is returned and the renewal is processed.

5. If the case discontinues correctly, a new application is required.
6. Never use the Reinstate or Reactivate function for cases that discontinue at renewal regardless if the discontinuance is correct or due to agency error.

Workers must always use the Add/Reapply function on the Case Summary screen for cases that discontinue at renewal.]

D. Reverification Requirements for Income and Resources

1. The following types of income require verification at renewal; any cases with these types of income will not be passively renewed:
 - a. Pension/Retirement
 - b. Earned income (wages, self-employment, etc.)
 - c. Worker's Compensation
 - d. Unemployment Insurance Benefits
 - e. Mineral Rights/Royalties
 - f. IRA Distribution
 - g. Dividends
 - h. Alimony/Spousal Support
 - i. Child Support
 - j. Friends or Family Contributions
 - k. Military Retirement
 - l. Loans
 - m. Oil Leases
 - n. [Participant Directed Services (PDS)]
 - o. Trust Income
 - p. Interest
 - q. Capital Gains
 - r. Other

2. The following types of income do not require verification at renewal. If these are the only types of income in the case, the case may be passively renewed if it meets all other criteria:
 - a. RSDI
 - b. Railroad Retirement
 - c. VA Pension or Compensation
 - d. Black Lung
 - e. LTC Insurance Payments (regardless who receives payment)
 - f. Annuity Payments
 - g. Indemnity Policy
 - h. Reverse Mortgage Payments
 - i. In-kind Income
 - j. Taxable State Tax Refund
 - k. Lottery Payments
 - l. Insurance Settlement Payments
 - m. U.S. Refugee Program
 - n. AmeriCorps

3. The following resources require verification at renewal. Cases with these types of resources will not be selected for passive renewal:
 - a. Whole Life Insurance
 - b. Modified Term Life Insurance

- c. Nursing Facility Resident Account
 - d. Direct Express Card
 - e. Reloadable Money Card
 - f. Individual Development Account
 - g. Stocks
 - h. Bonds
 - i. Mutual Funds
 - j. Oil Rights
 - k. Mineral Rights
 - l. Other
 - m. Liquid Asset Type of Other
 - n. Other Investments
4. The following resources do not require verification at renewal. If these are the only types of resources in the case, other than liquid assets, the case may be passively renewed if it meets all other criteria:
- a. Vehicles
 - b. Non-home Real Property
 - c. Reverse Mortgage
 - d. Term Life Insurance
 - e. Pre-arranged Funeral Contract
 - f. Burial Reserves
 - g. Life Estate
 - h. Annuity
 - i. Trust
 - j. Promissory Note
 - k. Land Contract
 - l. Deferred Payment Loan
 - m. Home Equity Line of Credit
 - n. Lifetime Care Agreement
 - o. Life Settlement Contract

MS 1510 TIMELY NOTICE OF DECREASE/DISCONTINUANCE (1)

[If information in a Medicaid (MA) case indicates reduction or discontinuance of benefits for any or all members in a case, the client must be notified of the proposed action 10 calendar days prior to the effective date, unless one of the exceptions to the timely notice requirement listed in C below applies. This 10-day timely notice period is referred to as adverse or negative action.

A. Worker Portal sends a notice for all negative actions. If the system issued notice has an incorrect denial, discontinuance, or negative change reason, immediately send manual form MA-105, Notice of Eligibility or Ineligibility, to inform the recipient of the correct negative action reason. Scan form MA-105 to the Electronic Case File (ECF) prior to sending.

B. Case changes which reduce or discontinue benefits are effective the next administratively feasible month.

1. Changes processed prior to the monthly adverse action date are effective the first day of the following month.

Example: Sue reports an increase in income on 10/5. The change is processed on 10/9 and Worker Portal determines that Sue is over the income limit and her MA discontinues. Because the change was processed prior to adverse action, the change will be effective 11/1.

2. Changes processed after the monthly adverse action date are effective the first day of the month after the following month.

Example: Bob reports an increase in income on 10/13. The change is processed on 10/23 and Worker Portal determines that Bob is over the income limit and his MA discontinues. Because the change was processed after adverse action, the change will be effective 12/1.

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

1. When death of a recipient has been verified.
2. When the recipient has moved out of state or it has been verified that assistance has been applied for or approved in another state.
3. When the recipient is under age 65 and enters a tuberculosis hospital or is between ages 21 and 65 and enters a mental hospital.
4. When a recipient requests discontinuance by a signed statement.
5. When the Spend Down or emergency time limited MA period ends. The recipient received notice at the time of approval that the case would discontinue at the end of time limited period.
6. When a State Supplementation recipient enters a Long Term Care (LTC) facility.]

MS 1530 REASONS FOR NEGATIVE ACTION (1)

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

A. Financial reason:

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

B. Technical eligibility does not exist:

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

C. Failure to comply with technical requirement:

1. Failure to fully complete or return application forms;
2. Failure to keep an appointment for an interview; including an OIG interview;
3. Failure to provide sufficient information or clarify conflicting information so that a determination of eligibility could be made;
4. Failure to provide birth verification;

5. Failure to explore eligibility for entitled benefits, e.g., Veterans Benefits, Railroad Retirement Benefits, pensions, IRA distributions, Black Lung Benefits, Social Security Benefits, etc.; or
 6. Disqualified, no extraordinary circumstance.
- D. Failure to meet patient status.
- E. Other reasons, including:
1. Request of individual or formal withdrawal;
 2. Inability to locate;
 3. Change of agency policy; or
 4. Individual is not a resident of Kentucky.]

MS 1540

MISREPRESENTATION AND FRAUD

(1)

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

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

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

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

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

MS 1547 RECIPIENTS MOVING INTO OR OUT OF KENTUCKY

[Worker Portal is designed to prevent individuals from receiving duplicate benefits within the state of Kentucky. Worker Portal does not have the functionality to prevent duplicate benefits for individuals who move into Kentucky and have received out-of-state benefits or for individuals who move out of Kentucky and apply in their new state of residence.

In order to avoid overlapping Medicaid (MA) eligibility for individuals or households who move into or out of Kentucky follow these procedures:

A. Take the following actions for individuals applying for Medicaid who received Medicaid in another state:

1. Contact the other state to determine the effective date of discontinuance;
2. Document thoroughly in Case Notes; and
3. Deny the application for the months already issued in the other state. Since KY Medicaid is issued for whole months, any partial month of eligibility must be issued by a special circumstance. Forward any requests for partial month MA issuance to MSBB through your regional chain of command.

Example: Bill applies for Medicaid on September 5. His previous state of residence has advised that the effective date of discontinuance will be September 10 and so the first day of potential eligibility in Kentucky is September 11. Deny the application for the month of September and approve ongoing benefits beginning October 1. Send a request to MSBB through the regional chain of command to issue benefits for September 11 through September 30.

B. Take the following actions for individuals who have active Medicaid and report moving out of Kentucky:

1. Enter the individual's new address, update residency, and dispose eligibility; and
2. Document thoroughly in Case Notes.

C. Supplemental Security Income (SSI) Recipient Moving Into Kentucky:

SSI recipients who move from another state into Kentucky and require medical services can receive Medicaid based on the following:

1. SSI and MA eligibility is on Worker Portal; or
2. The Social Security Administration (SSA) verifies to MSBB that eligibility exists. Send the recipient's name and social security number (SSN) to the program specialist who will then forward to MSBB. MSBB will contact SSA and request form MAP-527, Authorization for Initial Medical Card, to verify eligibility. If eligibility is verified, MSBB will issue the coverage.

- D. Individuals from other states who need information regarding MA should be referred to Medicaid Member Services at 1-800-635-2570.
- E. If the individual is unable to obtain MA coverage in another state because Kentucky has issued MA coverage for a specific month, they may request an immediate termination of Kentucky MA. Refer out-of-state individuals requesting immediate termination of MA to Medicaid Member Services at 1-800-635-2570.

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

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 (1)

Each individual (including children) applying for Medicaid must provide their Social Security Number (SSN). The Federal HUB will verify each individual's SSN with the Social Security Administration (SSA).

- A. If an individual has an SSN, but refuses to provide it or does not meet one of the acceptable exemptions below, that individual will be ineligible for Medicaid. If the individual does not have an SSN or it is not verified, the individual is temporarily approved and given 90 days to provide verification.
- B. The following are acceptable exemption reasons for not providing an SSN:
 - 1. Religious objections;
 - 2. [Immigrant status; or]
 - 3. Only issued an SSN for valid non-work reasons.
- C. Those individuals not seeking coverage for themselves, but who are included in the applicant's household, are not required to provide an SSN.
- D. Failure to comply with enumeration requirements means:
 - 1. Refusal to provide or apply for a SSN;
 - 2. Failure to apply for a SSN; or
 - 3. The member fails to supply documentation required for completion of form SS-5 without good cause. As long as a good faith effort is being made to provide the SSN, good cause exists for failing to provide the number.
- E. Worker Portal will exclude members, other than a deemed eligible newborn, who fail to comply with enumeration requirements.

The excluded household member becomes eligible upon providing the Agency with a SSN, or applying for a SSN, if otherwise eligible.
- F. Good cause criteria for non-cooperation with enumeration requirements are as follows:
 - 1. If the household member, based on religious grounds refuses to provide an SSN, the member has good cause for failing to comply.
 - 2. If the household member is unable to provide documentation necessary for completing form SS-5, such as out-of-state birth records, the member has good cause for failing to comply as long as a good faith effort is being made to obtain the documentation.

MS 1562 [APPLICATION FOR SOCIAL SECURITY NUMBER

When completing an application, if an individual has not yet applied for a Social Security Number (SSN), assist with completing form SS-5, Application for a Social Security Card. If an individual verifies they have applied for an SSN with the Social Security Administration (SSA), do not complete form SS-5.

Note: If an individual has questions about changing the SSN for an adopted child, refer them to the SSA.

Form SS-5 is available on the SSA website at: <https://www.ssa.gov/forms/>. When completing form SS-5 for a member, obtain verification of the individual's date of birth, identity, and citizenship. Acceptable verification sources are outlined on form SS-5. Review enumeration procedures as outlined on form SS-5 to ensure all SSN application procedures are followed.

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

Send completed form SS-5 along with original verification documents within a week to the Regional or District SSA office serving the specific county, unless the applicant wishes to submit the application themselves. SSA is responsible for returning original verification to the applicant.

Please note that SSA requires a face-to-face interview for all individuals age 12 or over applying for their first SSN card.]

MS 1568*

USE OF THE SSN

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

- A. Access BENDEX information regarding individuals who currently receive K-TAP, MA, or State Supplementation benefits and receive benefits under Title II of the Social Security Act (RSDI);
- B. Access the State Data Exchange (SDX), to determine if any household member is currently receiving SSI income and the amount;
- C. Access other computer files available to the Department, e.g., IEVS, UI, etc.; and
- D. Prevent duplicate participation and determine the accuracy and/or reliability of other income information given by households, e.g., wage records.

MS 1570 [CITIZENSHIP AND IDENTITY VERIFICATION REQUIREMENTS (1)

All individuals must verify citizenship or lawful presence as a qualified immigrant as specified in [MS 1577](#) as a technical eligibility requirement when applying for Medicaid (MA). Immigrants currently in this country on a temporary visa, including students and tourists, may be eligible for Emergency Time-Limited Medicaid. For more information on Emergency Time-Limited Medicaid refer to, [MS 1578](#).

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

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

These citizenship and identification procedures have no effect on Medicaid eligibility determinations for qualified immigrants per procedures outlined in [MS 1577](#).

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

1. The following individuals are not required to verify citizenship or identity:
 - a. Deemed eligible newborns under age 1;
 - b. Emergency Time-Limited Medicaid applicants;
 - c. SSI individuals;
 - d. Medicare recipients;
 - e. Foster care children;
 - f. Subsidized adoption Title IV-E children; and
 - g. RSDI recipients receiving benefits based on disability.
2. All other individuals must present verification of citizenship. The document must be original and show a U.S. place of birth or that the person is a U.S. citizen. First look for verification of citizenship from the primary tier, Tier 1. If verification cannot be obtained from Tier 1, look into subsequent tiers for possible acceptable forms of verification. When verification of citizenship is obtained from tiers 2, 3, 4, or if notarized statements are used, verification of identity must also be provided. If verification of identity is required, the verification must be an original document.

The following are the tiers of acceptable verification.

- a. Tier 1 (highest reliability)

Acceptable primary documentation for identification and citizenship may be one of the following:

- (1). A U.S. Passport;

- (2). A Certificate of Naturalization (DHS Forms N-550 or N-570); or
- (3). A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).

b. Tier 2 (satisfactory reliability)

Acceptable secondary documentation to verify proof of citizenship:

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

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

Acceptable third-level documentation to verify proof of citizenship:

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

d. Tier 4 (lowest reliability)

Acceptable fourth-level documentation to verify proof of citizenship:

- (1). Birth records of citizenship filed with Vital Statistics within five years of the birth; or
- (2). Federal or State census record showing U.S. citizenship or a U.S. place of birth for persons born 1900 through 1950. The applicant or worker completes Form DC-600, Application for Search of Census Records and Proof of Age. In remarks, state U.S. citizenship data requested for Medicaid eligibility. This form is on the U.S. Census website at <http://www.census.gov>; or

- (3). Institutional admission papers from a nursing home, skilled nursing care facility or other institution that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth; or
- (4). A medical (clinic, doctor, or hospital) record created at least 5 years before the initial Medicaid application date that indicates a U.S. place of birth unless the application is for a child under age 5; or
- (5). Indian tribal records. Forward this type verification to the Medical Support and Benefits Branch for approval by the Department for Medicaid Services.

e. LAST RESORT

- (1). Notarized statements may be accepted for citizenship verification only when no other documentation is available. Naturalized citizens are permitted to utilize this process as well.
- (2). Procedures are as follows:
Written notarized statements MUST be signed under penalty of perjury, from two individuals of which only one can be related;
 - i. These two individuals MUST have personal knowledge of the events establishing the applicant's claim of citizenship. At least one statement must contain information regarding why other documentation is not available;
 - ii. The person signing the notarized statement must provide proof of his/her own citizenship and identity.

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

1. Individuals who provide acceptable primary documentation from Tier 1 have met the identification technical requirements for MA.
2. Individuals who verify citizenship by documentation items listed in Tiers 2, 3 or 4, as well as those signing notarized statements for applicants, must also provide proof of identification. Acceptable original documentation to verify identity consists of the following:
 - a. Current state driver's license bearing the individual's picture or state identity document with the individual's picture; or
 - b. Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document; or
 - c. Other official documentation issued by the state in which the individual resides; or
 - d. The use of three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas, and employer ID cards; or
 - e. Data matches or documentation from other agencies which include:
 - (1). SNAP (for head of household only);
 - (2). Child Support;
 - (3). Law enforcement;
 - (4). Correctional agencies, including juvenile detention;
 - (5). Division of Motor Vehicle records;

- (6). Expired driver's license – unless questionable;
 - (7). Protection and Permanency documentation, including materials relating to child protection; or
 - (8). Other official documentation issued by local, state or federal governments from the individual's place of birth or residence.
- f. The facility director or administration may attest to the identity for disabled individuals in a residential care facility.
 - g. An affidavit or notarized statement signed under penalty of perjury by a parent or guardian attesting to the child's identity for children age 16 or older.
- C. Identification for children age 16 or younger may be documented by one of the following:
1. School identification card with a photograph;
 2. Military dependent's identification card if it contains a photograph;
 3. School record that shows date and place of birth and parent(s) name;
 4. Daycare or nursery school record showing date and place of birth;
 5. Form KIP-106, Attestation of Identity, can be generated and used to verify the identity of children under the age of 16 applying for Medicaid, when no other proof of identity is available.

Note: Form KIP-106 can only be generated at application, case change, or recertification.

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

MS 1575 PROCESSING CITIZENSHIP VERIFICATION (1)

[To meet citizenship requirements for Medicaid (MA), individuals age 19 or older must be a citizen of the United States or a qualified immigrant. Children age 18 and under need only be lawfully present. All individuals must verify citizenship or lawful presence when applying for MA.]

- A. If an individual attests they are a citizen of the United States, but does not have appropriate verification at the time of the interview [MS 1570](#), enter Client Statement as the Citizenship Verification source and Worker Portal will attempt to verify citizenship through the Federal Hub. If the individual's citizenship is verified by the Federal Hub, no additional verification is required.
- B. If citizenship is not verified by the Federal Hub, eligibility for Medicaid will be approved for up to 90 days, if otherwise eligible. An RFI is issued with a 90 day due date.
 - 1. If an individual returns verification of citizenship, enter the appropriate verification source on the Citizenship screen in Worker Portal.
 - 2. Do not deny, delay, reduce, or terminate benefits for a period of up to 90 days from the initial application for benefits. If the member is removed from case but provides verification that they are making a good faith effort and the delay in obtaining the documentation is beyond their control, issue eligibility for missed months of coverage once verification is received.
 - 3. If verification of citizenship is not provided or is insufficient, benefits are terminated the next administratively feasible month following the end of the 90 days. If the individual reapplies, they are not allowed another 90 days. Verification of citizenship is required before ongoing Medicaid eligibility may be approved.
- C. Individuals applying for a Spend Down are allowed the 90 days to return verification of citizenship. The application is processed if otherwise eligible and the individual is attempting to obtain satisfactory citizenship verification. If the case is inactive when verification is received, scan to the Electronic Case File (ECF) for future applications as the individual is not allowed another 90 days to provide verification.
- D. Applications on behalf of a deceased individual are not allowed the 90 days to provide verification of citizenship as the individual is not being denied access to services while the documentation is obtained.
- E. Individuals who are receiving Medicare Part A, Medicare Part B, or who are conditionally enrolled in (or are entitled to enroll in Medicare Part A) are not required to verify citizenship as they have already provided this information to the SSA.

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

MS 1577 CRITERIA FOR QUALIFIED IMMIGRANTS (1)

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

[Note: Pregnant women who meet qualified immigrant criteria are not subject to the 5-year date of entry ban and can receive Medicaid in one of the pregnancy Types of Assistance (TOA) before exploring Emergency Time-Limited Medicaid eligibility.]

A. The following qualified immigrants are subject to the 5-year date of entry ban and cannot receive Medicaid (except for emergency time-limited MA, see [MS 1578](#)) until they have remained in qualified immigrant legal status for at least 5 years from their date of entry into the United States:

1. Immigrants lawfully admitted for permanent residence ON or AFTER August 22, 1996;
2. Immigrants paroled in the U.S. under Section 212(d) (5) of the Immigration and Nationality Act (INA) for a period of one year. If U.S. Citizenship and Immigration Services (USCIS) document I-94 indicates the individual will be in U.S. for at least 1 year, eligibility may potentially start after parolee status is granted;
3. Any individuals listed in item B(6) below that have a final, non-appealable, legally enforceable order of deportation or exclusion entered against them; they are NOT eligible under the provision listed below in B(6).
4. Immigrants who are battered or subjected to extreme cruelty in the U.S.
 - a. Either as an adult or as a child if battered or subjected to extreme cruelty by:
 - (1). A spouse or a parent of the immigrant without the active participation of the immigrant in the battery or cruelty; or
 - (2). A member of the spouse or parent's family residing in the same household as the immigrant and the spouse or parent consented to the battery or cruelty;
 - b. The battered individual must:
 - (1). No longer reside in the household with the individual responsible for the battery or cruelty;
 - (2). Have a substantial connection between the battery or cruelty and the need for the benefit; and

- (3). Have been approved or has a petition pending for:
 - i. Status as a spouse or child of the U.S. citizen;
 - ii. Status as a permanent resident immigrant;
 - iii. Suspension of deportation status pursuant to Section 244(a)(3) of the INA.B

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

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

B. The following qualified immigrants are not subject to the 5-year ban and may receive Medicaid from their date of entry:

1. Children under the age of 19 who meet qualified immigrant criteria OR are lawfully present;
2. Immigrants lawfully admitted for permanent residence before August 22, 1996;
3. Afghan and Iraqi immigrants who are granted special immigration status under Section 1059 of the National Defense Authorization Act (NDAA) of 2006 or Section 1244 of the NDAA of 2008 are treated in the same manner as refugees admitted under Section 207 of the Immigrations and Nationality Act. These Iraqi and Afghan immigrants served as translators for the U.S. military. This special immigration status also applies to their spouses and unmarried dependent children. The law applies to Afghan and Iraqi immigrants who were already in the U.S. with special immigration status on the effective date of the law, December 19, 2009, and who enter on or after that date.
4. Refugees who were admitted under Section 207 of the Immigration and Nationality Act (INA) and asylees who were granted asylum under Section 208 of the INA.

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

5. Children under the Child Citizenship Act of 2000, who automatically acquire citizenship on the date that all of the following requirements are satisfied:
 - a. At least one parent is a U.S. citizen whether by birth or naturalization;

- b. The child is under 18 years of age; and
- c. The child is residing in the United States in the legal and physical custody of the citizen parent pursuant to a lawful admission for permanent residence.

Note: The parent can apply for a Certificate of Citizenship by filing Form N-600. They can also apply for a U.S. passport. If the applicant has other documentation that verifies the parent to the child is a U.S. citizen, such as the child's birth certificate or the parent's birth certificate, this can be used and the Certificate of Citizenship is not necessary.

- 6. Immigrants who are verified by the Office of Refugee Resettlement (ORR) to be victims of human trafficking, and eligible relatives. Refer to Volume I, MS 0562.
- 7. Immigrants granted status as a Cuban and Haitian entrant (as defined by Section 501(e) of the Refugee Assistance Act of 1980) whose I – 94 is annotated with the word "refugee".

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

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

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

- 8. Immigrants granted status as a Cuban or Haitian refugee who present an I-551 with a category status of 'CU6' (for Cuban refugee), 'HA6' (for Haitian National paroled under Haitian Refugee Fairness Act), or 'RE6' (Refugee who entered the U.S. on or after Apr. 1, 1980);
- 9. Immigrants admitted as an Amerasian immigrant under Section 584 of the Foreign Operations Export Financing and Related Programs Appropriation Act of 1988 (letter coded AM-1, AM-2, AM-3, AM-6, AM-7 and AM-8);
- 10. Immigrants whose deportation is being withheld (I-94 annotated with the words political asylees) under Section 243(h) of the INA or after April 1, 1997, the renumbered Section 241(b) of the INA;

11. Permanent resident immigrants who are veterans honorably discharged for reasons other than immigrant status, their spouses or unmarried dependent children;
 12. Permanent resident immigrants who are on active duty, other than active duty for training in the Armed Forces of the United States and fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d), their spouses or unmarried dependent children;
 13. Immigrants who are granted conditional entry pursuant to Section 203(a) (7) of the INA as in effect prior to 4/1/1980;
- C. Immigrants designated as PRUCOL, permanently residing under color of law, are NOT eligible for Medicaid (except for emergency time-limited MA, see [MS 1578](#)).
- D. The unqualified immigrants may receive for their children if the children are citizens or qualified immigrants.

MS 1578 EMERGENCY TIME-LIMITED MEDICAID (1)

Individuals who do not meet citizenship or qualified immigrant requirements for ongoing Medicaid (MA), may be eligible for Emergency Time-Limited MA if they have an emergency medical condition. This includes individuals currently in this country on a temporary visa, including students. Individuals present with a tourist or visitor visa do not meet residency requirements and are not eligible for Emergency Time-Limited MA.

- A. [All technical and financial requirements for Medicaid, with the exception of enumeration, must be met to be eligible for Emergency Time-Limited coverage.]
- B. Individuals applying for time-limited MA due to an emergency medical condition are exempt from enumeration requirements.
 - 1. Enter the Social Security Number (SSN) if provided, but do not require the individual to apply for an SSN if they do not have one.
 - 2. If the individual has no SSN, Worker Portal will assign a pseudo number.
- C. An emergency medical condition is defined as a medical condition in which the absence of immediate medical treatment could result in:
 - 1. Placing the patient's health in serious jeopardy;
 - 2. Serious impairment to bodily functions; or
 - 3. Serious dysfunction of any bodily organ.
- D. Verify the emergency medical condition by obtaining a written statement from the medical provider. The statement must contain the following:
 - 1. Information about the medical condition;
 - 2. The date of the emergency treatment; and
 - 3. Specific language that the medical provider considers the condition an emergency medical condition.

Note: If the statement is lacking information or the information is unclear, contact the medical provider for additional information or clarification. All clarifying information not included in the original written statement must be documented thoroughly in case notes.

- E. An ongoing chronic medical condition does not constitute an emergency medical condition. In order to be considered as having an emergency medical condition, the individual must have an emergency and receive treatment for that emergency. For example, having cancer does not qualify as having an emergency medical condition. However, if an individual visits the emergency room or is hospitalized then that may be considered an emergency medical condition. After the individual receives Emergency Time-Limited MA, they may be eligible for an extension. For more information on extensions refer to [MS 1579](#).

- F. Emergency Time-Limited MA coverage includes the first day of the month in which the emergency medical condition begins and continues through the following month.
- [G. The emergency medical condition must have occurred in the month of application or within the 3 months prior to application.]
- H. The normal delivery of a baby is considered an emergency medical condition and the following conditions apply:
1. The MA eligibility only covers the month of delivery and the following month;
 2. The individual is not eligible for postpartum coverage; and
 3. The newborn is considered deemed eligible.
- I. Emergency Time-Limited MA coverage does not include coverage for:
1. An organ transplant procedure, or
 2. Long Term Care including nursing facility, waiver services, or Hospice.
- J. There is no Emergency Time-Limited MA coverage in the Spend Down or KCHIP Medicaid categories.
- [K. Individuals approved for the initial two months of Emergency Time-Limited MA, may be eligible for an extension. For information regarding Emergency Time-Limited MA Extensions, refer to [MS 1579](#).]

MS 1579 EXTENSION OF EMERGENCY TIME-LIMITED MEDICAID (1)

[A recipient may request an extension of Emergency Time-Limited Medicaid (MA) once the initial 2-month Time-Limited coverage has been issued if the emergency medical condition continues. The Department for Medicaid Services (DMS) reviews, and makes a determination on all extension requests.

- A. The individual must apply within 30 days of the end of the initial coverage and submit an updated physician's statement verifying the emergency event is an ongoing condition. If an updated statement is not provided at the time of application, generate a Request for Information (RFI) requesting one.
- B. The new statement must contain detailed information of the recipient's emergency medical condition including the medical provider's estimate of how long the emergency medical condition will continue. A copy of the provider's previous statement is not acceptable. Scan the updated statement to the Electronic Case File (ECF) and generate a task for DMS to review.
 - 1. The extension request is entered on Worker Portal on the Emergency Medical Condition screen
 - 2. A task is generated to DMS to review the extension request when the worker answers "Yes" to the question, "Is Emergency Extension Requested?" The DMS Evaluation Status will update to "PE" for pending.
- C. DMS reviews the documentation and completes the task. Based on their determination, the DMS Evaluation Status changes to either "AP" for approved or "DE" for denied. Worker Portal automatically disposes eligibility once DMS completes the review.
 - 1. Approved extensions will be for a specified number of months as determined by DMS. The Coverage Through field in the Emergency Details section on the Emergency Medical Condition screen displays the effective dates of the approved coverage.
 - 2. If the extension is denied, review the Comments field in the Emergency Details section on the Emergency Medical Condition screen for the denial reason.
- D. Individuals may request as many additional extensions as needed. However, all extensions must be requested within 30 days of the last coverage and an updated physician's statement must be provided with each extension request.]

MS 1580

RESIDENCY

(1)

An individual must be a resident of Kentucky and intend to remain in order to be eligible for Medicaid. However, the individual does not have to live in the state for any specified amount of time to be considered a resident. Kentucky residents who are temporarily absent are considered residents as long as they state they intend to reside in Kentucky. Example: An individual is out of state for college, military, vacation, etc.

A. Individuals are considered residents if they:

1. Live in Kentucky with intent to remain or for an indefinite period;
2. Have moved to Kentucky seeking employment, with or without a job commitment; or
3. Live in Kentucky and are:
 - a. Incapable of stating intent; or
 - b. Blind or disabled and under 21 years old.

B. Institutionalized individuals must meet residency requirements.

1. The state of residence for individuals under age 21, who reside in an institution, including a personal care home (PCH), is:
 - a. The state where the parent or legal guardian lives at the time of placement; or
 - b. The state where the person lives who files the application, if the individual has been abandoned by his or her parents, does not have a legal guardian, and is institutionalized in that state.
2. For the institutionalized or PCH individual who is age 21 or older who became incapable of indicating intent prior to age 21 the state of residence may be that of the parent, or guardian when parental rights have been terminated, applying for Medicaid on the individual's behalf, if the parents reside in separate states.
3. For the institutionalized or PCH individual who became incapable of indicating intent at or after age 21, the state of residence is the state in which the individual is physically located, unless another state made the placement.

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

1. If there is reason to believe that an applicant is residing in the state on a temporary basis, the worker is to thoroughly question the individual and document the case record regarding the individual's statements of residency.
2. Immigrants who are legally present in the U.S. with a valid visa, such as students and tourists, DO NOT meet state residency requirements due to the time-limited status of their stay in the state/country. These immigrants are identified by the following types of INS documentation:
 - a. Form I-185, Canadian Border Crossing Card;
 - b. Form I-186, Mexican Border Crossing Card;
 - c. Form SW-434, Mexican Border Visitor's Permit;
 - d. Form I-95A, Crewman's Landing Permit; and
 - e. Form I-94, Arrival-Departure Record with letter codes A through L. The letter code indicates the entry status and has a number after it (e.g., B-2, H-3, etc.).

The following list defines the specific letter codes:

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

Undocumented immigrants and immigrants 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 they reside in the state and declares intent to remain in the state or for an indefinite period of time.

- D. Do NOT deny Medicaid because the individual:
1. Has not lived in the state for a specified period;
 2. Did not establish residence in the state before entering an institution;
or
 3. Does not maintain a fixed or permanent address.
- E. In cases of disputed residency, where two or more states cannot resolve which the state of residence is, the state of residency is the state where the individual is physically located.

- [F. Medicaid eligibility is not affected by residence in a Spouse Abuse Center.
- G. Medicaid for individuals placed in another state by the Department for Medicaid Services (DMS) does not discontinue due to residency. 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.

However, when a competent individual leaves the facility where they were placed by a state, they become a resident of the state in which the individual is physically located.

Example: Stanley has been placed in a facility in Indiana by DMS due to a facility closure in Kentucky. Although Stanley is physically located in Indiana, for Medicaid purposes Stanley is considered a resident of Kentucky and still meets residency requirements for Medicaid.]

Individuals housed in a prison, county jail, or detention center full-time are considered to be incarcerated for Medicaid purposes. These individuals are eligible for Medicaid while incarcerated and may even submit an application during this time. However, Medicaid *will not* pay for any services the individual incurs as the institution is responsible for providing their medical care. An incarceration suspension must be created to suspend the individual's managed care enrollment until they are released.

[A. The following individuals are NOT considered to be incarcerated.

1. Individuals residing in a halfway house;
2. Individuals on house arrest or home incarceration;
3. Individuals still serving their sentence that have been temporarily released from jail or prison. This is also known as a furlough;
4. Individuals sentenced to weekend jail or work release.

NOTE: These individuals are eligible for Medicaid and do not require an incarceration suspension. However, any expenses incurred while incarcerated are the responsibility of the institution.]

- B. Client statement is accepted for verification of non-incarceration status, unless there is sufficient reason to doubt.
- C. Enrollment in a Managed Care Organization (MCO) is suspended when a new record is created on the Living Arrangement screen in Worker Portal to show that the individual is incarcerated. The creation of this suspension terminates the individual's MCO enrollment.

The suspension is ended when a new record is added to the Living Arrangement screen, such as "In-Home," to show that the individual has been released and is now in another living arrangement. Reenrollment in an MCO becomes effective the day of the new living arrangement start date.

Example: Jon is released from incarceration on 10/25 and has an active Medicaid case. His incarceration status was reported by his Authorized Representative (AR) and an incarceration suspension was created. When a new record is added to the Living Arrangement screen his suspension is ended. He is reenrolled in his MCO effective 10/25.

- D. Incarcerated individuals are eligible for Medicaid to pay for services if they are hospitalized for more than 24 hours. This coverage is issued by MSBB in Central Office. Any inquiries regarding Medicaid coverage for incarcerated individuals who have been hospitalized should be sent to MSBB through the regional chain of command.

MS 1630

EMERGENCY SHELTER

[When an individual, or family, is temporarily staying in a public institution while awaiting a placement appropriate to their needs, they are potentially eligible for Medicaid. These public institutions are referred to as emergency shelters and are generally somewhere for an individual to live when they cannot live in their previous residence.

- A. Incarcerated individuals are not considered to be living in an emergency shelter. This includes those who are serving a jail/prison sentence, awaiting trial, or is in a public detention facility because of a delinquent or status offense. For more information on incarceration, refer to [MS 1600](#).
- B. Individuals or families in an emergency shelter are eligible for Medicaid if the following criteria is met:
 - 1. The individual or family group are residents of emergency shelters no more than 6 months in any 9 month period; and
 - 2. The individual or family group is otherwise eligible when outside the emergency shelter. Eligibility must have existed immediately prior to admittance to the shelter or must exist immediately after leaving the shelter.
- C. Take appropriate case action when the individual or family reports they have left the shelter.]

MS 1660 THIRD PARTY LIABILITY (TPL) (1)

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

A. At each Application, Renewal, and Case Change:

1. Explain the following to the individual:

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

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

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

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

a. Types of health insurance that must be recorded include

- (1) Health maintenance plan;
- (2) TRICARE; and
- (3) Employer sponsored health insurance plans or any other private health insurances.

b. Types of insurance that should not be recorded include:

- (1) Medicare, If the individual has Medicare, enter it on the Medicare Details Screen;
- (2) Long Term Care insurance. Refer to [MS 2220](#) for more information on Long Term Care Insurance.

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

4. Review the TPL requirements with the individual and add a new record to the Third Party Liability screen to record the individual's response.]
5. Redetermine eligibility if the Department for Medicaid Services (DMS) reports resources received from insurance settlements, etc.

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

6. If it is determined the individual no longer has health insurance or has obtained health insurance since the last case action, enter the end date on Worker Portal.

B. Refusal to Cooperate:

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

1. Supplemental Security Income (SSI) individuals. Non-cooperation with TPL requirements DOES NOT affect eligibility for the SSI payment but does affect eligibility for the receipt of Medicaid. Refer to [MS 4730](#).
2. Individuals who fail to file a claim on Long Term Care Insurance policies held by the applicant or spouse that would assist in the payment of the individual's care.

C. Good Cause for Refusing to Cooperate:

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

1. The applicant and spouse are estranged; therefore, the applicant is unable to provide the requested TPL information; or
2. Due to a physical and/or mental impairment of the applicant, the TPL information cannot be provided.

MS 1695

KI-HIPP OVERVIEW

(1)

Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) is an optional program that provides reimbursement for employer sponsored health insurance (ESI) premiums for qualified Medicaid members and their families. KI-HIPP may also provide reimbursement for premiums for coverage offered by the Consolidated Omnibus Budget Reconciliation Act (COBRA), United Mine Workers, and retiree health plans. The KI-HIPP program is administered by the Department for Medicaid Services (DMS); however, DCBS assists in entering health insurance information in Worker Portal, initiating KI-HIPP applications, and scanning documents returned by members.

A. Who is eligible:

1. Individuals who have access to or are enrolled in a health insurance plan. The policyholder does not have to be Medicaid eligible; however, at least one individual on the plan must be eligible for Medicaid.
2. The Medicaid member must be eligible for a KI-HIPP approved health insurance plan. If the member is not enrolled in a plan, KI-HIPP staff will determine if an available plan is eligible for KI-HIPP enrollment.
3. The health insurance plan must be cost effective and comprehensive. This is determined by KI-HIPP staff, not the DCBS worker.
4. Below are the Non-MAGI Types of Assistance (TOA) that are potentially eligible to receive KI-HIPP benefits:

TOA	Category
ABDM	Non-SSI Regular Medicaid
PTCC	Pass Through- Correct and Concurrent
PTEW	Pass Through-Disabled Early Widow(er)s or Disabled surviving Divorced Spouses
PTDC	Pass Through- Disabled Adult Child
MAWR	Medicaid Works
SSIR	Regular SSI Medicaid
EXPT	Exparte

Note: Individuals do not have to be receiving in a KI-HIPP eligible TOA for a KI-HIPP application to be initiated.

B. During the interview, ask individuals if they have access to or enrollment in health insurance. If an individual reports access or enrollment the following should be completed in Worker Portal:

1. Answer "Yes" to the question "The individual is enrolled in or has access to a health insurance?" on the Third Party Liability screen; and
2. Enter health insurance information on the Health Insurance Policy screen. Information entered on this screen determines if a KI-HIPP program notice is issued to the policyholder.

Note: Do not enter Medicaid or Medicare coverage on the Health Insurance Policy screen.

- C. Explain the KI-HIPP program to individuals who are employed full-time or report access to a health insurance plan during the interview;
1. Document in Case Notes that the KI-HIPP program was explained.
 2. DCBS is responsible for issuing a new KYHealth card if a KI-HIPP member requests a replacement.
 3. Refer individual's questions regarding the program to the Kentucky Healthcare Customer Service line at 855-459-6328.
- D. What happens after the member is enrolled in KI-HIPP:
1. The member's Managed Care Organization (MCO) enrollment is terminated effective the last day of the KI-HIPP approval month.
 2. KI-HIPP members may elect to receive premium reimbursement via check or Direct Deposit. Form KI-HIPP-63, Direct Deposit Authorization Form, is completed when an individual opts for direct deposit. A task is created for the KI-HIPP Team when the form is scanned into the Electronic Case File (ECF).
 3. KI-HIPP members must send in verification of premium payment(s) to KI-HIPP staff. This verification may be turned in through the following methods:
 - a. [Uploading documents via kynect benefits Self-Service Portal (SSP);]
 - b. Emailing documents directly to KI-HIPP staff at KIHIPPProgram@ky.gov;
 - c. Bringing documents into a DCBS office; or
 - d. Mailing documents to KI-HIPP at:

CHFS KI-HIPP Unit
275 East Main Street, 6C-A
Frankfort KY 40621

Note: If KI-HIPP documentation is returned to the local office, DCBS is responsible to scan into ECF under the appropriate KI-HIPP document category so that a task is created for the KI-HIPP Team.

4. The health insurance premium is reimbursed directly to the policyholder. Frequency of reimbursement is dependent upon how often the premium is paid by the policyholder, and when the member provides verification of premium payment.
5. Individuals approved for KI-HIPP remain eligible for Medicaid benefits as long as all other technical and financial criteria is met. Medicaid is the payer of last resort for KI-HIPP individuals.

MS 1700 [AGED/BLIND/DISABLED (1)

Individuals must meet the technical eligibility requirement of being aged, blind, or disabled in order to be eligible for Non-Modified Adjusted Gross Income (Non-MAGI) Medicaid (MA).

- A. To receive MA as an aged individual, the applicant must be age 65 or older. If there is reason to doubt an applicant's age, request verification. Use any reasonably authentic document to verify age, such as birth certificate, passport, Social Security Administration (SSA) or Medicare records, etc.
- B. To receive MA as a blind individual, the applicant must meet the Medicaid definition of blindness. Medicaid uses the SSA definition of blindness which is, "central visual acuity of 20/200 or less in the better eye with the use of a correcting lens."

If an individual has not been determined blind by SSA, submit a referral to the Medical Review Team (MRT). A determination of blindness by SSA or MRT is required for all MA applications based on blindness. Follow the same procedures for obtaining an MRT determination of disability as outlined below.

- C. To receive MA as a disabled individual the applicant must meet the Medicaid definition of disability. Medicaid uses the SSA definition of disability which is, "the 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."
- D. Disability can be established by a field determination or by the completion of an MRT referral.
 - 1. A field determination of disability can be made if:
 - a. Retirement, Survivors, Disability, Insurance (RSDI) or Railroad Retirement benefits based on disability are received;
 - b. The individual has End Stage Renal Disease;
 - c. Life-Time payments from workers compensation are received;
 - d. SSI was received during any portion of the 12 months prior to their application with DCBS, provided the SSI discontinuance was due to income or resources and not due to no longer being disabled. Always review the Payment Status Code on SDX to determine why SSI was terminated. If field determination of disability is made, submit an MRT referral for a disability determination at the next recertification;
 - e. MA eligibility is requested only for the month of death;
 - f. SSA has established disability but entitlement is pending due to the 5-month durational requirement on some disabilities. View notification establishing entitlement;
 - g. Disability has previously been determined by MRT, Hearing Officer, Appeal Board or Circuit Court and decision states no reexamination is necessary;

- h. Division of Disability Determination Services (DDS) has made a determination of disability which includes the MA application date and the onset of disability date if needed for retroactive months; or
 - i. A copy of the favorable hearing decision from SSA, Bureau of Hearings and Appeals is presented.
2. The receipt of the following cannot be used to make a field determination of disability and a MRT referral is required.
 - a. Receipt of Black Lung;
 - b. Receipt of Veteran's Administration (VA) benefits (even if 100% disabled);
 - c. Teacher's Retirement Disability; or
 - d. An SSI determination of presumptive eligibility.
3. An MRT referral is not appropriate if an individual is potentially eligible for RSDI or SSI. Refer these individuals to SSA for a disability determination.
 - a. Individuals with income and resources below the SSI standard must apply for SSI.
 - i. Worker Portal will issue form PA-5.1, Report Or Referral To The District Social Security Office, referring an individual to SSA to apply for SSI.
 - ii. Individuals can receive Medicaid in the MAGI ADLT category while waiting an SSI determination, if eligible.
 - iii. If the individual is denied SSI due to income or resources, then complete an MRT referral.
 - iv. Children alleging disability are not considered to be within the income and resource limit for SSI if parental income is above 159% of the federal poverty level (FPL). Complete the MRT referral.
 - b. Individuals who are potentially eligible for RSDI must apply, as it is an entitled benefit. Refer to [MS 1353](#) for RSDI eligibility guidelines.
4. Once the MRT request is completed on Worker Portal, a task is generated for MRT staff to complete the disability determination. Once a determination has been made, a task is generated for a worker to take appropriate action based on MRT's decision.
5. If statutory benefits, such as RSDI, 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 an MRT Referral and continue eligibility until the MRT decision is received.]

MS 1750 ALLOCATIONS, ALLOWANCES, AND STANDARDS (1)

The Type of Assistance an individual receives, or applies for, determines which allocations, allowances, and standards are used to determine eligibility for Non-MAGI Medicaid.

A. Personal Needs Allowance (PNA)

1. [Nursing Facility (NF) is \$40 (this amount does not change)

Note: For an institutionalized SSI recipient's PNA, refer to [MS 3350](#).]

2. Institutionalized Hospice is \$40 (this amount does not change)
3. [Waiver Services is \$2,849 (effective 1/1/2024)

B. Community Spouse Resource Allowance

1. Minimum is \$30,828 (effective 1/1/2024)
2. Maximum is \$154,140 (effective 1/1/2024)]

C. Community Spouse Income Allowance

1. Minimum is \$2,465 (effective 7/1/2023)
2. [Maximum is \$3854 (effective 1/1/2024)]

D. Community Spouse Minimum Shelter Allowance is \$740 (effective 7/1/2023)

E. Family Member Income Allowance is \$2,465 (effective 7/1/2023)

F. Blind or Disabled Child Allocations (effective 1/1/2024)

1. [Ineligible sibling allocation is \$472
2. Parental allocation
 - a. Unearned income (or combination of earned and unearned income)
 - 1) One Parent is \$963
 - 2) Two parent is \$1,435
 - b. Earned income
 - 1) One parent is \$1,971
 - 2) Two parent is \$2,915

G. Special Income Standard is \$2,829 (effective 1/1/2024)

H. Supports for Community Living (SCL) standard is \$5,658 (effective 1/1/2024)]

MS 1770 [APPLICANT WITH A SPOUSE (1)

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

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

1. Living apart due to institutionalization of 1 spouse.

a. Eligibility determination for the institutionalized spouse:

(1) Income:

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

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

(2) Resources:

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

b. Eligibility determination for the community spouse:

(1) Income:

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

(2) Resources:

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

2. Living apart due to reason other than institutionalization:
 - a. In the month of separation, treat spouses as living together. Consider income and resources of both spouses according to [MS 2610](#) and [2620](#).
 - b. Beginning the month after the month of separation, consider only the income and resources of the out-of-home spouse that are actually contributed to the spouse who is applying.]

MS 1810 BLIND OR DISABLED CHILD LIVING WITH PARENTS (1)

[Relative responsibility rules apply in the financial eligibility determination for a blind or disabled child under age 19 and living with parents. Please note: children living with parents but receiving waiver services or Hospice are considered separated the month after the month of admission, refer to MS 1820.

All countable resources of the parent and the child are considered when determining resource eligibility. Income eligibility for a blind or disabled child living with parents is determined as follows:

- A. Parental income is adjusted using the following steps to determine how much of the parental income is counted in the blind or disabled child's Medicaid (MA) eligibility determination.
 1. Income deductions, (\$20 general exclusion and/or \$65 & ½ as appropriate) are allowed from income of the parent(s) according to [MS 2480](#) to determine their countable income.
 2. Parental allocations are deducted from the countable income of the parent(s) as follows:
 - a. If the parent or parents have unearned income only, the parental allocation for unearned income is deducted.
 - b. If the parent or parents have earned income only, the parental allocation for earned income is deducted.
 - c. If the parent or parents have a combination of earned income and unearned income, they only get the parental allocation for unearned income.
 - d. If there are two parents in the home, the parental allocation for two is used, even if only one has income.
 - e. The ineligible sibling allocation is allowed for each ineligible sibling under age 18 living in the home with the blind or disabled child. If the ineligible sibling has income, that income is subtracted from the ineligible sibling allocation to determine how much of the sibling allocation will be deducted from the parental income.
3. If any parental income is left after appropriate deductions and allocations, it is counted in the blind or disabled child's eligibility determination.
- B. Income deductions are allowed from the blind or disabled child's income according to MS 2480 to determine his/her countable income.
- C. The countable income of the blind or disabled child is added to any remaining parental income. The result is compared to the MA Scale for one when determining the blind or disabled child's eligibility.]

