INTRODUCTION 1000-1199

Program Overview 1000-1049

MAGI Medicaid Overview 1000

Medicaid Definitions 1050-1069

MAGI Medicaid Definitions 1050

MA Categories 1070-1099

Categories of Assistance 1070

Type of Assistance 1075

Early and Periodic Screening, Diagnosis, and Treatment 1100

CASE ACTION 1200-2099

Application 1200-1299

MAGI Medicaid Application/Interview Process 1200

Authorized Representative 1205

Assisters 1210

Entitled Benefits 1220

Electronic Case File 1250

Changes 1290

Standards of Promptness 1320

Taking Action 1400-1799

Timely Notice of Discontinuance and Reasons for Negative Action 1460

Misrepresentation and Fraud 1500

KyHealth Card 1530

Retroactive Medicaid 1600
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive and Active Renewals</td>
<td>1650</td>
</tr>
<tr>
<td>Recipients Moving Into or Out of Kentucky</td>
<td>1750</td>
</tr>
<tr>
<td>Managed Care</td>
<td>1900-1910</td>
</tr>
<tr>
<td>Introduction to Managed Care</td>
<td>1900</td>
</tr>
<tr>
<td>Managed Care Providers</td>
<td>1901</td>
</tr>
<tr>
<td>Managed Care Definitions</td>
<td>1902</td>
</tr>
<tr>
<td>Managed Care Enrollment</td>
<td>1903</td>
</tr>
<tr>
<td>Exempt/Non-Exempt Managed Care</td>
<td>1904</td>
</tr>
<tr>
<td>Copay for Medicaid Recipients</td>
<td>1950</td>
</tr>
<tr>
<td>MAGI AND LONG TERM CARE</td>
<td>2000-2099</td>
</tr>
<tr>
<td>MAGI Individuals in Long Term Care</td>
<td>2000</td>
</tr>
<tr>
<td>TECHNICAL ELIGIBILITY</td>
<td>2100-2899</td>
</tr>
<tr>
<td>General Factors</td>
<td>2100-2149</td>
</tr>
<tr>
<td>Enumeration</td>
<td>2110</td>
</tr>
<tr>
<td>Citizenship and Identity</td>
<td>2150-2199</td>
</tr>
<tr>
<td>Citizenship Requirements</td>
<td>2150</td>
</tr>
<tr>
<td>Criteria for Qualified Aliens</td>
<td>2152</td>
</tr>
<tr>
<td>Emergency Time-Limited Medicaid</td>
<td>2160</td>
</tr>
<tr>
<td>Extension of Emergency Time-Limited Medicaid</td>
<td>2162</td>
</tr>
<tr>
<td>Residency</td>
<td>2200-2299</td>
</tr>
<tr>
<td>Residency</td>
<td>2200</td>
</tr>
<tr>
<td>Medical Support Enforcement (MSE)</td>
<td>2300-2349</td>
</tr>
<tr>
<td>Medical Support Enforcement</td>
<td>2300</td>
</tr>
<tr>
<td>Incarceration</td>
<td>2350-2599</td>
</tr>
<tr>
<td>Incarceration</td>
<td>2350</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>2600-2640</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>2600</td>
</tr>
</tbody>
</table>
Modified Adjusted Gross Income (MAGI) Medicaid (MA) is extended to adults and children who meet appropriate technical and financial eligibility factors. Medicaid is administered in compliance with Title XIX of the Social Security Act and provides a wide range of medical services to both categorically needy and medically needy individuals.

The Department for Medicaid Services (DMS) is the state agency with designated responsibility for the administration of Medicaid. The Department for Community Based Services (DCBS) is contracted by DMS to determine initial and ongoing eligibility for Medicaid. DMS is responsible for establishing the scope of medical services and paying for these services.

Applications for MAGI Medicaid and Kentucky Children’s Health Insurance Program (KCHIP) are entered and processed in the Integrated Eligibility and Enrollment System (IEES), commonly referred to as the Worker Portal. Applications may also be entered on the benefit Self-Service Portal (SSP).

A. MAGI Medicaid eligibility is determined in one of the following four categories:

1. Children under age 19;
2. Pregnant Women;
3. Parents and Caretaker Relatives; and
4. Low Income Adults age 19 through 64.

B. Individuals must meet technical (non-financial) and financial eligibility requirements to qualify for MAGI Medicaid. Both Federal and State data sources will be used to help determine if the individual meets these requirements.

C. Resources are not considered in the MAGI Medicaid eligibility determination.

D. Applicants are required to provide verification of citizenship, income, and incarceration if client stated information does not match with Federal or State data sources. Self-attestation, or client statement, is acceptable for residency, pregnancy, household composition, and relationship unless conflicting documentation is received.

E. MAGI Medicaid eligibility determinations will pend for 30 days to provide required verification.

F. Individuals with pending SSI applications can apply for, and receive, MAGI Medicaid.

G. Applications for individuals applying on the Federally Facilitated Marketplace (FFM) and determined to be potentially eligible for Medicaid are transferred to Worker Portal through account transfer. Individuals applying for Medicaid on
the SSP or Worker Portal who are determined to be over the income limits for Medicaid will have their information transferred to the FFM as potentially eligible for Qualified Health Plan (QHP) and/or Advanced Premium Tax Credit (APTC).]
Terms used in MAGI Medicaid:

ACCOUNT TRANSFER: The process by which an individual’s information is transferred from the Federally Facilitated Marketplace (FFM) to Worker Portal in order for Medicaid eligibility to be determined or by which an individual’s information is transferred from Worker Portal to the FFM in order for Advanced Premium Tax Credit (APTC) and/or Qualified Health Plan (QHP) eligibility to be determined.

ACTIVE RENEWAL: Form EDB-087, Renewal Form for Medical Coverage is issued at recertification. This occurs when an individual has opted out of on-going data checks or when there are individuals on the Medicaid case who are not eligible for passive renewal.

ADVANCED PREMIUM TAX CREDIT (APTC): A tax credit to lower the monthly premium of health plans offered through the FFM for families earning less than 400% of the Federal Poverty Level (FPL). These individuals cannot be income eligible for Medicaid. The FFM determines eligibility for APTC.

ASSISTER: Individuals certified to assist with applications for Medicaid. Assisters enter applications on the benefind Self Service Portal (SSP) and help individuals applying for APTC/QHP on HealthCare.gov.

BENEFIND: The website where an individual, Authorized Representative (AR) or Assister can enter an application for benefits.

CARETAKER RELATIVE: An individual related by blood, adoption, or marriage that provides care to a child in the household. The child must reside with the caretaker relative and the child’s parent cannot be in the home.

CERTIFIED APPLICATION COUNSELORS (CAC): An assister employed by, or a volunteer of, an entity designated to assist with applications and enrollment.

CHILD: An individual under the age of nineteen (19).

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

DEEMED ELIGIBLE PREGNANT WOMAN: A woman correctly determined eligible for Medicaid due to pregnancy is entitled to continued coverage through the 60 day post-partum period. This does not apply to individuals who move out of state during this period.

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

DEPARTMENT FOR MEDICAID SERVICES (DMS): State agency with designated responsibility for the administration of Medicaid in compliance with Title XIX of the Social Security Act.
ELIGIBILITY DETERMINATION GROUP (EDG): A method of forming groups for each individual to determine eligibility for Medicaid. This grouping establishes which individuals are considered in the household size and identifies what income will be considered in determining eligibility.

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

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

FEDERALLY FACILITATED MARKETPLACE (FFM): An eligibility and enrollment service for APTC and QHPs that is operated by the Federal Government.

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

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

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

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

LAWFUL PERMANENT RESIDENT: Individuals legally residing permanently in the United States. They may be issued immigrant visas by the Department of Homeland Security or adjusted to permanent resident status by U.S. Citizenship and Immigration Services in the United States.

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

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.

LOW INCOME ADULT: Individuals age 19 through 64 who are not pregnant, entitled to Medicare A or B, or eligible in another Medicaid eligibility group. The total countable income is less than or equal to 138% of FPL.

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

MANAGED CARE ORGANIZATION (MCO): Organizations that link Medicaid recipients with participating physicians who are responsible for coordinating and providing their primary medical care.
MIXED HOUSEHOLD: A household in which at least one individual receives Medicaid or KCHIP in Worker Portal, and at least one individual receives APTC/QHP on the FFM.

[MAGI MEDICAID: 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 before 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.]

NON-MAGI MEDICAID: Medicaid eligibility is determined using traditional methodology. This includes individuals receiving Medicaid as aged, blind, or disabled.

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

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

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

PASSIVE RENEWAL: No action is required by the worker or individual to initiate the recertification process.

PRESUMPTIVE ELIGIBILITY: A process which expedites an individual’s ability to receive temporary coverage. The Department for Medicaid Services is responsible for the administration of presumptive eligibility.

QUALIFIED ALIEN: Individuals lawfully admitted for permanent residence who have been granted legal immigration status through the U.S. Citizenship and Immigration Services (USCIS).

QUALIFIED HEALTH PLAN (QHP): A commercial insurance plan offered to Kentucky residents through the FFM.

REASONABLE COMPATIBILITY: The allowable difference between an individual’s stated amount of income and verification provided by the Federal HUB. The current standard for reasonable compatibility is 10%.

RSDI: Social Security retirement, survivors, and disability insurance benefits payable under Title II of the Social Security Act.

SELF-ATTESTATION: Client statement.

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

SELF SERVICE PORTAL (SSP): Online platform that allows individuals access to apply for and receive information about public assistance benefits (SNAP, TANF, Medicaid, Child Care). Kentucky’s SSP is called benefind.
STATUTORY BENEFIT PAYEE: The payee for the applicant/recipient’s SSI or statutory benefits, such as RSDI, VA, or Railroad Retirement.

SSI: Supplemental Security Income which is a money payment to aged, blind, or disabled individuals under Title XVI of the Social Security Act. SSI is administered by the Social Security Administration.

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

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

THIRD PARTY LIABILITY (TPL): The responsibility of any individual, entity, or program that is liable to pay for any medical assistance provided to a Medicaid beneficiary. Medicaid is the payer of last resort and pays only after the third party has met its legal obligation to pay.

WORKER PORTAL: The employee-facing system on which eligibility determinations for Child Care Assistance, KTAP, Kinship Care, Medicaid, SNAP, and State Supplementation are completed.
MAGI Medicaid eligibility is divided into four categories: Children, Pregnant Women, Parents and Caretaker Relatives, and Low Income Adults. The four categories are listed below with a brief description and the Type of Assistance (TOA):

A. Children: This category includes individuals under the age of 19. The countable income is compared to the current Federal Poverty Level (FPL) depending upon the child’s age. Eligible children may receive Medicaid or KCHIP.

1. Medicaid includes children under the age of 19. Individuals age 18 must be attending school to receive in a Medicaid TOA. Client statement is accepted for school attendance.

<table>
<thead>
<tr>
<th>TOA</th>
<th>Category</th>
<th>FPL</th>
<th>FPL with 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHL1</td>
<td>Medicaid Children &lt; age 1</td>
<td>195%</td>
<td>200%</td>
</tr>
<tr>
<td>CHL2</td>
<td>Medicaid Children ages 1-5</td>
<td>142%</td>
<td>147%</td>
</tr>
<tr>
<td>CHL3</td>
<td>Medicaid Children ages 6-19</td>
<td>142%</td>
<td>147%</td>
</tr>
<tr>
<td>CHL4</td>
<td>Medicaid Children ages 6-18</td>
<td>109%</td>
<td>N/A</td>
</tr>
<tr>
<td>TP45</td>
<td>Deemed Eligible Newborns</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

2. KCHIP includes children up to their 19th birthday who do not have health insurance. KCHIP has no school attendance requirements.

<table>
<thead>
<tr>
<th>TOA</th>
<th>Category</th>
<th>FPL</th>
<th>FPL with 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHEX</td>
<td>KCHIP Children age 0-19</td>
<td>159%</td>
<td>N/A</td>
</tr>
<tr>
<td>CHIP</td>
<td>KCHIP III Children &lt; age 19</td>
<td>213%</td>
<td>218%</td>
</tr>
</tbody>
</table>

B. Pregnant Women: This category includes women who are pregnant or in their postpartum period. The income limit for the pregnancy category is 195% FPL (200% FPL with the 5% increase). The TOA for women receiving Medicaid as a pregnant woman will be PREG or ADPR. For policy regarding pregnant women, refer to MS 2600.

C. Parents and Caretaker Relatives: This category includes individuals who have a child under the age of 19 who is related by blood, marriage, or adoption living in the same household and have income below the Medicaid Income Scale. The TOA for individuals receiving Medicaid as a parent/caretaker relative will be PACA.

D. Low Income Adults: The category includes individuals ages 19 through 64 who are not eligible to receive Medicare and who are not eligible in any other category of assistance. The income limit for the low income adult category is 133% FPL (138% FPL with the 5% increase). The TOA for individuals receiving Medicaid as a low income adult is ADLT.]
The following are the types of assistance, program names, and descriptions for each eligibility group used to identify eligible MAGI Medicaid individuals:

<table>
<thead>
<tr>
<th>TOA</th>
<th>Program Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADFF</td>
<td>Former Foster Care</td>
<td>Individuals who aged out of foster care in another state and have income at or below 138% of the Federal Poverty Level (FPL).</td>
</tr>
<tr>
<td>ADLT</td>
<td>Low-Income Adult</td>
<td>Modified Adjusted Gross Income (MAGI) Adult</td>
</tr>
<tr>
<td>ADPR</td>
<td>Pregnant Adult</td>
<td>Women who report pregnancy while receiving Medicaid in the ADLT TOA and whose household income is at or below 138% FPL.</td>
</tr>
<tr>
<td>CHEX</td>
<td>KCHIP</td>
<td>Children between 1 and 19 without private insurance.</td>
</tr>
<tr>
<td>CHIP</td>
<td>KCHIP</td>
<td>A child without private insurance.</td>
</tr>
<tr>
<td>CHL1</td>
<td>Child &lt; 1</td>
<td>Newborn child less than 1.</td>
</tr>
<tr>
<td>CHL2</td>
<td>Child</td>
<td>Children between 1 and 6.</td>
</tr>
<tr>
<td>CHL3</td>
<td>Child</td>
<td>Children between 6 and 19.</td>
</tr>
<tr>
<td>CHL4</td>
<td>Child</td>
<td>Children between 6 and 19.</td>
</tr>
<tr>
<td>EMC1</td>
<td>Time-Limited MA for MAGI</td>
<td>Time-limited MA for an alien under age 19 with an emergency medical condition.</td>
</tr>
<tr>
<td></td>
<td>Child Aliens</td>
<td></td>
</tr>
<tr>
<td>EMC2</td>
<td>Time-Limited MA for Pregnant</td>
<td>Time-limited MA for a pregnant alien with an emergency medical condition.</td>
</tr>
<tr>
<td></td>
<td>Aliens</td>
<td></td>
</tr>
<tr>
<td>EMC3</td>
<td>Time-Limited MA for PACA</td>
<td>Time-limited MA for a parent and caretaker relative alien with an emergency medical condition.</td>
</tr>
<tr>
<td></td>
<td>Aliens</td>
<td></td>
</tr>
<tr>
<td>EMC4</td>
<td>Time-Limited MA for MAGI</td>
<td>Time-limited MA for a low-income adult alien with an emergency medical condition.</td>
</tr>
<tr>
<td></td>
<td>Adult Aliens</td>
<td></td>
</tr>
<tr>
<td>FFCC</td>
<td>Former Foster Care</td>
<td>An individual who was in foster care and received Medicaid when they turned 18. FFCC can be received by individuals who are ages 19 through 26.</td>
</tr>
<tr>
<td>FFOS</td>
<td>Former Foster Care</td>
<td>Individuals who aged out of foster care in another state and have income above 138% FPL or who have income at or below 138% FPL, but are receiving LTC or Medicare.</td>
</tr>
<tr>
<td>PACA</td>
<td>Parent/Caretaker</td>
<td>A parent or caretaker relative with a minor child in the household.</td>
</tr>
<tr>
<td>PREG</td>
<td>Pregnancy</td>
<td>Pregnant Woman.</td>
</tr>
<tr>
<td>SPMA</td>
<td>Spend Down for MAGI Medicaid</td>
<td>Time limited MA for an individual with medical expenses who meets all technical eligibility requirements but has income in excess of the MA scale for the family size. Individuals eligible for or receiving Medicaid in the ADLT TOA are not eligible for a MAGI Spend Down.</td>
</tr>
<tr>
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<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>TP45</td>
<td>Deemed Eligible Newborn</td>
<td>A child under age 1 who was born to a mother receiving Medicaid for the birth month.</td>
</tr>
</tbody>
</table>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federally mandated program for children and jointly administered by the Division of Family Support (DFS) and the Department for Medicaid Services (DMS). EPSDT allows all MAGI Medicaid, foster care, and SSI recipients who are under age 21 to receive preventive health care services.

