

## Agency 129

# Kansas Department of Health and Environment— Division of Health Care Finance

### Editor's Note:

Pursuant to Executive Reorganization Order (ERO) No. 38, the Kansas Health Policy Authority was abolished on July 1, 2011. Powers, duties and functions were transferred to the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance. See L. 2012, Ch. 102.

### Editor's Note:

K.S.A. 2005 Supp. 75-7401 thru 75-7405 and Section 42 of Chapter 187, 2005 Session Laws of Kansas transferred specific powers, duties, and regulatory authority of the Division of Health Policy and Finance (DHPF) within the Department of Administration to the Kansas Health Policy Authority (KHPA), effective July 1, 2006. The statutes provide that KHPA will be the single state agency for Medicaid, Medikan and Health Wave in Kansas.

### Editor's Note:

The Division of Health Policy and Finance was established by 2005 Senate Bill 272. K.S.A. 2005 Supp. 75-7413 transferred specific powers, duties, and regulatory authority of the Secretary of Social and Rehabilitation Services on an interim basis to a new Division of Health Policy and Finance (DHPF) within the Department of Administration, created under K.S.A. 2005 Supp. 75-7406, effective July 1, 2005. The statute provides that DHPF will be the single state agency for Medicaid, Medikan and HealthWave in Kansas. The statute also establishes the Kansas Health Policy Authority (HPA) which will eventually assume these programs as well as other medical programs for the State of Kansas.

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- 129-10. ADULT CARE HOME PROGRAM.
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### Article 1.—DEFINITIONS

**129-1-1. Definitions.** (a) "Affordable care act" and "ACA" mean the patient protection and affordable care act of 2010, public law 111-148, as amended by the health care and education reconciliation act of 2010, public law 111-152, and any subsequent amendments.

(b) "Applicant" means any individual who is seeking an eligibility determination for that individual through the submission of an application for medical assistance.

(c) "Department" means Kansas department of health and environment and its designees authorized to administer the medicaid program and kancare-CHIP.

(d) "Division" means division of health care fi-

nance in the Kansas department of health and environment.

(e) "Federally facilitated exchange" and "FFE" mean an insurance exchange operated by the federal government as established under the patient protection and affordable care act, public law 111-148.

(f) "Kancare-CHIP" means the health insurance program for children administered by the department and authorized under title XXI of the social security act.

(g) "Medicaid" means the federal medical assistance program authorized under title XIX of the social security act.

(h) "Medical assistance" means assistance that covers all or part of the cost of medical care for

eligible persons through joint federal and state funding and state-only funding, including medicaid, kancare-CHIP, and medikan.

(i) “Medikan” means a totally state-funded program covering all or part of the cost of medical care for disabled individuals who do not qualify for medicaid but who are eligible for benefits under K.A.R. 129-6-95.

(j) “Recipient” means any individual who has been determined eligible and is receiving medical assistance.

(k) “Secretary” means secretary of the Kansas department of health and environment. (Authorized by and implementing K.S.A. 2013 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

#### Article 2.—GENERAL

##### 129-2-1. Uniformity of interpretation.

The contracted staff of the department shall follow the interpretation provided by manuals, other policy materials, and official releases or communications from the secretary or the secretary’s designee. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

##### 129-2-2. Fees for providing copies.

(a) Except as specified in subsection (b), the following fees may be charged for providing copies of department documents and records:

(1)(A) For copies, a fee of \$.25 per single-sided page; and

(B) an additional fee not exceeding the actual cost of furnishing copies, including the cost of staff time required to make the information available; and

(2) for electronic records in department data systems, a fee equal to the cost of any computer services, including staff time.

(b) No fee shall be charged if the request for documents or records meets any of the following conditions:

(1) Is in the administration of a department program;

(2) is in relationship to a fair hearing;

(3) is for medical diagnosis or treatment;

(4) is from a state department; or

(5) is pursuant to a regulation authorizing the release of the document or record without charging a fee. (Authorized by and implementing

K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective Feb. 28, 2014.)

#### Article 5.—PROVIDER PARTICIPATION, SCOPE OF SERVICES, AND REIMBURSEMENTS FOR THE MEDICAID (MEDICAL ASSISTANCE) PROGRAM

**129-5-1. Prior authorization.** (a) Any medical service may be placed by the Kansas department of health and environment, division of health care finance on the published list of services requiring prior authorization or precertification for any of the following reasons:

(1) To ensure that provision of the service is medically necessary;

(2) to ensure that services that could be subject to overuse are monitored for appropriateness in each case; and

(3) to ensure that services are delivered in a cost-effective manner.

(b) Administration of covered pharmaceuticals in the following classes shall require prior authorization. A cross-reference of generic and brand names shall be made available upon request:

(1) Ace inhibitors:

(A) Quinapril;

(B) moexipril;

(C) perindopril;

(D) ramipril; and

(E) trandolopril;

(2) retinoids:

(A) Tretinoin;

(B) alitretinoin; and

(C) bexarotene;

(3) adjunct antiepileptic drugs:

(A) Gabitril;

(B) zonegran;

(C) clobazam;

(D) lacosamide;

(E) rufinamide;

(F) eslicarbazepine;

(G) perampanel;

(H) ezogabine; and

(I) oxcarbazepine;

(4) angiotensin II receptor antagonists:

(A) Candesartan;

(B) candesartan-HCTZ;

(C) eprosartan;

(D) eprosartan-HCTZ;

(E) olmesartan;

- (F) olmesartan-HCTZ; and
- (G) azilsartan;
- (5) antibiotics:
  - (A) Telithromycin; and
  - (B) rifaximin;
- (6) anticholinergic urinary incontinence drugs:
  - (A) Flavoxate;
  - (B) oxybutynin XL;
  - (C) oxybutynin patches;
  - (D) trospium chloride;
  - (E) darifenacin; and
  - (F) oxybutynin, topical;
- (7) antiemetics:
  - (A) Nabilone; and
  - (B) doxylamine succinate-pyridoxine hydrochloride;
- (8) antipsoriatics:
  - (A) Alefacept; and
  - (B) ustekinumab;
- (9) antiretroviral drugs:
  - (A) Enfuvirtide; and
  - (B) maraviroc;
- (10) antirheumatics:
  - (A) Leflunomide;
  - (B) infliximab;
  - (C) anakinra;
  - (D) adalimumab;
  - (E) etonercept;
  - (F) abatacept;
  - (G) rituximab;
  - (H) golimumab;
  - (I) certolizumab;
  - (J) tocilizumab; and
  - (K) tofacitinib;
- (11) cervical dystonias:
  - (A) Onabotulinum toxin A;
  - (B) abobotulinum toxin A;
  - (C) rimabotulinum toxin B; and
  - (D) incobotulinum toxin A;
- (12) drugs for the treatment of osteoporosis:
  - teriparatide;
    - (13) antituberculosis products:
      - (A) Aminosalicylate sodium;
      - (B) capreomycin;
      - (C) ethambutol;
      - (D) ethionamide;
      - (E) isoniazid;
      - (F) pyrazinamide; and
      - (G) rifampin and rifampin-isoniazid combinations;
    - (14) all decubitus and wound care products;
    - (15) all intravenous and oral dietary and nutritional products, including the following:
      - (A) Amino acids, injectable;
      - (B) l-cysteine;
      - (C) lipids, injectable; and
      - (D) sodium phenylbutyrate;
    - (16) beta-blockers:
      - (A) Betaxolol;
      - (B) bisoprolol;
      - (C) carteolol;
      - (D) penbutolol;
      - (E) propranolol XL; and
      - (F) nebivolol;
    - (17) short-acting, inhaled beta 2 agonists:
      - (A) Metaproterenol inhaler;
      - (B) levalbuterol solution;
      - (C) albuterol solutions: 0.021% and 0.042%;
      - (D) levalbuterol inhaler; and
      - (E) pirbuterol inhaler;
    - (18) calcium channel blockers:
      - (A) Diltiazem extended release, with the following brand names:
        - (i) Cardizen SR<sup>®</sup>;
        - (ii) Cardizem CD<sup>®</sup>;
        - (iii) Cartia XT<sup>®</sup>;
        - (iv) Dilacor XR<sup>®</sup>;
        - (v) Taztia XT<sup>®</sup>; and
        - (vi) Cardizem LA<sup>®</sup>;
      - (B) verapamil sustained release, with the following brand names:
        - (i) Covera HS<sup>®</sup>; and
        - (ii) Verelan PM<sup>®</sup>;
      - (C) nifedipine sustained release, with the following brand names:
        - (i) Nifedical XL<sup>®</sup>; and
        - (ii) Procardia XL<sup>®</sup> and all generic equivalents;
      - (D) nisoldipine;
      - (E) felodipine;
      - (F) isradipine;
      - (G) nicardipine SR; and
      - (H) nifedipine immediate release, with the following brand names:
        - (i) Adalat<sup>®</sup> and all generic equivalents; and
        - (ii) Procardia<sup>®</sup> and all generic equivalents;
    - (19) fibric acid derivatives:
      - (A) Antara<sup>®</sup>; and
      - (B) Lofibra<sup>®</sup>;
    - (20) all growth hormones and growth hormone stimulating factor, including the following:
      - (A) Somatrem;
      - (B) somatropin;
      - (C) sermorelin; and
      - (D) mecasermin rinfabate;
    - (21) intranasal corticosteroids;

