

Division of Family Support
OPERATION MANUAL
Volume IVB

OMTL-673

MAGI Medicaid, APTC/CSR, and QHP
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MAGI MEDICAID OVERVIEW

MS 1000

(1)

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 Worker Portal. Applications may also be entered on the kynect benefits 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 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.

*MS 1040 DISCLOSURE OF MEDICAID INFORMATION (1)

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

- A. Public employees including any identified representative of the Department of Health and Human Services in the performance of their duties in connection with the administration of the public assistance or child support enforcement programs pursuant to part D of Title IV of the Social Security Act.
- B. Law enforcement agencies and their representatives including county and commonwealth attorneys, district and circuit court judges, and grand juries in discovering and prosecuting cases involving fraud.
 - 1. Potential Medicaid fraud may be identified by the Kentucky State Police during the course of other investigations. Form KSP-58, Request for Confidential Information, is utilized by the Kentucky State Police when requesting information concerning fraud or potential fraud investigations, whether identified by the Department for Community Based Services (DCBS) or another source.
 - 2. Upon presentation of form KSP-58 for the release of information, ensure it is completed in its entirety.
 - 3. If the form KSP-58 is not completed in its entirety DO NOT release the information and DO NOT sign the form.
 - 4. If the requesting officer indicates they wish to take case record material out of the office, offer to print the necessary documents from the Electronic Case File (ECF).
- C. Members of Congress and the General Assembly are limited to cases of individual constituents who have requested information regarding their application or Medicaid status.
- D. Any representative that has requested a hearing before an agency hearing officer, to the extent necessary for the proper presentation of the case. The release of information under this provision is limited to only that information applicable to the hearing request. In addition, any information or names obtained shall not be used for commercial or political purposes.
- E. Any audit or similar activity, e.g., review of expenditure reports or financial review, conducted in connection with the administration of any federal or federally assisted program. For Medicaid, the audit/activity must be conducted in connection with the administration of the Medicaid program. This is limited to governmental entities authorized by law to conduct such an audit or activity.

- F. Officials administering any title IV-E foster care and adoption assistance programs.
- G. Local law enforcement agency, the Kentucky State Police, Commonwealth or county attorney to report known or suspected instances of child abuse or neglect of a child receiving assistance. The local office cooperates in providing information necessary to verify a suspected or known senior or child abuse situation which has been reported to the proper authorities.
- H. Attorneys, absent parents, etc., who appear in the local office with a court order carrying a signature of a judge, or an individual with the authority of a judge such as a Domestic Relations Commissioner. If the court ordered information is due within 10 calendar days, the information can be released. If the local office has any questions on whether the court order meets the specified criteria or the local office has more than 10 calendar days to provide the information, contact the Medical Support and Benefits Branch (MSBB) through the Regional Office. Unless otherwise notified by regional office staff or the court, court orders must be followed. For procedures regarding subpoena requests, refer to Volume I, MS 0175.
- I. Board of Elections officials may only view forms and/or information utilized directly in the voter registration process. Otherwise, voter registration information remains confidential.

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

MS 1050 DEFINITIONS (1)

Terms used in MAGI Medicaid:

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.

ACTUARIAL VALUE: The average share of medical spending that is paid by a health plan as opposed to being paid out of pocket by the member.

ADVANCE PREMIUM TAX CREDIT (APTC): A tax credit to lower the monthly premium of health plans offered through the state based marketplace for families earning less than 400% of the Federal Poverty Level (FPL). These individuals are not income eligible for Medicaid. For Plan Years 2021 and 2022, individuals with income above 400% of FPL will be eligible for APTC. They will be required to contribute no more than 8.5% of household income toward the silver benchmark plan.

AGENTS: Individuals licensed by the state to sell insurance.

BENEFIT YEAR: The calendar year for which a health plan provides coverage for health 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.

CATASTROPHIC COVERAGE: Coverage available to individuals who are under the age of 30, individuals who are 30 or over who qualify for a hardship/affordability exemption certificate. Premium tax credits (APTC) cannot be used with catastrophic plans.

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

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

COST SHARING REDUCTION (CSR): A reduction of an individual's portion of payment for certain medical services, for example co-payments, deductibles, and coinsurance.

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 12 month postpartum period regardless of when Medicaid coverage is requested. This does not apply to individuals who move out of state during this period and is not

dependent on Medicaid eligibility at the time of birth.]

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

ENROLLEE: An eligible individual enrolled in a Qualified Health Plan (QHP).

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.

KYNECTOR: Individuals certified to assist with applications for Medicaid. Kynectors enter applications on the kynect benefits Self-Service Portal (SSP) and help individuals applying for APTC/QHP.

KYNECT BENEFITS: The website where an individual, Authorized Representative (AR), or kynector can enter an application for benefits.

KYNECT HEALTH COVERAGE: Kentucky's state-based health insurance marketplace. It's a one-stop shop that allows individuals, families, and small employers to access a range of health options including Medicaid, KCHIP, APTC, CSR, QHP, and KI-HIPP. Kynect health coverage is available through kynect benefits.

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 the individual to receive waiver services, Institutionalized Hospice, or have placement in a Nursing Facility.

LOW INCOME ADULT: Individuals aged 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.

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

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.

NAVIGATORS: Members of the community, public or private entities, or individuals that are to provide educational materials and help assist individuals in the selection of a QHP. These individuals are also a part of the kynector program.

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 HEALTH PLAN (QHP): A commercial insurance plan offered to Kentucky residents through kynect benefits.

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

QUALIFIED INDIVIDUAL: An individual determined eligible to enroll in a QHP through the state based marketplace.

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.

STATE BASED MARKETPLACE (SBM): An online marketplace for individuals and employers to compare and shop for insurance. Applications can also be completed for Medicaid and APTC. Kentucky's state based marketplace is referred to as kynect health coverage.

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 kynect benefits.

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.

[TWEENER: An individual with ongoing monthly income over 138% Federal Poverty Level (FPL), but whose total yearly income, from all sources, is below 100% FPL.]

WORKER PORTAL: The employee-facing system on which eligibility determinations for Child Care Assistance, Family Assistance Short-Term Program (FAST), Kentucky Transitional Assistance Program (KTAP), Kinship Care, Medicaid, Supplemental Nutrition Assistance Program (SNAP), and State Supplementation are completed. Worker Portal is also known as the Integrated Eligibility Enrollment System (IEES).

MS 1070 CATEGORIES OF ASSISTANCE (1)

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.

| TOA | Category | FPL | FPL with 5% |
|------|-----------------------------|------|-------------|
| CHL1 | Medicaid Children < age 1 | 195% | 200% |
| CHL2 | Medicaid Children ages 1-5 | 142% | 147% |
| CHL4 | Medicaid Children ages 6-18 | 109% | N/A |
| TP45 | Deemed Eligible Newborns | N/A | N/A |

[Note: These TOAs are dually eligible with the Medicare Savings Program.]

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

| TOA | Category | FPL | FPL with 5% |
|------|----------------------------|------|-------------|
| CHL3 | KCHIP Children ages 6 < 19 | 142% | 147% |
| CHEX | KCHIP Children age 0<19 | 213% | 218% |

B. Pregnant Women: This category includes women who are pregnant or in the 12 month postpartum period. The TOA for women receiving Medicaid as a pregnant woman is PREG, ADPR, or CHPR. For policy regarding pregnant women, refer to [MS 2600](#).

| TOA | Category | FPL | FPL with 5% |
|------|----------------|------|-------------|
| ADPR | Pregnant Adult | 138% | N/A |
| CHPR | Pregnant Woman | 213% | 218% |
| PREG | Pregnancy | 195% | 200% |

[Note: The PREG TOA is dually eligible with the Medicare Savings Program.]

C. Parents and Caretaker Relatives: This category includes individuals who are either the parents of, or a relative providing care for, a child under the age of 19. The child must be living in the same household and be related to the individual by blood, marriage, or adoption. Please note that if the child's parent(s) also resides in the home, another individual cannot be designated as a caretaker relative. The countable income for the EDG is compared to the appropriate Medicaid Income Scale. The TOA for individuals receiving Medicaid as a parent/caretaker relative is PACA.

[Note: This TOA is dually eligible with the Medicare Savings Program.]

- D. Low Income Adults: The category includes individuals ages 19 through 64 who are not eligible to receive Medicare and are also not eligible in any other category of assistance. Note: If an individual is eligible for Medicare but chooses not to enroll, they are not eligible to receive Medicaid as a low income adult. 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.

MS 1075 TYPE OF ASSISTANCE (1)

The following are the types of assistance, program names, and descriptions for each eligibility group used to identify eligible MAGI Medicaid individuals:

| <u>TOA</u> | <u>Program Name</u> | <u>Description</u> |
|------------|---|---|
| ADFF | Former Foster Care | Individuals who aged out of foster care in another state and have income at or below 138% of the Federal Poverty Level (FPL). |
| ADLT | Low-Income Adult | Modified Adjusted Gross Income (MAGI) Adult |
| ADPR | Pregnant Adult | Women who report pregnancy while receiving Medicaid in the ADLT TOA and whose household income is at or below 138% FPL. |
| APTC | Advance Premium Tax Credit | A tax credit to assist with paying the monthly premium of health plans offered through the marketplace. |
| [ASCC | ASMA Continuous Coverage | Continuous coverage for child in Adoption Subsidy.] |
| CHEX | KCHIP | Children between 1 and 19 without private insurance. |
| CHL1 | Child < 1 | Newborn child less than 1. |
| CHL2 | Child | Children between 1 and 6. |
| CHL3 | KCHIP | Children between 6 and 19 without private insurance. |
| CHL4 | Child | Children between 6 and 19. |
| [CHCC | Child Continuous coverage | Continuous coverage for a child.] |
| CHPR | Pregnant Woman | Pregnant woman between 19 and 64 without private insurance and with income less than 218% FPL (including 5% disregard). |
| [CXCC | KCHIP Continuous Coverage | Continuous coverage for KCHIP child. |
| DJCC | DJJM Continuous Coverage | Continuous coverage for a child in DJJ.] |
| DJJM | Department of Juvenile Justice (DJJ) Medicaid | Children under DJJ custody who are in residential homes or in the community, but not residing in a DJJ facility. |
| EMC1 | Time-Limited MA for MAGI Children | Time-Limited MA for children under age 19 with an emergency medical condition who does not meet qualified immigrant requirements. |
| EMC2 | Time-Limited MA for Pregnant Women | Time-Limited MA for a pregnant women with an emergency medical condition who do not meet qualified immigrant requirements. |

| | | |
|-------|---------------------------------|---|
| EMC3 | Time-Limited MA for PACA | Time-Limited MA for a parent/caretaker relative with an emergency medical condition who does not meet qualified immigrant status. |
| EMC4 | Time-Limited MA for MAGI Adults | Time-Limited MA for a low-income adult between ages 19-64 with an emergency medical condition who does not meet qualified immigrant status. |
| [FCCC | FCMA Continuous Coverage | Continuous coverage for foster care child.] |
| FFCC | Former Foster Care | 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. |
| FFOS | Former Foster Care | 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. |
| PACA | Parent/Caretaker Relative | A parent or caretaker relative with a child under age 19 in the household. |
| PREG | Pregnancy | Pregnant Woman |
| QHCP | Qualified Health Plan | A commercial insurance plan offered to Kentucky residents through the marketplace. |
| [SICC | SSIR Child Continuous Coverage | Continuous coverage for an SSI Child.] |
| SPMA | Spend Down for MAGI Medicaid | 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. NOTE: Individuals who are only technically eligible for Medicaid in the ADLT TOA are not eligible for a MAGI Spend Down. |
| TP45 | Deemed Eligible Newborn | A child under age 1 who was born to a mother receiving Medicaid for the birth month. |

MS 1100* EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (1)

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.

| MEDICAL SCREENING | | DENTAL SCREENING | |
|-------------------|----------|------------------|----------|
| 0-1 month | 8 years | 6-12 months | 15 years |
| 2 months | 9 years | 12-24 months | 16 years |
| 4 months | 10 years | 2 years | 17 years |
| 6 months | 11 years | 3 years | 18 years |
| 9 months | 12 years | 4 years | 19 years |
| 12 months | 13 years | 5 years | 20 years |
| 15 months | 14 years | 6 years | |
| 18 months | 15 years | 7 years | |
| 24 months | 16 years | 8 years | |
| 30 months | 17 years | 9 years | |
| 3 years | 18 years | 10 years | |
| 4 years | 19 years | 11 years | |
| 5 years | 20 years | 12 years | |
| 6 years | | 13 years | |
| 7 years | | 14 years | |

*MS 1120 MEDICARE SAVINGS PROGRAMS AND DUAL ELIGIBILITY (1)

Some individuals may receive a Medicare Savings Program (MSP) and be dually eligible to receive MAGI Medicaid benefits. Dual eligibility is determined based on the Medicaid type of assistance (TOA) and can be approved/discontinued as an individual transitions between MAGI categories.