Form MA-3, Facts About Early and Periodic Screening, Diagnosis and Treatment Benefits, is generated by Worker Portal and issues at each application. Form MA-3 also issues when an individual under age 21 is added to a household at case change. The individual completes the form when requesting assistance with scheduling EPSDT appointments. Information regarding EPSDT is also included on the back of each system generated notice.

A. Services provided include the following health check-ups:

1. Health and developmental history;
2. Physical examination;
3. Developmental assessment;
4. Immunizations appropriate for age and health history;
5. Assessment of nutritional status;
6. Vision testing;
7. Hearing testing; and
8. Laboratory procedures appropriate for age and populations groups, such as tests for tuberculosis, low blood iron, and kidney problems.

B. Additional services that may be covered with EPSDT are:

1. Diagnosis and treatment if problems exist;
2. Dental services furnished by direct referral to a dentist for diagnosis and treatment for children 3 and over; and
3. Long Term Care (LTC) for children who have special needs that cannot be met in a regular institution in-state or out-of-state.
C. EPSDT screenings occur at the following periodic intervals.

<table>
<thead>
<tr>
<th>MEDICAL SCREENING</th>
<th>DENTAL SCREENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 month</td>
<td>8 years</td>
</tr>
<tr>
<td>2 months</td>
<td>9 years</td>
</tr>
<tr>
<td>4 months</td>
<td>10 years</td>
</tr>
<tr>
<td>6 months</td>
<td>11 years</td>
</tr>
<tr>
<td>9 months</td>
<td>12 years</td>
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<tr>
<td>12 months</td>
<td>13 years</td>
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<tr>
<td>15 months</td>
<td>14 years</td>
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<tr>
<td>18 months</td>
<td>15 years</td>
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<tr>
<td>24 months</td>
<td>16 years</td>
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<tr>
<td>30 months</td>
<td>17 years</td>
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<td>3 years</td>
<td>18 years</td>
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<tr>
<td>4 years</td>
<td>19 years</td>
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<tr>
<td>5 years</td>
<td>20 years</td>
</tr>
<tr>
<td>6 years</td>
<td>13 years</td>
</tr>
<tr>
<td>7 years</td>
<td>14 years</td>
</tr>
</tbody>
</table>
All individuals have the right to make an application and receive a decision on their eligibility for Medicaid. Individuals are never refused the right to apply, even if it appears they do not meet technical or financial eligibility requirements. Individuals may make an application in any county office, regardless of the county of residence. Applications may be made by the individual, spouse, or Authorized Representative (AR). Applications for children may be made by the adult with whom the child lives and who has responsibility for the child. This may be a parent, caretaker relative, or unrelated adult.

Accept and process applications for deceased individuals. Medicaid is approved if medical bills were incurred during the application month or three months prior to the application and the individual was technically and financially eligible for the time period requested.

Accept and process an application for MAGI MA for an individual with a pending SSI application. This also includes individuals eligible in the Low Income Adult category. If the individual applies for MA within 60 days of an SSI denial, use the SSI application date as the MA application date and determine if the individual would have been MA eligible in any of the MAGI categories.

A. Individuals may make an application by any of the following methods:
   1. Calling the Contact Center at 1-855-459-6328;
   2. Calling DCBS at 1-855-306-8959;
   3. Mailing a completed paper application to DCBS at:
      P.O. Box 2104
      Frankfort, KY 40601
   4. Faxing a completed paper application to 1-502-573-2005;
   5. Making an application at www.benefind.ky.gov; or
   6. In person at any DCBS office.

B. Individuals applying for Medicaid by phone or in-person must be interviewed. Interviews are not required for applications made via the benefind Self-Service Portal (SSP) or by paper application.

C. The application is signed by the applicant, the applicant's statutory benefit or SSI payee, legal guardian, POA, or AR. If the application is signed by a mark (X), another person, either related or unrelated, must sign the application as a witness.

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

1. Interpreter services for hearing impaired individuals. Refer to Volume I, MS 0220.
2. If the individual is non-English speaking, obtain interpreter services. Refer to Volume I, MS 0230.
3. Additional space for the interview to accommodate an individual in a wheelchair;
4. Scheduling appointments when special transportation services are available; or
5. Making a home visit.

The following procedures apply when conducting an interview:

E. Before the interview:

1. Review all previous case information thoroughly;
   Note: An individual’s name must match the name on their social security card. A copy of the card is not required if it is system matched.
2. Inform the individual that if determined to be over the income limit for MAGI Medicaid, Worker Portal will complete an account transfer to the Federally Facilitated Marketplace (FFM) for an eligibility determination;

F. During the interview:

1. Inform the individual of their rights and responsibilities;
2. Review form MA-2, Medicaid Penalty Warning, and obtain client signature;
3. Advise the individual that changes must be reported within 30 days;
4. Advise the individual of the right to appeal any adverse action;
5. Explain retroactive Medicaid and ask if any members applying for Medicaid have incurred medical expenses in the prior three months. For more information regarding retroactive Medicaid, refer to MS 1600;
   Note: Retroactive Medicaid coverage may be issued by special circumstance if Worker Portal does not issue the requested eligible months at the time of application/reapplication.
6. If the head of household is present at the interview and is age 18 or older or will be age 18 before the next election, explain the voter registration process and complete the voter registration questions on Worker Portal;
7. Explain that tax filing status is used in determining eligibility, therefore it is essential that the individual gives accurate information regarding their status;

8. Explain that the agency uses trusted data sources in an attempt to verify the information given during the interview. If the information is unable to be verified by the trusted data sources, and the client does not have verification at the time of the interview, verification must be returned to DCBS by the required due date.

   a. If trusted data sources match the hub, dispose the case and Worker Portal will process the application.
   b. If trusted data sources do not match the hub, ensure that Worker Portal issues a correct Request for Information (RFI).

9. Explain that if income or incarceration verification is required, an individual will have 30 days to return the requested information, but a determination of eligibility will not be made until documentation is received;

10. Explain that individuals who claim disability, who are also within the SSI income standard, must apply for SSI through SSA. Individuals who are potentially eligible for SSI but do not apply, are not eligible for Medicaid;

11. Explain that if verification of citizenship is the only documentation requested, initial eligibility will be determined and if approved the individual has 90 days to return the requested information. If verification of citizenship is not returned at the end of 90 days, Medicaid eligibility will end the next administratively feasible month;

12. Explain the Managed Care Program. For more information on Managed Care refer to MS 1900;

13. Advise the individual that their Managed Care Organization (MCO) or Medicaid Member Services answers all questions regarding covered medical services and/or billing. The MCO’s phone number is listed on their member card and the phone number for Medicaid Member Services is 1-800-635-2570;

14. Explain Third Party Liability (TPL) and that Medicaid is the payer of last resort. Any other health or hospital insurance is billed before Medicaid. Enter all health insurance information on Worker Portal;

15. Enter all required case notes, ensuring any unusual circumstances or verification is documented; and

16. Answer all of the individual’s questions.

G. After the Interview:
1. Individuals may provide verification by mail or fax to the Centralized Mail Center, by uploading documentation to the SSP, or by returning documents to any DCBS office.

2. Scan all documents pertaining to eligibility and the signed hardcopy application, if applicable, into the ECF upon receipt.

3. If additional information is required from MSBB, send the request to the regional Program Specialist immediately to prevent delays in processing the case.

H. Applicants have 30 days to provide mandatory verification. If verification is not provided timely and the case denies, there is an additional 30 day grace period from which the application may be reactivated on Worker Portal without a new application being initiated by the applicant. This is referred to as a 30/60 reapplication.

1. The individual does not need to reapply.

2. Workers must indicate in case notes that the case is a 30/60 reapplication.

3. The grace period is either 30 days from the date of denial or 60 days from date of application. The reactivation date is the date all requested verification was received.

Example: An applicant applies on May 1, 2018 and income fails to match against trusted data sources. An RFI is issued requesting income verification by May 31, 2018. The applicant does not return the information timely and the application denies. On June 15th, the applicant returns the requested income verification. The denied application is reactivated on Worker Portal using the 6/15/18 date.

4. Retroactive Medicaid is appropriate if the individual attests to incurred medical expenses in the three months prior to the 30/60 application date.

   Example: The above applicant requests retroactive Medicaid coverage for February when he applies May 1, 2018, however he does not return the requested verification until June 15th. He is not eligible for February Medicaid coverage as his 30/60 application date is in June. He would be eligible for the retro months of March, April, and May.
Applicants may authorize another individual to act on their behalf for Medicaid purposes. These individuals are referred to as Authorized Representatives (AR). The applicant may grant the authorized representative permission to apply, recertify, and/or receive a copy of their notices. Once designated, the AR is responsible for providing complete and accurate information about the individual’s situation, and reporting any changes that may affect Medicaid eligibility.

If documentation granting the authorized representative permission to apply on behalf of the applicant is not provided at the time of application, complete the application process, and Worker Portal will pend the case for verification of the AR when eligibility is run. Client statement is accepted for verification of an AR’s identity for Medicaid.

NOTE: DCBS employees who wish to act as an applicant’s AR must obtain SRA approval.

A. The following individuals may act as authorized representative for an applicant:

1. The spouse, if currently married and there is NO existing divorce decree;
2. The parent or caretaker relative of a minor child;
3. An unrelated adult living with a child for whom they have primary responsibility;
4. A tax filer applying on behalf of their tax dependent;
5. The verified statutory benefit payee, court appointed guardian, Power of Attorney (POA); or
6. A representative of a nursing facility when the applicant is verified to be incapable of declaring intent (this does not include hospitalized individuals).

B. Individuals who do not meet the criteria listed above must be designated to act on behalf of an applicant by using form MAP-14, Authorized Representative. If an individual wishes to name an AR but does not have verification, this form should be provided to them.

NOTE: For MAGI Medicaid only, form KHBE-79, Authorized Representative Form, may also be used to designate an authorized representative.

Form MAP-14 may be accessed on the Department for Medicaid Services internet site at: https://chfs.ky.gov/agencies/dms/Pages/mapforms.aspx.

1. Form MAP-14 is completed and signed by both the AR and the applicant. However, the following individuals may sign on the applicant’s behalf.
   a. Spouse
   b. Parent or caretaker relative of a minor child
   c. Verified payee, POA, or legal guardian
2. Form MAP-14 remains valid from the date of signature until the applicant or AR rescinds the form. A new form is not needed for reapplication, recertification, or case change.

3. There is no limit to the number of ARs an individual may designate, however only two can be entered in Worker Portal. Workers must thoroughly review form MAP-14 to see what permissions have been granted to the AR prior to discussing the case.

4. Form MAP-14 is only appropriate for individuals who wish to act as authorized representative. Form DCBS-2, Informed Consent and Release of Information and Records, should be provided to individuals who only want to discuss the case. Form DCBS-2 and procedural instructions is found on the DCBS intranet site: https://olm.chfsinet.ky.gov/Manuals/FormsLibrary/SitePages/Browser.aspx#Section_IV_DCBS_Forms---DCBS-2

C. Form MAP-14 is not required of representatives from the Department of Corrections or local jail acting on the behalf of an incarcerated individual. Medicaid applications for incarcerated individuals are entered and processed by Central Office. For more information on incarcerated individuals refer to MS 2350.
Assisters are part of a collaborative effort between healthcare providers, local organizations, and the Commonwealth of Kentucky to provide outreach and assistance to individuals in need of healthcare. Assisters interview applicants and enter the individual’s information on the benfind Self-Service Portal (SSP). They do **not** determine Medicaid eligibility. However, if the individual’s stated income passes the Federal HUB, the application may be approved without worker action. If the individual is not eligible for Medicaid, the assister will help them apply for coverage on the Federally Facilitated Marketplace (FFM).

A. The KY Assister Consent Form Appendix B is used to designate a new assister. However, if the application is submitted on the SSP, the form may not be present in the Electronic Case File (ECF) as the designation was completed during the initial application.

   **NOTE:** Assisters do **not** need to complete form MAP-14, Authorized Representative and should **not** be listed as the individual’s authorized representative on Worker Portal.

B. Assisters are added to cases in the Post Eligibility Module in Worker Portal and should be given Medicaid information for any case on which they are listed as the Assister. Designated Assister information can be found on the Case Summary screen under the Assister tab.

C. There are three types of Assisters: In-Person Assisters, Navigators, and Certified Application Counselors (CAC).

   1. In-Person Assisters are paid with state funds to provide education and outreach to the public. They are able to travel to individuals and set up events at local health departments and libraries to provide outreach.

   2. Navigators are also paid with state funds and provide outreach to the public. The state of Kentucky only has two Navigator entities: Green River Health Department and Louisville Metro Corrections.

   3. Certified Application Counselors are private employees, or volunteers, trained and vetted by the Kentucky Health Benefit Exchange (KHBE). These assisters are not required to provide education or outreach.
MAGI Medicaid eligible individuals are required to apply for any benefits to which they may be entitled. These benefits include, but are not limited to, Veteran’s compensation and/or pension, Black Lung, RSDI, Railroad Retirement, annuities, pensions, IRA disbursements, retirement and Unemployment Insurance Benefits.

A. For MAGI Medicaid, self-attestation is acceptable verification that the individual has applied for entitled benefits.

B. For MAGI Medicaid eligibility purposes, DMS considers IRA funds in the same manner as entitled benefits. Individuals are required to withdraw IRA funds if the funds are available without penalty.