- (A) Flunisolide;  
 (B) beclomethasone; and  
 (C) ciclesonide;  
 (22) inhaled corticosteroids:  
 (A) Flunisolide-menthol;  
 (B) flunisolide; and  
 (C) budesonide inhaled suspension;  
 (23) proton pump inhibitors:  
 (A) Esomeprazole;  
 (B) omeprazole;  
 (C) omeprazole OTC;  
 (D) lansoprazole;  
 (E) pantoprazole;  
 (F) rabeprazole;  
 (G) omeprazole NaHCO<sub>3</sub>; and  
 (H) dexlansoprazole;  
 (24) monoclonal antibody for respiratory syncytial virus (RSV), including palivizumab;  
 (25) muscle relaxants:  
 (A) Tizanidine;  
 (B) orphenadrine;  
 (C) carisoprodol;  
 (D) carisoprodol-aspirin;  
 (E) carisoprodol-aspirin-caffeine;  
 (F) cyclobenzaprine;  
 (G) metaxalone;  
 (H) dantrolene; and  
 (I) orphenadrine-aspirin-caffeine;  
 (26) narcotics:  
 (A) Buprenorphine-naloxone; and  
 (B) buprenorphine;  
 (27) nonsteroidal, anti-inflammatory drugs:  
 (A) Nabumetone;  
 (B) diclofenac patches;  
 (C) diclofenac, topical; and  
 (D) ketorolac, intranasal;  
 (28) drugs for the treatment of obesity:  
 (A) Orlistat;  
 (B) phentermine;  
 (C) lorcaserin; and  
 (D) phentermine-topiramate ER;  
 (29) oxazolidinones, including linezolid;  
 (30) HMG-CoA reductase inhibitors:  
 (A) Pravastatin;  
 (B) fluvastatin;  
 (C) lovastatin; and  
 (D) pitavastatin;  
 (31) nonsedating antihistamines:  
 (A) Desloratidine;  
 (B) fexofenadine; and  
 (C) levocetirizine;  
 (32) H<sub>2</sub> antagonists: nizatidine;  
 (33) triptans:  
 (A) Zolmitriptan;  
 (B) frovatriptan;  
 (C) almotriptan;  
 (D) Alsuma<sup>®</sup>;  
 (E) Sumavel<sup>®</sup>;  
 (F) rizatriptan; and  
 (G) sumatriptan pens, vials, cartridges, and nasal sprays;  
 (34) antidiabetic drugs:  
 (A) Glipizide XL;  
 (B) glipizide-metformin;  
 (C) repaglinide;  
 (D) acarbose;  
 (E) Glucophage XR<sup>®</sup>;  
 (F) Fortamet<sup>®</sup>;  
 (G) Glumetza<sup>®</sup>;  
 (H) exenatide;  
 (I) pramlintide acetate; and  
 (J) liraglutide;  
 (35) the following types of syringes, penfills, and cartridges of insulin:  
 (A) Humalog<sup>®</sup>;  
 (B) Humalog Mix<sup>®</sup>;  
 (C) Humulin R<sup>®</sup>;  
 (D) Humulin N<sup>®</sup>;  
 (E) Humulin 70/30<sup>®</sup>;  
 (F) Novolog<sup>®</sup>;  
 (G) Novolog Mix<sup>®</sup>;  
 (H) Novolin R<sup>®</sup>;  
 (I) Novolin N<sup>®</sup>;  
 (J) Novolin 70/30<sup>®</sup>;  
 (K) Velosulin BR<sup>®</sup>; and  
 (L) insulin detemir;  
 (36) hypnotics:  
 (A) Zaleplon;  
 (B) zolpidem;  
 (C) zolpidem CR; and  
 (D) eszopiclone;  
 (37) serotonin 5-HT<sub>3</sub> receptor antagonist antiemetics:  
 (A) Granisetron;  
 (B) dolasetron; and  
 (C) ondansetron film;  
 (38) influenza vaccines: Flumist<sup>®</sup>;  
 (39) monoclonal antibody for asthma: omalizumab;  
 (40) bisphosphonates:  
 (A) Risedronate; and  
 (B) risedronate-calcium;  
 (41) combination products for hypertension:  
 (A) Enalapriol maleate-felodipine;  
 (B) trandolapril-verapamil; and  
 (C) telmisartan-amlodipine;

- (42) ophthalmic prostaglandin analogues:
  - (A) Bimatoprost; and
  - (B) unoprostone;
- (43) topical immunomodulators:
  - (A) Protopic® (topical formulation); and
  - (B) Elidel®;
- (44) narcotic analgesics: any transmucosal form of fentanyl;
  - (45) tramadol and all opioids, opioid combinations, and skeletal muscle relaxants, at any dose greater than the maximum recommended dose in a 31-day period;
- (46) progesterin for preterm labor: Makena®;
- (47) aromatase inhibitors:
  - (A) Letrozole;
  - (B) anastrozole; and
  - (C) exemestane;
- (48) long-acting, inhaled beta 2 agonists:
  - (A) Salmeterol;
  - (B) formoterol;
  - (C) arformoterol; and
  - (D) indacaterol;
- (49) miscellaneous biologic agents:
  - (A) Canakinumab;
  - (B) natalizumab;
  - (C) denosumab; and
  - (D) rilonacept;
- (50) stem cell mobilizers: plerixafor;
- (51) antidotes: methylaltraxone;
- (52) complement inhibitors:
  - (A) C1 esterase inhibitor;
  - (B) ecallantide;
  - (C) icatibant; and
  - (D) eculizumab;
- (53) anti-hepatitis C virus agents:
  - (A) Boceprevir;
  - (B) telaprevir;
  - (C) simeprevir; and
  - (D) sofosbuvir;
- (54) cystic fibrosis agents: ivacaftor;
- (55) agents for gout:
  - (A) Febuxostat; and
  - (B) pegloticase;
- (56) phenylketonurics: sapropterin;
- (57) topical anesthetics: lidocaine;
- (58) antithrombin agents: eltrombopag;
- (59) anti-malarials: quinine;
- (60) hormone analog for precocious puberty: histrelin acetate;
- (61) agents for chorea associated with Huntington's disease: tetrabenazine;
- (62) enzyme preparations: collogenase clostridium histolyticum;
- (63) agents for cataplexy: sodium oxybate;
- (64) topical acne agents:
  - (A) Adapalene;
  - (B) adapalene-benzyl peroxide;
  - (C) azelaic acid;
  - (D) dapsone;
  - (E) tazarotene; and
  - (F) tretinoin-clindamycin;
- (65) interferons:
  - (A) Interferon alfacon-1;
  - (B) interferon alfa-2b;
  - (C) interferon beta-1a;
  - (D) interferon beta-1b;
  - (E) peginterferon alfa-2a; and
  - (F) peginterferon alfa-2b;
- (66) pulmonary arterial hypertension agents:
  - (A) Ambrisentan;
  - (B) bosentan;
  - (C) epoprostenol;
  - (D) iloprost;
  - (E) macitentan;
  - (F) riociguat;
  - (G) sildenafil;
  - (H) tadalafil; and
  - (I) treprostinil;
- (67) testosterone agents:
  - (A) Androderm Transdermal®;
  - (B) AndroGel®;
  - (C) Axiron Topical Solution®;
  - (D) Delatestryl®;
  - (E) Fortesta Gel®;
  - (F) Striant Buccal®;
  - (G) Testim Gel®; and
  - (H) Testopel Pellets®;
- (68) antineoplastic agents:
  - (A) Afatinib;
  - (B) dabrafenib;
  - (C) everolimus;
  - (D) methotrexate;
  - (E) sipuleucel-T;
  - (F) trametinib; and
  - (G) trastuzumab;
- (69) multiple sclerosis agents:
  - (A) Dalfampridine;
  - (B) dimethyl fumarate;
  - (C) fingolimod;
  - (D) glatiramer; and
  - (E) teriflunomide;
- (70) immunosuppressive agents: belimumab;
- (71) inhaled long-acting beta2-agonists and corticosteroid products:
  - (A) Budesonide-formoterol; and
  - (B) fluticasone-vilanterol;

- (72) ammonia detoxicants:
  - (A) Glycerol phenylbutyrate; and
  - (B) sodium phenylbutyrate;
- (73) heavy metal antagonists:
  - (A) Deferasirox;
  - (B) deferiprone; and
  - (C) trientine;
- (74) pituitary corticotropin: H.P. Acthar® Gel;
  - (75) ocular agents:
    - (A) Ocriplasmin; and
    - (B) ranibizumab;
  - (76) miscellaneous antilipemic agents:
    - (A) Lomitapide; and
    - (B) mipomersen;
  - (77) miscellaneous analgesics: ziconotide intrathecal infusion;
  - (78) miscellaneous central nervous system agents: riluzole;
  - (79) calcimimetics: cinacalcet;
  - (80) radioactive agents: radium Ra 223 dichloride;
  - (81) dipeptidyl peptidase IV inhibitors:
    - (A) Alogliptin; and
    - (B) linagliptin; and
  - (82) antimuscarinics-antispasmodics: aclidinium bromide.
    - (c) Failure to obtain prior authorization, if required, shall negate reimbursement for the service and any other service resulting from the unauthorized or noncertified treatment. The prior authorization shall affect reimbursement to all providers associated with the service.
    - (d) The only exceptions to prior authorization shall be the following:
      - (1) Emergencies. If certain surgeries and procedures that require prior authorization are performed in an emergency situation, the request for authorization shall be made within two working days after the service is provided.
      - (2) Situations in which services requiring prior authorization are provided and retroactive eligibility is later established. When an emergency occurs or when retroactive eligibility is established, prior authorization for that service shall be waived, and if medical necessity is documented, payment shall be made.
      - (e) Services requiring prior authorization shall be considered covered services within the scope of the program, unless the request for prior authorization is denied. (Authorized by K.S.A. 2013 Supp. 39-7,120, K.S.A. 75-5625; implementing K.S.A. 2013 Supp. 39-7,120 and K.S.A.

2013 Supp. 39-7,121a; effective Oct. 28, 2005; amended June 2, 2006; amended Aug. 11, 2006; amended Nov. 17, 2006; amended March 16, 2007; amended Oct. 19, 2007; amended May 23, 2008; amended Feb. 17, 2012; amended Oct. 19, 2012; amended Aug. 1, 2014.)

**129-5-78. Scope of and reimbursement for home- and community-based services for persons with traumatic brain injury.**

(a) The scope of allowable home- and community-based services (HCBS) for persons with traumatic brain injury shall consist of those services authorized by the applicable federally approved waiver to the Kansas medicaid state plan. Recipients of services provided pursuant to this waiver shall be required to show the capacity to make progress in their rehabilitation and independent living skills.

(b) The need for HCBS shall be determined by an individualized assessment of the prospective recipient by a provider enrolled in the program. HCBS shall be provided only in accordance with a plan of care written by a case manager.

(c) HCBS, which shall require prior authorization by the Kansas medicaid HCBS program manager, may include one or more of the following:

(1) Rehabilitation therapies, which may consist of any of the following:

- (A) Occupational therapy;
- (B) physical therapy;
- (C) speech-language therapy;
- (D) cognitive rehabilitation; or
- (E) behavioral therapy;

(2) personal services;

(3) medical equipment, supplies, and home modification not otherwise covered under the Kansas medicaid state plan;

(4) sleep-cycle support services;

(5) a personal emergency response system and its installation; or

(6) provision of or education on transitional living skills.

(d) Case management services up to a maximum of 160 hours each calendar year, which may be exceeded only with prior authorization by the Kansas medicaid HCBS program manager, shall be provided to all HCBS recipients under the traumatic brain injury program.

(e) The fee allowed for home- and community-based services for persons with traumatic brain injury shall be the provider's usual and customary charges, except that no fee shall be paid in excess of the waiver's range maximum. (Authorized by

K.S.A. 2008 Supp. 75-7403 and 75-7412; implementing K.S.A. 2008 Supp. 75-7405 and 75-7408; effective July 18, 2008; amended Oct. 16, 2009.)

