CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Policy and Operations
(Amended at ARRS Committee)

907 KAR 20:010. Medicaid procedures for determining initial and continuing eligibility other than procedures related to a modified adjusted gross income eligibility standard or related to former foster care individuals.

RELATES TO: KRS 205.520, 42 C.F.R. 435.530, 435.531, 435.540, 435.541, 435.906, 435.914, 435.916, 435.926, 42 U.S.C. 416, 423, 1382, 1396a, b, d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes provisions relating to determining initial and continuing eligibility for assistance under the Medicaid Program except for individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals who aged out of foster care while receiving Medicaid coverage.

Section 1. Eligibility Determination Process.

(1)

(a) Except as provided in subsection (3) or (5) of this section, eligibility shall be determined prospectively.

(b) To receive or continue to receive assistance, a household shall meet technical and financial eligibility criteria, for the appropriate month of coverage, pursuant to:

1. This section;
2. Section 3 of this administrative regulation; and
3. As established in:
   a. 907 KAR 20:005;
   b. 907 KAR 20:020; and
   c. 907 KAR 20:025.

(2) A decision regarding eligibility or ineligibility for Medicaid shall be supported by facts recorded in the case record.

(a) The applicant or recipient shall be the primary source of information and shall:

1. Furnish verification of financial and technical eligibility as required by 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025; and
2. Give written consent to those contacts necessary to verify or clarify a factor pertinent to the decision of eligibility.

(b)

1. The department may schedule an appointment with an applicant or recipient to receive specified information as proof of eligibility.
2. Failure to appear for the scheduled appointment or to furnish the required information shall be considered a failure to present adequate proof of eligibility if the applicant or recipient was informed in writing of the scheduled appointment and the required information.

(3) Retroactive eligibility for Medicaid not related to the receipt of SSI benefits shall be effective no earlier than the third month prior to the month of application if:

(a) A Medicaid service was received;

(b) Technical and financial eligibility requirements were met as established in 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025; and

(c) The applicant is excluded from managed care organization participation in accordance with 907 KAR 17:010.

(4) Eligibility for qualified Medicare beneficiary coverage shall be effective the month after the month of case approval if technical and financial eligibility requirements were met as established in 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025.

(5) Retroactive eligibility for benefits for a specified low-income Medicare beneficiary benefits, Medicare qualified individual group 1 (QI-1), or a qualified disabled and working individual shall be effective no earlier than the third month prior to the month of application if the individual meets technical and financial eligibility requirements as established in 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025.

(6) An SSI-related recipient shall be eligible for Medicaid benefits effective the month prior to the first month of SSI payment if the individual:

(a) Is eligible to be enrolled with a managed care organization in accordance with 907 KAR 17:010; and

(b) Meets Medicaid eligibility requirements for that month.

(7) An SSI-related recipient shall be retroactively eligible for Medicaid benefits effective no earlier than the third month prior to the first month of SSI payment if the individual:

(a) Is excluded from managed care organization participation in accordance with 907 KAR 17:010; and

(b) Meets Medicaid eligibility requirements for these months.

Section 2. Continuing Eligibility.

(1) The recipient shall be responsible for reporting within thirty (30) days a change in circumstances which may affect eligibility.

(2) Eligibility shall be redetermined:

(a) Every twelve (12) months; or

(b) If a report is received or information is obtained about a change in circumstances.

Section 3. Continuous Eligibility for Children.

(1) An individual who is younger than nineteen (19) shall receive continuous eligibility, consistent with 42 C.F.R. 435.926.

(2) The continuous eligibility period for a child recipient shall be for a period of twelve (12) months.

(3) A child's eligibility during a continuous eligibility period shall only be terminated under the following circumstances:

(a) The child becomes nineteen (19) during the continuous eligibility period;

(b) The child, or representative, voluntarily requests that the eligibility be terminated;

(c) The child ceases to be a resident of the Commonwealth;

(d) The agency determines that the eligibility was granted due to:

1. Agency error; or

2. Fraud, abuse, or perjury attributed to the child or representative; or

(e) The death of the child.