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

C. KTAP or State Supplementation payments, SSI benefits, VA Aid and Attendance Allowance, or cash benefits of a similar nature are NOT considered entitled benefits.
All case records represent a continuing documentation of eligibility for Medicaid and must contain sufficient material to substantiate validity of all authorized assistance.

The Electronic Case File (ECF) for Medicaid should contain the following material as appropriate:

A. Signed applications;
B. Verification of technical and financial eligibility;
C. All appropriate forms;
D. Hearing information;
   1. Notice of scheduled hearing;
   2. Recommended Order;
   3. Exceptions; and
   4. Appeal Board Order.
E. Information regarding any potential fraud referrals; and
F. Any additional pertinent information or verification.
Individuals are required to report changes in circumstances within 30 days. Individuals may report changes in person, in writing, by phone, or through the benefind SSP.

A. A change in circumstances is defined as any change which may affect ongoing eligibility for Medicaid.

This includes:

1. Beginning or ending employment;
2. Increase or decrease in the number of work hours;
3. Pay rate change;
4. Increase or decrease in unearned income;
5. Change in farming/self-employment activities;
6. Change in tax filing status;
7. Receipt or termination of other health insurance, including Medicare;
8. Change in household composition; or
9. Change of residency, including moving out of state.

B. Do not consider normal fluctuations in income as a change in circumstances. This includes any change in work hours that do not exceed 30 days such as holiday, vacation, or sick leave. This also includes a 5th or periodic paycheck.

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

D. When adding a new member to a case the effective date is the first day of the month in which the change was reported. Note: When a deemed eligible newborn is added to a case, workers should ensure coverage is issued back to the date of birth.

E. Each member of the benefit group, other than a deemed eligible newborn, is required to furnish a Social Security Number (SSN) or apply for an SSN as a technical eligibility requirement. Members who are not enumerated, but are cooperating with the enumeration process should be included if they are requesting assistance. If the individual returns verification for the new member, but fails to enumerate that member or indicate they are cooperating with the enumeration process, the new member is technically excluded from the case.

Do NOT require an individual to provide an SSN or apply for an SSN who will not be a member of the benefit group.
DMS determines time frames for Medicaid eligibility determinations. 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 timeframe allows the client time to return requested information.

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. 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 day following the weekend or holiday.

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

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

1. A program inquiry was requested timely but a timely response is not received from MSBB. This should be documented in Case Notes.

To ensure that processing time frames 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.

2. Information is discovered that was not known to the agency at the time of application. Mail a new RFI requesting the additional verification.

   a. If the newly discovered information was worker error, allow additional time, if the due date is less than 10 days, and send an RFI with a new due date.

Example: John made an application for Medicaid on 8/17 and an RFI was generated requesting verification of wages with a due date of 9/16. When the verification is returned and later processed on 9/10, the worker discovers that alimony payments are garnished from John’s wages. Since wages stubs are not an acceptable form of verification for alimony payments, further verification is needed. The worker should
extend the RFI due date to 9/20 so that John has 10 days to provide the needed verification.

[Note: An alimony deduction can only be allowed if the separation or divorce agreement is finalized on or before 12/31/18.]

b. If the newly discovered information was due to the individual’s failure to report, mail a new RFI with an explanation of the additional verification that is needed. It is not appropriate to assign a new due date in this situation.

3. 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.

   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 RFI due date. Requests for additional time cannot be made at application, however workers should explain 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.

4. Allow the case to deny if:

   a. An extension is not requested timely, OR

   b. The individual did not take action to get the verification timely, OR

   c. The maximum extension has been allowed.
TIMELY NOTICE OF DISCONTINUANCE AND REASONS FOR NEGATIVE ACTION

Denials and discontinuances result from failure to meet technical and/or financial eligibility requirements for MAGI Medicaid. If action taken discontinues Medicaid for any or all members in a case, the client must be notified of the proposed action 10 calendar days prior to the effective date, unless one of the exceptions to the timely notice requirement applies. This 10-day period is known as the timely notice period.

A. Worker Portal generates form KIP-105.1, Notice of Eligibility, for any change in eligibility. If form KIP-105.1 has an incorrect denial/discontinuance reason for Medicaid, immediately send a manual form MA-105, Notice of Eligibility or Ineligibility, informing the client of the correct denial/discontinuance reason. Scan form MA-105 into ECF and thoroughly document Case Notes.

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: Client reports an increase in income on 10/5. The change is processed on 10/9. The adverse action date is 10/20. As the change was processed PRIOR to adverse action it 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: Client reports an increase in income on 10/11. The change is processed on 10/25. The adverse action date was 10/20. As the change was processed AFTER the adverse action date, it will be effective 12/1.

C. The following situations are exceptions to the 10-day timely notice and benefits will discontinue for the individual no matter what date the change is processed:

1. Death of a recipient has been verified.

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

3. The recipient is under age 65 and enters a state tuberculosis hospital, or is between age 21 and 65 and enters a mental hospital or psychiatric treatment facility.

4. A recipient requests discontinuance by a signed statement.

D. The negative action reasons for MAGI Medicaid are listed below.

1. Financial reasons:
a. Income exceeds limit;
b. Income has increased.

2. Technical reasons:
   a. Already received Medicaid;
   b. Individual is above the age limit of 64;
   c. Child is above the age limit;
   d. Ineligible for Medicaid in the Former Foster Care category;
   e. Ineligible alien/citizenship;
   f. Refused to cooperate with Medical Support Enforcement (MSE);
   g. Recipient deceased;
   h. Individual becomes eligible for Medicare and is no longer eligible for ADLT Type of Assistance (TOA);
   i. Child receiving KCHIP becomes insured;
   j. Individual is not a resident of Kentucky;
   k. Failure to provide Social Security Number (SSN);
   l. Failed or refused to cooperate with Third Party Liability (TPL);
   m. Failure to sign application;
   n. Failure to provide required information during the specified time frame;
   o. Pregnancy post-partum has ended.

3. Other reasons:
   a. Eligibility denied as individual is neither related to nor a tax dependent of any of the members in the case;
   b. Case is withdrawn for an individual;
   c. Client request;
   d. Unable to locate.
If a worker discovers that the recipient, or responsible party, withheld information or provided false information in order to receive MAGI Medicaid for which they were not entitled, refer to Volume I, MS 1200-1240 for appropriate action.

If an individual reports fraud regarding MAGI Medicaid, provide the Office of Inspector General (OIG) toll-free fraud hotline telephone number 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 by email at CHFS.fraud@ky.gov. Attach a copy of any available documentation with the OIG memorandum. Scan original documentation into the Electronic Case File (ECF).

[Send correspondence for OIG to:]

Office of Inspector General
Division of Special Investigations
275 E Main Street, 5E-A
Frankfort, KY 40621-0001]
A KYHealth card is issued at initial Medicaid approval to all individuals eligible for Medicaid who are not subject to managed care. Individuals subject to managed care will receive a card from their Managed Care Organization (MCO) and will not receive the KYHealth card. A KYHealth card is only issued to individuals at reapplication if they have not received Medicaid in the prior three months.

A KYHealth card is also issued at initial approval for Spend Down eligibility periods. A new card is not issued for subsequent Spend Down approval periods.

Please note that if an individual states they no longer have their KYHealth card, the worker should request a replacement card on Worker Portal.

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 DCBS office. This is an option of last resort and may only be used 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, attempt to contact the individual. If the individual provides a change of address, update Worker Portal and send the KYHealth card to the appropriate address.

3. If the individual cannot be located, refer to Volume I MS 0090 for further procedural instructions regarding returned mail.

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

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

D. Requests for replacement 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 replacement cards for individuals receiving SSI are also processed by DCBS staff.
If an individual is technically AND financially eligible for MAGI Medicaid during the month of application and has medical expenses in any of the three months prior to the application month, they are considered eligible for retroactive coverage. Retroactive coverage is the three months prior to the application month. For example, if an individual applies for Medicaid in April, the prior three months of retroactive coverage are January, February, and March.

A. An individual does not have to be ongoing eligible to receive retroactive MAGI Medicaid benefits.

B. Client statement is acceptable for verification of medical expenses.

C. Retroactive benefits should only be issued for those months that the individual attests expenses were incurred.

Example: Sue applies for Medicaid in April and states that she has incurred medical expenses in January and March. Retroactive coverage should only be issued for those two months.

DO NOT issue retroactive coverage for months that an individual did not incur a medical expense.]
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 on July 1st for Medicaid cases with a certification end date of August 31st.

Worker Portal will determine if MA cases meet the criteria to be passively renewed. 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. A passive renewal does not require an individual to take any action, including completing an interview or form, to initiate the recertification of their Medicaid benefits. Interviews are not required for passive or active renewals.

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

A. The following applies to passive renewals:

1. The case will be passively renewed if:
   
   a. The head of household has not opted-out of ongoing data checks; or
   
   b. Everyone in the case can be passively renewed. If any individual does not meet passive renewal criteria, the entire case must be actively renewed; or
   
   c. The Medicaid case is not in change or reinstate mode.

2. Worker Portal interfaces with the Federal Hub to verify the individual’s current income. If successful, the case is disposed and the renewal is completed without worker or client intervention. If the Federal Hub is unable to verify income, a Request for Information (RFI) is issued and the individual is given until the end of the renewal month to provide the required verification. Medicaid will discontinue at the end of the renewal month if verification is not provided.

3. Passive renewals will not be completed if the process is interrupted. If the process is interrupted the renewals 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 individual and complete an interview.

Example: Maddie sends a letter to DCBS to report a new job and a case change is initiated. However, her case is being passively renewed. Since the change interrupted the renewal process, the case will not be passively renewed. The
worker must contact her for a phone interview so that the renewal can be completed.

4. The passive renewal process is completed within seven days. The completion of the process is indicated by a change in the certification dates or by the generation of an RFI.

B. The following applies to active renewals:

1. 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 is due on 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 recertification 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.

2. If any information entered on the form is missing, unclear, or if the form has not been signed, the renewal must still be entered in Worker Portal. The individual must also be contacted for clarification of any unclear information. If the individual cannot be reached or if further verification is needed, pend the case and ensure that the needed information is requested on the RFI.

   a. If all verification is provided, run eligibility and dispose the case. Worker Portal will automatically update the certification period.
   b. 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 generated giving the individual until the last day of the renewal month to provide the required verification. Medicaid will automatically discontinue at the end of the renewal month if verification is not returned.
   c. 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: Bonnie’s renewal month is April and she returns form EDB-87 on April 20th. Verification of income is required to determine her ongoing eligibility and an RFI is generated with a due date of May 20th. The case remains pending and in Renewal Mode, but no coverage is issued for May until verification is returned and the renewal is processed.

C. Discontinuances at Renewal

1. If a renewal is initiated prior to the last day of the certification period and MAGI Medicaid is discontinued for failure to return the verification requested at renewal, individuals are given 90 days from the date of the discontinuance to provide the verification. This 90 day grace period begins the 1st day of the month following the discontinuance. If verification is returned during the 90 day grace period, a new application is not required and case should be put back on using the Add/Reapply Program function.
The 90 day grace period does not apply to individuals who receive Non-MAGI Medicaid.

Note: Eligibility is effective the first day of the month verification is received. However, retroactive coverage may be issued if the individual states they have unpaid medical bills.

Example: Perry’s Medicaid case goes through the passive renewal process. However, the Federal Hub is unable to verify income and an RFI is generated with a due date of 8/31. Income documentation is not returned by the RFI due date and the case discontinues effective 9/1 for failure to return verification. On 10/15, Perry provides check stubs to verify his income. As verification was provided during the 90 day grace period, a new application is not required and action should be taken to issue Medicaid via the Add/Reapply Program function. Medicaid eligibility will be effective 10/1.

2. If the case discontinues correctly and verification is not returned within the 90 day grace period, a new application is required.

3. Never use the Reinstate or Reactivate function for cases that discontinue during renewal regardless if the discontinuance is correct or due to agency error. Workers must always use the Add/Reapply Program function on the Case Summary screen for cases that discontinue during renewal.
An individual who received Medicaid in another state is not eligible to receive benefits in KY for the same month. Follow the below procedures to avoid overlapping Medicaid eligibility for households who either move into or out of Kentucky.

A. For individuals applying for Kentucky Medicaid who received Medicaid in another state:

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

2. Deny the application for the months already issued in the other state. Since Worker Portal will only issue Medicaid for whole months, a special circumstance must be completed to issue a partial month of coverage. Any requests to issue a partial month of Medicaid should be forwarded to MSBB through the regional chain of command; and

Example: John applies for Medicaid in Kentucky on September 5. He states that he received Medicaid in Ohio. A worker in Ohio has verified that the date of discontinuance is September 12. The first day of potential eligibility in Kentucky is September 13. Deny the application for the month of September, approve ongoing benefits beginning October 1, and forward the case to MSBB through the regional chain of command.

3. Document in Case Notes.

B. For individuals with active Medicaid who report that they are moving out of Kentucky:

1. Enter the individual’s new address, update residency, and dispose eligibility;

2. If the change in address is reported after cutoff, the case must be manually withdrawn prior to disposition so that eligibility will not pend for adverse action; and

3. Document the action in Case Notes.

C. If the applicant is unable to obtain Medicaid coverage in another state because Kentucky has issued Medicaid coverage for a specific month refer them to Medicaid Member Services, at (800) 635-2570.
Managed Care is a health delivery system organized to manage cost, utilization, and quality. Managed Care Organizations (MCOs) link Medicaid recipients with participating physicians who are responsible for coordinating and providing primary medical care to these recipients.

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

B. [Non-exempt Medicaid recipients are required to enroll with an MCO unless they are exempt.

C. During the interview process, workers should ask applicants which MCO they prefer.
   1. If the Medicaid application approves, the worker should navigate to the shopping module and complete the MCO enrollment process;
   2. If the Medicaid application pends for verification, the worker should annotate Case Notes with the preferred MCO to allow the worker processing the case to complete the enrollment process once eligibility is approved and disposed.

D. For applicants who do not select an MCO, annotate Case Notes with this information. Explain to the applicant that once Medicaid is approved, all non-exempt members will be automatically enrolled with an MCO based on auto assignment rules.

   Note: For information regarding auto assignment rules, refer to MS 1903.

E. Once enrollment is completed, MCOs issue welcome packets to new enrollees including a handbook and other instructional material.

F. DMS maintains a Managed Care toll-free telephone number to assist providers and recipients who have questions pertaining to managed care. The Managed Care Member Services phone number is 1(855)446-1245, and is available from 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday.
G. Managed Care has a grievance procedure for issues such as dissatisfaction with a provider assignment. Refer individuals to their MCO or member handbook for detailed information.

H. There are no fair hearing procedures for managed care as the delivery method of MA is not a qualifying event for a fair hearing.
The Department for Medicaid Services (DMS) contracts with Managed Care Organizations (MCOs) to coordinate health care for most Medicaid (MA) members.