**129-5-118. Scope of federally qualified health center services.** For purposes of this regulation, a federally qualified health center shall mean a community health center, federally qualified health center (FQHC) look-alike, or an urban Indian organization receiving funds under the Indian health care improvement act that is accepted by the centers for medicare and medicaid to furnish federally qualified health center services for participation under medicare and medicaid. An FQHC look-alike shall mean an organization that meets all of the eligibility requirements of an organization that receives a public health service (PHS) section 330 grant but does not receive grant funding. (a) The services provided by the following health care professionals shall be billable as federally qualified health center services:

- (1) Physician and physician assistant pursuant to K.A.R. 129-5-88;
  - (2) advanced registered nurse practitioner pursuant to K.A.R. 30-5-113;
  - (3) dentist and dental hygienist pursuant to K.A.R. 30-5-100;
  - (4) licensed mental health practitioner pursuant to K.A.R. 30-5-104;
  - (5) clinical social worker pursuant to K.A.R. 30-5-86;
  - (6) visiting nurse pursuant to K.A.R. 30-5-89; and
  - (7) for can be healthy nursing assessments only, registered nurse pursuant to K.A.R. 30-5-87.
- (b) Covered services of federally qualified health centers shall include the following:
- (1) The services and supplies furnished as an incident to the professional services provided by the health care professionals specified in subsection (a); and
  - (2) other ambulatory services covered under the medicaid state plan, if provided by the federally qualified health center.
- (c) (1) Preventive primary services shall be furnished by or under the direct supervision of any of the following:
- (A) Physician;
  - (B) nurse practitioner;
  - (C) physician assistant;
  - (D) nurse midwife;
  - (E) licensed mental health practitioner;

- (F) clinical social worker; or
  - (G) either a member of the center's health care staff who is an employee of the center or a physician under arrangements with the center.
- (2) Preventive primary services shall include only drugs and biologicals that cannot be self-administered, unless §1861(s) of the social security act provides for coverage of the drug regardless of whether the drug is self-administered.
- (d) The following preventive primary services may be covered when provided by federally qualified health centers to medicaid beneficiaries:
- (1) Medical social services;
  - (2) nutritional assessment and referral;
  - (3) preventive health education;
  - (4) children's eye and ear examinations;
  - (5) prenatal and postpartum care;
  - (6) prenatal services;
  - (7) well child care, including periodic screening;
  - (8) providing immunizations, including tetanus-diphtheria booster and influenza vaccine;
  - (9) voluntary family planning services;
  - (10) taking patient history;
  - (11) blood pressure measurement;
  - (12) weight measurement;
  - (13) physical examination targeted to risk;
  - (14) visual acuity screening;
  - (15) hearing screening;
  - (16) cholesterol screening;
  - (17) stool testing for occult blood;
  - (18) dipstick urinalysis;
  - (19) risk assessment and initial counseling regarding risks; and
  - (20) the following services, for women only:
    - (A) Clinical breast exam;
    - (B) referral for mammography; and
    - (C) thyroid function test.
  - (3) Preventive primary services shall not include group or mass information programs, health education classes, and group education activities, which may include media productions and publication and services for eyeglasses and hearing aids.
- (e) "Visiting nurse" shall include a registered nurse or licensed practical nurse who provides part-time or intermittent nursing care to a patient at the beneficiary's place of residence under a written plan of treatment prepared by a physician. The place of residence shall not include a hospital or long-term care facility. This nursing care shall be covered only if there is no home health agency in the area.

(f) Federally qualified health center services provided at a location other than a federally qualified health center shall meet the following conditions:

(1) No services are provided at an inpatient hospital, outpatient hospital, or hospital emergency room.

(2) The services provided are listed in subsection (b).

(3) The services are provided to a patient of a federally qualified health center.

(4) The health professional providing the services is an employee of a federally qualified health center or under contract with a federally qualified health center and is required to seek compensation for that person's services from the federally qualified health center. (Authorized by K.S.A. 2008 Supp. 75-7403 and 75-7412; implementing K.S.A. 2008 Supp. 75-7405 and 75-7408; effective June 2, 2006; amended March 19, 2010.)

**129-5-118a. Reimbursement for federally qualified health center services.** Reimbursement shall not exceed the reasonable cost of federally qualified health center services and other ambulatory services covered under the Kansas medical assistance program. "Reasonable cost" shall consist of the necessary and proper cost incurred by the provider in furnishing covered services to program beneficiaries, subject to the cost principles and limits specified in K.A.R. 129-5-118a (c)(1) and K.A.R. 129-5-118b. (a) Reimbursement method. An interim per visit rate shall be paid to each federally qualified health center provider, with a retroactive cost settlement for each facility fiscal year.

(1) Interim reimbursement rate. The source and the method of determination of interim rate shall depend on whether the federally qualified health center is a new enrollee of the Kansas medical assistance program or is a previously enrolled provider. Under special circumstances, the interim rate may be negotiated between the agency and the provider.

(A) Newly enrolled facility. If the facility is an already-established federally qualified health center with an available medicare cost report, an all-inclusive rate derived from the cost report may be used for setting the initial medicaid interim payment rate. If the facility is an already-established federally qualified health center opening a new service location, then the rate from the already-established federally qualified health center shall

be used for the new service location. If the facility converted from a rural health clinic to a federally qualified health center, then the rate from the rural health clinic shall be used for the new federally qualified health center. For all other circumstances, the initial payment rate shall be based on the average of the current reimbursement rates for previously enrolled federally qualified health center providers.

(B) Previously enrolled facility. After the facility submits a federally qualified health center cost report, the agency shall determine the maximum allowable medicaid rate per visit as specified in subsection (c). If a significant change of scope of services or a significant capital project has been implemented, the federally qualified health center shall submit an interim cost report if the center wants a change to the existing rate. The agency and the federally qualified health center shall use the interim cost report to negotiate a new interim rate.

(2) Visit. A "visit" shall mean face-to-face encounter between a center patient and a center health care professional as defined in K.A.R. 129-5-118. Encounters with more than one health professional or multiple encounters with the same health professional that take place on the same day shall constitute a single visit, except under either of the following circumstances:

(A) The patient suffers an illness or injury requiring additional diagnosis or treatment after the first encounter.

(B) The patient has a different type of visit on the same day, which may consist of a dental, medical, or mental health visit.

(3) Retroactive cost settlement. For each reporting period, the agency shall compare the total maximum allowable medicaid cost with the total payments to determine the program overpayment or underpayment. Total payments shall include interim payments, third-party liability, and any other payments for covered federally qualified health center services. The cost report and supplemental data submitted by the provider, the medicare cost report, and the medicaid-paid claims data obtained from the program's fiscal agent shall be used for these calculations.

(b) Cost reporting. Each federally qualified health center shall submit a completed cost report. The form used for cost reporting shall be the most current version of the medicare financial and statistical report form for independent rural health clinics and freestanding federally qualified

health centers with adjustments made, as necessary, to report the cost and number of visits for medicaid-covered services pursuant to K.A.R. 129-5-118.

(1) Filing requirements. Each provider shall be required to file annual cost reports on a fiscal year basis.

(A) Cost reports shall be received no later than five months after the end of the facility's fiscal year. An extension in due date may be granted by the agency upon request, if necessary due to circumstances beyond the control of the federally qualified health center.

(B) Each provider filing a cost report after the due date without a preapproved extension shall be subject to the following penalties:

(i) If the cost report has not been received by the agency by the close of business on the due date, all further payments to the provider may be withheld and suspended until the complete financial and statistical report has been received.

(ii) Failure to submit the completed financial and statistical report within one year after the end of the cost report period may be cause for termination from the Kansas medical assistance program.

(2) Fiscal and statistical data. The preparation of the cost report shall be based upon the financial and statistical records of the facility and shall use the accrual basis of accounting. The reported data shall be accurate and adequately supported to facilitate verification and analysis for the determination of allowable costs.

(3) Supplemental data. The following additional information shall be submitted to support reported data and to facilitate cost report review, verifications, and other analysis.

(A) A working trial balance. This balance shall contain account numbers, descriptions of the accounts, the amount of each account, the cost report expense line on which the account was reported, and fiscal year-end adjusting entries to facilitate reconciliation between the working trial balance and the cost report. The facility shall bear the burden of proof that the reported data accurately represents the cost and revenue as recorded in the accounting records. All unexplained differences shall be used to reduce the allowable cost.

(B) Financial statements and management letter. These documents shall be prepared by the facility's independent auditors and shall reconcile with the cost report.

(C) Depreciation schedule. This schedule shall

support the depreciation expense reported on the cost report.

(D) Other data. Data deemed necessary by the agency for verification and rate determination shall also be submitted.

(c) Determination of reimbursable medicaid rate per visit.

(1) Allowable facility costs. This term shall mean costs derived from reported expenses after making adjustments resulting from cost report review and application of the cost reimbursement principles specified in K.A.R. 129-5-118b.

(2) Allocation of overhead costs.

(A) Total allowable administrative and facility costs shall be distributed to the following cost centers:

(i) Federally qualified health center costs;  
(ii) non-federally qualified health center costs;  
and

(iii) nonreimbursable costs, excluding bad debt.

(B) Accumulated direct cost in each cost center shall be used as the basis for the overhead cost allocation.

(3) Average allowable cost per visit. The total allowable facility costs shall be divided by the total number of visits.

(4) Reimbursable medicaid rate. The reimbursable medicaid rate per visit shall not be more than 100 percent of the reasonable and related cost of furnishing federally qualified health center services covered in K.A.R. 129-5-118b.

(d) Fiscal and statistical records and audits.

(1) Recordkeeping. Each provider shall maintain sufficient financial records and statistical data for accurate determination of reasonable costs. Standardized definitions and reporting practices widely accepted among federally qualified health centers and related fields shall be followed, except to the extent that these definitions and practices may conflict with or be superseded by state or federal medicaid requirements.

(2) Audits and reviews.

(A) Each provider shall furnish any information to the agency that may be necessary to meet the following criteria:

(i) Ensure proper payment by the program pursuant to this regulation and K.A.R. 129-5-118b; and

(ii) substantiate claims for program payments.

(B) Each provider shall permit the agency to examine any records and documents necessary to ascertain information for determination of the ac-

curate amount of program payments. These records shall include the following:

(i) Matters of the facility ownership, organization, and operation;

(ii) fiscal, statistical, medical, and other record-keeping systems;

(iii) federal and state income tax returns and all supporting documents;

(iv) documentation of asset acquisition, lease, sale, or other transaction;

(v) management arrangements;

(vi) matters pertaining to the cost of operation; and

(vii) health center financial statements.

(C) Other records and documents shall be made available to the agency as requested.

(D) All records and documents shall be available in Kansas.

(E) Each provider shall furnish to the agency, upon request, copies of patient service charge schedules and any subsequent changes to these schedules.

(F) The agency shall suspend program payments if it is determined that a provider does not maintain adequate records for the determination of reasonable and adequate rates under the program or if the provider fails to furnish requested records and documents to the agency.

(G) Thirty days before suspending payment to the provider, written notice shall be sent by the agency to the provider of the agency's intent to suspend payment. The notice shall explain the basis for the agency's determination and identify the provider's recordkeeping deficiencies.

(H) All provider records that support reported costs, charges, revenue, and patient statistics shall be subject to audits by the agency, the United States department of health and human services, and the United States general accounting office. These records shall be retained for at least five years after the date of filing the cost report with the agency. (Authorized by K.S.A. 2008 Supp. 75-7403 and 75-7412; implementing K.S.A. 2008 Supp. 75-7405 and 75-7408; effective March 19, 2010.)