A. QMB recipients are dually eligible with the following MAGI TOAs:

1. Pregnant Women (PREG)
2. Parents and Caretaker Relatives (PACA)
3. Transitional Medical Assistance (TMAE, TMCE, TMAS, TMCS)
4. Child Continuous Coverage (CHCC)
5. Qualified Health Plan (QHP) and Advance Premium Tax Credit (APTC when specific criteria are met).

B. SLMB recipients are dually eligible with the following MAGI TOAs.

1. Pregnant Women (PREG)
2. Parents and Caretaker Relatives (PACA)
3. Transitional Medical Assistance (TMAE, TMCE, TMAS, TMCS)
4. Child Continuous Coverage (CHCC)

C. QI1 is not dually eligible with any other Medicaid TOAs. When it is determined an individual may be eligible for another TOA, the individual must decide which TOA they want to receive. Thorough case must be entered to explain which TOA the individual chooses to receive.

D. Individuals who are eligible for or receiving Medicare are not technically eligible for Medicaid in the ADLT or ADPR types of assistance. Therefore, there is no dual eligibility for the ADLT and ADPR TOAs and an MSP.

E. Children who receive KCHIP and pregnant women who receive CHPR are not eligible for Medicaid if they have other health insurance, including Medicare. For this reason, there is no dual eligibility for any KCHIP or CHPR TOAs.

MS 1200 APPLICATION/INTERVIEW PROCESS (1)

All individuals have the right to make an application and receive a decision on their eligibility for Medicaid, Advance Premium Tax Credit (APTC), Cost Sharing Reduction (CSR), and Qualified Health Plans (QHP). 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.kynect.ky.gov; or
6. In person at any DCBS office.

B. Individuals applying for Medicaid, APTC, or QHP by phone or in-person must be interviewed.

Interviews are not required for applications made via the kynect benefits 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 automatically determine eligibility for APTC and CSR; and
3. Inform the individual that in addition to determining eligibility for MAGI Medicaid, APTC, and CSR, Worker Portal will also automatically determine eligibility for QHP.

F. During the interview:

1. Inform the individual of their rights and responsibilities;
2. Review form MA-2, Medicaid Penalty Warning, and obtain the individual's 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 individuals applying for Medicaid have incurred medical expenses in the prior three months. Case Notes must be entered to reflect that retroactive Medicaid was explored and include any months coverage that was requested. 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 individual 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. Inform the individual of the APTC/CSR eligibility processes:

- a. Explain that individuals applying for APTC must agree to file a federal income tax return for the time period any benefits are received;
- b. Explain spouses *must* file a joint return to be eligible for APTC;
Note: Individuals may file married filing separately and be eligible for APTC if they are victims of domestic abuse and spousal abandonment.
- c. Explain that individuals must attest that no one else will claim them as a dependent on their federal income tax return for the benefit year;
- d. Explain that individuals must attest that they will claim a personal exemption deduction on their federal tax return for any individual who is listed on the application as a dependent, who is enrolled in coverage through kynect health coverage, and whose premium for coverage is covered in whole or part by APTC in the benefit period;
- e. Explain that all changes are required to be reported within 30 days of the date of the change;
- f. Explain that individuals may apply the full amount of APTC they have been approved to receive or any portion of that amount towards the purchase of any metal level plan of their choosing;
- g. Explain that any and all discrepancies will be reconciled by the Internal Revenue Service (IRS) when the individual files their tax return for the benefit year;
- h. Explain if determined eligible for CSR, the individual must enroll in a silver level metal plan to receive this benefit. Note: American Indian/Alaskan Native (AIAN) individuals can enroll in any metal plan to receive CSR; and
- i. Explain that if additional verification is required for the APTC/CSR application the case will approve for 90 days based on client attested information. The individual will be issued an RFI with what documentation is required. If the requested documentation is not provided at the end of 90 days, the case will discontinue the next administratively feasible month.

16. Inform the individual of the QHP eligibility processes:

- a. Explain that insurance agents are the only individuals qualified to recommend a plan;
- b. Explain that an individual does not have to select a plan on the day of application; however, if the individual does not make a selection by the 15th of the month, the plan will not be effective the first of the next month. Individuals who experience certain qualifying events may be able to pick a plan by the last day of the month and have coverage start the first day of the next month. For more information on qualifying events refer to [MS 4300](#).

For example, an individual applies for QHP and is approved on January 3rd. The individual does not select and enroll in a plan until January 20th. The plan will be effective March 1st as they enrolled after the 15th of the month;

- c. Explain that individuals can only select a plan outside the open enrollment period if they have a qualifying event;

- d. Explain that the initial payment for a QHP must be received by the issuer within 7 calendar days of the coverage effective date. Coverage does not become active until the first premium is paid; and
 - e. Explain to the individual that kynect will direct an individual to an issuer's website for online payments. If an individual does not wish to pay online, payment arrangements must be made through the issuer in accordance with their payment process.
17. Enter all required case notes, ensuring any unusual circumstances or verification is documented; and
 18. 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.

*MS 1205

AUTHORIZED REPRESENTATIVES

(1)

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](#).

MS 1210

KYNECTORS

(1)

[Kynectors 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. Kynectors interview applicants and enter the individual's information on the kynect benefits 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 system will automatically determine eligibility for Advance Premium Tax Credit (APTC) and a Qualified Health Plan (QHP).]

- A. The KY Assister Consent Form Appendix B is used to designate a new kynector. 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: Kynectors 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. Kynectors 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 kynector. Designated kynector information can be found on the Case Summary screen under the Assister tab.
- C. There are three types of kynectors: In-Person kynectors, Navigators, and Certified Application Counselors (CAC).
1. In-Person kynectors 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 kynectors are not required to provide education or outreach.

MS 1215*

CASE NOTES

(1)

Comprehensive and thorough Case Notes are crucial, especially with statewide processing. Case Notes are necessary in order to capture information that may conflict with system entries or that require explanation beyond data found on Worker Portal. Case Notes are also necessary to address any unusual circumstances regarding an individual's eligibility.

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

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

A. Interview:

1. The type of interview.
2. Any deviation in normal office operating procedures, such as home visit interview, paper application, sign language interpreter used, etc.
3. The worker reviewed prior Case Notes.
4. Rights and Responsibilities were explained and the individual states that they understand.
5. All required forms were given.
6. The reason a Request for Information (RFI) was issued.
7. Reason for any delays in case processing.
8. If Medicaid is pending, document in Case Notes the individuals preferred Managed Care Organization (MCO). For applicants who do not select an MCO, annotate Case Notes with this information.
9. The KI-HIPP program was explained to the individual.

B. Residency: The individual is a Kentucky resident, how residency is verified, and if questionable.

C. Household Composition: How household composition is verified, reasons for excluding a household member, and if questionable.

D. Citizenship: The individual is a U.S. citizen or an immigrant and methods used to verify.

E. Identity: Methods used to verify identity.

F. Income:

1. All types of income, who receives the income, and how income is verified.
2. If the individual has no income, how no income is verified, and if questionable.
3. Income calculations that conflict with standard procedures or system entries.
4. Explain excluded income types.
5. The reason a check stub is not included in ongoing projections.
6. The reason a tax return or personal records used to verify self-employment income are not reflective of ongoing income.
7. Explain any income entered as "Other".

G. Deductions: The type, and amount, of MAGI deduction and how it is verified.

H. Medical Expenses:

1. Retroactive coverage was discussed, months that were requested, and if it was issued.
2. Third Party Liability (TPL) was explored and the requirement to report other health insurance was explained.

I. Procedural/Case Record Information:

1. Whether the Medicaid effective date was backdated or if the standard of promptness was not met.
2. If a claim is suspected and reason it is or is not referred.
3. Changes in the certification period.
4. Document any special circumstance issuance.
5. Program inquiries/directives from Central Office.
6. The household's voluntary request for a denial or discontinuance.
7. If additional time is requested to return mandatory verification, the individual must explain what action they have taken to obtain the verification and document in Case Notes.
8. If the case is a 30/60 reapplication.

9. If the KIP-105.1, Notice of Eligibility, has an incorrect denial/discontinuance reason and form MA-105, Notice of Eligibility for Medicaid, is sent to the individual.
10. Resolution of a System Match.
11. All case changes must be documented.
12. If the case is sent to the Help Desk, enter details of the issue, any action taken based on special instructions from the Help Desk, and any ticket number assigned.

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

MS 1250 ELECTRONIC CASE FILE (1)

[All case records represent a continuing documentation of eligibility for Medicaid, Advance Premium Tax Credits (APTC), Cost Sharing Reductions (CSR), and Qualified Health Plans (QHP) and must contain sufficient material to substantiate validity of all authorized assistance.

The Electronic Case File (ECF) for Medicaid, APTC, CSR, and QHP 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.

MS 1290 CHANGES (1)

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

- A. [A change in circumstances is defined as any change which may affect ongoing eligibility for Medicaid, Advance Premium Tax Credits (APTC), Cost Sharing Reductions (CSR), and Qualified Health Plans (QHP).]

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 kynect benefits 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. When a deemed eligible newborn is added to a case, workers should ensure coverage is issued back to the date of birth.

[Note: A newborn is not considered deemed eligible if the mother received APTC/QHP during the month of the baby's 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.

MS 1320 STANDARD OF PROMPTNESS (1)

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.

MS 1460 TIMELY NOTICE OF DISCONTINUANCE (1)
AND REASONS FOR NEGATIVE ACTION

[Denials and discontinuances result from failure to meet technical and/or financial eligibility requirements for MAGI Medicaid or Advance Premium Tax Credits (APTC). If action taken discontinues Medicaid or APTC for any or all members in a case, the individual 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 for Medicaid, informing the client of the correct denial/discontinuance reason. Scan form MA-105 into the Electronic Case File (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: Bob 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: Sue 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 ages 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, APTC, Cost Sharing Reductions (CSR), and Qualified Health Plans (QHP) are listed below.]

1. Financial reasons:

- a. Income exceeds limit;
- b. Income has increased;
- [c. Eligibility denied since individual did not provide premium amount for potential employer insurance.]

