MEDICAID ELIGIBILITY AND PATIENT LIABILITY DETERMINATIONS
The Department for Medicaid Services (DMS) contracts with the Department for Community Based Services (DCBS) to determine technical and financial eligibility for Medicaid applicants.

The Eligibility Policy Branch in the Division of Member Services monitors this contract.
Kentucky is a 1634 state, meaning that we rely on the Social Security Administration to determine Medicaid eligibility for the Supplemental Security Income (SSI) beneficiaries of our state.
Categorically Needy—eligible because they receive (or could receive) another means tested benefit. Such as:

- SSI recipients;
- The state cash assistance program: TANF formerly known as AFDC;
- State Supplementation
- This group also includes pregnant women & children
Federal Eligibility groups

• Means-tested benefit group

Is a group of welfare recipients who receive services based not only on a need, but on income levels and available resources.
Federal Eligibility Groups

• **Medically Needy**-
  An option for states to extend eligibility to additional qualified persons who may have too much income to qualify under the categorically needy group, this option includes “spend down”.

• **K-CHIP**-
  Children eligible based solely on family income.
Eligibility Systems

- **KAMES**-Kentucky Automated Management and Eligibility System. DCBS eligibility system for food benefits, TANF benefits and Medicaid

- **PAS**-Public Assistance System, also known as PA-62 (after the input document). DCBS eligibility system used mostly to issue LTC eligibility for SSI recipients

- **SDX**- State Data Exchange. SSA SSI eligibility file
Eligibility Period

Kentucky Medicaid eligibility usually begins on the first day of the month application is made.

Retroactive eligibility may be approved for up to 3 months prior to the application, if the applicant was eligible and had medical expenses during that time. (Passport region is excluded from retroactive coverage, except as spend-down).

Eligibility must be reviewed annually.
Basic Medicaid Eligibility

• Must be a Kentucky resident
• Must have a Social Security Number
• Must verify identity
• Must be a US Citizen or qualified alien
• Must comply with Third Party Liability (TPL). If there is other health coverage, it must be billed before Medicaid.
Kentucky’s eligible population falls into one of the following:

- **Family MA** (based on AFDC policies)- child under 19 years old, caretaker relative of a child who is deprived of parental support, or a pregnant woman.

- **Adult MA** (based on SSI policies)- aged (65 or older), blind, or disabled.

- **KCHIP** (Title XXI) coverage for low income, uninsured children
Medicaid Financial Eligibility

For the Adult, Family, and KCHIP group’s household income and resources must fall within established guidelines.

- Income includes both earned and unearned
- Resources are anything that can be converted to cash (KCHIP eligible is based on income alone)
Financial Eligibility rules for LTC

• There are additional financial rules that apply to individuals needing LTC assistance to cover Nursing Home and/or Community Care Waivers.
  – Look back/transfer rules
  – Community Spouse impoverishment rules
  – Cost share rules
  – Expanded Income guidelines (Miller Trust/Qualifying Income Trust)
  – Estate recovery
Look Back Rules

With the passage of the Deficit Reduction Act (DRA) of 2005, signed into law Feb. 8, 2006, look back rules were tightened, and the look back time frame was expanded from three years to five years.

Individuals applying for LTC benefits can not have disposed of any assets for less than fair market value during the look back period.

If transfers occurred a penalty period is established.
Spousal Impoverishment Rules

• These rules apply when one member of a couple enters a NF or Waiver and is expected to remain there for at least 30 days. These provisions help ensure that the spouse who is living in the community retains adequate income and resources to maintain their standard of living.

• Not applicable if both spouses are in a NF or Waiver.
Spousal Impoverishment Rules

Income rules:

• The Institutionalized Spouse (IS) may deem income to the Community Spouse (CS), as needed to bring the CS income up to $1,822. If the spouse has monthly shelter expenses over $547, that excess shelter cost may be added to the $1,822 (the total cannot be more than $2,267).

• If there are dependent children in the home, an addition amount of money can be deemed to provide for their care.