**129-5-118b. Cost reimbursement principles for federally qualified health center services and other ambulatory services.** The medicare cost reimbursement principles contained in subparts A and G in 42 C.F.R. part 413, as revised on October 1, 2009 and hereby adopted by reference, and the cost principles specified in

this regulation and in K.A.R. 129-5-118a shall be applicable to the financial and statistical data reported by the federally qualified health center for the determination of reasonable cost of providing covered services. (a) Nonreimbursable costs. Each cost that is not related to patient care and is not necessary for the efficient delivery of covered federally qualified health center services and other ambulatory services shall be excluded from the medicaid rate determination. In addition, the following expenses shall be considered nonreimbursable:

(1) Salaries and fees paid to nonworking directors and officers;

(2) uncollectible debts;

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes including the following:

(A) Those from which the provider is entitled to obtain exemption;

(B) those on property not used in providing covered services; and

(C) those levied against a patient and remitted by the provider;

(6) life insurance premiums for directors, officers, and owners;

(7) the imputed value of in-kind services rendered by nonpaid workers and volunteers;

(8) the cost of social, fraternal, civic, and other organizations associated with activities unrelated to patient care;

(9) all expenses related to vending machines;

(10) board of director costs;

(11) the cost of advertising for promoting the services offered by the facility to attract more patients;

(12) public relations and public information expenses;

(13) penalties, fines, and late charges, including interest paid on state and federal payroll taxes;

(14) the cost of items or services provided only to non-Kansas medical assistance program patients and reimbursed by third-party payers;

(15) all expenses associated with the ownership, lease, or charter of airplanes;

(16) bank overdraft charges and other penalties;

(17) the cost associated with group health education classes, activities, and mass information programs including media productions, brochures, and other publications;

(18) expense items without indication of their nature or purpose including "other" and "miscel-

laneous,” without proper documentation when requested;

(19) non-arm’s-length transactions;

(20) legal and other costs associated with litigation between a provider and state or federal agencies, unless litigation is decided in the provider’s favor; and

(21) legal expenses not related to patient care.

(b) Costs allowed with limitations and conditions.

(1) Loan acquisition fees and standby fees. These fees shall be amortized over the life of the loan and shall be allowed only if the loan is related to patient care.

(2) Taxes associated with financing the operations. These taxes shall be allowed only as amortized cost.

(3) Special assessments on land for capital improvements. These assessments shall be amortized over the estimated useful life of the improvements and allowed only if related to patient care.

(4) Start-up costs of a new facility.

(A) Start-up costs may include the following:

(i) Staff salaries and consultation fees;

(ii) utilities;

(iii) taxes;

(iv) insurance;

(v) mortgage interest;

(vi) employee training; and

(vii) any other allowable cost incidental to the operation of the facility.

(B) A start-up cost shall be recognized only if it meets the following criteria:

(i) Is incurred before the opening of the facility;

(ii) is related to developing the facility’s ability to provide covered services;

(iii) is amortized over a period of 60 months or more; and

(iv) is identified in the cost report as a start-up cost.

(5) Expenses. Each cost that can be identified as an organization expense or capitalized as a construction expense shall be appropriately classified and excluded from start-up costs.

(6) Payments made to related parties for services, facilities, and supplies. These payments shall be allowed at the lower of the actual cost to the related party and the market price.

(7) Premium payments. If a provider chooses to pay in excess of the market price for supplies or services, the agency shall use the market price

to determine the allowable cost in the absence of a clear justification for the premium.

(8) Job-related training. The cost of this training shall be the actual amount minus any reimbursement or discount received by the provider.

(9) Lease payments. These payments shall be allowed only if reported in accordance with the generally accepted accounting principles appropriate to the reporting period.

(c) Interest expense. Only necessary and accurate interest on working capital indebtedness shall be an allowable cost.

(1) The interest expense shall be allowed only if it is established with either of the following:

(A) Any lender or lending organization not related to the borrower, or

(B) the central office and other related parties under the following conditions:

(i) The terms and conditions of payment of the loans are on arm’s-length basis with a recognized lending institution;

(ii) the provider demonstrates, to the satisfaction of the agency, a primary business purpose for the loan other than increasing the rate of reimbursement; and

(iii) the transaction is recognized and reported by all parties for federal income tax purposes.

(2) Interest expense shall be reduced by investment income from both restricted and unrestricted idle funds and funded reserve accounts, except when the income is from restricted or unrestricted gifts, grants, and endowments held in separate accounts with no commingling with other funds. Income from the provider’s qualified pension fund shall not be used to reduce interest expense.

(3) Interest earned on restricted and unrestricted industrial revenue bond reserve accounts and sinking fund accounts shall be offset against interest expense up to and including the amount of the related interest expense.

(4) The interest expense on that portion of the facility acquisition loan attributable to an excess over historic cost or other cost basis recognized for program purposes shall not be considered a reasonable cost.

(d) Central office cost. This subsection shall be applicable in situations in which the federally qualified health center is one of several programs or departments administered by a central office or organization and the total administrative cost incurred by the central office is allocated to all components.

(1) Allocation of the central office cost shall use a logical and equitable basis and shall conform to generally accepted accounting procedures.

(2) The central office cost allocated to the federally qualified health center shall be allowed only if the amount is reasonable and if the central office provided a service normally available in similar facilities enrolled in the program.

(3) The provider shall bear the burden of furnishing sufficient evidence to establish the reasonability of the level of allocated cost and the nature of services provided by the central office.

(4) All costs incurred by the central office shall be allocated to all components as a central cost pool, and no portion of the central office cost shall be directed to individual facilities operated by the provider or reported on any line of the cost report other than the appropriate line of the central office cost on any other line of the cost report outside of the central office cost allocation plan.

(5) Only patient-related central office costs shall be recognized, which shall include the following:

(A) Cost of ownership or arm's-length rent or lease expense for office space;

(B) utilities, maintenance, housekeeping, property tax, insurance, and other facility costs;

(C) employee salaries and benefits;

(D) office supplies and printing;

(E) management consultant fees;

(F) telephone and other means of communication;

(G) travel and vehicle expenses;

(H) allowable advertising;

(I) licenses and dues;

(J) legal costs;

(K) accounting and data processing; and

(L) interest expense.

(6) The cost principles and limits specified in this regulation shall also apply to central office costs.

(7) Estimates of central office costs shall not be allowed.

(e) Revenue offsets. Revenue items shall be deducted from the appropriate expense item or cost center in accordance with this subsection.

(1) Revenue with insufficient explanation of its nature or purpose shall be offset against operating costs.

(2) Expense recoveries credited to expense accounts shall not be reclassified as revenue. (Authorized by K.S.A. 2008 Supp. 75-7403 and 75-7412; implementing K.S.A. 2008 Supp. 75-7405

and 75-7408; effective June 2, 2006; amended March 19, 2010.)

### **Article 6.—MEDICAL ASSISTANCE PROGRAM—CLIENTS' ELIGIBILITY FOR PARTICIPATION**

**129-6-30. Implementation of provisions specific to the ACA.** The definitions in K.A.R. 129-6-34 and the provisions of K.A.R. 129-6-41, 129-6-42, 129-6-53, 129-6-54, 129-6-103, 129-6-106(e), 129-6-110(a) and (b), 129-6-111(a) and (b), 129-6-112, and 129-6-113 shall apply to all eligibility determinations completed on and after November 1, 2013. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

#### **129-6-34. Definitions; covered groups.**

(a) The terms defined in K.A.R. 129-1-1 shall be applicable to this article. In addition and for purposes of this article, each of the following terms shall have the meaning specified in this regulation, unless the context clearly indicates otherwise:

(1) "Buy-in process" means the process by which the medicaid program pays a recipient's medicare premiums to establish medicare coverage.

(2) "Caretaker" means the person who is assigned the primary responsibility for the care and control of the child and who is any of the following persons:

(A) Guardian, conservator, legal custodian, or person claiming the child as a tax dependent;

(B) parent, including parent of an unborn child;

(C) sibling;

(D) nephew;

(E) niece;

(F) aunt;

(G) uncle;

(H) person of a preceding generation who is denoted by a term that includes any of the following prefixes: "grand," "great-," "great-great-," or "great-great-great-";

(I) stepfather, stepmother, stepbrother, or stepsister;

(J) legally adoptive parent or another relative of an adoptive parent as listed in paragraph (a)(1); and

(K) spouse of any person listed in paragraph (a)(1) or former spouse of any of these persons, if marriage is terminated by death or divorce.

(3) "Child" means a natural or biological child, adopted child, or stepchild.

(4) "Earned income" means income, in cash or in kind, that an applicant or recipient currently earns, through the receipt of wages, salary, or profit, from activities in which the individual engages as an employer or as an employee with responsibilities that necessitate continuing activity on the individual's part.

(5) "Eligible caretaker" means a caretaker who is considered in the assistance plan with the child.

(6) "Family group" means the applicant or recipient and all individuals living together in which there is a relationship of legal responsibility or a caretaker relationship.

(7) "HCBS" means home- and community-based services. Home- and community-based services are medical and nonmedical services provided to a medicaid recipient in the recipient's home that prevent the recipient from being placed in a nursing facility, hospital, or intermediate care facility.

(8) "Household size" means the number of persons counted as members of an individual's tax household in accordance with K.A.R. 129-6-41 and 129-6-53. For each pregnant woman in the household, the household size shall include the woman and the number of children she is expected to deliver.

(9) "Independent living" means any living arrangement in which ongoing medical care or treatment is not routinely provided, including living in one's own home, renting, living with other family members or friends, living in a room-and-board arrangement, and living in certain specialized living arrangements, including homeless shelters, shelters for battered women, and alcohol and drug abuse facilities.

(10) "Legally responsible relative" means the person who has the legal responsibility to provide support for the person in the assistance plan.

(11) "Long-term care" means care that is received in a nursing facility or other institutional arrangement, a home- and community-based services arrangement, or a program of all-inclusive care for the elderly (PACE) arrangement and whose duration is expected to exceed the month the arrangement begins and the following two months.

(12) "Modified adjusted gross income" and "MAGI" mean income as defined in 26 U.S.C. 36B(d).

(13) "PACE" means program of all-inclusive

care for the elderly. The program of all-inclusive care for the elderly provides medical services to frail elderly medicaid recipients in institutional settings and non-institutional settings.

(14) "Parent" means natural or biological parent, adoptive parent, or stepparent.

(15) "Protected income level" means the amount of monthly income that is not considered available for the payment of medical expenses. The protected income level is based on the number of persons in the assistance plan in accordance with K.A.R. 129-6-42 and the number of legally responsible relatives.

(16) "Sibling" means natural or biological sibling, adopted sibling, half sibling or stepsibling.

(17) "Supplemental security income" and "SSI" mean the low-income assistance program administered by the social security administration in accordance with 42 U.S.C. 1381 et seq., which provides monthly benefits to elderly and disabled persons.