2. Technical reasons:

- a. Already received Medicaid;
- b. Individual is above the age limit of 64;
- c. Child is above the age limit;
- d. [Individual is age 26 and no longer eligible for parent's QHP;]
- e. Ineligible for Medicaid in the Former Foster Care category;
- f. Citizenship or qualified immigrant requirements are not met;
- g. Refused to cooperate with Medical Support Enforcement (MSE);
- h. Recipient deceased;
- i. Recipient becomes eligible for Medicare and is no longer eligible for ADLT Type of Assistance (TOA);
- j. Child receiving KCHIP becomes insured;
- k. Individual is not a resident of Kentucky;
- l. Failure to provide Social Security Number (SSN);
- m. Failed or refused to cooperate with Third Party Liability (TPL);
- n. Failure to sign application;
- o. Failure to provide required information during the specified time frame;
- p. Pregnancy post-partum has ended;
- q. [Individual did not provide verification of loss of Minimum Essential Coverage (MEC);
- r. Individual does not intend to file taxes;
- s. Individual denied APTC as he/she is ineligible for QHP;
- t. Individual denied APTC since he/she did not file a return reconciling the advance payments with any tax credit available;

- u. Individual ineligible for American Indian/Alaskan Native (AIAN) categories, since he/she did not verify AIAN status;
 - v. Individual denied APTC, since he/she has or is offered affordable employer sponsored insurance;
 - w. Individual denied APTC, since his/her tax filer is APTC ineligible;
 - x. Individual has MEC and is not eligible for APTC or Medicaid in the Adult or KCHIP categories;
 - y. Eligibility is denied since individual has employer sponsored insurance that doesn't end 60 days from today;
 - z. Individual does not meet all eligibility requirements for CSR.]
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;
 - e. [Individual denied Employer Sponsored Insurance (ESI) as he/she opted out;
 - f. Employee terminates coverage from QHP;
 - g. Already received benefits;
 - h. Individual does not meet QHP relationship requirement;
 - i. Individual denied eligibility on parents' QHP, since he/she is a child of head of household and is married;
 - j. Approved for QHP, but outside of open enrollment, individual cannot select a plan.
- E. When an individual dis-enrolls from a QHP, Worker Portal sends a notice to the insurance provider. The insurance provider sends the appropriate notice to the individual regarding termination of coverage. The individual's kynect benefits Self Service Portal (SSP) account is updated with the termination date.]

MS 1500 MISREPRESENTATION AND FRAUD (1)

If a worker discovers that the recipient, or responsible party, withheld information or provided false information in order to receive 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

[The Internal Revenue Service (IRS) reconciles all potential overpayments for Advance Premium Tax Credit (APTC).

If an individual reports fraud regarding Qualified Health Plans (QHP), provide the Office of Kentucky Health Benefit Exchange (OKHBE) toll free telephone number 1-855-459-6328.]

MS 1530

KYHEALTH CARD

(1)

[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.]

MS 1600 RETROACTIVE MEDICAID (1)

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.

- [D. Case Notes must always document that retroactive coverage was explored and if retroactive coverage is requested by the applicant, what months are requested.]

MS 1650 PASSIVE AND ACTIVE RENEWALS (1)

[Once approved for Medicaid, each recipient is approved for a 12-month certification period. Before the end of the coverage year, eligibility for each recipient must be reviewed to ensure they continue to meet all technical and financial eligibility requirements. This is done on an individual level and if all criteria are met, the individual is issued a new 12-month certification period. This renewal process must be done annually.

- A. The renewal process begins on the 1st day of the month prior to the renewal month, which is when the certification period ends, through either the passive or active renewal process. For example, the renewal process will begin July 1st for Medicaid cases with a certification end date of August 31st.

Worker Portal will determine if a Medicaid case meets the criteria to be passively renewed.

1. A passive renewal does not require worker or member intervention.
2. 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. In addition to completing form EDB-087, individuals have the option to complete their Medicaid renewal in-person, by phone, or by logging into the Self-Service Portal (SSP).
3. An interview is not required for renewals completed on SSP nor passive renewals. However, an interview is required if the renewal is initiated or completed in-person or by phone. This applies to all MAGI Medicaid types.

- B. 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; and
 - 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; and
 - 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. If verification is provided, a Document Processing task will be created. During the renewal process, Medicaid will not discontinue if there are pending Document Processing tasks waiting to be reviewed by field staff after an RFI due date.

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.

C. 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. Individuals cannot be transitioned from Medicaid to APTC through the passive renewal process. If the Federal Hub, or other trusted data sources, verify that an individual is no longer eligible for MAGI Medicaid during passive renewal, an active renewal must be completed. Worker Portal will issue form EDB-087 to the recipient. If the renewal is not initiated by the 15th of the renewal month, the individual will be transitioned to APTC effective the first of the following month.

1. Example: Sue receives Medicaid in the ADLT type of assistance (TOA). Her case is due a renewal in August. The Federal HUB verifies that her income exceeds the limit for MAGI Medicaid during passive renewal and the case will transition to APTC. However, an active renewal must be completed and she is sent form EDB-087. She returns the form and reports that her income has changed. It is below the income limit and she remains eligible for MAGI Medicaid.
2. Example: Jay receives Medicaid in the ADLT TOA. His case is due a renewal in August. The Federal Hub verifies that his income exceeds the limit during passive renewal and the case will transition to APTC. However, an active renewal must be completed, and he is sent form EDB-087. No renewal is initiated. The case will transition to APTC effective the first of the following month.

D. Discontinuances at Renewal

1. If MAGI Medicaid is discontinued for failure to return the renewal form or required verification to complete the renewal, individuals are given 90 days from the date of the discontinuance to provide the required documentation. 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 the case should be put back on using the Reactivate function.

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.

2. If the case discontinues correctly and the renewal form and/or verification is not returned within the 90 day grace period, a new application is required.
3. Never use the Reinstate function for cases that discontinue during renewal regardless of if the discontinuance is correct or due to agency error. Instead, use the Reactivate function on the Case Summary screen for cases that discontinue during renewal. This ensures members retain the correct 12-month certification period when their renewal is processed.
4. Example 1: 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 Reactivate function. Medicaid eligibility will be effective 10/1.

5. Example 2: Angie's active Medicaid renewal is due 5/31. Angie returns form EDB-088 along with income verification on 7/5. As the renewal form and required verification is provided within 90 days of the Medicaid discontinuance, a new application is not required, and action should be taken to issue Medicaid via the Reactivate function. Angie's Medicaid eligibility will be effective 7/1.]

MS 1750* RECIPIENTS MOVING INTO OR OUT OF KENTUCKY (1)

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.

MS 1900 INTRODUCTION TO MANAGED CARE (1)

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.]

MS 1901 MANAGED CARE PROVIDERS (1)

The Department for Medicaid Services (DMS) contracts with Managed Care Organizations (MCOs) to coordinate health care for most Medicaid members.

- A. The following MCO providers are available to members subject to managed care enrollment:
1. Aetna Better Health of Kentucky;
 - [2. Humana Healthy Horizons in Kentucky;
 3. Passport Health Plan by Molina Healthcare;
 4. UnitedHealthcare Community Plan of Kentucky; and
 5. WellCare of Kentucky.]
- B. MCO website at <https://chfs.ky.gov/agencies/dms/dpqo/mco-cmb/Pages/mco-options.aspx> may be accessed by workers and recipients to search for information on each MCO including links to each MCOs website.
- C. Managed Care recipients may contact Managed Care Member Services for information at 1-855-446-1245.

MS 1902 MANAGED CARE DEFINITIONS (1)

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 Kentucky MCO's and contact numbers are:

- | | |
|---|-----------------|
| • Aetna Better Health of KY | 1-855-300-5528 |
| • Humana Healthy Horizons in KY | 1-800-444-9137 |
| • Passport Health Plan by Molina Healthcare | 1-844-778-2700 |
| • UnitedHealthcare Community Plan of KY | 1-866-293-1796 |
| • WellCare of Kentucky | 1-877-389-9457] |

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

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

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

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

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

MS 1903

MANAGED CARE ENROLLMENT

(1)

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 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 contact their current MCO for information regarding the Disenrollment for Cause 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.

MS 1904 WHO IS REQUIRED TO ENROLL IN AN MCO
AND WHO IS EXEMPT (1)

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].

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.

MS 2000 MAGI MEDICAID WITH LEVEL OF CARE (1)

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 Program for All-Inclusive Care for the Elderly (PACE) LOC can be added to the ADLT type of assistance. However, individuals not eligible to receive MAGI Medicaid must have their eligibility for Non-MAGI Medicaid explored.]

C. 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

D. 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.

E. 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).
- 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.

MS 2110 ENUMERATION (1)

[Each individual (including children) applying for MAGI Medicaid, Advance Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), and Qualified Health Plan (QHP) must provide their 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, or does not meet one of the acceptable exemption reasons below:
 - 1. Religious objections;
 - 2. Immigrant status; or
 - 3. Only issued an SSN for valid non-work reasons.
- C. Those individuals not seeking coverage for themselves, but who are included in the applicant's household, are not required to provide an SSN.

MS 2150 CITIZENSHIP REQUIREMENTS (1)

To be eligible for MAGI Medicaid, an individual must be a citizen of the United States or a qualified immigrant 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.

[All individuals applying for Advance Premium Tax Credits (APTC), Cost Sharing Reductions (CSR), and Qualified Health Plans (QHP) must verify that they are a US citizen or a Lawfully Present Resident (LPR).]

If an individual attests he/she is 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, a Request for Information (RFI) will be issued with a 90 day due date. Eligibility for Medicaid can be approved for up to 90 days, if otherwise eligible. If verification is not provided or is insufficient, benefits are terminated the next administratively feasible month following the end of the 90 days. The individual will not be eligible for APTC. If the individual reapplies, verification of citizenship will be required before Medicaid, APTC, CSR, and QHP can be approved. Individuals will be given another 90 days to verify citizenship.]

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 immigrants 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 individual 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 immigrants may still be eligible for Emergency Time-Limited Medicaid. For more information regarding Emergency Time-Limited Medicaid, refer to [MS 2160](#).

MS 2152 CRITERIA FOR QUALIFIED IMMIGRANTS (1)

To qualify for MAGI Medicaid, individuals who are not U.S. Citizens must meet qualified legal immigrant status. Qualified legal immigrants 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 immigrants who entered the U.S. after August 22, 1996. Once it has been determined that an individual meets qualified immigrant 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 immigrants who entered the U.S. after August 22, 1996.

To qualify for Advance Premium Tax Credit (APTC), Cost Sharing Reduction (CSR), or Qualified Health Plan (QHP) non-U.S. Citizens must be Lawfully Present. These are individuals who are immigrants or noncitizens that have permission from USCIS to live in the U.S. or who have not overstayed the time they were admitted.

[Note: Pregnant women who meet qualified immigrant criteria are not subject to the 5-year date of entry ban and can receive Medicaid in one of the pregnancy Types of Assistance (TOA) without exploring eligibility for Emergency Time-Limited Medicaid.]

- A. The following qualified immigrants 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 legal qualified immigrant status for at least 5 years from their date of entry into the United States:

Example: Alex applied for Medicaid. He provided documentation that he is a qualified immigrant and that his date of entry was 7/15/20. Since he has not been in the United States for at least 5 years, he is not eligible for Medicaid.

1. Immigrants lawfully admitted for permanent residence ON or AFTER August 22, 1996;
2. Immigrants paroled in the U.S. under Section 212(d)(5) of the Immigration and Nationality Act (INA) for a period of one year. If U.S. Citizenship and Immigration Services (USCIS) document I-94 indicates the individual will be in 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. Immigrants who are battered or subjected to extreme cruelty in the U.S.