MS 1820 BLIND OR DISABLED CHILD LIVING APART FROM FAMILY

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

- A. For the month of separation and retroactive MA eligibility consider resources and income of the parent.
 1. Allow appropriate income deductions from the income of the parent according to [MS 2480](#).
 2. Deduct from income of the parent:
 - a. Income as needed to raise the siblings' income to the maximum ineligible sibling allocation. Allow a separate deduction for each ineligible sibling under age 18 living in the home. If application is made for more than one blind or disabled child in the same family, hospitalized or institutionalized, allow allocation of parental income to the ineligible siblings living in the home in each case;
 - b. The maximum parent allocation for unearned income only, or a combination of unearned income and earned income;
 - c. Up to the maximum parent allocation for earned income only;
 - d. If there are two parents in the home, use the parent allocation for two, even if only one of the parents has the earned or unearned income; and
 - e. See [MS 1750](#) for parental and sibling allocation maximums.
- B. Consider total resources and income of the child.
 1. Allow appropriate income deductions from the income of the child according to [MS 2480](#);
 2. Combine the deemed income of the parent and the countable income of the child;
 3. Allow verified incurred medical expenses of the parent, sibling, and the child; and
 4. Use the MA Scale for one in the eligibility determination.
- C. After the month of separation consider only the child's resources and income, including any continuing contribution, and compare to the MA Scale for one.

MS 1850 OVERVIEW OF RESOURCES (1)

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

Resources must be verified and documented in the case as to whether they are countable or excluded. Obtaining verification of resources is the applicant's responsibility unless the total combined client stated resource amount passes reasonable compatibility or can be verified by an online data source, such as Eligibility Advisor (EA). Scan all resource verification into the Electronic Case File (ECF), including results from EA if used as verification.

- A. Verify and document resources at the initial eligibility determination:
 - 1. For the application month;
 - 2. For the prior 3 months if retro eligibility is requested; and
 - 3. For the month of application and prior 3 months for all long term care applications.
- B. All resources must be verified at application. However, the following types of resources are not required to be verified at renewal if no change in the resource is reported.

Vehicles	Non-home real property	Reverse Mortgage
Term Life Insurance	Pre-arranged Funeral Contract	Burial Reserves
Life Estate	Annuity	Trust
Promissory Note	Lifetime Care Agreement	Land Contract
Life Settlement Contract	Deferred Payment Loan	Home Equity Line of Credit

- C. If the individual reports a transfer of resources or there are questionable transactions, additional verification should be requested as appropriate. Additional verification may also be requested if it appears the individual has had an increase in or has spent down resources as this may indicate a transfer of resources has occurred. For more information on transfers of resources, refer to [MS 2050](#).

NOTE: If the total countable resource value is near the resource limit, workers must make the applicants/recipients aware, and remind them of the requirement to report all changes in circumstances timely.

- D. When a resource is sold, the proceeds from the sale are not considered income but a change in the type of resource. It must be determined whether the proceeds are considered as a countable or excluded resource.

- E. Reasonable compatibility is performed at intake, renewal, and case changes to determine if the total combined countable resources in the case are below the resource limit for the non-MAGI Medicaid Type of Assistance (TOA).

Note: Reasonable compatibility for Non-MAGI Medicaid only applies to resources. This is different from reasonable compatibility for MAGI Medicaid which applies to income. For more information on reasonable compatibility for MAGI Medicaid, refer to Volume IVB MS 3000.]

MS 1860

RESOURCE LIMITS

(1)

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. If a child under age 18 lives with one parent, \$2,000 of the parent's total countable resources does not count.
2. If a child under age 18 lives with two parents, \$3,000 of the parents' total countable resources does not count.
3. Any resources over the parents' limits are countable as part of the child's \$2,000 resource limit.

Note: After the month of separation for waiver, or other long-term care, only consider the child's resources when determining eligibility.]

D. Medicaid does NOT recognize prenuptial agreements. Include all resources in a prenuptial agreement in the total combined resources for the Medicaid applicant/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 applicant/recipient is resource eligible for the month if total countable resources are equal to, or less than, the limits when an application or recertification is processed.
- H. The applicant/recipient 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 applicant/recipient is resource eligible for the month of discontinuance or denial, if reapplication is made and resources are reduced at or below the resource limit during the month without transfer of resources to establish eligibility.

MS 1880

EXCLUDED RESOURCES

(1)

Excluded resources are assets not counted in the Medicaid (MA) eligibility determination. Resources may be excluded because they are inaccessible, earmarked for a specific purpose, or due to the source of the asset. Some resources are excluded for a limited amount of time while others may be excluded entirely. Workers must review all resources thoroughly and compare to the list of excluded resources below to determine how the resources should be entered in the case.

When an excluded resource is sold, the proceeds are not considered income, but a change in the type of resource. It must be determined if the proceeds are a countable or excluded resource.

The following resources are excluded:

A. Homestead Property

1. Homestead property is excluded in the eligibility determination for Medicaid, Medicare Savings Program, and State Supplementation.
2. If an individual is institutionalized in a Long Term Care (LTC) facility, such as a Nursing Facility (NF), the homestead property is excluded for 6 months from the admit date unless:
 - a. A spouse or dependent family member lives in the home;
 - b. There is a verified reasonable effort to sell the property at FMV; or
 - c. The member states intent to return home.
3. Exclude proceeds from the sale of a home, or insurance payments from the loss of a home, for 3 months from the date the proceeds were received if the intent is to use them to purchase another home.

Refer to [MS 1975](#) for more information regarding homestead property.

- B. Life estate interest in real estate property or other property, such as mineral rights or an oil lease. Refer to [MS 2055](#) for more information regarding life estates.
- C. Property being *purchased* by an applicant/recipient on a land contract.
- D. The first \$6,000 of equity value of non-home, income producing property whether or not it is used in a trade or business, if it is essential for self-support of the individual, spouse, or family group. The remaining equity value is a countable resource.

NOTE: If the individual is in a NF, income producing property cannot be considered essential for the self-support of that individual, as their support is being provided by the NF.

- [E. Household equipment, such as furniture or appliances, and personal effects, such as clothing, jewelry, musical instruments, or hobby materials.

NOTE: Items that were acquired or are held for their value or as an investment such as gems, jewelry that is not worn or held for family significance, coins, comic books

or other collectibles are countable resources. Acceptable verification of their current market value includes a recent sales slip, an appraisal of the item(s), or insurance coverage. Do not use insurance replacement value in lieu of current market value.]

- F. Equity value of all equipment (including tools, machinery, etc.), livestock, or other inventory used in a farming or self-employment enterprise.
- G. A vehicle if used by the spouse, for employment, as a home, to obtain medical treatment, or is specially equipped for the disabled.
 - 1. Exclude \$4,500 from the total value of non-excluded vehicles.
 - 2. Recreational vehicles are counted in their entirety unless excluded for one of the reasons above.
- H. Lump sum back payments from Supplemental Security Income (SSI) and/or Retirement, Survivors, Disability Insurance (RSDI) are excluded for the first 6 months following the month of receipt. Deduct current month's benefits from the back payment prior to determining the excluded resource amount. At the end of the 6 month period, consider any remaining amount as a countable resource.
- I. All resources of an SSI recipient.
- J. Retirement plans, such as IRAs, KEOGH plans, deferred compensation, tax deferred retirement plans and other tax deferred assets are excluded from consideration as a resource; however, regular withdrawals, such as monthly, quarterly, or yearly disbursements, are considered as other unearned income.
- K. An individual development account (IDA) up to a total of \$5,000, plus accrued interest.
- L. ABLE accounts (known as STABLE accounts in Kentucky) are excluded in their entirety regardless of which state the account is located.
- M. Burial space items such as conventional gravesites, crypts, mausoleums, urns, vaults, caskets, headstones, and opening and closing of the grave. Refer to [MS 2033](#).
- N. Term and burial life insurance policies. Refer to [MS 2036](#).
- O. Burial funds, if payable upon death only. Refer to [MS 2031](#).
- P. \$1500 from burial reserves for each member of the assistance group for the following assets set aside for burial such as cash, whole life insurance policies or prearranged funeral contracts without an irrevocable assignment. Refer to [MS 2031](#).
- Q. Interest on burial reserves, if allowed to accrue.
- R. The value of a prearranged funeral contract if:
 - 1. Funded by life insurance that has been irrevocably assigned to the funeral home;
or
 - 2. Funded by cash with an Irrevocable Funeral Trust Agreement

Refer to [MS 2037](#) for more information regarding prearranged funeral agreements.

S. Cash, check, etc. received to repair or replace a damaged, lost, or stolen excluded resource. Allow 9 months for the repair or replacement of the excluded resource and an additional 9 months, if requested and the individual shows good cause. Also exclude any interest that accrues while waiting for the repair or replacement of the item.

[T. Tax refunds, advanced tax credits, and Earned Income Tax Credit (EITC) payments for 12 months from the month of receipt.]

U. 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 Relocation subject to the treatment required by Section 216 of such Act.

V. All payments received from Agent Orange.

W. Payment for a medical or social service. Exclude as a resource in the month of receipt and the following month. The payment, or any remainder of the payment, is considered a resource if still held the second month following receipt.

Medical or social services include:

1. A medical expense not covered by insurance or MA;
2. A social service expense, such as drug counseling;
3. A reimbursement for a medical or social service bill the individual has already paid.

X. Disaster relief assistance.

Y. Resources which are inaccessible for 30 days or more. Require written verification of inaccessibility of the resource from the institution holding the resource.

Z. Refunds from a waiver provider made to a waiver recipient who was determined to be otherwise Medicaid eligible retroactively and should not have incurred a patient liability. This includes individuals who should have been previously determined eligible for Pass Through. There is no time limit to this exclusion.

AA. Energy Employees Occupational Illness Compensation (EEOIC). These payments must be kept separate and not comingled with other countable resources. Interest on the unspent EEOIC payment is a countable resource the month after receipt.

BB. Victims Compensation payments. Exclude completely for nine months any 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.

CC. LTC Partnership Insurance Program designated resources. For more information regarding LTC Partnership Insurance, refer to [MS 1885](#).

- DD. 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 Worker Portal. If the hemophiliac is resource ineligible for some other reason, pend the application and contact the Medical Support and Benefits Branch (MSBB) through your Regional Program Specialist for further instructions.
- EE. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.
- FF. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.
- GG. 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.
- HH. 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.
- II. Resources included in a Plan for Achieving Self-Support (PASS).
- JJ. The 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. Medicaid Qualifying Trusts must be reviewed by the Office of Legal Services (OLS).
- KK. VA Aid and Attendance payments are considered an excluded resource in the month of receipt and the following month. Afterward they are considered as a countable resource.
- LL. General Electric (GE) Retiree Reimbursement Accounts are used to reimburse an individual for eligible medical expenses. These payments are not considered income and are considered an excluded resource in the month received but are considered a countable resource in the following month.

MS 1885

LONG TERM CARE PARTNERSHIP
INSURANCE PROGRAM

(1)

[The Kentucky Long Term Care Partnership Insurance Program is designed to encourage individuals to purchase Long Term Care (LTC) insurance. The program is a partnership between the Department for Medicaid Services (DMS), the Department of Insurance (DOI), and private LTC insurance companies. Under this program, certain LTC insurance policies, known as Partnership policies, provide coverage of LTC costs to the consumer and may allow the consumer to qualify for Medicaid (MA) services for the cost of LTC without exhausting all their assets.

Not all LTC insurance policies are Partnership policies. LTC Partnership insurance policies have been certified by the DOI to meet inflation protection requirements. These policies are referred to as Partnership Qualified (PQ).

A. What PQ Policies Cover:

PQ LTC insurance policy holders are eligible for a "dollar for dollar" asset disregard during the Medicaid eligibility determination for benefits protected by their PQ policies. This means that for every dollar the insurance policy pays for an individual's LTC needs, a dollar of their resources can be excluded when an application is made for MA.

Example: John has a LTC Partnership Insurance policy that pays benefits of \$3,000.00 per month for a maximum of 36 months. He applies for MA when his insurance benefits are exhausted. His insurance paid \$108,000.00 for his care prior to his application for Medicaid; therefore, \$108,000.00 of his resources will be excluded when determining Medicaid eligibility. These assets will also be protected from estate recovery.

B. The Medicaid Application:

The applicant is not required to exhaust the full benefits of the PQ LTC policy prior to applying for Medicaid, however:

1. The date of application locks in the dollar amount of assets to be excluded as long as the application is approved;
2. The applicant must identify the assets to be protected when applying for MA; and
3. The individual cannot change their choice after Medicaid is approved.

Note: If an application is denied, the dollar amount of assets to be disregarded may increase if the client continues to use benefits from a PQ policy, and additional assets may be identified for disregard at the new application. A new statement of benefits is required.

Protected resources are not "locked in" until the application is approved.

C. Verification:

Require a copy of the PQ LTC insurance policy. The applicant will contact the insurance company for a Statement of Benefits Paid. This statement will verify the amount of benefits that have been paid by the PQ policy. Scan the documentation into the Electronic Case File (ECF).

D. Consideration:

Enter the policy information on Worker Portal. A task will generate to the Medical Support and Benefits Branch (MSBB) to review the documentation to ensure it is a Partnership policy. Once a determination has been made, a task will generate for a worker to take appropriate action.

E. Protected Assets when there is a Community Spouse:

Applicants are not required to choose which assets are protected when the Resource Assessment is completed. Instead, the terms of the PQ policy are evaluated after the completion of the Resource Assessment to determine which assets will be protected at Medicaid approval. In order for the applicant to understand their options, Resource Assessment requests with a PQ policy are handled as follows:

1. Complete a Resource Assessment on Worker Portal;
2. Ask the individual the amount of benefits paid by the PQ policy and inform the individual of the impact the benefits paid will have on the amount of resources to be spent down;
3. If the individual then opts to complete an application, proceed accordingly.

At application, review the Resource Assessment to determine which resources the institutionalized spouse wishes to protect. Remind the applicant that once resources are selected and the case is approved, choices cannot be changed. The dollar amount of assets to be protected is determined by the "Statement of Benefits Paid."

F. When PQ Policy Benefits Exceed the LTC Spouse's Share of Resources:

If the paid amount listed on the Statement of Benefits Paid exceeds the institutionalized spouse's share of resources, they can identify resources to protect that is greater than their share.

Example: Betty is a resident of a LTC facility and has exhausted her PQ policy benefits. Her spouse, Bob, applies for MA on her behalf. Bob verifies that he and Betty have \$250,000.00 total countable resources. Bob's half of their combined resources exceeds the maximum community spouse resource allowance. Bob provides a Statement of Benefits Paid to verify Betty's PQ policy has paid LTC benefits in the amount of \$140,000.00. The amount paid by the PQ policy

MS 1885

(3)

exceeds Betty's share of the resources by \$15,000.00 so Betty can identify up to \$15,000.00 of Bob's resources to protect, thereby reducing the amount of resources Bob has to spend down.

- G. Resources selected by the recipient as excluded assets are protected from estate recovery.
- H. If an application is denied, the applicant will continue to use their PQ policy benefits if they have not been exhausted. At the new application, a new Statement of Benefits Paid will be required.

Protected resources are not "locked in" until the application is approved.]

MS 1890

ANNUITIES

(1)

[An annuity is an investment from which an individual receives fixed payments for a lifetime or for a specified number of years. The Office of Legal Services (OLS) reviews certain annuities to determine how they should be considered for Medicaid (MA) eligibility. Once OLS has reviewed an annuity and provided the outcome, the annuity does not have to be reviewed again unless changes are made.

A. Pension annuities do not have to be reviewed by OLS as the principal of these annuities is never a countable resource and should not be entered on Worker Portal as annuities. Payments made from these annuities are considered unearned income and must be entered on the Unearned Income screen. The following are examples of annuities that do not require OLS review:

1. Any annuity designated as a Pension Account, including;

- a. United States Office of Personnel Management Annuities;
- b. New York Life Polyone Merged Pension Plan Annuities; and
- c. GE Retirement Services Annuities.

2. Any annuity designated as a Retirement Account; and

3. Any annuity designated as a Traditional Individual Retirement Account.

All other annuities must be reviewed by OLS.

B. Review the annuity, when provided, to ensure that that the entire annuity contract and any attachments are included. If any part of the annuity or attachments are missing, request the missing information. Scan the annuity documentation into the Electronic Case File (ECF). As a last resort the client can provide a statement from the Annuity Provider listing the following:

1. Owner;
2. Annuitant;
3. Beneficiary;
4. Date of purchase;
5. Date of annuitization (annuity date);
6. Initial Premium Amount; and
7. Cash Surrender Value (if applicable)

C. When the annuity details have been entered on the Annuity screen and the question "Document Provided?" is answered 'Yes', a task will generate for OLS to review the annuity.

1. When OLS completes the review, they will enter one of the following responses:

- a. Countable Resource;
- b. Excluded Resource;
- c. Consider as Income;
- c. Transferred Resource;

- d. Insufficient Documentation; or
 - e. This is not an Annuity.
2. Once OLS has entered the review outcome in Worker Portal, a *Process Review Outcome for Annuity* task will generate for a worker to take appropriate action based on the response entered in the Outcome field on the Annuity screen. The case will remain pending until a response is received from OLS, the worker completes the task, runs eligibility, and disposes the case.
 3. Questions concerning the status or results of an annuity review are directed to the Medical Support and Benefits Branch (MSBB) through the regional Program Specialist.
- D. Declaration of Annuities is required for all Long Term Care (LTC) applications, recertifications, and resource assessments, whether or not the individual has an annuity. The Declaration of Annuities screen is available on Worker Portal and the individual must indicate that they have disclosed all interest that they have in annuities. The individual must also indicate their willingness to name DMS as beneficiary for all annuities that were signed or annuitized on or after February 8, 2006.

The types of cases requiring Declaration of Annuities are:

1. LTC facilities, including:
 - a. Nursing Facility (NF);
 - b. Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);
 - c. Mental Health/Psychiatric Facility (for age 65 or older); and
 - d. Institution for Mental Diseases (IMD).
 2. Waivers, including:
 - a. Home and Community Based Services (HCBS);
 - b. Supports for Community Living (SCL);
 - c. Michelle P;
 - d. Model Waiver II; and
 - e. Acquired Brain Injury (ABI)/ABI LTC.
 3. Institutionalized Hospice
- E. For annuities owned by the applicant and signed on or after February 8, 2006, or those annuitized after that date, the Department for Medicaid Services (DMS) must be named as a beneficiary, after a spouse or minor/disabled child. For annuities owned by the community spouse, DMS is to be named before the institutionalized spouse. This also applies in situations where both spouses are institutionalized.
1. Example: An individual purchased an annuity on December 1, 2005, and it was annuitized at that time. It is not required that DMS be named beneficiary.

2. Example: An individual purchased an annuity on December 1, 2005, but it was not annuitized until February 15, 2006. DMS must be named as a beneficiary, after a spouse or minor/disabled child.
3. Example 3: An individual purchased an annuity on February 8, 2006. DMS must be named as a beneficiary, after a spouse or minor/disabled child.

Note: For individuals/community spouses who do not comply with adding DMS as beneficiary, the annuity will be considered a prohibited transfer of resources. For more information regarding transfer of resources, refer to [MS 2050](#).

- G. The Division of Program Integrity within DMS tracks the annuities for changes and the death of the applicant.]

MS 1900

LIFE EXPECTANCY TABLE

(1)

[2019 Period Life Table									
Exact	Life Expectancy		Exact	Life Expectancy		Exact	Life Expectancy		
Age	Male	Female	Age	Male	Female	Age	Male	Female	
0	76.22	81.28	40	38.74	42.76	80	8.43	9.83	
1	75.69	80.69	41	37.84	41.82	81	7.90	9.23	
2	74.72	79.72	42	36.94	40.88	82	7.39	8.65	
3	73.74	78.73	43	36.04	39.95	83	6.91	8.09	
4	72.76	77.75	44	35.15	39.01	84	6.44	7.56	
5	71.77	76.76	45	34.26	38.08	85	6.00	7.05	
6	70.78	75.77	46	33.37	37.16	86	5.57	6.56	
7	69.79	74.77	47	32.49	36.24	87	5.17	6.10	
8	68.79	73.78	48	31.61	35.32	88	4.80	5.67	
9	67.80	72.79	49	30.74	34.41	89	4.45	5.26	
10	66.81	71.80	50	29.88	33.50	90	4.12	4.88	
11	65.82	70.80	51	29.02	32.60	91	3.82	4.52	
12	64.82	69.81	52	28.18	31.71	92	3.54	4.20	
13	63.83	68.82	53	27.34	30.82	93	3.29	3.90	
14	62.85	67.83	54	26.51	29.93	94	3.06	3.63	
15	61.87	66.84	55	25.69	29.06	95	2.86	3.39	
16	60.89	65.85	56	24.89	28.19	96	2.69	3.17	
17	59.93	64.87	57	24.09	27.33	97	2.54	2.98	
18	58.97	63.89	58	23.31	26.48	98	2.40	2.81	
19	58.01	62.91	59	22.53	25.63	99	2.28	2.65	
20	57.07	61.93	60	21.77	24.79	100	2.16	2.49	
21	56.13	60.95	61	21.01	23.96	101	2.05	2.34	
22	55.20	59.98	62	20.27	23.14	102	1.94	2.20	
23	54.27	59.01	63	19.54	22.32	103	1.83	2.07	
24	53.35	58.04	64	18.81	21.51	104	1.73	1.94	
25	52.42	57.07	65	18.09	20.70	105	1.63	1.82	
26	51.50	56.11	66	17.37	19.89	106	1.54	1.70	
27	50.58	55.14	67	16.67	19.10	107	1.45	1.59	
28	49.66	54.17	68	15.97	18.31	108	1.37	1.48	
29	48.74	53.21	69	15.28	17.52	109	1.28	1.38	
30	47.83	52.25	70	14.59	16.75	110	1.21	1.28	
31	46.91	51.29	71	13.91	16.00	111	1.13	1.19	
32	46.00	50.34	72	13.25	15.25	112	1.06	1.10	
33	45.09	49.38	73	12.59	14.52	113	0.99	1.02	
34	44.18	48.43	74	11.95	13.80	114	0.92	0.94	
35	43.27	47.48	75	11.32	13.10	115	0.86	0.87	
36	42.36	46.53	76	10.71	12.41	116	0.80	0.80	
37	41.45	45.59	77	10.11	11.74	117	0.74	0.74	
38	40.55	44.64	78	9.54	11.08	118	0.68	0.68	
39	39.64	43.70	79	8.97	10.45	119	0.63	0.63	

Note: The period life expectancy at a given age for 2019 represents the average number of years of life remaining if a group of persons at that age were to experience the mortality rates for 2019 over the course of their remaining life.]

MS 1930

HOME EQUITY PLANS

(1)

[Home Equity Plans (HEP) allow homeowners to borrow against the equity value of their home. Payments from these loans are either received at one time in a lump sum or over a period of time. Additionally, some HEPs create a line of credit that the homeowner can continue to pay off and borrow against, like a credit card. Each HEP must be carefully reviewed to determine how it is considered for Medicaid purposes.

A. The four Home Equity Plans are:

1. DEFERRED PAYMENT LOANS (DPL) are one-time lump sum loans used to repair/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.
2. REVERSE MORTGAGES allow a homeowner to borrow some percentage of the appraised value of their home through a mortgage contract. 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 is not repaid until the homeowner dies, sells the home, or moves.
3. 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.
4. TIME SALE allows the homeowner to sign a contract to sell their home at death but keep the home's title and continue to live there. 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.

B. VERIFICATION. Copy of the Home Equity Plan such as a reverse mortgage, time sale, sale-leaseback, or loan.

C. 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, this is a conversion of resources, and the entire amount of the line of credit must be considered as a countable resource effective the month the line of credit becomes available. Additionally, review the home equity plan to determine whether any property debt should be considered.
2. If the money from the mortgage is paid to the Medicaid applicant/recipient as a lump sum payment and/or a down payment, consider the amount paid

MS 1930

(2)

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, do not meet the definition of a converted resource, but are considered as unearned income, according to [MS 2220](#).]

MS 1940

JOINTLY HELD RESOURCES

(1)

[Jointly held resources are resources owned or held by more than one person. Allow individuals the opportunity to rebut ownership if they state that they do not contribute to or withdraw from a jointly held resource, such as a checking or savings account, Certificate of Deposit (CD), savings bonds, etc. Enter joint ownership in Worker Portal on the appropriate resource screen and indicate the joint owners.

- A. Verify joint ownership by reviewing the bank statement, property deed, or other appropriate documents.
- B. Do not consider the placement of another individual's name on a checking or savings account to be a transfer of resources if the joint ownership is set up to only require one signature unless:

- 1. Action is taken by the added individual to withdraw funds from the account;

Example: Jane receives waiver services and has added her daughter, Linda, to her checking account so that Linda can grocery shop for her. This would not be considered a transfer of resources. However, it must be verified that the transactions completed by Linda were made for the benefit of Jane.

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

For jointly held resources, the 60-month look back period for the transfer of resources policy applies when any action is taken by the individual or any other party to reduce or eliminate the individual's ownership or control of the resources.

- C. When only one signature is required to withdraw funds from a joint account the total balance of the account is considered available to the individual.
- D. When more than one signature is required to withdraw funds from a joint account, only consider the individual's share as available. Establish shares by a signed statement from the other joint owner(s) as to the division of the resource. If the other owner(s) refuses to co-sign to make the resource available, do not count the resource. Obtain verification of the other owner's refusal to sign.
- E. If more than one of the account holders is an eligible individual, divide the funds equally among the eligible individuals when determining resource eligibility. This applies 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.
- F. For a business enterprise, if there are no predetermined allocation of shares, determine the individual's available share by dividing the value of the business enterprise by the number of owners.
- G. For jointly held resources other than checking/savings accounts and business enterprises, determine individual's share by dividing the value of the jointly

held resource by the number of owners unless it is specified that the individual owns a certain percentage.

Example 1: Sue and her two brothers inherited a piece of property from their father. The value of the property is divided by 3 to determine Sue's share of the property.

Example 2: Sally's mother left a \$10,000 CD to Sally and her two children. The will specified that $\frac{1}{2}$ the CD was for Sally and the other half was for the grandchildren. Sally's share of the CD is \$5,000 while each of the children get \$2,500.

- H. Do not consider a resource to be available when it is verified that 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 to release their portion.

Example: Tina and her brother Sam are joint owners of a camper. Sam provides a signed statement to verify that he does not wish to sell the camper because he likes to go camping. Since Tina cannot sell the camper without Sam's cooperation, it is excluded in Tina's eligibility determination.

- I. 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.
- J. In order for an individual to rebut the ownership of jointly held resources, the individual must provide:
1. A written statement from the applicant/recipient outlining who deposits and withdraws from a jointly held account;
 2. A written statement from each of the other joint account holders which confirms the individual's statement, unless the other 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 to the individual beginning the month their name is removed from the account.]

MS 1960 LIFETIME CARE AGREEMENT (1)

[Lifetime Care Agreements are agreements made with another individual or organization for the lifetime care of an individual or family in exchange for the resources of the individual or family.

A. Obtain a copy of the Lifetime Care Agreement from the organization or individual providing care. Review the documentation to determine whether the agreement is an actual Lifetime Care Agreement, or whether it is a personal caregiver agreement.

1. A Lifetime Care Agreement includes characteristics of an agreement made in which a resource(s) is transferred, such as property or a lump sum of money, to an individual or organization in exchange for caregiver services rendered over the individual's lifetime or an extended period.
2. A personal caregiver agreement includes characteristics of an agreement made in which an individual or organization receives payments, such as an hourly wage, in exchange for caregiver services. If the agreement is a personal caregiver agreement, not a Lifetime Care Agreement, refer to [MS 2070 C\(2\)](#) to determine whether a prohibited transfer of resources has occurred or whether an exception to a prohibited transfer exists. Personal caregiver agreements may also be referred to as caretaker agreements or personal care agreements.

Note: If the agreement is a personal caregiver agreement and not a Lifetime Care Agreement, do not enter on the Lifetime Care Agreement screen or request DMS to review the agreement.]

B. The Department for Medicaid Services (DMS) reviews all Lifetime Care Agreements and will advise on how the agreements are considered for Medicaid eligibility.

1. Once the Lifetime Care Agreement details have been entered on Worker Portal, a task will generate for DMS to review. Scan a copy of the agreement into the Electronic Case File (ECF).
2. Ensure that any attachments listed in the Lifetime Care Agreement are scanned to ECF. If any part of the agreement or attachments is missing, request the missing information from the individual.
3. Once DMS has entered the outcome of their review, a task will generate for a worker to take appropriate action based on that outcome.
4. Applications and recertifications should remain pending until a response is received.
5. Questions concerning the status of a Lifetime Care Agreement review are to be directed to the Medical Support and Benefits Branch (MSBB) through the regional Program Specialist.

- C. If resources are still available to the individual or organization with whom the agreement is made, the case is ineligible. If the individual or organization holding an agreement provides a written statement that the resources have been exhausted or reduced, compute current resources to determine if within the resource limit.

MS 1965* REASONABLE COMPATIBILITY (1)

Reasonable compatibility is performed at intake, active and passive renewal, and case change. Client reported resource values and the liquid asset verification from Eligibility Advisor (EA) are used when performing the reasonable compatibility test. If the total combined resources pass reasonable compatibility, a Request for Information (RFI) will *not* be generated for verification of liquid assets.

The reasonable compatibility test is performed when resources are verified by client statement.

- A. For active renewals, if a new liquid asset balance has not been reported within the last 90 days, in order for reasonable compatibility to be performed a new record must be entered using the previous balance and client statement as the source of verification.
- B. For passive renewals, if resource values do not pass reasonable compatibility, an RFI is generated.
- C. Spouses are treated as individuals for the reasonable compatibility test if one or both are institutionalized and resources have been separated. For jointly owned resources, the full value found in EA will be counted for each joint owner during the reasonable compatibility test.
- D. In order to pass reasonable compatibility, the total combined resources (in the case) must be below the resource limit for the Medicaid Type of Assistance (TOA).
 - 1. For cases with dually eligible individuals, the lowest resource limit among the different TOA's will be used.
 - 2. If an individual reports liquid assets and other resources which combined are under the resource limit, however EA reports a liquid resource amount over the resource limit, reasonable compatibility fails and an RFI is generated for both liquid resources and the other resources.
 - 3. If an individual reports liquid assets and other resources which combined are under the resource limit, and EA reports a liquid resource amount under the resource limit, reasonable compatibility is passed and no additional verification of liquid resources is required.
- E. If no EA data is found for the individual, an RFI will be generated.
- F. If an individual's resources pass reasonable compatibility but there is reason to doubt or the individual reports excess resources, a manual RFI must be issued in order to request the verification.

MS 1970

LIQUID ASSETS

(1)

[Liquid assets are cash on hand or other resources that can be readily converted into cash. Some types of liquid assets convertible to cash include, but are not limited to, checking accounts, savings accounts, cash cards such as Direct Express cards, Certificate of Deposit (CD), stocks, bonds, mutual fund shares, promissory notes, mortgages, and land contracts.

A. Consideration of Liquid Assets

1. Consider liquid assets in the non-MAGI Medicaid eligibility determination unless listed in [MS 1880](#) as excluded.
2. Do not consider the proceeds from the conversion or sale of any resource as income, but a change in the type of resource.

For example, Bob has savings bonds valued at \$3,000. Bob cashes the bonds. The resource type changed from a bond to cash. Do not consider the \$3,000 received as lump sum income.

3. The value of stocks, bonds, and mutual fund shares is based on market value on the day verified.
4. Consider promissory notes, loans, mortgages, and land contracts as resources, if salable or negotiable. For more information, refer to [MS 2220](#).
5. Consider interest received from interest bearing checking and savings accounts as a resource beginning the month after the month of receipt.
6. Consider both the principal and interest of a CD as a resource, if the interest is allowed to accrue and is not paid directly to the individual owner.

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

7. Consider certain cash payments received for medical or social services as a resource if still held the second month following receipt.
 - a. These cash payments are money (cash, check, specified fund) contributed to an individual from an agency or interested party for the specific purpose of paying for a medical expense not covered by insurance or Medicaid, 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.

For example, in January Bob received \$200 from his church to purchase eyeglasses. He deposits the money in his checking account. If Bob does not use the money, consider the \$200 a resource beginning in March.
 - b. Consider as a countable resource any reimbursements for medical or social service bills already paid by the individual.

For example, Bob purchased eyeglasses. His church reimbursed him \$200. Since Bob already paid for his eyeglasses, consider the \$200 as a resource.

8. Resources inaccessible for 30 days or more are exempt in the resource eligibility determination until they are accessible. This applies in situations when the individual is attempting to liquidate excess resources. Require written verification from the institution that the resource is inaccessible. This exclusion DOES NOT apply to life insurance policies.

For example, Bob reports he has \$3,000 worth of savings bonds in a safety deposit box at the bank. Bob lost his key. He provides verification from the bank that it will take 60 days to get a replacement key. Consider the bonds as inaccessible resources until Bob gets a replacement key.

9. A Medicare Set-Aside (MSA) account is a financial agreement that allocates a portion of a worker's compensation or personal injury settlement to pay for future medical services related to the injury, illness, or disease. Consider the value of Medicare Set-Aside accounts a countable resource. The recurring annual payments earmarked for the MSA are not considered income and are not countable when determining Medicaid eligibility. These accounts can be verified by a financial document or contract.
10. Consider the value of mineral and oil rights a countable resource.

B. Verification of Liquid Assets

1. The following are acceptable sources of verification for resources:
 - a. Eligibility Advisor (EA);
 - b. Statements from banks or other financial institutions;
 - c. Account printouts from the bank or the bank's website;
 - d. Stock certificates;
 - e. Copies of bonds;
 - f. Financial instruments, such as contracts; or
 - g. Other sources of documentation such as dated ATM receipts.

Note: ATM receipts are only allowed if no other documentation is obtainable. The ATM receipt must have a legible date and may only verify account balances for the month dated. The account holder must sign the ATM receipt.

2. Check Eligibility Advisor at every application and recertification for declared or undeclared resources. Refer to [MS 1971.](#)]

MS 1971

ELIGIBILITY ADVISOR (EA)

(1)

[Eligibility Advisor (EA) is an automatic asset verification service that can be used to verify identity, liquid assets, and property. Additionally, EA verifies employment and income through The Work Number. Eligibility Advisor searches for bank accounts and property records nationwide and provides results for the prior 5 years.

Staff must NEVER use EA to obtain information on themselves, family members, or acquaintances.

- A. Eligibility Advisor must validate identity prior to returning verification of assets or income. Workers must click on the EA link and select the individual's name from the drop down. If unable to validate identity, EA will not verify liquid assets, property, or income.

EA uses information contained in an individual's credit history to verify identity and residency. If an individual does not have a credit history (such as a child) then EA will not be able to validate identity.

- B. Eligibility Advisor can verify the following liquid assets:

1. Checking Accounts;
2. Savings Accounts;
3. Certificates of Deposit (CD); and
4. Individual Retirement Accounts (IRA).

Liquid assets within EA are updated on the first of each month and should be used to verify that month's account balance. No further verification should be requested unless there is reason to doubt. Additionally, Eligibility Advisor indicates if the individual receives a direct deposit into their account for income from the Social Security Administration (SSA) only. EA does not provide the amount of income direct deposited, so verification is required to exclude this income from the resource total. For policy regarding liquid assets, refer to [MS 1970](#).

Note: EA may verify that an individual has bank accounts, but not return account balances. In these situations, request appropriate verification.

- C. Eligibility Advisor can verify real property that is owned or has been purchased, sold, or transferred. The property files on EA are updated weekly, but how current the information is dependent upon how quickly the Property Valuation Administrator (PVA) and County Clerk's Office processes property transactions and updates its records. Workers must review all property records returned by EA. Additional verification must be requested from the individual if the information returned is incomplete (i.e. the market value is not populated), if the individual disputes the results returned, or if the results are unclear. Workers must

document thoroughly in case notes regarding any clarifying verification obtained from the PVA or County Clerk's Office.

- D. Effective 2/6/17, Eligibility Advisor is used to complete the bank and property check for all Long Term Care (LTC) types of care subject to transfer of resource policy. Please refer to the following when completing the bank and property check:
1. If the individual states they have no property and EA returns no property, no further verification is needed.
 2. If the individual states they have no bank accounts and EA returns no banks accounts, no further verification is needed.
 3. If the individual reports a bank account(s), but EA returns no bank accounts or returns bank accounts but does not verify the balances, then the appropriate verification must be requested.
 4. Workers must review accounts and account balances returned by EA for potential transfer of resources during the lookback period and request additional verification when needed. For example, EA displays an account balance of \$50,000 for January 2015 but the same account displays a balance of \$5,000 for February 2015. The worker must explore whether or not a prohibited transfer of resources occurred. For more information on Transfer of resources, refer to [MS 2050](#).

If the individual reports owning, selling, or transferring property, but EA returns no results or returns incomplete results, then the appropriate verification must be requested. The worker may assist the individual by contacting the PVA or County Clerk's office. If unable to validate identity on EA and the individual states they have no bank accounts, no further verification is needed. If the individual reports bank accounts, request appropriate verification. Workers must contact the PVA to complete the property check when unable to validate identity.

After completing the bank and property check, workers must answer "Yes" to the question "Has Bank and Courthouse Asset Check Been Completed?" on the Resource Questions screen and comment thoroughly in case notes so that it is clearly documented how the asset check was completed. This will assist anyone reviewing the case for any reason, such as another worker processing the case, Quality Assurance (QA) case reviews, Quality Control (QC), or Hearings.

- E. As there is a cost associated with each verification request, workers must print the results and scan to the Electronic Case File (ECF). Income verification can be printed from EA, but there is no print option for accounts or property. Workers must copy the results using print screen, save to a Word document, and scan into ECF.]

MS 1975

HOMESTEAD PROPERTY

(1)

Homestead property is the individual's principal place of residence, whether occupied or unoccupied. A homestead can be a dwelling and the land it is built on, a dwelling only (such as a mobile home), or the land only (such as a vacant lot). Any adjoining land can be considered part of the homestead provided there is no other house built on that property. Homestead property is an excluded resource for regular Medicaid, waiver services, and the Medicare Savings Program (MSP). However, homestead property is a countable resource for individuals institutionalized in a Nursing Facility (NF) or other Long Term Care (LTC) facility unless an exclusion listed below applies.

- A. [Individuals with equity value in their home greater than \$713,000 are ineligible for Long Term Care Medicaid in a LTC facility (including NF), waiver services, or Hospice unless a community spouse, minor child, disabled child of any age, or dependent family member resides in the home. Equity value of the home is determined by subtracting verified debt from the Fair Market Value (FMV).

The FMV of a property is verified by using the Property Valuation Administrator (PVA) assessment or property tax notice. Do not allow the homestead exemption or any other exemptions when determining the FMV of a property. If a property is sold at public auction, the amount the property is sold for is considered the FMV.

Note: If an individual is ineligible for vendor payment due to homestead with equity interest greater than \$713,000, Worker Portal will still determine eligibility for regular Medicaid and/or MSP.]

- B. Exclude homestead property when a community spouse or other dependent family member resides in the home, regardless of the equity value. A dependent family member is a child, stepchild, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, or half-sister. If there is no community spouse, the following information is needed to exclude the homestead for a dependent family member:
1. Must have been living with the institutionalized individual prior to admission to an LTC facility and continue to live in the home; and
 2. Must have received more than one-half of their annual financial support from the institutionalized individual; and
 3. Must be claimed as a dependent of the institutionalized individual.
- C. Homestead property is excluded the first 6 months of institutionalization. A Medicaid recipient is considered permanently institutionalized after 6 consecutive months in a NF facility, or other LTC facility. After the 6th month, homestead property can no longer be considered the individual's home and is treated as non-home property. The 6 month count starts with the month of admission to the facility, not the month of application.

Note: If a recipient is discharged from the facility for more than 30 days, an exclusion is allowed for the first 6 months of the new institutionalization period.

D. An individual's homestead property may be excluded after the first 6 months of institutionalization if one of the following applies:

1. The individual states an intention to return home. Advise the individual of the exemption for intent to return home at application. The individual must provide a written statement indicating the intent to return home and the expected date of return. The statement must be signed by the recipient or their Power of Attorney (POA), legal guardian, or Authorized Representative (AR).

Note: If the homestead property is out of state, and the individual declares intent to return home, the individual does not meet residency requirements.

2. When there is a verified continuing effort to sell. The non-home property may be excluded for an additional 6 months if there is a verified continuing effort to sell it at FMV. A reasonable effort to sell the property shall consist of:
 - a. Listing the property with a real estate agent. Obtain a copy of the sales agreement or contract and verify:
 - 1) A "For Sale" sign has been placed on the property which is clearly visible from the nearest public road; and
 - 2) The property is advertised in the local newspaper, on local television or radio stations, or the internet.
 - b. If the individual is trying to sell the property privately, a combination of at least two of the following actions must occur:
 - 1) Advertising the property in the local newspaper, on television or radio stations, or the internet;
 - 2) Placing a "For Sale" sign on the property which is clearly visible from the nearest public road;
 - 3) Distributing fliers advertising the property for sale;
 - 4) Posting notices regarding availability of the property on community bulletin boards; or
 - 5) Showing the property to interested parties on a continuing basis, documented on a log with dates.

E. If homestead property is rented, it becomes non-home property and is no longer considered as homestead property.

1. Rental property cannot be excluded for intent to return home; but
2. Rental property can be excluded if it meets verified effort to sell criteria for non-home property outlined in [MS 1980 D](#).

F. When homestead property is excluded, inform the applicant that if the home is sold, it must be reported within 30 days.

- G. On the 15th day of the 6th month of institutionalization, Worker Portal will issue a KIP-105.12, Excluded Resource Notice, advising the individual that their homestead property will be countable and to contact DCBS. When contact is made, determine if the individual intends to return home or if they are making a verified effort to sell the property. If no contact is made, Worker Portal will consider the value of the property as a countable resource.
1. Allow the recipient 10 days to provide verification that the property has been sold, provide verification of the effort to sell the property, or to provide a statement of intent to return home.
 2. Once the property is sold, obtain a copy of the closing statement, and consider the proceeds a resource. Proceeds are what the individual actually receives after commissions, closing costs, mortgage, etc. are paid. Enter the compensation received on Worker Portal. If the individual no longer has the money from the sale of the property, they must provide verification of how the money was spent. If verification is not provided, consider as a prohibited transfer of resources.

C. Consideration of jointly owned property.

If non-home property is jointly owned, determine the recipient's share by dividing the equity value by the number of owners, unless the deed specifies percentage of ownership. Exclude the property from resource consideration if the other owner(s) refuse to sell. The other owner(s) must verify in writing an unwillingness to sell their interest in the property. This does not apply to community spouses. Verify the joint owner's refusal to sell at each application and recertification.

D. Exclusion of property due to inability to sell.

Non-home real property may be excluded from resource consideration for a reasonable effort to sell. This exclusion is not permanent. At each recertification or reapplication, it must be reviewed and verified that there has been and continues to be a reasonable effort to sell the property at FMV.

A reasonable effort to sell the property consists of:

1. Listing the property with a real estate agent. Obtain a copy of the sales agreement or contract and verify:
 - a. A "For Sale" sign has been placed on the property which is clearly visible from the nearest public road; and
 - b. The property is advertised in the local newspaper, on local television or radio stations, or the internet.
2. If the individual is trying to sell the property privately, a combination of at least two of the following actions must occur:
 - a. Advertising the property in the local newspaper, on local television or radio stations, or the internet;
 - b. Placing a "For Sale" sign on the property, which is clearly visible from the nearest public road;
 - c. Distributing fliers advertising the property for sale;
 - d. Posting notices regarding availability of the property on community bulletin boards; or
 - e. Showing the property to interested parties on a continuing basis, documented on a log with dates.]

4. Tax rebates are excluded in the month of receipt and the following two months. Any proceeds from the rebates after the third month are considered a countable resource.
 5. If the lump sum is from an insurance settlement, inheritance, or lottery winning, it is countable income.
 - a. Reduce insurance settlements by subtracting verified amounts used, or obligated, to repair or replace items damaged or destroyed and by any associated medical expenses not covered by Medicaid.
 - b. Consider as countable income, the remainder of the insurance settlement or the actual amount of other windfall profit received by the individual.
 6. Lump sums from accumulated back-payments of Supplemental Security Income (SSI) and Retirement, Survivors, Disability, Insurance (RSDI) are excluded as a resource for the first 6 months following the month of receipt.
- D. Verify the lump sum amount using a:
1. Statement from lawyer/trustee; or
 2. Letter of award; or
 3. Check.]

MS 2010

TRUSTS

(1)

[A trust is a contract in which a resource is transferred from the owner (also called the “grantor” or “settlor”) to be managed by an appointed trustee for the benefit of another individual, called the “beneficiary”. The grantor, trustee, and beneficiary may be the same person or multiple people. All trusts have a trust document that outlines how resources placed in the trust are managed. The Office of Legal Services (OLS) reviews all trusts, other than funeral trusts and Qualifying Income Trusts, to determine how they should be considered for Medicaid purposes.

- A. When an individual reports a trust at application, recertification, or case change, request a complete copy of the trust for verification. When provided, scan the trust into the Electronic Case File (ECF) and complete the following:
1. Review the trust documents to ensure all attachments listed in the trust have been provided. OLS requires the following information when reviewing a trust:
 - a. All pages of the trust;
 - b. If the individual’s home was placed in a trust, include a copy of the deed showing the home placed in the trust;
 - c. Verification of how the trust is funded (documentation of what has been placed in the trust);
 - d. If a guardian established the trust, include a copy of the guardianship court documents; and
 - e. A list of all parties involved with the trust and their relationship to the member.

Note: If any parts of the trust or attachments are missing, request the missing information from the individual.

2. Complete the Trust Information section on the Trust screen on Worker Portal. Once all trust documents have been scanned to ECF, answer “Yes” to “Document Provided” and a task will generate for OLS to review the trust.
- B. Applications and recertifications will pend until a response from OLS is received.
- C. In some situations, OLS may need additional information to complete the review. When the OLS outcome is “Insufficient Documentation” Worker Portal will generate a task for the worker. Request the required information from the applicant/recipient promptly.
- D. OLS determines if the trust is an excluded, countable, or a transferred resource and enters the results in the Review Outcome section of the Trust screen on Worker Portal. OLS will also determine whether any income is received from the trust or transferred to another individual or entity. Once OLS has entered the outcome of their review, a task will generate for a worker to act on OLS’ decision.
1. If excluded, no additional verification is required.
 2. If the trust is countable, the worker must request verification of the contents of the trust and the value and enter on the appropriate Resource screens.