(18) "Tax dependent" means a dependent under 26 U.S.C. 152 for whom another individual claims a deduction for a personal exemption under 26 U.S.C. 151 for a taxable year.

(19) "Title IV-E" means the adoption assistance and child welfare act of 1980, which provides federal funding for foster care, adoption assistance, and other permanency and placement programs for children.

(20) "Unearned income" means all income that is not earned income.

(b) The medical assistance program shall include applicants and recipients classified as automatic eligibles and as determined eligibles.

(c) The medical assistance program shall provide coverage to the following groups:

(1) MAGI-based coverage groups whose eligibility is based on the application of MAGI methodologies as specified in K.A.R. 129-6-41 and 129-6-53, including the following:

(A) Caretaker relatives and children under K.A.R. 129-6-70;

(B) newborn children who meet the provisions of K.A.R. 129-6-65(e);

(C) poverty-level pregnant women under K.A.R. 129-6-71;

(D) poverty-level children under K.A.R. 129-6-72;

(E) determined-eligible pregnant women under K.A.R. 129-6-73; and

(F) determined-eligible children under K.A.R. 129-6-74; and

(2) MAGI-excepted coverage groups whose eligibility is not based on the application of MAGI methodologies in accordance with K.A.R. 129-6-42 and 129-6-54, including the following:

(A) Children receiving title IV-E or non-title IV-E foster care payments under K.A.R. 129-6-65(f) or 129-6-80;

(B) children for whom an adoption support agreement under title IV-E is in effect under K.A.R. 129-6-65(g);

(C) children for whom a non-title IV-E adoption support agreement is in effect under K.A.R. 129-6-65(h);

(D) children receiving title IV-E guardianship care payments under K.A.R. 129-6-65(i);

(E) former foster care children under the age of 26 under K.A.R. 129-6-91;

(F) persons receiving supplemental security income (SSI) benefits in accordance with K.A.R. 129-6-65(a);

(G) persons receiving state supplemental payments in accordance with K.A.R. 129-6-65(b);

(H) persons deemed to be receiving SSI in accordance with K.A.R. 129-6-65(c);

(I) children under the age of 21 in an institutional arrangement in accordance with K.A.R. 129-6-81;

(J) aged, blind, or disabled persons under K.A.R. 129-6-85, including persons 65 years of age or older, persons whose eligibility is based on being blind or disabled under social security administration criteria, and persons whose eligibility is determined on the basis of the need for long-term care including nursing facility or institutional services, home- and community-based services, and PACE services;

(K) poverty-level and low-income medicare beneficiaries under K.A.R. 129-6-86;

(L) poverty-level working disabled individuals under K.A.R. 129-6-87;

(M) disabled individuals with earned income under K.A.R. 129-6-88;

(N) individuals with breast or cervical cancer under K.A.R. 129-6-89;

(O) persons living in nursing facilities for mental health under K.A.R. 129-6-94; and

(P) determined-eligible medicaid beneficiaries under K.A.R. 129-6-95. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-35. Application process.** (a) An ap-

plication for medical assistance shall be submitted by an applicant, an adult who is in the applicant's household or family, or another person authorized to act on the applicant's behalf, except that an application on behalf of a person mandated to receive tuberculosis care or on behalf of a deceased person may be made by any responsible person.

(b)(1) An application for medical assistance shall be made using a department-approved form. The applicant or person authorized to act on behalf of the applicant shall sign the application. Electronic signatures, including telephonically recorded signatures, and handwritten signatures transmitted by any other means of electronic transmission shall be acceptable. If any person signs by mark, the names and addresses of two witnesses shall be required. Each application on behalf of a deceased person shall be made within three months of the month of the person's death.

(2) Whenever assistance is requested for a family member following approval of assistance for other family members, the month of application for that family member shall be the month of the request, if all other eligibility requirements are met.

(3) Each application shall be submitted electronically on the state's application web site or the federally facilitated exchange web site, by telephone, in person, by mail, by electronic mail, or by fax.

(c)(1) For each application submitted online, the date of receipt of the application shall be the date the application is received from the state's application web site or the date the application is transmitted from the federally facilitated exchange web site.

(2) If the department denies an application within 90 days of the department's receipt of a signed application for medical assistance that is dependent upon a finding of disability and the applicant reapplies or provides required information within this 90-day period, the application shall be reactivated. If the department denies any other signed application within 45 days of the department's receipt of the application and the applicant reapplies or provides required information within this 45-day period, the application shall be reactivated. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-36. Redetermination of eligibility**

**process.** (a) Each recipient shall provide the department with information on the recipient's current situation and have an opportunity to review the eligibility factors so that the department can redetermine the recipient's continuing eligibility for medical assistance.

(b) Each recipient shall complete the redetermination process by either of the following:

(1) Reviewing and, if necessary, responding to information provided from the department's records, including information obtained through electronic data matching with other state or federal agencies; or

(2) completing and returning information on the individual's current situation requested by the department.

(c) Each recipient's eligibility for medical assistance shall be redetermined as often as a need for review is indicated. Redetermination shall occur at least once each 12 months.

(d) If a recipient fails to respond to a required redetermination request or to provide necessary information, the recipient and the members of the recipient's assistance plan shall be ineligible for assistance in accordance with K.A.R. 129-6-56. If the recipient responds to the request or provides information within 90 days of termination of assistance, the redetermination shall be completed without requiring a new application. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-38.** (Authorized by K.S.A. 2005 Supp. 75-7412; implementing K.S.A. 2005 Supp. 75-7412 and 75-7413, as amended by L. 2006, ch. 4, § 2; effective Aug. 11, 2006; revoked, T-129-10-31-13, Nov. 1, 2013; revoked Feb. 28, 2014.)

**129-6-39. Responsibilities of applicants and recipients.** Each applicant or recipient shall perform the following:

(a) Submit an application for medical assistance on a department-approved form. Any applicant may withdraw the application between the date the application is submitted and the date of the notice of the department's decision;

(b) supply information essential to the establishment of eligibility, to the extent that the applicant or recipient is able to do so;

(c) give written permission for the release of information regarding resources, when needed;

(d) report any change in circumstances within 10 calendar days of the change or as otherwise

required by the program. Changes to be reported shall include changes to income, living arrangement, household size, family group members, residency, alienage status, health insurance coverage, and employment;

(e) meet that individual's own medical needs to the extent that the individual is capable of doing so;

(f) take all necessary actions to obtain income or resources due the person or any other person for whom the individual is applying or who is receiving medical assistance; and

(g) except for persons for whom a determination under presumptive medical assistance as defined in K.A.R. 129-6-151 has been made, request a fair hearing in writing if the individual is dissatisfied with any department decision or lack of action in regard to the application for or the receipt of assistance. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-41. Assistance planning for MAGI-based coverage groups.** (a) The assistance plan for the groups described in K.A.R. 129-6-34(c)(1) shall consist of those persons in the household as determined in subsections (b) through (f).

(b) For each person who is not claimed as a tax dependent by any other taxpayer and is expected to file a tax return, the household shall consist of the person and all of the person's tax dependents, except as noted in subsection (e). If a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which assistance is determined, the inclusion of the individual in the household of the taxpayer shall be determined in accordance with subsections (d) and (e).

(c) For each person claimed as a tax dependent by another taxpayer, the household shall consist of that taxpayer and the taxpayer's dependents, except as noted in subsection (e).

(d) For each person who neither files a tax return nor is claimed as a tax dependent, the household shall consist of the person and, if living with the person, the following:

(1) The person's spouse;

(2) the person's natural children, adopted children, and stepchildren under the age of 21;

(3) the person's natural parents, adoptive parents, and stepparents, if the person is under the age of 21; and

(4) the person's natural siblings, adopted siblings, and stepsiblings under the age of 21, if the person is under the age of 21.

(e) For each person who is claimed as a tax dependent by another taxpayer, the household shall be determined in accordance with subsection (d) if the person meets one of the following conditions:

(1) Is not a spouse of the taxpayer and is not a biological child, an adopted child, or stepchild of the taxpayer;

(2) is claimed by one parent as a tax dependent and is living with both parents who do not expect to file a joint tax return; or

(3) is under the age of 21 and expected to be claimed as a tax dependent by a noncustodial parent.

(f) For any married couple living together, each spouse shall be included in the household of the other spouse, whether both spouses expect to file a joint tax return under 26 U.S.C. 6013 or whether one spouse expects to be claimed as a tax dependent by the other spouse. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-42. Assistance planning for MAGI-excepted coverage groups.** (a) In independent living arrangements for the groups described in K.A.R. 129-6-34(c)(2), the following requirements shall apply:

(1) For any child who is not blind or disabled, the assistance plan shall consist of all children in the family group and the legally responsible relatives of the children, if living together.

(2) For any child who is not living with a legally responsible relative, a separate assistance plan shall be applicable and shall include the siblings of the child if in the family group.

(3) For SSI recipients, a separate assistance plan shall be applicable and shall include only the SSI recipient.

(4) For all other persons, the assistance plan shall consist of those members of the family group for whom assistance is requested and eligibility is determined.

(5) For any deceased person for whom an application is made, the assistance plan shall be determined as if the person were living.

(b) In long-term care arrangements for the groups described in K.A.R. 129-6-34(c)(2), each

person shall have a separate assistance plan, unless one of the following exceptions applies:

(1) The person's protected income level is being computed as if the person were maintaining an independent living arrangement.

(2) The person's income and resources are considered available to both members of a couple, as specified in K.A.R. 129-6-106(f).

(3) A couple is residing in the same long-term care institutional arrangement, and only one spouse has income. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-50. Determined eligibles; general eligibility factors.** The general eligibility requirements in K.A.R. 129-6-51 through 129-6-60 and in K.A.R. 129-6-63 shall be eligibility factors applicable to determined eligibles, except as specified in those regulations. Certain eligibility requirements may be waived by the secretary and additional eligibility requirements may be adopted by the secretary for all, or designated areas, of the state for the purpose of utilizing special project funds or grants or for the purpose of conducting special demonstration or research projects. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-51. General eligibility requirements.** (a) Eligibility process. The determination of eligibility shall be based upon information provided by the applicant or recipient, or on behalf of the applicant or recipient, as well as electronic data matches with other state and federal databases, including the social security administration, department of homeland security, department of labor, and the department's office of vital statistics. If the information is unclear, incomplete, conflicting, or questionable, a further review, including contact with third parties, may be required.

(b) Eligibility for medical assistance. Each applicant or recipient shall be eligible for medical assistance only if all applicable eligibility requirements have been met. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-52. Act on own behalf.** (a) For pur-

poses of this regulation, each of the following terms shall have the meaning specified in this subsection:

(1) "Emancipated minor" means either of the following:

(A) A person who is aged 16 or 17 and who is or has been married; or

(B) a person who is under the age of 18 and who has been given or has acquired the rights of majority through court action.

(2) "Medical facilitator" means a person authorized to help complete the application or reenrollment process on behalf of an applicant or recipient under written authorization made by the applicant or recipient. The medical facilitator may help with completing and submitting the application or reenrollment form, providing necessary information and verifications, and receiving copies of notices or other official communications from the department to the applicant or recipient. A medical facilitator shall not be authorized to apply for medical assistance on behalf of another person.