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

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

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

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

1. Children under the age of 19 who meet qualified immigrant 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. Immigrants lawfully admitted for permanent residence before August 22, 1996;
3. Afghan and Iraqi immigrants who are granted special immigration status under Section 1059 of the National Defense Authorization Act (NDAA) of 2006 or Section 1244 of the NDAA of 2009 are treated in the same manner as refugees admitted under Section 207 of the Immigrations and

Nationality Act. These Iraqi and Afghan immigrants served as translators for the U.S. military. This special immigration status also applies to their spouses and unmarried dependent children. The law applies to Afghan and Iraqi immigrants who were already in the U.S. with special immigration status on the effective date of the law, December 19, 2009, and who enter on or after that date;

4. Refugees who were admitted under Section 207 of the INA and asylees who were granted asylum under Section 208 of the INA;

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

5. Children under the Child Citizenship Act of 2000, who automatically acquire citizenship on the date that all of the following requirements are satisfied:
 - a. At least one parent is a U.S. citizen whether by birth or naturalization;
 - b. The child is under 18 years of age; and
 - c. The child is residing in the United States in the legal and physical custody of the citizen parent pursuant to 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. Immigrants 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. Immigrants granted status as Cuban or Haitian entrant as defined by Section 501 (e) of the Refugee Assistance Act of 1980

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. Immigrants granted status as a Cuban or Haitian refugee who present an I-551 with a category status of 'CU6' (for Cuban refugee), 'HA6' (for Haitian National paroled under Haitian Refugee Fairness Act), or 'RE6' (Refugee who entered the U.S. on or after April 1, 1980);
 - 9. Immigrants admitted as an Amerasian immigrant under Section 584 of the Foreign Operations Export Financing and Related Programs Appropriation Act of 1988 (letter coded AM-1, Am-2, AM-3, AM-6, AM-7, and AM-8);
 - 10. Immigrants whose deportation is being withheld (I-94 annotated with the words political asylees) under Section 243 (h) of the INA or after April 1, 1997, the renumbered Section 241 (b) of the INA;
 - 11. Permanent resident immigrants who are veterans honorably discharged for reasons other than immigration status, their spouses or unmarried dependent children;
 - 12. Permanent resident immigrants who are on active duty, other than active duty for training in the Armed Forces of the United States and fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d), their spouses or unmarried dependent children;
 - 13. Immigrants who are granted conditional entry pursuant to Section 203(a) (7) of the INA as in effect prior to 4/1/1980.
- C. The following individuals do not meet qualified immigrant status and are 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. Immigrants designated as PRUCOL, permanently residing under color of law;
 - 2. Adults with I-20 student visas;
 - 3. Deferred Action for Childhood Arrivals (DACA) recipients as although they are protected from deportation and allowed to work, they are not lawfully present.

MS 2160 EMERGENCY TIME-LIMITED MEDICAID (1)

[Individuals who do not meet citizenship or qualified immigrant 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 therefore 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, this occurrence 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 Medicaid categories.
- K. Individuals approved for the initial two months of Emergency Time-Limited MA, may be eligible for an extension. For information regarding Emergency Time-Limited MA Extensions, refer to [MS 2162](#).

MS 2162 [EXTENSION OF EMERGENCY TIME-LIMITED MEDICAID (1)

A recipient may request an extension of Emergency Time-Limited Medicaid (MA) once the initial 2-month Time-Limited coverage has been issued if the emergency medical condition continues. The Department for Medicaid Services (DMS) reviews 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.]

*MS 2165 IDENTITY REQUIREMENTS (1)

All individuals applying for Medicaid must present proof of identity as a technical eligibility requirement. If the individual's citizenship is verified by the Federal Hub, no additional verification for identity is required.

A. Identification requirements for individuals age 16 and older are as follows:

1. Individuals who provide the following documentation have met the identification requirements:
 - a. A U.S. Passport;
 - b. A Certificate of Naturalization (DHS Forms N-550 or N-570); or
 - c. A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).
2. Individuals who verify citizenship by documentation items listed in Tiers 2, 3 or 4 found in [MS 2150](#), as well as those signing notarized statements for applicants, must also provide proof of identification. Acceptable original documentation to verify identity consists of the following:
 - a. State driver's license bearing the individual's picture or state identity document with the individual's picture; or
 - b. Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document; or
 - c. Other official documentation issued by the state in which the individual resides; or
 - d. The use of three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas, and employer ID cards; or
 - e. Data matches or documentation from other agencies which include:
 - 1) SNAP (for head of household only);
 - 2) Child Support;
 - 3) Law enforcement;
 - 4) Correctional agencies, including juvenile detention;
 - 5) Division of Motor Vehicle records;
 - 6) Expired driver's license – unless questionable;
 - 7) Protection and Permanency documentation, including materials relating to child protection; or
 - 8) Other official documentation issued by local, state or federal governments from the individual's place of birth or residence.
 - f. The facility director or administration may attest to the identity for disabled individuals in a residential care facility.
 - g. An affidavit or notarized statement signed under penalty of perjury by a parent or guardian attesting to the child's identity for children age 16 or older.

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

1. School identification card with a photograph;
2. Military dependent's identification card if it contains a photograph;
3. School record that shows date and place of birth and parent(s) name; or
4. Daycare or nursery school record showing date and place of birth.

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

MS 2200 RESIDENCY (1)

An individual must be a resident of Kentucky and intend to remain in the state in order to be eligible for Medicaid, Advance Premium Tax Credit (APTC), Cost Sharing Reduction (CSR), and Qualified Health Plan (QHP). 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.
- C. 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.
- D. 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.
- E. 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.
- F. 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.
- G. [The Returned Mail Bot is an automated process triggered when undeliverable mail is returned and scanned into Knowledge Lake for individuals with active Medicaid.
 - 1. The Returned Mail Bot is not applicable to the following situations.
 - a. If undeliverable mail is returned for an individual receiving Supplemental Security Income (SSI) Medicaid, notices will not be scanned into the system and the automated system actions will not be taken. If an SSI individual is active on a case with other non SSI members, the notices will be scanned into the system and the automated system actions will be taken on the case but not for the SSI individual.

- b. The Returned Mail Bot process is not completed for undeliverable mail returned for an Authorized Representative (AR). Instead, an Undeliverable Mail Review Task is generated on Worker Portal for a worker to process.
- 2. When undeliverable mail is returned, Worker Portal takes the following actions:
 - a. An Undeliverable Mail Review task is created;
 - b. A Request for Information (RFI) is issued for Residency;
 - c. A banner created by the Undeliverable Mail Review task appears on the Self-Service Portal (SSP) and Worker Portal explaining the United States Postal Service has returned undeliverable mail. The mailing address for all members must be reviewed and updated as needed;
 - d. The system enters a case note for the Undeliverable Mail Review task;
 - e. Conduent is notified to reach out to the individual regarding the undeliverable mail if contact information is available on Worker Portal or SSP; and
 - f. The Undeliverable Mail Review task is marked complete.
- 3. When a worker enters a case that has the Undeliverable Mail Review banner on the Case Summary screen, the worker must attempt to contact the individual to update the address. Case Notes must be added to explain all actions taken.
 - a. A new section, Undeliverable Mail Review, is displayed on the Residency screen when an Undeliverable Mail Review task is processed. The question "Undeliverable mail has been returned. Has Residency review been completed?" becomes active and defaults to "No".
 - b. Once the Residency screen is updated, or the question is updated from "No" to "Yes", the Undeliverable Mail Review banner is reset and the Undeliverable Mail Review section is disabled to view only.]

MS 2300* MEDICAL SUPPORT ENFORCEMENT (1)

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.

MS 2310* THIRD PARTY LIABILITY (1)

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

A. At Application/Recertification/Case Change:

1. Explain the following to the individual:

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

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

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

a. Types of health insurance that must be recorded include

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

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

- (1) Medicare. If the individual has Medicare, enter it on the Medicare Details Screen;
- (2) Long Term Care insurance. Please see Volume IVA MS 2310 for more information on Long Term Care Insurance.

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

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

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

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

B. Refusal to Cooperate:

If the individual refuses to cooperate with TPL, without good cause, vendor payment IS NOT approved as the individual is not Medicaid eligible. This also applies to Supplemental Security Income (SSI) individuals. Non-cooperation with TPL requirements DOES NOT affect eligibility for the SSI payment but does affect eligibility for the receipt of Medicaid. Refer to Volume IVA MS 1680 for more information.

C. Good Cause for Refusing to Cooperate:

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

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

MS 2350 INCARCERATION (1)

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.

[An incarcerated individual is not eligible for Advance Premium Tax Credit (APTC), Cost Sharing Reduction (CSR), or a Qualified Health Plan (QHP).]

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.

[E. APTC, CSR, and QHP will approve if the information given is inconsistent with trusted data sources and the individual will be given 90 days to verify non-incarceration. If non-incarceration is not verified at the end of 90 days the eligibility will discontinue the next administratively feasible month.]

MS 2600

PREGNANCY

(1)

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

1. 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.

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

B. [The postpartum period is 12 months. Postpartum begins the day the pregnancy ends and ends the last day of the 12th month. Medicaid can be requested and approved at any time during the 12-month postpartum period. Coverage does not have to be issued at the end of a pregnancy in order to be eligible for postpartum coverage.

Example: Alexis had a baby 6 months ago and did not have Medicaid during the month of birth. She's applying for Medicaid for herself and the baby. Even though she did not receive Medicaid when the child was born, she's still eligible for Pregnancy Medicaid as she is within the 12-month postpartum period. However, the child is not a deemed eligible newborn since Alexis did not receive coverage in the month of birth.]

1. If the pregnancy is terminated for any reason, postpartum coverage will be given to the client. The postpartum period begins at the time the pregnancy is terminated.
2. Pregnant women receiving Medicare can be dually eligible for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) benefits with the PREG Type of Assistance (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.
3. Medicaid for Children under the age of 19 who become pregnant is issued in the PREG TOA.
4. If the birth of a child is not reported by the due date, Worker Portal will automatically begin the postpartum period.

C. Pregnant Women may receive Medicaid in either the PREG, ADPR, or CHPR TOA.

1. If a woman reports pregnancy at application for Medicaid she will receive Medicaid in the PREG or CHPR TOA based on income. Pregnant women with income at or below 200% FPL will receive Medicaid in the PREG TOA. A pregnant woman aged 19 to 64 with income less than 218% FPL, but above 200%, and without health insurance will receive Medicaid in the CHPR 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.
 6. Women receiving Medicaid in the PREG TOA and report a change of income that exceeds 200% FPL will transition to CHPR if they do not have other health insurance.
- D. [The 5-year date of entry ban is waived for pregnant women. Additionally, they only must be lawfully present to be eligible for Medicaid and do not need to meet qualified immigrant criteria. Eligibility for Medicaid in one of the pregnancy TOA's must be explored before Emergency Time-Limited Medicaid is issued.]

MS 2645 PRIVATE NON-PROFIT ADOPTIONS OVERVIEW (1)

[Once an adoption is final, a child in a private non-profit adoption is considered the same as any other child in a parent's case. If the family applies for Medicaid, eligibility will be determined based on the household's financial situation. Their application will follow standard eligibility rules as there are no special categories of assistance for adopted children, unless the adoption is subsidized by the state.]

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: Subsidized adoptions are handled through the Division for Protection and Permanency (DPP) and the adoptive parents receive a copy of the subsidy agreement. If the parent reports the adoption is subsidized, explain that the child will receive Medicaid on a separate case in the child's name. The Medicaid case is maintained by the Children's Benefit Worker (CBW). Refer to [MS 2647](#) for more information on subsidized adoptions.]

*MS 2647

SUBSIDIZED ADOPTION

(1)

Certain special needs children adopted while in foster care qualify for a monthly payment, or subsidy, from the Commonwealth. These are referred to as subsidized adoptions. Children with subsidized adoptions automatically receive Medicaid through their 18th birthday, regardless of parental income. The Type of Assistance (TOA) for children receiving Medicaid through subsidized adoption is ASMA. Please note the child may receive Medicaid in the SSIR TOA if they are disabled and financially eligible.

- A. Medicaid applications for subsidized adoption cases are completed by the assigned Protection and Permanency worker in The Worker Information System (TWIST) and are interfaced to Worker Portal.
 - 1. The case name is the child's legal name and the child is the only member listed on the case. If multiple children are adopted by the same parent(s), they will each have their own Medicaid case.
 - 2. Subsidized adoption cases are maintained by the Children's Benefit Worker (CBW). Field staff should never attempt to access a CBW owned case. If any changes are reported, the change should be sent to the regional CBW or to MSBB through the regional Program Specialist.
- B. Medicaid eligibility for the child discontinues when they age out or move out of state.
- C. An infant born to a child receiving Medicaid in the ASMA TOA is deemed eligible for their first year of life as their mother received Kentucky Medicaid at the time of birth. To ensure action is taken to issue coverage for the newborn, a 'Newborn of FCMA/ASMA Mother' task is generated for field staff.
- D. Children with subsidized adoptions have the option to enroll and participate in the Supporting Kentucky Youth (SKY) program. The child may opt in or out of the program at any time. The parent must contact the Managed Care Hotline to make changes to the child's MCO enrollment whether participating in the SKY Program or not. For more information on the SKY Program refer to [MS 2665](#).