A. The following MCO providers are available to members in all MAGI Medicaid categories:
   1. Aetna Better Health of Kentucky (formally known as Coventry Cares);
   2. Wellcare of Kentucky;
   3. Humana;
   4. Passport; and
   5. Anthem

B. MCO website at https://prd.chfs.ky.gov/ManagedCare/ may be accessed by workers and recipients to search for:
   1. Participating managed care providers and physicians in a particular county;
   2. The MCO and ID number;
   3. The provider’s name, address, phone number, provider type, and the National Physicians Identification Number; or
   4. The provider’s Specialty.

C. Managed Care recipients may contact Managed Care Member Services for information at 1-855-446-1245.
The following is a list of definitions used for managed care:

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

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

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

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

**C. Partnership** – A regional group of health care providers, such as doctors, hospitals, drug stores, therapists, and laboratories. Kentucky is divided into eight partnership regions. Each region has a unique name.

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

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

**F. Behavioral Health Services** – medical services related to the treatment of mental disorders and substance abuse.
Enrolled individuals will be contacted by their Managed Care Organization (MCO). The MCO issues Managed Care cards and members should contact the MCO for replacement cards. Refer member questions regarding services or billing to Managed Care Member Services at 1-855-446-1245 or their designated MCO. MCO numbers are located on the back of the managed care card. Please note that individuals who enrolled in managed care only receive a managed care card and are not issued a KYHealth card.

A. New Medicaid (MA) applicants and members reapplying more than 60 days since the last MCO enrollment have the opportunity to select an 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 the initial enrollment to change their MCO.

3. Recipients who were enrolled with an MCO within the last 60 days are assigned 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 annual 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 DMS for information regarding the Disenrollment for Cause process. Please advise individuals to contact DMS member services at 1-800-635-2570 for information on this process.
F. 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 a MCO beginning the date that the suspension ended.
The majority of MAGI Medicaid recipients will be subject to managed care enrollment unless they meet a reason to be exempt. Non-exempt individuals are given the opportunity to select a Managed Care Organization (MCO) during the application process. For more information regarding MCO enrollment, refer to MS 1903. Workers should provide individuals with basic information about the managed care program.

A. The following Medicaid recipients are non-exempt and are required to enroll in an MCO, if no criteria in section B applies:

1. Children under age 19;
2. Low Income Adults ages 19 through 64;
3. Parent and Caretaker Relatives;
4. Pregnant women;
5. Former foster care youth;
6. Individuals receiving Transitional Medical Assistance (TMA);
7. Individuals who are dually eligible, such as TMA recipients, Parent and Caretaker Relatives, and pregnant women who also receive QMB or SLMB.

B. The following Medicaid recipients are exempt and not required to enroll in an MCO:

1. Individuals in Long Term Care (LTC) facilities, such as Nursing Facilities (NF), Institutionalized Hospice, and Intermediate Care Facility for Individuals with an Intellectual Disability (ICF IID);
2. Individuals receiving waiver services;
3. Individuals receiving KI-HIPP; and
4. Individuals with eligibility that is time-limited, such as Spend Down and Emergency Time-Limited MA for Aliens.

   Note: Although TMA is time-limited, individuals receiving TMA are subject to managed care.

C. [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 ended.]
Some Medicaid recipients are required to pay fees for healthcare services to their providers at the time the service is received. These fees are referred to as copays. Workers must explain copay requirements to individuals during the application interview and when a change is reported that affects an individual’s copay requirement.

If the recipient is unable to pay the copay at the time of the service, the provider cannot refuse services. However, the individual is still responsible for payment. Providers who have trouble collecting copays may decide to stop providing services to Medicaid patients; or with prior notice, they may choose to discontinue future services for recipients with a history of non-payment.

NOTE: If an individual has any additional questions on copays, they should be referred to their Managed Care Organization (MCO) or provider.

A. Copays are not required for preventative services, which include but are not limited to:
   1. Screenings;
   2. Check-ups; and
   3. Patient counseling to prevent illnesses, disease, or other health problems.

B. The following is a list of copays for prescription drugs:
   1. $1 copay for preferred and non-preferred generic drugs;
   2. $1 copay for brand name preferred on formulary over generic equivalent; and
   3. $4 copay for brand name drugs.

C. The following is a list of copays for common services that an individual may receive:
   1. An $8 copay is charged at the time of service for an emergency room visit that Medicaid deems as non-emergent, such as a visit for allergies or a sore throat.
   2. A $3 copay is required for services by the following providers:
      a. General ophthalmologic services provided by physicians;
      b. Advanced Registered Nurse Practitioners (ARNP);
      c. Rural health clinics;
      d. Primary care centers; and
      e. Physician’s office.
   3. Recipients are required to pay $50 per recipient, per provider, per date of service for each covered admission to a hospital for inpatient hospital services.
4. A $3 copay is required for some services rendered by the following providers:
   a. Dentists;
   b. Optometrists;
   c. Opticians;
   d. Hearing Aid Dealers (a co-payment is not imposed on hearing aids);
   e. Chiropractors; and
   f. Podiatrists.

D. The following recipients are exempt from copay requirements, with the exception of the $8 copay for non-preferred brand drugs:

1. Children under age 19:
   a. If the 19th birthday is on the first day of the month, the individual is subject to copays.
   b. If the 19th birthday is after the first day of the month, the individual is exempt from copays until the following month.

2. Recipients in Nursing Facilities (NF) and Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF IID);

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

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

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

6. Recipients age 18, who are in state custody and are in foster care or residential placement.
A Level of Care (LOC) record is received in Worker Portal as notification that an individual is now receiving waiver services, Hospice, or has entered a facility, such as a Nursing Facility. A LOC can be added to some MAGI Medicaid types of assistance (TOA) to allow the issuance of patient liability. If a Level of Care is received for a MAGI Medicaid recipient, review the case to ensure that the individual’s current TOA is compatible with the type of care the individual now receives.

For an explanation on the types of assistance, refer to MS 1075.

A. Nursing facility and Hospice LOCs can be added to the following TOAs:
   1. ADLT Please note, there is a $0 patient liability for these individuals.
   2. CHL1, CHL2, CHL3, CHL4
   3. CHEX
   4. PACA
   5. PREG/ADPR
   6. TMA

B. A Level of Care for waiver services can be added to any of the following TOAs. A determination of disability is not required for individuals to be eligible to receive in these types of assistance.
   1. CHL1, CHL2, CHL3, CHL4
   2. CHEX
   3. PACA
   4. PREG/ADPR
   5. TMA

C. The initial LOC may be received without provider information, as Medicaid must be approved in a type of assistance that will support vendor payment in order for the plan of care to be submitted. Once the plan of care is submitted, the provider information is updated and received by Worker Portal.

D. If an individual receiving Medicaid in the ADLT type of assistance reports that they are applying for, or receiving waiver services, their eligibility for Non-MAGI Medicaid must be determined.

   1. Initiate a Case Change to update the individual’s information to reflect their current situation. This includes their disability information, income and resources, and any transfers of resources.
2. If the individual reports income and resources within the SSI limits, they must apply for SSI and receive a determination of disability from the Social Security Administration (SSA).

3. If the individual reports income and resources that exceed the SSI limits, they are not eligible for SSI and must receive a determination of disability from the Medical Review Team (MRT).

E. The CHIP type of assistance will **not** support any level of care. If it is reported that a child receiving Medicaid in this TOA has been admitted to a facility or is receiving waiver services, their ongoing eligibility must be determined as a disabled child.

   1. Initiate a Case Change to update the case to reflect the family’s current status, this includes disability information, income and resources, and any transfers of resources.

   2. If the family states that the child is NOT disabled, they are not eligible for vendor payment.

   3. Complete an MRT referral to receive a disability determination for the child.

F. If a Level of Care record has been received for an individual but it has been determined that the services are not medically necessary, the message: “Note: Eligibility will not consider this Level of Care record because the LOC has not been met” will be displayed beside the Date LOC Met field. The individual’s eligibility will be determined without consideration of the LOC.
Each individual (including children) applying for MAGI Medicaid must provide his/her social security number (SSN). The Federal HUB will verify each individual’s SSN with the Social Security Administration (SSA).

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

A. If an individual has an SSN, but refuses to provide it or does not meet one of the acceptable exemptions below, that individual will be deemed ineligible. If the individual does not have an SSN or it is not verified, the individual is temporarily approved and given 90 days to provide verification.

B. The 90 day grace period is not allowed for individuals refusing to apply for an SSN, who are not deemed eligible and do not meet one of the acceptable exemption reasons below:

1. Religious objections;
2. Alien status; and
3. Only issued an SSN for valid non-work reasons.

C. Those individuals not seeking coverage for themselves, but who are included in the applicant’s household, are not required to provide an SSN.
To be eligible for MAGI Medicaid, an individual must be a citizen of the United States or a qualified alien as specified in MS 2152. Individuals from Puerto Rico, U.S. Virgin Islands, American Samoa, Guam, or Swain's Island are equivalent to U.S. citizens.

If an individual attests they are a citizen of the United States, Worker Portal will attempt to automatically verify citizenship through the Federal Hub. If the individual's citizenship is verified by the Federal Hub, no additional verification is required. If the Federal Hub is unable to verify citizenship, a Request for Information (RFI) is issued.

A. If citizenship is not verified by the Federal Hub, eligibility for Medicaid can be approved for up to 90 days, if otherwise eligible. An RFI is issued with a 90 day due date. If verification 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, verification of citizenship will be required before Medicaid can be approved.

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

1. The following individuals are not required to verify citizenship:
   a. Deemed eligible newborns under age 1;
   b. Ineligible aliens applying for Emergency Time-Limited Medicaid;
   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 if citizenship cannot be verified by the Federal Hub. The document must be original and show a U.S. place of birth or verify that the person is a U.S. citizen. Request verification of citizenship from the primary tier, Tier 1. If verification cannot be obtained from Tier 1, request documentation from subsequent tiers for possible acceptable forms of verification.

The following are the tiers of acceptable verification:

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

b. TIER 2 (satisfactory reliability)
Acceptable secondary documentation to verify proof of citizenship:

1) A Certification of Birth issued by the Department of State (Form DS-1350, FS-240 or FS-545);
2) A U.S. birth certificate. Workers may also utilize DCBS External Agency Search for verification by viewing the certificate online and documenting in Case Notes. Workers may access the website for vital statistics to obtain information for the applicant/recipient on how they can request birth certificates from other states at http://www.vitalchek.com/listphone.asp;
3) A U.S. Citizen I.D. card (DHS Form I-197 or I-179);
4) An American Indian Card, Form I-872, issued by the Department of Homeland Security with the classification code “KIC”;
5) Final adoption decree;
6) Evidence of Civil Service employment by the U.S. government before June 1976;
7) An official military record of service showing a U.S. place of birth; or
8) A Northern Mariana Identification Card, Form I-873.

c. TIER 3 (satisfactory reliability – use only when primary or secondary documentation 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 facility or other institution that was created at least 5
years before the initial Medicaid application date and indicates a U.S. place of birth; or
4) A medical (clinic, doctor, or hospital) record that was created at least 5 years before the initial Medicaid application date that indicates a U.S. place of birth unless the application is for a child under age 5; or
5) Indian tribal records. Forward this type of verification to MSBB for approval by DMS.

e. LAST RESORT

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

Procedures are as follows:

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

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

Note: Individuals who are not U.S. citizens or Qualified Aliens may still be eligible for Emergency Time-Limited Medicaid. For more information regarding Emergency Time-Limited Medicaid, refer to MS 2160.]
To qualify for MAGI Medicaid, individuals who are not U.S. Citizens must meet qualified legal alien status. Qualified legal aliens are individuals lawfully admitted for permanent residence who have been granted legal immigration status through the U.S. Citizenship and Immigration Services (USCIS). The Personal Responsibility and Work Opportunity Act imposed a 5 year ban from receiving Medicaid that affects certain qualified aliens who entered the U.S. after August 22, 1996. Once it has been determined that an individual meets qualified alien status, then the individual must have met the Medicaid 5 year date of entry ban, unless an exemption reason is met.

The Personal Responsibility and Work Opportunity Act imposed a 5 year ban from receiving Medicaid that affects certain qualified aliens who entered the U.S. after August 22, 1996.

A. The following qualified aliens are subject to the 5 year date of entry ban and cannot receive MAGI Medicaid (except for Emergency Time-Limited MA) until they have remained in qualified alien legal status for at least 5 years from their date of entry into the United States:

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

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

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

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

      a. Either as an adult or as a child if battered or subjected to extreme cruelty by:

         1) A spouse or parent of the alien without the active participation of the alien in the battery or cruelty; or

         2) A member of the spouse or parent’s family residing in the same household as the alien – and the spouse or parent consented to the battery or cruelty.
b. The battered individual **must**:

1) No longer reside in the household with the individual responsible for the battery or cruelty;
2) Have a substantial connection between the battery or cruelty and the need for the benefit; and
3) Have been approved or has a petition pending for:
   a) Status as a spouse or child of the U.S. Citizen;
   b) Status as a permanent resident alien; or
   c) Suspension of deportation status pursuant to Section 244 (a)(3) of the INA.

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

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

B. The following qualified aliens are **NOT** subject to the 5-year ban and **MAY** receive MAGI Medicaid from their date of entry:

1. Children under the age of 19 who meet qualified alien criteria OR are lawfully present;
   
   [Example: Sophia and Marcus are in the U.S. attending college and have I-20 student visas. They have a child Isabella who is age 10. As Isabella is lawfully present and under age 19, she can receive Medicaid without waiting 5 years, if she is financially and otherwise technically eligible.]

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

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

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

5. Children under the Child Citizenship Act of 2000, who automatically acquire citizenship on the date that all of the following requirements are satisfied:
   a. At least one parent is a U.S. citizen whether by birth or naturalization;
   b. The child is under 18 years of age; and
   c. The child is residing in the United States in the legal and physical custody of the citizen parent pursuant to the lawful admission for permanent residence.

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

6. Aliens who are verified by the Office of Refugee Resettlement (ORR) to be victims of human trafficking, and eligible relatives. For more information regarding victims of human trafficking, refer to Volume I, MS 0562;

7. Aliens granted status as Cuban or Haitian entrant (as defined by Section 501 (e) of the Refugee Assistance Act of 1980) whose I-94 is annotated with the words “refugee”. Section 501 (e) defines Cuban and Haitian entrants as any individual who is:
   a. Granted parole status as a Cuban/Haitian entrant (status pending);
   b. Granted parole status as a Cuban/Haitian entrant under Section 212 which is considered in the same manner as those entering under Section 501;
   c. Granted any other special status established under INA laws for these nationals;
   d. Being a national of Cuba or Haiti paroled into the U.S. and has not acquired another status under INA;
   e. Subject to exclusion or deportation proceedings under INA; or
   f. Having an application for asylum pending with INS.