For example, OLS determined Mary's trust was countable. Mary verified that the trust contained a savings account and non-home property. She provided a bank statement and the tax bill to verify the current value. The worker completes the Liquid Resource screen for the savings account and completes the Real Property screen for the non-home property.

3. If determined to be a transferred resource, the worker must request verification of the value of the contents of the trust at the time placed in the trust. The worker must enter all transfers on the Transfer/Sold Resource screen and answer all questions appropriately for Worker Portal to determine if the transfer occurred during the lookback period and whether a penalty period should be imposed.

For example, OLS determined Jane's trust to be a transfer of resources. Jane verified what was placed in the trust, when it was placed in the trust and what the value was at the time it was placed in the trust. The worker completes the Transfer/Sold Resource screen for each asset in the trust.

4. If the question "Are there non-medical payments from trust income" in the OLS review section is answered "Yes" then the worker must determine if the client is receiving payments from the trust. If so you must enter a "Trust Income" unearned income record.

Please note: A trust can be considered as both a countable resource and any distributions received as unearned income. However, it cannot be considered as both income and a resource in the same month.

- E. If recipients, representatives, or attorneys have questions about the status of the trust review, check the Task History section of the Case Summary screen to see if a Process Review Outcome for Trust task has been generated. If so, take appropriate action.

If the task is not present, review the case to ensure all questions on the Trust screen have been answered correctly. If so, send an update request to the Medical Support and Benefits Branch (MSBB) through the regional Program Specialist. DO NOT refer any individuals to OLS, DMS, or MSBB. All update requests must come through the Program Specialist.

- F. Once OLS has reviewed a trust, it does not need to be reviewed again unless changes are made to the trust or the client requests a redetermination.]

MS 2011 CONSIDERATION OF INCOME FROM A MEDICAID (1)
 QUALIFYING TRUST ESTABLISHED ON OR BEFORE 8/10/1993

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

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

If the individual alleges that the 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. Note: A Medicaid Qualifying Trust is not a Qualifying Income Trust (QIT). For more information on QIT's refer to [MS 3505](#).

MS 2030

VEHICLES

(1)

[Vehicles, whether used for transportation or recreation, are considered a resource when determining Medicaid eligibility. Vehicles include, but are not limited to, cars, trucks, vans, motorcycles, motor homes, campers, boats, ATVs, etc. A vehicle is considered a countable or excluded resource depending upon how it is used by the Medicaid recipient, community spouse, or dependent child.

A. Vehicles, including some recreational vehicles, may be excluded as a resource if used by a member of the household for one of the reasons listed below. Worker Portal will exclude only one vehicle per person per reason.

1. It is used to obtain medical treatment; or
2. It is specially equipped for the disabled; or
3. It is used by the community spouse; or
4. It is used for employment or self-employment; or
5. It is used as an owner occupied home.

NOTE: Whenever a vehicle is excluded to obtain medical treatment, the individual is not eligible for nonemergency medical transportation services.

B. Vehicles which do not meet any of the criteria in section A above are countable resources in Medicaid eligibility determination.

1. Worker Portal excludes \$4,500 from the combined equity value of vehicles which are primarily used for transportation, such as cars, trucks, and vans.

Example: William verifies that he owns a 2010 Camry valued at \$5,000 and a 2002 Chevy truck valued at \$2,000. No debt is owed on either vehicle. Neither vehicle can be excluded, since William does not use the vehicles for any of the reasons listed in section A above. Worker Portal will exclude \$4,500 from the \$7,000 total equity value of both vehicles and count \$2,500 when determining William's Medicaid eligibility.

2. The total equity value of recreational vehicles, including but not limited to, boats, four wheelers, Jet Skis, motor homes, campers, etc., is a countable resource unless the recreational vehicle can be excluded for one of the reasons listed in section A above..

Example: Jessica owns a camper valued at \$75,000. It cannot be excluded since she does not use it for any of the reasons listed in section A above. Jessica verifies that she still owes \$70,000 on the camper. Worker Portal will count the total equity value of \$5,000 when determining Jessica's Medicaid eligibility.

C. Use the following to verify the Fair Market Value of a vehicle:

1. The Vehicle's Registration; or
2. Avis, which is accessed through the DCBS External Agency Search located on KOG; or
3. Program 68, Vehicle Reg-Avis, which is accessed through KYIMS located on the KAMES Mainframe; (use the Current NADA amount) or
4. The National Automobile Dealers Association (NADA) located at www.nada.com.

Note: If the client states the vehicle is not worth the value verified by NADA or Vehicles Reg-Avis, a written statement from a mechanic, wrecker services, or used car dealer verifying the value can be accepted. The written statement must be on the business letterhead.

- D. At the time of admission, if an institutionalized individual does not own a vehicle, and wishes to use their resources to purchase a vehicle, the vehicle may only be excluded if:
1. One of the criteria listed above in section "A" is met; and
 2. It is verified by a statement from the nursing facility (NF) the recipient resides in that the vehicle being purchased is specially equipped for the recipient's use; and
 3. The vehicle purchased is in the recipient's name. However, if the vehicle is not in the recipient's name, it is a transfer of resources. Refer to [MS 2050](#) for further information regarding transfers of resources.

Example: Bob is in a nursing facility. He has \$20,000 in excess resources which he uses to purchase a compact sedan. However, a written statement from the nursing facility he resides in verifies that he is physically limited to stretcher transportation. This vehicle cannot be excluded as it is not equipped to meet Bob's needs and is considered a countable resource.]

[Burial reserves are resources set aside or designated by an individual to pay for funeral/burial expenses. Each individual is allowed up to a \$1,500 exclusion for burial reserves. The exclusion can be applied to cash set aside for burial, burial funds not verified to be payable upon death, the Cash Surrender Value (CSV) of a life insurance policy, a prearranged funeral not irrevocably assigned, or a combination of any of those.

To consider a resource a burial reserve and allow the \$1,500 exclusion, the individual must state that the resource will be used to pay for their funeral. Thorough case notes must be added to Worker Portal explaining which resources are designated by the individual as a burial reserve.

Burial reserves may be in the form of:

- A. Cash set aside for burial purposes, which includes checking accounts, savings accounts, Certificates of Deposit (CD), or cash.

Note: If the cash set aside for burial is 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 ongoing.

Example: Ruth verifies she has \$3,000 in her savings account. Ruth states she has saved \$2,000 for her funeral and the other \$1,000 is her rainy day fund. \$1,500 can be excluded from the balance of the savings account at application; however, Ruth must set up a separate account for the \$2,000 designated as burial reserves in order to continue receiving the \$1,500 exclusion.

- B. Burial funds are held in an account at a financial institution (i.e., a bank) and can only be disbursed for burial expenses for the account holder. These 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.

1. Verify that the balance of the burial fund is inaccessible and is only payable upon death. The contractual agreement from the financial institution will specify "payable upon death" or may be marked as "POD".
2. Exclude the entire amount of the burial fund if it is verified to be only payable upon death of the recipient.
3. If the burial fund is not verified to be payable upon death, then treat as cash set aside for burial. Only the \$1500 exclusion is given to the total amount of the burial fund.

- C. Life insurance is a means to set aside money to be used at the time of the individual's death. There are four types of life insurance policies: term life (including modified term life), whole life, group life, and burial insurance. Refer to [MS 2036](#) for more information on life insurance policies.

- D. Prearranged funeral contracts are agreements between an individual and the funeral home that allow the individual to preselect funeral items and services. A prearranged funeral also allows the individual to pay for, or to begin paying for, their funeral in advance. Refer to [MS 2037](#) for more information on prearranged funeral contracts.]

MS 2033

BURIAL SPACES AND ITEMS

(1)

[Burial reserves are used to purchase burial spaces and items either prior to or when an individual dies. The following burial spaces and burial space items can be excluded from resource consideration in the Medicaid eligibility determination if they meet the appropriate criteria.

- A. Burial spaces for the Medicaid applicant, spouse, and immediate family members are exempt for Medicaid eligibility purposes. Burial spaces include burial plots, gravesites, crypts, and mausoleums.
 - 1. Immediate family is defined as the individual's minor and adult children (natural, adopted, or step), siblings, parents, adoptive parents, and the spouses of those individuals. Grandparents or grandchildren are not considered immediate family members.
 - 2. One burial space can be excluded per person for the applicant, spouse, or immediate family member. The value of any additional spaces is treated as a countable resource.
 - 3. A burial space can be excluded for an immediate family member even if they are not a dependent or they do not live in the same household.
 - 4. The purchase of a burial space for an immediate family member is not considered a prohibited transfer of resources.
- B. Burial space items are exempt for the Medicaid applicant, spouse, and immediate family members. Burial space items are defined as a casket, urn, niche, or other repository item that are customarily and traditionally used for the deceased individual's bodily remains.

Burial space items also include necessary and reasonable improvements or additions to burial spaces such as vaults, headstones, markers or plaques, burial containers, opening and closing of the gravesite, adding a date of death to a headstone or marker, and contracts for care and maintenance of the gravesite.]

MS 2036

LIFE INSURANCE POLICIES

(1)

[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).

An individual 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. 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. Client statement is accepted as verification that a life insurance policy is designated for burial purposes.

There are three distinct types of insurance policies: term life (including modified term life), burial insurance, and whole life insurance. An individual may have group life insurance. This is a life insurance policy which can be provided by an individual's employer, credit union, credit card company, or other entity. The entity owns the policy and individuals are added to the group covered by the policy.

Each type of life insurance policy is considered individually. Each individual term life insurance, burial insurance, and whole life insurance policy must be entered in Worker Portal and verified as follows.

A. Term Life Insurance policies are active and payable for a designated period of time. Term Life Insurance policies are those that generally have no CSV or loan value. The benefits for these policies can only be accessed at the death of the policyholder. Although these policies are totally excluded from consideration for Medicaid eligibility purposes, it is still required to enter these policies on Worker Portal.

1. The following must be verified and documented:

- a. Name of policy owner;
- b. Name of covered individual;
- c. Name of company;
- d. Policy Number; and
- e. Face Value.

A copy of the policy must be scanned into the Electronic Case File (ECF).

2. Term Life Insurance policies are an excluded resource in the Medicaid eligibility determination. However, if a modified term life insurance policy has a CSV the policy is a countable resource. A modified term life policy should be treated and entered on Worker Portal as whole life insurance for Medicaid eligibility determination.

B. Burial insurance policies are life insurance policies that can only be used to pay the burial costs for the deceased policyholder. Burial insurance policies are those that have no CSV or loan value. The benefits for these policies are only received at the time of death of the policyholder. Burial insurance policies are usually marked "Payable On Death" or "POD" and are only paid upon the death of the insured. Although these policies are totally excluded from consideration for Medicaid eligibility purposes, it is still required to enter these policies on Worker Portal.

1. The following must be verified and documented:
 - a. Name of policy owner;
 - b. Name of covered individual;
 - c. Name of company;
 - d. Policy Number; and
 - e. Face Value.

A copy of the policy must be scanned into ECF.

2. Burial Insurance is an excluded resource in the Medicaid eligibility determination.

C. Whole life insurance policies build a CSV over time which the policyholder can withdraw or borrow against. This is considered an available resource in the Medicaid eligibility determination. The individual can designate a whole life insurance policy for burial purposes which will allow a \$1,500 exclusion from the countable resource.

1. 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 renewal); and
 - g. Loan Balance, if any (at application, reapplication, and renewal).

A copy of the policy must be scanned into ECF. It is the responsibility of the individual to request the verification from the insurance company. However, if the whole life insurance policy does not have 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. If the policy was written by a company no longer in business within the state of Kentucky, the Department of Insurance can be contacted to determine the company who is currently responsible for the policy. The phone number for the Department of Insurance is (800) 595-6053.

2. To determine the countable value of a whole life insurance policy, compare the Face Value and the CSV. The lesser amount of the two, minus any verified loan values, is a countable resource. The \$1,500 exclusion is allowed if the individual states the policy is intended to pay for the insured's funeral expenses and this must be explained in case notes. Any remaining amount is a countable resource in Medicaid eligibility determination. 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 per the individual's total policies' cash surrender value.

Note: If an individual has more than one form of burial reserve, only one can be excluded.

- a. Example: The individual has a prearranged funeral contract for \$3,000 that is irrevocably assigned to the funeral home. They also have 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.
- b. Example: An individual has a whole life insurance policy with a CSV of \$1,250, which is not designated for burial. There is a \$300 loan against the policy.

\$1,250 CSV
-300 Loan against policy
 \$950 Countable resource

- c. Example: An individual has a whole life insurance policy with a CSV of \$2,000, which has been designated for burial. There is a \$600 loan against the policy.

\$2,000 CSV
-600 Loan against policy
 \$1,400 Remainder
-1,500 Burial exclusion
 \$0 Countable resource

- d. Example: 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.

\$600 – Silver Life policy	\$5,200 – total CSV for all policies
\$600 – Silver Life policy	<u>-\$1,500 – burial exclusion</u>
\$1,000 – Gold Shield policy	\$3,700 – total countable resource
\$1,000 – Gold Shield policy	
<u>+\$2,000 – Golden Age policy</u>	
\$5,200 – total CSV for all policies	

- D. Group life insurance is usually a single policy that provides coverage to an entire group of people. These policies are often provided as part of an employee benefit package. Group life insurance policies may also be provided by an individual's bank, credit union, credit card company, or other entity. As the applicant is not the owner of the group policy, it is not considered as their resource, and is not entered in Worker Portal. Verification must still be provided and thorough case notes added explaining all actions taken.]

MS 2037

PREARRANGED FUNERAL CONTRACTS

(1)

[A prearranged funeral contract is an agreement an individual makes with a funeral home that allows them to preselect and purchase burial items. The contract may be funded by a life insurance policy, cash, or a combination of both. All prearranged funeral contracts must include an itemized statement of goods and services that is signed by both the individual and funeral home. The individual's spouse, Power of Attorney (POA), or legal guardian may sign on their behalf. The itemized statement must list each selected item with its value separately and cannot be a total package value. A potential prohibited transfer of resources exists if the itemized statement of goods and services is not provided. Additionally, if the itemized statement is not signed by both the individual and funeral home, only the \$1,500 burial exclusion can be allowed.

NOTE: If an applicant has a prearranged funeral contract with an out of state funeral home, DCBS cannot require the funeral home to follow Kentucky policy and procedures. If all required verification is received, such as irrevocable assignment, then the Prearranged Funeral Contract screen must be completed using the documentation submitted. The case should be sent to MSBB through the regional Program Specialist for guidance if all required verification cannot be provided.

A. There are five types of prearranged funeral contracts which can be identified by the source of funding.

1. Prearranged funeral contracts funded by a whole life insurance policy with an irrevocable assignment.

a. These contracts are funded by a life insurance policy that has been transferred to the funeral home by an *irrevocable* change in either beneficiary or ownership. This is an excluded resource if documentation is provided from the life insurance company to verify an irrevocable change has been made.

If an irrevocable change in ownership or beneficiary has not been made, the funeral contract is *not* considered to be funded. Instead, the lesser of the life insurance policy's face value or cash surrender value is considered a countable resource in the eligibility determination. Refer to [MS 2036](#) for more information regarding life insurance policies.

b. The following must be verified and documented:

- (1) Verification from the insurance company that the irrevocable change has been made;
- (2) Detailed, itemized statement of goods and services signed by both the funeral home and individual; and
- (3) Face Value (FV) and Cash Surrender Value (CSV) of the life insurance policy.

If all information pertaining to the life insurance policy is not verified, the application should deny for failure to provide verification.

c. If verification of irrevocable assignment is provided, but a signed, itemized statement of goods and services is not returned, the lesser of the policy's FV

or CSV is potentially a transfer of resources. This must be entered on the Transfer/Sold Resource screen to determine if a prohibited transfer of resources exists.

- d. If the total cost of selected goods and services exceeds the greater of the FV or CSV, the contract is over funded. Refer to section B (1) below for more information regarding over funded contracts.
- e. If the prearranged funeral contract is funded by a group life insurance policy, the contract is considered to be funded by cash for Medicaid purposes as applicants are not the owners of a group life policy. Additionally, the individual is not required to provide verification of irrevocable assignment.

2. Prearranged funeral contract funded by cash *without* an Irrevocable Funeral Trust Agreement.

- a. These contracts are purchased by the applicant with cash. However, the funding has not been irrevocably assigned to the funeral home, and the individual still is able to cancel the contract and be reimbursed. The value of the contract is considered a countable resource with the following considerations:

- (1) Interest or dividends on burial reserves are excluded, if allowed to accrue;
- (2) The value of burial space items listed in [MS 2033 B](#) are excluded;
- (3) The \$1,500 burial exclusion; and
- (4) Any remaining value after the above exclusions are deducted is a countable resource.

Example: Megan purchased a \$6,000 prearranged funeral contract with cash and selected the following items: a casket for \$2,500, burial plot valued at \$1,000, opening and closing of grave for \$500, funeral services for \$1,000, embalming cost of \$500, clothing valued at \$200, limousine at \$200, and flowers at \$100.

MS 2033 B lists caskets, plots, and opening and closing of the gravesite as excluded burial items. The clothing, funeral service, flowers, and limousine cannot be excluded and are countable. The calculations for the countable resource are:

\$6,000	Value of the contract
-4,000	Value of burial space items
2,000	Remainder
-1,500	Burial Reserve Exclusion
\$500	Countable Resource

- b. The following must be verified and documented:
 - (1) Detailed itemized statement of goods and services signed by both the funeral home and individual; and
 - (2) Source of cash, such as a copy of the check or receipt.

Note: The purchase of the prearranged funeral contract is a potential transfer of resources if an itemized statement of goods and services is not provided. This must be entered on the Transfer/Sold Resource screen to determine if a prohibited transfer of resources exists.

3. Prearranged funeral contract funded by cash *with* an Irrevocable Trust Agreement.

a. These contracts are purchased by the applicant with cash and are verified to be irrevocably assigned to the funeral home. By signing the Irrevocable Funeral Trust Agreement (known as an FDAK in Kentucky), the individual is unable to cancel the contract and the value of the prearranged funeral contract is considered an excluded resource if each of the following criteria are met.

- (1) All entries are completed on the Irrevocable Funeral Trust Agreement (or FDAK); and
- (2) The form is signed and dated no more than 30 days prior to the date of application.

b. The following must be verified and documented:

- (1) Detailed, itemized statement of goods and services signed by both the funeral home and individual;
- (2) Irrevocable Funeral Trust Agreement (or FDAK) signed within 30 days of the Medicaid application date; and
- (3) Source of cash, such as a copy of the check or receipt.

NOTE: A new irrevocable funeral trust agreement is required if the individual leaves vendor payment status for over 30 days.

c. The contract is considered to be funded by cash *without* an Irrevocable Trust Agreement if:

- (1) The Irrevocable Funeral Trust Agreement (or FDAK) is signed more than 30 days prior to the application date and a new agreement is not provided by application due date; or
- (2) An Irrevocable Funeral Trust Agreement is not provided by the application due date.

d. If an Irrevocable Funeral Trust Agreement is provided and signed less than 30 days prior to the application date, but a signed, itemized statement of goods and services is not returned, the cash provided to fund the contract is a transfer of resources.

4. Prearranged Funeral Contract funded by cash with a purchase of a life insurance policy through the funeral home.

a. Funeral contracts funded by a life insurance policy purchased through the funeral home are an excluded resource if the funeral home is the irrevocable owner or beneficiary of the life insurance policy. Examples of insurance policies purchased through the funeral home include Forethought and Investors Heritage.

If an irrevocable assignment has not been made, the contract is *not* considered to be funded. Instead, the lesser of the life insurance policy's face value or cash surrender value is considered a countable resource in the eligibility determination.

- b. The following must be verified and documented:
- (1) Detailed, itemized statement of goods and services signed by both the funeral home and individual;
 - (2) A copy of the insurance policy showing it has been irrevocably assigned to the funeral home;
 - (3) FV and CSV of the life insurance policy; and
 - (4) Source of payment, such as a copy of the check or receipt.

NOTE: If all information pertaining to the life insurance policy is not verified, the application should deny for failure to verify.

- c. If verification of irrevocable assignment is provided, but a signed, itemized statement of goods and services is not returned, the value of the funding for the insurance policy is a prohibited transfer of resources if the irrevocable assignment occurred within the look back period.
- d. If the face value of the policy exceeds the total cost of goods and services, the contract may be over funded.
- (1) If the policy *does not* have a CSV, the difference between the cost of goods and services and the FV is a prohibited transfer of resources. Enter the transfer on the Transfer/Sold Resource screen. The FV of the policy is the Fair Market Value (FMV) and the cost of goods and services is the Compensation Received.
 - (2) If the CSV of the policy is *equal to or less than* the cost of goods and services, the contract is either under or fully funded. Refer to sections B (2) and (3) below for more information.
 - (3) If the CSV of the policy is *greater than* the cost of goods and services, the funeral contract is over funded. The difference between the CSV and the cost of goods and services is a prohibited transfer of resources. Refer to section B (1) below for more information.

5. Prearranged Funeral Contracts funded by a combination of funding sources.

- a. Prearranged funeral contracts purchased using both cash and a life insurance policy as the source of funding have two sources of funding and both are reviewed when determining how to consider the resource in the eligibility determination. The contract is an excluded resource if the insurance policy is irrevocably assigned to the funeral home and an Irrevocable Funeral Trust Agreement (FDAK) is signed no more than 30 days from the Medicaid application date.
- (1) If verification that the life insurance policy has been irrevocably assigned to the funeral home is not provided by the due date, only the amount funded through cash is excluded and the life insurance policy is a countable resource. Burial items cannot be excluded, and the \$1,500 burial exclusion cannot be applied.
 - (2) If an Irrevocable Funeral Trust Agreement (FDAK) is not provided by the due date, or the provided statement is not signed within 30 days of the application date, only the amount funded by the life insurance policy is excluded and the amount funded by cash is a countable resource. Burial

items cannot be excluded, and the \$1,500 burial exclusion cannot be applied.

- (3) If verification of irrevocable assignment for neither the life insurance policy nor the amount funded by cash is provided, both the life insurance policy *and* the amount funded by cash are a countable resource. Burial items cannot be excluded but the \$1,500 burial exclusion is applied to determine the countable amount.

NOTE: A new Irrevocable Funeral Trust Agreement (FDAK) is required if the individual leaves long term care for over 30 days.

b. The following must be verified and documented:

- (1) Verification from the insurance company that the irrevocable change in ownership or beneficiary has been made;
- (2) A detailed, itemized statement of goods and services signed by both the funeral home and individual;
- (3) Irrevocable Funeral Trust Agreement (FDAK) for the cash portion of the contract signed no more than 30 days prior to the Medicaid application; and
- (4) Source of the payment, such as a copy of the check or receipt.

If all information pertaining to the life insurance policy is not verified, the application should deny for failure to verify.

B. General funding rules:

1. *UNDER FUNDED*: An underfunded contract means the individual has selected goods and services that total more than the amount of funding (cash or a life insurance policy) and still owes the funeral home for the remaining balance. The funding provided to the funeral home is the value of the contract and the amount entered in Worker Portal. For example, Marie selected \$10,000 in goods and services but only provided the funeral home with \$5,000 in cash, which means she has an under-funded funeral contract.
2. *FULLY FUNDED*: A fully funded contract occurs when 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 a service or an item (such as exchanging a cherry casket for an oak casket), they cannot add funds to this prearranged funeral contract.
3. *OVER FUNDED*: An over funded contract occurs when the individual has provided funds in excess of the selected goods and services and is a potential transfer of resources. When reviewing an over funded funeral contract, verify the date the source of funding (cash or life insurance) was assigned (life insurance) or put in a trust (cash).
 - a. If the date the contract was established is *beyond* the look back period for transfer of resources, the entire amount of the contract is entered on Worker Portal. Worker Portal will exclude the entire contract as long as all requirements for exclusion are met.
 - b. If the date the contract was established is *within* the look back period, review the purchase of the contract as a potential transfer of resources. Use the

amount of itemized goods and services as the funeral value. This is also the amount of compensation the individual received when they potentially transferred the funding to the funeral home. The amount of funding is the FMV of the transferred resource.

Example: Lana has an overfunded contract purchased with cash. The contract was established within the look back period on 2/15. She used \$15,000 to fund the contract but only selected \$7,500 in goods and services. When completing the Transfer/Sold Resource screen: Enter 2/15 as the Transaction Date, \$15,000 in the FMV field, and \$7,500 in the Compensation received field.

- C. If the individual makes changes to an existing prearranged funeral contract, verification must be provided to show what changes were made and how they were funded. When this occurs a new, detailed, itemized statement of goods and services and verification of payment for the new burial items must be requested.

Example: Max established a prearranged funeral contract last year but did not select a vault. His representative contacted the funeral home last week to add a vault to the contract. To verify the changes made, the worker must request a new detailed, itemized list of goods and services as well as verification of how Max paid for the vault.

- D. If the contract specifies that once the individual dies excess funds may be given to a designated individual, such as a beneficiary, a potential transfer of resources exists, as the excess funds must be designated to the estate of the deceased.]

MS 2050

TRANSFER OF RESOURCES

(1)

[A transfer of resources occurs when cash, other types of liquid assets, or property is voluntarily transferred, sold, given away, or otherwise disposed of at less than Fair Market Value (FMV) for the purpose of establishing Medicaid eligibility. A *prohibited* transfer occurs when the individual sells or disposes of the resource for less than FMV during the look back period. The look back period is the 60 months prior to the date the individual was both institutionalized *and* applied for Medicaid, refer to [MS 2080](#) for more information. Applicants and Medicaid recipients with prohibited transfers of resources may be subject to a penalty period and be disqualified from receiving Medicaid in a type of assistance that will pay for Nursing Facility or waiver services.]

Transfer of resources policy applies to applicants, or recipients, and their community spouse. This includes individuals in State Guardianship and those who receive Supplemental Security Income (SSI). Refer to [MS 4740](#) for policy regarding SSI recipients and transfer of resources.

A. Transfer of resources policy and penalties apply to the following types of care:

1. Nursing Facility (NF);
2. Acquired Brain Injury (ABI);
3. ABI LTC;
4. Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);
5. Supports for Community Living (SCL);
6. Michelle P. Waiver;
7. Model Waiver II; and
8. Home and Community Based Services (HCBS).

B. [The following types of care are not subject to transfer of resource penalties:

1. Institutionalized Hospice;]
2. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); and
3. Programs of All-Inclusive Care for the Elderly (PACE) and Institutionalized Programs of All-Inclusive Care for the Elderly (IPACE).

C. When a community spouse transfers resources for less than FMV, a penalty period may be applied to the institutionalized spouse depending on when the transfer occurs. However, the community spouse must be listed as a household member in the individual's case in order for Worker Portal to correctly determine how to apply the penalty.

1. If the community spouse transfers assets *before* the institutionalized spouse is approved for Medicaid, a penalty will be applied to the institutionalized spouse.
 - a. [If the community spouse later becomes institutionalized and is both Medicaid and vendor payment eligible, Worker Portal will divide any remaining penalty period between the spouses. Note: A worker must review the penalty period to ensure that it is correct.]
 - b. If the community spouse is deceased but listed as a household member when the applicant's eligibility is determined, a penalty will be applied to the institutionalized spouse.
 - c. If one spouse is no longer subject to the penalty, such as the spouse no longer receives NF services or dies, the balance of the penalty period applicable to both spouses must be served by the remaining spouse.
2. After the month of approval, transfers of resources made by the community spouse or institutionalized spouse are only considered toward the individual who transferred the resource. If the community spouse transfers assets *after* the month the institutionalized spouse is approved for Medicaid, and later becomes institutionalized, only the former community spouse is subject to a penalty period.
3. If a PACE or IPACE individual has an institutionalized spouse and the spouse is receiving benefits that are subject to a transfer of resources penalty, the entire penalty must be served by the spouse.
 - a. In cases where the individual is already serving a penalty, starts receiving PACE or IPACE services, and has an institutionalized spouse, the remaining penalty for the individual must be served by the spouse.
 - b. If the spouse receiving PACE or IPACE services is discharged but remains institutionalized, any part of the penalty that has not yet been served should be split between the couple.
- D. If both spouses are institutionalized, transfer of resources policy is applied based on the month(s) of admission and how the couple is being considered for Medicaid purposes. As a reminder, LTC couples residing in both the same facility *and* room are considered as individuals or as a couple depending on which is more advantageous to them. Refer to [MS 3540](#) for more information on LTC couples.
 1. If the couple is admitted to the facility in the *same* month, the penalty should be shared for resources transferred prior to or in the month of admission. If any amount of assets is returned, the penalty should be reduced for both individuals.
 2. If the couple is being treated as a couple, the penalty should be shared for any resources transferred after the month of admission. If the couple can be treated as individuals, workers must review the potential transfer of resources penalty with the applicant, or their Authorized Representative, to ensure they understand how it can be applied prior to disposition. If any amount of assets is returned, the penalty should be reduced for both individuals.

3. If the couple is being treated as individuals, each individual should only serve penalties for the transfers of resources they individually made. If any amount of assets is returned, the penalty should only be reduced for the individual who actually received the payment.
- E. Transfer of resources policy applies to property transferred or sold for less than FMV, including but not limited to:
1. Homestead property;
 2. Non-home real property; and
 3. Property with life estate interest (refer to [MS 2055](#)).
- F. The Office of Legal Services (OLS) is responsible for reviewing trusts. They determine how DCBS should consider any assets, including homestead property, placed into the trust for eligibility purposes.
- 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. Workers must complete a review of the individual's (and their spouse, if applicable) assets for potential transfer of resources during the look back period. Workers must use Eligibility Advisor (EA) to verify bank account and property transactions completed during the look back period. Refer to [MS 1971](#) for more information on EA.
- I. Do not apply transfer of resources policy to transfers made by recipients in an ICF IID or SCL setting prior to 8/10/93.

MS 2055

LIFE ESTATE

(1)

[A life estate is created when an individual transfers ownership of their property to someone else and retains certain rights to the property for the rest of their life. By establishing a life estate, the individual has a legal right to live on the property during their lifetime but does not own the property outright. A life estate ends at the death of the individual. The value of the life estate itself is considered an excluded resource when determining Medicaid eligibility. However, life estate interest in a property entitles an individual to income produced by the property.

If an individual transfers property for less than Fair Market Value (FMV), transfer of resource policy applies even if the individual retains a life estate. If the individual does not receive compensation for the FMV of the transferred portion of the property, a potential prohibited transfer of resources has occurred unless one of the exceptions listed in Volume IVA MS 2070 is met. Refer to Volume IVA [MS 2050](#) for more information regarding transfers of resources.

Example: Esther owns a property that's worth \$100,000. She gives the property to her son for love and affection but retains a life estate in the property. Since Esther did not receive compensation for the portion of the property transferred to her son, a prohibited transfer of resources has occurred.

A. When an individual sells, or transfers, a property, but life estate interest is retained, the following steps are taken to determine the value of the property transferred:

1. Determine the FMV of the property at the time the property was transferred and the life estate was established.
2. Determine the recipient's age at the time of transfer. The age at the time of the transfer determines the appropriate life estate remainder to use. The life estate remainder can be found on the Life Estate Table located in Volume IVA [MS 2056](#).
3. The value of the property is multiplied by the life estate remainder to determine the amount of the transferred resource.

Example: Martha, age 79, is in a Nursing Facility. She transferred her homestead to her son 2 years ago but retained a life estate interest. The FMV of the property was \$100,000 at the time of the transfer. The life estate remainder, based on her age at the time of the transfer (77), is .51258. The transferred amount is calculated as follows:

FMV of the property	\$100,000
Remainder	<u>x.51258</u>
	\$51,258

Martha did not receive compensation of \$51,258 so this is a prohibited transfer of resources subject to a penalty period. Refer to [MS 2050](#) for more information regarding transfer of resources.

B. If an individual relinquishes their life estate for any reason, such as the property is sold or otherwise transferred, the individual must receive compensation for the value of their life estate at the time of relinquishment. If they do not receive compensation for the value of the life estate a potential transfer of resources has occurred. To determine the value of the life estate at the time of relinquishment, complete the following steps:

1. Determine the FMV of the property at the time the life estate is relinquished.
2. Determine the recipient's age at the time the life estate was relinquished. The age at the time of the relinquishment determines the appropriate life estate factor to use. The life estate factor can be found on the Life Estate Table located in [MS 2056](#)
3. The value of the property is multiplied by the life estate factor to determine the value of the life estate at the time of relinquishment.

Example: Judy, age 80, gave her homestead to her children 10 years ago but retained a life estate in the property. Judy relinquished her life estate when she entered the Nursing Facility two months ago. The current value of the property is \$150,000. The life estate factor, based on her age at the time she relinquished the life estate (80) is .43659. The value of Judy's life estate is calculated as follows:

FMV of property	\$150,000
Factor	<u>x.43659</u>
	\$65,488.50

Judy did not receive compensation of \$65,488 when she relinquished her life estate, so this is a prohibited transfer of resources subject to a penalty period. Refer to Volume IVA MS 2080 for more information regarding transfer of resource penalties.

- C. If an individual receives compensation for the property when they establish a life estate, or for the value of the life estate when it is relinquished, the compensation received is a countable resource.
- D. If an individual inherits a life estate, or is otherwise granted a life estate, in a property they never owned, they have no rights to that property except to live there until their death. There is no penalty if the individual relinquishes their life estate in a property that they never owned.

Example: Nancy's father willed his homestead to his grandson but granted Nancy a life estate so she could live there until her death or for as long as she wanted. When Nancy was admitted to the Nursing Facility, she relinquished her life estate in the property. This is not a prohibited transfer of resources because she never owned the property.]

MS 2056

LIFE ESTATE TABLE

(1)

[Use the following table to identify the life estate remainder or factor. Refer to [MS 2055](#) to determine what age to use and whether to use the life estate remainder or the life estate factor.]

Age	Factor	Remainder	Age	Factor	Remainder	Age	Factor	Remainder
0	.97188	.02812	37	.93026	.06974	74	.53862	.46138
1	.98988	.01012	38	.92567	.07433	75	.52149	.47851
2	.99017	.00983	39	.92083	.07917	76	.50441	.49559
3	.99008	.00992	40	.91571	.08429	77	.48742	.51258
4	.98981	.01019	41	.91030	.08970	78	.47049	.52951
5	.98938	.01062	42	.90457	.09543	79	.45357	.54643
6	.98884	.01116	43	.89855	.10145	80	.43659	.56341
7	.98822	.01178	44	.89221	.10779	81	.41967	.58033
8	.98748	.01252	45	.88558	.11442	82	.40295	.59705
9	.98663	.01337	46	.87863	.12137	83	.38642	.61358
10	.98565	.01435	47	.87137	.12863	84	.36998	.63002
11	.98453	.01547	48	.86374	.13626	85	.35359	.64641
12	.98329	.01671	49	.85578	.14422	86	.33764	.66236
13	.98198	.01802	50	.84743	.15257	87	.32262	.67738
14	.98066	.01934	51	.83674	.16126	88	.30859	.69141
15	.97937	.02063	52	.82969	.17031	89	.29526	.70474
16	.97815	.02185	53	.82028	.17972	90	.28221	.71779
17	.97700	.02300	54	.81054	.18946	91	.26955	.73045
18	.97590	.02410	55	.80046	.19954	92	.25771	.74229
19	.97480	.02520	56	.79006	.20994	93	.24692	.75308
20	.97365	.02635	57	.77931	.22069	94	.23728	.76272
21	.97245	.02755	58	.76822	.23178	95	.22887	.77113
22	.97120	.02880	59	.75675	.24325	96	.22181	.77819
23	.96986	.03014	60	.74491	.25509	97	.21550	.78450
24	.96841	.03159	61	.73267	.26733	98	.21000	.79000
25	.96678	.03322	62	.72002	.27998	99	.20486	.79514
26	.96495	.03505	63	.70696	.29304	100	.19975	.80025
27	.96290	.03710	64	.69352	.30648	101	.19532	.80468
28	.96062	.03938	65	.67970	.32030	102	.19054	.80946
29	.95813	.04187	66	.66551	.33449	103	.18437	.81563
30	.95543	.04457	67	.65098	.34902	104	.17856	.82144
31	.95254	.04746	68	.63610	.36390	105	.16962	.83038
32	.94942	.05058	69	.62086	.37914	106	.15488	.84512
33	.94608	.05392	70	.60522	.39478	107	.13409	.86591
34	.94250	.05750	71	.58914	.41086	108	.10068	.89932
35	.93868	.06132	72	.57261	.42739	109	.04545	.95455
36	.93460	.06540	73	.55571	.44429			

The life estate factor and the remainder always equal 1 when added together—this represents the total value of the property.]

MS 2070 EXCEPTIONS TO TRANSFER OF RESOURCES (1)

o not apply a transfer of resource penalty to an individual if it is verified that one of the following exceptions exists.

A. The homestead property was transferred to one of the following individuals. If non-homestead property is transferred, the following exceptions are not applicable.

1. The spouse;
2. [A natural, adopted, or step- child under 21, or a child of any age who has been determined blind or disabled. The child's relationship must also be verified;]
3. An adult child, other than the above, who lived with the institutionalized individual for at least two years, immediately, before the individual was institutionalized. The child must have lived there continuously, since that time, and be able to prove they provided care to the individual that prevented institutionalization.

Each of the following criteria must be verified.

- a. The child's relationship to the applicant:
 - (1) The child may be a natural, adopted, or stepchild.
 - (2) The age of the child is not a factor.
 - (3) Use birth, adoption, and marriage records to establish relationship.
 - b. Verification must be provided to prove that the child lived with the individual for two years prior to institutionalization. Require a statement from a collateral contact who knows the family's situation and can verify the child's living arrangement.
 - c. Verification must be provided to prove the care may have delayed institutionalization. Request a statement from a collateral contact medically qualified, such as the applicant's doctor, to verify that the care provided delayed institutionalization.
4. A sibling who has equity interest (joint owner) in the home and lived with the institutionalized individual for one year prior to institutionalization. Request verification that the sibling lived with the applicant for one year prior to institutionalization and also have equity interest in the property.

NOTE: The transfer of the homestead property to any individual not listed above, or the addition of another individual's name to the homestead property, even if the name of the original owner remains on the deed, is a prohibited transfer of resources.

B. A resource that would have been exempt from consideration had the transfer not occurred, such as the transfer of a vehicle that was excluded for use to obtain medical treatment.

1. This exception DOES NOT APPLY to homestead property or the transfer of property where the member retained a life estate interest.
 2. This exception also does not apply to resources used to purchase excluded resources. For example, May has \$15,000 in her checking account that she uses to purchase a vehicle to use for medical transportation. The vehicle is excluded in her Medicaid eligibility determination and is also co-owned with her daughter. Even though the vehicle is excluded, this exception is not applicable to May's situation as the \$15,000 was a countable resource and the purchase of the vehicle must be reviewed as a potential transfer of resources. Since the daughter is a joint owner, the amount owned by her is considered to be a cash gift and a penalty must be applied if none of the other exceptions are met.
- C. The individual presents convincing evidence that the transfer was exclusively for a purpose other than establishing Medicaid eligibility. Examples may include, but are not limited to:
1. Satisfactory proof is provided indicating the individual intended to dispose of the resources at their Fair Market Value (FMV). For example, a copy of the ad showing FMV sale price and date.
 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. Only those payments made after the contract was in effect are considered to be made for reasons other than gaining Medicaid eligibility. Any payments made *prior* to the contractual agreement are a prohibited transfer of resources. Additionally, any payments made *after* institutionalization are also a prohibited transfer of resources.]
 3. The transfer was for expenses incurred as a result of a family emergency.

If the individual states or if the worker believes that the transfer of resources was NOT done to gain Medicaid eligibility, they should select 'Yes' to the question, "Was the transfer exclusively for a purpose other than eligibility?" on the Transfer/Sold Resource screen. Answering 'Yes' will generate a task for the Medical Support and Benefits Branch (MSBB) to review the transfer to determine whether or not a transfer penalty should be applied. Once the MSBB review is complete, workers will receive a *Process Review Outcome for Transferred Resource* task to finish processing the case.

- D. The resource was transferred to another individual for the sole benefit of the community spouse. Please note that spouses may transfer resources between themselves without incurring a transfer of resources penalty.
- E. [The resource was transferred to the individual's child of any age who is blind or permanently and totally disabled. Request verification of the child's disability. If the child has not yet been determined to be disabled and the child is under age 65, complete a manual referral to the Medical Review Team (MRT). Additionally, the child's relationship must be verified.]
- F. The individual had good cause for transferring the resource.

1. Good cause may be established if the expense incurred due to one of the following events is equal to or greater than the amount of resources transferred. The acceptable reasons for good cause are:
 - a. A natural disaster, fire, flood, storm, or earthquake;
 - b. Illness resulting from accident or disease, hospitalization or death of an immediate family member; or
 - c. Civil disorder or other disruption resulting in vandalism, home explosions, or theft of essential household furnishings.
 2. Enter the good cause reason and the verification of good cause on Worker Portal.
- G. A determination is made that denial of eligibility creates an undue hardship. Undue hardship exists when:
1. Application of transfer of resource penalties or consideration of funds placed in a trust deprives an individual of medical care to the extent that the individual's health and life would be endangered;
 2. Application of the transfer of resources or trust provisions would deprive the individual of food, clothing, shelter or other necessities of life.

If issuing form MA-105, Notice of Eligibility, to notify recipients of a transfer of resources penalty, include an explanation of the undue hardship exception.

To request an undue hardship:

- a. A family member or the facility must compose and submit the request for undue hardship. This request must include an explanation of the circumstances that led to the Medicaid Long Term Care (LTC) denial or discontinuance. The local office cannot compose this request.
- b. This request must include a statement from the facility which states that the individual will be discharged due to non-payment and the date of discharge.
- c. Scan the statement requesting a hardship determination along with the statement from the facility into the Electronic Case File (ECF).
- d. Complete the *Request Undue Hardship* screen on Worker Portal. A task will generate to the Department for Medicaid Services (DMS) for their review.
- e. Once a determination is made, a task will generate for a worker to take appropriate action on the outcome.

NOTE: A hardship cannot be requested unless the transfer of resources penalty has been applied to the case.

MS 2080 CONSIDERATION OF TRANSFERRED RESOURCES (1)

During the Medicaid application, workers must review the applicant and community spouse's assets for any potential prohibited transfers of resources. This includes using Eligibility Advisor (EA), online sources, bank statements, etc., to help determine if any transfers were made. The findings must be thoroughly documented in Case Notes. For more information regarding transfers of resources, refer to [MS 2050](#).

- A. The look back period is 60 months prior to when the individual is *both* institutionalized and applies for Medicaid. Transfers occurring during the look back period should be reviewed to determine if a prohibited transfer of resources has occurred.

Note: A new look back period is established for each application.

- a. If retroactive coverage is requested, the look back period begins with the first month of retroactive coverage.

Example: Jane was admitted to the Nursing Facility (NF) on 12/2020. Her husband completes a Medicaid application for her in 2/2021 and requests retroactive coverage for 12/2020 and 1/2021. Jane's look back period begins in December 2015 as this is 60 months before she is both institutionalized and applies for Medicaid.

- b. If retroactive coverage is not requested, the look back period begins 60 months prior to the application month.

- B. If a resource was transferred during the past 60 months and none of the exceptions in [MS 2070](#) apply, it is presumed that the transfer was made for the purpose of establishing Medicaid eligibility.

1. If a transfer of resources occurred beyond the look back period, it is not considered to be prohibited and a penalty should not be applied.
2. For trusts established on or before August 10, 1993 and resources were transferred into the trust after August 10, 1993, the look back period is 36 months.
3. For trusts established after August 10, 1993, the look back period is 60 months.

NOTE: The addition of another's name to an asset is a transfer of resources even if the name of the original owner remains on the asset.

- C. The start date of the penalty period for prohibited transfers of resources is either the first day of the month resources were transferred for less than Fair Market Value (FMV) OR the day the individual is eligible for Medicaid vendor payment. Use whichever date occurs last.

Example: Jon applied for Medicaid on 5/1/19. He transferred property on 1/1/19 for less than FMV to his son, which was within the look back period. He was over the resource limit for May and was eligible for vendor payment on 6/1/19. The penalty period start date is 6/1/19 as this date occurred last.

Example: Sue applied for Medicaid on 2/1/19 and is requesting retroactive coverage for November, December, and January. She transferred money from her checking account to her sister on 12/15/18, which is within the look back period. She is eligible for vendor payment on 11/1/18. The penalty period start date is 12/1/18 as this date occurred last.

1. Once eligibility has been determined and a penalty period is established, it continues until expiration.
 - a. The penalty period applies only to payment for Long Term Care (LTC) services while in a NF or receiving waiver services. Hospice is not subject to a transfer of resource penalty.

Example: Mark is in a NF and has an application for Medicaid submitted on his behalf. He transferred property for less than FMV and a penalty period was imposed. He temporarily transitioned to hospice and went back to the NF when his hospice services ended. The penalty period continues when Mark is readmitted to the Nursing Facility.

- b. Once the penalty period is imposed, it cannot be interrupted or temporarily suspended. The penalty period will continue even if the individual stops receiving Long Term Care services.

Example: Kay is in a NF and is serving a transfer of resources penalty. She is discharged from the NF, goes home for a few months and is readmitted to the NF. The penalty period will continue during this entire time without interruption.

2. For penalty periods resulting in partial months, the individual will not be penalized for the whole month.

Example: Bob's penalty period ends 2/13. He reapplies for Medicaid on 3/1. His eligibility should be backdated to 2/14 if other technical and financial requirements are met.

3. A denial notice, along with form KIP-105.13, Disqualification Notice, is issued to Medicaid applicants when a penalty is imposed. Worker Portal will not use the special income standard when determining the applicant's eligibility as they are no longer eligible for LTC Medicaid. The case will deny due to excess income if the individual's income exceeds the regular Medicaid standard.

If the income is within the limits, the case will remain eligible for Medicaid only, this includes Pass Through. However, the recipient will not be

eligible for vendor payment until the penalty period expires. For more information regarding the special income standard, refer to [MS 3500](#).

Example: Nick is disqualified due to a transfer of resources. His income is \$200.00 monthly RSDI. His case will remain active for Medicaid only. He will not be eligible for vendor payment until his penalty period expires.

4. When a penalty period is imposed, a 10-day adverse action notice is generated. Form KIP-105.13, Disqualification Notice, is issued to the individual.
5. The penalty period cannot begin until the expiration of any other existing ineligibility periods.
6. If a transferred resource is returned to the individual in its entirety, the penalty is removed as if the transfer of resources never occurred.