MS 2650 DEEMED ELIGIBLE NEWBORNS (1)

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.

*MS 2652

CONTINUOUS COVERAGE FOR CHILDREN

(1)

Upon Medicaid approval, each child will receive 12 months of continuous coverage. Once initial Medicaid eligibility is issued, coverage cannot discontinue until renewal except for the following reasons: (1) when the child turns 19 years old; (2) the child or child's representative requests benefits be discontinued; (3) the child moves out of the state; (4) the agency determines that eligibility was erroneously approved; (5) if the child is deceased; (6) the child fails to meet citizenship criteria; (7) or the child is receiving Medicaid in another state. An erroneous, or incorrect, approval includes agency error or fraud, abuse, or perjury attributed to the child or the child's representative and must have occurred at the most recent application or renewal.

- A. Continuous coverage is calculated as 12 months from the application month, even if retroactive coverage is requested.
- B. Medicaid will be issued for the child in one of the following types of assistance when a child loses Medicaid in the middle of their certification period.

| TOA Code | Description |
|----------|--------------------------------|
| SICC | SSIR Child Continuous Coverage |
| FCCC | FCMA Continuous Coverage |
| ASCC | ASMA Continuous Coverage |
| DJCC | DJJM Continuous Coverage |
| CXCC | KCHIP Continuous Coverage |
| CHCC | Child Continuous Coverage |

- C. During the continuous coverage period, Worker Portal will not request verification that will not impact eligibility for the child. A Request for Information (RFI) will only be generated for continuous coverage children to verify the following: US citizenship, household, residency, out of state benefits, and date of death of the child.
- D. If a child has continuous coverage, a transition to other Medicaid TOA's is allowable if the member meets eligibility criteria. However, transition to the Medicare Savings Program (MSP) is not allowable as it does not provide full Medicaid benefits.
- E. During the 12-month continuous coverage, benefits cannot be terminated if the head of household is deceased unless the child is moved to a different case and is approved.
 - 1. Worker Portal will create a Head of Household Death Task when the head of household is deceased and there is an active child on the case under 19 years old who receives Medicaid.
 - 2. When the task is completed, workers should select the Continuous Coverage option as an Out of Household Reason in Worker Portal on the existing case and add the child as a household member on the case in which they now live. The child will have a new 12-month continuous coverage period.

3. If the child's new residence cannot be determined, no action should be taken and they will continue receiving Continuous Coverage on the deceased member's case.

Example: Carl is receiving Medicaid in the CHL4 TOA from 1/1/23 to 12/31/23. On 2/15/23, it is reported that his mother Betty (head of household) has passed away and her benefits are going to discontinue effective March 2023. Carl's benefits will not discontinue on Betty's case. Worker Portal will create a Head of Household Death task to be processed. Carl now lives with his aunt Kelly and should be added to her case. He will continue to be eligible for continuous coverage.

- F. When a child moves from one household to another, select the Continuous Coverage as the Out of household reason. This will allow Worker Portal to issue continuous coverage in the new household.
- G. If a child is added to an existing case, the renewal date for child will be aligned to existing Medicaid recertification date of other members on the case. However, if they are not successfully renewed, system will still maintain the child's continuous coverage and update their renewal date to align to the continuous coverage end date.

Example: Tim is receiving Medicaid as a continuous child in the CHL2 TOA on his mother's case from 1/1/23 to 12/31/23. He moved out of his mother's home and now lives with his aunt Sue and has been added to her case. The renewal date for her case is 6/30/23. However, she fails to complete her renewal. As Tim is a child who receives continuous coverage, his benefits will remain active and he will have a recertification date of 12/31/23 as that is the date that first aligned with his continuous coverage.

- H. During continuous eligibility, Worker Portal will not deny/discontinue children due to non-financial conditions, such as absence of level of care, invalid living arrangement or not meeting blind/disabled criteria, if they are not potentially eligible for another Medicaid TOA.
- I. Continuous coverage does not apply to patient liability. Patient liability will be discontinued if the member does not have a valid level of care record but remains eligible for Medicaid during continuous coverage period.
- J. At reapplication and reinstatement, Worker Portal will calculate a new coverage period, which will be based on 12 months from the approval month.
- K. Eligibility tests including financial, non-financial, resource and verification tests, will still be performed during continuous eligibility period for children but terminations shall not be processed if the termination reason is not valid during continuous eligibility period.

Example: Brad has been approved for Medicaid in the CHL3 TOA from 1/1/23 to 12/31/23. A change of income is reported on 4/15/23. This change of income exceeds the income limit; however, he will continue to receive Medicaid and transition to the CHCC TOA as continuous coverage and will be redetermined for benefits at renewal in December 2023.

- L. A renewal must be completed for the case. Medicaid coverage can be discontinued during the renewal process if the child is no longer eligible for Medicaid. Children that continue to be eligible for Medicaid during the renewal process will be granted a new 12-month continuous coverage period.
- M. Children receiving Medicaid in the ASMA, DJJM, and FCMA TOA are eligible for continuous coverage until age 19.
- N. Children receiving Medicaid in the SSIR TOA are eligible for continuous coverage until age 18. These children do not have a case recertification. Their continuous coverage will be maintained by a system batch. A 12-month period will be determined from initial approval and their eligibility will be redetermined at the end of continuous coverage. If they continue to remain eligible, coverage will be extended by another 12 months. If the child is receiving SSIR Medicaid and a termination is received, SSIR benefits will be discontinued and the child will be approved for the SICC TOA through the continuous coverage end date.
- O. CHCC is considered dually eligible; therefore, a child can receive CHCC with QMBP or SLMB. CXCC is not considered dually eligible.
- P. Vendor payment can be added to all continuous coverage TOAs.

*MS 2653

CHILDREN IN FOSTER CARE

(1)

Foster care children are children in the protective custody of the state who may have been removed from their parents due to abuse or neglect. Children in state foster care are Kentucky residents and are eligible for Medicaid regardless of their citizenship status. The Type of Assistance (TOA) for children receiving Medicaid as a foster care child is FCMA. Please note that if a child in foster care is disabled and financially eligible, they may receive Medicaid in the SSIR TOA.

A. When a child is placed in foster care, their information is entered into The Worker Information System (TWIST) and then interfaced to Worker Portal.

1. The case name is the foster care child's legal name and the child is the only member listed on the case. If multiple children are removed from the same home, they will each have their own Medicaid case.
2. Medicaid cases for foster care children are maintained by the Children's Benefit Worker (CBW). Field staff should never attempt to access a CBW owned case. If any changes are reported, the change should be sent to the regional CBW or to MSBB through the regional Program Specialist.

B. Medicaid eligibility for a foster care child discontinues when:

1. The child turns 18 and ages out.
 - a. Eligibility must be explored for Medicaid in the Former Foster Care category once the child ages out of foster care at age 18. For more information about former foster youth refer to [MS 2655](#).
 - b. Children who choose to recommit to the cabinet can extend their foster care status to age 21. They will continue to receive Medicaid as a foster care child as long as they remain in state custody. This ensures they do not have Medicaid copays while still in foster care. At age 21, they may begin receiving Medicaid as a former foster youth.
2. The child is released from foster care.
 - a. When the child is released from foster care, it is the parent's or new caregiver's responsibility to apply for Medicaid on the child's behalf. Eligibility for the child will be determined using technical and financial Medicaid rules.
 - b. Children released from foster care before their 18th birthday are not eligible for Medicaid in the Former Foster Care category.

C. Infants born to an individual receiving Medicaid in the FCMA TOA during the birth month are deemed eligible for their first year of life. To ensure timely coverage is

issued for the newborn, a 'Newborn of FCMA/ASMA Mother' task is generated for field staff.

- D. Foster care children eligible for managed care enrollment are required to participate in the Supporting Kentucky Youth (SKY) program. Their enrollment is managed by the CBW. For more information on the SKY Program refer to [MS 2665](#).

*MS 2654 JUVENILE JUSTICE CHILDREN (1)

The Department of Juvenile Justice (DJJ) provides prevention programs for at-risk youth, court intake, pre-trial detention, residential placement and treatment services, probation, community aftercare, and reintegration, as well as the confinement of youth awaiting adult placement or court hearings. Medicaid is issued by DCBS to children and youth under the age of 21 in the DJJ custody placed in residential homes or in the community, and not residing in a DJJ facility. This coverage is issued in the DJJM Type of Assistance (TOA).

A. Juvenile Justice workers apply for Medicaid on behalf of these children.

1. Applications are taken in the name of the child and processed/maintained by the Medical Supports and Benefits Branch (MSBB).
2. The Juvenile Justice worker is listed as the Authorized Representative (AR).

B. Children receiving Medicaid in the DJJM TOA are mandatory participants in the SKY program, unless otherwise exempt to managed care enrollment due to living arrangement. Refer to Volume IVB [MS 2665](#) for more information on the SKY program.

If a DJJ child receives SSI, the child is a mandatory participant in the SKY program, unless otherwise exempt to managed care enrollment due to living arrangement.

C. These children are exempt from Medical Support Enforcement (MSE) since they are committed to the Department of Juvenile Justice.

D. Children receiving Medicaid in the DJJM TOA are eligible for continuous coverage until age 19. For more information on continuous coverage, refer to [MS 2652](#).

MS 2655

FORMER FOSTER CARE

(1)

[Former foster care youth are individuals ages 19 through 26 who were in foster care *and* received Medicaid when they turned 18. This includes those who aged out of foster care in other states. These individuals are deemed eligible to receive Medicaid until they turn 26 years old as long as they reside in Kentucky.

MSBB receives a monthly list of individuals who have aged out of foster care and processes a Medicaid application to explore eligibility for each individual in the Former Foster Care category. 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. Workers may also be contacted by individuals who have aged out in another state.

A. The following applies to these former foster care individuals:

1. The Medicaid case for former foster care individuals 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 considered in the former foster care eligibility determination. However, it is best practice to request the individual's financial information as their income is required to determine ongoing eligibility once they age out. Additionally, their income may be required to determine eligibility for other members on the case. For example, if an individual reports that they are married and their spouse requests Medicaid, the individual's income is required to determine Medicaid eligibility for the spouse.
4. Former foster care individuals are eligible for retroactive Medicaid coverage.
5. To explore eligibility for Medicaid in the Former Foster Care category, select "Yes" to the question, "Was anyone in the household ever in Foster Care?" on the Household Question screen to trigger the Former Foster Care screen.

Please note that workers must be sure to advise the individual to always report a change of address to DCBS.

B. Individuals eligible for Medicaid in the Former Foster Care category 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 Medicaid 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.

- C. Former foster care individuals have the option to enroll and participate in the Supporting Kentucky Youth (SKY) program. They may choose to opt in or out of the program at any time. For more information on the SKY Program refer to [MS 2665](#).
- D. Some foster care children may choose to recommit their custody to the Commonwealth and therefore extend their foster care status to age 21. These individuals are still considered foster care children and will continue to receive Medicaid in the FCMA TOA. When they age out at 21, eligibility in the Former Foster Care category must be explored. For more information on foster care children refer to [MS 2653](#).]

MS 2665

SKY PROGRAM

(1)

The Supporting Kentucky Youth (SKY) program offers enhanced benefits and wraparound services to foster care children, former foster youth, and those with subsidized adoption by enrolling all members into one Managed Care Organization (MCO). The current MCO for the SKY Program is Aetna.