Note: If any of the individuals listed in item 6 have a final, non-appealable, legally enforceable order of deportation or exclusion entered against them, they are NOT eligible under this provision.
8. Aliens granted status as a Cuban or Haitian refugee who present an I-551 with a category status of ‘CU6’ (for Cuban refugee), ‘HA6’ (for Haitian National paroled under Haitian Refugee Fairness Act), or ‘RE6’ (Refugee who entered the U.S. on or after April 1, 1980);

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

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

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

12. Permanent resident aliens who are on active duty, other than active duty for training in the Armed Forces of the United States and fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d), their spouses or unmarried dependent children;

13. Aliens who are granted conditional entry pursuant to Section 203(a) (7) of the INA as in effect prior to 4/1/1980.

C. [The following individuals do not meet qualified alien status and NOT eligible for ongoing Medicaid, however may be eligible for Emergency Time-Limited Medicaid. For more information regarding Emergency Time-Limited Medicaid, refer to MS 2160.]

1. Aliens designated as PRUCOL, permanently residing under color of law;

2. Adults with I-20 student visas;

3. DACA recipients as although they are protected from deportation and allowed to work, they are not lawfully present.]
Individuals who do not meet citizenship or qualified alien requirements for ongoing MAGI Medicaid, may be eligible for Emergency Time-Limited Medicaid (MA) due to an emergency medical condition. This includes individuals currently in this country on a temporary visa, including students. Individuals present with a tourist or visitor visas do not meet residency requirements and so are not eligible for Emergency Time-Limited MA.

A. All technical and financial requirements for MAGI 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. Update Case Notes with all clarifying information not included in the written statement.

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, a cancer diagnosis does not qualify as an emergency medical condition. However, if the individual visits the emergency room or is hospitalized due to complications resulting from cancer, may be considered an emergency medical condition.
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 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 Organ transplant procedures or Long Term Care (LTC) including Nursing Facility (NF), waiver services, or Hospice.

J. There is no Emergency Time-Limited MA coverage in the Spend Down or KCHIP III types of assistance.

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 2162.]
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 all extension requests and either approves or denies.

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.
An individual must be a resident of Kentucky and intend to remain in the state 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.

A. Client statement is accepted for residency unless there is reason to doubt, such as when returned mail or a PARIS match is received.

B. If there is reason to doubt, select “Not Verified” from the dropdown menu as the residency verification source. Worker Portal will generate a Request for Information (RFI) allowing the individual 30 days to provide verification.

The application will pend and at the end of 30 days, Medicaid will deny if the individual does not make contact or other verification is not provided.

C. Do not deny MA because the individual:

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

D. Kentucky residents who are temporarily out of the state maintain their residency status. Persons temporarily out of the state include, but are not limited to: students going to college in another state, someone hospitalized in another state, or someone deployed for the military.

E. Persons residing in the state on a temporary basis include are not considered residents. These individuals include but are not limited to: students, tourists, and individuals who enter the state for medical treatment and intend to leave as soon as the treatment is completed.]
Parents and caretaker relatives caring for a child deprived of parental support due to voluntary absence are required to cooperate with Medical Support Enforcement (MSE). Cooperation with MSE is a technical eligibility requirement for parents or caretaker relatives to receive Medicaid for themselves. Non-cooperation results in a disqualification. MSE referrals are entered on Worker Portal for children applying for Medicaid and KCHIP.

A. The following are types of voluntary absences:
   1. Birth out of Wedlock;
   2. Desertion;
   3. Divorce;
   4. Legal separation;
   5. Marriage annulment; or
   6. Forced separation.

B. Information about the non-custodial parent is entered on Worker Portal. Workers are responsible for explaining MSE and the penalties for non-cooperation.

C. If a parent or caretaker relative refuses to cooperate with MSE without good cause, he/she is disqualified from receiving Medicaid. Refusing to cooperate includes, but is not limited to:
   1. Refusing to provide DCBS information about the absent parent;
   2. Refusing to cooperate with Child Support Enforcement (CSE); or
   3. Failing to keep an appointment scheduled by CSE.

D. To cure an MSE disqualification, individuals must:
   1. Cooperate with DCBS by providing information regarding the absent parent;
   2. Provide verification that they are cooperating with CSE; or
   3. Provide verification of good cause.

   Individuals are eligible for Medicaid the next administratively feasible month after curing the MSE disqualification.

E. If a pregnant woman refuses to cooperate with MSE, she will not be disqualified from receiving Medicaid during the duration of her pregnancy and post-partum.
F. SSI recipients are required to cooperate with MSE, if applicable. If an SSI recipient refuses to cooperate with MSE, without good cause, a disqualification must be placed on his/her SSI Medicaid, by 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. If the SSI recipient starts cooperating with MSE, send a request to MSBB through the regional chain of command to remove the disqualification.

G. If the individual claims good cause for not cooperating with MSE, enter the good cause information in the Cooperation with CSE/MSE section on the Absent Parent Information screen.

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.
Individuals housed in a prison, county jail, or detention center fulltime 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 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/home incarceration; and
3. 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 jail.

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 added to 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 to show that the individual has been released and is now in another living arrangement, such as “In-Home.” Reenrollment in an MCO is effective on the individual’s release date.

Example: Jacob is released from incarceration on 7/28 and has an active Medicaid case. His incarceration status was reported by his authorized representative 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 7/28.

D. Incarcerated individuals are eligible for Medicaid to pay for services if 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.]

Client statement is accepted for verification of pregnancy and the due date. Medicaid coverage for pregnant women is provided through the pregnancy plus the post-partum period.

A. The following applies to Medicaid for pregnant women:

1. Pregnant women are deemed eligible through the postpartum period as long as they remain in Kentucky. A women must be eligible for Medicaid as a pregnant woman in the application month to be considered deemed eligible.

   a. Deemed eligibility does not apply to pregnant women who are eligible in a retro month but not eligible as a pregnant woman in the application month.

      Example: Betty applied in December and is 3 months pregnant. She had no income in October, but began working in November. Her income is over the limit for the PREG type of assistance. Betty is eligible for October but will be denied for the application month and ongoing.

   b. Deemed eligibility does not apply to pregnant women who were incorrectly determined eligible at application.

2. Post-partum begins the date the pregnancy ends and extends 60 days, ending the last day of the month in which the 60 days concludes. In order to be eligible for post-partum coverage, a woman must be eligible for Medicaid for the month the child is born.

3. If the pregnancy is terminated for any reason, post-partum coverage will be given to the client. Post-partum will begin at the time the pregnancy is terminated.

4. Pregnant women receiving Medicare can be dually eligible for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) with the PREG TOA, if their income is within the limits for those programs. Note: A pregnant woman who is dually eligible will be subject to managed care enrollment.

5. Children under the age of 19 who become pregnant will have Medicaid eligibility issued in the PREG TOA.

6. If the birth of a child is not reported by the due date, Worker Portal will automatically begin the post-partum period.

B. Pregnant Women may receive Medicaid in either the PREG or ADPR TOA.

1. If a woman reports pregnancy at application for Medicaid she will receive Medicaid in the PREG TOA.
2. If a woman reports pregnancy while receiving Medicaid in the ADLT TOA, she will transition into the ADPR TOA as long as the household income does not exceed 138% FPL and she meets all technical eligibility requirements. The change in TOA is effective the month following the month in which pregnancy is reported and the case is disposed.

3. A woman receiving Medicaid in the ADPR TOA whose countable income exceeds 138% FPL will transition to the PREG TOA.

4. Nursing Facility (NF), other Long Term Care (LTC) facility, and Hospice Level of Care (LOC) can be added for an individual receiving Medicaid in the ADPR TOA. ADPR is not a waiver compatible TOA. Patient Liability will not be calculated when a waiver LOC is received on a woman receiving in the ADPR TOA. These situations should be sent to MSBB through the regional chain of command.

   Note: Any type of LTC or waiver may be added to the PREG TOA.

5. Pregnant women will move from the ADPR TOA to the PREG TOA if they fail to meet income requirements, at recertification (whether completed or not), or if they become eligible for Medicare.
Once an adoption is final, a child in a private non-profit adoption is considered the same as any other child in a parent’s case. The family may apply for MAGI Medicaid and eligibility will be determined based on the household’s financial situation.

If the adoption proceedings are pending the following criteria applies:

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

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

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

[To view a listing of the agencies registered with OIG refer to https://chfs.ky.gov/agencies/os/oig/drcc/Pages/cccpb.aspx and click on the Child Placing Agencies Directory.]

For the children meeting the criteria in items A or B the following procedures are followed:

1. The child is entered on Worker Portal and the worker should review the situation to determine if the child meets criteria for deemed eligibility;

2. The case is in the child’s name;

3. Inquire if parental rights are terminated. Annotate this information in Case Notes;

4. Ask if the adoption agency carries health insurance on the child. Annotate this information in Case Notes; and

5. All required verification must be provided.

Note: If the adoption is subsidized, the adoptive parents will have a copy of the subsidy agreement. Subsidized adoptions are handled through the Division for Protection and Permanency (DPP). These cases are Non-MAGI and are processed by the Children’s Benefits Worker (CBW). There are no special cases for adopted children unless the adoption is subsidized by the state.
A child under 1 year of age born to a mother who received Medicaid (MA) in Kentucky at the time of the newborn’s birth is considered deemed eligible. This includes receipt of Medicaid in any category, including MAGI Medicaid, Non-MAGI Medicaid, Time-Limited Medicaid, and Supplemental Security Income (SSI).

Once deemed eligible, the newborn is guaranteed Medicaid from the birth month through the 12th month as long as they continue to reside in Kentucky. The newborn is considered deemed eligible regardless of whether the mother and/or other case members remain eligible to receive Medicaid. Medicaid must be issued for a deemed eligible newborn even if the mother does not want the coverage. The deemed eligible newborn must have the same Managed Care Organization (MCO) as the mother for the first 60 days.

A. A child is considered a deemed eligible newborn even in situations where:

1. The Medicaid application for the mother is made after the birth of the newborn, as long as the birth month is the month of application or one of the 3 retroactive months for which the mother is approved.

2. The mother is approved for Spend Down eligibility and the excess is obligated on or before the newborn’s date of birth.

B. Worker Portal will interface with Vital Statistics regarding newborns. If the mother’s case is identified on Worker Portal, the deemed eligible newborn will be automatically added to the case and coverage will be issued. If the mother’s information is not found on Worker Portal, the newborn information will be sent to DMS for resolution.

C. If the deemed eligible newborn’s birth information is reported to DCBS and the newborn is not active on Worker Portal, action must be taken to add the child and issue coverage.

D. If the newborn’s mother receives MA in a Foster Care, Subsidized Adoption, or DJJ case set up a separate case for the newborn.

E. After the newborn’s first birthday, all technical and financial eligibility requirements must be met for the child to continue to receive MAGI Medicaid. If a child’s birthday is after the first day of the month, deemed eligibility ends that month.

Example: A deemed eligible child’s date of birth is 5/15/15, therefore deemed eligibility will end 5/31/16 and the child must meet all eligibility requirements effective 6/1/16 in order to continue to be eligible for MAGI Medicaid.

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

Example: A deemed eligible child’s date of birth is 5/1/15, therefore deemed eligibility will end 4/30/16 and the child must meet all eligibility requirements effective 5/1/16 in order to be continued eligible for MAGI Medicaid.
Former foster care individuals are individuals age 19 through 26 who received Medicaid in the FCMA TOA when they turned 18. This includes individuals who age out in other states. These individuals are deemed eligible to receive Medicaid until they turn 26 years old as long as they continue to reside in Kentucky.

The Medical Support and Benefits Branch (MSBB) receives a monthly list of individuals that have aged out of foster care placement and processes an application for each individual as Former Foster Care. However, these applications are not limited to MSBB as workers may also take applications for Former Foster Care individuals. For example, an individual may contact DCBS when they have aged out of foster care to apply for Medicaid or to reapply if their case has discontinued.

A. The following applies to these individuals:

1. The Former Foster Care case is not a stand-alone case like a Foster Care case and other household members may be added, such as the individual’s spouse or child. In addition, other programs such as SNAP may be requested on the case.

2. Resources are not considered in the eligibility determination.

3. Income is not required for Former Foster Care. However, it is best practice to request an individual’s income as their income may be required if there are other members on the case. For example, if an individual reports that they have gotten married and their spouse requests Medicaid, income would be required to determine Medicaid eligibility for the spouse.

4. Former foster care individuals are eligible for retroactive Medicaid coverage.

5. On the Household Questions screen, selecting “Yes” to the question, “Was anyone in the household ever in Foster Care?” triggers the Former Foster Care screen.

B. Individuals eligible for former foster care Medicaid will receive in one of the following TOA’s.

1. FFCC – Individuals who aged out of foster care while residing in Kentucky.

2. FFOS – Individuals who aged out of foster care in another state and have income above 138% FPL or individuals who have income at or below 138% FPL but are receiving Long Term Care (LTC) or Medicare.

3. ADFF – Individuals who aged out of foster care in another state and have income at or below 138%.

Note: Individuals receiving in the FFCC and FFOS TOA who report pregnancy will transition to the PREG TOA. Individuals receiving in the ADFF TOA who report pregnancy will transition to the ADPR TOA.
MAGI Spend Down provides time-limited Medicaid (MA) to individuals in all MAGI categories, except Low Income Adults, who meet all technical requirements however have income in excess of the appropriate Federal Poverty Level (FPL) Scale for the Eligibility Determination Group (EDG) size. For example, an individual who is technically eligible as a Parent/Caretaker Relative, but is over the income limit for Medicaid may be eligible for a Spend Down.

Worker Portal reviews for regular MA eligibility before it determines Spend Down eligibility. MAGI Spend Down eligibility may only be established in the RETROACTIVE quarter. The Spend Down may be for one, two, or all three prior months prior to the month of application during which an applicant incurred a medical expense. Which months are included in the retroactive quarter is the applicant’s decision.

Note: There is no Spend Down eligibility for individuals over the income limit for Emergency Time-Limited Medicaid.

A. To determine eligibility for a retroactive Spend Down the applicant must:

1. Verify actual medical expenses incurred in any of the retroactive months for which the Spend Down application is made. The medical bills used must be currently owed and may be for any member of the MA household even if that member is not applying for or receiving MA. Medical bills turned over to a collection agency are no longer considered as a medical expense and cannot be used. Any unpaid bills used in a previous spend down approval cannot be used again for the current application; and

2. Verify income received in months for which a Spend Down application is made.

B. Spend Down eligibility begins the day an individual meets the Spend Down obligation amount; i.e., the day medical expenses equal or exceed the excess income amount. Advise recipients the Spend Down obligated amount is met with medical bills incurred by any case member during the Spend Down time period. The household’s obligated amount is met with the first providers who bill MA.

Example: The Spend Down obligation amount is $1200 for the Spend Down period of 3/23/18 through 5/31/18. The household is responsible for the $1200 Spend Down obligation as well as the bills prior to 3/23/18 that were used to meet the obligated Spend Down amount. If the first bill received by DMS is for services on 4/6/18 for $600, the amount of that bill is deducted from the obligated amount of $1200. The next bill received by DMS is $300 for services on 3/23/18, and on the same day an additional bill is submitted for $300 for services on 5/1/18. These are deducted from the obligated amount, the client is responsible for paying them, and the Spend Down obligated amount is met. Any subsequent bills are paid by DMS as long as they are within the Spend Down period of 3/23/18 through 5/31/18.
If an individual has a large bill covering several days, enter daily amounts instead of the total so that Worker Portal can determine the correct date the individual met the Spend Down obligation.