Example: Kim transferred property to her daughter, Becky, and is serving a penalty period. Becky transferred the property back to Kim in its entirety. The penalty period is removed as if it never occurred.

7. If a transferred resource is partially returned to the individual, the penalty period is reduced by the appropriate number of days.

Example: Tom transfers \$10,000 from his checking account to his son, Doug, and is serving a penalty period. Doug gives half of the money back to his dad. The penalty period is recalculated using the new transfer amount of \$5,000.

D. Complete the following steps to determine the length of a penalty period.

1. Determine the uncompensated equity value of the transferred resource. This is done by subtracting the resource's Fair Market Value, minus any debt owed, from the compensation received.

Example: Molly's house is valued at \$250,000 and she still owes \$15,000 on her mortgage loan. She sold the house for \$235,000. With the consideration of the debt Molly owed on her home, there is no uncompensated equity.

$$(\$250,000 - \$15,000) - \$235,000 = \$235,000 - \$235,000 = \$0$$

- [2. Worker Portal divides the uncompensated equity value by the transferred resource divider. This is a daily amount used to calculate how many days a penalty should last. Round down to the nearest whole number when calculating the individual's total ineligibility period. The transfer of resources divider changes annually. Use the transferred resource divider for the year in which the transfer was made known to the agency. This will often coincide with the individual's application month. Effective January 1, 2024, the transfer of resource divider is \$305.28.

Example: An application is taken on 1/3/24. The applicant is income and resource eligible. The applicant was admitted to LTC on 1/2/24. \$50,000 was given away on 12/10/20 resulting in a disqualification period for LTC vendor payment. The disqualification period is determined as follows:

$\$50,000$ divided by $\$305.28$ (daily transfer of resource factor) = 163.78.
The ineligibility period is rounded down to 163 days.

In this example, the count begins with the day of admission to the LTC facility because the applicant has met all other technical and financial eligibility criteria. The disqualification period is 1/2/24 through 6/13/24. June 14, 2024 is the first day the applicant would be eligible for LTC vendor payment.

E. Workers must review the reported changes in assets during each recertification to determine if resources were transferred during the certification period. As with applications, workers must use EA, online resources, and verification provided by clients to help determine if a transfer of resources has occurred. Their findings, along with the reason for the transfer, must also be documented in Case Notes.

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 first of the month in which the transfer occurred.

Example: At recertification on 1/1/24 it is discovered that the recipient sold property for less than FMV on 12/15/23. The FMV of property was \$40,000. The recipient sold the property for \$20,000. There was no debt owed on the property. The transferred resource amount is \$20,000. Determine the disqualification period as follows:

$\$20,000$ divided by $\$305.28$ = 65.51 days, rounded down to 65 days.

In this situation, the date of discovery is 1/1/24. The date of transfer occurred after the application date; therefore, the count will begin with the first of the month in which the transfer occurred. The current year transfer resource divider is used since the transfer was reported during the current year.

The disqualification period is 12/01/23 to 2/04/24. As the disqualification ended prior to the recertification month, the case will remain active. Even though the individual received Medicaid during this timeframe, the penalty period has been served.

F. Multiple transfers are treated as a single transfer. For multiple transfers, calculate and impose a single period of ineligibility.

Example: An application was made on 1/3/24. There were multiple transfers that occurred prior to the application. The individual was admitted to the Nursing Facility on 1/1/24 and meets all technical and financial requirements.

\$10,000 was given away on 1/1/22.

\$12,000 was given away on 5/15/22.

\$8,000 was given away on 7/19/22.

Total all transfers together: $\$10,000 + \$12,000 + \$8,000 = \$30,000$

Worker Portal will divide the total by the current transfer of resource factor and display a single penalty period.

$\$30,000$ divided by $\$305.28 = 98.27$ days rounded down to 98 days. The disqualification period is 1/1/24 to 4/08/24. The client will be vendor payment eligible on 4/09/24.]

- G. Worker Portal will calculate the transfer of resource penalty and will display the ineligibility period on the Disqualification/Penalty Information screen from the Individual Summary.

If an individual will be discharged from the nursing home or will lose waiver services because they cannot pay, they can request a hardship determination. For more information regarding a request for a hardship determination, refer to [MS 2070](#).

- H. While an individual has a penalty, they may be eligible for a Spend Down. However, a Spend Down will not pay for vendor payment.

MS 2120 SPECIAL RESOURCE CONSIDERATIONS FOR AN
INSTITUTIONALIZED SPOUSE WITH A COMMUNITY SPOUSE (1)

When one spouse is institutionalized and the other remains at home, there can be a financial hardship. To prevent this, resources of an institutionalized spouse with a community spouse are treated differently when determining Medicaid eligibility.

- A. [Provisions of the policy include an assessment of the institutionalized and community spouse's combined countable resources. Resource Assessments on Worker Portal can be completed at the request of either spouse or the representative acting on behalf of the couple for the current, continuous period of institutionalization. This assessment may be completed independent of the Medicaid application as a preapplication Resource Assessment.
- B. The Resource Assessment provides a prescreening of resource eligibility to assist the couple in financial planning and in their decision to apply for Medicaid. 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. The LTC Resource Transfer Consent screen must be completed prior to approval of the application to substantiate the institutionalized spouse's intent to transfer excess resources to the community spouse.
- C. By law, the community spouse resource allowance cannot exceed the maximum allowable amount, which may change annually. However, once calculated, the resource allowance does not change, unless there has been a break in institutionalization of 30, or more, days. 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. In the fifth month after Long Term Care (LTC) Medicaid is approved, Worker Portal will issue notice KIP-105.11, Resource Transfer Content. The notice will advise to return proof of the resources the institutionalized spouse now has and where the excess resources went. If verification is not returned by the notice due date, Medicaid will discontinue. Resource considerations for the community spouse who applies for, or receives, Medicaid have not changed.
- D. Apply the policy to spouses admitted to an LTC facility on or after 9/30/89, 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 a Resource Assessment or the LTC Resource Transfer Consent and LTC Income Statement screens].

EXAMPLE 1: If an institutionalized spouse is eligible for vendor payment and declines the vendor payment, the community spouse resource allowance is applied in the institutionalized spouse's case.

EXAMPLE 2: If an institutionalized spouse is vendor payment ineligible for any reason, but eligible for a spend down, the community spouse resource allowance is applied in the institutionalized spouse's case.

- F. For spouses institutionalized or receiving HCBS, Supports for Community Living or Hospice before 9/30/89, follow previous policy for consideration of resources. If the spouse leaves the facility, HCBS, Supports for Community Living or Hospice for a 30 consecutive day period and is readmitted, apply current resource policy. If an institutionalized spouse is not likely to be institutionalized for at least 30 consecutive days, DO NOT APPLY the community spouse resource allowance in the institutionalized spouse's case. If a change in circumstance results in a couple no longer having an institutionalized/community spouse situation, i.e., one spouse dies, community spouse is institutionalized, etc., do not apply the special resource considerations the month following the month in which the change occurs.

MS 2130

RESOURCE ASSESSMENT

(1)

A resource assessment is the documentation and verification of all resources belonging to an institutionalized individual and/or their community spouse. An individual may complete a pre-application resource assessment or may complete the resource assessment as part of the application; either way, a resource assessment is completed for all individuals with a community spouse. A resource assessment is NOT completed prior to the potential applicant admittance to the Nursing Facility (NF), Hospice, or waiver services.

The resource assessment covers a continuous period of institutionalization which begins when the individual is admitted to the NF, Hospice (institutionalized or non-institutionalized), or waiver services and is expected to remain in the facility or receive services for at least 30 consecutive days. Whenever there is a break in institutionalization of more than 30 days, a new assessment must be completed at re-application based on the new circumstances.

Note: A resource assessment is only applicable if institutionalization in a NF, Hospice, or waiver, began on or after September 30, 1989.

- A. A pre-application resource assessment is completed at the request of either spouse or the representative acting on behalf of the couple.
 - 1. Complete the pre-application resource assessment within 45 days of the date of request unless additional time is requested.
 - 2. If additional verification is required, Worker Portal will generate a Request for Information (RFI) to the individual or representative.
 - 3. Once the verification is provided, complete the resource assessment. Do not use the 45-day period as a waiting period to complete the assessment.
 - 4. When all resource verification is provided and the resource assessment is authorized, Worker Portal generates a copy and mails of the completed resource assessment to the individual or representative.
- B. The community spouse resource allowance amount is calculated only one time for a continuous period of institutionalization of the institutionalized spouse. If a resource assessment is not requested and completed prior to the application, Worker Portal completes the resource assessment during the application process.
- C. The results of the pre-application resource assessment cannot be appealed. Opportunity to appeal the assessment is provided if and when the institutionalized spouse makes an application for Medicaid.
- D. [When an application for Medicaid is made, compare resources owned by the couple at the time of the resource 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 \$713,000 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.]

- E. When a resource assessment is completed in another state and the applicant subsequently moves to Kentucky, and there has been no interruption in institutionalization, contact the appropriate state agency and request a copy of the resource assessment completed by that state. Complete a resource assessment to determine the spouse's share. This is accomplished by using the resource amounts/types verified by the previous state's resource assessment but applying Kentucky's resource policies.
- F. 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.

MS 2135 COMMUNITY SPOUSE RESOURCE ALLOWANCE CALCULATION (1)

The community spouse resource allowance is a designated amount deducted from the combined countable resources of the institutionalized spouse and community spouse prior to determining resource eligibility of the institutionalized spouse. The allowance represents the amount of resources necessary for the non-institutionalized spouse to maintain themselves in the community. The allowance is calculated based on the couple's circumstances. Using the resources that have been entered, Worker Portal will determine the community spouse resource allowance.

A. Community Spouse Resource Allowance Calculation

1. The calculation makes a comparison to the minimum and maximum community spouse resource allowances established by the Centers for Medicare and Medicaid Services (CMS). These allowances are revised by CMS. For the current minimum and maximum community spouse resource allowance, refer to [MS 1750](#). The community spouse resource allowance can be no less than the minimum but not greater than the maximum.
2. [The community spouse resource allowance is equal to one-half of the couple's combined countable resources up to the maximum allowance (\$154,140). If the spousal resource allowance is less than the minimum (\$30,828), the community spouse resource allowance is the minimum allowance.

Example 1: The combined countable resources of a couple are \$350,000. One-half of the couple's resources is \$175,000 (\$350,000 divided by 2 = \$175,000). As the amount is greater than the maximum amount allowable, the community spouse resource allowance is the maximum, \$154,140. For the institutionalized spouse to be resource eligible \$193,860 must be spent down.]

Example 2: The combined countable resources of a couple are \$128,000. The community spouse resource allowance is \$64,000 (\$128,000 divided by 2 = \$64,000) which is less than the maximum allowance. For the institutionalized spouse to be resource eligible \$62,000 must be spent down.

[Example 3: The combined countable resources of a couple are \$22,000. One-half of the couple's resources is \$11,000 (\$22,000 divided by 2 = \$11,000). The community spouse resource allowance is \$30,828. As the community spouse is allowed the minimum resource allowance, the institutionalized spouse can transfer their portion to the community spouse.]

- B. The community spouse resource allowance may exceed the calculated amount or the maximum only by court order or a fair hearing decision. For more information about the community spouse resource allowance exceeding the calculated amount, refer to [MS 2140](#).

C. Institutionalized Spouse Resource Eligibility Determination

To determine the resource eligibility for the institutionalized spouse, subtract the community spouse resource allowance from the combined countable resources of the couple. If the remainder is greater than \$2,000, the resource limit for the institutionalized spouse, the institutionalized spouse is resource ineligible.

[(Using Example 3 in item A2)

Combined resources of the couple	\$22,000
Minus Community Spouse Allowance	<u>-30,828</u>
Remainder	\$ 0

Resource eligible – remainder is less than \$2,000]

(Using Example 2 in item A2)

Combined resources of the couple	\$128,000
Minus Community Spouse Allowance	<u>-64,000</u>
Remainder	\$ 64,000

Resource ineligible – remainder exceeds \$2,000.

- D. The community spouse resource allowance remains constant for the same continuous period of institutionalization or waiver services. The continuous period ends when there is an absence from institutionalization or waiver services are terminated for 30 consecutive days. If the institutionalized spouse reapplies following a 30-day period of absence from the facility or waiver services, a new community spouse resource allowance is calculated.
- E. For cases determined resource eligible, completion of the LTC Resource Transfer Consent screen, is required to obtain the institutionalized spouse's declaration of intent to transfer resources in excess of \$2,000 to the community spouse within 6 months.

MS 2140 RESOURCE ELIGIBILITY DETERMINATION (1)
FOR APPLICANTS WITH A COMMUNITY SPOUSE

The community spouse's resources are not considered the month after the month Medicaid/patient liability is approved. 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 Medicaid Scale 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 a pre-application, also known as a standalone, Resource Assessment, or an in-application Resource Assessment on Worker Portal, if applicable, verifying resources of the couple. The LTC Resource Transfer Consent screen must be read to the individual to explain their responsibilities. Case notes must be entered that each screen was read and understood by the individual, and what response given.]
 3. Deduct the community spouse resource allowance. The community spouse resource allowance is the maximum amount of the couple's combined resources that 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 (1)

Once initial resource eligibility is established, determine the amount, if any, of resources belonging solely or jointly to the institutionalized spouse that 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 their 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 Medicaid approval.
 2. [To indicate intent, the institutionalized spouse must agree to the LTC Resource Transfer Consent screen in Worker Portal. To ensure the individual is fully aware of their responsibilities, the screen must be read to the applicant in full. Case notes must then be entered to state the worker read the screen and the information was and understood by the individual.
 3. If the institutionalized spouse fails to comply with or refuses to agree to the LTC Resources Transfer Consent screen, 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 Medicaid approval to transfer resources to the community spouse. The individual must agree to the LTC Resource Transfer Consent screen prior to case approval. In the fifth month from approval, Worker Portal will issue notice KIP-105.11, Resource Transfer Content, requesting the current resources for the institutionalized spouse be verified and where the excess resources went. 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 for the anticipated completion date. If there are no documented delays, consider all transfers completed within the specified timeframes. If resources remain in the institutionalized spouse's name, the case will discontinue effective 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 Medicaid 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. [Case Notes must be entered that the previously completed LTC Resource Transfer screen is still valid for the new obtained resources.]

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 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

(1)

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. [A timely notice is issued 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 [OVERVIEW OF INCOME (1)

Income is money received from any source, either earned or unearned. Earned income, such as wages and some self-employment, is money derived from the direct involvement in a work related activity. Unearned income, such as RSDI, SSI, pensions, etc. is money received which does not involve direct activity. It is important to determine if income is earned or unearned so Worker Portal will allow the correct deductions.

- A. Income may be countable or excluded in the Medicaid (MA) eligibility determination. Refer to [MS 2470](#), for types of excluded income. Any income not listed in [MS 2470](#) is countable. Any questions regarding consideration of income should be sent to the Medical Support and Benefits Branch (MSBB) at dfs.Medicaid@ky.gov.
- B. All income must be verified at application. However, the following types of income do not have to be verified at recertification as long as no changes in that type of income are reported.

RSDI	Black Lung	Railroad Retirement
VA Pension	VA Compensation	Annuity Payments
In-Kind Income	Indemnity Policy	Reverse Mortgage Payments
Taxable State Tax Refund	Lottery Payments	Insurance Settlement
U.S Refugee Program	Americorp	LTC Insurance Payments

- C. Verify the gross income before any deductions such as taxes, health insurance, Medicare premiums, overpayments, etc. The gross income is always entered on the system. Worker Portal will allow appropriate deductions when eligibility is run. Document any unusual circumstances related to income in Case Notes. Scan income verification into the Electronic Case File (ECF).
- D. When determining income eligibility, the total countable income is compared to the MA Scale for an individual or couple. If the total countable income (gross income minus any deductions) is equal to or less than the MA scale, income eligibility is met.

Family Size	MA Scale
1	235
2	291

- E. If total countable income is greater than the MA Scale, but the individual meets technical requirements and is resource eligible, Worker Portal will explore Spend Down eligibility as outlined in [MS 2650](#).]

MS 2200

INCOME ROUNDING

- A. DO NOT round unearned income.
- B. Determine gross monthly wages. When rounding, 50 cents is rounded to the next dollar.
 - 1. HOURLY - Multiply the number of hours in the work week by the hourly rate and round to the nearest dollar.
 - 2. WEEKLY - Round weekly income to nearest dollar. Combine rounded weekly amounts, average, and round to nearest dollar. Multiply by 13, divide by 3, and round result to nearest dollar.
 - 3. BIWEEKLY - Round to nearest dollar. Combine rounded bi-weekly amounts, average, and round to nearest dollar. Multiply by 13, divide by 6, and round to nearest dollar.
 - 4. SEMIMONTHLY - Round to nearest dollar, average, and round if 2 pay periods are used, and multiply by 2.
 - 5. MONTHLY - Round to nearest dollar.
- C. For self-employment income:
 - 1. Use actual dollar and cent amount of gross income.
 - 2. Use actual dollar and cent amount of expenses.
 - 3. Subtract actual expenses from actual income and round the difference to the nearest dollar.
- D. Round the total of each type of other earned income to the nearest dollar.
- E. Total all types of income.
- F. Round the total income to the nearest dollar and compare to the appropriate MA Scale.

MS 2220 [UNEARNED INCOME (1)

Unearned income is money received which does not involve direct activity.

The following types of income are considered unearned income:

A. Annuities. An annuity is an investment from which an individual receives fixed payments for a lifetime or a specified number of years.

1. Verification. The entire annuity contract must be obtained.

2. Consideration.

- a. All payments received from an annuity are considered countable income.
- b. Payments received less frequently than monthly are converted to a monthly amount.

B. Child and spousal support. Child and spousal support income is the amount of court ordered or voluntary support regularly received by an applicant or recipient. Voluntary payments are support payments made by a legal, alleged, or adjudicated parent without a court order. If court ordered, the child support and spousal support may be in two separate orders. When child or spousal support is court ordered, it can be considered as non-continuing only if terminated by a court order and months of zero receipt are verified. Any amount of a military allotment designated as child or spousal support is considered as support.

Note: Child support income received for a child is not considered when determining the parents' eligibility for Non-MAGI Medicaid.

1. Verification. The following are acceptable verifications of child or spousal support:

- a. Child Support Enforcement (CSE) External Search;
- b. Court records;
- c. Checks; or
- d. A written statement from the Non-Custodial Parent (NCP).

2. Refer to steps below when entering child support:

- a. If the amount of child support is representative of ongoing income, manually calculate the total amount of child support for the 3 prior months and divide that amount by 3 to get the average monthly amount. Once the average monthly amount is calculated, drop the cents, and enter that amount in Worker Portal.

Example: Amy applies in June. She received \$104.75 in May, \$100.26 in April, and \$96.43 in March as verified by CSE external search. $104.75 + 100.26 + 96.43 = 301.43/3 = 100.48$ \$100 will be the amount considered as unearned income.

- b. If the amount of child support income is not representative of ongoing income due to a VERIFIED change in circumstances, consider the anticipated child support in the ongoing budget.

Example: Alice applies in August. She received \$200 in each of the last 3 months; however, she provided a written statement from the NCP which verified that due to job loss he would be paying \$75 a month until he regained employment. Consider \$75 child support income in the ongoing budget.

3. Consideration.

- a. Worker Portal excludes one third of child support payments received for a blind or disabled child when determining Medicaid (MA) eligibility. The remainder is considered as unearned income.
- b. Worker Portal considers child support payments received for a blind or disabled child in a Nursing Facility (NF) as unearned income in its entirety when determining patient liability for NF or Psychiatric Residential Treatment Facility (PRTF) cases.
- c. If the child receiving child support payments would be eligible for Medicaid if not receiving waiver services, the child's patient liability will be \$0.

4. Case Notes should be annotated with the manual calculations used to determine the child support amount and verification source.

C. Contributions. Contributions are cash received from any source, including a parent involuntarily absent from the home.

1. Verification. A written statement from individual providing contribution or copy of checks.
2. Consideration. To determine the monthly amount of contribution, average amounts received from previous 3 months if contributions are expected to continue.

D. Farm/Business. Farm/business income is unearned if there is no direct involvement in farm/business activities. In cases of divided ownership, divide profit between the owners, unless by mutual consent entire proceeds are available to the individual. If the Social Security Administration (SSA) considers all income as available to the SSI parent, do not enter income from this source in the MA case. If the SSA considers only part of the farm/business income available, consider appropriate shares available to the MA case.

1. Verification. Use records maintained by the individual, current income tax returns, or a copy of a lease agreement.
2. Consideration. To determine profit, deduct work expenses directly related to producing the goods or services without which the goods or services could not be produced. If the farming arrangements have changed, use anticipated income from the new arrangement.

- a. ALWAYS annualize farm and business income and the expenses; use the tax return, client accounts etc. for the past year to compute the countable income if available, otherwise average previous 3 months actual reported income and expenses.
- b. If the farming arrangement has changed, do not consider the income of the past year. Use the income received from the sale of the new crop once it is sold to anticipate the income.
- c. If this is a new farm or farming activity AND:
 - (1). The farm or farming activity has been in existence for less than a year and the individual has received income from the farm or farming activity, prorate the income over the period of time the farm or farming activity has been in operation. Use the monthly amount as the anticipated income for the next year.
 - (2). The farm or farming activity has not been in existence long enough to receive income, no income is considered. Use the income once received to anticipate the income.
- d. If farming activities have been discontinued, no income is considered.
- e. Deduct the following:
 - (1). Wages paid to employees;
 - (2). Rent or interest on a mortgage and taxes, but only if the enterprise is carried on from a site other than the home;
 - (3). Interest payments only on the purchase of capital assets, equipment, etc;
 - (4). Cost of stock offered for resale;
 - (5). Cost of materials and supplies including seed, feed, crop insurance, fertilizer, and utilities required to carry on the enterprise;
 - (6). Mileage rate allowed as a deduction for business purposes if the vehicle expenses are directly related to the operation of the business enterprise – provided the person uses their private vehicle. The mileage deduction is equivalent to the amount shown on the federal tax return. If a tax return is not filed use the IRS mileage rate. This information can be accessed at: <http://www.irs.gov>. To access the current year's mileage rate enter the term "mileage rate" in the search box;
 - (7). Other non-personal items directly related to producing the goods or services;
 - (8). Repairs or maintenance of equipment and property used in the business. If the business is carried on from the home DO NOT allow a deduction for repairs to the home; and
 - (9). Management fees incurred in managing property, including management fees charged by a relative.
- f. Do not deduct the following:
 - (1). Personal work or business expenses such as taxes, FICA, lunches, etc.;
 - (2). Amounts claimed for depreciation;
 - (3). Prior or current losses;
 - (4). Purchase of capital equipment;
 - (5). Payments on principal for the purchase of property, durable goods, capital assets, equipment, etc.;
 - (6). Entertainment expenses;
 - (7). Personal transportation;

- (8). Salary or commission paid to the individual by the self employment enterprise; and
 - (9). Rent, when the self-employment enterprise is based in the individual's residence.
 - g. Rental income is unearned if the individual is not actually involved in collecting the rent, making or supervising repairs, etc.
 - (1). For verification use a statement from a tenant, a current income tax return or other records.
 - (2). Determine net profit by the same method used to determine earned rental income.
 - h. Document how the income and expenses were calculated and verified.
- E. Home Equity Plans (HEP). HEP's are designed to allow elderly homeowners to convert the equity value of their homes into cash without being forced to leave their homes.
 - 1. The following HEP's are currently available.
 - a. 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.
 - b. 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.
 - c. 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.
 - d. 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.
 - 2. Verification. Copy of specific HEP, such as a reverse mortgage, time sale, sale leaseback or loan.
 - 3. Consideration. Carefully review the plan to determine the type of compensation the homeowner is to receive, frequency/schedule of receipt, amounts, etc.
 - a. 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.

- b. The interest portion of any installment note or contract payment is considered as unearned income in the month received.
 - c. 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](#).
- F. 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.
- 1. Verification
 - a. Statement from Bureau for Rehabilitation Services;
 - b. Copy of income protection plan; or
 - c. Hospital confinement policy, etc.
 - 2. Consideration. Consider regular monthly income supplementation in determining initial and ongoing eligibility.
- G. Loans. Loans are amounts of money borrowed which require repayment.
- 1. 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.
 - 2. Consideration.
 - a. Exclude loans verified by form PAFS-73 or from a legal lending institution.
 - b. If a completed form PAFS-73 is not received, consider this income:
 - (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:
 - i. A contribution if regularly received; or
 - ii. A nonrecurring lump sum if received once.
- H. Long Term Care (LTC) Insurance. LTC insurance policies provide a benefit to help individuals pay for services received while residing in a Nursing Facility (NF). These policies may also pay for LTC services received in the individual's home.
- 1. Verification.
 - a. Require a copy of the LTC insurance policy to determine the amount of payment and who receives the payment.
 - b. Review the policy to determine if payment is made to the individual or directly to the NF. Regardless of who receives the payment, it must be entered on Worker Portal.
 - (1). If payment is made directly to the NF, it is excluded as the facility will reduce this amount from the amount billed to Medicaid (MA).

The patient liability does not change. Select Unearned Income Type "LTC Insurance Payments Facility" when entering on Worker Portal.

- (2). If payment is made to the individual it is counted as income, however it is only considered in the post eligibility calculation of patient liability. Select Unearned Income Type "LTC Insurance Payments – Individual" when entered on Worker Portal.
2. Consideration. LTC insurance, whether paid to the NF or directly to the individual is considered a third party payment. These payments cannot be used for deductions such as the community spouse income allowance or medical expenses. Third party payments are added to the patient liability calculation after all income deductions have been allowed.
- I. Lottery and gambling winnings. Lottery and gambling winnings are monies received from gambling or winning the lottery. These payments may be received as recurring installments or as a lump sum payout. Worker Portal receives a weekly interface from the Kentucky Lottery Commission for all members who received lottery winnings of \$600 or more.
1. Verification.
 - a. The Kentucky Lottery Commission interface; or
 - b. Written statement from the source of the lottery or gambling winnings.
 2. Consideration.
 - a. If a match is found for a recipient, an unearned income record is added as Lottery Payments. If the lottery winnings are received as a lump sum payout, a record is also added to the Liquid Resources screen with the Liquid Resource type as Other.
 - b. If the winning amount is received as a lump sum payout, it is treated as a non-recurring lump sum and is considered as unearned income in the month received and as a resource in the following month. The income is considered as verified upon receipt if received by the Kentucky Lottery Commission interface. A Request for Information (RFI) is issued requesting verification of resources for the month following receipt.
 - c. If the winning amount is received as recurring installment payments, it is considered ongoing unearned income. Additional verification is not required if the payments are verified by the interface with the Kentucky Lottery Commission.
- J. Other unearned income. Other unearned income includes, but is not limited to miner's benefits, pensions, oil leases, mineral rights, income received from an income indemnity policy, and trust income actually available, unless from a Medicaid Qualifying Trust.
1. Verification.
 - a. Checks
 - b. Award letters;
 - c. Written verification from company;

- d. Contract;
- e. Bank and other financial statements (for investments only); or
- f. Trust agreement.

2. Consideration.

- a. Consider all continuing unearned income
- b. Compute monthly amount if necessary.
- c. If unearned income is received irregularly or in irregular amounts, average the prior 3 months' actual income, even if some of the months have zero income, to arrive at the monthly amount. Sixty dollars per quarter is excluded from the calculation of irregular and infrequent unearned income.
- d. Income from IRA's. Individuals are required to withdraw funds from an IRA when available. If the individual is at least age 59½ and eligible to withdraw funds, failure to apply for withdrawals results in ineligibility for Medicaid. There are no distinctions between traditional and Roth IRA's. Amounts of required withdrawals are determined by the financial institution. If disbursements are not received monthly, then the amount received is prorated over the period of time it is intended to cover. For example, a quarterly payment is divided by 3 and is considered as monthly income.

Note: An individual may have several IRA's from the same company but only have a disbursement withdrawn from one account. This is allowable as long as proper verification is provided. A written statement is required from the financial institution verifying that the total disbursement amount is based on the value of all the IRA's combined.

K. Promissory Notes, Loans, Mortgages, and 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.

1. Verification. Contract or other written agreement.

2. Promissory Notes, Loans, Mortgages and Land Contracts have to meet the following criteria:

- a. 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).
- b. Payments must be made in equal amounts during the term of the loan with no deferral of payments and no balloon payments; and
- c. The promissory note, loan, mortgage or land contract must prohibit the cancellation of the balance upon the death of the lender. If a balance remains upon the death of the lender, it must be designated to the estate of the deceased in order for the promissory note to be considered valid.

3. Consideration. If the criteria in K. 2 are NOT met, the purchase of the promissory note, loan, land contract or mortgage must be treated as a prohibited transfer of resources. Ineligibility periods must be determined and

applied. The ineligibility period is based on the amount of the transfer minus the principal payments received since the date of the transfer.

Example: Daniel transfers a \$10,000 motorcycle to his nephew Jon in exchange for a promissory note. Jon makes five \$100 payments to Daniel. \$90 of each payment goes to the principal and the remaining \$10 of each payment goes to interest, making it a total of \$450 ($\90×5) 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.

4. Consideration. If the criteria in K. 2 are met and:

- a. The resource remains in the client's name, the Fair Market Value (FMV) is a countable resource and the interest portion of the continuing payments is counted as unearned income.
- b. The resource is no longer in the client's name; consider both principal and interest of payments received as unearned income.

Note: If payments received on a land contract are treated as income in the case, deduct any verified amounts the client pays for mortgage, insurance and taxes, to determine total countable income.

L. Supplemental Security Income (SSI). SSI is the federally funded and administered money payment assistance program for needy aged, blind or disabled individuals.

1. Verification. Verify and document by using any of the following sources:

- a. Current benefit verification letters;
- b. Copy of check;
- c. SSA verification forms; or
- d. System inquiry.

2. Consideration. Count SSI benefit received to determine the unearned income of the State Supplementation or LTC recipient. If SSI withholds income due to overpayment, the amount actually received is the amount considered.]

MS 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 2410 [EARNED INCOME (1)

Earned income is money received from the direct involvement in a work related activity. Taxes may or may not be withheld from earned income prior to receipt of pay. Earned income can include, but is not limited to; income received from full or part-time employment, contract employment, seasonal employment, occasional employment, self-employment, severance pay, accumulated annual leave, or commissioned employment. The following are types of earned income:

A. Wages are income received in which taxes are withheld prior to receipt of pay. The following are types of wages:

1. Wages from full or part-time employment, is income received as an employee with either a full-time or part-time employee status, designated by the specific employer.

a. Verification of full or part-time employment may include:

- i. Wage stubs;
- ii. Eligibility Advisor (EA) or Electronic Income Verification (EIV)
For more information regarding EIV, refer to [MS 2461](#);
- iii. Written statement from employer;
- iv. Form PAFS-700, Verification of Employment and Wages;
- v. Collateral contact with employer; or
- vi. Program 48.

b. Full or part-time employment income is considered in the following manner:

- i. To determine the estimated monthly income, verify and use income from all pay periods in the two calendar months prior to the application month. If the prior two month's income does not represent the ongoing situation due to sick leave, holiday pay, overtime, etc., it should be excluded from the MA eligibility determination and documented in case notes.
- ii. Count the gross income received, prior to tax withholdings or other deductions.
- iii. For individuals obtaining employment who have not yet received a pay check or do not have a full month's wage stubs, consider anticipated earnings. Determine the anticipated earnings based on the verified hourly rate and the estimated number of hours to be worked during a pay period.

2. Contract employment is income from a job in which there is a signed contract such as a school teacher, bus driver, etc.

a. Verification of contract employment may include:

- i. Contract stating salary and terms; or
- ii. Collateral contact with employer.

b. Contract employment income is considered in the following manner:

When the individual is contractually employed, calculate gross monthly income by dividing contracted agreed upon amount by 12 and round to the nearest dollar, unless the contract states income will be paid for fewer months.

- i. If the contract states the income will be received for fewer than 12 months, divide the contracted agreed upon amount by the number of months in the contract and round to the nearest dollar.
- ii. If the contract 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 amount for the remainder of the 12-month period.

3. Seasonal employment is income received from employment during a limited period within the year.

Example: An individual working at Keeneland is a seasonal employee as Keeneland is only open during the Fall and Spring.

a. Verification of seasonal employment may include:

- i. Wage stubs;
- ii. Written statement from employer;
- iii. Current income tax return;
- iv. Collateral contact with employer; or
- v. Records maintained by the individual.

b. Seasonal employment income is considered in the following manner:

- i. Count anticipated earnings or actual earnings received in the month.
- ii. If seasonal employment has ended prior to case disposition, do not consider this income.

4. Occasional employment is income from working an irregular schedule that is not known in advance such as substitute teaching, day labor, PRN nurse, etc.

a. Verification of occasional employment may include:

- i. Wage stubs;
- ii. Written statement from employer; or
- iii. Collateral contact with employer.

b. Occasional employment income is considered in the following manner:

- i. Determine ongoing monthly income by totaling actual amounts of income received in prior 3 months and divide by 3.
- ii. Manually exclude \$30 per quarter when calculating the monthly amount.

- B. Self-Employment is income received in which taxes are NOT withheld prior to receipt of pay. This may include, but is not limited to, income received from farming, odd jobs, small business enterprises, roomers or boarders, or from rental properties. Refer to Volume IVA MS 2450 for additional information on self-employment.

Note: If contract employment does not withhold taxes, such as a contract to paint a house, install a roof, etc., it is considered self-employment.

- C. Other earned income is any other income received from the direct involvement in work related activities that does not fall under wages or self-employment. The following are types of other earned income:

1. Severance pay is compensation received from an employer after employment ends.

a. Verification of severance pay may include:

- i. Wage stubs;
- ii. Written statement from employer; or
- iii. Collateral contact with employer.

b. Severance pay income is considered in the following manner:

- i. If income is received over a set amount of time, calculate the monthly amount by dividing the total amount by the number of months the income is intended to cover.
- ii. If income is received as one non-recurring lump sum, refer to MS 1990.

2. Accumulated annual leave is accrued annual leave benefits that may be paid to the individual after employment ends.

a. Verification of accumulated pay may include:

- i. Wage stubs;
- ii. Written statement from employer; or
- iii. Collateral contact with employer.

b. Accumulated annual leave is divided by the amount of time for which it was paid and is considered the month following the month it was received.

For example, Bob was paid for 2 months of accumulated annual leave in January. This amount would be divided by 2 and considered as income in February and March.

3. Commissioned employment is income received as a percentage of the money received from sales.
 - a. Verification of commissioned employment may include:
 - i. Wage stubs;
 - ii. Written statement from employer; or
 - iii. Collateral contact with employer.
 - b. Commissioned employment income is considered in the following manner:
 - i. Determine ongoing monthly income by totaling actual amounts of income received in prior 3 months and divide by 3.
 - ii. Manually exclude \$30 per quarter when calculating the monthly amount.
4. Wages received under the Senior Community Service Employment Program (SCSEP) as authorized by Title V of the Older American Act, P.L. 100-175 when taxes are withheld.
 - a. Organizations that receive Title V funds are:
 1. Experience Works;
 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 of income received under Title V funds may include:
 - i. Wage stubs;
 - ii. Written statement from employer; or
 - iii. Collateral contact with employer.
 - c. Title V funds are considered as continuing income.
5. Participant Directed Services (PDS), previously referred to as Consumer Directed Option (CDO) wages, is income received by providing services to individuals receiving waiver services, such as Home and Community Based Services (HCBS), Adult Day, Supports for Community Living (SCL), and Acquired Brain Injury (ABI). For more information on PDS refer to MS 2800.

Note: Income verification and consideration for this income is the same as wages received from full or part-time employment, refer to MS 2410 A-1.]

MS 2450

SELF-EMPLOYMENT

Self-employment income is income derived from farming, small business enterprise, rental, roomers/boarders, etc. where taxes are NOT withheld prior to receipt of pay.

- A. VERIFICATION. Records maintained by individual, statement from tenant, current income tax return, copy of lease agreement or other records.
- B. CONSIDERATION.
 - 1. ALWAYS annualize farm income.
 - 2. Annualize non-farm self-employment income and expenses if Individual Income Tax Return reports self-employment income.
 - 3. When non-farm self-employment income is not filed on Individual Income Tax Return, average previous 3 months actual income and expenses.
 - 4. To determine profit, deduct work expenses directly related to producing the goods or services and without which the goods or services could not be produced.
- C. FARM/SELF-EMPLOYMENT INCOME is considered earned income if derived from active physical engagement or managerial responsibilities in farming/self-employment. In such instances, it is subject to earnings deductions.
 - 1. If farming/self-employment activity is done by one or more family members, prorate to determine individual family member's share from profit.
 - 2. If farming/self-employment arrangements have changed, use anticipated income from the new arrangement.
 - 3. If the individual has never farmed or been self-employed, base anticipated income on the previous year's crop/self-employment activity for the particular farm/self-employment.
 - 4. If farming/self-employment activities have been discontinued, consider no income.
 - 5. In cases of divided ownership of farm/self-employment, divide profit between the owners, unless by mutual consent entire proceeds are available to the individual.
 - 6. If SSA considers all farm/self-employment income available to an SSI individual, do not enter income from this source in the MA case. If SSA considers only part of the farm/self-employment income available, consider appropriate shares available in the MA case.

7. Allowable deductions are:
- a. Wages paid to employees;
 - b. Rent or interest on a mortgage and taxes, as appropriate, but only if the enterprise is carried on from a site other than the home;
 - c. Interest payments only on the purchase of capital assets, equipment, etc.;
 - d. Cost of stock offered for resale;
 - e. Cost of materials and supplies including seeds, feed, crop insurance, fertilizer, and utilities required to carry on the enterprise;
 - f. [Mileage rate allowed as a deduction for business purposes if the vehicle expenses are directly related to the operation of the business enterprise – provided the person uses their private vehicle. The mileage deduction is equivalent to the amount shown on the federal tax return. If a tax return is not filed use the IRS mileage rate. This information can be accessed at: <http://www.irs.gov>. To access the current year's mileage rate enter the term "mileage rate" in the search box;]
 - g. Other non-personal items directly related to producing the goods or services;
 - h. Repairs or maintenance of equipment and property; and
 - i. Management fees incurred in managing property, including management fees charged by a relative.

8. DO NOT ALLOW the following deductions:

- a. Personal work or business expenses, such as, taxes, FICA, lunches, personal transportation, entertainment expenses, etc.;
- b. Amounts claimed for depreciation, prior losses or loss from one business to another;
- c. Purchase of capital equipment;
- d. Payments on principal for the purchase of property, durable goods, capital assets, equipment, etc.; and
- e. Improvements, such as paving a drive, new roof, putting up a fence, etc.

D. RENTAL/BOARDER income is considered earned income if the individual personally collects the rent, makes or supervises repairs or gives other services in relation to the property. Consider profit from rental of property owned or being purchased by the individual.

1. The total amount of allowable deductions may be either prorated or annualized to offset income. Allow the deduction to the advantage of the individual.
 - a. The total amount of expenses may be averaged over a timeframe which is less than or greater than 12 months if necessary to allow the whole deduction.
 - b. A spot check is required to ensure the deduction is removed once the total amount of the allowable deduction has been used.

2. From rental income of non-home property deduct the following:
 - a. Property taxes, state and local taxes on rental property;
 - b. Interest on mortgages, debts, property improvement loans for rental property;
 - c. Insurance on property;
 - d. Repairs or maintenance to keep rental property in good operating condition; and
 - e. Expenses for managing the property.

If the home is not occupied and not being rented, do not allow deductions to offset income.

3. For roomer or rental income from renting or sub-renting a portion of the home occupied by the individual, determine deductions as follows:
 - a. Deduct a fraction of the expenses equal to the fraction of the home rented, e.g., if 2 rooms of a 6 room house are rented, then 1/3 of the expenses are used in calculating rental deductions. Do not use halls, baths, etc., in determining the number of rooms.
 - b. Determine the total cost of repairs or maintenance of the home, the home's utilities, property insurance, property taxes and interest on mortgage, if any. Multiply the monthly expenses by the fraction of the home rented to obtain the rental deduction.

EXAMPLE:

Interest on mortgage	\$1,200
Utilities	800
Property Insurance	300
Property Taxes	100

\$2,400 divided by 12 = \$200 Monthly Cost

\$200 x 1/3 = \$66.67 monthly rental deduction

4. For boarder only, deduct an amount equal to the food stamp allotment for the number of boarders.

EXAMPLE: There are 3 boarders; the deduction equals the food stamp allotment of a 3 person household.

5. For roomer/boarder:
 - a. Deduct an amount equal to food stamp allotment. If roomer/boarder is a member of the food stamp case, do not allow a food deduction.
 - b. Rental deduction is computed the same as for a roomer. Do not compute if the roomer/boarder payment is the same as, or less than, the food stamp allotment.

*MS 2461 ELECTRONIC INCOME VERIFICATION (EIV) (1)

Electronic Income Verification (EIV) is a method of obtaining verification of a client's earned income online. An online service may be used to assist clients when verification of earned income is not readily available and the client advises the worker that the income is available by a free on-line service. See Volume I, [MS 0131](#).

It remains the client's responsibility to provide verification of earned income if information from the online service is incorrect or incomplete.

Some online services may have gross wages and tip income combined, therefore, since the income is not separated, workers must request check stubs and a daily tip log. See Volume IV, [MS 3720](#).

If the client receives bonuses included in the gross amount that are not expected to continue, the client must provide check stubs to verify earned income.

If the client receives paid overtime included in the gross amount and which is not expected to continue, the client must provide check stubs to verify earned income.

MS 2465 NON-RECURRING LUMP SUM (1)

[A nonrecurring lump sum is money received at one time which will not recur, such as accumulated back-payments from unemployment insurance (UI), escrow child support money forwarded by CSE, child support money received as a result of an IRS intercept, back-pay from employment, severance payments, money received from insurance settlements, workers compensation settlements, gifts, inheritances, lottery winnings, etc.

Income from the sale of property, including an initial down payment from a land contract sale, IS NOT considered a nonrecurring lump sum, but a change in the type of resource.

- A. CONSIDERATION. Lump sum payments, other than accumulated back payments of SSI and/or RSDI or tax rebates, are considered as unearned income in the month received, if possible. After the month of receipt, consider any portion remaining as a resource.

EXAMPLE #1: An active LTC recipient receives and gives away a lump sum back-payment from VA in May and reports receipt in the same month. Since MA benefits would already be issued for May, the lump sum cannot be considered as income in the month of receipt. However, any amount remaining as of June would be considered as a resource.

Transfer of resources policy also applies to assets, such as lump sum payments, not yet considered as a resource. Consider lump sum payments given away in the month of receipt a transfer of resources for individuals receiving LTC, HCBS, SCL or ICF IID. Follow transfer of resource policy outlined in MS 2050.

EXAMPLE #2: A SCL applicant receives VA in the month of application and reports the lump sum before the case is processed. Consider the lump sum as income in the application month, and any remaining amount as a resource in following months.

- B. VERIFY the lump sum amount by:
1. Statement from lawyer/trustee;
 2. Award letter; or
 3. Check.
- C. EXCEPTIONS. If the lump sum is from a federal or state income tax refund, it is excluded income for 12 months from the month of receipt. If the lump sum is from a worker's compensation settlement and includes a one-time lump sum payment and continuing weekly or monthly benefits, consider the one-time payment as a nonrecurring lump sum payment and the continuing benefits as unearned income in the appropriate month. If the lump sum is from accumulated annual leave or severance pay it is

considered continuing earned income, not a nonrecurring lump sum, in the first possible month following the month received.

Lump sums from accumulated back-payments of SSI and/or RSDI are excluded as a resource for the first 6 months following the month of receipt. If the back-payment includes current benefits for the month in which the payment is received, deduct that amount prior to determining the excluded resource amount. Set up a spot check for the end of the 6 month period. Consider any remaining amount as a countable resource.

Tax rebates are considered as excluded in the month of receipt and the following two months. Any proceeds from the rebates after the third month is considered a countable resource.]

MS 2470 EXCLUDED INCOME (1)

Excluded income is income received, but not considered in determining financial eligibility.

- A. KTAP and Kinship Care payments.
- B. Supplemental Security Income (SSI) benefits.
- C. Low Income Home Energy Assistance Program (LIHEAP) payments.
- D. Any payments received for child foster care, adult foster care, subsidized adoptions or personal care assistance.
- E. In-kind income.
- F. Home produce for household consumption.
- G. Third Party Payments which are payments on behalf of or for the benefit of a Medicaid individual made directly to a doctor, pharmacist, landlord, or utility company by another individual.
- H. Replacement of income already received which is lost, stolen, or destroyed for which the individual receives a replacement.
- I. Money or an in-kind item received to repair or replace a damaged, lost, or stolen excluded resource. Allow 9 months to repair or replace the excluded item, and an additional 9 months when the individual shows good cause.
- J. Educational grants and scholarships obtained and used under conditions that preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill and educational payments made under the Carl D. Perkins Vocational and Applied Technology Educational Act Amendments of 1990 made available for attendance costs. Attendance costs are described as:
 - 1. Tuition and fees normally assessed a student carrying the same academic workload required of all students in the same course of study as determined by the institution, including cost for rental or purchase of any equipment, materials or supplies; and
 - 2. An allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.
- K. Principal of loans, including educational loans. Verify the loan by a commercial loan contract or form PAFS-73, Verification of Contributions – Loans – Roomer/Boarder Payments. When verification is received, exclude the loan amount. If verification is not received, consider the principal of the loan as a contribution in the month received and any remaining amount as a resource in subsequent months.