- A. [Foster care children receiving Medicaid in the FCMA, FCCC, SSIR, SICC, or EXPT Types of Assistance (TOAs) are required to participate in the SKY program. This includes children placed in Kentucky foster care through the Interstate Compact on the Placement of Children (ICPC). Enrollment for these members is managed by the regional Children's Benefit Worker (CBW). For policy regarding foster care children refer to [MS 2653](#).
- B. Children with subsidized adoption receiving Medicaid in the ASMA, ASCC, SSIR, SICC, or EXPT TOAs have the option to participate in the SKY Program. This includes children adopted through the Interstate Compact on Adoption and Medical Assistance (ICAMA). Enrollment for these members is managed by Medicaid Member Services. Refer parents wanting to opt in or out of the SKY program to the Managed Care Hotline. For policy regarding children with subsidized adoption refer to [MS 2647](#).
- C. Children under the Department of Juvenile Justice (DJJ) custody receiving Medicaid in the DJJM, DJCC, SICC, or SSIR TOA are required to participate in the SKY program. Their cases and enrollment are maintained by MSBB.]
- D. Individuals receiving Medicaid as Former Foster Care in the FFCC, FFOS, and ADFF TOAs have the option to participate in the SKY program. DCBS caseworkers are responsible for maintaining their SKY program enrollment. For policy regarding Former Foster Care refer to [MS 2655](#).
- E. Members exempt from managed care enrollment are not eligible to participate in the SKY program. For example, Nick is a foster care child and currently receives waiver services. Since he is exempt managed care enrollment, he cannot participate in the SKY program. However, if Nick is discharged from waiver services and becomes subject to managed care enrollment, he will be enrolled in the SKY program.
- F. Members enrolled in the SKY program cannot request to change their MCO. However, if the individual's SKY program enrollment is optional, they may opt out of the program and choose a new MCO.
- G. Members enrolled in the SKY Program are not eligible to change their MCO during the annual open enrollment period and will not be sent open enrollment notices.
- H. Optional members may opt in and out of the SKY program at their discretion regardless of the annual open enrollment period.

1. If the member chooses to opt into the SKY program, their current MCO enrollment will be discontinued on the last day of the current month and enrollment with Aetna will be effective the first day of the following month. For example, Jess is a former foster care child and is opting into the SKY program on 10/7. Her current MCO enrollment with Wellcare will discontinue on 10/31 and she will be enrolled with Aetna beginning 11/1.
 2. Members choosing to opt out of the SKY program are dis-enrolled the first day of the following month. For example, Brett receives Medicaid in the DJJM TOA and opts out of the SKY program on 10/27. He will be dis-enrolled from Aetna on 10/31 and enrolled with Humana on 11/1.
- I. Members participating in the SKY Program are issued a SKY MCO Letter notice upon SKY enrollment. The notice explains the member's managed care coverage as well the program's benefits. Members with optional SKY enrollment receive a notice explaining how they may opt out and change their MCO.
- [J. Members receiving Medicaid in a SKY eligible TOA will continue with SKY enrollment, and the same opt-in and opt-out rules, if moving to a Continuous Coverage TOA (does not include CXCC or CHCC).]

MS 2700

MAGI SPEND DOWN PROCESS

(1)

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 due to potential ongoing eligibility for Advance Premium Tax Credits (APTC). Individuals may apply for a retroactive spend down the following month(s) provided they were not approved for APTC and enrolled in a Qualified Health Plan (QHP) during the month the medical expense was incurred. The Spend Down may be for one, two, or all three 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 individual 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.

MS 2710 MEDICAL EXPENSES IN MAGI SPEND DOWN (1)

Spend down medical expenses are expenses incurred by an individual, a spouse or dependent child under 21 in the home or away from home for school attendance. Unless already receiving Medicaid (MA), these expenses are allowed regardless of whether or not these family members are included in the case and/or regardless of whether or not their income is considered in the MA eligibility determination.

A. Consideration of Medical Expenses:

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

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

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

Example: Two years ago, an individual purchased an \$800 hearing aid and charged the full amount. Every month a \$25 payment is made on the

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

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

B. Verification of Medical Expenses:

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

C. Medical Expense Restrictions:

1. Do not list any expense to be paid by a third party, such as Medicare, health insurance, insurance settlement, family members, etc. with the following exceptions:
 - a. DO NOT hold spend down applications pending for verification of payment of medical expenses as a result of an unforeseen accident which may be covered by liability insurance owned by another person. It is the responsibility of DMS to obtain reimbursements from third party liability sources. This procedure does not apply to health insurance policies, such as, Medicare, Blue Cross/Blue Shield, Humana, etc. and Worker's Compensation. Spend down applications are held pending verification of payment of medical expenses by these third party liability sources.
 - b. For persons undergoing renal dialysis treatment, do not hold spend down applications pending for 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 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.

MS 2900 HOUSEHOLD DETERMINATION (1)

For MAGI Medicaid, Advance Premium Tax Credits (APTC), and Qualified Health Plans (QHP) 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 taxpayer 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 couple is applying for Medicaid for themselves and their 3 children, ages 4, 6, and 10. They state they aren't married and do not intend to file taxes. All household 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 size is 4. This includes the parent and all children under the age of 19. The couple is not included in each other's EDG as they are not married.

2. A mother applies for Medicaid for herself and her 10 year old son. She states she files taxes as single. Her son 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 Tax Filer rules and her EDG is calculated using her tax household.

3. A grandmother is applying for Medicaid for herself and her 14 year old granddaughter. She states she files taxes as head of household and claims her granddaughter as a dependent.

The child's EDG is 1 as she falls under Non-Filer rules due to being claimed by someone other than a parent.

The grandmother's EDG is 2 and is calculated using Tax Filer Rules.

4. The household consists of married parents and their minor child. They state they intend to file a joint income tax return and claim their 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 is 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 parents 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 Tax Filer rules and his EDG is 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 a 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.

Her EDG size is 2 and includes herself and her mother as no exceptions apply and therefore is based on the 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 custodial parent, as a dependent.

His EDG is 2 as it is based on Tax 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. The 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 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 is claimed by a non-custodial parent and meets one of the exceptions listed above.

Note: The custodial parent must apply and receive Medicaid for a child. In true joint custody situations where the child spends $\frac{1}{2}$ of the time with one parent and $\frac{1}{2}$ 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 an 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 are 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.

15. A 24 year old applies for financial assistance and states that she is filing taxes as single. Her annual income is \$24,980 and does not have health insurance through her employer. Her EDG is 1. She is eligible for APTC and QHP.

16. The household consists of married parents and their 10 year old daughter. The tax filing status is married filing jointly with the daughter claimed as a dependent. Their income is \$3,900 monthly and they are not offered health insurance through their employer. The daughter is eligible for Medicaid. The parents are eligible for APTC and QHP. Their EDG is 3.

17. The household consists of a grandmother, her daughter, and her son's 5 year old daughter. Neither parent of the 5 year old lives in the home. The grandmother files as head of household with her grandchild as a 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.

18. The household consists of a married couple applying for financial assistance to help pay for a QHP. They state that their tax filing status is married filing separately. They are denied APTC and only approved for QHP as they do not file taxes jointly.]

MS 2910 INCOME SCALES (1)

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

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

- A. All Medicaid Types of Assistance (TOA) other than CHL4 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 5% disregard is not applied for individuals receiving APTC or CSR.

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

| TOA | Category | FPL | With 5% disregard |
|------|----------------------------------|------|-------------------|
| TP45 | Deemed Eligible Newborn | N/A | N/A |
| CHL4 | Medicaid Children ages 6-18 | 109% | N/A |
| CHL2 | Medicaid Children ages 1-5 | 142% | 147% |
| CHL1 | Medicaid Children < age 1 | 195% | 200% |
| CHL3 | KCHIP Children ages 6 - 19 | 142% | 147% |
| CHEX | KCHIP Children ages 0 - 19 | 213% | 218% |
| PREG | Pregnant Women | 195% | 200% |
| CHPR | Pregnant Women | 213% | 218% |
| ADLT | Low-Income Adult 19 – 64 | 133% | 138% |
| ADPR | Low-Income Adult who is pregnant | 133% | 138% |
| APTC | Advance Premium Tax Credit | 400% | N/A |

- 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 FPL table on Worker Portal for MAGI Medicaid income limits effective 4/1/25.

E. APTC and CSR are required to use the same FPL limits for an entire coverage year. The chart below was effective 4/1/2025 and is utilized for APTC/CSR for the coverage year of 1/1/2025 to 12/31/2025:

| EDG Size | 100% | 133% | 138% | 150% | 185% | 200% | 250% | 300% | 400% |
|----------|--------|--------|--------|--------|--------|---------|---------|---------|----------|
| 1 | 15,660 | 20,820 | 21,600 | 23,484 | 28,956 | 31,308 | 39,132 | 46,956 | 62,604 |
| 2 | 21,156 | 28,140 | 29,196 | 31,728 | 39,132 | 42,300 | 52,884 | 63,456 | 84,600 |
| 3 | 26,652 | 35,448 | 36,780 | 39,984 | 49,308 | 53,304 | 66,636 | 79,956 | 106,608 |
| 4 | 32,160 | 42,768 | 44,376 | 48,228 | 59,484 | 64,308 | 80,376 | 96,456 | 128,604 |
| 5 | 37,656 | 50,076 | 51,960 | 56,484 | 69,660 | 75,300 | 94,128 | 112,956 | 150,600 |
| 6 | 43,152 | 57,396 | 59,556 | 64,728 | 79,836 | 86,304 | 107,880 | 129,456 | 172,608 |
| 7 | 48,660 | 64,716 | 67,140 | 72,984 | 90,012 | 97,308 | 121,632 | 145,956 | 194,604 |
| 8 | 54,156 | 72,024 | 74,736 | 81,228 | 28,956 | 108,300 | 135,384 | 162,456 | 216,600] |

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

| EDG SIZE | Standard | With Disregard |
|----------|----------|----------------|
| 1 | 235 | 285 |
| 2 | 291 | 358 |
| 3 | 338 | 422 |
| 4 | 419 | 521 |
| 5 | 492 | 611 |
| 6 | 556 | 692 |
| 7 | 621 | 775 |
| 8 | 687 | 858 |

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

MS 3000

INCOME ELIGIBILITY

(1)

[Income is considered verified for Modified Adjusted Gross Income (MAGI) Medicaid, Advance Premium Tax Credits (APTC), and Cost Sharing Reductions (CSR) when the client stated amount and that received from the trusted data source is reasonably compatible. Reasonable compatibility is defined as a 25 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 amount, 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. Please see MS 1320 C for more information regarding extensions of verification due dates.

For APTC and CSR, if income is not within reasonable compatibility or is not available, the application is approved based on client stated information for an initial 90-day period. The individual is issued a Request for Information (RFI) to provide verification of the client stated amount. If this information is not provided at the end of the initial 90-day period, Worker Portal will re-determine eligibility based on the trusted data sources. If information from trusted data sources is not available, eligibility for APTC/CSR will discontinue.

Note: APTC is based on annual income, rather than monthly income.

The following are examples of reasonable compatibility:

- A. If the individual attests to income that is greater than the MAGI income limits, then they 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 accepted and the application is approved based on the self-attested amount.
- C. If self-attestation of income is below the MAGI income limit but the trusted data sources return information above the income limit, as long as the self-attested amount is reasonably compatible, then the self-attested amount will be taken and application approved based on this amount.
- D. For APTC, if the client stated income is above that of the trusted data sources, client stated amount is accepted and that is considered reasonably compatible.

- E. Individuals are given the opportunity to dispute and provide satisfactory verification at any time if electronic information received will negatively impact eligibility.

MS 3100 INCOME (1)

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 25 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. For Advance Premium Tax Credit (APTC) and Cost Sharing Reduction (CSR), if the individual is required to provide verification of income, the individual is approved for an initial 90 days and an RFI is sent to the individual. If the information is not provided at the end of the 90 days, eligibility will be re-determined based on information received from the trusted data sources. If information from trusted data sources is not available, eligibility for APTC/CSR will discontinue.
- E. It is important that all income details are accurately entered in Worker Portal. This includes income begin dates and hours worked.