Section 4. Determination of Incapacity or Permanent and Total Disability.

(1) Except as provided in subsections (2) and (3) of this section, a determination that a parent with whom the needy child lives is incapacitated, or that the individual requesting Medicaid due to disability is both permanently and totally disabled, shall be made by the medical review team following review of both medical and social reports.

(2) A parent shall be considered incapacitated without a determination from the medical review team if:

(a) The parent declares physical inability to work;

(b) The worker observes some physical or mental limitation; and

(c) The parent:

1. Is receiving SSI benefits;

2. Is age sixty-five (65) years or over;

3. Has been determined to meet the definition of blindness or permanent and total disability as contained in 42 U.S.C. 1382c, 416, or 423 by either the Social Security Administration or the medical review team;

4.

a. Has previously been determined to be incapacitated or both permanently and totally disabled by the medical review team, hearing officer, appeal board, or court of proper jurisdiction without a reexamination requested; and

b. Has not demonstrated any visible improvement in condition;

5. Is receiving Retirement, Survivors, and Disability Insurance benefits, federal black lung benefits, or railroad retirement benefits based on disability as evidenced by an award letter;

6. Is receiving Veterans Affairs benefits based on 100 percent disability, as verified by an award letter; or

7. Is currently hospitalized and a statement from the attending physician indicates that incapacity will continue for at least thirty (30) days. If application was made prior to the admission, the physician shall indicate if incapacity existed as of the application date.

(3) An individual shall be considered permanently and totally disabled without a determination from the medical review team if the individual:

(a) Receives RSDI or railroad retirement benefits based on disability;

(b) Received SSI benefits based on disability during a portion of the twelve (12) months preceding the application month and discontinuance was due to income or resources and not to improvement in physical condition;

(c) Has been determined to meet the definition of blindness or both permanent and total disability as contained in 42 U.S.C. 416 or 1382 by the Social Security Administration; or

(d)

1. Has previously been determined to be permanently and totally disabled by the medical review team, hearing officer, appeal board, or court of proper jurisdiction without a reexamination requested; and

2. Has not demonstrated any visible improvement in condition.

(4)

(a) A child who was receiving SSI benefits on August 22, 1996 and who, but for the change in definition of childhood disability established by 42 U.S.C. 1396a(a)(10) would continue to receive SSI benefits, shall continue to meet the Medicaid definition of disability.

(b) If a redetermination is necessary, and in accordance with 923 KAR 2:470, the definition of childhood disability effective on August 22, 1996 shall be used.

Section 5. Disqualification. An adult individual shall be disqualified from receiving Medicaid for a specified period of time if the department or a court determines the individual has committed an intentional program violation in accordance with 907 KAR 1:675, Program integrity.

Section 6. Applicability. The provisions and requirements of this administrative regulation shall not apply to an individual whose Medicaid eligibility is determined:

(1) Using the modified adjusted gross income as the income standard pursuant to 907 KAR 20:100; or

(2) Pursuant to 907 KAR 20:075.

(21 Ky.R. 2590; 22 Ky.R. 294; eff. 7-26-1995; 23 Ky.R. 3642; 4167; eff. 6-16-1997; 25 Ky.R. 442; 864; eff. 9-16-1998; 26 Ky.R. 1253; 1572; eff. 2-1-2000; 34 Ky.R. 881; 1468; eff. 1-4-2008; Recodified from 907 KAR 1:605, 9-30-2013; 40 Ky.R. 1157; 1761; 2153; eff. 4-4-2014; Crt eff. 12-6-2019; 49 Ky.R. 2388; 50 Ky.R. 695; eff. 9-27-2023.)

FILED WITH LRC: August 8, 2023

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-6746; fax 502-564-7091; email CHFSregs@ky.gov.