- L. 20% RSDI increase received in August, 1972, if the individual was a money payment recipient.
- M. For Nursing Facility (NF) and Waiver cases, exclude the first \$90 of Veterans Administration (VA) pensions. For VA pensions less than \$90, exclude the entire amount. Note: This exclusion is for pensions only; it does not include VA compensation.
- N. Highway relocation assistance.
- O. Urban renewal assistance.
- P. Federal disaster assistance and State disaster grants.
- Q. One-third of child support, received by an eligible blind or disabled child, when determining MA eligibility. However, the entire amount of child support is considered when calculating patient liability.
- R. Federal tax refunds are excluded as income.
- S. Payments by credit life or credit disability insurance.
- T. Experimental housing allowance program payment made under annual contributions contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended, and HUD Section 8 payments or existing housing under Title 24, Part 882.
- U. Reparation payments from the Republic of Germany.
- V. Public Law benefits and payments to:
 - 1. Elderly persons, age 60 or older, under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;
 - 2. Elderly persons, age 55 or older, 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. Experience Works;
 - b. National Council on Aging;
 - c. National Council of Senior Citizens;
 - d. American Association of Retired Persons;
 - e. U.S. Forest Service;
 - f. National Association for Spanish Speaking Elderly;
 - g. National Urban League; and
 - h. National Council on Black Aging.
 - 3. VISTA volunteers under Title I of PL 93-113 pursuant to Section 404(g);

4. Individual volunteers for supportive services or reimbursement of out-of-pocket expenses while serving as foster grandparents, senior health aides, or senior companions and to persons serving in Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE), and any other programs under Titles II and III, pursuant to Section 418 of PL 93-113; and
 5. Indian tribe members under PL 92-524, PL 93-134, PL 94-114 pursuant to Section 5 effective October 17, 1975 or PL 94-540.
- W. Up to \$12,000 to Aleutians and \$20,000 to individuals of Japanese ancestry for payments made by the federal government to compensate for hardship experienced during World War II. All recipients of these payments are provided with written verification by the federal government.
- X. VA Aid and Attendance Allowance (VA A&A), VA Unreimbursed Medical Expenses (VA UME), and VA Compensated Work Therapy (VA CWT).
- Note: VA Aid and Attendance payments are an excluded resource in the month of receipt and the following month, and afterward are considered a countable resource.
- Y. Income of the ineligible spouse/parent, if less than or equal to \$50, when determining MA or spend down eligibility for the aged, blind or disabled spouse/parent.
- Z. All payments received from Agent Orange.
- AA. Victim compensation payments received from a fund established by a state to aid victims of crime.
- BB. Interest on burial reserves if allowed to accrue.
- CC. Income included in a Plan for Achieving Self-Support (PASS).
- DD. Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.
- EE. All student work study income, educational grants and loans to any undergraduate made or insured under any program administered by the U.S. Commissioner of Education or under the Bureau of Indian Affairs student assistance programs.
- FF. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.
- GG. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using SSI standards. This income is NOT excluded by the Social Security Administration (SSA), so these recipients should not be SSI eligible. If the hemophiliac is income ineligible for some other reason,

pend the application, and contact the Medical Support and Benefits Branch (MSBB) through your Regional Program Specialist for further instructions.

- HH. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.
- II. Payments made from the Crime Victims Funds.
- JJ. Section 401 of the Veterans Benefits and Health Care Improvement Act of Public Law 106-149, provides for certain benefits for individuals with covered birth defects during the Vietnam era. There is no age limit for recipients of these benefits. These individuals will receive the benefits until they die. The amount of these Vietnam Veterans benefits are considered as excluded income and resources.
- KK. Thirty dollars per quarter of infrequent/irregular earned income from an employer, a trade, or a business. Income is considered to be received infrequently if an individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not these payments occur in different calendar quarters. Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.
- LL. Sixty dollars per quarter of infrequent/irregular unearned income received from an individual, a household, an organization, or an investment. Income is considered to be received infrequently if an individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether or not these payments occur in different calendar quarters. Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.
- MM. The earned income of a blind or disabled child who is a student in regular school attendance.
- NN. [All interest and dividend income of individuals, community spouses and parents of disabled children. This income is excluded for Non-MAGI MA eligibility and LTC vendor payment determinations if it is reinvested or held in a stock or retirement account, or it is reinvested in or paid to a life insurance policy. The source of all interest and dividend income must be explored to determine the value and whether it is a countable resource.]
- OO. Tobacco Settlement Income is excluded in the month of receipt and the month after receipt. It is considered a countable resource in the third month and thereafter.
- PP. Military combat pay.
- QQ. Placing Adults in Competitive Employment (PACE) income.

MS 2470

(5)

RR. Income received to pay for personal care assistance such as the Hart Support Living Grant and Personal Care Attendant Program (PCAP) is considered excluded.

SS. Payments from General Electric (GE) Retiree Reimbursement Accounts which are used to reimburse an individual for eligible medical expenses. These payments are not considered income, and are considered an excluded resource in the month received but are considered a countable resource in the following month.

MS 2480

DEDUCTIONS

Deductions are subtracted from income to allow for specific expenses or allowances.

- A. VERIFICATION. Verify related work expenses by viewing and documenting receipts, checks, etc.
- B. CONSIDERATION. Deduct the following items in the following order.
 - 1. The \$20 general exclusion, first to unearned income, with the balance, if any, applied to earned income.
 - 2. \$65 from earned income.
 - 3. The Impairment Related Work Expense (IRWE) is allowed for individuals who are disabled, for any amount expended for specific items or services which enable an individual to work.

Deduct the following IRWE items and/or services only if not included in a PASS. Allow deductions in the month incurred, or divide over a 12 month period, beginning with the month of the first payment, whichever is more beneficial to the individual.

- a. Payment for attendant care services such as assistance in traveling to and from work, and assistance with personal functions at home in preparing for work such as eating, personal hygiene, dressing, etc.
- b. Payment for medical devices such as durable medical equipment such as wheelchairs, canes, crutches, inhalators, pacemakers, etc.
- c. Payment for prosthetic devices such as, but not limited to, artificial arm, leg, etc.
- d. Payment for work-related equipment for specialized use such as one-handed typewriter, telecommunication devices for the deaf, etc.
- e. Payment for residential modifications that aid an individual to work such as the installment of a ramp or enlargement of a doorway for a wheelchair.
- f. Payment for nonmedical appliances and equipment essential for the control of a disabling condition that are medically verified as necessary, such as an electric air cleaner for an individual with a respiratory disease, etc.
- g. Payment for drugs and medical services to control an individual's impairment, such as anticonvulsant drugs or anticonvulsant blood test monitoring for epilepsy, medications for mental disorders, immunosuppressive medications, etc.

- h. Payment for medical supplies and services which enable a person to work such as incontinence pads, catheters, irrigating kits, physical therapy, speech therapy, etc.
- i. Payment for transportation costs associated with vehicle structural or operational modifications and payment for use of driver assistance.
- j. Payment for installing, maintaining, and repairing impairment related items.

A blind individual may receive either the Blind Work Expense (BWE) or the Impairment Related Work Expense (IRWE), but can not concurrently receive both.

- 4. 1/2 the remaining earned income.
- 5. The Blind Work Expense (BWE) is any expense incurred as the result of working. Deductions for employed blind individuals may include, but are not limited to, transportation, lunches, federal, state and local income taxes, F.I.C.A., union dues, prosthetics, special equipment, job related training, etc. Do not allow usual living expenses, rent, food, etc., and educational expenses which are not job related. The special deductions are applicable to both the individual and responsible relative, only if not included in a PASS.
- 6. Plan for Achieving Self-Support (PASS). Work-related allowances or expenses included in an approved PASS. See [MS 2490](#).

MS 2490 PLAN FOR ACHIEVING SELF-SUPPORT (PASS)

[PASS is an income and/or resource exclusion that allows a blind or disabled applicant/recipient who does not have the capability for self-support, to set aside income and/or resources for a work goal such as education, vocational training, or starting a business.

PASS can enable an individual to maintain or establish SSI eligibility when the individual would otherwise be ineligible due to excess income and/or resources. A PASS may decrease an individual's net income used to determine MA eligibility and vendor payment, when the income considered in the PASS is excluded.

Individuals inquiring about the PASS program are referred to the Social Security Administration (SSA). Applications for PASS are approved or denied by SSA personnel who are trained to evaluate vocational/rehabilitative plans. Individuals that are approved for PASS will receive Supplemental Social Security (SSI). If an individual is denied for PASS the individual has appeal rights which are filed with SSA for reconsideration. While the PASS application is in appeal for a final decision the SSI/Medicaid application also remains pending with SSA.]

MS 2560

TECHNICALLY ELIGIBLE APPLICANT

Do the following to determine the income eligibility of a technically eligible applicant.

- A. Determine gross unearned income
- B. Deduct \$20 general exclusion. If unearned income is less than \$20, deduct the remainder of the general exclusion from earned income.
- C. Determine gross earned income.
- D. Allow appropriate deductions according to [MS 2480](#).
- E. Combine countable earned and unearned income.
- F. Deduct the MA Scale for 1.
- [G.] If there is no excess, the individual is MA eligible.
- [H.] If the countable income exceeds the MA scale, determine spend down eligibility.

MS 2570 TECHNICALY 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 2610 BOTH INDIVIDUAL AND SPOUSE ARE TECHNICALLY ELIGIBLE

A computation is required to determine the amount of income to be considered when both the applicant and his/her spouse are technically eligible.

- A. Combine unearned income of the couple.
- B. Deduct one \$20 general exclusion.
- C. Combine earned income of the couple. If unearned income is less than \$20, deduct the remainder of the general exclusion from earned income.
- D. Deduct one \$65 and 1/2 the remainder deduction for the couple. Deduct other earned income deductions for each spouse, if applicable.
- E. Combine countable unearned and earned income.
- F. If total countable income is less than the MA Scale for 2, both are eligible.
- G. If total countable income is more than the MA Scale for 2, use spend down procedures.
- H. If one of the technically eligible spouses becomes institutionalized during a spend down quarter, the spend down liability for the community spouse remains the same through the remainder of the established quarter. If the community spouse reapplies for a subsequent quarter, consider only the community spouse's gross income plus the amount actually made available to the community spouse from the institutionalized spouse. Compare income to MA family size of 1.

Compute the institutionalized spouse's eligibility and patient liability using policy in [MS 3540](#).

MS 2620

TECHNICALLY ELIGIBLE INDIVIDUAL WITH
TECHNICALLY INELIGIBLE SPOUSE

[A computation is required to determine the amount of income to be deemed from the ineligible spouse to the aged, blind, or disabled spouse.

Two budgets are computed. The result of the higher budget is used for the aged, blind, or disabled spouse's spend down amount.]

A. Step I - Technically ineligible spouse:

1. [If the ineligible spouse's gross income is less than or equal to \$50, no income is deemed to the aged, blind, or disabled spouse. Use countable income computed in Step II to determine the aged, blind, or disabled spouse's ongoing MA eligibility or spend down liability.] Do not complete Step III.
2. If the ineligible spouse's income is greater than \$50, complete Step II and Step III.

B. Step II - Aged, blind, or disabled technically eligible individual:

1. Determine gross unearned income of the aged, blind, or disabled individual.
2. Deduct \$20 general exclusion.
3. Determine gross earned income of the aged, blind, or disabled individual. If unearned income is less than \$20, deduct the remainder of the general exclusion from earned income.
4. Deduct one \$65 and 1/2 the remainder and other earned income deductions as appropriate.
5. Combine countable unearned and earned income.
6. Deduct MA Scale for 1.
7. If the result is \$0, and there is no spousal income to consider, the aged, blind, or disabled individual is MA eligible. Otherwise proceed to Step III.

C. [Step III - For an aged, blind, or disabled but technically eligible individual and technically ineligible spouse:]

1. Determine gross unearned income of aged, blind, or disabled individual.
2. Add gross unearned income of ineligible spouse.

3. Deduct the \$20 general exclusion.
4. Determine gross earned income of aged, blind, or disabled individual.
5. Add gross earned income of ineligible spouse. If unearned income is less than \$20, deduct the remainder of the general exclusion from earned income.
6. Deduct one \$65 and 1/2 the remainder for the couple, as appropriate. Deduct other earned income deductions for each spouse, if applicable.
7. Add the results from items 3 and 6. This is total countable income.
8. Deduct the MA Scale for 1.
9. If the result is \$0, in Step II and Step III, the aged, blind, or disabled individual is MA eligible.

If the result is greater than \$0, in Step II or Step III the result reflects a potential spend down amount for the aged, blind, or disabled individual. Proceed to Step IV.

D. Step IV - Spend down comparison:

1. Compare the spend down amount computed in Step II to the spend down amount computed in Step III.
2. Use the greater amount to determine spend down eligibility for the aged, blind, or disabled individual.
3. Follow regular spend down procedures to determine medical expenses used to reduce the excess income of the aged, blind, or disabled individual.

MS 2650

SPEND DOWN PROCESS

(1)

[Spend Down provides time-limited Medicaid (MA) 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 Eligibility Determination Group (EDG) size. Worker Portal automatically explores Spend Down eligibility if the individual is determined income ineligible for ongoing Medicaid. Eligibility is determined on a quarterly basis using the month of application and two following months for a current quarter Spend Down or some or all of the three months prior to the month of application for a retroactive Spend Down. For more information regarding current quarter, refer to [MS 2671](#). For more information regarding retroactive, refer to [MS 2670](#).

- A. The obligation amount is the amount the individual must pay for the Spend Down time period. The obligation amount is the amount that Medicaid will not pay.
- B. Spend Down eligibility begins on the day an individual meets the Spend Down obligation amount, such as the day medical expenses equal or exceed the excess income amount. Advise recipients the Spend Down obligated amount is met with medical bills incurred by any case member during the Spend Down time period. The household's obligated amount is met with the first providers who bill Medicaid. Use medical expenses that are incurred during the quarter or currently owed from a prior period that was not previously covered by Spend Down or regular MA.

Example: The Spend Down obligation amount is \$100.00 for the Spend Down period of 3/23 through 5/31. The household is responsible for payment of bills prior to 3/23 used to meet the obligated Spend Down amount, as well as the \$100 Spend Down obligation. If the first bill received by the Department for Medicaid Services (DMS) is for services on 4/6 for \$50.00, the amount of that bill is deducted from the obligated amount of \$100.00. The next bill received by DMS is \$25.00 for services on 3/23, and a bill is submitted the same day to DMS for \$25.00 for services on 5/1. These are deducted from the obligated amount, the client is responsible for paying them, and the Spend Down obligated amount is met. Any subsequent bills paid by DMS as long as they are within the Spend Down period of 3/23 to 5/31.

- C. Advise recipients they need to wait until they receive a statement from the provider that DMS has been billed, and the bill was denied for use in meeting the obligated amount, before they make any payments for services during the Spend Down timeframe.
- D. Medicaid is always payer of last resort. If other health insurance coverage exists, an explanation of benefits from the insurer must be provided. Only the amount the individual is responsible to pay can be considered towards the Spend Down excess.

It may take a while for the applicant to receive the explanation of benefits from the insurer and because of this MA may not be approved, until the eligible current quarter has expired. Inform applicants of this possibility.

Example: Sue applies in April for a current quarter Spend Down for May and June. She has other health insurance coverage and is waiting on an explanation of benefits from the insurer. The case remains pending until the document is provided. She receives the document in July after the quarter has expired.

- E. Effective dates of coverage begin on the day an individual meets the Spend Down obligation amount and end on the last day of the month of the approved Spend Down month or period, as appropriate.

Example: Mark applies for a Spend Down on 4/15. He is requesting a one month retroactive Spend Down only. He has medical bills for March and meets his obligation amount on 3/15. His Spend Down coverage is effective 3/15 to 3/31.

- F. A Spend Down application is approved as soon as possible, but not to exceed 30 days from the date of application. If a Spend Down application cannot be processed within 30 days due to additional information being requested or if it is the beginning of the Spend Down quarter and applicant's obligation for payment of bills has not been met, the application is held pending for receipt of incurred expenses up to 90 days. When the verification is received, the case must be worked with the task due date or the 30th day, whichever is first.

- G. If, after a determination has been made, additional verification of medical expenses is provided by the recipient, a re-computation is completed.

1. If it is determined that the Spend Down liability was met earlier in the quarter, complete a Special Circumstance to issue MA eligibility for the earlier date.

Example: Bob was approved for a Spend Down effective 4/22. Bob found a medical bill that he was unaware of from 4/5. The medical bill could have helped him meet his Spend Down liability earlier on 4/5. A Special Circumstance can be issued for the earlier date from 4/5 to 4/21.

2. If the re-computation results in the determination that the applicant met the spend down liability later in the quarter, no action is required.

- H. If medical expenses for the quarter are less than the quarterly excess income; deny the application.

- I. There is no Spend Down eligibility for individuals over the income limit for Emergency Time-Limited Medicaid.

- J. Refer to Processing Medicaid Spend Downs in R5 Worker Portal Quick Reference Guide dated 3/4/16 for information on processing a Spend Down.

- K. A household that includes an aged, blind or disabled parent can choose a Spend Down determination that includes their spouse and children in MAGI or Non-MAGI MA for themselves. The worker is to review the situation and explain the option which would be the applicant's best advantage.]

MS 2670 ESTABLISHING THE RETROACTIVE SPEND DOWN QUARTER (1)

[Months to which medical expenses can be applied are broken up into quarters. Eligibility established for a retroactive quarter may include any of the three prior months from the month of application during which an applicant incurred a medical expense. Which months are included in the retroactive quarter is a decision left up to the applicant as eligibility may be established for only one or two months of the retroactive quarter even if there are medical bills in the other months.

A. To determine eligibility for the retroactive quarter Spend Down the following must be verified:

1. The individual must verify that medical expenses were incurred in any of the retroactive months for which the Spend Down application is made.
 - a. The medical bills used must be currently owed, unless the bills were paid in the Spend Down month.
 - b. The bills can be owed by any member of the MA household even if that member is not applying for or receiving MA.
 - c. If the medical bills have been turned over to a collection agency, the bills are no longer considered as owed and cannot be used.
 - d. Any bills already used in a previous Spend Down approval cannot be used again for the current application.
2. The applicant must verify actual income and resources for each of the retroactive months for which the Spend Down application is made.

B. Consideration:

1. The application may or may not be approved as a retroactive quarter Spend Down depending on the income.
 - a. If the individual meets technical and financial eligibility and has an incurred medical expense in any of the three months prior to the application month, regular MA coverage is approved for those months. Check each month separately.

Example: A retroactive quarter spend down is established for Mary. She had medical expenses for the retroactive quarter but only had \$220 per month income for those three months. She now gets \$875 per month in RSDI. Since Mary is currently over the standard MA scale for 1 (\$235) and has no current quarter medical expenses, she is denied for ongoing MA. As she was under the MA scale for the retroactive months, she is approved for regular MA for the retroactive months.

- b. If the applicant does NOT meet income eligibility for any of the three months prior to the application month but meets technical and resource eligibility and has incurred medical expenses for one, two or three months, there is a liability.

Example: A retroactive quarter spend down is established for Annie. She had medical expenses for the retroactive quarter and had \$975 per month income for each of those three months. Annie was over the MA scale for the retro months; therefore, she does have spend down liability.]

MS 2671 ESTABLISHING THE CURRENT SPEND DOWN QUARTER (1)

[Review for regular Medicaid eligibility before determining Spend Down eligibility. Months to which medical expenses can be applied are broken up into quarters. Eligibility established for a CURRENT quarter includes the current month and the two following months. The Spend Down liability for the current month and the following two months must be met before the current quarter Spend Down is approved. The applicant is allowed until the last day of the current quarter to meet the current quarter Spend Down liability.

Before initiating the CURRENT quarter Spend Down it is important that the applicant understands all options. If the applicant has one large bill to be paid and does not expect to incur bills in the next two months, a CURRENT quarter Spend Down is not advisable. Explain to the applicant that it is to their advantage to complete a retro quarter Spend Down as their obligation amount will be less. Refer to [MS 2670](#). If the applicant chooses to wait to apply, provide the applicant with an appointment date and time for them to return to complete the application.

If payment of the bills is of lesser importance to the applicant than having Medicaid coverage for all three months in the current quarter proceed with the CURRENT quarter Spend Down application.

A. VERIFICATION

To determine eligibility for the CURRENT quarter Spend Down verify the following:

1. The applicant must verify they have enough unpaid medical expenses to meet the liability for the entire current quarter. The medical bills can be old bills incurred in previous months however they must be currently owed. The bills can be owed by any member of the Medicaid household even if that member is not applying or receiving Medicaid. However, if the medical bills have been turned over to a collection agency, the bills are no longer considered a medical bill and cannot be used. Any bills used in a previous Spend Down approval cannot be used again for the current application; and
2. The applicant must verify INCOME received in the two months prior to the month of application. If the applicant states that income received for the prior two months is not representative of ongoing income, verification of ongoing income must be provided.

B. CONSIDERATION

If the applicant meets technical and resource eligibility, average and convert income received in the previous two months to calculate the CURRENT quarter Spend Down liability.

EXAMPLE: Janie applies for a current quarter Spend Down on June 10th and states she needs help to pay for a surgery she had on June 1st. She anticipates more medical expenses for July and August. Her income is \$875 monthly

RSDI. Since this will be a current quarter Spend Down, average the prior two months income (\$875) and subtract the standard MA scale for 1 (\$235) and apply the appropriate income deductions, in this case, the \$20 unearned income general exclusion. This leaves \$620 excess which is her current quarter Spend Down liability. Since all three months must be considered for a current quarter Spend Down, Janie must incur \$1,860 ($\620×3) in medical bills during the current quarter (June, July, August) before the current quarter Spend Down can be approved.

Note: Applicants are allowed the entire current quarter to meet the Spend Down liability.

If the applicant does not meet Spend Down eligibility due to a lack of medical bills, pend the application until the last day of the current quarter in order to allow the applicant time to meet the Spend Down liability. If sufficient medical bills are not provided by the end of the current quarter, the Spend Down is denied.

- C. A retro and current quarter Spend Down can be processed simultaneously. If the Spend Down liability is met for the retro quarter, but not for the current quarter, process the retroactive Spend Down and continue to pend for medical bills for the current quarter. Issue a Request for Information (RFI) to request verification of additional medical expenses for the current quarter Spend Down.]

MS 2720 CONSIDERING MEDICAL EXPENSES IN SPEND DOWN (1)

Spend down medical expenses are expenses incurred by an individual, a spouse or dependent child under 21 in the home or away from home for the purpose of school attendance. Unless already receiving MA, these expenses are allowed regardless of whether or not these family members are included in the case and/or regardless of whether or not their income is considered in the MA eligibility determination.

[Consideration of Medical Expenses:

- A. Consider any verified recognized medical expense(s) incurred DURING the established quarter. Begin with the first day of the quarter and list daily expenses.
- B. Consider the unpaid balance of any verified recognized medical expense incurred PRIOR TO the established quarter.
 1. Consider the expense as incurred on the first day of the first month of the established quarter.
 - a. Medical expense type code "14 – PRIOR MEDICAL EXP" on the Application Medical Expense screen and is used to identify allowable unpaid medical expenses incurred prior to the established quarter. When using prior medical expenses to meet the spend down amount, always show the date the expense was incurred as the first day of the spend down quarter. If the spend down amount is met with prior medical expenses only, the member spend down liability will be \$0.
 - b. Unpaid medical expenses from a prior quarter must be verified as still owed. If the bill has been written off or has been paid by a third party, it cannot be used. If verification cannot be provided that the bill is still owed, it cannot be used to meet the spend down liability. The "SPD LIAB" (spend down liability) field on the third General Member Information Inquiry screen is uploaded with the member's spend down liability amount.
 2. Consider only the portion of the expense needed to obligate the spend down excess.
 - a. If consideration of a portion of the expense obligates the spend down excess, then the remaining balance of the expense can be used to obligate a future spend down excess. For these situations, annotate the amount used to obligate the excess for the established quarter, and the amount remaining for future spend down use in case comments.
 - b. Review the case record to ensure the expense has not been considered in a previous quarter to establish MA eligibility.

EXAMPLE: An individual's spend down excess for the current quarter is \$1,200. Two years ago, the individual incurred a \$1,600 hospital bill, made a payment of \$100 leaving an unpaid balance of \$1,500. The \$1,200 portion of the hospital bill is considered on the first day of the first month of the current quarter for spend down. The remaining \$300 of the bill can be used to obligate a future spend down excess.

- C. Verified payments on medical bills for services when MA was not received are deducted if paid during the quarter.

EXAMPLE: Two years ago, an individual purchased an \$800 hearing aid and charged the full amount. Each month a \$25 payment is made on the account. The individual applies for MA as a spend down case. Consider the \$25 as a recognized medical expense and record as a spend down expense the day the \$25 payment is made.

- D. When all verified recognized medical expenses presented by the individual are recorded, determine if, on any day in the quarter, the total amount of expenses for the period is as much as the excess income.

Verification of Medical Expenses:

- A. Medical bills or statements;
- B. Receipts for payment of medical expenses;
- C. Medicare Summary Notices (MSN) which shows covered/uncovered and paid/unpaid medical expenses;
- D. Health insurance statements showing amount paid;
- E. Other appropriate means.

Medical Expense Restrictions:

- A. Do not list any expense to be paid by a third party, such as Medicare, health insurance, insurance settlement, family member, etc.

EXCEPTIONS:

1. DO NOT hold spend down applications pending for verification of payment of medical expenses as a result of an unforeseen accident which may be covered by liability insurance owned by another person. It is the responsibility of DMS to obtain reimbursements from third party liability sources.

This procedure does not apply to health insurance policies, such as, Medicare, Blue Cross/Blue Shield, Humana, etc. and Worker's Compensation. Spend down applications are held pending verification of payment of medical expenses by these third party liability sources.

2. For persons undergoing renal dialysis treatment, do not hold spend down applications pending for Medicare Summary Notices (MSN) if:
 - a. They have Medicare but no other health insurance; and
 - b. The renal dialysis clinic provides a statement verifying the date of service, cost of service and the anticipated amount of Medicare reimbursement for each date of service. The difference between the Medicare billed amount and the anticipated Medicare payment amount is allowed as the spend down medical expense.

Use this statement and any other verified medical expenses that will not be reimbursed by Medicaid, such as prescriptions. Other verified medical expenses subject to Medicare reimbursement cannot be used to meet the spend down liability as the application is to be processed prior to receipt of the MSN.

These cases are given priority and processed as soon as the spend down liability is met. When MSN's are received for other medical expenses, the case is reworked at the individual's request, to determine if an earlier date was met for the spend down program.

- B. Do not consider medical expenses for which individual is absolved from payment, such as a medical bill written off by provider as uncollectible. If the medical expense is more than 90 days old, OR if the individual's responsibility for payment of the medical expense is questionable, the appropriate provider MUST be contacted to determine whether or not the individual is liable for payment of the expense.
- C. Do not consider medical bills or payment on medical bills used to obligate the liability amount for any previous spend down quarter.

EXAMPLE: During the current quarter, an individual purchased eyeglasses costing \$129. The total amount was charged on the 6th day of the 1st month of the current quarter. The total amount is considered on the 6th for spend down. During the next quarter, \$25 a month has been paid on the \$129 charge. The \$25 payments cannot be used as the entire \$129 was used in the quarter the expense was incurred.

- D. Unpaid medical expenses are allowed as a spend down medical expense unless B or C of this section apply.
- E. For the child excluded from an K-TAP grant and for whom a separate spend down case has been established:
 1. Combine income and resources of the K-TAP group and the excluded child.
 2. Apply verified incurred medical expenses of the excluded child.
 3. Apply uncovered verified incurred medical expenses of the responsible relative to the spend down amount.

4. Do not consider medical expenses of the K-TAP children.
- F. For a blind or disabled child living at home:
1. Consider income and deductions of the parent and the blind or disabled child according to [MS 1810](#); and
 2. Apply uncovered, verified incurred medical expenses of the parent, blind, or disabled child and siblings to the spend down amount.
- G. All bills, statements, and receipts, must show the actual date of service and daily charge to determine the day the excess is met.
- H. Deductions for prescription drug expenses incurred during a period of Medicaid eligibility may be allowed ONLY if the recipient verifies that Medicaid denied coverage of the drug at the time, and that a prior authorization request was also denied. A deduction can be given for a Medicare Part D premium if paid by the recipient.]

MS 2730 ALLOWABLE SPEND DOWN MEDICAL EXPENSES (1)

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

- A. Health insurance premiums including Supplementary Medical Insurance (SMI), and specified disease policies such as cancer and/or any other policies paying for services within the scope of the program. Consider the entire amount when paid or prorated payment for months of actual coverage, to the benefit of the client whichever they choose.

EXAMPLE: A \$90 premium is paid July 15 to cover August, September and October. Allow \$30 for August 1, September 1 and October 1 or use the entire \$90 on July 15.

- B. Insurance policies paying specific benefits per day to an individual while hospitalized or during recuperation. Premiums paid on these policies are considered a medical expense.
- C. Nursing facility insurance premiums.
- D. Transportation expenses for health care that are not available free of charge. Costs for use of the individual's own car are deductible at the current federal standard medical mileage rate. This information is accessed at www.irs.gov. To access the current year's medical mileage rate enter the term "mileage rate" in the search box;
- E. The actual amount paid for caretaker, Family Care, Personal Care, or Community Integration Supplementation (CIS) services if the individual is paying the private pay rate.

If medical expenses of a spouse are being considered and the spouse is receiving state supplementation payments then consider the payment for caretaker services as a medical expense.

- F. In-patient hospital services including services in institutions for tuberculosis, mental disease or other specialty hospitals regardless of age;
- G. Laboratory and x-ray services;
- H. Nursing Facility services, including services in institutions for tuberculosis or mental disease, for all individuals regardless of age;
- I. Any physician's services;
- J. Medical care or any other type of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice as defined by state law;
- K. Home health care services, including intermittent or part-time services of a nurse or home health aid according to a physician's plan of treatment;

- L. Private duty nursing services by a Licensed Practical Nurse or Registered Nurse;
- M. Clinic services;
- N. Dental services, including dentures prescribed by a licensed and practicing dentist;
- O. Physical therapy and related services including supplies such as hearing aids;
- P. Drugs prescribed by a licensed physician, osteopath or dentist;
- Q. Prosthetic devices, including braces, and artificial limbs;
- R. Eye glasses and other aids to vision, prescribed by an ophthalmologist or an optometrist;
- S. Ambulance services when medically indicated and/or other transportation costs necessary to secure a medical examination or treatment;
- T. X-ray, radium and radioactive isotope therapy;
- U. Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations, including surgical dressings and related items, used at the direction of a physician for continuing treatment of a health problem;
- V. If not available from a Home Health Agency, rental or purchase of durable medical equipment including, but not limited to iron lung, oxygen tents, hospital beds, wheelchairs, crutches, braces and artificial limbs including replacements if required because of change in the patient's condition;
- W. Purchase, care and maintenance costs of Seeing Eye dogs;
- X. Consider the cost of lodging, which may include the lodging cost of a nurse/attendant, a necessary medical expense if it can be determined lodging was necessary to secure required medical service or treatment.
 - 1. Question the client to determine if circumstances necessitated lodging and annotate case record.
 - 2. If the need for lodging cannot be determined, request a physician's statement to verify reported expenses were actually medically necessary.
 - 3. The allowable amount may not exceed commercial lodging costs prevalent in area.
- Y. Incurred medical expenses paid by a public program of the State or a political subdivision without federally designated funds. Political subdivisions include city, county, or local governments. These medical expenses are also

allowed as deductions for LTC, waiver and Hospice cases if MA eligibility is determined by exceptional spend down, Step II process.

1. Examples of public programs of the State include;
 - a. Hospitals such as, UK Medical Center, Humana University Hospital;
 - b. Health departments;
 - c. Community Service Centers;
 - d. Primary Care Centers operated by local health departments; and
 - e. Comprehensive Care Centers.
 2. Medical expenses paid by programs of the federal government, including Medicare and VA. Bills that have been written off as uncollectible are not allowable as spend down deductions.
 3. Obtain a copy of the bill to verify that a medical expense was incurred and that the expense was paid by a State public program or political subdivision without federally designated funds prior to allowing the deduction.
- Z. Any item verified by a doctor's statement that is medically necessary for controlling a patient's allergy problem. Items may include:
1. The purchase of electrostatic air filters;
 2. Humidifiers;
 3. Air conditioning;
 4. Central heating systems;
 5. Hardwood floors;
 6. Payment for carpet/upholstered furniture cleaning; and
 7. Carpet removal.
- AA. Other items clearly identified as medical in nature.
1. This includes:
 - a. Aspirin;
 - b. Antacids;
 - c. Peroxide;
 - d. Band-Aid's;
 - e. Nutritional supplements such as Ensure; and
 - f. Incontinent care products.
 2. Cash register receipts are acceptable verification of the expense. If the receipt does not specify the item, the individual's statement is accepted.

BB. Consider charges from a physician who is not enrolled in the Medicaid program as a medical expense on the date of service in the spend down calculation. While the expenses can be deducted, Medicaid cannot make payments to a physician who is not an enrolled provider.

[CC. Non-Institutionalized Hospice expenses.

DD. Any medical expense that a Managed Care Organization (MCO), nor any other third party insurance, doesn't cover is an allowable medical expense.]

MS 2770

PATIENT LIABILITY FOR INDIVIDUALS
OTHERWISE MEDICAID ELIGIBLE

(1)

[When an individual who is already Medicaid eligible begins receiving waiver services, the individual has a \$0 patient liability even if the countable income exceeds the Personal Needs Allowance (PNA). This applies only to waiver admissions, not to nursing facility admissions.

Example 1: Bob is currently receiving Medicaid as a Pass Through individual when he is admitted to HCBS waiver and a Level of Care interfaces to his case. Worker Portal will calculate his patient liability as \$0 because he is otherwise Medicaid eligible.

Example 2: Jill applies for Medicaid for a type of assistance that will pay for waiver services. She has no medical expenses and her only income is \$1100 RSDI. Because her income exceeds the MA scale for a family size of 1 (\$235), the special income standard must be applied for her to be financially eligible for Medicaid. She will have a patient liability amount of \$309 as she is not otherwise Medicaid eligible.]

MS 2800 [PARTICIPANT DIRECTED SERVICES (1)

Participant Directed Services (PDS), formerly known as Consumer Directed Option (CDO), allows individuals eligible for Medicaid (MA) waiver services to choose their own providers for non-medical waiver services. Individuals are eligible to participate in PDS once admitted to Home and Community Based Services (HCBS), Supports for Community Living (SCL), Michelle P. Waiver, Acquired Brain Injury Long Term Care (ABI LTC), or Acquired Brain Injury (ABI). All technical and financial criteria for MA and waiver eligibility apply. By choosing PDS, an individual can maintain better control over how services are provided. PDS is not an increase in or expansion of services.

- A. PDS may be provided by a family member, friend, or neighbor.

For example, John receives Medicaid as a Pass Through recipient and lives with his mother. He is approved for HCBS waiver and chooses PDS. He wishes his mother to be his PDS provider and this is allowable even though she is related and lives in the home.

- B. Pay received by a PDS employee is countable as earned income when determining eligibility for Non-MAGI MA and should be entered as wages.

For example, John's mother applies for Medicare Savings Program (MSP). The PDS income she receives for providing services to John is countable earned income when determining her eligibility for MSP.

- C. Individuals may choose to receive only traditional services such as HCBS, Michelle P. Waiver, ABI LTC, SCL, or ABI, or they can combine traditional services with PDS depending on their needs and approved plan.

- D. Refer individuals with questions regarding PDS to contact their case manager, or local Community Mental Health Center (CMHC) if not currently receiving waiver services.]

Some aged or disabled individuals receive waiver services to help them live in the community and maintain their independence and prevent admittance to a Nursing Facility (NF). However, for Medicaid purposes individuals receiving waiver services are considered as institutionalized even though they reside at home.

A. Kentucky offers the following waiver programs:

1. Supports for Community Living (SCL)
2. Michelle P. Waiver (MPW)
3. Home and Community Based Services (HCBS)
4. Acquired Brain Injury (ABI)
5. Acquired Brain Injury LTC (ABI LTC)

B. Applications for waiver services are completed through the Self-Service Portal (SSP) and monitored by the Medicaid Waiver Management Application team. Individuals wishing to apply for waiver services must have either active or pending Medicaid.

1. If they do not have Medicaid, the provider will advise the family or responsible party to apply for the individual.
2. If the individual has Medicaid in a Type of Assistance (TOA) that does not support waiver, a case change must be completed with all income, resources, and other information updated to reflect their current situation.
3. If the individual already receives Medicaid in a TOA that supports waiver, their eligibility does not have to be redetermined.

To ensure eligibility is correctly determined, enter the Living Arrangement Type as 'In Home' and the Type of In Home Care as 'Waiver' on the Living Arrangement screen. Once all verification is returned, Worker Portal will pend the application for up to 90 days to receive the Level of Care (LOC) record for individuals who are not otherwise Medicaid eligible. Note: All required verification must be returned timely or the application will deny regardless of the LOC status.

C. Technical Eligibility Requirements

1. All recipients must meet the technical eligibility requirements to receive Medicaid, which include enumeration, residency, third party liability, etc. Additionally, if not otherwise eligible for Medicaid, the individual must meet the aged, blind, disabled criteria outlined in [MS 1700](#).

Note: Those individuals whose receipt of Medicaid is not dependent on having a level of care are considered to be otherwise Medicaid eligible.

2. A Level of Care record must be received in Worker Portal. This record is received as notice that the individual was assessed, and it was determined that it is medically necessary for them to receive waiver services. For more information on the level of care process, refer to [MS 3650](#).
- D. If a waiver recipient temporarily enters a Nursing Facility for 60 days, or less, they are not required to have a new LOC if they resume services with the same provider when discharged.

[The Supports for Community Living (SCL) waiver program is available statewide and provides home and community based services to Medicaid recipients with an intellectual or developmental disability who would otherwise require institutional care in an ICF IID facility. Community Mental Health Centers (CMHC) are certified by the Department for Medicaid Services (DMS) to provide intermediate care services for individuals eligible for the SCL waiver program. These services are delivered through Participant Directed Services (PDS), or by a combination of SCL and PDS. Refer to [MS 2800](#) for more information regarding PDS.

The following services are covered by the SCL waiver program:

- A. Adult Day Habilitation Component: Includes services provided in outpatient settings designed to provide an organized program of training in developmental skills, using age-appropriate methods.
- B. Case Management/Recipient Evaluation: Includes case coordination, evaluation, preparation of plan of care, and follow-up assessment.
- C. Habilitation Component: Includes behavior management; medical and psychological services; occupational, physical and speech therapy; etc.
- D. In-Home Support Component: Includes in-home training, home-maker/home health aide services, and personal care services provided to SCL recipients residing at home.
- E. Prevocational Services: Includes services aimed at preparing the SCL recipient for paid or unpaid employment and assists the recipient in acquiring and maintaining basic work and work-related skills.
- F. Residential Component Services: Includes training, homemaker, personal care services provided to SCL recipients in alternative living units (ALUs) by ALU staff. The residential component does not include room and board.
- G. Respite Component: Includes short term care and supervision of SCL recipient provided for the temporary relief of the family or residential staff, or for the safety and relief of the SCL recipient.
- H. Supported Employment: Includes paid work in a variety of work settings in which individuals with mental retardation/developmental disabilities are employed. These services may include development of physical capacities, psychomotor skills, interpersonal and communicative skills, development of appropriate work behavior, work performance skills, and job seeking and job keeping skills.]

MS 2815

MICHELLE P. WAIVER

(1)

[Michelle P. Waiver offers many of the same services as the Home and Community Based Services (HCBS) and Supports for Community Living (SCL) waiver programs. In order to qualify for Michelle P. Waiver, an individual must meet Medicaid financial eligibility and the level of care for an Intermediate Care Facility (ICF) or Nursing Facility (NF) established by Medicaid. Refer individuals to their local Community Mental Health Center (CMHC) for an assessment to see if they meet the level of care.

- A. Michelle P. Waiver requires a Level of Care (LOC) in Worker Portal before Medicaid in the LTCM Type of Assistance (TOA) is issued.
- B. Individuals receiving Michelle P. Waiver have the same Personal Needs Allowance (PNA) that is allowed for non-institutionalized individuals receiving waiver services.
- C. Individuals receiving State Supplementation, who reside in a Family Care Home (FCH), receive Community Integration Supplementation (CIS), or Caretaker Services are eligible to receive services from Michelle P. Waiver, if verified that there is no duplication of services. The worker must verify there is no duplication of services by requesting a list of services from both providers.

Note: Residents of a Personal Care Home (PCH) are not eligible for Michelle P. Waiver.

- D. When an otherwise Medicaid eligible individual begins receiving Michelle P. Waiver, their patient liability is \$0 regardless of income.]

MS 2816*

HCBS WAIVER PROGRAM

(1)

The Home and Community Based Services (HCBS) waiver program is available statewide and allows Medicaid recipients who would otherwise be institutionalized to receive necessary services at home. The services are provided by home health agencies that are certified by Medicaid. Recipients of the HCBS waiver program are considered institutionalized for financial eligibility even when they live in their own home and may have services delivered through Participant Directed Services (PDS), or by a combination of HCBS and PDS. Refer to [MS 2800](#) for more information on PDS.

The following services are covered by HCBS:

- A. 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").
- B. Assessment: A registered nurse 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.
- C. Case Management: Arranges for needed services, monitors services provided, etc.
- D. Homemaker Services: Performs general household activities, such as meal preparation and routine household chores for the individual.
- E. Minor Home Adaptations: Includes adding rails, ramps, etc., to individual's home.
- F. Personal Care: Performs medically oriented tasks such as assistance with bathing, dressing, ambulation, medications, etc.
- G. Respiratory Therapy Services: Provides a qualified respiratory therapist for ventilator dependent recipients who are also receiving home health services.
- H. Respite Care: Provides short term relief for caregiver.

MS 2817* ACQUIRED BRAIN INJURY WAIVER PROGRAM (1)

The Acquired Brain Injury (ABI) Waiver Program allows Medicaid 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 Participant Directed Services (PDS) or through a combination of ABI and PDS. Refer to [MS 2800](#) for more information on PDS.

The individual must meet criteria for the ABI waiver as determined by the Department for Mental Health/Mental Retardation (MHMR). 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 are then paid by the primary provider.

MS 2818* ABI LONG TERM CARE (LTC) WAIVER (1)

The Acquired Brain Injury Long Term Care (ABI LTC) waiver program is designed for individuals who meet the level of care criteria for the Acquired Brain Injury (ABI) waiver but require ongoing supportive services beyond the intensive rehabilitation services provided by the traditional ABI waiver program. Individuals in the ABI LTC waiver program are not expected to recover. Eligibility for ABI LTC individuals is determined as follows:

- A. In addition to technical eligibility requirements for Non-MAGI Medicaid, the individual must also:
 - 1. Meet the level of care for the ABI waiver program; and
 - 2. Be age 18 or older; and
 - 3. Be within Non-MAGI Medicaid income and resource limits.

- B. Program requirements for ABI LTC Waiver are:
 - 1. Recipients may have only one provider.
 - 2. Recipients are identified by the provider type on the Level of Care screen in Worker Portal.
 - 3. The ABI LTC Waiver case will be processed within 30 days of receipt of a complete application.
 - 4. Coverage cannot start prior to the onset date of the program 10/1/08.
 - 5. If the individual is already receiving Medicaid when they start receiving ABI LTC, the patient liability will be \$0 regardless of income. If the individual is not otherwise Medicaid eligible, the patient liability may be incurred depending on the case income.
 - 6. Participant Directed Services (PDS) is an option available to ABI LTC Waiver recipients and can be used to receive respite companion care and personal care. For more information on PDS refer to [MS 2800](#).
 - 7. State Supplementation recipients in a Family Care Home (FCH), Community Integration Supplementation (CIS), or receiving Caretaker Services are eligible to receive ABI LTC Waiver, as long as there is no duplication of services.
 - 8. Individuals receiving Personal Care Home (PCH) services are not eligible to receive ABI LTC Waiver services.

Complete the following steps to determine financial eligibility and patient liability for single adults applying for Medicaid in a type of assistance that supports waiver services.

A. Determining Medicaid Eligibility *Without* Using the Special Income Standard

1. Determine countable income of the individual. Consider gross income and/or net profit, less the \$20 general exclusion and work related expenses, if appropriate.
2. Deduct the Medicaid Scale for 1.
3. Deduct verified, incurred medical expenses of the 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 Medicaid. For more information on allowable medical expenses, refer to [MS 3480](#).
4. If the individual receives Supports for Community Living (SCL) wavier services, deduct the SCL standard.
5. If there is no excess, the individual is Medicaid eligible. If there is an excess, the individual's eligibility must be determined using the special income standard.

B. Determining Medicaid Eligibility *Using* Special Income Standard

1. Determine gross income of the individual.
 - a. If the gross income is equal to, or less than, the special income standard the individual potentially is Medicaid eligible. The special income standard is three times the SSI limit and the current standard can be found in [MS 1750](#).
 - b. If the gross income is greater than the special income standard, the individual can establish a Qualifying Income Trust (QIT). The income exceeding the special income standard may be placed in the QIT which will allow the individual to become eligible for Long Term Care Medicaid. For more information on QITs, refer to [MS 3505](#).

If a QIT is not established, the individual is not eligible for Medicaid. If a QIT is established and funded, the individual is potentially eligible for Medicaid.

2. To be eligible for Medicaid, the individual must also be admitted to waiver services for 30 days. If Medicaid eligibility is only pending for 30 days of institutionalization, Worker Portal will process the case on the 31st day without worker intervention.

C. Determining Patient Liability

1. Determine gross income and/or net profit of the individual.
2. Deduct the personal needs allowance.
3. Deduct an increased personal needs allowance, if appropriate, from income of the individual.
4. Deduct verified, incurred medical expenses of the 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 Medicaid.
5. Add any third party payment paid directly to the provider, if appropriate. Do not use these payments for other deductions such as medical expenses.
6. The result is the individual's patient liability, or payment toward the cost of care.

NOTE: When an individual who is already Medicaid eligible begins receiving waiver services, the patient liability is \$0 regardless of income.]

MS 2850

[WAIVER CHILD

(1)

Disabled children receiving waiver services are considered as living separately from their parents beginning the month after the month of admission. For the month of admission, consider the income and resources of both the child and parent(s), as appropriate. After the month of admission, only the child's income and resources are considered. Refer to [MS 1810](#) for further information on disabled children living with parents and [MS 1820](#) for information on disabled children living apart.

A. Determining Medicaid Eligibility for the Month of Admission

1. Parental income is adjusted using the following steps to determine how much is counted in the child's eligibility determination.
2. Parental allocations are deducted from the parents' countable income as follows:
 - a. If the parent(s) only has unearned income, allow the parental allocation for unearned income.
 - b. If the parent(s) only has earned income, allow the parental allocation for earned income.
 - c. If the parent(s) has a combination of earned and unearned income, only allow the parental allocation for unearned income.
 - d. If there are two parents in the home, the parental allocation for two is used, even if only one has income.
 - e. The ineligible sibling allocation is allowed for each ineligible sibling, under age 18, living in the home with the blind or disabled child. If the sibling has income, that income is subtracted from the ineligible sibling allocation to determine how much will be deducted from the parental income.

Refer to [MS 1750](#) for the current parental and ineligible sibling allocations.