MS 3150 MAGI INCOME VERIFICATION (1)

[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.]

MS 3160 VERIFICATION OF NO INCOME (1)

[Client statement of no income is accepted for Modified Adjusted Gross Income (MAGI) Medicaid, Advance Premium Tax Credit (APTC), Cost Sharing Reduction (CSR), and Qualified Health Plans (QHP).]

- 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.

MS 3180 MAGI DEDUCTIONS (1)

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.]

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 over the earned income threshold requiring them to file taxes.]
- 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.

MS 3200 EXCLUDED INCOME (1)

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 dependent'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.

MS 3300

TWEENERS

(1)

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, 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 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 of income for the year. Her monthly income is over 138% FPL. However, her yearly income is below 100% FPL.

[Calculations: $\$1,405$ (monthly RSDI) $\times 6$ (July to Dec) = $\$8,430$. The 100% FPL for one is $\$1,305 \times 12 = \$15,660$ (yearly amount).]

2. Jon has been laid off from his job and has started receiving \$1,700 monthly UIB effective October. Before he was laid off, he grossed \$13,000 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: $\$1,700$ (monthly UIB) $\times 3$ (Oct to Dec) = $\$5,100$. Jon's total yearly income is: $\$5,100 + \$13,000 = \$18,100$. The 100% FPL for one is $\$1,305 \times 12 = \$15,660$ (yearly amount).

3. Kay started a new job in September and makes \$1,700 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: $\$1,700$ (monthly income) $\times 4$ (Sept to Dec) = $\$6,800$. The 100% FPL for one is $\$1,305 \times 12 = \$15,660$ (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.

MS 3400 LOTTERY AND GAMBLING WINNINGS (1)

Lottery and gambling winnings are monies an individual receives from gambling or winning the lottery. These winnings are countable income in the winners MAGI Medicaid eligibility determination. Winnings may be received as either a lump sum payout or as recurring installments and is considered income beginning the month the winnings are received.

Worker Portal receives a weekly interface from the Kentucky Lottery Commission for all members who received lottery winnings of \$600 or more. If a match is found for a member, an unearned income record is added with the Income Type as Lottery Payments. Information received from this interface is considered verified upon receipt and further verification is not required.

A. If the winning amount is received as a lump sum payout, the income is considered as follows:

1. If the winning amount is under \$80,000, the amount is considered as unearned income only in the month received for the winner and any members with whom the winner is included in their Eligibility Determination Group (EDG).

Example: Kim and her spouse, Rob, both receive MAGI Medicaid. Kim wins \$50,000 in the lottery and chooses a lump sum payout which she receives on 6/12. \$50,000 is counted as a non-recurring lump sum for Kim and Rob for the month of June.

2. If the winning amount is \$80,000 or above:

- a. For the winner, winnings of \$80,000 or above, but less than \$90,000, is considered as income over two months, with equal amounts counted in each month. For each additional \$10,000 won, one month is added. The total winnings are then divided and counted as income with an equal amount considered in each month.

Example: Dan wins the lottery on 3/12 and receives a lump sum payout of \$80,000. \$40,000 is counted as income in the months of March and April ($\$80,000/2=\$40,000$).

Example: Cindy wins the lottery on 2/17 and receives a lump sum payout of \$93,000. \$31,000 is considered as income in the months of February, March, and April ($\$93,000/3=\$31,000$).

- b. The chart below displays the months in which income is considered in the MAGI Medicaid eligibility determination for the member who won.

| Income from Amount | Income up to Amount | Number of Months the Income is Counted |
|--------------------|---------------------|--|
| \$1 | \$79,999 | 1 |
| \$80,000 | \$89,999 | 2 |
| \$90,000 | \$99,999 | 3 |
| \$100,000 | \$109,999 | 4 |
| \$110,000 | \$119,999 | 5 |
| \$120,000 | \$129,999 | 6 |
| \$130,000 | \$139,999 | 7 |
| \$140,000 | \$149,999 | 8 |
| \$150,000 | \$159,999 | 9 |
| \$160,000 | \$169,999 | 10 |
| \$170,000 | \$179,999 | 11 |
| \$180,000 | \$189,999 | 12 |
| \$190,000 | \$199,999 | 13 |
| \$200,000 | \$209,000 | 14 |

Note: The sequence in the chart above continues, with an additional month added per each additional \$10,000 of winnings received. The maximum number of months winnings may be counted is 120 months, which equals winnings of \$1,260,000 or above.

- c. For other members in whose EDG the winner is included, the lump sum payout is considered non-recurring lump sum income only in the month the winnings are received.

Example: Bert and his wife, Barbara, both receive MAGI Medicaid. Bert wins \$80,000 and receives a lump sum payout on 11/12. \$40,000 is countable income in the months of November and December for Bert ($\$80,000/2=\$40,000$). \$80,000 is considered as non-recurring lump sum income in the month of November only for Barbara.

Example: Rick and his wife, Deb, both receive MAGI Medicaid. Rick wins the lottery on 7/27 and receives \$96,000 as a lump sum payout. \$32,000 is countable income in the months of July, August, and September for Rick ($\$96,000/3=\$32,000$). The \$96,000 winnings are counted as income in the month of July only for Deb.

- B. Lottery winnings received as recurring installment payments are considered as ongoing unearned income for all members included in the winners EDG.

Example: Vickie and her husband, Ray, receive MAGI Medicaid. Vickie wins \$95,000 in the lottery on 8/3 and receives recurring installment payments in the amount of \$500 monthly. Unearned income of \$500/month is counted in Vickie and Ray's eligibility determination beginning in August.

- C. If lottery or gambling winnings received as a lump sum payout results in the discontinuance of the member's MAGI Medicaid eligibility, a notice "Information Regarding Lottery/Gambling Winnings" is issued to explain the period in which

the income is considered in their eligibility determination. Individuals ineligible for Medicaid as a result of receiving winnings as a lump sum payout over \$80,000 may request a hardship exemption. To request a hardship exemption, individuals must provide a written statement explaining the circumstances leading to the Medicaid denial or discontinuance, and why it causes an undue hardship. The statement requesting a hardship determination along with any supporting documents must be scanned into the Electronic Case File (ECF). Complete the Request Undue Hardship screen on Worker Portal to generate a task for the Department for Medicaid Services (DMS) review. Once a determination is made, a task will generate for a DCBS worker to take appropriate action based on DMS outcome.

Example: Bob wins \$300,000 in the lottery and chooses to receive it as a lump sum payout. He spends all his winnings to buy a house and a new car, not knowing this income would make him ineligible for Medicaid. Now Bob needs surgery but has no money left to pay for it and his Medicaid is discontinued. Bob may request a hardship exemption for DMS to determine if he may still receive Medicaid.

- D. [Individuals who are ineligible for Medicaid due to lottery or gambling winnings are still potentially eligible for a Qualified Health Plan (QHP) and/or Advance Premium Tax Credit (APTC) through the State Based Marketplace (SBM).]

MS 4000 TRANSITIONAL MEDICAL ASSISTANCE (1)

[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 correctly 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.

*MS 4100 TMA ELIGIBILITY AND REPORTING REQUIREMENTS (1)

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.

MS 4300 [QUALIFIED HEALTH PLAN (1)

Individuals who are not eligible for Medicaid or who are looking for affordable health care coverage may enroll in a Qualified Health Plan (QHP) through the State Based Marketplace (SBM). In addition to enrolling in a QHP, individuals can also apply for financial assistance towards paying for a QHP on the SBM through the Advance Premium Tax Credit (APTC) program and Cost Sharing Reduction (CSR) program. For more information regarding APTC refer to MS [4303](#). For more information regarding CSR refer to MS [4305](#).

- A. A QHP is a commercial insurance plan offered through the SBM. These plans are offered to individuals at full premium cost without subsidy or with premium assistance for qualified individuals. These plans are available to all US citizens, or lawfully present non-citizens, who are residents of Kentucky and are not incarcerated.
- B. QHPs available on the SBM offer various levels of coverage. These metal levels do not reflect the quality or amount of care the plans provide. The level determines the amount of premium costs each month and copays or coinsurance (e.g. doctor or hospital visits, or prescription medications). It also affects the total out-of-pocket costs – the total amount that an individual will spend for the year if medical care is needed.
 - 1. Bronze – 60/40
 - 2. Silver – 70/30
 - 3. Gold – 80/20
 - 4. Platinum – 90/10
 - 5. Catastrophic Plans

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

Issuers participating in the SBM are only required to offer a silver or gold level plan and a catastrophic plan in the individual insurance market.

Catastrophic plans may be available to people under 30 years old or individuals who receive a hardship exemption. A catastrophic health plan is minimum coverage designed to provide an emergency safety net for unexpected medical costs.

- C. Individuals receiving Medicare are not eligible to purchase a QHP.
- D. An individual may submit an application for a QHP at any time during the year, but the individual can only enroll in a QHP during open enrollment and special enrollment periods.
 - 1. Open enrollment- The initial open enrollment for the plan year of 2022 will begin November 1, 2021, and extend through January 15, 2022.

A plan selected during open enrollment cannot be effective prior to January 1st. However, the actual effective date after January 1st is

dependent upon when an individual enrolls and when their premium payment is received. Most plans start dates are based on the mid-month rule, which states that if a plan is selected between the 1st and the 15th of the month, coverage starts on the first day of the following month. However, if a plan is selected between the 16th and the last calendar day of the month, the coverage effective date starts on the 1st day of the second following month.

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

Depending on the qualifying life event type, individuals may have 60 days before or 60 days following the event to enroll in a health plan. A qualified individual may enroll or make changes to the QHP when a qualifying event occurs. Some examples are:

- a. A qualified individual or dependent of the qualified individual loses Minimum Essential Coverage (MEC), including employer sponsored coverage;

Note: Failure to pay premiums will not qualify an individual for a Special Enrollment Period;

- b. A qualified individual or dependent of the qualified individual is enrolled in COBRA continuation coverage, and the employer contributions for such coverage completely cease;
- c. A qualified individual or dependent of the qualified individual loses pregnancy-related coverage or loses medically needy coverage through Medicaid;
- d. A qualified individual gains or becomes a dependent through marriage, birth, adoption, placement for adoption or foster care, or child support or other court order;
- e. A qualified individual gains status as a citizen or lawful presence status is met;
- f. A qualified individual or dependent of the qualified individual loses coverage due to non-renewal of expiring individual coverage;
- g. The enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation, or if the enrollee or dependent of enrollee passes away;
- h. A qualified individual or dependent of a qualified individual enrolls or fails to enroll in QHP due to an error, misrepresentation, or inaction of an officer, employee, or agent of the SBM or Health and Human Services (HHS);

- i. An enrollee or dependent of an enrollee demonstrates to the SBM that the QHP substantially violates a provision of its contract;
- j. An enrollee is determined newly eligible or newly ineligible for APTC or has a change in eligibility for CSR;
- k. A qualified individual or dependent of a qualified individual who is enrolled in an employer-sponsored plan is determined newly eligible for APTC in part on a finding that the individual will no longer be eligible for qualifying coverage in that plan in the next sixty days and is allowed to terminate existing coverage;
- l. A qualified individual or dependent of a qualified individual or enrollee gains access to a QHP as a result of a change in residence;
- m. An individual is an American Indian/Alaskan Native who may enroll in a QHP or change from one QHP to another QHP one time per month; or
- n. An individual demonstrates to the SBM exceptional circumstances.

Note: An individual may have to provide verification of the qualifying event.]

MS 4303 ADVANCE PREMIUM TAX CREDIT (1)

Advance Premium Tax Credit (APTC) is assistance for premium payments offered through the State Based Marketplace (SBM) for the purchase of a Qualified Health Plan (QHP) to families whose annual income is between 100% and 400% of the Federal Poverty Level (FPL). The assistance is in the form of a tax credit that can be applied monthly or utilized as an annual tax credit when filing a federal income tax return. An individual must be determined ineligible for Modified Adjusted Gross Income (MAGI) Medicaid to qualify for APTC.