Example: Mary applies on 3/1/18. Her Spend Down obligated amount is $1600. She was hospitalized 2/6/18 through 2/10/18 and the total bill is $9000. The itemized bill provided shows that Mary was charged $1500 on 2/6/18, $2500 on 2/7/18, $2500 on 2/8/18, and $1500 on 2/9/18, and $1000 on 2/10/18. By entering the daily amounts, Worker Portal will correctly determine that Mary met her Spend Down obligation on 2/7/18.

C. Notices for Spend Downs show the case obligation amount rather than the individual’s obligation amount. The obligation amount is the amount Medicaid will not pay.

D. If health insurance coverage other than MA exists, that insurance provider’s payment for the incurred services must be determined prior to approving the Spend Down application. Only the amount the individual is responsible to pay can be considered towards the Spend Down excess.

E. When quarterly excess income equals verified recognized incurred medical expenses, paid or owed, the application may be approved on a time-limited basis. Effective dates of coverage begin on a specific day and end on the last day of the month approved.

F. A Spend Down application is approved as soon as possible, but not to exceed 30 days from the date of application, unless additional time is requested by the applicant. When the verification is received, the case must be worked WITHIN 7 WORK DAYS from receipt of the required verification or the 30th day, whichever is first.

G. Advise recipients they need to wait until they receive a statement from the provider showing that DMS has been billed, and the bill was denied for use in meeting the obligated amount, before they make any payments for services during the Spend Down timeframe. This is necessary to establish which provider bills are adjusted based on the family/member’s obligation amount.

H. If, after a determination has been made, additional verification of medical expenses are provided by the recipient, a recomputation is completed.

1. If it is determined that the Spend Down liability was met earlier in the quarter, complete a Special Circumstance Transaction to authorize MA eligibility for the earlier date.

2. If the re-computation results in the determination that the applicant met the Spend Down liability later in the quarter, no action is required.

I. If medical expenses for the requested period (one, two, or three months) are less than the excess income, deny the application.

Example: Sue requests a one month Spend Down and her excess income is 1000.00, however total medical expenses are 800.00.
Spend down medical expenses are expenses incurred by an individual, a spouse or dependent child under 21 in the home or away from home for school attendance. Unless already receiving Medicaid (MA), these expenses are allowed regardless of whether or not these family members are included in the case and/or regardless of whether or not their income is considered in the MA eligibility determination.

A. Consideration of Medical Expenses:

1. Consider any verified allowable medical expense(s) incurred DURING the retro quarter. Begin with the first day of the quarter and list daily expenses.

2. Consider the unpaid balance of any verified allowable medical expense incurred PRIOR TO the established quarter.
   a. Consider the expense as incurred on the first day of the first month of the established quarter.
      1) When using prior medical expenses to meet the spend down amount, always show the date the expense was incurred as the first day of the spend down quarter. If the spend down amount is met with prior medical expenses only, the member spend down liability will be $0.
      2) Unpaid medical expenses from a prior quarter must be verified as still owed. If the bill has been written off or has been paid by a third party, it cannot be used. If verification cannot be provided that the bill is still owed, it cannot be used to meet the spend down liability.
   b. Consider only the portion of the expense needed to obligate the spend down excess.
      1) If consideration of a portion of the expense obligates the spend down excess, then the remaining balance of the expense can be used to obligate a future spend down excess. For these situations, annotate the amount used to obligate the excess for the established quarter, and the amount remaining for future spend down use in case comments.
      2) Review the case record to ensure the medical expense has not been considered in a previous quarter to establish MA eligibility.

Example: An individual's spend down excess for the prior quarter is $1,200. Two years ago, the individual incurred a $1,600 hospital bill, made a payment of $100 leaving an unpaid balance of $1,500. The $1,200 portion of the hospital bill is considered on the first day of the first month of the retro quarter for spend down. The remaining $300 of the bill can be used to obligate a future spend down excess.

3. Verified payments on medical bills for services when MA was not received are deducted if paid during the quarter.

Example: Two years ago, an individual purchased an $800 hearing aid and charged the full amount. Every month a $25 payment is made on the
account. The individual applies for a MA spend down case. Consider the $25 as an allowable medical expense and record as a spend down expense the day the $25 payment is made.

4. When all verified allowable medical expenses presented by the individual are recorded, determine if, on any day in the quarter, the total amount of expenses for the period is as much as the excess income.

B. Verification of Medical Expenses:

1. Medical bills or statements;

2. Receipts for payment of medical expenses;

3. Medicare Summary Notices (MSN) which shows covered/uncovered and aid/unpaid medical expenses;

4. Health insurance statements showing amount paid;

5. Other appropriate means.

C. Medical Expense Restrictions:

1. Do not list any expense to be paid by a third party, such as Medicare, health insurance, insurance settlement, family members, etc. with the following exceptions:

   a. DO NOT hold spend down applications pending for verification of payment of medical expenses as a result of an unforeseen accident which may be covered by liability insurance owned by another person. It is the responsibility of DMS to obtain reimbursements from third party liability sources. This procedure does not apply to health insurance policies, such as, Medicare, Blue Cross/Blue Shield, Humana, etc. and Worker's Compensation. Spend down applications are held pending verification of payment of medical expenses by these third party liability sources.

   b. For persons undergoing renal dialysis treatment, do not hold spend down applications pending for MSN’s if the following applies as these cases are given priority and processed as soon as the spend down liability is met:

      1) They have Medicare but no other health insurance;
      2) The renal dialysis clinic provides a statement verifying the date of service, cost of service and the anticipated amount of Medicare reimbursement for each date of service. The difference between the Medicare billed amount and the anticipated Medicare payment amount is allowed as the spend down medical expense.

Use this statement and any other verified medical expenses that will not be reimbursed by Medicaid, such as prescriptions. Other verified medical expenses subject to Medicare reimbursement cannot be used to meet the spend down liability as the application is to be processed prior to receipt of the MSN; and
3) When MSN’s are received for other medical expenses, the case is reworked at the individual's request, to determine if an earlier date was met for the spend down program.

2. Unpaid medical expenses are allowed as a spend down medical expense however:

   a. Do not consider medical expenses for which individual is absolved from payment, such as a medical bill written off by provider as uncollectible. If the medical expense is more than 90 days old, OR if the individual's responsibility for payment of the medical expense is questionable, the appropriate provider MUST be contacted to determine whether or not the individual is liable for payment of the expense.

   b. Do not consider medical bills or payment on medical bills used to obligate the liability amount for any previous spend down quarter. Example: During the current quarter, an individual purchased eyeglasses costing $129. The total amount was charged on the 6th day of the 1st month of the current quarter. The total amount is considered on the 6th for spend down. During the next quarter, $25 a month has been paid on the $129 charge. The $25 payments cannot be used as the entire $129 was used in the quarter the expense was incurred.

3. All bills, statements, and receipts, must show the actual date of service and daily charge to determine the day the excess is met.

4. Deductions for prescription drug expenses incurred during a period of MA eligibility may be allowed ONLY if the recipient verifies that MA denied coverage of the drug at the time, and that a prior authorization request was also denied. A deduction can be given for a Medicare Part D premium if paid by the recipient.

D. Allowable Spend Down Medical Expenses

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

1. Health insurance premiums including SMI, and specified disease policies such as cancer and/or any other policies paying for services within the scope of the program. Consider the entire amount when paid or prorate payment for months of actual coverage, to the benefit of the individual whichever they choose. Example: A $90 premium is paid July 15 to cover August, September and October. Allow $30 for August 1, September 1 and October 1 or use the entire $90 on July 15.

2. Insurance policies paying specific benefits per day to an individual while hospitalized or during recuperation. Premiums paid on these policies are considered a medical expense.
3. Nursing Facility (NF) insurance premiums.

4. Transportation expenses for health care that are not available free of charge. Costs for use of the individual's own are are deductible at the state rate per mile;

5. The actual amount paid for caretaker, family care or personal care services if the individual is paying the private pay rate. If medical expenses of a spouse are being considered and the spouse is receiving state supplementation payments then consider the payment for caretaker services as a medical expense.

6. In-patient hospital services including services in institutions for tuberculosis, mental disease or other specialty hospitals regardless of age;

7. Laboratory and x-ray services;

8. NF services, including services in institutions for tuberculosis or mental disease, for all individuals regardless of age;

9. Any physician's services;

10. Medical care or any other type of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice as defined by state law;

11. Home health care services, including intermittent or part-time services of a nurse or home health aide according to a physician's plan of treatment;

12. Private duty nursing services by a Licensed Practical Nurse or Registered Nurse;

13. Clinic services;

14. Dental services, including dentures prescribed by a licenses and practicing dentist;

15. Physical therapy and related services including supplies such as hearing aids;

16. Drugs prescribed by a licensed physician, osteopath, or dentist;

17. Prosthetic devices, including braces and artificial limbs;

18. Eye glasses and other aids to vision, prescribed by an ophthalmologist or an optometrist;

19. Ambulance services when medically indicated and/or other transportation cost necessary to secure a medical exam or treatment;

20. X-ray, radium and radioactive isotope therapy;
21. Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations and related items used at the direction of physician for the continuing treatment of a health problem;

22. If not available from a Home Health Agency, rental or purchase of durable medical equipment including, but not limited to iron lung, oxygen tents, hospital beds, wheelchairs, crutches, braces and artificial limbs including replacements if required because of change in the patient's condition;

23. [Purchase, care, and maintenance costs of animals designated as Service Animals;]

24. Consider the cost of lodging, which may include the lodging cost of a nurse/attendant, a necessary medical expense if it can be determined lodging was necessary to secure required medical service or treatment.
   a. Question the individual to determine if circumstances necessitated lodging and explain in case comments.
   b. If the need for lodging cannot be determined, request a physician's statement to verify reported expenses were actually medically necessary.
   c. The allowable amount may not exceed commercial lodging costs prevalent in area.

25. Incurred medical expenses paid by a public program of the State or a political subdivision without federally designated funds. Political subdivisions include city, county, or local governments.
   a. Examples of public programs of the State include hospitals, health departments, community service centers, primary care centers operated by local health departments, and comprehensive care centers.
   b. Medical expenses paid by programs of the federal government including Medicare and VA. Bills that have been written off as uncollectible are not allowable as spend down deductions.
   c. Obtain a copy of the bill to verify that a medical expense was incurred and that the expense was paid by a state public program or political subdivision without federally designated funds prior to allowing the deduction.

26. Any item verified per a doctor's statement that is medically necessary for controlling a patient's allergy problem such as purchase of electrostatic air filters, humidifiers, air conditioner, central heating system, hardwood floors, payment for carpet/upholstered furniture clearing, and carpet removal;

27. Other items clearly identified as medical in nature such as aspirin, antacids, peroxide, Band-Aids, nutritional supplements such as Ensure, and incontinent care products. Cash register receipts are acceptable verification of the
expense. If the receipt does not specify the item, the individual’s statement is accepted; and

28. Consider charges from a physician who is not enrolled in the MA program as a medical expense, however even though the expense can be deducted, MA cannot make payments to a physician who is not enrolled an enrolled provider.
For MAGI Medicaid, household composition is determined based on Filer or Non-Filer rules. Each individual is designated a Filer or a Non-Filer based on tax filing status.

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

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

1. A tax filer is an individual who intends to file an income tax return for the benefit year and no other tax payer will claim this person as a dependent. This includes spouses filing a joint income tax return; or

2. A tax dependent is an individual for whom someone else claims a personal exemption deduction during the taxable year.

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

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

1. The individual expects to be claimed as a dependent by someone other than a spouse, biological, adopted or step-parent;

2. A child under the age of 19 living with both parents and the parents do not intend to file jointly; or

3. A child under age 19 who will be claimed by a non-custodial parent.

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

a. Spouse;

b. The individual’s children if they are under the age of 19; and

c. If the individual is under age 19, includes the individual’s parents and any siblings under the age of 19.

Note: Spouses who reside together count in each other’s EDG, regardless of tax filing status.
C. The following are EDG examples:

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

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

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

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

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

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

3. Grandmother is applying for Medicaid for herself and her 14 year old granddaughter. She files as head of household with the granddaughter as her dependent.

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

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

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

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

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

   The 23 year old meets the definition of a tax dependent, therefore he falls under Filer rules and his EDG would be 3. His parents are included in his EDG even though they are not applying for assistance.
Note: If he works and files taxes to recover his withholdings, he is both a filer and dependent. Medicaid defaults to dependent rules in these situations.

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

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

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

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

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

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

9. A 30 year old woman applies for Medicaid. She resides with her mother and states she files taxes as “single” and is not a dependent in any other tax household.

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

10. A 32 year old woman shares joint custody of her 2 year old daughter with her ex-husband. The child resides with the mother. The mother is a tax filer however the father claims the child as a dependent on his taxes.

The mother’s EDG size is 1 as she does not claim the child. The child’s EDG is 2 as her eligibility is determined by Non-Filer rules as she meets one of exceptions listed above.

Note: The custodial parent must apply and receive Medicaid for a child. In true joint custody situations where the child spends ½ of the time with one parent and ½ with the other parent, the child may receive on the case of whichever parent applies first.

11. The household consists of unmarried parents and their 4 children, ages 9, 7, 4, and 2. Only the mother and children are applying for Medicaid. The father files taxes and claims the mother and children as dependents.

The children’s EDG size is 6 as they are all under the age of 19.
The mother’s EDG is 5 as she is a tax dependent of someone who is not her spouse, biological, adopted, or step-parent. Her eligibility is determined by Non-Filer rules.

12. The household consists of uncle, aunt, and their 3 nephews. The children are siblings and each receive RSDI.

   Siblings living in the same household must be included in the same case. In addition, the income of the children living with and being claimed by someone other than a parent is countable regardless of tax filing requirement. The siblings should be included in each other’s EDGs and the RSDI income is countable.

13. The household consists of married parents and their 19 year old son. The tax filing status is married filing jointly with the son as a dependent. The son is out of the state attending college in Ohio, but intends to return and reside in Kentucky. Even though, he is out of the state temporarily attending school, he is still considered in the household.

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

14. A 23 year old applies for Medicaid and states that she is filing taxes as single. She lives in the home with her parents and they are filing taxes as married filing jointly with her as a dependent.

   Even though she is filing taxes, her parents claim her as a dependent and she would meet Filer rules. All members of the tax household would be included in her EDG.]
MAGI income is compared to the appropriate Federal Poverty Level (FPL) for the Eligibility Determination Group (EDG) size for MAGI Medicaid categories for Children under age 19, Pregnant Women, and Low Income Adults.

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

A. All Types of Assistance (TOA) other than CHL4 and CHEX are allowed a 5% disregard if needed to gain eligibility. If income exceeds the initial income limit, 5% is added to the FPL for the appropriate EDG size and income is compared to the increased scale. Worker Portal automatically compares the income to the appropriate FPL plus 5% if necessary for eligibility.