3. If any parental income remains after the appropriate deductions and allocations, it is counted in the child's eligibility determination.
4. Determine the child's countable income.
5. Combine the deemed income of the parent and the countable income of the child.
6. Deduct verified, incurred medical expenses of the child 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 Medicaid. For more information on allowable medical expenses, refer to [MS 3480](#).
9. Deduct the Medicaid Scale for one.

10. For children receiving Supports for Community Living (SCL) waiver services, deduct the SCL Standard.
11. If there is no excess, the child is Medicaid eligible. If an excess remains for the month of admission, the child is not eligible for that month. The child is potentially eligible for a spend down, however it does not pay for waiver services. The spend down should be processed using the regular Medicaid Scale.

B. Determining Medicaid Eligibility for the Month *after* the Month of Admission

1. Determine the child's countable income.
2. Deduct verified, incurred medical expenses of the child 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 Medicaid.
3. Deduct the Medicaid Scale for one.
4. For children receiving Supports for Community Living (SCL) waiver services, deduct the SCL Standard.
5. If there is no excess, the child is Medicaid eligible.
6. If there is an excess, the child's eligibility must be established using the special income standard. This means they must be admitted to waiver services for 30 days before being approved for Medicaid. Refer to [MS 3500](#) for more information regarding the special income standard.

C. Determining Patient Liability

1. Determine gross income and/or net profit of the child.
2. Add income of the parent calculated in Section A for the patient liability for the month of admission only.
3. Deduct the personal needs allowance.
4. Deduct an increased personal needs allowance from income of the child, if appropriate.
5. Deduct verified, incurred medical expenses of the child 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 Medicaid.
6. If income of the parent is considered, deduct verified, incurred medical expenses of the parent. Note: This only applies to calculations for the month of admission.

7. Add any third party payments paid directly to the provider, if appropriate. Do not use these payments for other deductions, such as medical expenses.
8. The result is the child's patient liability, or payment toward cost of care.

Note: When a disabled child who is already Medicaid eligible begins waiver services, the patient liability is \$0 regardless of income.]

MS 2860 [WAIVER INDIVIDUAL WITH COMMUNITY SPOUSE (1)

The countable income in waiver cases involving couples is determined by whether the spouses are both receiving services. If only one spouse is receiving services, they are considered the institutionalized spouse, even though they are still living in the home. The other is considered the community spouse. The following steps are completed by Worker Portal to calculate the amount of countable income in each waiver case involving couples.

A. Determining Medicaid Eligibility

1. Determine gross income of the spouse receiving waiver services and deduct the Medicaid Scale for 1. If the individual receives Supports for Community Living (SCL) waiver services, deduct the SCL standard.
2. If gross income is equal to or less than the special income standard, the individual is Medicaid eligible.
3. If the gross income is greater than the special income standard, the individual can establish a Qualifying Income Trust (QIT). The income exceeding the special income standard may be placed in the QIT which will allow the individual to become eligible for Long Term Care Medicaid. For more information on QITs, refer to [MS 3505](#).

If a QIT is not established, the individual is not eligible for Medicaid. If a QIT is established and funded, the individual is potentially eligible for Medicaid.

4. To be eligible for Medicaid, the individual must also be admitted to waiver services for 30 days. If Medicaid eligibility is only pending for 30 days of institutionalization, Worker Portal will process the case on the 31st day without worker intervention.

B. Determining Community Spouse Income Allowance

The income of an institutionalized spouse with a community spouse is treated differently to prevent the financial hardship that may happen when one spouse begins receiving waiver services. The current community spouse allowances and standards can be found in [MS 1750](#). 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. Worker Portal calculates the community spouse income allowance based on the process outlined in MS [3550](#).

C. Determining Family Income Allowance

Determine family income allowance if there is a minor child or dependent child, dependent parent or dependent sibling of either spouse who is residing with the community spouse. Note: The family income allowance can only be allowed if there is a 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.

D. Determining Patient Liability

1. Determine gross income and/or net profit of the 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 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 Medicaid. For more information on allowable medical expenses, refer to [MS 3480](#).
7. Add any third party payment paid directly to the provider, if appropriate. Do not use these payments for other deductions, such as medical expenses.
8. The result is the individual's patient liability, or payment toward cost of care.]

MS 2870

[WAIVER COUPLE

(1)

To be considered an eligible couple, both spouses must be aged, blind, or disabled; income and resources eligible as a couple; and both receiving waiver or long term care services. The applications do not have to be completed at the same time. However, if only one spouse is receiving waiver or long term care services, eligibility should be determined as a wavier individual with a community spouse.

A. Determining Medicaid Eligibility

1. Determine the gross income of each spouse and deduct the Medicaid Scale for 1. If the individual receives Supports for Community Living (SCL) wavier services, deduct the SCL standard.
2. If the gross income of one, or both, of the spouses is equal to, or less than the special income standard, the individual is Medicaid eligible.
3. If the gross income of one, or both, of the spouses is greater than the special income standard, the individual with excess income can establish a Qualifying Income Trust (QIT). The income exceeding the special income standard may be placed in the QIT which will allow the individual to become eligible for Long Term Care Medicaid. For more information on QITs, refer to [MS 3505](#).

If a QIT is not established, the individual is not eligible for Medicaid. If a QIT is established and funded, the individual is potentially eligible for Medicaid.

4. To be eligible for Medicaid, each spouse must also be admitted to waiver services for 30 days. If Medicaid eligibility is only pending for 30 days of institutionalization, Worker Portal will process the case on the 31st day without worker intervention.

B. Determining Patient Liability

1. Determine gross income of the couple and divide by 2. Consider 1/2 of the income while calculating patient liability.
2. Deduct the personal needs allowance for each spouse.
3. Allow 1/2 of total deductions as an increased personal needs allowance for each spouse as appropriate.
4. Deduct verified, incurred medical expenses of the 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 Medicaid. For more information on allowable medical expenses, refer to [MS 3480](#).
5. Add any third party payment paid directly to the provider, if appropriate. Do not use these payments for other deductions, such as medical expenses.

6. The result is the patient liability, or payment toward cost of care, each spouse is responsible for paying.]

MS 3050

[SCOPE OF HOSPICE PROGRAM]

(1)

The Hospice program offers medical services to Medicaid eligible individuals who are terminally ill and have a life expectancy of less than six months. Recipients may choose to elect Hospice as a greater variety of services are provided than in traditional long term care. Individuals may receive care while in their home or a facility. Non-institutional Hospice services are provided in an individual's home, while Institutional Hospice services are provided in a Nursing Facility (NF). Please note that a Level of Care will not be received for Non-institutionalized Hospice.

- A. The following are examples 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. 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 provider to notify the Department for Medicaid Services (DMS) of Hospice elections, revocations, provider changes, and

terminations. The designated Hospice is responsible for providing these forms to DMS for processing.]

MS 3060

HOSPICE RATES

(1)

[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 determines the Hospice rate.

- A. Boone, Bracken, Campbell, Gallatin, Grant, Kenton, and Pendleton counties' daily Hospice rates are: \$195.92 for 1-60 days of care, and \$154.83 for 61 or more days of care.
- B. Boyd, Carter, and Greenup counties' daily Hospice rates are: \$183.26 for 1-60 days of care, and \$144.82 for 61 or more days of care.
- C. Bullitt, Henry, Jefferson, Oldham, Shelby and Spencer counties' daily Hospice rates are: \$186.12 for 1-60 days of care, and \$147.09 for 61 or more days of care.
- D. Henderson County's daily Hospice rates are: \$194.36 for 1-60 days of care, and \$153.60 for 61 or more days of care.
- E. Bourbon, Clark, Fayette, Jessamine, Scott, and Woodford counties' daily Hospice rates are: \$186.92 for 1-60 days of care, and \$147.72 for 61 or more days of care.
- F. Daviess, Hancock, and McLean County's daily Hospice rates are: \$182.77 for 1-60 days of care.
- G. Warren County's daily Hospice rates are: \$185.14 for 1-60 days of care and \$146.31 for 61 or more days of care.
- H. For all other counties the daily Hospice rates are: \$176.78 for 1-60 days of care and \$139.70 for 61 or more days of care.]

MS 3070 HOSPICE TECHNICAL ELIGIBILITY REQUIREMENTS (1)

[Determine Medicaid technical eligibility for the Institutionalized Hospice applicant as follows:

- A. The applicant must be enrolled with a Department for Medicaid Services (DMS) certified Hospice provider. Form MAP-374, Election of Medicaid Hospice Benefits, verifies Hospice election, date of enrollment, and long term inpatient care in a nursing facility, if appropriate. An individual 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 DMS.]
- B. The applicant must meet all technical eligibility requirements for Medicaid 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 eligible for Medicaid in another category.
- C. [If a recipient revokes or terminates Hospice benefits, a second form MAP-374 is forwarded by the Hospice provider to DMS verifying Hospice election for the remaining benefit period(s).]

MS 3100 NONINSTITUTIONAL HOSPICE MEDICAID ELIGIBILITY (1)

[A Level of Care (LOC) will not be received for Non-Institutionalized Hospice as these services are paid through a Managed Care Organization (MCO). Therefore, individuals in Non-Institutionalized Hospice must be Medicaid eligible in a Type of Assistance (TOA) that requires an MCO.

Medicaid eligibility is determined using only the individual's income. The special income standard is not used. Individuals who are receiving Non-Institutionalized Hospice who are not eligible for a type of Medicaid assistance that does not require the use of the special income standard are not eligible for Medicaid which covers Non-Institutionalized Hospice services.

The following TOA's are not compatible with Non-Institutionalized Hospice: LTCM, Emergency Time-Limited, and Spend Down.

Non-Institutionalized Hospice individuals will not have a patient liability. A resource assessment is not required.]

MS 3210 INSTITUTIONALIZED HOSPICE INDIVIDUAL (1)

[Determine Medicaid eligibility and patient liability for an Institutionalized Hospice Individual as follows:

A. Determining Medicaid Eligibility Using the Special Income Standard

- 1 Determine the gross income of the 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 Medicaid eligible.
3. If gross income is greater than the special income standard for an individual, refer to [MS 3505](#).

B. Determining Patient Liability

1. Determine the gross income and/or net profit of the individual.
2. Deduct the personal needs allowance.
3. Deduct, if appropriate, the increased personal needs allowance from the income of the individual.
4. If dependents have income less than the MA Scale, deduct an amount to bring the 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 (1)

[Determine Medicaid eligibility and patient liability for a blind or disabled child who receives Institutionalized Hospice services using the following steps. Please note, the child must be under age 18 or age 18 through 20 if in school. For the month of admission, consider the income and resources of the Hospice child and parent, as appropriate. After the month of Hospice admission, recalculate considering only the income and resources of the Hospice child. Refer to [MS 1810](#) for further information on disabled children living with parents and [MS 1820](#) for disabled children living apart from parents.]

A. Determining Medicaid Eligibility Using the Special Income Standard

1. Determine the 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 child has been in Hospice for 30 full consecutive days, the child is eligible for Medicaid.]
3. If gross income is greater than the special income standard for an individual, refer to [MS 3505](#).

[B. Determining Patient Liability

1. Determine the 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, the increased personal needs allowance from the income of the Hospice child.
5. If dependents have income less than the 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 patient 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.]

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 premium, prorated health insurance premiums and/or actual payment on a current or prior medical bill not subject to third party payment or covered by Medicaid.]
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 (1)

[Determine Medicaid eligibility and patient liability for Institutionalized Hospice couple applicants as follows:

A. Determining Medicaid Eligibility Using Special Income Standard]

1. Determine gross income for each member of the Hospice couple.
 EXCEPTION: Do not consider income of an SSI spouse.
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.
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. Determining Patient Liability for Hospice Couple

1. Spouses in same LTC facility during the month of separation.]
 - 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 premium, prorated health insurance premiums, and/or actual payments on a current or prior medical bill not subject to third party payment or covered by Medicaid. Deduct 1/2 of the amount for each spouse's eligibility determination. 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. Consider resources of the couple as available to each other during the month of separation.

3. Beginning the month after the month of Hospice election, consider only the individual's income and resources.
4. Spouses in different LTC facilities during the month of separation.]
 - 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 Medicaid 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 be most advantageous to the couple, unless the couple chooses otherwise.]
 - e. Deduct verified, incurred medical expenses of the LTC individual not subject to third party payment. Deduct actual payment on a current or prior medical bill not covered by MA. This may cause a monthly change in the 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.
- [5. Consider resources of the couple as available to each other during the month of separation.
6. Beginning the month after the month of separation, consider only the individual's income and resources.]

MS 3260 INSTITUTIONALIZED HOSPICE CASE ACTION (1)

- A. [Form MAP-374 notifies the Department for Medicaid Services (DMS) of the date Hospice is elected and verifies that medical eligibility requirements are met, the individual is terminally ill, and has a life expectancy of six months or less. Additionally, form MAP-374 identifies the Long Term Care (LTC) facility the individual is residing and includes the level of care received at the facility.

- B. If the individual does not currently receive Medicaid, the Hospice provider notifies the individual's family or responsible party to apply on their behalf. Once the application is submitted, eligibility for Medicaid in a type of assistance that supports Hospice must be determined. However, the special income standard does not apply if a Level of Care (LOC) record is not received. The LOC is entered in Worker Portal by DMS who will then scan form MAP-374 into the Electronic Case File (ECF).

- C. If the individual is an SSI or an SSI/other income recipient, consider any SSI or SSI/other income received. Authorize vendor payment when the LOC record is added by DMS. If SSI is discontinued, then the case is also automatically discontinued, including the vendor payment. The individual must reapply for ongoing Medicaid.]

MS 3300 WHO IS ELIGIBLE FOR LTC MEDICAID (1)

[Individuals admitted to long term care must meet all technical and financial eligibility requirements in order to receive Medicaid in a category that will help pay for vendor payment services. A Level of Care (LOC) record is received in Worker Portal as notice that an individual has been institutionalized or is now receiving waiver services. Benefits cannot be approved for Long Term Care (LTC) Medicaid without an LOC. The individual's patient liability, or cost of care, is calculated when eligibility is determined and the case is approved.

A. The following Levels of Care may be received for Medicaid cases.

1. Nursing Facility (NF)
2. Home and Community Based Services (HCBS)
3. Michelle P. Waiver (MPW)
4. Acquired Brain Injury/Acquired Brain Injury LTC (ABI/ABI LTC)
5. Supports for Community Living (SCL)
6. Institutionalized Hospice
7. Programs of All-Inclusive Care for the Elderly (PACE)/ Institutionalized Programs of All-Inclusive Care for the Elderly (IPACE)
8. Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID)
9. Model II Waiver

B. Individuals who are aged, blind, or disabled may receive coverage in the ABDM or LTCM Types of Assistance (TOA). Children determined blind or disabled may receive Medicaid in the ABDM or LTCM TOA, whichever is appropriate, if not eligible for a type of MAGI Medicaid that covers LTC services.

C. Individuals receiving Medicaid in a Type of Assistance supporting their level of care will continue to receive their current benefits. This includes MAGI Medicaid. Additionally, individuals admitted to waiver and otherwise eligible for Medicaid will continue receiving Medicaid in their current Type of Assistance. For more information on individuals otherwise eligible for Medicaid, refer to [MS 2770](#).

If the individual's current TOA does not support the long term care services they are applying for, or receiving, eligibility must be explored for LTC Medicaid. This can include determining the individual's disability to ensure they are technically eligible. For more information on disability determinations, refer to [MS 1700](#).

Note: Time limited benefits such as spend down and Emergency Time-Limited Medicaid do not support vendor payment. Individuals receiving this coverage must have their eligibility redetermined for LTC Medicaid.

D. In addition to all other technical and financial eligibility requirements, the following criteria must be met by any individuals applying for LTC Medicaid:

1. Medical necessity for the receipt of waiver services, Hospice, or placement in a Nursing Facility or other institution is established by the Department for Medicaid Services (DMS), the Peer Review Organization (PRO), or Medicare. Once medical necessity is determined, a Level of Care record is uploaded to Worker Portal through the Kentucky Level of Care System (KLOCS) or the Medicaid Waiver Management Application (MWMA) system.
2. The applicant has been in LTC for 30 full, consecutive days. If the applicant dies prior to the 30th day, the 30 day requirement does not apply.

Note: If the individual leaves the LTC facility and is admitted into the hospital and then goes from the hospital to another facility, the individual is still considered to be meeting the 30 day requirement without it being considered a break in coverage.

3. In order to be eligible for the ABDM TOA, the individual's countable income must be below the appropriate Medicaid Scale. To be eligible for the LTCM TOA, the countable income must be below the special income standard, or the individual must have an approved Qualifying Income Trust (QIT).
4. If the individual is in an Institution for Mental Diseases (IMD), they must be age 18 to 21, up to age 22 if institutionalized on their 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. The personal care unit in an IMD is Central Kentucky Recovery Center located at Eastern State Hospital.

E. If an individual admitted to LTC has income of less than \$50:

1. Explain SSI and refer them to the Social Security Administration (SSA) if the individual is potentially eligible;
2. Complete an application; and
3. Determine Medicaid eligibility. Please note that individuals technically eligible for Non-MAGI Medicaid due to disability and potentially eligible for SSI, must apply for SSI. These individuals cannot have their disability determined by the Medical Review Team (MRT).]

MS 3350 SSI RECIPIENT INSTITUTIONALIZED (1)

[When a Supplemental Security Income (SSI) recipient is admitted to an institution, their benefits may remain unchanged, be reduced, or terminated. This is determined by the Social Security Administration (SSA).

- A. A Level of Care (LOC) record with the Long Term Care (LTC) provider information will automatically be added to Worker Portal for an SSI individual without worker intervention. Worker Portal will then issue form PA-5.1, Report or Referral to the District Social Security Office to report the SSI recipient's move to an LTC facility.
- B. SSA determines SSI eligibility for an institutionalized individual using the following criteria:
 - 1. If income other than SSI is \$50 or more, SSI will be discontinued.
 - a. The individual will receive a notice from SSA notifying them that their SSI benefits have been discontinued.
 - b. Individuals are notified to contact DCBS to apply for ongoing Medicaid coverage.
 - 2. If income other than SSI is less than \$50, Worker Portal will consider \$30 of SSI income and the other income in the case. The individual will have a \$40 Personal Needs Allowance (PNA) and any remaining income will be considered in the patient liability calculation.

Example: Jane receives \$45 from RSDI, and \$726 from SSI monthly. Upon admission to the Nursing Facility, Worker Portal will count a total monthly income of \$75 ($45+30=75$). Jane's PNA is \$40, and her patient liability will be \$35.
 - 3. If the only income is SSI, Worker Portal will consider \$30 SSI income in the case. The individual will have a patient liability of zero, and a PNA of \$30.
- C. Individuals may receive uninterrupted SSI benefits for up to three full months when they are temporarily institutionalized for medical care in a LTC facility. SSA determines eligibility for continued payments and sends notification to the SSI individual. Worker intervention is not required.
 - 1. A temporary stay is defined as three full months in a medical facility. This may also include the partial month prior and the partial month after the three full months.
 - 2. This allows the recipient to pay some or all of the necessary expenses to maintain their home or living arrangement where they may return upon discharge from the facility. Worker Portal will not count the continued SSI benefits when determining patient liability.]

MS 3390 [LONG TERM CARE (LTC) CASE CHANGE (1)

Individuals already receiving Medicaid when admitted to long term care do not have to reapply for benefits if their type of assistance does not support their level of care. Instead, their eligibility for Medicaid in a type of assistance that supports their level of care must be determined through a case change.

- A. When completing the case change to determine LTC Medicaid eligibility, review and update the case information to reflect the individual's and their community spouse's current situation.

Workers must contact the individual, or Authorized Representative, to clarify any unknown information and mail a Request for Information (RFI). Please note that all online resources, such as Eligibility Advisor (EA), Program 68, Program 48, and the Property Value Administrator's (PVA) Office, must be checked prior to generating an RFI. The following must be reviewed in order to accurately redetermine the individual's eligibility.

1. Update the living arrangement to reflect the individual's correct type of Long Term Care arrangement;
 2. Review and update all technical eligibility information, including disability information;
 3. Update all income and resource information for the individual and community spouse;
 - a. Check all federal data sources for updated income and resource information;
 - b. Enter any potential transfer of resources;
 - c. Ensure the Resource Assessment is complete and correct, if the LTC individual has a community spouse;
 4. Request current verification of all medical expenses;
 5. Request verification of the community spouse's household expense information, if applicable.
- B. When all verification and information have been received, determine eligibility for LTC Medicaid, and update eligibility.
1. For Medicare Savings Program recipients admitted to LTC:
 - a. If LTC Medicaid is denied, the individual will continue to receive Medicare Savings Program benefits if all eligibility requirements are met.
 - b. If LTC Medicaid approves, Medicare Savings Program eligibility will be updated as follows:

(1) QMB and SLMB recipients who are approved for LTC Medicaid will continue to receive Medicare Savings Program benefits, as these categories are dually eligible.

- (2) Q11 recipients approved for LTC Medicaid will no longer be eligible for Medicare Savings Program benefits, as the Q11 category is not dually eligible with other Medicaid types of assistance. Q11 benefits received in any retroactive months which LTC Medicaid is approved will be recouped.
2. For MAGI Medicaid recipients admitted to Long Term Care, refer to Volume IVB MS 2000.]

MS 3450

[PATIENT LIABILITY

(1)

Patient liability is the amount individuals in long term care are responsible for paying for their care. This is also referred to as the recipient's cost of care. Patient liability is calculated by subtracting verified, allowable expenses from the gross income.

- A. The patient liability for the month of admission to the facility is \$0. Individuals are considered to be readmitted after being out of a facility for more than 30 days after their initial admission. Patient liability for the first month at a new facility or if an individual transitions to a different LOC type will also be \$0.

Example 1: An individual is admitted to a nursing facility 9/1 and is approved for Medicaid. Their patient liability is \$0 for the month of September, and they will be responsible for their full patient liability beginning in October.

Example 2: An individual receiving Medicaid is discharged from a nursing facility in November and is readmitted in January. They apply and are approved for Medicaid again beginning in January. Their patient liability for January is \$0 and they will be responsible to pay their full patient liability again beginning in February.

Example 3: An individual was receiving Medicaid and residing in Sunshine Nursing Home since 6/1. On 10/15 they move to Bluebird Nursing home. Their patient liability for Bluebird Nursing home will be \$0 in October and they will be responsible to pay their full patient liability to Bluebird Nursing home in November.

- B. An individual is not eligible for vendor payment in any month they private pay. When the source for private pay is insufficient or exhausted and they are no longer able to pay, they may be eligible for vendor payment. Private pay sources include Worker's Compensation, VA, private insurance, or the individual's own resources.]

MS 3460 COUNTABLE INCOME FOR PATIENT LIABILITY DETERMINATION (1)

The following types of income are countable when calculating an individual's patient liability. Do not consider any payment made by a relative or other authorized representative, to obtain a private room, telephone, television services, etc. as income.

- A. Earnings from therapeutic placement: The facility must supply a written statement showing employment is for therapeutic and rehabilitative purposes.
- B. The amount of a VA pension over \$90: Exclude the first \$90 of Veterans Administration (VA) pensions. For VA pensions less than \$90, exclude the entire amount.
 - 1. For veterans who are approved for a VA pension and receive a lump sum retroactive payment, the \$90 exclusion and the \$40 personal needs allowance (PNA) must be applied retroactively in the patient liability determination. Consider any remainder of the payment as a lump sum in the month of receipt, if possible.

EXAMPLE: A veteran is approved for a \$300 VA pension effective January and receives and reports a \$1,800 ($\300×6) lump sum payment in June. Since the first \$90 is excluded and the individual is entitled to the \$40 PNA, a total of \$780 ($\$90 + \$40 = \$130 \times 6$) would be deducted from the lump sum. The remainder, $\$1,800 - \$780 = \$1,020$ is considered lump sum income. Since the lump sum was reported in the month of receipt (June), it is not administratively feasible to count the lump sum as income since MA benefits have already been issued for June. Therefore, any remainder of the \$1,020 is considered a resource beginning the month following the month of receipt.

- 2. [Do not increase patient liability for any prior months. However, complete the computation to determine the lump sum payment amount. Complete a case change if it is possible to consider the lump sum income.]
- C. Due to a change in the Federal law, effective August 1, 2002, VA Aid and Attendance (A&A) and VA Unreimbursed Medical Expenses (UME) are countable for VA beneficiaries in state-operated veteran's nursing facilities that accept Medicaid.
- D. VA Dependency and Indemnity Compensation is countable income in Medicaid eligibility determinations.
- E. [Consider the RSDI entitlement amount. Allow SMI charges, if appropriate, as a medical deduction. If accessing BDX (Bendex inquiry) on Worker Portal for the RSDI benefit amount, use the amount shown as "NET" in the calculation process.]
- F. Accumulated back payments of statutory benefits are considered according to [MS 2465](#).

- G. For the SSI only recipient, count \$30 of the SSI payment.
- H. If an SSI recipient has other income of less than \$50, count \$30 of the full SSI payment.
- I. For SSI children in EPSDT LTC who continue to receive full SSI benefits 3 months after form PA-5.1, Report or Referral to the District Social Security Office was sent to SSA, allow the personal needs allowance and count the remaining SSI.
- J. State Supplementation payments continuing beyond the month of LTC admission:
1. If the admission is not temporary, request the check(s) be returned to the Division of Family Support, Family Self-Sufficiency Branch, KTAP Section, 275 E. Main St., 3E-I, Frankfort, KY 40621.
 2. If not returned, show the total State Supplementation payment as income the month following the month of admission.
- K. Income received from property. This includes rental property, leases, and royalties.
1. Unless a legal document specifically states otherwise, or the institutionalized spouse establishes that ownership interest of income produced from property is other than stated below, consider the income from such property in both the MA eligibility and post-eligibility determination as follows:
 - a. Consider income paid solely to the institutionalized spouse or the community spouse available to that person.
 - b. Divide income paid in the names of the institutionalized spouse and the community spouse between them.
 - c. Consider income paid in the names of the institutionalized spouse, community spouse, and at least one other person, available to each individual on an equal share basis, unless one or more of the persons can verify a different share of ownership exists.
 - d. Divide income paid to a couple from property when there is no legal document establishing ownership between them.
 2. Allow the institutionalized spouse to rebut the ownership of income produced from property. The institutionalized spouse must provide:
 - a. A written statement from the applicant regarding ownership of income;
 - b. A written statement from each of the other persons receiving income from the property which corroborates the applicant's statement, unless the individual is a minor or is incompetent; and
 - c. Verification the applicant's name has been removed from the property.

- Do not consider the income available the month the applicant's name is removed from the property.
3. A fair hearing may be requested when the institutionalized spouse disagrees with the Agency's decision on the ownership of this income.
- L. Consider income available from trust property to each member of a couple in accordance with the specific terms of the trust. When the trust document is not specific as to the couple's ownership interest in income, use the same procedures used to establish ownership interest in property.
- M. Long Term Care (LTC) insurance policies provide payment for services while an individual is residing in a nursing facility. If the payment is paid directly to the individual, it is considered a reimbursement for medical services. NOTE: The money is countable only in the determination of patient liability. See Volume IVA [MS 2220](#).
- N. Nazi Persecution Victims Eligibility Benefits Act (P. L. 103 286) provide for payments to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required. Consider payments as income in the patient liability determination ONLY.
- O. Dividends or interest income only if it is paid directly to the individual, community spouse, or parent of a disabled child. Please note that if the dividend/interest income is reinvested, held in a stock or retirement account, or it is reinvested in or paid to a life insurance policy, it is excluded in the Non-MAGI Medicaid eligibility and patient liability determinations.

MS 3470 EXCLUDED INCOME FOR LTC/WAIVER (1)

Do not use the following types of income when calculating patient liability.

- A. Do not consider as income, any payment made by a relative or other interested party to obtain a private room, telephone, television service, etc.
- B. [VA beneficiaries in LTC are usually eligible for an Aid and Attendance Allowance (VA A&A) and/or Unreimbursed Medical Expenses (VA UME). Exclude the VA A&A and/or VA UME in the MA and patient liability determination. Note: VA A&A and VA UME are countable for VA beneficiaries in state-operated veteran's nursing facilities that accept Medicaid.]
 - 1. Refer individuals to the Regional VA Office to apply for VA Aid and Attendance Allowance and/or VA Unreimbursement Medical Expenses.
 - a. Application for VA A&A is NOT a condition of MA eligibility.
 - b. Require the individual to apply for VA UME.
 - 2. Spot check to verify receipt of the increase, if application is made.
- C. Exclude the first \$90 of Veterans Administration (VA) pensions. For VA pensions less than \$90, exclude the entire amount.
- D. Exclude the uninterrupted SSI and State Supplementation payments for up to 3 full months for recipients who are temporarily institutionalized for medical care in an LTC facility, and who otherwise would receive a reduced benefit or none at all.
- E. Exclude the entire SSI payment for the SSI recipient with other income of \$50 or more.

- (2) Payment for medical devices and durable medical equipment such as wheelchairs, canes, crutches, inhalators, pacemakers, etc.
 - (3) Payment for prosthetic devices such as artificial arms, legs and other parts of the body.
 - (4) Payment for work related equipment for specialized use such as a one-handed typewriter, telecommunication devices for the deaf, etc.
 - (5) Payment for residential modifications that aid an individual to work, such as the installment of a ramp or enlargement of a doorway for a wheelchair.
 - (6) Payment for nonmedical appliances and equipment essential for the control of a disabling condition that is medically verified as necessary, such as an electric air cleaner for an individual with a respiratory disease, etc.
 - (7) Payment for drugs and medical services to control an individual's impairment such as anticonvulsant drugs or anticonvulsant blood test monitoring for epilepsy, medications for mental disorders, immunosuppressive medications, etc.
 - (8) Payment for medical supplies and services which enable a person to work, such as incontinence pads, catheters, irrigating kits, physical therapy, speech therapy, etc.
 - (9) Payment for transportation costs associated with vehicle structural or operational modifications and payment for use of driver assistance.
 - (10) Payment for installing, maintaining and repairing impairment related items.
- C. Compute a family income allowance for each dependent family member with income less than the family income allowance, who is claimed by either spouse for tax purposes.
1. This can include minor children, dependent children, dependent parent or dependent siblings who are residing with the community spouse.
 2. Require verification if a dependent is age 18 or over.
 3. Subtract the family member's gross income from the family income allowance standard. Divide the remainder by three, round to the nearest dollar and allow that amount as a deduction from patient liability. The deduction can be allowed without proof that the money is made available to the family member.
- D. For an institutionalized individual who has a community spouse, consider the amount needed to bring the community spouse's gross monthly income up to the community spouse income allowance as calculated per [MS 3550](#).
1. Allow the community spouse income allowance only if the money is actually given to the community spouse.
 2. This amount can be increased only:

- a. If a court has entered an order against an institutionalized spouse for monthly support for the community spouse in an amount which exceeds the difference between the community spouse's available income and the community spouse income allowance. Allow the greater amount as a deduction to the institutionalized spouse's income; or
 - b. An Administrative Hearing officer establishes through the fair hearing process that the community spouse needs income above the level established as the community spouse income allowance. Either spouse may request a hearing to present evidence that additional income is needed due to significant financial duress. These hearings must be held within 30 days of the request. If the hearing officer determines that exceptional circumstances which cause financial duress exist, the hearing officer grants the increase in the community spouse allowance for a stated period of time. 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. Scan a copy of the memorandum into the Electronic Case File (ECF). 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 LTC waiver services in the following types of care will be allowed a \$65 and $\frac{1}{2}$ the remainder disregard from earned income in determining patient liability:
1. Home and Community Based Services (HCBS);
 2. Non-Institutionalized Hospice;
 3. Supports for Community Living (SCL);
 4. Model Waiver II;
 5. Adult Day Care;
 6. Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);
 7. Acquired Brain Injury (ABI)/ABI LTC; or
 8. Michelle P.

Compute \$65 plus $\frac{1}{2}$ the remainder of earnings.

- F. All SSI recipients are covered by the State SMI Buy-In. Do not show SMI as a deduction for any recipient who is aged, blind, or disabled and receives SSI.
- G. Allow the cost of SMI if the aged, blind, or disabled recipient does not receive SSI or State Supplementation and verifies that they are responsible for the premium.
- H. Allow the cost of Medicare Part D if the recipient verifies they are responsible for the premium. If the recipient receives Low Income Subsidy (LIS) but has chosen a plan with a premium that exceeds the subsidy amount, a deduction can be given for the difference if the recipient verifies they are responsible to pay the difference.
- I. Allow premiums for medical insurance actually incurred and paid by the LTC recipient.
 - 1. Prorate premiums if paid prospectively. Allow as a deduction for months the premium covers. For example, if health insurance of \$90 is paid in May to cover June, July and August, allow \$30 as an expense in each covered month or allow the entire premium in the month incurred (May).
 - 2. View all medical insurance policies and record identifying information.
 - 3. Complete the Health Insurance screen as appropriate.
- J. Deduct verified, incurred medical expenses the facility is not required to provide; for example, eyeglasses, hearing aids, dentures, chiropractic services. In no case will a deduction be allowed for a period prior to the month in which the change was reported to a worker.
 - 1. Deduct the cost of a medically necessary attendant if payment for such an attendant is not available from another MA provider at no cost to the individual.

Example: A 22-year-old HCBS individual lives in the home with his parents. Both parents work outside the home and must hire a person to take care of the individual, who is a quadriplegic. The parents request cost of attendant care be allowed as a deduction in the HCBS case. The parents provide a doctor's statement that it is medically necessary for the individual to have care at all times. Attendant care cannot be provided by a family member.
 - 2. Allow as deductions against current patient liability computations any unpaid, incurred medical expenses from a period of time prior to MA eligibility for which the individual is currently responsible.
 - a. If the individual requests the deduction for the purpose of paying the incurred medical expense, it is not necessary to verify that the individual is actually using the amount deducted to pay the incurred medical expense.
 - b. The total allowable deduction cannot exceed the amount of the outstanding medical expense. Example: If an outstanding medical

expense is \$4,000.00 when the deduction is first allowed, the total amount of the allowable deduction cannot exceed \$4,000.00.

- c. Allow the deduction to the advantage of the individual. The total amount may be averaged over a time frame selected by the individual.
3. When allowing a deduction for incurred medical expenses owed to a LTC provider for months prior to MA eligibility, the individual's portion of the monthly cost of care is subtracted from the medical expense, as the individual would have been responsible for his/her patient liability in those months had the individual been MA eligible.

Example: An individual is ineligible for vendor payment for the month prior to application due to excess resources. The individual requests a medical deduction for NF costs of \$5,000.00 for that month. The individual has income of \$800.00 per month and no monthly deductions other than the PNA of \$40.00. If the individual had been eligible, the monthly patient liability would have been \$760.00 (\$800 - \$40). Subtract \$760.00 from the \$5,000.00 cost of care expense for a patient liability deduction of \$4,240.00.

4. Do not allow as a medical expense deduction an unpaid cost of NF care incurred during vendor payment ineligibility period due to a transfer of resource penalty.
- K. Do not deduct items and/or services the facility is required to provide, such as, wheelchairs, crutches, walkers, incontinent supplies, durable medical equipment, prosthetics, orthotics, medical supplies, furniture, personal care items, etc.
 - L. Allow a deduction for co-pays when computing patient liability. The recipient can choose to use an average of the prior 3 months co-pays or provide the actual co-pays for each month.
 - M. Allow a deduction for prescription drug expenses IF the individual verifies that the Department for Medicaid Services (DMS) 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.

Note: Waiver recipients are responsible for prescription drug copays. Medical deductions to reduce patient liability cannot be allowed for prescription copays, including Medicare Part D copays, for these individuals.

- N. Monthly representative payee service fees charged by facilities to their recipients are not allowable medical deductions.

MS 3500 SPECIAL INCOME STANDARD (1)

The special income standard is three times the SSI income limit. The individual's gross income is compared to the special income standard when determining eligibility for Medicaid (MA) when they have been admitted to Long Term Care (LTC) for 30 consecutive days or more. The current special income standard is located in [MS 1750](#).

Note: If the individual has been in LTC for more than 30 full consecutive days and has income over the special income standard, refer to [MS 3505](#) on Qualifying Income Trust (QIT).

A. The special income standard is applied by Worker Portal when the individual is not otherwise MA eligible and the 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 as long as there is no break in services.
2. If MA eligibility only is pending for 30 days of institutionalization, Worker Portal will process on the 31st day without worker intervention.

Example: Sue was admitted to HCBS waiver and applied for Medicaid on 8/6. She receives \$2,300 in RSDI each month. Sue was discharged from waiver on 8/15 and was admitted to the Nursing Facility on 8/16 where she continues to reside. The 30 full days is met on 8/30 and her application is processed on 8/31 without any worker intervention.

3. Worker Portal determines MA eligibility by comparing gross income to the special income standard and considering the number of days the individual has been in LTC.
4. [Once the special income standard is applied, eligibility may be determined for retroactive months, even if they did not meet the institutionalization requirement at the time.

Example: Joseph was admitted to a nursing facility on 6/1 and was discharged 15 days later. He was readmitted on 7/1 and continues to reside there. The full 30 days is met on 8/1 and he applies for Medicaid that same month. We can apply the special income standard for June even though he was not in the facility for 30 days at that time and issue coverage if otherwise eligible.

B. Individuals whose income is in excess of the special income standard and do not have an approved QIT and individuals who are institutionalized less than 30 consecutive days are not eligible for vendor payment. Medicaid eligibility may be determined by Spend Down, however Spend Down does not cover LTC vendor payment.]

MS 3505

QUALIFYING INCOME TRUST (QIT)

(1)

Applicants with countable income over the Special Income Standard may set up a Qualifying Income Trust (QIT), sometimes referred to as a Miller Trust, to help them become financially eligible for Medicaid. The Qualifying Income Trust document may be signed by the applicant, their spouse, court appointed guardian, or Power of Attorney (POA). If the document is signed by the court appointed guardian or POA, verification must be provided to show that the individual has the authority to sign on the applicant's behalf. Once the QIT is established, the applicant must place their monthly income in excess of the Special Income Standard into the QIT. The excess income placed in the QIT *is excluded* from the Medicaid eligibility determination but *is considered* in the patient liability calculation. The Special Income Standard is three times the SSI income limit and the current standard can be found in [MS 1750](#).

Note: A QIT is *not* required in order to complete a Resource Assessment.

- A. The Department for Medicaid Services (DMS) requires that a QIT meets the following criteria:
1. It must be established in Kentucky.
 2. The QIT must be irrevocable.
 3. Income must be put into the QIT to bring the individual below the Special Income Standard.
 4. No resources may be put into the QIT. For example: Money in a savings account cannot be placed into the QIT account if the savings account is closed.
 5. [A separate account must be established in Kentucky with a bank that operates in Kentucky.]
 - a. An existing account cannot be designated as the QIT account. For example, Mary established a QIT and states that she currently owns a savings account she doesn't use. Even though this account is not regularly used, Mary is still required to open a new bank account designated as the QIT account.
 - b. QIT funds cannot be co-mingled with other funds.
 - c. A separate resident trust account at a Nursing Facility (NF), or other long term care institution, cannot be opened and designated as a QIT account.
 6. The trustee must consult with Medicaid on payments from the trust before they are made in order to assure that those payments are allowable under federal and state laws
 7. Upon the death of the individual, DMS receives all monies remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the individual by Medicaid. Any funds remaining after Medicaid is reimbursed will be the property of the individual's estate.

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. Refer to Volume IVA [MS 2480](#) for more information on determining an applicant's countable income.
2. Monies placed in the trust can be disbursed for:
 - a. The Personal Needs Allowance (PNA);
 - b. Community spouse/family support;
 - c. The cost of other health insurance;
 - 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 of the individual).
4. Send a written request for the expenditure to the Medical Support and Benefits Branch (MSBB) through your Program Specialist. The request must include:
 - a. A physician's statement as to why the expenditure is needed;
 - b. A copy or estimate of the bill;
 - c. The date the expense was incurred; and
 - d. Verification of the balance owed.
5. Payments from the trust must be made at regular intervals (monthly or by the end of the month following the month funds were placed in the trust.)

C. At application, if the individual's countable income exceeds the Special Income Standard:

1. Explain that the individual may set up a QIT. Case Notes must be entered to state what was explained to the individual and their understanding.
2. Provide form 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 30 days.
4. Once a QIT is returned, all documentation must be reviewed to ensure the criteria in section A is met. Please note that verification of funding is only required if the individual states that they are funding the QIT to request coverage for a month prior to when the QIT was established.

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, but the individual will no longer be required to place income in the QIT. DMS is not reimbursed from the QIT until the individual dies.

MS 3530 LONG TERM CARE (LTC) INDIVIDUAL (1)

[Complete the following steps to determine financial eligibility and patient liability for single adults applying for Long Term Care Medicaid.

A. Determining Medicaid Eligibility *Without* Using the Special Income Standard

1. Determine countable income of the individual. Consider gross income and/or net profit, less the \$20 general exclusion and work-related expenses, if appropriate.
2. Deduct the Medicaid Scale for 1.
3. Deduct verified, incurred medical expenses of the 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 Medicaid. For more information on allowable medical expenses, refer to [MS 3480](#).
4. If there is no excess, the individual is Medicaid eligible. If there is an excess, the individual's eligibility must be determined using the special income standard.

B. Determining Medicaid Eligibility *Using* Special Income Standard

1. Determine gross income of the individual.
 - a. If the gross income is equal to, or less than, the special income standard the individual potentially is Medicaid eligible. The special income standard is three times the SSI limit and the current standard can be found in [MS 1750](#).
 - b. If the gross income is greater than the special income standard, the individual can establish a Qualifying Income Trust (QIT). The income exceeding the special income standard must be placed in the QIT which will allow the individual to become eligible for Long Term Care Medicaid. For more information on QITs, refer to [MS 3505](#).

If a QIT is not established, the individual is not eligible for Medicaid. If a QIT is established and funded, the individual is potentially eligible for Medicaid.

2. To be eligible for Medicaid, the individual must also be admitted to waiver services for 30 days. If Medicaid eligibility is only pending for 30 days of institutionalization, Worker Portal will process the case on the 31st day without worker intervention.

C. Determining Patient Liability for the LTC single individual.

1. Determine the countable gross income and/or net profit of the individual, less the \$20 general exclusion.

2. Deduct the Personal Needs Allowance (PNA).
3. Deduct increased personal needs allowance, if appropriate, from income of the applicant.
4. If dependents have income less than MA Scale, deduct the amount needed 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 including Medicare and/or other health insurance premiums, deductibles, and coinsurance. Deduct actual payment on a current or prior medical bill not covered by Medicaid. This may cause a monthly change in the applicant's liability. For more information on allowable medical expenses, refer to [MS 3480](#).
6. Add any third-party payment, such as LTC insurance payments made to the member. Do not use these payments for other deductions such as medical deductions.
7. The result is the individual's patient liability or payment toward cost of care.

NOTE: Patient liability for the month of admission to a Nursing Facility is always \$0.]

MS 3540 LONG TERM CARE (LTC) COUPLE (1)

Determine Medicaid eligibility and patient liability for individuals as a couple if it is more advantageous to the couple. To be considered an eligible couple, both spouses must be aged, blind or disabled, income and resource eligible as a couple, living in the same facility and room, and both must apply for Medicaid. The applications do not have to be made at the same time.

[Redetermine Medicaid 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.

A. Determining Medicaid Eligibility

1. Determine the gross income for each spouse and deduct the Medicaid Scale for 1. If the gross income of one, or both, of the spouses is equal to or less than the special income standard, the individual is Medicaid eligible.
2. If the gross income of one, or both, of the spouses is greater than the special income standard, the individual with excess income can establish a Qualifying Income Trust (QIT). The income exceeding the special income standard may be placed in the QIT which will allow the individual to become eligible for Long Term Care Medicaid. For more information on QITs, refer to MS 3505.

If a QIT is not established, the individual is not eligible for Medicaid. If a QIT is established and funded, the individual is potentially eligible for Medicaid.

3. To be eligible for Medicaid, each spouse must be admitted to the facility for 30 days. If Medicaid eligibility is only pending for 30 days of institutionalization, Worker Portal will process the case on the 31st day without worker intervention.]

B. Determining Patient Liability for LTC individual.

1. Spouses in the Same LTC Facility

[To determine MA and patient liability for LTC individuals when both spouses are in the same LTC facility and in the same room:

- a. Determine the couple's combined income and divide by 2. Consider one half of the couple's income for each spouse when calculating patient liability.
- b. Deduct the personal needs allowance for each spouse.
- c. If dependents have income less than the MA scale, determine the amount required to bring the dependents' total income up to the MA Scale for the family size. Deduct one half of the amount for each spouse.

- d. Determine the couple's combined medical expenses and deduct one half of the verified, incurred medical expenses in each case which are not subject to third party payment including Medicare and/or other health insurance premiums, deductibles, and coinsurance. Deduct actual payments on a current or prior medical bill not covered by Medicaid. This may cause a monthly change in the recipient's patient liability.
- e. Add any third party payment paid directly to the facility for LTC cost, if appropriate. Deduct one half of the amount in each case. Do not use these payments for other deductions, such as medical expenses.
- f. The result is the individual's patient liability or payment toward cost of care.]

Note: If it is more advantageous to the couple to treat them as separate even if they are in the same facility and same room, complete the steps below in B.2.

2. Spouse in a Different LTC Facility

Treat the LTC couple as a couple during the month of separation even though they are not residing in the same household. Beginning the month after the month of separation, treat the couple as individuals and complete the following:

- a. Determine gross income and/or net profit of the applicant. Do not consider income as a couple.
- b. Deduct the personal needs allowance for each.
- c. Deduct increased personal needs allowance for each individual if appropriate, from the income of the individual.
- d. If dependents have income less than the MA Scale, determine the amount required to bring the dependents' total income up to the MA Scale for the family size. Deduct the amount in only one case. Apply the deduction to the case which will be most advantageous to the couple, unless the couple chooses otherwise.
- e. [Deduct verified, incurred medical expenses of the LTC individual NOT subject to third party payment 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 the recipient'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 or other deductions, such as medical expenses.]
- g. The result is the applicant's patient liability or payment toward cost of care.

Note: The couple is considered living apart during the month of separation when one spouse is institutionalized in LTC and the other spouse is in a Personal Care Home (PCH) or Family Care Home (FCH).

MS 3550 LONG TERM CARE INDIVIDUAL WITH COMMUNITY SPOUSE (1)

Complete the following steps to determine Medicaid eligibility and patient liability for an institutionalized individual with a community spouse.