* These amounts are adjusted annually in July.
Spousal Impoverishment Rules

Resource rules:

A resource assessment can be completed after institutionalization to identify the amount the community spouse can protect, and the amount that must be counted as available to the institutionalized spouse, and spent down to gain eligibility.

If the period of institutionalization ends (out of care for > 30 days) a new assessment will be needed.
Cost Share Rules

• When receiving benefits at Nursing Facility level of care the member has cost share known as Patient Liability (PL). Medicaid’s payment to the provider shall be reduced by the amount of the member’s PL.

• PL amount is determined by DCBS.
Cost Share Rules

Calculating Patient Liability

• The process starts by determining the total income of the member and subtracting from that allowable deductions, the balance is the PL.

• Allowable deductions include:
  – A personal needs allowance:
    • $40 NF { $30 for SSI recipients},
    • $694 Waiver- adjusted yearly to equal the SSI benefit plus $20
  – Community spouse’s monthly income allowance (if applicable and paid)
  – Family income allowance if there are minor children in the home
  – Allowable medical expenses
Income limits for LTC

- Under the Medically Needy group, for LTC benefits, income can be as high as three times the SSI benefit level.
- For applicants with income in excess of this amount, income eligibility can be obtained by use of a Qualifying Income Trust (QIT)/Miller Trust. The applicant routes their excess income to the Trust, and can not utilize these funds for any purpose not authorized by 42 ISC 1396p(d)(4)(B).
What is estate recovery?

Federally mandated process where Medicaid recoups certain Medicaid payments after a recipient’s death.

States must alert individuals of this effort during their initial application, and at every re-determination.
For active members in a covered group who are later identified as needing Nursing Facility Level of Care (LOC) by the Peer Review Organization (PRO). DCBS receives notification that a LOC has been met (the active member was admitted to a NF or Waiver) and completes the needed tasks to determine LTC eligibility. Once completed the eligibility system generates a MAP-552.
SHP’s, our PRO, receives the request for LOC and makes the medical determination. For the following:

Once LOC is approved it passes to KAMES:

- NF/PRTF/Free Standing Facility
- HCB Waiver, and
- Model Waiver II

For all other’s the LOC passes when a service is PA’ed.
The LOC passed to KAMES includes:

- The admit dates;
- The date LOC was met;
- The provider number; and
- The date it was passed to DCBS.
LOC for an SSI recipient

Basic eligibility has already been established for this population, that eligibility included penalties for transfers imposed by SSA.

SSI recipients with no other income who enter a NF, will have their SSI payment reduced to $30, and will have a zero PL. SSI recipients with other unearned income equal to or greater than $50 will lose their SSI, and an application will need to be made at the local DCBS office.

For SSI recipients DCBS should generate the MAP-552 within 10 calendar days of their receipt of the LOC.
LOC for SSI recipients

There are valid issues that can delay this time frame.

- The member has multiple LOC’s (waiver and NF) and the prior provider failed to notify DCBS of the discharge.
- The PA 62 system rejects the document.
- The LOC did not pass to KAMES.
LOC for SSI recipients

What is being done to improve this performance level

- Steps are being taken to move this population from the PA-62 system to KAMES.
- Reports are being generated to detail the timeline between LOC and PL.
- Commitments have been made by both DCBS and DMS to reduce delays in this area.
LOC for an SSI recipient

What can you do?

• Check KY HealthNet to verify the member is an SSI recipient. SSI populations will be A, B or D program codes.

• Alert DCBS in a timely fashion of discharges.

• After 10 calendar days from your PA you can contact the local DCBS office.

• If contact with the local DCBS has failed to resolve your issue, you can contact Member Services at 1-800-635-2570.
Please note Medicare Savings Plan members are not active Medicaid members, therefore an application must be filed. These members have Program codes beginning with “Z”.

For some active members the receipt of LOC is much like the SSI population, the MAP-552 is generated attached to their existing case, and should be completed within 10 calendar days.