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

The FPL chart below outlines the appropriate FPL for the MAGI Medicaid categories of Children under 19, Pregnant Women, and Low Income Adults:

<table>
<thead>
<tr>
<th>TOA</th>
<th>Category</th>
<th>FPL</th>
<th>With 5% disregard</th>
</tr>
</thead>
<tbody>
<tr>
<td>TP45</td>
<td>Deemed Eligible Newborn</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>CHL4</td>
<td>Medicaid Children ages 6-18</td>
<td>109%</td>
<td>N/A</td>
</tr>
<tr>
<td>CHL2</td>
<td>Medicaid Children ages 1-5</td>
<td>142%</td>
<td>147%</td>
</tr>
<tr>
<td>CHL3</td>
<td>Medicaid Children ages 6 &lt; 19</td>
<td>142%</td>
<td>147%</td>
</tr>
<tr>
<td>CHL1</td>
<td>Medicaid Children &lt; age 1</td>
<td>195%</td>
<td>200%</td>
</tr>
<tr>
<td>CHEX</td>
<td>KCHIP Children ages 0 &lt; 19</td>
<td>159%</td>
<td>N/A</td>
</tr>
<tr>
<td>CHIP</td>
<td>KCHIP Children &lt; age 19</td>
<td>213%</td>
<td>218%</td>
</tr>
<tr>
<td>PREG</td>
<td>Pregnant Women</td>
<td>195%</td>
<td>200%</td>
</tr>
<tr>
<td>ADLT</td>
<td>Low-Income Adult 19 – 64</td>
<td>133%</td>
<td>138%</td>
</tr>
<tr>
<td>ADPR</td>
<td>Low-Income Adult who is pregnant</td>
<td>133%</td>
<td>138%</td>
</tr>
</tbody>
</table>

B. If total countable income is equal to or less than the appropriate FPL scale for the EDG size, income eligibility is met.

C. The Medicaid EDG will include any unborn children of a pregnant woman.

D. [MAGI Medicaid uses current FPL income limits in the eligibility determination. Refer to the chart below for MAGI Medicaid income limits effective 3/1/20: ]
E. Income for individuals in the Parent/Caretaker Relative category is compared to the current MAGI MA scale below:

<table>
<thead>
<tr>
<th>EDG Size</th>
<th>Standard 109%</th>
<th>Standard 133%</th>
<th>Standard 138%</th>
<th>Standard 142%</th>
<th>Standard 147%</th>
<th>Standard 159%</th>
<th>Standard 195%</th>
<th>Standard 200%</th>
<th>Standard 213%</th>
<th>Standard 218%</th>
<th>Standard 250%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1,159</td>
<td>1,414</td>
<td>1,467</td>
<td>1,510</td>
<td>1,563</td>
<td>1,691</td>
<td>2,073</td>
<td>2,127</td>
<td>2,265</td>
<td>2,318</td>
<td>2,658</td>
</tr>
<tr>
<td>2</td>
<td>1,567</td>
<td>1,911</td>
<td>1,983</td>
<td>2,041</td>
<td>2,113</td>
<td>2,285</td>
<td>2,803</td>
<td>2,873</td>
<td>3,061</td>
<td>3,133</td>
<td>3,592</td>
</tr>
<tr>
<td>3</td>
<td>1,973</td>
<td>2,407</td>
<td>2,498</td>
<td>2,571</td>
<td>2,661</td>
<td>2,878</td>
<td>3,530</td>
<td>3,620</td>
<td>3,856</td>
<td>3,946</td>
<td>4,525</td>
</tr>
<tr>
<td>4</td>
<td>2,380</td>
<td>2,904</td>
<td>3,013</td>
<td>3,100</td>
<td>3,210</td>
<td>3,471</td>
<td>4,257</td>
<td>4,367</td>
<td>4,650</td>
<td>4,759</td>
<td>5,458</td>
</tr>
<tr>
<td>5</td>
<td>2,788</td>
<td>3,400</td>
<td>3,528</td>
<td>3,631</td>
<td>3,759</td>
<td>4,066</td>
<td>4,987</td>
<td>5,113</td>
<td>5,447</td>
<td>5,575</td>
<td>6,392</td>
</tr>
<tr>
<td>6</td>
<td>3,194</td>
<td>3,897</td>
<td>4,043</td>
<td>4,161</td>
<td>4,308</td>
<td>4,659</td>
<td>5,714</td>
<td>5,860</td>
<td>6,241</td>
<td>6,388</td>
<td>7,325</td>
</tr>
<tr>
<td>7</td>
<td>3,601</td>
<td>4,393</td>
<td>4,559</td>
<td>4,691</td>
<td>4,856</td>
<td>5,252</td>
<td>6,441</td>
<td>6,607</td>
<td>7,036</td>
<td>7,201</td>
<td>8,258</td>
</tr>
<tr>
<td>8</td>
<td>4,008</td>
<td>4,890</td>
<td>5,074</td>
<td>5,222</td>
<td>5,406</td>
<td>5,847</td>
<td>7,171</td>
<td>7,353</td>
<td>7,833</td>
<td>8,016</td>
<td>9,192</td>
</tr>
</tbody>
</table>

F. Individuals determined over the income limit in the Parent/Caretaker Relative category automatically have eligibility explored in the Low Income Adult category.
Income is considered verified for Modified Adjusted Gross Income (MAGI) Medicaid when the client stated amount and that received from the trusted data source is reasonably compatible. Reasonable compatibility is defined as a 10 percent difference between the self-attested amount and the information returned by the trusted data sources.]

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

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

The following are examples of reasonable compatibility:

A. If the individual attests to income that is greater than the MAGI income limits, then he/she will be determined ineligible for MAGI Medicaid and the application will be denied, regardless of what the trusted data sources return. The individual has the opportunity to appeal this decision.

B. If self-attestation of income and that returned by the trusted data sources are both below the MAGI income limits, then self-attestation is sufficient and the application is approved based on the self-attested amount.

C. If self-attestation of income is below the MAGI income limit but the trusted data sources return information above the income limit, as long as the self-attested amount is reasonably compatible, then the self-attested amount will be taken and application approved based on this amount.

[Individuals are given the opportunity to dispute and provide satisfactory verification at any time if electronic information received will negatively impact eligibility.]
Income is money received from any source, either earned or unearned. Earned income, such as wages and self-employment, is money derived from the direct involvement in a work-related activity. Unearned income, such as RSDI and Unemployment Insurance Benefits (UIB), is money received that does not involve direct activity.

A. The amount of countable income for MAGI cases is determined based on tax filing rules.

B. Both Federal and State data sources are used to verify income. The Federal data source is the initial source for verification and takes precedence over all other data sources. The client stated amount and the income verified by the trusted data sources must be compatible within 10 percent, this is known as reasonable compatibility.

If reasonable compatibility fails, additional income verification is required and Worker Portal will generate an RFI.

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

D. It is important that all income details are accurately entered in Worker Portal. This includes income begin dates and hours worked.]
Income calculations for MAGI Medicaid are based on federal tax rules. The MAGI total is the Adjusted Gross Income (AGI) plus tax exempt interest, foreign earned income, RSDI received by adults, RSDI received by children living with someone other than a parent, and RSDI received by dependents if they have a tax filing requirement.

Client stated income entered in Worker Portal should reflect an individual’s current and ongoing situation. If the stated income meets reasonable compatibility it is considered “Passed” and no further verification is required. If the income does not meet reasonable compatibility it will “Fail” federal and state data matches, and verification is required.

Do not limit an individual to one particular type of verification. When verification is requested, the worker should review the various acceptable sources with an individual. All verification of income should be scanned into ECF upon receipt.

Workers should ensure that the correct date that the income began and the correct number of hours worked are entered in Worker Portal.

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

A. Federal Tax Forms, such as 1040, 1040A, and 1040EZ and appropriate supplemental federal forms such as Schedule C, Schedule F, etc. for self-employment and farm income:

1. Wages may be verified by using tax forms as long as the individual states that they anticipate having the same earnings for this benefit year. This income can be entered as an annual amount; however, workers should ensure that the income covered the entire taxable year. If not, the worker should calculate and enter the monthly amount.

For example, an individual indicates that the wages listed on form 1040 are only for a six month period as current employment started on 6/1. Divide the total by 6, enter as a monthly amount, and document in Case Notes how the monthly amount was calculated.

2. Review all entries on the tax form and ensure that the income received the previous tax year is representative of the current situation. If the income is no longer representative, the individual must provide a different form of verification.

3. If an IRA distribution is shown on the form, inquire if the individual plans to take the distribution in the current benefit year. A written statement from the individual is acceptable verification if he/she states they do not intend to take the distribution.

4. Do not use Tax forms to verify RSDI or Unemployment benefits. These are entitled benefits and must be verified using an award letter, system inquiry, or contact with the appropriate agency.
5. If there is a negative amount (loss) of self-employment or farm income, Worker Portal will reduce the total countable household income by this amount.

B. Wage Stubs:

1. Request prior two months, if representative. Verification of prior two months may include but is not limited to the following: actual pay stubs, printout from employer, or pay information obtained from Eligibility Advisor.

2. Enter pay stubs according to pay date.

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

3. When entering income from pay stubs, do not include in the gross any pre-taxed amounts such as deductions for IRA or HealthCare Spending Accounts. Workers should review pay stubs for these pre-taxed amounts and clarify any questions with the individual. Pre-taxed amounts are entered as “monthly pre-taxed deduction” on the Earned Income Verification screen.

4. Determine if all pay received in prior two months is representative of ongoing income. If it is determined that a pay stub(s) is not representative, select “no” to “Include in Projection” on the Earned Income Verification screen. Document in Case Notes the reason(s) the check is not included in ongoing projections.

For example, the client states that a pay stub received is not representative as it included overtime which they do not expect to continue to receive.

5. Ensure the correct number of hours worked per pay period are entered in Worker Portal.

C. Award Letters:

Current award letters can be used to verify entitled benefits, such as RSDI or Unemployment Insurance Benefits (UIB), Veteran’s Affairs (VA) benefits, and pensions.

D. Written Statement:

1. Workers may use a written statement from an employer to verify ongoing income if prior wage stubs are unavailable or not representative. The written statement must be signed and dated by the employer along with appropriate information, such as hours worked and hourly rate of pay.

For example, an individual has been employed for several months at the same business, but states that they are going to receive a raise in pay effective with their next pay period. Because the prior two months are not representative of the ongoing situation, request an employer statement including amount, effective date, and other pertinent information.
2. Forms such as PAFS-700 may also be used in lieu of a written statement.

E. Personal Records:

1. Personal Records may be used to verify self-employment income if tax forms are not representative of ongoing income.
2. Be sure to request records showing income and expenses.
3. Personal Records may be used to verify earned income as a last resort.

F. System Inquiry:

1. Program 48, WAGE RECORDS, on KYIMS;
2. BENDEX;
3. Supplemental Data Exchange (SDX); and
4. Eligibility Advisor.

G. Collateral Contacts:

1. Person and/or Agency issuing payment;
2. Document in Case Notes the name, date, and phone number of collateral.
Client statement of no income is accepted for Modified Adjusted Gross Income (MAGI) Medicaid.

A. Verification of no income is not required for any member of the household, including the head of household, unless questionable.

B. For individuals whose statement of no income is accepted, select “No” from the drop down menu on Worker Portal for the question, “Is no income verification required?”

C. If the client’s statement of no income is questionable, select “Yes” from the drop down menu on Worker Portal for the question, “Is no income verification required?” and request verification. Document in case notes why verification is being requested.

Verification can be provided by collateral contact, a signed written statement from a non-household member, or Form PAFS-702, Proof of No Income.
MAGI calculations allow for certain deductions from the Adjusted Gross Income (AGI). Verification of MAGI deductions is not mandatory. If an individual fails to provide the requested documentation, eligibility will be determined without the deduction.

[A. Educator Expenses:

1. The maximum allowable deduction is $250.00 for a single filing status or $500.00 for a married filing joint tax return;

2. Acceptable verifications are Federal Tax Forms 1040 (Line 23) or Federal Tax Form 1040A (Line 16).

B. Student Loan Interest:

1. The deduction should be entered on Worker Portal under the person responsible for the expense;

2. The maximum allowable deduction is $2,500.00.

3. Acceptable verification is Form 1098-E, Federal Tax Form 1040 (Line 33) or Federal Tax Form 1040A (Line 18).

C. Contributions to Health Savings Account:

1. The deduction should be entered on Worker Portal under the person making the contribution;

2. The maximum allowable deduction is $3,450.00 for a single filing status or $6,900.00 for a family filing status.

3. Acceptable verifications are check stubs under Voluntary Deductions, annual statements or Federal Tax Form 1040 (Line 25).

D. IRA Contributions:

1. The deduction should be entered on Worker Portal under the person responsible for the contribution;

2. The maximum allowable deduction is $5,500.00.

3. Acceptable verification is Federal Tax Form 1040 (Line 32).

E. Alimony:

1. The deduction should be entered on Worker Portal under the person making the contribution;

2. The deduction can only be allowed if the separation or divorce agreement is finalized on or before 12/31/18.
Note: The deduction cannot be allowed if the separation or divorce agreement is finalized on or after 12/31/18.

3. Acceptable verifications are Federal Tax Form 1040 (Line31a) or Court Documents to verify the amount of the deduction. Acceptable verifications are Separation or Divorce Agreement to verify the finalized date.
MS 3190*  COUNTABLE INCOME  (1)

Countable income is money received by an individual that is considered in determining financial eligibility for MAGI Medicaid. The amount of countable income is determined based on the tax filing requirement, even if the individual does not intend to file taxes. Countable income for MAGI Medicaid includes, but is not limited to the following:

A. Wages and salaries, including bonuses received from an employer;
B. Self-employment, including farm and rental income;
C. Participant Directed Services (PDS). This is formerly known as Consumer Directed Options (CDO). Note: PDS income is only countable in MAGI Medicaid if being received for caring for a member outside of the household;
D. Statutory benefits, such as Unemployment Insurance Benefits (UIB) and RSDI;
E. Contributions from family and friends;
F. All student work study income;
G. Alimony payments if the separation or divorce agreement is finalized on or before 12/31/18;
H. Earned income of children requiring them to file taxes. The earned income threshold for tax year 2019 is $12,200.
I. RSDI of children if they are living with someone other than a parent;
J. Nonrecurring lump sums;
K. Annuity payments;
L. Pensions and Retirement;
M. Adult foster care income if the provider cares for more than five individuals;
N. Gift Cards received on an ongoing basis, as a method of payment for services rendered, or given in exchange for other types of income;
O. Payments received under the Senior Community Service Employment Program (SCSEP) as authorized by Title V of the Older Americans Act if taxes are withheld;
P. Trade Readjustment Allowances (TRA) under the Trade Act. These payments are an extension of unemployment benefits;
Q. Funds withdrawn from a trust;
R. Ready to Work; and
S. Lottery winnings.
EXCLUDED INCOME

Income received by an individual but not considered in determining their financial eligibility for Medicaid is referred to as excluded income. In addition to income for which there is not a federal tax requirement, the following types of income are considered as excluded income for MAGI Medicaid:

A. Child Support;
B. Black Lung;
C. Worker’s Compensation;
D. Veteran’s Disability (Both VA Pension and VA Compensation);
E. KTAP and Kinship Care payments;
F. SSI benefits and any other income of SSI beneficiaries;
G. SSI essential person’s portion of the SSI payment;
H. Low Income Home Energy Assistance Program (LIHEAP) payments;
I. In-kind income;
J. Any payment made by the Division of Protection and Permanency (DPP) for child foster care, adult foster care, subsidized adoptions, or personal care assistance;
K. Adult foster care income if the provider cares for less than five individuals;
L. Home produce for household consumption;
M. Vendor payment income, payments on behalf of or for the benefit of the individual made DIRECTLY to a doctor, pharmacist, landlord, or utility company by another individual;
N. Income of a child technically excluded from MA case;
O. MAGI Medicaid child’s income when below the limit required to file Federal Income Tax;
P. Educational scholarships, awards, and fellowships used for educational purposes
Q. Highway relocation assistance;
R. Urban renewal assistance;
S. Federal disaster assistance and State disaster grants;
T. Reparation payments from the Federal Republic of Germany;
U. Experimental housing allowance program payments made under the annual contributions contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended, and HUD Section 8 payments for existing housing under Title 24, Part 882;

V. Public Law benefits and payments to:

1. Elderly persons under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;

2. VISTA volunteers under Title I of PL 93-113 to Section 404(g);

3. Individual volunteers for supportive services or reimbursement of out-of-pocket expenses while serving as foster grandparents, senior health aides or senior companions and to persons serving in Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other programs under Titles II and III, pursuant to Section 418 of PL 93-113;

4. Indian tribe members under PL 92-524, PL 92-134, and PL 94-114 pursuant to Section 5 effective October 17, 1975 or PL 94-540;

5. Natural children of women’s veterans who served in Vietnam during the Vietnam era who receive benefits based on Sec. 401 of the Veteran Benefits and Health Care Improvement Act of 2000, Public Law 106-419;

W. Consider the income not available when the parties of jointly held income are not willing to release their portion of the income or one party cannot be contacted for a release of his/her portion. Verify that litigation would be required or is pending to determine to whom an income belongs.