A. Determining MA Eligibility Using the Special Income Standard:

1. Determine the gross income of the institutionalized spouse and deduct the Medicaid scale for 1.
2. If the gross income is equal to or less than the special income standard, the individual is Medicaid eligible.
3. If the gross income is greater than the special income standard, the individual can establish a Qualifying Income Trust (QIT). The income exceeding the special income standard must be placed in the QIT which will allow the individual to become eligible for Long Term Care Medicaid. For more information on QITs, refer to [MS 3505](#).

If a QIT is not established, the individual is not eligible for Medicaid. If a QIT is established and funded, the individual is potentially eligible for Medicaid.

4. To be eligible for Medicaid, the individual must also be admitted to the nursing facility for 30 days. If Medicaid eligibility is only pending for 30 days of institutionalization, Worker Portal will process the case on the 31st day without worker intervention.

B. Determining the Community Spouse Income Allowance:

Income of an institutionalized spouse who has a spouse living at home in the community is treated differently to prevent financial hardship which may result when one spouse is institutionalized. Federal regulations require computation of a community spouse income allowance taking into consideration the community spouse's income and shelter expenses.

1. The following allowances and standards are used to calculate the community spouse income allowance:
 - a. \$2,465 Minimum Community Spouse Income Allowance, effective 7/1/2023.
 - b. [\$3,853.50 Maximum Community Spouse Income Allowance, effective 1/1/2024.]
 - c. \$740 Minimum Community Spouse Shelter Allowance, effective 7/1/2023.
2. Worker Portal calculates the community spouse income allowance for an institutionalized spouse case. The Shelter Expense and Utility Expense Screens are used to collect and verify the monthly shelter expenses of the community spouse. Shelter expenses include:

- a. Rent or mortgage;
- b. Property taxes;
- c. Home insurance costs;
- d. Utility expenses; and
- e. [Telephone standard of \$66, effective 10/1/2023, if applicable.]

For a deduction to be allowed for shelter expenses the expense must be verified. The telephone standard is given for verified phone expense.

3. 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 \$740.
- c. The remainder is the community spouse excess shelter expense.

Verification of shelter expenses is NOT mandatory and is NOT a reason for case denial or discontinuance. The case may be worked without the shelter expenses if all other technical and financial eligibility have been met.

4. PART II: Community Spouse Income Allowance Calculation

- 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 (\$3,853.50, effective 1/1/2024).
- c. If the result is greater than the maximum, the community spouse allowance is the maximum (\$3,853.50, effective 1/1/2024).]
- d. Subtract the community spouse's gross income from the income allowance to determine the amount which may be deemed to the community spouse.

5. 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](#).

6. Policy and procedures for allowing a community spouse an income allowance as a deduction from the patient liability determination is outlined in [MS 3480](#). The deduction is allowed only if the income is actually made available to the community spouse each month. The LTC Income Statement Screen is completed to confirm that the institutionalized spouse understands this stipulation.

C. 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. A minor child or dependent does not have to reside with the community spouse in order to receive the family income allowance.

Note: A minor child is the couple's minor child or if older than a child, the member must be under 21 and being claimed as a dependent by either spouse on their taxes.

1. Verify the dependent member's gross income;
2. Subtract that income from the family member income allowance standard (\$2,465, effective 7/1/2023);
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. Determining Patient Liability for LTC Spouse:

1. Determine gross income and/or net profit of the institutionalized spouse.
2. Deduct the Personal Needs Allowance (PNA) (\$40).
3. Deduct the increased PNA, if appropriate, from the income of the institutionalized spouse, refer to [MS 1750](#).
4. Deduct the community spouse income allowance computed in "B" up to the maximum.
5. Deduct the family income allowance computed in "C".
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 Medicaid. This may cause a monthly change in patient liability.
7. Add any third party payment, such as LTC insurance. Do not use these payments for other deductions such as the community spouse income allowance or medical expenses.
8. The result is the individual's patient liability or payment toward cost of care to the facility.

MS 3560

LTC BLIND OR DISABLED CHILD

(1)

[Blind or disabled children (under age 18 or age 18 through 20 if in school) living in a Long Term Care (LTC) facility are considered as living separately from their parents beginning the month after the month of admission to the facility.]

Determine Medicaid and patient liability for a child admitted to LTC and living with parent(s) as follows:

- A. For the month of admission and for any retroactive eligibility, consider the income of the child and the parent.
- B. Allow appropriate income deductions from the income of the parent according to [MS 2480](#).
- C. Allocate income up to the ineligible sibling allocation for each ineligible sibling under age 18 living in the home of the LTC child. This is the ineligible sibling allocation minus gross income of each ineligible sibling.
 1. If more than one blind or disabled child applies for LTC, allocate parental income to the ineligible sibling living in the home when computing deemed income to the LTC child.
 2. Deduct a parent allocation for unearned income only or a combination of unearned income and earned income for one parent or for two parents.
 3. Deduct a parent allocation for earned income only for one parent or for two parents.
 4. If there are two parents in the home, use the parent allocation for two, whether one or both of the parents have the earned or unearned income.
 5. See [MS 1750](#) for parental and sibling allocation maximums.
- D. Consider total income of the LTC child.
- E. Allow appropriate income deductions from the income of the LTC child according to [MS 2480](#).
- F. Combine the countable income of the parent and income of the LTC child.
- G. Allow verified, incurred medical expenses of the parent, ineligible 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.
Note: This is not required for Medicaid.

MS 3590

CHANGE IN STATUS

(1)

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;
- F. Recipient dies;
- [G. An interruption in the individual's stay in the LTC facility, or
- H. The recipient is discharged and admitted to another LTC facility, Hospice, HCBS, or SCL with no interruption in stay.]

MS 3610 [EFFECTIVE DATE OF PATIENT LIABILITY (1)

When a change is reported that affects patient liability, the effective date of the new amount is determined by the time of month the change is processed and if the change increases or decreases patient liability.

A. When a change increases patient liability for individuals in Long Term Care (LTC), apply 10-day adverse action policy (see [MS 1510](#)). If the change is processed:

1. Before cutoff, it is effective the following month.
2. After cutoff, it is effective the month following the month after the change is processed.

Example: Clyde applies for Medicaid on 9/1/19 with an income of \$1,500 RSDI and reports a monthly medical expense of \$100. He was admitted to the Nursing Facility on 6/5/19. Clyde is approved for ongoing Medicaid coverage on 9/25 with a patient liability amount of \$1,360. On 9/30, Clyde reports that he is no longer paying the \$100 monthly medical expense. Clyde's patient liability will increase to \$1,460 11/1/19.

Note: Patient liability should never be increased retroactively without direction from Central Office. If a worker receives a request to retroactively increase patient liability, they should forward an inquiry to MSBB through their regional chain of command.

B. When a change decreases patient liability for individuals in LTC, the change is effective the first day of the month the change is processed.

Note: Patient liability may be decreased retroactively if issued incorrectly due to agency error.

C. Patient liability is \$0 for the month the individual is admitted to LTC.

Example: Lewis was admitted to HCBS waiver 8/1 and applied for Medicaid on 8/15 with \$1,000 RSDI income and no medical expenses. He is approved for Medicaid on 9/1 with a patient liability amount of \$0 for August and \$960 for September ongoing.]

MS 3650 LEVEL OF CARE (1)

Worker Portal receives a Level of Care (LOC) record when an individual has been assessed and it is determined they require a specific type of provider services in order to meet their medical care needs.

A. The different levels of care are:

1. [Nursing Facility (NF);
2. Home and Community Based Services (HCBS);
3. Michelle P. Waiver (MPW);
4. Acquired Brain Injury/Acquired Brain Injury LTC (ABI/ABI LTC);
5. Supports for Community Living (SCL);
6. Institutionalized Hospice
7. Programs of All-Inclusive Care for the Elderly (PACE)/ Institutionalized Programs of All-Inclusive Care for the Elderly (IPACE)
8. Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);
9. Model Waiver II;

B. When an individual reports that they have applied, intend to apply, or are already approved for any level of care, update the living arrangement and in home type of care, if appropriate, on the Living Arrangement screen in Worker Portal.

1. Worker Portal will pend the case for 90 days to receive the LOC. All required verification must be returned timely or the case will deny regardless of the LOC status.
2. If the LOC is not received within 90 days, the case will deny if the individual is not otherwise Medicaid eligible.
3. If an individual is otherwise Medicaid eligible, the case will not pend for the LOC. For additional information on otherwise Medicaid eligible individuals, refer to [MS 2770](#).
4. When an LOC interfaces to an SSI Medicaid case, vendor payment approves automatically without worker intervention.

- C. For NF, ICF IID, and Institutionalized Hospice, the Date LOC Met is not used to determine Medicaid eligibility and patient liability. For these Level of Care types, Medicaid eligibility and patient liability are calculated based on the LOC admit/start date. Note: The Date LOC Met is used by all other Level of Care types to determine Medicaid eligibility and patient liability.
- D. An LOC record may be received even though the level of care was not met. The Level of Care record will display a note next to the "LOC met date" on the Level of Care screen which states eligibility will not consider this Level of Care record because the LOC has not been met. The individual is not eligible for vendor payment. Determine ongoing Medicaid eligibility using non-institutionalized aged, blind, or disabled Medicaid policy for individuals not meeting LOC.

Example: Jeffrey applies for Medicaid on 9/1. He was admitted to the Nursing Facility on 8/16. He has a Nursing Facility LOC record, but there is a note next to the LOC met date that states eligibility will not consider this Level of Care because the LOC has not been met. Jeffrey is not eligible for vendor payment; however, he remains eligible for Medicaid in another type of assistance.

Note: If the LOC is not met the verified facility costs may be used as a recognized medical expense for a Medicaid spend down.]

[An admission review is completed by the Peer Review Organization (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. Peer Review Organization (PRO) initial certification process:

1. For LTC Level of Care (LOC) determinations, the automated certification notifies the local office of the approvals to or changes in LTC with the admission date, LOC, and date LOC met. Refer to [MS 3650](#) for more information on the Level of Care process.
2. For mental/psychiatric LOC determinations, the automated certification notifies the local office of the approval with the admission date.
3. A continued stay review is completed by PRO during the initial LOC 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.

B. An adverse determination is made by the Peer Review Organization when an individual does not require the Level of Care being provided.

1. The adverse determination notice is issued when an applicant's admission or a continued stay review is denied.
2. An adverse determination is effective 10 days from the date an adverse determination notice is issued.
3. The PRO allows a 10-day grace period for an individual receiving an adverse determination notice to find other placement.
4. Medicaid benefits continue during the grace period.
5. If an adverse determination notice is received at the initial admission, no grace period is allowed.

C. A reconsideration may be requested if the individual, physician of record, or facility is dissatisfied with an adverse determination.

1. The request for a reconsideration is accepted by the Peer Review Organization in written form only and must be received within 40 days of a continued stay denial or within 3 days of an admission denial.
 - a. If the reconsideration request for continued stay denial is received within the 10-day grace period, Medicaid benefits continue until the reconsideration decision is determined.

- b. 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.
 - c. The local office is notified in writing when a hearing decision is rendered.
2. 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.
 3. If the adverse determination is upheld by the hearing officer, discontinue vendor payments, or deny the care being provided.
- D. 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 Medicaid benefits during the appeal process.
1. 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.
 - a. The appeal must include the name of the individual, facility, and the reason the individual or responsible party disagrees with the hearing officer's decision.
 - b. The appeal is sent to the appropriate PRO.
 2. A decision is rendered within 15 days of receipt of the appeal request.]

MS 3700 PRIVATELY OWNED/OPERATED FACILITIES (1)

- A. [Privately owned/operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF IID) in Kentucky:
 - 1. Cedar Lake Lodge, Oldham County;
 - 2. Higgins Learning Center, Union County; and
 - 3. Wendel Foster Center, Daviess County.

- B. Placement services in privately owned/operated facilities:
 - 1. If the Confirmation Notice shows the appropriate level of care, placement services are not required.
 - 2. If the Confirmation Notice shows level of care is not appropriate and an alternate level of care is indicated, immediately request placement services.
 - a. Send a memorandum to MH/MR.
 - b. Give the individual's name, case number, name of facility and level of care required.
 - 3. If the Confirmation Notice shows level of care is not appropriate but an alternate level of care is not indicated, immediately:
 - a. Send a memorandum to MH/MR.
 - b. Give the individual's name, case number and name of facility.
 - c. Request an assessment by the PRO to determine the level of care needed.

- C. Placement in or from ICF IID cannot be accomplished within 30 days of receiving the confirmation notice:
 - 1. MH/MR notifies DCBS by memorandum of efforts to place individual.
 - 2. Forward this report to the Department for Medicaid Services (DMS), Division of Administration and Financial Management.
 - 3. MH/MR submits progress reports at 60 day intervals, for forwarding to DMS, until placement is accomplished.
 - 4. Continuing vendor payment is contingent on DMS receiving progress reports.

- D. Acceptance/refusal of beds:

1. Approved bed becomes available.
 - a. First name on waiting list is expected to accept placement.
 - b. Do not consider bed available if facility refuses to accept the individual.
 2. Available bed refused:
 - a. Send form MA-105 to the recipient/committee and a copy to MH/MR.
 - b. The vendor payment is discontinued.
- E. Appeal Panel Hearing Procedure:
1. ICF IID hearings on patient status must be conducted by an Appeal Panel.
 2. The panel is composed of:
 - a. A DCBS hearing officer who chairs the Appeal Panel;
 - b. A representative from the facility;
 - c. A neutral representative from the county in which the facility is located appointed by the County Judge/Executive; and
 - d. A DCBS worker, with the case record, who represents the Agency.
 3. Action following the hearing.
 - a. The chair takes a vote of the panel.
 - b. The decision is written.
 - c. The chair notifies the parent/payee/guardian/committee of the decision.
 4. Decisions of the Appeal Panel.
 - a. Decision reversed, vendor payment continues.
 - b. Decision upheld, may be appealed within 30 days of date of decision to either:
 - (1) The Circuit Court of the county where the State facility is located;
 - (2) The Circuit Court of the home county of the parents, guardian, committee or payee; or
 - (3) The Franklin Circuit Court.
- F. Hearings on Patient Status. Recipients in ICF IID have the same hearing rights as any other recipients.]
1. When a hearing is requested:
 - a. Send the PAFS-78 form to the Hearing Branch.
 - b. Attach a copy for MH/MR.
 - c. Indicate if the request is timely.

- d. If timely, vendor payment continues during hearing process.
 - e. Hearing Branch sends a copy of the decision to MH/MR for action regarding vendor payment.
2. Decisions of Hearing Branch.
- a. Decision reversed, vendor payment continues.
 - b. Decision upheld:
 - (1) DMS notifies Service Region Administrator by memorandum that payment continues for 10 days to allow for appropriate placement.
 - (2) Immediately notify MH/MR of the decision and request placement in the appropriate level of care.

MS 3710

STATE OWNED/OPERATED FACILITIES

(1)

- A. [State owned/operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF IID) in Kentucky:
 - 1. Hazelwood, Jefferson County;
 - 2. Oakwood, Pulaski County;
 - 3. Outwood, Hopkins County; and
 - 4. Central State, Jefferson County.

- B. Placement services in State owned/operated facilities are not the responsibility of the Department for Community Based Services (DCBS).

- C. Reclassification of ICF IID recipients: MH/MR is responsible for sending written notice of reclassification to the parent/guardian/payee/committee to advise of hearing rights.

- D. Hearings on Patient Status/Reclassification:
 - 1. When a hearing request is received within 30 days of the notice of reclassification, vendor payment continues until the decision is rendered.
 - 2. The DCBS office:
 - a. Accepts all hearing requests.
 - b. Sends requests to:

Cabinet for Health and Family Services
Division of Administrative Hearings
Families and Children
Administrative Hearings Branch
105 Sea Hero Road, Suite 2
Frankfort, KY 40601]
 - 3. The Administrative Hearings Branch sends a copy of the acknowledgement of the request to the DCBS office in the county where the facility is located.

MS 3715 MONEY FOLLOWS THE PERSON (MFP) (1)

[MFP is a program for individuals who have met Level of Care (LOC) for a Nursing Facility (NF), Supports for Community Living (SCL) waiver, or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID) for at least six months and have been eligible for Medicaid (MA) at least one month. The program is designed to provide transitional assistance to these individuals to enable them to move back into the community and live more independently. Individuals cannot apply for MFP as the Department for Medicaid Services (DMS) identifies Money Follows the Person recipients.

A. DMS and DCBS Responsibilities:

1. Individuals that qualify for MFP are identified by DMS and DMS MFP staff manage services.
2. When an individual is identified as participating in MFP:
 - a. DMS sets the MFP indicator on Worker Portal and SDX. The worker can confirm the case has been identified as MFP by inquiring on the Individual Summary screen and clicking on MFP. The MFP screen shows MFP status, begin date, and end date. If the MFP individual is an SSI recipient, the worker can confirm placement in MFP on SDX.
 - b. When an individual moves from a facility to a home environment the Medical Support and Benefits Branch (MSBB) receives form MAP-24M, Initial Admission, Change or Discharge of an Individual in KY Transitions Money Follows the Person, which indicates the required level of care. A LOC interface will not be received for MFP, and form MAP-24M is sufficient verification for MSBB to add the LOC.

B. An individual, who is identified as MFP, cannot lose Medicaid eligibility for any reason during the first 365 days of MFP eligibility. The 365 days are tracked by DMS and only applies to days the individual remains in the community setting. The 365-day count of MFP period ends if the individual enters a hospital or returns to a nursing facility.

C. If an MFP individual is temporarily admitted to a hospital or returns to a nursing facility, MSBB receives notification of this change from DMS by form MAP-24M. When an individual has shelter expenses while residing in the community, an increased Personal Needs Allowance (PNA) deduction is allowed to make it feasible for the individual to continue to pay the shelter expenses to maintain the dwelling while temporarily institutionalized.

D. If DCBS staff receive questions regarding MFP, forward the questions to MSBB through regional chain of command.]

MS 3720

ESTATE RECOVERY

(1)

Estate recovery results in the State filing a claim against the estate of an individual in order to recoup Medicaid (MA) expenditures paid on the individual's behalf. An estate is subject to estate recovery if the individual is at least 55 years of age at the time of death and has previously received Long Term Care (LTC) Medicaid.

- A. Estate recovery applies to the following Levels of Care (LOC):
1. NF, not including institutionalized Hospice;
 2. HCBS;
 3. Adult Day Care;
 4. SCL;
 5. Michelle P. Waiver;
 6. ABI/ABI LTC;
 7. ICF IID services; or
 8. Mental Health Psychiatric Care Facility (age 65 or older).
- B. The deceased individual's estate includes all assets such as cash, personal possessions, and homestead property.
1. A claim is filed against the estate for the total amount of Medicaid expenditures accruing on and after February 2, 1994.
 2. Medicaid expenditures prior to February 2, 1994 are not subject to estate recovery.
- C. The estates of individuals under 55 years of age are also subject to estate recovery if the individual has been receiving MA for NF or ICF IID services for a total of six consecutive months or more at the time of death.
- [D. If an individual was in Long Term Care (LTC) or receiving waiver services prior to receiving Hospice services, Estate Recovery must be completed.]

MS 3730 DCBS RESPONSIBILITIES FOR ESTATE RECOVERY (1)

[The Department for Community Based Services (DCBS) obtains information for purposes of Estate Recovery from all individuals applying for or receiving services from a Nursing Facility (NF), Home and Community Based Services (HCBS), Supports for Community Living (SCL), Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID), Mental Health Psychiatric Care Facility (age 65 or over), Michelle P. Waiver, Acquired Brain Injury (ABI) or ABI Long Term Care (LTC). Estate Recovery information passes directly from Worker Portal to the Department for Medicaid Services (DMS) system.

- A. The Estate Recovery Screen on Worker Portal should be completed and/or reviewed at every application, recertification, and case change.
- B. DMS will recover against ALL assets held by the individual at the time of death. Form MAP-708, Medicaid Estate Recovery Fact Sheet, advises the individual that the estate may be subject to recoupment of monies expended on their behalf for services received during periods of institutionalization.
 1. Post form MAP-708, Medicaid Estate Recovery Fact Sheet, in each local office waiting room to notify applicants and recipients of estate recovery information. Form MAP-708 is system generated and mailed to individuals at vendor payment approval.
 2. Advise individuals requesting additional information for members who are still living to contact DMS at 502-564-6890.
 3. Advise individuals requesting additional information after the death of a member to contact DMS at 502-564-4958 or submit their questions in writing to:

Department for Medicaid Services
Division of Program Integrity
Third Party Liability Branch
275 East Main Street, 6E-A
Frankfort, KY 40621

- C. Cooperation in estate recovery is not a technical eligibility requirement for receipt of Medicaid (MA) benefits and DMS will still move recoup assets upon death even if the individual states they will not cooperate.
- D. A notice of death is sent electronically to DMS from the Vital Statistics death match and Worker Portal discontinuances due to the death via nightly batch match. A notice is system generated from the Office of Inspector General (OIG) to the individual designated as the Executor or Administrator at case approval, recertification, or case change. This notifies the designated individual of the ability/intent of DMS to recover against assets of the member for cost of care, unless certain exemptions are met. If the member is inactive at the time of death, OIG will contact the designated individual concerning the estate of the deceased once the date-of-death match is received from Vital Statistics.]

MS 3800 NON-EMERGENCY MEDICAL TRANSPORTATION (1)

[Medicaid individuals are eligible for medical transportation services if non-emergency medical transportation criteria are met. Non-emergency medical transportation is for Medicaid individuals who do not have access to free transportation that suits their medical needs and need to be transported to a Medicaid covered service. Depending on an individual's needs, transportation is provided by taxi, van, bus, or public transit. Wheelchair service is also provided if required by medical necessity. Transportation to a Methadone clinic is limited to individuals 21 or under, former foster youth, and pregnant women.

- A. 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.
 - 1. The HSTD system is administrated by the Kentucky Transportation Cabinet.
 - 2. 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.

- B. 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 502-564-2687 or 1-800-635-2570. A referral from an individual's primary care physician is required. 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 (1)

The following is a list of transportation brokers that provide Non-Emergency Medical Transportation (NEMT) and phone numbers at which they may be contacted to request services.

Regions	Counties	Brokers	Phone Numbers
1	Ballard Calloway Carlisle Fulton Graves Hickman Marshall McCracken	Audubon Area Community Service, Inc. (GRITS)	1-800-816-3511 or 1-270-686-1651
2	Caldwell Christian Crittenden Hopkins Livingston Lyon Muhlenberg Todd Trigg	Pennyrile Allied Community Services (PACS)	1-800-467-4601 or 1-270-886-6641
3	Daviess Hancock Henderson McLean Ohio Union Webster	Audubon Area Community Service, Inc. (GRITS)	1-800-816-3511 or 1-270-686-1651
4	Breckinridge Grayson Hardin Larue Marion Meade Nelson	Audubon Area Community Service, Inc. (GRITS)	1-800-816-3511 or 1-270-686-1651
5	Adair Barren Butler Edmonson Green Hart Logan Metcalf Simpson Taylor Warren	LKLP Community Action Council	1-800-245-2826 or 1-606-487-1872
6	Bullitt Henry	Federated Transportation Services of the Bluegrass	1-888-848-0989 or 1-859-233-0066

	Jefferson Oldham Shelby Spencer Trimble	(FTSB)	
8	Anderson Boyle Casey Franklin Garrard Jessamine Lincoln Mercer Scott Washington Woodford	Bluegrass Community Action Partnership (BGCAP)	1-800-456-6588 or 1-502-695-4290
9	Boone Campbell Carroll Gallatin Grant Kenton Pendleton Owen	Federated Transportation Services of the Bluegrass (FTSB)	1-888-848-0989 or 1-859-233-0066
10	Fayette	Federated Transportation Service of the Bluegrass (FTSB)	1-888-848-0989 or 1-859-233-0066
11	Bourbon Clark Estill Harrison Madison Montgomery Nicholas Powell	Federated Transportation Services of the Bluegrass (FTSB)	1-888-848-0989 or 1-859-233-0066
12	Bell Clinton Cumberland Knox Laurel McCreary Monroe Pulaski Rockcastle Russell Wayne Whitley	Rural Transit Enterprises Coordinated (RTEC)	1-800-321-7832 or 1-606-256-9835
13	Breathitt Clay Harlan Jackson Knott Lee	LKLP Community Action Council	1-800-245-3826 or 1-606-487-1872

	Leslie Letcher Owsley Perry Wolfe		
14	Floyd Johnson Magoffin Martin Pike	Sandy Valley Transportation Services (SVTS)	1-800-444-7433 or 1-606-886-7039
15	Bath Boyd Carter Elliot Greenup Lawrence Menifee Morgan Rowan	LKLP Community Action Council	1-800-245-2826 or 1-606-487-1872
16	Bracken Robertson Mason Fleming Lewis	Licking Valley Community Action Program (LVCAP)	1-800-327-5196 or 1-606-845-0081

MS 3900*

MEDICAID WORKS OVERVIEW

The Kentucky Medicaid Works program offers disabled individuals who are unable to engage in Substantial Gainful Activity (SGA), but are working and are not financially eligible for regular MA the opportunity to “buy in” into Medicaid. For an explanation of SGA, refer to [MS 3912](#). Medicaid Works applicants who receive Medicare may also receive Qualified Medicare Beneficiaries (QMB) or Special Low-Income Medicare Beneficiaries (SLMB) if their income is below the income limits for the specific program.

Medicaid Works applicants with spouses must meet an initial income test. The income limit for an ineligible spouse is \$3,750 per month. If the ineligible spouse’s income exceeds \$3,750 per month, the applicant is not eligible. If the income of the ineligible spouse does not exceed \$3,750, then apply the remaining appropriate income tests as explained next.

Medicaid Works applicants that have already been determined disabled by a Federal/State entity have to pass two different income limit tests. The first test is the unearned income limit test set by the SSI income standards. The second is the earned income limit set by the 250% Federal Poverty Level (FPL).

Medicaid Works applicants that have NOT been determined disabled have to pass three different income limit tests. The first test is the unearned income limit set by the SSI income standards. The second test is the earned income limit set by the 250% FPL. The third test is the SGA income standards. For an explanation of SGA, refer to [MS 3912](#).

Medicaid Works recipients that stop working can continue to be eligible for up to 6 months as long as they intend to return to work.

MS 3910 MEDICAID WORKS APPLICATION (1)

A. To be technically eligible for Medicaid Works an applicant must be:

1. Between the ages of 16 and 64;
2. Actively employed or actively self-employed;
3. Under the unearned income limit AND the earned 250% Federal Poverty Level income limit;
4. Determined to be totally and permanently disabled;
5. Unable to engage in Substantial Gainful Activity (SGA).
 - a. [A disabled individual earning \$1,550 per month (effective 1/1/24) or more is considered ABLE to engage in SGA.
 - b. A blind individual earning \$2,590 per month (effective 1/1/24) or more is considered ABLE to engage in SGA; and]
6. Meet all other technical and financial eligibility requirements for Medicaid (MA).

B. For applicants who have NOT been determined disabled:

1. Determine if the applicant's income and resources are within the Supplemental Security Income (SSI) standard. If so, refer the applicant to the Social Security Administration (SSA) for a disability determination. Worker Portal will issue form PAFS-5.1, Report or Referral To The District Social Security Office, referring an individual to SSA to apply for SSI. Individuals can receive MAGI Medicaid while waiting on an SSI determination, if eligible.
2. For those applicants whose income and resources are over the SSI standard, complete a Medical Review Team (MRT) referral. For more information regarding the MRT process, refer to [MS 1700](#).
3. Prior to completing the MRT referral, determine if the Medicaid Works applicant is able to engage in SGA. For more information regarding 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, refer to [MS 3912](#).

C. For applicants already determined disabled:

Coverage is effective the date of application. Explain to the applicant that the effective date of medical assistance is the date of application, not the 1st day of the month of application. Enter the date of application as well as all other information on Worker Portal. There is no retroactive coverage.

- D. If an applicant has medical expenses prior to the date of application, up to the 3 prior calendar months, Worker Portal will explore eligibility for Spend Down coverage. Do not process a Spend Down for the same month in which a member has been approved for coverage. The client may elect to wait until the first of the following month to apply for on-going benefits if they need to apply for Spend Down for the current month. It is the decision of the client; however, ensure the client understands that no coverage will exist prior to the date of application in the application month.

If Spend Down coverage is requested for any portion of the prior quarter, complete the Spend Down as a special circumstance transaction, provided all verification has been received. Document the case comments accordingly. Refer to [MS 2650](#), Spend Down Process, for the instructions for processing spend downs by special circumstance.

MS 3912 MEDICAID WORKS SUBSTANTIAL GAINFUL ACTIVITY (1)

Substantial Gainful Activity (SGA) is a term used by the Social Security Administration (SSA) to describe a level of work activity and earnings. It is considered in situations involving disabled or blind individuals. Individuals determined to be engaged in SGA are not eligible for Medicaid Works.

HOW TO DETERMINE SUBSTANTIAL GAINFUL ACTIVITY:

For applicants who have not been determined disabled, establish if the applicant meets the criteria to have the Medical Review Team (MRT) complete a review by determining if the applicant is engaged in SGA.

To determine if an applicant is engaged in SGA, compare the applicant's actual income received for the prior month to the SGA income limits set by SSA annually.

[Effective 1/1/24, the current SGA monthly income limit is:

SGA for Disabled Individual	SGA for Blind Individual
\$1,550	\$2,590]

Note: If the income for the prior month is not representative of ongoing, compute the income by totaling actual amounts of income received in the prior 3 months and dividing by 3. If the applicant claims his/her income will change, but is over the SGA standard for the current month, the application is denied for the current month and the individual is advised to reapply in the next month.

Prior to completing an MRT, determine if the applicant's income is more than the SGA standards. If it is, the applicant is considered to be engaged in SGA and does NOT meet the definition of disability. Do not complete an MRT referral. If the applicant earns less than the SGA standards, complete an MRT referral.

A. The MRT referral is NOT sent for review and the worker is to:

1. 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;
2. Document in case notes why the MRT referral was not completed.

Example 1: Dan (under the age of 65) works and earns \$1,080 and receives \$300 in RSDI monthly.

Dan passed the unearned income test because the \$300 in RSDI is under the SSI income standards. Dan also passed the second income test as his total combined income (\$1,300/mo.) is less than the 250% Federal Poverty Level for one. However, Dan's verified earned income is above the SGA income limit. Therefore, he is considered to be engaged in SGA and does not meet the definition of disability.

B. If an MRT referral is required, the worker is to:

1. Complete the MRT referral screens on Worker Portal. This will create a task to MRT. Refer to [MS 1700](#).
2. Review the MRT-15 screen on Worker Portal with the individual and provide them with a copy.
3. Complete the task that is generated from MRT once a determination has been made.

Example 2: Dan's co-worker Jimmy (also disabled and under age 65) earns \$979 and receives \$200 in VA benefits monthly.

Jimmy has passed the unearned income test and his VA benefit is under the SSI standards. Jimmy has also passed the second income test as his total combined income is less than the 250% FPL for one. Additionally, Jimmy's verified earned income is below the SGA income limit. Therefore, he is considered to NOT be engaged in SGA and DOES meet the definition for disability.

MS 3920 MEDICAID WORKS FINANCIAL ELIGIBILITY (1)

The following are the resource and income limits for individuals in the Medicaid Works program.

A. The resource limits are:

1. \$5,000 for a single individual; and
2. \$10,000 for a couple.

B. The income limits are:

1. [The income limit (gross earned and unearned) for applicants is \$3,138 which is 250% of the Federal Poverty Level (FPL), effective 4/1/24.]
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 the Supplemental Security Income (SSI) standard of \$943 plus \$20).

Note: If there are any changes in the SSI standard they are effective January of each year.

Calculate income as follows:

1. For a technically eligible applicant, refer to [MS 2560](#).
2. For a technically eligible applicant and spouse, refer to [MS 2610](#).
3. For a technically eligible applicant with a technically ineligible spouse, refer to [MS 2620](#).

For financial eligibility and verification of employment, refer to [MS 2480](#) for allowable income deductions. Refer to [MS 2470](#) for a list of excluded income. When income is over the limit, but the individual meets technical requirements and is resource eligible, Worker Portal will explore Spend Down eligibility.

Applicants who receive Medicare Part A and/or Part B and whose income is under the 100% FPL scale are also eligible for Qualified Medicare Beneficiaries (QMB). They are eligible for Specified Low-Income Medicare Beneficiaries (SLMB) if income falls under the 120% FPL scale and they have Medicare Part B. For more information regarding income limits for the Medicare Savings Program, refer to [MS 4455](#).

[Income Scale effective 4/1/24

Family Size	100% FPL (QMB)	120% FPL (SLMB)	250% FPL
1	\$1,275	\$1,526	\$3,158
2	\$1,724	\$2,064	\$4,279

Note: The above income limits include the \$20 general unearned income exclusion.]

MS 4150

PASS THROUGH OVERVIEW

(1)

Federal law protects MA eligibility for certain RSDI beneficiaries. The MA category for such individuals is called Pass Through. These beneficiaries previously received MA as a Supplemental Security Income (SSI) or State Supplementation recipient, and lost those benefits due to an increase in, entitlement to, or recomputation of RSDI benefits. Increases in RSDI benefits may be the result of a cost of living adjustment (COLA).

There are three Pass Through groups:

- A. Those who previously received SSI/State Supplementation and RSDI correctly and concurrently (in the same month). Applicants in this group can receive in the "F", "G", or "H" category based on age, blindness, or disability.
- B. Those losing SSI/State Supplementation benefits due to an entitlement to or increase in RSDI Disabled Adult Child (DAC) benefits. Applicants in this group can receive in the "F", "G", or "H" category based on age, blindness, or disability. [If approved in "G" or "H", there is no need to change the category once age 65 or older.]
- C. Disabled or early widows/widowers or disabled surviving divorced spouses who are not yet eligible for Medicare Part A. Applicants in this group can only receive in the "G" or "H" category.

These individuals may be technically eligible in more than one category. Case workers are to first apply DAC or widows eligibility before applying correct and concurrent receipt.

When an individual who formerly received SSI applies for Medicaid, Pass Through eligibility must be explored. If an individual is otherwise Medicaid eligible (such as Pass Through eligible) and receiving waiver services, the individual's patient liability is \$0.

[Technical eligibility for Pass Through is verified for previous SSI recipients by worker completion of form PA-9. In addition to entering the Pass Through information on KAMES, workers are required to manually compute income eligibility of the Pass Through individual on form PA-1A, Supplement A, Pass Through Computation Sheet.

Form PA-9 is not used for applicants who are no longer eligible for State Supplementation. Inquire the case on KAMES to determine why the individual lost State Supplementation benefits. These individuals can only receive Pass Through in the correct/concurrent Pass Through category.]

MS 4160 CONCURRENT SSI/STATE SUPPLEMENTATION

Current RSDI recipients who, after April 1977, previously received SSI or State Supplementation and RSDI correctly and concurrently (in the same month) and lost SSI or State Supplementation may be eligible in this category of Pass Through. Concurrent receipt must also be correct receipt. Concurrent receipt is considered correct if any portion of an RSDI lump sum payment is awarded for the month of SSI receipt.

There are three types of individuals who may fall into the Concurrent SSI/State Supplementation grouping:

- A. Those individuals who would still be eligible for SSI/State Supplementation benefits if all RSDI cost-of-living adjustments (COLA) since last receiving SSI/State Supplementation were deducted from countable income. It is not necessary to wait for another COLA to pass before applying. For example: An individual loses SSI due to COLA effective December 2007. He will meet the Pass Through requirement without having to wait for another COLA.
 1. If the individual has a spouse and the spouse receives RSDI, deduct every COLA the spouse has received since the time of SSI discontinuance from the individual's countable income in determining the individual's Pass Through eligibility.
 2. If the individual is a child, and the child's responsible relative receives RSDI, deduct every COLA the responsible relative has received from the time of SSI discontinuance from the child's countable income in determining the child's Pass Through eligibility.
 3. The individual's claim number will end in an A, B, C, D or W.
 4. Eligibility in this category is not affected by receipt of Medicare Part A.
 5. If SSI is discontinued due to a RSDI COLA increase, the old amount of RSDI (smaller amount) is used to calculate the Pass Through amount. This RSDI amount can be found on the PA-9, Part II, A2. This is the RSDI amount to be entered on the Pass Through screen on KAMES.
 6. For those individuals who lost SSI/State Supplementation as a result of a COLA, the Pass Through amount is the sum of all COLA increases received since the termination of the SSI/State Supplementation payment.
- B. Those individuals who lost SSI/State Supplementation due to a recomputation of RSDI or to a new RSDI entitlement. At least one COLA must have been received since termination of SSI/State Supplementation for the Pass Through requirement to be met.

1. The loss of SSI/State Supplementation must be the individual's, not the spouse's.
 2. The individual's claim number will end in an A, B, C, D or W.
 3. If SSI/State Supplementation is discontinued due to a recomputation of RSDI, the amount of RSDI (larger amount) which caused the SSI/State Supplementation to discontinue is used. This RSDI amount can be found on the PA-9, Part II, A4. This is the RSDI amount to be entered on the Pass Through screen on KAMES.
 4. Eligibility in this category is not affected by receipt of Medicare Part A.
 5. These individuals may be technically eligible in this category, but not financially eligible.
- C. Those individuals who lost SSI/State Supplementation due to an increase in income other than RSDI. This refers to only the Pass Through applicant's income, not any other household member's income. At least one COLA must have been received since termination of SSI/State Supplementation for the Pass Through requirement to be met. In many instances, these individuals may not be financially eligible even though technical eligibility is met.
1. Eligibility in this category is not affected by receipt of Medicare Part A.
 2. The individual's claim number will end in an A, B, C, D or W.
 3. If SSI/State Supplementation is discontinued due to an increase in income other than RSDI, the RSDI amount to be used on the Pass Through screen can be found on the PA-9, Part II, A4. This is the RSDI amount to be entered on the Pass Through screen on KAMES. This RSDI amount should match the amount found on the PA-9, Part II, A2. This is the RSDI amount to be entered on the Pass Through screen on KAMES. You will find the amount of the other income that caused the loss of the SSI on Part I B, 3, c of the PA-9.

For those who lost SSI/State Supplementation due to an increase in income other than RSDI, do the following when completing the PA-1A Supp A, Part II, A or B:

- a. Add the other income which caused the loss of the SSI/State Supplementation to the current gross RSDI benefit to determine total income.
 - b. Verification of the other income must be requested from the individual.
5. These individuals may be technically, but not financially eligible in this category.

MS 4180

DISABLED ADULT CHILD

[Continued MA coverage is provided to certain blind or disabled individuals, age 18 and older, who lose SSI as a result of an entitlement to or increase in RSDI Disabled Adult Child (DAC) benefits. Neither concurrent receipt of RSDI and SSI or receipt of an RSDI COLA is a technical eligibility requirement for this group of Pass Through applicants/recipients. Once an individual is technically qualified as a DAC, he/she is always a DAC. However, the individual could become financially ineligible for Pass Through.

- A. To be classified as a DAC, an individual would have to be determined to be disabled by the Social Security Administration (SSA) before age 22.
- B. These individuals previously received SSI and lost SSI on or after July 1, 1987 due to:
 - 1. An entitlement to RSDI DAC benefits; or
 - 2. Previously received RSDI DAC benefits concurrently with SSI and lost SSI due to an increase in RSDI DAC benefits.
- C. These individuals would still be eligible for SSI if all COLAs and the amount of the RSDI DAC entitlement or increase were deducted from countable income.
- D. The RSDI claim number for a DAC is the social security number of the parent the individual is receiving on followed by the letter "C".
- E. Eligibility in this category is not affected by receipt of Medicare Part A.
- F. A listing of potential applicants is on RDS report HRSDXRDA, Disabled Children Report. This report is released on a quarterly basis.
- G. For individuals who received SSI and RSDI and lost SSI due to a new entitlement or increase in RSDI DAC benefits, the Pass Through amount is the amount of the RSDI DAC benefits which resulted in the SSI discontinuance plus all subsequent COLA's received since SSI was lost. Calculate the Pass Through amount using the RSDI amount found on the PA-9, Part II, B2. This is the RSDI amount to be entered on the Pass Through screens.
- H. For individuals who received SSI only and who lost SSI due to a new entitlement to RSDI DAC benefits, the RSDI amount to be used on the Pass Through screen is zero and may be found on the PA-9, Part II, B2. This is the RSDI amount to be entered on the Pass Through screens.
- I. To receive benefits in the Pass Through category as a DAC, an individual must be at least 18 years of age. For applications and program transfers, the age will be determined by the age of the individual on the first day of the application/program transfer month.

Example: An application is taken on 2/6/06. The birthday of the applicant is 3/6/88. The individual is 17 years of age. An "N" will be uploaded for the question, "Did he/she lose SSI/SSP due to entitlement/increase in Disabled Adult child Benefits (DAC)?" This field will be protected to prevent the worker from answering "Y" to the question.

KAMES has an edit in place which prevents an applicant under 18 years of age from receiving benefits in the "G" or "H" category as a DAC.]

MS 4190 DISABLED EARLY WIDOWS AND WIDOWERS OR DISABLED SURVIVING
DIVORCED SPOUSES WITH NO MEDICARE PART A

The following individuals are to be considered for Pass Through eligibility:

- [A. Individuals, ages 60 through 64, who lost SSI or State Supplementation as a result of entitlement to RSDI early widow's or widower's benefits, and who are not yet entitled to Medicare Part A.] The RSDI claim number will end with a "D" or "W".
- [B. Individuals, ages 50 through 59, who received SSI or State Supplementation and who lost SSI or State Supplementation as a result of entitlement to RSDI disabled widow's or widower's or disabled surviving divorced spouse's benefits, and are not yet entitled to Medicare Part A.] The RSDI claim number will end with a "D" or "W".

The following criteria apply to both A and B individuals listed above:

- [1. Concurrent receipt of SSI/State Supplementation and RSDI is not a requirement.
- 2. Once an individual's entitlement to Medicare Part A is established, Pass Through eligibility terminates in this category. Explore eligibility in the concurrent receipt category.] When Pass Through terminates, explore eligibility for QMB, SLMB, QDWI, or QI1.
- 3. Set up a spot check for those individuals who will reach age 65 or become entitled to Medicare Part A prior to the next case recertification.
- 4. Terminate Pass Through when entitlement to Medicare Part A is established, even if the individual fails to enroll.
- 5. This category of Pass Through does not require that a COLA occur prior to determining eligibility.
- 6. [For individuals who received SSI/State Supplementation and RSDI and lose SSI/State Supplementation due to a new entitlement or increase in RSDI, the Pass Through amount is calculated using the amount of the RSDI benefit which resulted in the SSI/State Supplementation discontinuance plus all COLA increases received since SSI/State Supplementation was lost. The RSDI amount is found on the PA-9, Part II, C2. This is the RSDI amount to be entered on the Pass Through screen on KAMES.
- 7. For an individual who received SSI/State Supplementation only and who lost SSI/State Supplementation due to a new entitlement to RSDI, the Pass Through amount is calculated using the RSDI benefit amount of 0. This is the RSDI amount to be entered on the Pass Through screen on KAMES.
- 8. If the individual reaches age 65 or becomes entitled to Medicare Part A and receipt was correct and concurrent, the RSDI amount to be used to calculate the Pass Through amount can be found on the PA-9, Part II, C4. This is the RSDI amount to be entered on the Pass Through screen on KAMES.]

MS 4220

[PASS THROUGH RESOURCES

Verify and consider countable resources according to policy and procedures in MS [1810](#) and [1820](#). If resources exceed limits, the case is ineligible. The total countable resources allowed for individuals or couples receiving Pass Through are:

1. Individual \$2000
2. Couple \$3000]

MS 4230

INCOME CALCULATION

(1)

[Follow the steps below to calculate income for Pass Through eligibility:

- A. To obtain the amount of RSDI the individual received at the time of SSI discontinuance, complete form PA-9, Pass Through Verification Letter, according to procedural instructions for the form. Do not complete form PA-9 for State Supplementation discontinuance. See [MS 4150](#) for instructions for State Supplementation discontinuance.
 1. It is not necessary to complete a new form PA-9 for a recertification or subsequent reapplication unless the information on the form is in question or the form is out-of-date. If the previously completed PA-9 is in the hardcopy case record, scan it into the electronic case file (ECF). The case record must contain form PA-9 with a revision date no earlier than 11/08.
 2. If the system information entered on form PA-9 is questionable or not available and the issue cannot be resolved, forward to MSBB through the program specialist.
- B. Workers are required to manually compute income eligibility of the Pass Through individual on form PA-1A, Supp A, Pass Through Computation Sheet and scan it into ECF. KAMES makes these calculations internally.]
- C. Income eligibility is determined by comparing the individual's countable income minus the Pass Through amount to the current SSI or State Supplementation standard for one. If the remainder is equal to or less than the standard, income eligibility exists.
- D. Determine countable income according to policies stated for the Aged, Blind, or Disabled MA Program. These policies can be found in [MS 2180](#) – [MS 2480](#) of this volume.

MS 4235*

APPLICANT WITH ELIGIBLE SPOUSE

- A. For an individual or couple who received SSI, and who lost SSI, compare countable income to the current SSI standard for an individual or couple, as appropriate.
 1. If a couple received SSI and lost SSI and both are applying, a PA-9 is required for the individual and spouse to determine Pass Through for each.
 2. For a couple where only one wants to apply for Pass Through, use the information on the individual's PA-9, Part III, for spouse's information.

- B. For a couple, who both received State Supplementation caretaker services and lost State Supplementation, compare the couple's countable income to the current State Supplementation caretaker services standard for a couple, both eligible.

MS 4240

APPLICANT WITH INELIGIBLE SPOUSE

For a couple, when one loses SSI or State Supplementation and the other spouse is technically or financially ineligible for SSI or State Supplementation:

- A. [If a technically or financially ineligible spouse's income EXCEEDS the difference between the SSI or State Supplementation standard for an individual and the SSI or State Supplementation standard for a couple, only one requiring care, add the ineligible spouse's income to the applicant's income.

Subtract one \$20 general exclusion, earned income deductions, if applicable, and the total Pass Through amount. Compare the remaining income to the SSI standard for an individual or the State Supplementation standard for an eligible individual with an ineligible spouse.