A. Along with the income guidelines, the individual must also meet the following technical eligibility requirements to qualify for APTC:

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

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

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

1. The tax credit is based on the total gross income compared to the appropriate FPL. This comparison determines the percentage of household income that is required to be contributed towards the cost of coverage and is based on estimated yearly income. The credit a person receives is the difference between that percentage and the cost of the second lowest silver plan that could cover eligible members.
2. Once an individual (tax filer) is determined eligible for APTC, Worker Portal will display the amount they are eligible to receive. The member can then select a QHP. Once a plan is selected, the member must then determine how much of the tax credit they would like to apply to the monthly premium. APTC may be used to reduce the monthly cost of the QHP premium or the member may choose to be reimbursed for the out-of-pocket premium expense when an annual income tax return is filed, up to the amount of the APTC.
3. If an individual chooses to use the APTC credit at the time they purchase a plan, the Issuer of the chosen plan will send an invoice to the Federal Government for the APTC. The monthly cost of the plan an individual is responsible to pay is reduced by the amount of APTC credit and no money is actually received by an individual.

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

- D. [If the income matched with the Federal HUB and the client stated amount of income are not reasonably compatible, a Request for Information (RFI) is sent giving the individual 90 days to provide sufficient verification.
1. The individual can continue to receive APTC during the 90-day period. However, if sufficient verification is not received, eligibility is re-determined based on the income information obtained from the trusted data sources. The tax credit is reconciled at the end of the year and the individual may be required to pay back any amount of tax credit they received in error.
 2. If the income returned by the Federal HUB differs from the member's anticipated, annual income, a statement of Reasonable Explanation can be provided as clarification. This statement is written by the member to verify their income for APTC only cannot be used for Medicaid. Examples of Reasonable Explanation include, but are not limited to:
 - a. Contract worker or self-employed;
 - b. Have not filed taxes yet;
 - c. Income varies month by month;
 - d. Income includes commissions, dividends, or royalties;
 - e. Living situation/homelessness;
 - f. Loss or change in unearned income;
 - g. Lost job;
 - f. Multiple employers;
 - i. Newly divorced or married;
 - j. Seasonal or gig worker; and
 - k. Victim of domestic violence, identity theft, or natural disaster.
 3. If APTC is discontinued, the individual must pay the full amount of the premium for the QHP.]
- E. Individuals who are currently covered through an affordable Employer Sponsored Insurance (ESI) are not eligible for APTC. However, if the ESI employee premium for employee-only coverage is more than 9.5 percent of the household income, the coverage is deemed unaffordable and the individual can dis-enroll from ESI and become eligible for APTC.
- F. Individuals are not eligible to receive APTC if they are eligible for MEC. MEC is the minimum amount of coverage an individual needs to meet the individual responsibility requirement as outlined in the Affordable Care Act (ACA).

Individuals should not be receiving APTC if:

1. The individual is eligible to receive Medicaid or KCHIP;
2. The individual is enrolled in one of the following: Peace Corps insurance, Veteran's Affairs programs, TRICARE, or other qualifying government insurance programs, such as Medicare;
3. The individual's employer provides coverage that is affordable, of minimum value, and offered to all members of the family;

4. The family's APTC eligibility may not be affected if only one person in the household is receiving MEC and all remaining members are not. At least one of the remaining members may be eligible for APTC.
- G. Individuals already enrolled in a Qualified Health Plan who later become eligible for Medicare, may be dually eligible for QHP/APTC and Medicare, if certain criteria are met.
1. If an individual already is enrolled in a QHP becomes eligible for Medicare Part B, they may remain enrolled in their QHP and keep their APTC.
 2. If an individual is enrolled in a QHP and later becomes eligible for Medicare Parts A and B, they are allowed to remain enrolled in their QHP but are not eligible for APTC.
 3. Individuals only eligible for Medicare Part A do not have dual eligibility for medical QHPs and APTC.
 4. Individuals dually eligible for Medicare and QHP cannot change their enrollment, even during the annual Open Enrollment period. If the enrollment is changed, the individual will lose their dual eligibility.
- H. APTC shall be authorized by Kentucky Health Benefit Exchange (KHBE), on behalf of a tax filer, only if the KHBE obtains necessary attestations for the tax filer that:
1. An income tax return will be filed for the benefit year;
 2. A joint tax return is filed, if the tax filer is married;
 3. No other taxpayer will be able to claim the tax filer as a dependent for the benefit year; and
 4. The tax filer will claim a personal exemption deduction on the tax filer's return for the applicants identified as members of the tax filer's family.
- I. An individual can still receive APTC for the initial plan year even if they did not file a tax return for the previous year.
- J. [Individuals filing taxes as married filing separately are not eligible for APTC.

Note: Individuals may file married filing separately and be eligible for APTC if they are victims of domestic abuse and spousal abandonment. Client statement is accepted as verification of domestic abuse.]

MS 4305 COST SHARING REDUCTION (1)

Cost Sharing Reduction (CSR) is a program offered through the State Based Marketplace (SBM) that reduces out-of-pocket expenses for consumers with income up to 250% of the Federal Poverty Limit (FPL), eligible for the Advance Premium Tax Credit (APTC), and purchase a Qualified Health Plan (QHP) through the SBM. This program lowers deductibles, co-pays, and co-insurance by the government sharing the costs with the consumer. In Kentucky, CSRs are referred to as special discounts.

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

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

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

| Income | Out-of-Pocket Maximum for Silver QHPs (individual/family) |
|----------------|--|
| 100 – 150% FPL | [\$2,900/individual; \$5,800/family] |
| 150 – 200% FPL | \$2,900/individual; \$5,800/family |
| 200 – 250% FPL | \$6,950/individual; \$13,900/family] |

D. American Indians/Alaskan Natives (AIAN) are eligible for CSR if they purchase any level QHP and they meet the following criteria:

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

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

MS 4307* AMERICAN INDIAN/ALASKAN NATIVE (1)

Native Americans are often referred to in federal programs or documents as American Indian/Alaskan Native (AIAN). AIAN individuals can qualify for increased Cost Sharing Reduction (CSR) benefits. These special discounts are available to AIAN individuals no matter what plan they enroll in; they do not need to enroll in a silver plan.

AIAN individuals also can enroll in health coverage at any time during the year, not just during Open Enrollment and change plans up to once a month. AIAN status must be verified only if the individual is either applying for CSR benefits or enrolling in or changing plans outside of Open Enrollment.

There are no tribal lands in the state of Kentucky, but tribal members do reside here. AIAN must be verified only if the individual is applying for CSR benefits or enrolling in a plan outside of Open Enrollment.

Tribal members can verify AIAN status by providing adequate documentation of tribal affiliation.

No electronic sources exist to verify AIAN status.

MS 4315* RENEWALS FOR QHP, APTC, AND CSR (1)

The renewal process for Qualified Health Plans (QHP), Advance Premium Tax Credit (APTC), and Cost Sharing Reduction (CSR) is completed annually. This process is initiated automatically by Worker Portal on September 1st each year, regardless of the month the individual was approved. When the renewal process is completed any changes are effective with the upcoming benefit year beginning January 1st.

An individual must either agree or disagree to authorize Worker Portal to access the Federal Hub to obtain updated tax information in order to conduct the renewal process. This authorization is only needed if an enrollee is requesting a redetermination of APTC or CSR. The individual will be asked to select 0 to 5 years. If an individual disagrees and selects 0, the individual will not be able to be passively renewed.

If authorization to access the Federal HUB has not been given, Worker Portal will re-determine the enrollee's eligibility for QHP, and the individual will be notified that the renewal process cannot proceed for APTC or CSR until authorization has been granted.

If the individual does not grant the authorization, Worker Portal will issue a Request for Information (RFI) requesting verification from the individual to determine eligibility for APTC and CSR.

If authorization has been given, Worker Portal will request updated tax information on the individual(s) from the Federal Hub. A combined notice of eligibility redetermination and notice of annual open enrollment will be issued on September 1st. An enrollee will have 30 days to report any changes to the information that is prepopulated on the notice.

The annual redetermination notice will contain the following information:

1. Information used in most recent eligibility determination; and
2. The projected eligibility for the upcoming benefit year.

This notice must be signed *and* returned, and any changes reported will be verified by Worker Portal via the Federal Hub. If the notice is not returned, eligibility will be re-determined using information obtained from the Hub. Upon redetermination of eligibility, Worker Portal will issue a second notice of final eligibility determination for the upcoming benefit year.

If an individual remains eligible for coverage in a QHP after the final eligibility determination, they will continue with the same plan unless the individual terminates coverage and enrolls in a different QHP.

MS 4500

MAGI ACRONYMS

(1)

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.

| Acronym | Definition |
|---------|--|
| ACA | Affordable Care Act |
| [AIAN | American Indian/Alaskan Native] |
| APTC | Advance Premium Tax Credit |
| AR | Authorized Representative |
| CAC | Certified Application Counselors |
| CBW | Children's Benefit Worker |
| CMS | Centers for Medicare & Medicaid Services |
| CSE | Child Support Enforcement |
| [CSR | Cost Sharing Reduction] |
| DCBS | Department for Community Based Services |
| DHS | Department of Homeland Security |
| DMS | Department for Medicaid Services |
| ECF | Electronic Case File |
| EDG | Eligibility Determination Group |
| ESI | Employer Sponsored Insurance |
| FFM | Federally Facilitated Marketplace |
| FPL | Federal Poverty Level |
| HIPAA | Health Insurance Portability and Accountability Act |
| KCC | Kentucky Career Center |
| KCHIP | Kentucky Children's Health Insurance Program |
| KI-HIPP | Kentucky Integrated Health Insurance Premium Payment |
| KOG | Kentucky Online Gateway |
| LPR | Lawful Permanent Resident |
| LTC | Long Term Care |
| MA | Medicaid |
| MAGI | Modified Adjusted Gross Income |
| MCO | Managed Care Organization |
| MEC | Minimum Essential Coverage |
| MSBB | Medical Support and Benefits Branch |
| MSE | Medical Support Enforcement |
| OIG | Office of Inspector General |
| PARIS | Public Assistance Reporting Information System |
| PCP | Primary Care Provider |
| PDS | Participant Directed Services |
| PE | Presumptive Eligibility |
| POA | Power of Attorney |
| PRTF | Psychiatric Residential Treatment Facility |
| PTC | Premium Tax Credit |
| QA | Quality Assurance |
| QHP | Qualified Health Plan |
| QMB | Qualified Medicare Beneficiary |
| RFI | Request for Information |
| RSDI | Retirement, Survivors, Disability Insurance |

| | |
|-------|--|
| [SBM | State Based Marketplace] |
| SLMB | Specified-Low Income Medicare Beneficiaries |
| SSA | Social Security Administration |
| SSI | Supplemental Security Income |
| SSP | Self Service Portal |
| SUD | Substance Use Disorder |
| TPL | Third Party Liability |
| TMA | Transitional Medical Assistance |
| TOA | Type of Assistance |
| USCIS | United States Citizenship and Immigration Services |

MS 5000

KI-HIPP OVERVIEW

(1)

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

A. Who is eligible:

1. Individuals who have access to or are enrolled in a health insurance plan. The policyholder does not have to be Medicaid eligible; however, at least one individual on the plan must be eligible for Medicaid.
2. The Medicaid member must be eligible for a KI-HIPP approved health insurance plan. If the member is not enrolled in a plan, KI-HIPP staff will determine if 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 kynect benefits Self-Service Portal (SSP);]
 - b. Emailing documents directly to KI-HIPP staff at KIHIPPProgram@ky.gov;
 - c. Bringing documents into a DCBS office; or
 - d. Mailing documents to KI-HIPP at:

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

Note: If KI-HIPP documentation is returned to the local office, DCBS is responsible to scan them 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.