(3) "Medical representative" means a person who is authorized to act on behalf of an applicant or recipient under a written authorization made by the applicant or recipient and who is knowledgeable of the applicant's or recipient's financial holdings and circumstances.

(b) Each applicant or recipient shall be legally capable of acting on that individual's behalf and shall also have the right to designate a representative to assist or act on behalf of the applicant or recipient.

(1) A legally incapacitated adult who is not capable of acting in that individual's own behalf shall not be eligible for medical assistance, unless a legal guardian, conservator, medical representative, or representative payee for social security benefits applies for assistance on the adult's behalf.

(2) Each emancipated minor shall be eligible to receive medical assistance on that individual's own behalf.

(3) An unemancipated minor shall not be deemed capable of acting on that individual's own behalf and shall not be eligible to apply for or receive medical assistance on that individual's own behalf, except as specified in this paragraph. An unemancipated minor shall not be eligible unless a caretaker, representative payee for social security benefits, or other nonrelated responsible adult who resides with the child and is approved by the parent or legal guardian applies for assistance on

the minor's behalf. However, an unemancipated minor may apply for or receive medical assistance on that individual's own behalf if one of the following conditions exists:

(A) The parents of the minor are institutionalized.

(B) The minor has no parent who is living or whose whereabouts are known, and there is no other caretaker who is willing to assume parental control of the minor.

(C) The health and safety of the minor has been or would be jeopardized by remaining in the household with the minor's parents or other caretakers. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-53. Financial eligibility for MAGI-based coverage groups.** This regulation shall apply to all groups described in K.A.R. 129-6-34(c)(1).

(a) Definitions. For purposes of this regulation, each of the following terms shall have the meaning specified in this regulation.

(1) "Household income" means the sum of the MAGI-based income of every individual included in the individual's household minus an amount equivalent to five percentage points of the federal poverty level for the applicable family size, for purposes of determining the individual's eligibility under the highest income standard for which the individual is eligible.

(2) "MAGI-based income" means income calculated using the same financial methodologies used to determine MAGI as defined in 26 U.S.C. 36B(d), with the following exceptions:

(A) An amount received as a lump sum shall be counted as income only in the month received;

(B) scholarships, awards, or fellowship grants used for education purposes and not for living expenses shall be excluded from income; and

(C) for American Indian and Alaska native funds, the following shall be excluded from income:

(i) Distributions from Alaska native corporations and settlement trusts;

(ii) distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the secretary of the interior;

(iii) distributions and payments from rents,

leases, rights-of-way, royalties, usage rights, or natural resource extraction and harvest from rights of ownership or possession in any lands described in this paragraph or federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) distributions either resulting from real property ownership interests related to natural resources and improvement located on or near a reservation or within the most recent boundaries of a prior federal reservation or resulting from the exercise of federally protected rights relating to these real property ownership interests;

(v) payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom; and

(vi) student financial assistance provided under the bureau of Indian affairs education programs.

(b) Exceptions to household income. Financial eligibility for families and children shall be based on household income, except for the following:

(1) The MAGI-based income of an individual who is included in the household of the individual's natural parent, adoptive parent, or stepparent and is not expected to be required to file a tax return under 26 U.S.C. 6012(a) for the taxable year in which eligibility is being determined shall not be included in household income whether or not the individual files a tax return.

(2) The MAGI-based income of a tax dependent described in K.A.R. 129-6-41(e)(1) who is not expected to be required to file a tax return under 26 U.S.C. 6012(a) for the taxable year in which eligibility is being determined shall not be included in household income whether or not the tax dependent files a tax return.

(c) Income deductions. No other deductions shall be applied in determining household income.

(d) Financial eligibility.

(1) Financial eligibility shall be based on the current monthly income and family size of the household, unless a change in circumstances is expected. In this case, financial eligibility shall be based on the projected monthly income and family size of the household.

(2) For children and pregnant women determined eligible based on K.A.R. 129-6-73 and K.A.R. 129-6-74, the provisions of K.A.R. 129-6-

54(a), (b), (c), and (e) regarding base periods and spenddown determinations shall be applicable.

(e) Exclusion of resources. The value of the household's resources shall not be taken into consideration in determining financial eligibility. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-54. Financial eligibility for MAGI-excepted coverage groups.** This regulation shall apply to all groups described in K.A.R. 129-6-34(c)(2), except that subsections (c) and (d) of this regulation shall not apply to any medicare beneficiary who meets the requirements of K.A.R. 129-6-86 or to any working disabled individual who meets the requirements of K.A.R. 129-6-87.

(a) Definitions. For purposes of this regulation, each of the following terms shall have the meaning specified in this regulation:

(1) "Client obligation" means the amount that the individual is required to pay towards the cost of care that the individual receives in a long-term care arrangement. Client obligation shall be based on the amount of applicable income that exceeds the income standard in the eligibility base period.

(2) "Eligibility base period" means the length of time used in the determination of financial eligibility. The length of the eligibility base period varies from one month to six months as specified in subsection (b).

(3) "Spenddown" means the amount of applicable income that exceeds the protected income level in the eligibility base period and that is available to meet medical costs.

(b) Eligibility base period.

(1) The base period shall be determined according to the following:

(A) For prior eligibility, the base period shall be the three months immediately preceding the month of application.

(B) Except for persons determined eligible under K.A.R. 129-6-85, the base period shall be one month for current eligibility.

(C) For persons determined eligible under K.A.R. 129-6-85, the base period shall be one month for persons in long-term care and six months for persons in independent living for current eligibility. A six-month base period shall be shortened in certain instances including when the recipient begins long-term care, becomes eligible for cash assistance, or dies.

(2) The base period shall begin on the first day

of the month in which the application was received. Subsequent eligibility base periods for recipients shall begin on the first day of the month following the expiration of the previous base period. Each reapplication received outside of a previously established eligibility base period shall be treated as a new application without regard to any previous eligibility base period. However, if the reapplication includes a request for prior eligibility, the base period of prior eligibility shall not extend into a previously established eligibility base period.

(c) Financial eligibility for persons in independent living.

(1) The total of all applicable income in the eligibility base period, as determined in accordance with K.A.R. 129-6-111, shall be compared to the income standard, as specified in K.A.R. 129-6-103, for the base period. If the total applicable income is less than the income standard and the individual owns property that has value within the allowable limits, the individual shall be financially eligible for medical assistance. If the total applicable income exceeds the income standard, the individual shall be ineligible for medical assistance except for persons determined eligible under K.A.R. 129-6-73, 129-6-74, and 129-6-85.

(2) For determined eligibles under K.A.R. 129-6-73, 129-6-74, and 129-6-85, if the total applicable income exceeds the income standard and the individual owns property that has value within the allowable limits, the excess applicable income shall be the spenddown.

(A) Each applicant or recipient shall incur allowable medical expenses in an amount at least equal to the spenddown before becoming eligible for assistance. Medical expenses paid either voluntarily or involuntarily by third parties shall not be utilized to meet the spenddown, except for medical expenses paid by a public program of the state other than medicaid.

(B) A previously unconsidered increase in total applicable income during the current eligibility base period that results in an additional spenddown shall not alter the base period. The individual shall meet the additional spenddown during the eligibility base period before the individual becomes eligible or regains eligibility for medical assistance. A payment made through the program within the current eligibility base period shall not be considered an overpayment if a previously eligible individual fails to meet the additional

spenddown within the current eligibility base period.

(d) Financial eligibility for persons in long-term care arrangements.

(1) Total gross income shall not exceed 300 percent of the payment standard for one person in the supplemental security income program as specified in K.A.R. 129-6-103(a)(13).

(2)(A) If the person is eligible in accordance with paragraph (d)(1), the total of all applicable income in the eligibility base period, as determined in accordance with K.A.R. 129-6-111, shall be compared to the income standard, as specified in K.A.R. 129-6-103(b) for institutional arrangements and K.A.R. 129-6-103(c) for HCBS arrangements, for the base period. If the total applicable income is less than the income standard and the individual owns property that has value within the allowable limits, the individual shall be financially eligible for medical assistance. If the total applicable income exceeds the income standard and the individual owns property that has value within the allowable limits, the excess applicable income shall be the client obligation.

(B) If the person is not eligible in accordance with paragraph (d)(1), financial eligibility shall first be determined in accordance with subsection (c). If allowable medical expenses, including the cost of the long-term arrangement, are in an amount that is at least equal to the spenddown, a final determination of financial eligibility shall then be determined in accordance with paragraph (d)(2)(A), including application of the appropriate institutional or HCBS income standard as specified in K.A.R. 129-6-103(b) or (c). If allowable medical expenses are not in an amount that is at least equal to the spenddown, financial eligibility shall be determined in accordance with subsection (c).

(3) Each applicant or recipient shall incur allowable medical expenses in an amount at least equal to the client obligation before becoming eligible for assistance. Medical expenses paid either voluntarily or involuntarily by third parties shall not be utilized to meet this obligation, except for medical expenses paid by a public program of the state other than medicaid.

(4) Any increase in total applicable income during the current eligibility base period may result in financial ineligibility or in additional obligation, but this increase shall not alter the base period. A payment made through the program within the current eligibility base period shall not be consid-

ered an overpayment if a previously eligible individual becomes ineligible because of an increase in total applicable income or fails to meet any additional obligation within the current eligibility base period.

(e) Allowable expenses. The following expenses shall be applied to a spenddown or client obligation if the individual provides evidence that the individual has incurred or reasonably expects to incur the expenses within the appropriate eligibility base period, or has incurred and is still obligated for expenses outside of the appropriate eligibility base period that have not been previously applied to a spenddown or obligation:

- (1) Co-pay requirements;
- (2) the pro rata portion of medical insurance premiums for the number of months covered in the eligibility base period regardless of the actual date of payment, past or future;
- (3) any medicare premiums that are not covered by the department through the buy-in process. Premiums that are subject to the buy-in process shall not be allowable before completion of the buy-in process, even if the individual pays the premiums or the premiums are withheld;
- (4) if medically necessary and recognized under Kansas law, all expenses for medical services incurred by the individual or a legally responsible family group member. Expenses for social services designated as medical services under the HCBS program shall be allowable under this paragraph for persons in the HCBS program. Expenses for routine supplies, as defined in K.A.R. 129-10-15a, and for institutional care if the individual does not meet nursing facility criteria through the level-of-care evaluation or reevaluation process as defined in K.A.R. 30-10-7, shall not be allowable under this paragraph; and
- (5) the cost of necessary transportation by appropriate mode to obtain medical services specified in paragraph (e)(4). (Authorized by and implementing K.S.A. 2013 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-55. Residence, citizenship, and alienage.** (a) Residence. Each applicant or recipient shall be a resident of Kansas. Temporary absence from a state with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, shall not be considered to interrupt continuity of residence. Residence shall be considered to be retained until

abandoned or established in another state. Residence shall be established as specified in this subsection.