If the remaining income is LESS THAN OR EQUAL TO the SSI or State Supplementation standard, the applicant is income eligible for Pass Through. If the remaining income is OVER the standard, the applicant is not eligible. On PA-1A Sup A this calculation would be completed on Part III, B1.

- B. If a technically or financially ineligible spouse's income is EQUAL TO OR LESS THAN the difference between the SSI or State Supplementation standard for an individual and the SSI or State Supplementation standard for a couple, only one requiring care, DO NOT consider that spouse's income in the calculation.

After subtracting one \$20 general exclusion, earned income deductions, if applicable, and total Pass Through amount. Compare the applicant's remaining income to the current SSI or State Supplementation standard for an individual.

If the applicant's remaining income is LESS THAN OR EQUAL TO the SSI or State Supplementation standard, the applicant is income eligible for Pass Through.

If the applicant's remaining income is OVER the standard, the applicant is not eligible. On the PA-1A, Sup. A, this calculation would be completed on Part III, B2.]

MS 4245* PASS THROUGH FOR INDIVIDUAL LOSING
STATE SUPPLEMENTATION

For those individuals who received State Supplementation and lost State Supplementation, compare the individual's countable income to the appropriate current State Supplementation standard. Refer to [MS 4910](#).

An individual with a spouse who is approved for Long Term Care (LTC) vendor payment is considered an individual the month following the month of separation. This individual's countable income is also compared to the appropriate current State Supplementation standard.

MS 4250 PASS THROUGH APPLICATION PROCESS (1)

[Adult Medicaid applications are completed during a face to face interview in the local office or at a home visit, except for individuals who choose to submit a mail-in application in the "Z" category (see [MS 4500](#)) or individuals who apply in the "Z" category via an Low Income Subsidy (LIS) referral. The application process is completed as follows:

- A. The application is signed by the applicant, statutory benefit payee, power of attorney (POA), committee/guardian, authorized representative (AR), or a witness (related or unrelated) if the applicant signs by a mark (X).

If the payee does not live in Kentucky, a phone interview may be permitted if it is a hardship to the payee to come to the local office. The application is entered on KAMES on the date assistance is requested and the case is carried in the county where the applicant lives.

- B. PROGRAM CODE. Use the appropriate program code for aged (F), blind (G), or disabled (H) individuals.]
- C. CASE NUMBER. Use the SSN of the applicant as the case number.
- D. CASE NAME. Use the applicant's full legal name for the case name even if the application is filed by someone other than the applicant.
- E. APPROVAL. If countable income, minus the Pass Through amount, is equal to or less than the current SSI standard or current State Supplementation standard for one, income eligibility is established. If all other eligibility criteria are met, approve the case.

[Establish the effective date as the first day of the month, up to 3 months prior to the month of application.]

- F. CONTINUING ELIGIBILITY. Complete a recertification every 12 months.
- G. CASE RECORD. The case record must contain:
 - 1. [Form PA-9, Pass Through Verification Letter, (except in cases where State Supplementation has been received);]
 - 2. Form PA-1A, Supp A, Pass Through Computation Sheet. A new PA-1A Supp A must be completed at each recertification.
- H. Refer to [MS 1350](#) – [MS 1380](#) for further information on the application process.

MS 4260

DISCONTINUANCES

Discontinue a Pass Through case when:

- [A. RSDI less Pass Through amount(s) plus other income exceeds the current appropriate SSI/State Supplementation standard for one;]
- B. Resources exceed limits;
- C. Recipient dies;
- D. Recipient leaves the state; or
- E. Recipient address is unknown and mail directed to the individual has been returned. Such cases are reinstated if the recipient is located and no other reason for discontinuance is valid. Restore the original recertification month if the reinstatement is within the certification period.
- [F. A Disabled or Early Widow/Widower or Disabled Surviving Divorced Spouse becomes entitled to Medicare Part A and no other Pass Through category applies. Explore eligibility in other MA categories of assistance.]

MS 4280 [PASS THROUGH INDIVIDUALS RECEIVING
WAIVER OR HOSPICE SERVICES] (1)

[When a PRO Certification or form MAP-374, Election of Hospice Benefits Form, is received for a Pass Through recipient indicating receipt of waiver services or non-institutional hospice, an interim change is completed.

- A. Enter the appropriate information on the "LL" LTC/Waiver screen on KAMES. The case will remain in the Pass Through category.
- B. Patient liability will always be \$0 for Pass-Through recipients approved for waiver services because they were otherwise eligible for Medicaid.
- C. If the recipient is discharged from Waiver or Hospice, notify the recipient of vendor payment ineligibility. Do not change the program code. Continue Pass Through eligibility.

A Pro Certification is used to verify the individual has met level of care in Home and Community Based Services (HCBS) Model II Waiver, Supports for Community Living (SCL), Acquired Brain Injury Waiver (ABI), Adult Day and Consumer Directed Options (CDO).

Form MAP-374 verifies admission to Non-Institutional Hospice.

Form MAP-24C, SCL or ABI Admission, Discharge or Program Transfer, verifies changes and discharges for Supports for Community Living (SCL) and Acquired Brain Injury Waiver (ABI) recipients.]

MS 4300*

INTRODUCTION

Qualified Disabled Working Individuals (QDWI) are individuals who lose RSDI benefits due to earnings, but who continue to be eligible for or eligible to enroll in Medicare. QDWI recipients are eligible ONLY for Buy-In of Medicare Part A. Medicare deductibles and co-insurance are not paid. As Buy-In is the only benefit of the QDWI program, Medicaid Identification Cards are not issued to QDWI recipients. Additionally, QDWI individuals may not receive QDWI and regular MA as a dual eligibility case, nor may QDWI eligibility exceed 48 months from the date of eligibility notification by the SSA.

MS 4310

GENERAL INFORMATION

[Take applications for Qualified Disabled Working Individuals (QDWI) individuals and process in the same manner as QMB applications using program code "Z".]

Since the QDWI recipients are working individuals, they do not meet the disabled criteria for MA eligibility. However, discontinue if a QDWI recipient chooses to be included in a case with a dependent child. Since these individuals are not entitled to dual benefits, do not include the QDWI individual in the case for any month in which they received QDWI benefits.

[QDWI recipients are not dually eligible for any other category of Medicaid. QDWI recipients approved for Spend Down lose their buy-in for the months of Spend Down coverage. Workers are to allow a medical deduction for the SMI premium for each Spend Down month, and are to advise recipients that the SMI premium for those months may be recouped by the Centers for Medicare and Medicaid Services (CMS).]

MS 4320

TECHNICAL ELIGIBILITY

- A. To be eligible for QDWI, the individual must meet the following criteria:
1. Has not attained age 65;
 2. Has been entitled to RSDI based on disability;
 3. Has lost RSDI due to earnings exceeding the Substantial Gainful Activity (SGA) level; [See [MS 3912](#).]
 4. Continues to have a disabling physical or mental condition;
 5. Has or is entitled to enroll in Medicare Part A;
 6. Is not eligible for MA; and
 7. Has not received QDWI benefits for more than 48 months.
- B. The SSA sends notice to the individual at the time RSDI entitlement ends advising them of QDWI.
1. The individual has seven months in which to enroll in Medicare Part A if Medicare has been terminated.
 2. After that period of time, the individual may enroll for Medicare Part A only during the general enrollment period, January, February and March of each year.
 3. The SSA notification letter may be used to verify that the individual meets QDWI requirements. Otherwise, verification must be obtained from SSA.
- C. All other technical eligibility requirements for Aged, Blind, or Disabled MA, except Third Party Liability, must be met.

MS 4330

FINANCIAL ELIGIBILITY FOR QDWI

(1)

The resources of a Qualified Disabled Working Individual (QDWI) are considered the same as for a Qualified Medicare Beneficiaries (QMB) individual with the exception that the prior 3 months resources must be verified to receive retroactive coverage.

Resource Limits:

Family Size	Resource Limit
1	\$4,000
2	\$6,000

Consideration of income for a QDWI individual is the same as consideration for a QMB individual with the exception that the QDWI Scale is used.

[Compare total countable income to the following QDWI Income Scale (effective 4/1/23).

Family Size	Income Limit
1	\$4,945
2	\$6,659]

If countable income is equal to or less than the appropriate QDWI Scale, income eligibility is met.

MS 4340*

QDWI EFFECTIVE DATES

Effective date of eligibility can be retroactive to 3 months prior to month of application, if all eligibility criteria were met during the 3 month period. QDWI eligibility cannot exceed 48 months.

MS 4350

INTERIMS/RECERTIFICATIONS

[Complete interims/recertifications for QDWI individuals in the same manner as interims/recertification for QMB individuals per [MS 4530](#).]

Benefits for QDWI individuals end when:

- A. A disabling condition no longer exist;
- B. Recipient requests voluntary termination of coverage;
- C. Recipient becomes eligible for Medicare under some other provision, i.e., premium-free Medicare; or
- D. 48 months of eligibility have expired. Spot check the case for the expiration of the 48 month period of eligibility.

MS 4390

MEDICARE PART D

Medicare Part D is the prescription drug plan offered to individuals receiving Medicare A and B. There are multiple companies who offer Part D plans, at various costs and benefit levels. Low income individuals can apply for "Extra Help" with the cost of this plan through Low Income Subsidy (LIS). LIS is a federal payment that is equal to the average cost of a basic Part D plan in each state and is adjusted annually according to premium cost. If a person receiving LIS enrolls in a Medicare Part D plan which has a premium higher than the LIS payment, the beneficiary is responsible for paying the difference in the premium. Individuals who receive any form of Medicaid, including Medicare Saving Plan (QMB, SLMB and QI1) automatically meet the criteria for LIS.

The Social Security Administration's (SSA) definition of dual eligibility is an individual who receives Medicare Part A and/or Part B and some form of Medicaid benefit at the same time. Partial duals are those receiving cost sharing assistance under Medicare Savings Program (QMB, SLMB or QI1). Full dual eligibility is an individual that receives Medicaid. Individuals that receive either dual or partial dual eligibility are deemed as qualified for LIS. Qualified individuals who are not already enrolled in a Part D plan are automatically enrolled with LIS for the full calendar year. Dual eligibility includes the receipt of Medicaid by way of spend down Medicaid coverage. Even if the spend down card is received for only one month, the receipt of Medicaid for that one month qualifies the individual for LIS benefits through the end of the calendar year, which exempts recipients from the "Donut Hole" for the remainder of the current calendar year.

Note: The "Donut Hole" is as follows; once the total retail cost of covered medications reaches the allowed amount for that calendar year, the participants enter a coverage gap and are responsible for their prescription costs until they meet the obligated amount for that calendar year. This period is referred to as the "Donut Hole". Once an individual passes the "Donut Hole" period, they enter into the last phase of the Medicare Part D program. During this phase Medicare Part D will pay at a higher amount than before the coverage gap.

Individuals who receive Medicaid for nursing facility stays are qualified for Medicare Part D and therefore, automatically eligible to receive LIS and will be auto enrolled if they have not opted out of Medicare Part D. Once enrolled in a Part D plan, these individuals do not have co-pays and do not have a "Donut Hole" period. If the individual has a Part D plan upon entering the nursing facility, their Part D provider is notified of the change in their status automatically qualifying them for LIS. This change in status could take several months and until the change is completed the incurred co-pays and premiums are to be used as a medical deduction in calculating patient liability. Field staff must spot check case to verify and remove these deductions after two months of continuous stay in the nursing facility. If the individual selected a plan with a higher premium than the LIS payment, the difference can be given as a medical

deduction through the end of the calendar year. Note: Individuals receiving Medicaid for HCBS waiver services will continue to be responsible for co-pays.

Full benefit dual eligible for LIS may opt out of or affirmatively decline auto enrollment into a Part D plan. The primary method for doing so is by calling 1-800-MEDICARE, but they can also call the provider of the Part D plan which they have been assigned. If the member has opted out of Medicare Part D, Medicaid will not pay for the individual's prescriptions and the prescription expense cannot be given as a deduction to reduce patient liability. However, the current cost of the prescriptions or the amount of those still owed can be used to reduce the individual's portion of liability for a spend down case. Individuals who opt out do not permanently surrender their eligibility for enrollment in a Part D plan. Those eligible for LIS can re-enroll at any time, they are not limited to open enrollment.

MS 4400 MEDICARE SAVINGS PROGRAM OVERVIEW (1)

Medicare Savings Programs can assist individuals/couples in paying for their Medicare Premiums. Medicare Savings Programs include: Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Medicare Qualified Individuals Group 1 (QI1). QMB, SLMB and QI1 individuals must meet all technical eligibility requirements for Aged, Blind or Disabled MA.

Individuals may receive benefits in the QMB or SLMB categories in addition to regular MA benefits in another category. This is dual eligibility. However, QI1 recipients are not dually eligible for any category of Medicaid.

A. QMB

QMB recipients are eligible for limited MA and for Buy-In. Coverage for QMB individuals provides for payment of Medicare Part A and Medicare Part B premiums, Medicare deductibles, and Medicare coinsurance amounts. Due to payment of coinsurance amounts, QMB coverage is extended to all Medicare services or items outside the scope of MA coverage except:

1. Limit coverage for individuals eligible only for QMB to the above. Other MA covered services such as prescription drugs and medical transportation are not covered.
2. QMB does not cover Medicare deductibles and coinsurance for individuals age 21, or age 22 if uninterrupted treatment began prior to age 21, through 64 in a psychiatric hospital.

B. SLMB

For individuals whose countable income is in excess of the QMB standard, determine eligibility for SLMB. SLMB recipients meet all of the technical requirements for QMB benefits, except for having income in excess of the QMB standard but less than or equal to the SLMB scale maximum limit. Coverage for SLMB individuals provides for payment of the Medicare Part B premium only and may be effective three months prior to the SLMB application month. SLMB eligibility cannot be met through spend down.

C. QI1

[Individuals who receive Medicare Parts A and B can be eligible for payment of the buy-in for their Part B payment. Individuals ineligible for SLMB must be evaluated to see if eligibility for QI1 exists.]

- D. KYHealth cards are ONLY issued for recipients receiving QMB. SLMB or QI1 recipients do not receive a KYHealth card.
- E. For services requiring co-payments refer to [MS 1060](#).

MS 4420 MAIL-IN APPLICATIONS FOR MEDICARE SAVINGS PROGRAM (1)

Individuals who are applying for the Medicare Savings Program, may complete a mail-in application form called MAP-205, Application for Medicare Savings Program. Individuals applying for the Medicare Savings Program using the mail-in application are not required to complete an interview.

- A. [Form MAP-205 instructs individuals to return the completed form, along with verification, to their local DCBS office. The individual may also return the form by mail or fax to the Centralized Mail Center.
1. If the individual returns the form to the DCBS office, it must be date stamped the day it is received. Scan the form as pending into the Electronic Case File (ECF). A task is generated for a worker to process.
 2. The date the mail-in application is received in the DCBS office is the date of application. The application must be entered on Worker Portal within 3 days of the stamped date of receipt.

Note: QMB coverage is effective the month after the month of approval and retroactive coverage cannot be issued; therefore, it is very important to adhere to the 3 days.

- B. If an unsigned application is received, enter all information and generate an RFI for an application signature. Worker Portal will issue the application summary to the individual for signature and the case will pend for its return. A case cannot be approved without a signed application. Document Case Notes thoroughly.
- C. If form MAP-205 is received for an individual who has an active Medicare Savings Program TOA, review the form for possible changes in address, income, resources, etc., act on any reported changes, and send form MA-105, Eligibility Notice, advising the individual that an application is not needed as he/she is currently active in a case.

Note: Form MAP-205 can be used as an application for all MA as there is not a separate application process for the Medicare Savings Program.]

MS 4430 TECHNICAL ELIGIBILITY FOR MEDICARE SAVINGS PROGRAM

[Individuals applying for the Medicare Savings Program (MSP) must meet all technical eligibility requirements for Medicaid, with the exception of Third Party Liability (TPL). In order to be eligible for SLMB and QI1, individuals must receive both Medicare Parts A and B. However, individuals may only receive Medicare Part A to be eligible for QMB.

A. Medicare Open Enrollment:

The annual open enrollment period for Medicare Part A begins in January and ends in March each year. During this time individuals may enroll in Medicare Part A.

1. Individuals who enroll in Medicare Part A during the annual open enrollment period do not begin receiving Part A until July.
2. Individuals who miss the current year's open enrollment period cannot enroll in Medicare Part A until the open enrollment period in the following year.

B. Conditional Enrollment in Medicare Part A:

Some individuals are not eligible to receive Medicare Part A for free and are required to pay a premium. However, as enrollment in Medicare Part A is a technical eligibility requirement to receive QMB benefits, the Social Security Administration (SSA) has a process in place to allow individuals to be enrolled in Medicare Part A on the condition that they are eligible for QMB benefits so that the premium will be paid through the Medicare Savings Program. These individuals still must meet all technical and financial eligibility requirements for QMB. Conditional Enrollment and the effective date of Medicare Part A is verified by a letter from SSA.

1. An application must be initiated for individuals who contact DCBS with a letter of conditional enrollment.
2. Individuals who are conditionally enrolled in Medicare Part A are only eligible to receive standalone QMB benefits as KY Medicaid will not pay for Medicare Part A for those receiving full MA benefits.]

C. The receipt of Medicare may be verified by:

1. A copy of the individual's Medicare card;
2. Written verification from SSA;
3. BENDEX; or
4. TBQ.

Note: Scan a copy of the Medicare card or written verification from SSA into the Electronic Case File (ECF). Enter the Medicare Details in Worker Portal. Document in Case Notes how Medicare was verified.

MS 4450 RESOURCE LIMITS FOR MEDICARE SAVINGS PROGRAM (1)

Use the regular Age, Blind or Disabled MA policy for relative responsibility, resource verification and consideration to determine resource eligibility.

[A. Total countable resources for QMB, SLMB and QI1 are compared to the following limits:

- Individual \$9,430
- Couple \$14,130]

B. The following exceptions apply to QMB, SLMB and QI1 when determining resource eligibility:

1. Resources of a child are not considered in determining eligibility of a parent.
2. Resources of a married couple is compared to a couple resource limit whether the spouse is eligible or not.
3. Resources of an ineligible spouse are counted even if their income is not being counted.

C. Dual Eligibility (QMB or SLMB and regular MA benefits in another category)

For individuals dually eligible for QMB, SLMB and waiver services, SCL, or non-institutionalized Hospice, consider spousal resources following the first month after election to waiver services, SCL, or non-institutionalized Hospice for the QMB or SLMB eligibility determination.

Note: There is no dual eligibility for QI1 recipients.

D. Resource requirements for retroactive eligibility

1. QMB – Retroactive coverage for QMB recipients does not exist, therefore verification of resources for 3 months prior to the application month IS NOT required.
2. SLMB – Individuals eligible for SLMB may be eligible for retroactive coverage. Verification of resources for 3 months prior to the application month IS required for consideration of retroactive coverage.
3. QI1 – Individuals eligible for QI1 may be eligible for retroactive coverage. Verification of resources for 3 months prior to the application month IS required for consideration of retroactive coverage.

MS 4455 INCOME LIMITS FOR MEDICARE SAVINGS PROGRAM (1)

Compare total countable income to the appropriate income scale to determine Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Medicare Qualified Individuals Group 1 (QI1) eligibility. QMB/SLMB/QI1 eligibility cannot be met through spend down.

[Note: The following standards include the \$20 general unearned income exclusion. Due to system functionality the amount in the Worker Portal Reference Table does not include the \$20 general exclusion.

- A. The QMB income limit is equal to the 100% Federal Poverty Level (FPL) MA Scale for 2024.

Family Size	Limit
1	\$1,275
2	\$1,724

If countable income is equal to or less than the appropriate QMB Scale, income eligibility is met.

- B. The SLMB income limit is equal to the 120% FPL MA Scale for 2024.

Family Size	Minimum Limit	Maximum Limit
1	\$1,276	\$1,526
2	\$1,725	\$2,064

If countable income is equal to or greater than the minimum limit, and equal to or less than the maximum limit, income eligibility is met. If countable income is less than the minimum limit, explore potential QMB eligibility. If countable income exceeds the maximum limit, explore potential QI1 eligibility.

- C. The income limit for QI1 is equal to the 135% FPL MA Scale for 2024.

Family Size	Minimum Limit	Maximum Limit
1	\$1,527	\$1,715
2	\$2,065	\$2,320]

MS 4460 MEDICARE SAVINGS PROGRAM INCOME (1)

For an individual or a married couple living together or apart, use regular Aged, Blind or Disabled MA policy for relative responsibility, income verification and consideration to determine financial eligibility for Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), or Medicare Qualified Individuals Group 1 (QI1) with the following exceptions.

For each of the following situations, use the maximum income limit from the appropriate QMB, SLMB, or QI1 income scale for a married couple:

A. If there is an ineligible spouse and dependent children:

1. The spouse's gross income can be allocated to each child to reduce the countable income of the ineligible spouse. The allocation is equal to $\frac{1}{2}$ of the QMB, SLMB or QI1 income scale for each child.

[Example 1: A household consists of a Medicare recipient receiving unearned income of \$936.90 RSDI; her ineligible spouse receives RSDI of \$975 and 2 dependent children. Use the current QMB income standard for an individual. Allocate $\frac{1}{2}$ of the standard (\$627.50) to each child for a total of \$1,255 subtracted from ineligible spouse's income leaving \$0 income considered to the Medicare recipient. Client would be eligible for QMB.]

Note: Do not allocate income from the ineligible spouse to any child whose countable income exceeds $\frac{1}{2}$ the appropriate maximum income limit for one. Using the example above, if one of the children had income over $\frac{1}{2}$ of the QMB standard then none of the ineligible spouse's income would be allocated to that child.

[Example 2: A household consists of the same members as example 1, except that the one child receives child support of \$300 monthly. In that situation, this child would be allocated \$327.50 (\$627.50 - \$300) and the other child would be allocated \$627.50. Add \$327.50 + \$627.50 = \$955. Subtract \$955 from \$975 for a countable amount of \$20 for the ineligible spouse.]

2. Compare the ineligible spouse's remaining income to the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two.

[Example: Using example 2 above, add the allocation deemed to the children for a total of \$955. Subtract the result from the ineligible spouse's income; \$975-\$955= \$20. Compare the remainder to the difference between the QMB standard for an individual, \$1,255, and the QMB standard for a couple, \$1,704, for a difference of \$449.]

- a. If the result is equal to or less than the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two, DO NOT consider any of the ineligible spouse's income to the QMB/SLMB/QI1 individual; or

- b. If the result is greater than the difference between the appropriate maximum income limit for one and the appropriate maximum limit for two, consider the remaining amount available to the QMB/SLMB/QI1 individual.

Note: In the example above the income of the ineligible spouse would not be considered towards the Medicare recipient.

3. If the income is over the limit for a QMB couple, the same calculations to reduce the ineligible spouse's income are applied by using the SLMB income scales.

Note: Using the SLMB scales may reduce the countable income to within the QMB income limit, however, SLMB is approved rather than QMB as the SLMB disregard was used to get to the net income. The same applies for QI1.

B. If there is an ineligible spouse and no dependent children:

1. Compare the ineligible spouse's gross income to the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two;
 - a. If the ineligible spouse's gross income is equal to or less than the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two, DO NOT consider any of the ineligible spouse's gross income to the QMB/SLMB/QI1 individual; or
 - b. If the ineligible spouse's gross income is greater than the difference between the appropriate maximum income limit for one and the appropriate maximum income limit for two, consider the gross income as being available to the QMB/SLMB/QI1 individual.
2. The countable income of the QMB/SLMB/QI1 individual is compared to the appropriate maximum limit for two, even if there is deemed spousal income.

C. For individuals dually eligible for QMB/SLMB and SCL, waiver services, State Supplementation, Pass Through or non-institutional Hospice, who have a spouse living in the home:

1. Continue to consider the eligible spouse's income. Compare the countable income to the appropriate scale for a couple.
2. Continue to consider the ineligible spouse's income if greater than the difference between the appropriate maximum income limit for one to the appropriate maximum income limit for two. Compare the countable income to the appropriate income scale for a couple.

[Example: The ineligible spouse's income is \$300 monthly. The difference between the QMB maximum for one of \$1,255 subtracted from the maximum for two of \$1,704 equals \$449. Compare the gross income of the ineligible spouse of \$300 to the difference of \$449. If less than the difference, then

none of the ineligible spouse's income is considered towards dual eligibility for individual.]

If greater than the difference, consider this income during the month of election as well as the months after election to SCL, waiver services, State Supplementation, Pass Through or non-institutional Hospice for the QMB/SLMB eligibility determination.

Although Worker Portal does not consider the ineligible spouse's income available for purposes of waiver vendor payments after 30 days separation, it does count the income of the ineligible spouse when determining dual eligibility.

MS 4470

Medicare Savings Program Deductions

To determine the countable income to be compared to the minimum and/or maximum QMB/SLMB/QI1 limits:

- A. Deduct the \$20 general exclusion:
 1. From the unearned income;
 2. Deduct the balance, if any, from the earned income; and
 3. If spousal income is considered, apply the exclusion to the combined unearned and earned income of the QMB/SLMB/QI1 individual and spouse.

- B. Deduct \$65 and 1/2 the remainder:
 1. From earned income;

Note: If spousal income is considered, combine the earned income of the QMB, SLMB or QI1 individual and spouse and allow only one \$65 and 1/2 the remainder deduction; and
 2. Allow other work related deductions, if appropriate.

MS 4500 MEDICARE SAVINGS PROGRAM CASE ACTIONS (1)

[Individuals approved for Medicare Savings Program (MSP) will receive in one of the following categories: Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), or Medicare Qualified Individuals Group (QI1). All case actions for MSP need to be completed promptly to ensure no interruption of benefits for QMB/SLMB/QI1 recipients and no gaps in coverage for QMB recipients.

A. Applications

Individuals may apply for MSP in person, by telephone, via the self-service portal (SSP), or by completing form MAP-205, Application for Medicare Savings Program. An interview is not required if an individual applies for MSP through the SSP or by form MAP-205.

NOTE: Workers are still required to complete a thorough interview with individuals applying in person or by phone.

1. Individuals applying for MSP are allowed 30 days from the application date to return information before the application denies.
2. Retroactive Eligibility:
 - a. QMB – QMB is effective the month after the month of approval. Retroactive coverage cannot be issued for QMB recipients. For example, Bob applied for MSP June 15th. He returned all verification June 29th but his case was not processed until July 7th. Bob was approved for QMB which is effective August 1st.
 - b. SLMB – SLMB is effective the month of application regardless of when it is approved. Retroactive coverage can be issued for SLMB. For determination of retroactive eligibility, choose the appropriate retroactive months when entering the application on Worker Portal. Only choose retroactive months in which the individual was receiving Medicare.
 - c. QI1 – Retroactive eligibility for QI1 follows the same rules as SLMB.

B. Recertifications

MSP cases require a recertification every 12 months. The renewal process starts on the 1st day of the month prior to the renewal month. For example, the renewal process will begin July 1 for Medicaid cases with an August recertification date. Renewals are completed annually through the passive or active renewal process. For information regarding the passive and active renewal process, refer to [MS 1500](#).

C. Interim Changes

QMB, SLMB, and QI1 interim changes are processed according to regular MA policy.]

MS 4515 QMB, SLMB, OR QI1 EFFECTIVE DATE (1)

The effective date for QMB is based on the date of approval. The effective date of SLMB and QI1 is based on the date of application.

A. QMB:

For QMB the effective date is the first day of the month after the month of approval. There is no retroactive coverage for QMB.

Note: For SSI individuals automatically eligible for QMB benefits, the QMB effective date is the month after the system takes action.

B. SLMB:

SLMB is effective the month of application. SLMB can be retroactive up to 3 months prior to the month of application if all eligibility criteria are met.

C. QI1:

[QI1 is effective the month of application. QI1 can be retroactive up to 3 months prior to the month of application if all eligibility criteria are met.]

MS 4525 ACCRETES, DELETES, AND RESTORATIONS (1)

[Buy-In is the purchase of Medicare coverage by the Department for Medicaid Services (DMS) for eligible individuals. There is a 120 day processing period for cases approved for Buy-In as the transmittal of information passes from Worker Portal to DMS then to the Centers for Medicare and Medicaid Services (CMS). CMS forwards the approval to the Social Security Administration (SSA) and DMS, and then to the individual.

During the 120-day processing period, CMS passes the information on to SSA to no longer deduct the Supplementary Medical Insurance (SMI) premium from the individual's SSA benefits and issue reimbursement, if necessary. If no changes have occurred to the individual's SSA entitlements after 120 days, this may indicate a possible absence or break in the transmittal of information. If this occurs, the DCBS office responds to the individual's inquiries by completing form MSP-1, Request for Accrete, Delete, or Restoration of Buy-In, and forward the form to the Medical Support and Benefits Branch (MSBB) Medicare Savings Program (MSP) Restoration Requests mailbox at MSPRR@ky.gov. Scan the completed form MSP-1 to the Electronic Case File (ECF).

A. The worker indicates on form MSP-1 whether the request is for an accrete, a delete, or a restoration.

1. An accretion is requested when the SMI premium continues to be deducted from the beneficiaries RSDI, even though Worker Portal shows an approved Medicare Savings Program (MSP) Type of Assistance.
 - a. Do not send accretion request unless it has been at least 120 days since approval of MSP.
 - b. Once accretion has been requested it can take up to 120 days to complete the process. Additional accretion requests should not be sent unless 120 days have passed from the request of the first accretion.

Example: Ryan is approved for MSP on February 1st. On June 28th Ryan contacts DCBS to report that the SMI premium is still being withheld from his RSDI. The DCBS worker completes form MSP-1, Request for Accrete, Delete, or Restoration of Buy-In, and forwards the form to MSBB. On September 20th Ryan contacts DCBS again stating the SMI premium is still being withheld from his RSDI. The worker inquires his case and determines that the accretion request was sent to MSBB less than 120 days ago, and another request is not appropriate at this time.

2. A delete is a request to terminate Buy-In eligibility. A delete request is appropriate when Medicaid (MA) continues to pay for the SMI premium after the individual is no longer eligible for MSP. 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 MSP eligibility that were not issued as the result of agency error. This may occur if:

- a. An application approval is completed untimely causing eligibility to be effective in a preceding month; or
- b. Retroactive coverage for prior months was not issued for SLMB or Q11 cases.

Note: It is not appropriate to request a restoration for the month of QMB approval, as QMB eligibility is effective the month after the month of approval and retroactive coverage cannot be issued.

Example: Bob applied for MSP on June 15th. He returned all verification on June 29th, but his case was not processed until July 7th. Bob was approved for QMB, which is effective August 1st.

- B. If an individual contacts the agency with questions regarding their SMI Buy-In:
 1. Review the case to ensure all entries are correct.
 - a. Are entries on the Medicare Details screen correct?
 - b. Is the Medicare claim number correct? If the Medicare claim number is verified using the Medicare card, it should be scanned to ECF. The Medicare claim number can also be verified through an interface with SSA. If the claim number is incorrect, send the discrepancy to MSBB for correction.
 2. Has it been 120 days since the case was approved, or since the last accrete, delete or restoration request was sent to MSBB?
 - a. If it has been at least 120 days since the last request, forward a second request to MSBB.
 - b. If it has not been 120 days, do not forward an additional request.]

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

(1)

[The Social Security Administration (SSA) determines disability and blindness for individuals who have income and resources below the Supplemental Security Income (SSI) standards. The SSI standards may be found in [MS 4670](#). Individuals eligible for, but not receiving SSI benefits are not eligible to receive Non-MAGI Medicaid (MA). A pending SSI application with SSA is considered a pending application for Non-MAGI MA. If an individual has a pending SSI application, deny any duplicate application for non-MAGI MA made with DCBS. Individuals may receive MAGI Medicaid while waiting on an SSI determination, if eligible. Never discourage or refuse an MA application.

A. If an individual wants to apply for MA, enter the application on Worker Portal.

1. Correctly complete the Pending/Appealed SSI screen to indicate if an individual has a pending SSI application.
2. When running eligibility, individuals who are potentially eligible for SSI will show as a denied SSIP Type of Assistance (TOA). This indicates that the individual is aged, blind, or disabled with income below the SSI standard, and an SSI application is required to determine MA eligibility.

B. Worker Portal will issue form PA-5.1, Report of Referral to the District Social Security Office, referring the individual to SSA to apply for SSI.

C. If an individual is potentially eligible for SSI a Medical Review Team (MRT) determination must not be requested as a disability determination must be made by the SSA.

Note: Children applying for Medicaid and alleging disability or blindness are not required to apply for SSI if parental income is above 150% of the Federal Poverty Level (FPL). An MRT referral must be completed to determine disability. Furthermore, a child must not be denied Medicaid if a parent refuses to apply for SSI for the child.]

MS 4662

MA ELIGIBILITY FOR DECEASED APPLICANTS

The Department for Community Based Services (DCBS) is responsible for determining MA eligibility for an individual, without a spouse or parent in the household, who dies during the application or appeal phase of an SSI request, prior to a determination being made. Application can be made by any individual on behalf of the deceased individual. The application date is the date the SSI application was filed. Take an application and send a completed PA-601T, Referral for Determination of Incapacity or Disability, and signed/witnessed MRT-15 (with a revision date of 5/01 or after) forms, Authorization for Information/Release of Information, to MRT for determination of disability. File any hearings on these actions through the local office. The MRT-15 may be signed by the next of kin, such as a spouse, child, sibling or parent. [If there is no next of kin, the individual's attorney, executor of the estate or other authorized representative may sign the form.] See also Volume IVA, [MS 1374](#).

MS 4665* APPLICATION AFTER DENIAL OF SSI BENEFITS (1)

Deny Medicaid applications based on disability for individuals denied SSI within the prior 12 months due to a Social Security Administration (SSA) determination of nondisabled. 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 condition considered by SSA in their most recent disability determination.

- A. If an individual applies for Medicaid (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 Medicaid within 60 days of an SSI denial based on non-disability 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 no disability, 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 4670 SUPPLEMENTAL SECURITY INCOME FINANCIAL STANDARDS (1)

Supplemental Security Income (SSI) income and resource policies are more restrictive than Medicaid (MA) policy. If an individual, who was denied MA due to potential SSI eligibility, is denied SSI for a financial reason and reapplies for MA within 60 days of the SSI denial date, use the date of the original MA application as the application date.

For individuals who wish to apply for Non-MAGI 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:

<u>SSI ONLY</u>	[Individual	\$943
	Couple	\$1,415 (Effective 1/1/24)]

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 MA. Examples are personal belongings, jewelry, and household items.
2. Compare countable resources to the SSI resource standard.
3. The current SSI resource standards are:

Individual	\$2,000
Couple	\$3,000

The SSI resource standard for a couple is less than the MA resource standard of \$4,000 for a couple.

4. If resources are equal to or less than the standard, determine income eligibility.

MS 4690

INSTITUTIONALIZED APPLICANTS

[Institutionalized individuals are not eligible for SSI if other monthly income is \$50 or more.] Do not deny these MA applications or refer these individuals to SSA.

MS 4710*

RESIDENCY

The STATE OF RESIDENCE of an SSI recipient moving into Kentucky is determined by the SSA.

- A. If the recipient is determined a Kentucky resident, the individual is eligible for MA. The MAID card shows coverage effective the month of transfer. In some situations, SSA issues form PA-527 allowing medical coverage to be provided more quickly.
- B. If an SSI recipient moves out-of-state, the new state of residence may require verification of the date of discontinuance of Kentucky MA.

[If such requests are received, forward the inquiry by memorandum to the Department for Medicaid Services, who advises the requesting state of the correct date of MA discontinuance.]

- C. For LTC cases, see residency policy in [MS 3330](#).

MS 4720 MA ELIGIBILITY FOR SSI RECIPIENTS (1)

[Individuals who meet all eligibility factors are approved by the Social Security Administration (SSA) for Supplemental Security Income (SSI). Once approved for SSI, the individual is automatically approved for Medicaid. The Medicaid Type of Assistance (TOA) on Worker Portal is SSIR. SSI benefits are effective the month after the month of the SSI application.

No SSI payment is received for the month of application; however, the SSI recipient may be Medicaid eligible for that month.

A. Month of Application

If the SSI recipient requests retroactive Medicaid, provided eligibility is met, Medicaid will be issued for the month of application and the two months prior to the application month. Retroactive eligibility is issued by the Medical Support and Benefits Branch (MSBB).

B. SSI Recipients Not Meeting Eligibility Requirements For One or More Months Prior to SSI Approval.

SSI recipients who have been approved for SSI benefits effective a month or more after their application month must have Medicaid eligibility determined for the period of time between the SSI application and approval. Since Medicaid income and resource policy is different than the policy used to determine SSI eligibility, these individuals may be eligible for regular Medicaid or Spend Down benefits if SSI was denied due to excess income or resources.

1. Approvals, when the SSI eligible month is later than the application month, are identified on a monthly basis through a system match. These individuals are issued form PA-SSI-3, advising them to contact DCBS to apply for Medicaid.
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 an application must be filed within 60 days from the date of the notice and what verification is required.
3. These applications ensure a Medicaid eligibility determination is made for the period of time between the SSI application and approval. This is in addition to the procedure for determining eligibility for the application month and the two months prior to the SSI application month. Form PA-11, Application for Extra Medical Coverage for SSI Approvals, will continue to be generated for an eligibility determination for that time period.
4. Recipients approved in a month following the application month but who are not considered disabled prior to the approval month will not receive notices. For example, if an SSI application is made in January but

approved in March due to a determination that no disability exists prior to March, form PA-SSI-3 will not be issued.

C. SSI Recipients Eligible for Retroactive Medicaid.

Retroactive Medicaid coverage is available for individuals with medical bills during the SSI application month and the two months prior, if eligible.

1. Worker Portal sends form PA-11, a computer-generated application form to the SSI individual.
 - a. Form PA-11 is completed by the individual and returned to MSBB within the time frame specified on the form for the determination of eligibility for retroactive Medicaid coverage.
 - b. If the recipient reports non-receipt of form PA-11, contact MSBB through your Regional Chain of Command to verify if the form has been generated.
 2. If an individual contacts DCBS following the denial of retroactive coverage due to excess income, determine financial eligibility for Spend Down status. The Medicaid application date is the date of the application for SSI.
 3. When the SSI individual contacts DCBS to request a hearing on retroactive Medicaid coverage, complete the hearing request on Worker Portal.
- D. Receipt of excess income or resources may cause an SSI individual to be ineligible. This will trigger the Exparte process. The SSI case will automatically discontinue after the two months of Exparte Medicaid coverage. Refer to [MS 4770](#) for more information on the Exparte.
- E. When an SSI individual is admitted to an institution, SSI benefits may remain unchanged, be reduced, or terminated. This is determined by SSA. Upon receipt of a Level of Care (LOC) record, Worker Portal will automatically add the Long Term Care (LTC) provider information. Refer to [MS 3350](#) for more information on an SSI recipient that is institutionalized.
- F. SSI Medicaid will be discontinued at the end of the month without following adverse action rules if the SSI Payment Status Code is X01 (moved out of state) or T01 (death of recipient). For example, Bob is receiving SSIR benefits with a SSI Payment Status Code of C01. On 12/26/19, his SSI code changes to X01 as Bob has moved out of state. His SSIR benefits will be discontinued as of 12/31/19.
- G. If an SSI recipient has an active Level of Care and a SSI suspension payment status code (S06, S07, S08) is received, the individual will receive Medicaid for two months. For example, Sue has active Medicaid in the SSIR TOA and is receiving waiver services. On 7/15/19, the SSI payment status code is updated to S06. Sue will be eligible for Medicaid for two additional months from 8/1/19 to 9/30/19.]

MS 4730

THIRD PARTY LIABILITY AND
MEDICAL SUPPORT ENFORCEMENT
FOR SSI RECIPIENTS

(1)

The Social Security Administration (SSA) advises SSI applicants of Third Party Liability (TPL) requirements for Medicaid (MA) eligibility. Medicaid is always the payer of last resort; therefore, other health insurance is always billed before Medicaid. Assignment of rights and cooperation with TPL or Medical Support Enforcement (MSE) requirements for SSI recipients DOES NOT affect eligibility of the SSI payment, but DOES affect eligibility of Medicaid.

A. If an SSI recipient refuses to cooperate with TPL requirements AND does not have good cause for refusing to cooperate, the individual is not eligible for Medicaid. This includes vendor payment.

1. If the individual cooperates with TPL requirements, SSA will gather the TPL information at that time and will provide the information to DCBS with a Third Party Insurance Indicator code on 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.

2. If the individual refuses to cooperate, SSA will refer the individual to DCBS.

3. When the individual contacts DCBS:

- a. Discuss TPL requirements with the individual;
- b. Determine the reason for refusal to assign rights and/or cooperate;
- c. Explore good cause, if applicable. Good cause includes, but is not limited to the following:
 - (1). The applicant and spouse are estranged, therefore the applicant is unable to provide the requested TPL information; or
 - (2). Due to a physical and/or mental impairment of the applicant, the TPL information cannot be provided.

d. If good cause exists, send to MSBB through regional chain of command.

B. If an SSI recipient refuses to cooperate with MSE, without good cause, a disqualification must be placed on his/her Medicaid by MSBB. These requests should be sent to MSBB through regional chain of command. Verification of non-cooperation must be provided. MSBB will enter a stop on SDX, and Medicaid will stop the next administratively feasible month.

[Disqualifications may be viewed on SDX under the Primary section in the "Date Maid Iss. Stop by CO" field. If the SSI recipient starts cooperating with MSE, send a request to MSBB through regional chain of command to remove

the disqualification. Verification of cooperation must be provided. Medicaid will resume the next administratively feasible month.]

1. Good Cause for failing to cooperate exists only when one or more of the following criteria are met:
 - a. Cooperation in support activities could result in physical or emotional harm of a serious nature to the child and/or custodial parent;
 - b. Support action is not in the child's best interest due to incest;
 - c. Support action is not in the child's best interest due to rape;
 - d. Support action is not in the best interest of the child because of pending adoption proceedings; or
 - e. Support action is not in the best interest of the child because the custodial parent is being assisted by a public or licensed private social agency to resolve whether to keep the child or release him/her for adoption AND discussion has not gone on for more than 3 months.
2. Documentation must be provided by the individual within 20 calendar days of the date of the good cause claim unless an extension is granted. Documentation which supports a determination of good cause includes, but is not limited to, the following:
 - a. Birth certificates, medical, or law enforcement records indicating that the child was conceived as a result of incest or rape;
 - b. Court documents or other records indicating legal proceedings for adoption of the child by a specific family are pending before a court of competent jurisdiction;
 - c. Records (court, medical, criminal, child protective services, social services, psychological, or law enforcement) indicating the noncustodial parent might inflict emotional harm on the child or caretaker relative;
 - d. A written statement from a public or licensed private social agency that assistance is being given to the custodial parent to resolve the issue of whether to keep the child or relinquish the child for adoption AND the issue has not been pending for more than 3 months; or
 - e. Notarized statements from individuals, other than the custodial parent with the knowledge of the circumstances which provide the basis for the good cause claim.

MS 4740* SSI RECIPIENTS AND TRANSFER OF RESOURCES (1)

Transfer of resources policy and penalties also apply to individuals receiving SSI.

- A. Federal law requires the Social Security Administration (SSA) to identify and provide information to assist the Agency in determining whether the transfer of resources will result in a penalty period.
- B. Use the following procedures for SSI cases identified by SSA as transferring resources.
 - 1. Determine if active SSI recipients applying for, or receiving, Long Term Care (LTC) while in a Nursing Facility (NF) or receiving waiver services are identified as transferring resources.
 - 2. If a transfer of resources occurred, send the SSI recipient an appointment by manual correspondence to discuss the transfer. Verify information provided by SSA and make a determination regarding the transfer prior to imposing a penalty. For more information on transfer of resources refer to [MS 2050](#).
 - 3. If it has been determined that a prohibited transfer of resources has occurred, a disqualification must be placed on the recipient's Medicaid by the Medical Support and Benefits Branch (MSBB). These requests should be sent to MSBB through regional chain of command.

Disqualifications may be viewed on SDX under the Primary section in the "Date Maid Iss. Stop by CO" field.

MS 4770

EXPARTE

(1)

[Exparte is Medicaid (MA) coverage issued for two-months after Supplemental Security Income (SSI) discontinues. Exparte is only issued when SSI is discontinued for one of the following five reasons excess income (N01), Living Arrangement such as going into a nursing facility (E01), excess resources (N04), refusal of treatment for drug addiction (N10), and refusal of treatment for alcoholism (N11). Individuals who lose SSI for reasons other than the ones listed above are not eligible for Exparte. If there is a suspension code prior to a discontinuance payment status code, the individual is ineligible for Exparte. Individuals whose SSI is discontinued and request a hearing can only continue to receive MA during the hearing process, if they continue to receive the SSI payment. For information on hearings due to discontinuance of SSI and the continuation of benefits, refer to Volume I, MS 0470.

- A. The State Data Exchange (SDX) monthly cutoff date is nine workdays from the end of the month. Individuals discontinued due to payment status code of N01, E01, N04, N10 or N11 receive two-months of continued MA and Buy-In benefits if eligible. Worker Portal automatically issues Exparte coverage when one of the above payment status codes are identified through SDX. The effective date of Exparte coverage is the first day of the month following the SSI discontinuance and continues through the end of the following month. The Exparte MA end date will allow the case to automatically discontinue if the individual fails to submit an application for ongoing MA benefits.

EXAMPLE: An SSI discontinuance with status code N01 is identified in March. The Exparte effective date is April 1st, and the Exparte end date is May 31st.

- B. Notice KIP-10-SSI.2, Important Notice Regarding Medicaid Eligibility, is issued to SSI individuals to advise them to contact DCBS. When contacted, workers should review the individual's situation and advise them of the MA application process. Individuals may submit an application for ongoing MA coverage at anytime while receiving Exparte.
- C. Applications for ongoing MA benefits are initiated on Worker Portal. The case mode will be "inactive" in the month of the application, although eligibility has been issued for that month. Workers can review issued Exparte coverage on the Disposition History screen. If the application is submitted after the second month of Exparte coverage, ensure retroactive eligibility is explored.
- D. SSI recipients who reside in a Nursing Facility (NF) and lose SSI benefits with a payment status code of N01, N04, E01, N10 or N11 on SDX will have Exparte issued. The vendor payment eligibility continues through the last day of the two-month Exparte period. An application must be submitted to determine ongoing MA eligibility.
- E. Exparte recipients who are not subject to Managed Care enrollment may request a Medicaid replacement card, which is issued by DCBS through Worker Portal.]