However, some members are active in cases that can not co-exist with a vendor payment, anyone who needs a MAP-552 is a vendor payment case. These include Medicaid Works cases (Program code KW and MW), some State Supplementation cases and KCHIP P7 children.
If the member is in a case that can’t support a MAP-552, the member must make an informed decision regarding the two benefits.

• For example someone receiving Medicaid via Medicaid Works may have a higher cost share if they elect waiver, once they learn the amount of the cost share they may chose to retain their current Medicaid status.
Some State Supplementation cases can not co-exist with Waiver. As many of these create overlapping benefits for the member. In those instances the member must indicate to their DCBS worker which services they want.
LOC for non-Medicaid individuals

- An application must be filed and it is preferable that this function be completed by a family member. Facilities can make the application, however because they are not familiar with the circumstances prior to admittance, this is not the recommended practice. Making a false statement on an application for public assistance is fraud.

- A MAP-14 may be needed if the facility makes the application.
Applicants must meet **Patient Status** before Medicaid can be approved. Patient Status is met once the individual is receiving services for 30 consecutive days. The only exception is when death occurs prior to the 30th day.
LOC for non-Medicaid individuals

The application process for this population can be time consuming.

Providers can request the applicant provide them with copies of documents received when the application is filed. They can request updates as time passes.

Items that would delay processing include:

- Trust
- Annuities
- Pre-paid burial’s funded by life insurance
LOC for non-Medicaid Individuals

• Minor Children residing with their parents

Children can be separated from their parent’s income and resources after being at NF LOC for 30 consecutive days. They must have a determination of disability, if one has not been made DCBS will request this determination from DDS. This process can take up to 60 days or more. If the parent’s income is greater than the allowable limit, the first month of services will be private pay and Medicaid eligibility can be determined for the following month, counting only the child’s income and resources.
The original first month of eligibility PL is generally zero, this is because the first month has generally lapsed before the notification is generated alerting the member of their responsibility. However, individuals spending down with private pay dates will have a PL in the month of approval.

If the eligibility process extends beyond 30 days, providers may choose to counsel with their patients to reserve an estimated portion of their income to cover the cost of care.
Undue Hardship

• For applicants who have been denied benefits due to a transfer during the look back period, the provider can request an undue hardship determination. To make the request contact the local DCBS office. The request should include a discharge notice, all efforts the individual has made to recover the assets, and a summary of events that led to the transfer.
• For example.
  – Mary’s POA transferred Mary’s home to herself and left town. Mary was denied benefits and is now being discharged from your facility for non-payment. You have made efforts to reach the POA by mailing Certified letters, you have counseled with the individual and another POA has been named. You have documentation that the new POA has filed legal action against the offending party. All supporting documentation must be included in your request for undue hardship.
Frequent Problems and Resolutions

• The start date of eligibility does not agree with your admit date.

  **Possible problem**

  • Private pay dates
  • Wrong admit date entered on the LOC
  • Ineligibility period due to a transfer in the look back period
  • DCBS worker error

  **Resolution:**
  
  Contact the DCBS worker to verify the above, if not resolvable at that level call Member Service.
Frequent Problems and Resolution

• The PL on the MAP-552 does not agree with MMIS
  – Possible problem
    • The date did not update correctly on MMIS
    • You do not have the most recent MAP-552
  – Resolution
    • Soon MAP-552’s will be found on KY Health Net
    • Call Member Services at 1-800-635-2570 they can advise if you have the most recent MAP-552 and make corrections if necessary
Frequent Problems and Resolution

Timelines have passed and no MAP-552 has been generated.

Resolution:

For active cases if contact with the local office does not resolve contact Member Services

For pending cases, if contact with the local office does not resolve, ask to speak with the supervisor, then the program specialist. If that does not produce results contact the Eligibility Policy Branch at 502-564-6204
Frequent Problems and Resolution

• We will update and expand this section as issues are identified.
• Member Services Call Center 800-635-2570
• To locate the phone number for the local DCBS office: https://apps.chfs.ky.gov/Office_Phone/index.aspx
• Eligibility Policy Branch 502-564-6204