(1) Individuals aged 21 and over.

(A) For each individual not residing in an institution, the individual shall choose the state of residence, based on one of the following:

(i) The state in which the individual is living and intends to reside, including without a permanent address;

(ii) the state that the individual has entered with a job commitment or for seeking employment, whether or not the individual is currently employed; or

(iii) the state in which the individual is living, if the individual is not capable of stating intent.

(B) For each individual who is residing in an institution, the state of residence shall be any of the following, whether or not the individual is capable of stating intent:

(i) The state in which the parent or permanent guardian resides, if the individual became incapable of stating intent before the age of 21;

(ii) the state in which the individual is living if the individual became capable of stating intent on or after the age of 21;

(iii) the state that placed the individual in an out-of-state institution; or

(iv) for any other institutionalized individual, the state in which the individual is living and intends to reside.

(2) Individuals under the age of 21.

(A) For each individual who is not residing in an institution and is not eligible for title IV-E foster care or adoption support assistance, the individual shall choose the state of residence, based on one of the following:

(i) The state in which the individual meets the conditions of paragraph (a)(1)(A)(i) or (ii), if the individual is capable of stating intent and either is emancipated from the individual's parents or is married;

(ii) the state in which individual resides, including without a permanent address, if the individual does not meet the conditions of paragraph (a)(2)(A)(i); or

(iii) the state in which the individual's parent or caretaker resides, if the individual lives with the parent or caretaker and does not meet the conditions of paragraph (a)(2)(A)(i).

(B) For each individual residing in an institution, the state of residence shall be the state in which the individual's parent or guardian is resid-

ing, whether or not the individual is capable of stating intent, unless the individual has been placed in an out-of-state institution. If the individual has been placed in an out-of-state institution, the state of residence shall be the state making the placement.

(b) Citizenship and alienage. Each applicant or recipient shall be a citizen of the United States or shall be a noncitizen who meets the conditions in paragraph (b)(1) or (2).

(1) The individual entered the United States before August 22, 1996 and meets one of the following conditions:

(A) Is a refugee as specified in 8 U.S.C. 1101, including any person who is a Cuban or Haitian entrant as defined in public law 96-422 or is admitted as an Amerasian immigrant as defined in public law 100-202;

(B) is granted asylum pursuant to 8 U.S.C. 1158;

(C) has deportation withheld under 8 U.S.C. 1253(h) as in effect before April 1, 1997 or under 8 U.S.C. 1231(b)(3);

(D) is a lawful, permanent resident;

(E) is an honorably discharged veteran or is on active duty in the armed forces or is the spouse or unmarried dependent child of the veteran or the person on active duty;

(F) has been paroled into the United States for at least one year under 8 U.S.C. 1182(d)(5);

(G) has been granted conditional entry under 8 U.S.C. 1157;

(H) has been battered or subjected to extreme cruelty by a U.S. citizen or lawful permanent spouse or parent and has a pending or approved violence against women act (VAWA) case or petition before the department of homeland security pursuant to 8 U.S.C. 1641(c); or

(I) is a certified victim of severe forms of trafficking, as defined in 22 U.S.C. 7105.

(2) The individual entered the United States on or after August 22, 1996 and meets one of the following conditions:

(A) Is a refugee, as specified in 8 U.S.C. 1101, including any person who is a Cuban or Haitian entrant as defined in public law 96-422 or is admitted as an Amerasian immigrant as defined in public law 100-202;

(B) is granted asylum pursuant to 8 U.S.C. 1158;

(C) has deportation withheld under 8 U.S.C. 1253(h) as in effect before April 1, 1997 or under 8 U.S.C. 1231(b)(3);

(D) is an honorably discharged veteran or is on active duty in the armed forces or is the spouse or unmarried dependent child of the veteran or the person on active duty;

(E) is an Iraqi or Afghani special immigrant under the 2006 national defense authorization act, public law 109-163;

(F) is a certified victim of severe forms of trafficking, as defined in 22 U.S.C. 7105;

(G) is a lawful, permanent resident who has resided in the United States for at least five years;

(H) has been paroled into the United States under 8 U.S.C. 1182(d)(5) for at least one year and has resided in the United States for at least five years;

(I) has been granted conditional entry under 8 U.S.C. 1157 and has resided in the United States for at least five years; or

(J) has been battered or subjected to extreme cruelty by a U.S. citizen or lawful permanent spouse or parent, has a pending or approved violence against women act (VAWA) case or petition before the department of homeland security pursuant to 8 U.S.C. 1641(c), and has resided in the United States for at least five years.

(3) Each applicant or recipient declaring to be a citizen or national of the United States shall present evidence of citizenship or nationality in accordance with "KDHE-DHCF policy no. 2013-10-01," as adopted by reference in K.A.R. 129-14-27. This requirement shall not apply to any of the following:

(A) Newborn children who meet the provisions of K.A.R. 129-6-65(e);

(B) individuals receiving SSI benefits;

(C) individuals entitled to or enrolled in any part of medicare;

(D) individuals receiving disability insurance benefits under section 223 of the social security act or monthly benefits under section 202 of the social security act, based on the individual's disability; or

(E) individuals who are in foster care and who are assisted under title IV-B of the social security act as amended by public law 109-288 and individuals who are recipients of foster care maintenance or adoption assistance payments under title IV-E.

(4) Each individual declaring to be a noncitizen shall present evidence of that individual's status in accordance with "KDHE-DHCF policy no. 2013-10-01," as adopted by reference in K.A.R. 129-14-27. Each noncitizen who has provided evidence

of qualified noncitizen status that has been verified with the department of homeland security shall be eligible for medical assistance.

(5) Each applicant or recipient shall have 90 days from the date the application is approved to provide the evidence described in paragraph (b)(3) or (4). (Authorized by and implementing K.S.A. 2013 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-56. Cooperation.** (a) Establishment of eligibility. Each applicant or recipient shall cooperate with the department in the establishment of the applicant's or recipient's eligibility by providing all information necessary to determine eligibility as specified in K.A.R. 129-6-39. Failure to provide all information necessary shall render members of the assistance plan, as defined in K.A.R. 129-6-41 or 129-6-42, ineligible for medical assistance.

(b) Potential resources. Each adult applicant or recipient shall cooperate with the department by obtaining any resources, including income, due the adult or any other person for whom assistance is claimed. In applicable situations, this cooperation shall include claiming an inheritance due the applicant or recipient and taking a share of an estate due the applicant or recipient as a surviving spouse. Failure to cooperate without good cause shall render the adult ineligible for medical assistance. Good cause shall include failure to pursue a potential resource when the cost of legal action would be greater than the value of the resource and, for pregnant women, failure to pursue unemployment benefits.

(c) Social security number. Except as noted in this subsection, each applicant or recipient shall cooperate by providing the department with the applicant's or recipient's social security number. Failure to provide the number, or failure to apply for a number if the applicant or recipient has not previously been issued a social security number, shall render the applicant or recipient ineligible for medical assistance. The following individuals shall be exempt from this requirement:

- (1) Any individual who is not eligible to receive a social security number;
- (2) any individual who does not have a social security number and can be issued a number only for a valid non-work reason; and
- (3) any individual who refuses to obtain a social

security number because of well-established religious objections.

(d) Paternity and support. Except for pregnant women, each applicant or recipient shall cooperate with the department by establishing the paternity of any child born out of wedlock for whom medical assistance is claimed and in obtaining medical support payments for the applicant or recipient and for any child for whom medical assistance is claimed. Failure to cooperate shall render the applicant or recipient ineligible for medical assistance, unless the individual demonstrates good cause for refusing to cooperate. Cooperation shall include the following actions:

- (1) Appearing at the local child support enforcement office, as necessary, to provide information or documentation needed to establish the paternity of a child born out of wedlock, to identify and locate the absent parent, and to obtain support payments;

- (2) appearing as a witness at court or at other proceedings as necessary to achieve the child support enforcement objectives;

- (3) forwarding to the child support enforcement unit any support payments received from the absent parent that are covered by the support assignment; and

- (4) providing information, or attesting to the lack of information, under penalty of perjury.

Good cause shall include pending legal proceedings for adoption of the child and threat of domestic violence as a result of cooperation.

(e) Third-party resources. Each applicant or recipient shall cooperate with the department by identifying and providing information to assist the department in pursuing any third party who could be liable to pay for medical services under the medical assistance program. Failure to cooperate without good cause shall render the applicant or recipient ineligible for medical assistance. Good cause shall include the unknown whereabouts of a liable third party and no legal standing to pursue a third party.

(f) Group health plan enrollment. Each applicant or recipient who is eligible to enroll in a group health plan offered by the applicant's or recipient's employer shall cooperate with the department by enrolling in that group health plan if the department has determined that the plan is cost-effective. To be cost-effective, the amount paid for premiums, coinsurance, deductibles, other cost-sharing obligations under the group health plan, and any additional administrative

costs shall be less than the amount paid by the department for an equivalent set of medicaid services. Failure to cooperate without good cause shall render the applicant or recipient ineligible for medical assistance. Good cause shall include lack of reasonable geographic access to care such that the applicant or recipient has to routinely travel more than 50 miles to reach providers participating in the plan. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-57. Transfer of assets.** (a) Definitions. For purposes of this regulation, each of the following terms shall have the meaning specified in this regulation:

(1) "Assets" means all income and resources of the individual and the individual's spouse, including any income or resources that the individual or the individual's spouse is entitled to but does not receive because of action by any of the following:

(A) The individual or the individual's spouse;

(B) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(C) any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(2) "Compensation" means all money, real or personal property, food, shelter, or service received by the individual or spouse at or after the time of transfer in exchange for the asset in question. A service received shall be considered compensation only if the service is provided under the terms of a legally enforceable agreement to provide the service in exchange for the assets in question and if the terms are established before delivery of the service. Payment or assumption of a legal debt owned by the individual or spouse in exchange for the asset shall be deemed compensation.

(3) "Fair market value" means the market value of an asset at the earlier of the time of the transfer or the contract of sale. Current market value shall be determined in accordance with K.A.R. 129-6-106(b).

(4) "Institutionalized individual" means an applicant or recipient who meets any of the following conditions:

(A) Is residing in a nursing facility;

(B) is residing in a medical institution that is providing the individual with a level of care equivalent to the care provided by a nursing facility;

(C) is residing in an HCBS living arrangement; or

(D) is participating in PACE.

(5) "Transfer of assets" means any transfer or assignment of any legal or equitable interest in any asset that partially or totally passes the use, control, or ownership of the asset of an applicant or recipient, or the spouse of an applicant or recipient, to another person or corporation, including any of the following:

(A) Giving away an interest in an asset;

(B) placing an interest in an asset in a trust that is not available to the grantor;

(C) removing or eliminating an interest in a jointly owned asset in favor of other owners;

(D) disclaiming an inheritance of any property, interest, or right;

(E) failing to take a share of an estate as a surviving spouse; or

(F) transferring or disclaiming the right to income not yet received.