X. Reimbursement for:

1. Training-related expenses made by a manpower agency to recipients in institutional or work experience training;

2. Transportation, lodging and meals in performance of employment duties, if identifiable; and

3. Training-related expenses or other reimbursements by WIA to a MA child.

Y. Income excluded by terms of a trust;

Z. Education related transportation payment and school supplies provided by a public agency or nonprofit organization;

AA. 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;

BB. Federal tax refunds including advance Earned Income Tax Credit (EITC) payments;
CC. All payments received from Agent Orange;

DD. Interest on burial reserves, if allowed to accrue;

EE. Any payments received from the Radiation Exposure Compensation Trust Fund;

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

GG. Educational grants and scholarships obtained and used, even if conditions do not preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill; education payments made under the Carl D. Perkins Vocational and Applied Technology Educational Act Amendments of 1990 made available for attendance costs. Attendance costs are described as:

1. Tuition and fees normally assessed for a student carrying the same academic workload as determined by the institution, and including cost for rental or purchase of any equipment, materials or supplies required of all students in the same course of study; and

2. Allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

HH. AmeriCorps educational awards paid directly to the institution;

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

JJ. Money paid to hemophiliacs as a part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using SSI standards. This income is NOT excluded by SSA, so these recipients should not be SSI eligible;

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

LL. Family Alternatives Diversion (FAD) payments;

MM. Kentucky Works Program (KWP) supportive services and transportation payments;

NN. 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;

OO. Gifts, Loans, and Inheritances;
PP. Participant Directed Services (PDS) income is excluded if it is not taxable and being received for caring for a household member. Note: PDS income is countable if being received for caring for a member outside of their household; and

[QQ. Alimony payments are excluded if the separation or divorce agreement is finalized on or after 12/31/18. Note: Alimony payments are considered countable income if the separation or divorce agreement was finalized on or before 12/31/18.]
Tweeners refers to individuals with ongoing monthly income over 138% Federal Poverty Level (FPL), but their total yearly income from all sources is below 100% FPL. These situations typically occur at the end of the year when an individual experiences an increase in income, such as starting a new job or receiving a raise. When this occurs, the tweener is financially eligible for Medicaid until the end of the year. However, in order to maintain eligibility, they must continue to meet technical requirements such as residency, age, and citizenship.

Note: Tweeners must state they intend to file taxes in order to be eligible for Medicaid.

A. The following are examples of situations that may cause an individual to become a tweener:

1. Sue has been approved for RSDI of $1,405 monthly beginning in July. This is her only source income for the year. Her monthly income is over 138% FPL. However, her yearly income is below 100% FPL.

   Calculations: $1,405 (monthly RSDI) x 6 (July to Dec) = $8,430. The 100% FPL for one is $1,012 x 12 = $12,144 (yearly amount).

2. Jon has been laid off from his job and has started receiving $1,500 monthly UIB effective October. Before he was laid off, he grossed $10,000 for this year. His monthly income is over 138% FPL. His yearly income is also over the 100% FPL and he is not eligible for Medicaid as a tweener.

   Calculations: $1,500 (monthly UIB) x 3 (Oct to Dec) = $4,500. Jon’s total yearly income is: $4,500 + $10,000 = $14,500. The 100% FPL for one is $1,012 x 12 = $12,144 (yearly amount).

3. Kay started a new job in September and makes $1,600 monthly. This is her only source of income for the year. Her monthly income is over 138% FPL. However, her yearly income is below 100% FPL.

   Calculations: $1,600 (monthly income) x 4 (Sept to Dec) = $6,400. The 100% FPL for one is $1,012 x 12 = $12,144 (yearly amount).

B. When tweener status is reported or discovered, send the case to MSBB through the regional program specialist to request further guidance on system entry.
Some families receiving Medicaid (MA) in the Parent Caretaker Relative (PACA) type of assistance (TOA) may receive up to 12 months of Transitional Medical Assistance (TMA) if they have increased income which exceeds the MA Scale. The parent/caretaker relative must have received MA in the PACA TOA in 3 of the prior 6 months. The parent/caretaker relative must continue to meet technical eligibility requirements for the PACA TOA including having a dependent child in the household.

A. Families may be eligible for TMA if the parent/caretaker relative is no longer income eligible for Medicaid due to:

1. New or increased earned income which causes household income to exceed the MA scale; or

2. New or increased spousal support which causes household income to exceed the MA scale.

B. The following are the different TOA’s for TMA:

1. TMAE – adult in TMA household with earnings.
2. TMCE – child in TMA household with earnings.
3. TMAS – adult in TMA household with spousal support.
4. TMCS – child in TMA household with spousal support.

C. TMA recipients are required to participate in managed care.

D. TMA eligibility begins the first month the parent/caretaker relative becomes ineligible for PACA.

E. When TMA is discontinued, Worker Portal will explore eligibility in other TOA’s.
Transitional Medical Assistance (TMA) with earnings consists of two 6 month periods of eligibility. TMA with spousal support consists of one 4 month eligibility period. There is no income limit for TMA with earnings in the first 6 month eligibility period. TMA with spousal support has no income limit for the entire 4 month eligibility period.

A. TMA with Earnings

1. In the first 6 months of TMA receipt individuals are required to report their income in the 4th month to determine income eligibility for the second 6 months of TMA.

2. In the second 6 months of TMA receipt the countable household income must not exceed 185% of the Federal Poverty Level (FPL). In the 7th and 10th months of TMA receipt, income must be reported to determine continuing eligibility for TMA.

3. Form MA-800, Transitional Medical Assistance Report Form, is used to report income in the 4th, 7th, and 10th months.
   a. Form MA-800 is issued on the 21st day of the month prior to the report month.
   b. If form MA-800 is not received by the 10th day of the report month, the MA-801 reminder notice is issued along with another form MA-800.

B. TMA with Spousal Support

There are no reporting requirements or income limits for TMA with spousal support.
Form MA-800, Transitional Medical Assistance Report Form, is considered untimely if received after the 21st day of the report month. If form MA-800 is received after the 21st, make a good cause determination.

A. Good cause exists for returning form MA-800 untimely if one of the following reasons are met:

1. The parent/caretaker relative is out-of-town for the entire reporting period;
2. An immediate family member living in the home is institutionalized or died during the reporting period;
3. The household was the victim of a declared natural disaster, such as a flood, storm, earthquake or serious fire; or
4. The household moved and reported the move timely, but the move resulted in a delay in receiving or failing to receive the report form.

B. If good cause exists for the untimely return of form MA-800 and the case has discontinued, the case should be reinstated.

C. If form MA-800 is received untimely and good cause does not exist, Transitional Medical Assistance (TMA) will end and Worker Portal will explore eligibility in a different type of assistance (TOA).
Individuals who are not eligible for Medicaid but are looking for affordable health care coverage may enroll in a qualified health plan (QHP) through the Federally Facilitated Marketplace (FFM). In addition to enrolling in a QHP, individuals can also apply for financial assistance towards paying for a QHP on the FFM through the Advanced Premium Tax Credit (APTC) program.

A. A QHP is a commercial insurance plan offered through the FFM. These plans are offered to individuals at full premium cost or with premium assistance for qualified individuals.

B. APTC is premium payment assistance for individuals and families whose income is between 100% and 400% of the Federal Poverty Level (FPL). The assistance is in the form of a tax credit that can be applied monthly or utilized as an annual tax credit when filing a federal income tax return. An individual must be determined ineligible for Medicaid in order to qualify for APTC.

C. Individuals receiving Medicare are not eligible to purchase a QHP or receive APTC.

D. An individual may submit an application for APTC or QHP at any time during the year, but the individual can only enroll in a QHP during open enrollment and special enrollment periods.
Beginning with the 2017 open enrollment period (November 1, 2016 – January 31, 2017) all Advanced Premium Tax Credit (APTC) and Qualified Health Plan (QHP) eligibility determinations for the 2017 coverage year will be made by the Federally Facilitated Marketplace (FFM).

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

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

B. Individual applies through the FFM:
   1. If an individual is approved for APTC and/or QHP, no account transfer to Worker Portal will occur.
   2. If an individual is found to be potentially eligible for Medicaid, an account transfer will occur from the FFM to Worker Portal so that a Medicaid eligibility determination can be made.

   a. Account transfers from the FFM will attempt to automatically run eligibility; however, there are instances in which worker intervention will be required before eligibility can be determined. When worker intervention is required, one of the following tasks will be created:

      1) **Incoming Application Task** – Created when an incoming account transfer is missing necessary information for eligibility to be determined;

      2) **Report a Change or Renewal Task** – Created when an individual in a Mixed Household reports a case change, or initiates an APTC/QHP renewal at the FFM;

      3) **Failed Member Match** – Created when an individual in an account transfer has a partial or full member match with an individual already present in Worker Portal.
C. Mixed Households:

1. These are households which consist of at least one member receiving Medicaid or KCHIP and at least one member receiving APTC and/or QHP.

2. In these situations a household will have an account with, and eligibility determined by, both the FFM and DCBS.

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

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

The parents are both assessed as potentially eligible for 2017 coverage year APTC/QHP and have their account transferred to the FFM for their APTC/QHP eligibility to be determined.
This is a general glossary of commonly used acronyms associated with Modified Adjusted Gross Income (MAGI) Medicaid. Detailed definitions of the more commonly used terms can be found in MS 1050, MAGI Medicaid Definitions.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>APTC</td>
<td>Advance Premium Tax Credit</td>
</tr>
<tr>
<td>AR</td>
<td>Authorized Representative</td>
</tr>
<tr>
<td>CAC</td>
<td>Certified Application Counselors</td>
</tr>
<tr>
<td>CBW</td>
<td>Children’s Benefit Worker</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CSE</td>
<td>Child Support Enforcement</td>
</tr>
<tr>
<td>DCBS</td>
<td>Department for Community Based Services</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Homeland Security</td>
</tr>
<tr>
<td>DMS</td>
<td>Department for Medicaid Services</td>
</tr>
<tr>
<td>ECF</td>
<td>Electronic Case File</td>
</tr>
<tr>
<td>EDG</td>
<td>Eligibility Determination Group</td>
</tr>
<tr>
<td>ESI</td>
<td>Employer Sponsored Insurance</td>
</tr>
<tr>
<td>FFM</td>
<td>Federally Facilitated Marketplace</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>KCC</td>
<td>Kentucky Career Center</td>
</tr>
<tr>
<td>KCHIP</td>
<td>Kentucky Children’s Health Insurance Program</td>
</tr>
<tr>
<td>KI-HIPP</td>
<td>Kentucky Integrated Health Insurance Premium Payment</td>
</tr>
<tr>
<td>KOG</td>
<td>Kentucky Online Gateway</td>
</tr>
<tr>
<td>LPR</td>
<td>Lawful Permanent Resident</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>MA</td>
<td>Medicaid</td>
</tr>
<tr>
<td>MAGI</td>
<td>Modified Adjusted Gross Income</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>MEC</td>
<td>Minimum Essential Coverage</td>
</tr>
<tr>
<td>MSBB</td>
<td>Medical Support and Benefits Branch</td>
</tr>
<tr>
<td>MSE</td>
<td>Medical Support Enforcement</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
<tr>
<td>PARIS</td>
<td>Public Assistance Reporting Information System</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>PDS</td>
<td>Participant Directed Services</td>
</tr>
<tr>
<td>PE</td>
<td>Presumptive Eligibility</td>
</tr>
<tr>
<td>POA</td>
<td>Power of Attorney</td>
</tr>
<tr>
<td>PRTF</td>
<td>Psychiatric Residential Treatment Facility</td>
</tr>
<tr>
<td>PTC</td>
<td>Premium Tax Credit</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>QHP</td>
<td>Qualified Health Plan</td>
</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
</tr>
<tr>
<td>RFI</td>
<td>Request for Information</td>
</tr>
<tr>
<td>RSDI</td>
<td>Retirement, Survivors, Disability Insurance</td>
</tr>
<tr>
<td>SLMB</td>
<td>Specified-Low Income Medicare Beneficiaries</td>
</tr>
<tr>
<td>SSA</td>
<td>Social Security Administration</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
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<td>---------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
</tr>
<tr>
<td>SSP</td>
<td>Self Service Portal</td>
</tr>
<tr>
<td>SUD</td>
<td>Substance Use Disorder</td>
</tr>
<tr>
<td>TPL</td>
<td>Third Party Liability</td>
</tr>
<tr>
<td>TMA</td>
<td>Transitional Medical Assistance</td>
</tr>
<tr>
<td>TOA</td>
<td>Type of Assistance</td>
</tr>
<tr>
<td>USCIS</td>
<td>United States Citizenship and Immigration Services</td>
</tr>
</tbody>
</table>
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 a 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.

   Note: Individuals receiving Time-Limited Medicaid or Kentucky Children’s Health Insurance Program (KCHIP) are not eligible to receive KI-HIPP benefits. However, Individuals do not have to be receiving in a KI-HIPP eligible Type of Assistance (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 to KI-HIPP staff regularly. This verification may be turned in through the following methods:
   a. Uploading documents via the benefind Self Service Portal (SSP);
   b. Emailing documents directly to KI-HIPP staff at KIHIPP.Program@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.