907 KAR 1:006. Coverage of and payment for services for persons eligible for benefits under both Title XIX and Title XVIII.

RELATES TO: KRS 205.520, 42 U.S.C. 1396a, 1396a(n)
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), EO 2004-726
NECESSITY, FUNCTION, AND CONFORMITY: EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services. The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program in accordance with Title XIX of the Social Security Act. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. This administrative regulation establishes the provisions for coverage of and payment for services for categorically needy and medically needy individuals eligible for benefits under both Title XIX (42 U.S.C. 1396 to 1396v) and Title XVIII (42 U.S.C. 1395 to 1395ggg).

Section 1. Definitions. (1) "Coinsurance" means that portion of each bill a Medicare-eligible person pays for a covered benefit, including copayments.
(2) "Deductible" means an amount paid by a Medicare-eligible person before Medicare begins paying its portion of a medical bill.
(3) "Department" means the Department for Medicaid Services or its designee.
(4) "Medicare Part A" means federal health insurance that covers:
(a) Inpatient hospital or skilled nursing facility services, including blood;
(b) Hospice services; and
(c) Home health services.
(5) "Medicare Part B" means federal health insurance that covers:
(a) Physician services;
(b) Outpatient hospital services;
(c) Durable medical equipment; and
(d) Other services not covered under Medicare Part A.
(6) "Premium" means a monthly amount paid for coverage of Medicare Part A or Part B.
(7) "Qualified disabled and working individual" or "QDWI" means an individual who meets the requirements in 42 U.S.C. 1396d(s).
(8) "Qualified individual one" or "QI-1" means an individual who meets the requirements in 42 U.S.C. 1396a(a)(10)(E)(iv)(II).
(9) "Qualified Medicare beneficiary" or "QMB" means an individual who meets the requirements in 42 U.S.C. 1396d(p)(1).
(10) "Specified low-income Medicare beneficiary" or "SLMB" means an individual who meets the requirements in 42 U.S.C. 1396a(a)(10)(E)(iii).

Section 2. Medicare Buy-in. The department shall purchase through the Social Security Administration:
(1) Medicare Part B for a recipient eligible for Medicare who is receiving a money payment under the state program of optional or mandatory supplementation;
(2) Medicare Part A and Medicare Part B for a recipient determined eligible as a QMB;
(3) Medicare Part B for a recipient determined eligible as a SLMB;
(4) Medicare Part A for a recipient determined eligible as a QDWI; and
(5) Medicare Part B for a recipient determined eligible as a QI-1.

Section 3. Payment of Deductibles and Coinsurance. (1) The department shall pay the deductible and coinsurance for a benefit covered under Medicare Part A or Medicare Part B for an individual eligible for:

(a) QMB coverage; or

(b) Both Title XVIII and Title XIX benefits.

(2) The amount of deductible and coinsurance paid by the department to a provider for a benefit covered under Medicare Part A shall be the lesser of:

(a) The Medicaid-allowed amount minus the Medicare payment; or

(b) The Medicare coinsurance and deductible, up to the Medicaid-allowed amount.

(3) With the exception of services identified in subsection (4)(a) through (m) of this section, the amount of coinsurance and deductible paid by the department to a provider for a benefit covered under Medicare Part B shall be the full amount of the deductible and coinsurance.

(4) The amount of deductible and coinsurance paid by the department for a service provided in accordance with one (1) of the following administrative regulations and covered under Medicare Part B shall be the lesser of the Medicaid-allowed amount minus the Medicare payment or the Medicare coinsurance and deductible up to the Medicaid-allowed amount:

(a) 907 KAR 23:010, Outpatient Pharmacy Program; or

(b) 907 KAR 1:026, Dental services;

(c) 907 KAR 1:028, Other laboratory and x-ray services;

(d) 907 KAR 1:038, Hearing and Vision Program services;

(e) 907 KAR 1:044, Mental Health Center services;

(f) 907 KAR 1:060, Medical transportation;

(g) Ancillary services pursuant to 907 KAR 1:065, Payments for Price-based Nursing Facility Services;

(h) Ancillary services pursuant to 907 KAR 1:025, Payment for services provided by an intermediate care facility for the mentally retarded and developmentally disabled, a dually-licensed pediatric facility, an institution for mental diseases, and a nursing facility with an all-inclusive rate unit;

(i) 907 KAR 1:102, Advanced registered nurse practitioner services;

(j) 907 KAR 1:270, Podiatry Program services;

(k) 907 KAR 1:479, Durable medical equipment covered benefits and reimbursement;

(l) 907 KAR 3:005, Physicians' services; or

(m) 907 KAR 3:125, Chiropractic services and reimbursement.

(5) A payment made by the department under this section of this administrative regulation shall be considered as payment in full for a benefit provided under Medicare Part A or B.

Section 4. Obligation for a QMB Enrolled in a Medicare Managed Care Organization. (1) The department shall be responsible for payment of Part A and Part B premiums, deductibles and coinsurance, copayments, and enrollment premiums for a QMB recipient enrolled in a Medicare managed care organization.

(2) The department shall reimburse deductibles and coinsurance in accordance with Section 3 of this administrative regulation.

Section 5. Special Provisions. An individual determined eligible as a QI-1, shall:

(1) Be limited by a block grant with eligibility established on a first-come first-serve basis;

(2) In calendar years following the year of initial approval, be given preference over another individual who may apply who was not eligible the previous year; and

(3) Have eligibility terminated when the block grant authorized under 42 U.S.C. 1396u-3(c)(1) is no longer available from federal Medicaid funds. (2 Ky.R. 100; eff. 9-10-1975; Recodified from 904 KAR 1:006, 5-6-1986; 15 Ky.R. 1960; 2156; eff. 3-15-1989; 17 Ky.R. 546; eff. 10-14-1990; 25

Ky.R. 437; 858; eff. 9-16-1998; 30 Ky.R. 105; 871; eff. 10-31-2003; 1615; 1937; eff. 2-16-2004; TAm eff. 10-6-2017; Crt eff. 12-6-2019.)