(6) "Uncompensated value" means the fair market value of an asset less the amount of any compensation received by the individual or spouse in exchange for the asset.

(b) Ineligibility for payment of services. If an individual or spouse has transferred or disposed of assets for less than fair market value on or after the specified look-back date as determined by the date of transfer, the individual shall not be eligible for payment of services for any institutionalized individual as specified in paragraphs (a)(4)(A) through (D).

(c) Exempted transfers. An individual shall not be ineligible for payment of services due to a transfer of assets in any of the following circumstances:

(1) The fair market value of the assets transferred has been received.

(2) A written request to transfer the assets has been submitted by the individual and approved by the secretary before the date of the transfer.

(3) The transfer has been executed pursuant to the division of assets provisions of K.A.R. 129-6-106.

(4) A transfer of an interest in the individual's home has been made to any of the following, as determined by the interest conveyed:

(A) The spouse of the individual;

(B) a child of the individual who is under the

age of 21 or who meets the blindness or disability criteria of K.A.R. 129-6-85;

(C) a sibling of the individual who has an equity interest in the home and who was residing in the home for at least one year immediately before the date the individual entered an institutional or HCBS arrangement; or

(D) a child of the individual, other than the child described in paragraph (c)(4)(B), who was residing in the home for at least two years immediately before the date the individual entered an institutional or HCBS arrangement and who provided care to the individual that permitted the individual to reside at home.

(5) The assets have been transferred to any of the following:

(A) The individual's spouse or to another individual for the sole benefit of the individual's spouse;

(B) the institutionalized individual's child who meets the blindness or disability criteria of K.A.R. 129-6-85 or a trust established solely for the benefit of the child; or

(C) a trust established solely for the benefit of an individual under 65 years of age who meets the blindness or disability criteria of K.A.R. 129-6-85.

(6) A transfer of assets has been made, and a satisfactory showing that the individual intended to dispose of the assets at fair market value, for other valuable consideration, or exclusively for a purpose other than to qualify for medicaid has been established. The following criteria shall be used to establish a satisfactory showing:

(A) A record of the facts, in chronological order, related to each transfer of assets within the applicable look-back period shall be assembled; and

(B) a transfer of assets for less than fair market value shall be presumed to have been for the purpose of establishing or maintaining medicaid eligibility, unless the individual presents clear and convincing evidence that the transfer was exclusively for some other purpose. The burden shall be on the individual to rebut this presumption by furnishing clear and convincing evidence that the asset was transferred exclusively for some other purpose. A signed statement by the individual shall not be, by itself, clear and convincing evidence. Each transfer shall be considered in the light of the circumstances at the time the transfer was made. The total amount of the transfer shall be considered in proportion to the length of the interval between the date of the transfer and the date of the application for medical assistance. In

addition, the following factors shall be taken into account:

(i) Whether the transfer was ordered by the court and neither the individual, the spouse, the conservator, the guardian, the beneficiary of the transfer, nor anyone else acting in their legal authority or direction took action to effectuate the transfer; and

(ii) whether the individual could not have anticipated the need for medical assistance at the time of transfer due to an unexpected event occurring after the transfer that resulted in the traumatic onset of disability or blindness, the diagnosis of a previously undetected disability, or the loss of other income or resources, completely outside of the control of the individual or spouse, that would have otherwise precluded medical eligibility.

(7) The transferred asset has been returned to the individual or has been made available for use by the individual or spouse.

(d) Look-back date. The look-back date shall mean the earliest date on which a penalty for transferring assets for less than fair market value can be assessed, as specified in this subsection. A penalty shall be assessed for all transfers by the individual or the individual's spouse that take place on or after the look-back date. A penalty shall not be assessed for any transfers that take place before the look-back date.

(1) For transfers of assets before February 8, 2006, multiple transfers that occur within a single month shall be treated as a single transfer. The look-back date shall be either of the following:

(A) 60 months before the date the individual received or was otherwise eligible to receive institutional care or HCBS and has applied for medical assistance in the case of payment from a trust or portions of a trust that are treated as assets disposed of by the individual as specified in K.A.R. 129-6-109(c)(1) and (2); or

(B) 36 months before the date the individual received or was otherwise eligible to receive institutional care or HCBS and has applied for medical assistance in the case of all other transfers of assets.

(2) For transfers of assets on and after February 8, 2006, multiple transfers that occur within a single month shall be treated as a single transfer. The look-back date shall be the date that is 60 months before the date the individual received or was otherwise eligible to receive institutional care or HCBS and has applied for medical assistance.

(e) Transfer period of ineligibility. If the indi-

vidual or spouse has transferred assets for less than fair market value, the individual shall not be eligible for the services specified in paragraphs (a)(4)(A) through (D), as follows:

(1) For transfers before February 8, 2006, the penalty period shall be equal to the number of months calculated by taking the total cumulative uncompensated value of the assets transferred by the individual or spouse on or after the look-back date, divided by \$4,000.

(2) For transfers on and after February 8, 2006, the penalty period shall be equal to the number of days calculated by taking the total cumulative uncompensated value of the assets transferred by the individual or spouse on or after the look-back date, divided by the average daily private-pay cost of nursing facilities in the state in effect on the date the penalty begins. The average daily private-pay cost shall be determined at least annually based on the rates reported by the nursing facilities and compiled by department for aging and disability services.

(f) Penalty start date.

(1) The date on which the penalty period begins shall be determined by the date of the transfer, as follows:

(A) For transfers before February 8, 2006, the penalty start date shall be the first day of the month in which the transfer occurred for applicants and no later than the second month following the month of transfer for recipients giving timely and adequate notice as defined in K.A.R. 129-7-65.

(B) For transfers on and after February 8, 2006, the penalty start date shall be the later of the following:

(i) For applicants, the later of the following: the first day of the month in which the transfer occurred or the first day on which the individual is eligible for medical assistance based on an application for medical assistance and is receiving institutional care or would be receiving HCBS but for the application of the penalty period; and

(ii) for recipients giving timely and adequate notice as defined in K.A.R. 129-7-65, no later than the second month following the month of transfer.

(2) Separately established penalty periods shall be served consecutively. Once the penalty period is imposed, the period shall not be interrupted or suspended even if the individual no longer receives institutional care or HCBS.

(3) If the spouse of the individual transfers an asset that results in a penalty period and that

spouse is subsequently institutionalized and is determined otherwise eligible for medical assistance, the remaining penalty period shall be divided between the spouses.

(g) Hardship waiver.

(1) A penalty period shall be initially waived or suspended if the imposition of the penalty period would cause an undue hardship on the individual. To cause an "undue hardship" on the individual shall mean to deprive the individual of either of the following:

(A) Medical care to the extent that the individual's health or life would be endangered; or

(B) food, clothing, shelter, or other necessities of life to the extent that the individual would be at risk of serious harm.

(2) Undue hardship shall not exist if the application of a penalty period merely causes an individual or any individual's family members inconvenience or restricts their lifestyle. Undue hardship shall not exist if the individual transferred the assets to the spouse and the spouse refuses to cooperate in making the resources available to the individual.

(3)(A) Any individual claiming undue hardship may submit a written request to the department at any time during the penalty period. The request shall include a description of the undue hardship along with evidence to support the claim.

(B) The facility in which the individual resides shall obtain written consent from the individual or the individual's personal representative in order to assert a claim of undue hardship on behalf of the individual and provide supporting information on behalf of the individual. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-60. Public institutions.** (a) Definitions. For purposes of this regulation, each of the following terms shall have the meaning specified in this subsection:

(1) "Institution" means an establishment that furnishes food, shelter, and some form of treatment or services to four or more persons who are unrelated to the proprietor.

(2) "Public institution" means any institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(b) Living arrangement. Each applicant or recipient who lives in a public institution shall be

ineligible for medical assistance, unless the applicant or recipient meets one of the following conditions:

(1) Lives in a state institution and is under the age of 21 or at least aged 65;

(2) is blind or disabled, as defined by the social security administration, and is living in a state institution that has been approved as a medicaid intermediate care facility;

(3) is under the age of 21, under the age of 22 if receiving inpatient psychiatric care on the person's 21st birthday, or at least aged 65 and is receiving inpatient care in either of the following:

(A) A state institution that has been approved as a medicaid-accredited psychiatric hospital; or

(B) a nursing facility for mental health that has been approved for medicaid coverage of inpatient services;

(4) is receiving inpatient care in a psychiatric residential treatment facility, as defined in K.A.R. 28-4-1200, and is under the age of 21 or, if receiving inpatient treatment on the person's 21st birthday, under the age of 22; or

(5) meets the provisions of subsection (c) regarding persons who are residing in a jail or prison or under the care, custody, and control of the criminal justice system.

(c) Residing in a correctional facility.

(1) For purposes of this subsection, an inmate shall mean a person serving time for a criminal offense or confined involuntarily in a state correctional facility. Inmates in other correctional facilities, including county or city correctional facilities, shall not be eligible under this paragraph. The following requirements shall apply:

(A) The inmate shall otherwise qualify for medicaid and meet all general and financial eligibility criteria for the appropriate medical program. No inmate shall be eligible for medical assistance under K.A.R. 129-6-86.

(B) Each inmate shall be covered for inpatient services received outside of the correctional facility. No coverage shall be provided for outpatient care outside of the correctional facility or for medical services provided on the premises of the facility.

(C) For budgeting purposes, each inmate shall be treated as a household of one, except for pregnant women. Each pregnant woman shall be treated as a household of two or more, based on the number of children the woman is expected to deliver. Neither the income nor resources of the

parent or the spouse of the inmate shall be included in the eligibility determination.

(2) The following provisions shall apply to each individual in a correctional facility:

(A) Except as noted in paragraph (c)(2)(B), there shall be no eligibility for medicaid for each person who meets any of the following conditions:

(i) Is physically residing in a correctional facility;

(ii) is an accused person or convicted criminal under the custody of the juvenile or adult criminal justice system. A person may receive medical assistance if there is no indication of custody or if the person has been pardoned or released on the person's own recognizance, is on probation, parole, bail, or bond, or is participating in a prison diversion program operated by a privately supported facility; or

(iii) is placed in a detention facility.

(B) Any inmate of a correctional facility administered by the department of corrections may be eligible for medical assistance to cover inpatient hospital services. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-63. Assignment of rights to support or other third-party payments.** Each applicant or recipient shall assign to the secretary any accrued, present, or future rights to the following:

(a) Medical support payments received for any individual for whom medical assistance is claimed; and

(b) third-party payments for medical care that the individual could receive on the individual's own behalf or on behalf of any other family member who is or would be in the individual's assistance plan. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-65. Automatic eligibles.** Each of the following individuals shall be automatically eligible for medical assistance without meeting any additional requirements, except that the individual shall meet the general eligibility requirements of K.A.R. 129-6-50 and 129-6-109(c)(2):

(a) A person who is legally entitled to and receiving supplemental security income (SSI) benefits and who is in compliance with the residence requirements of K.A.R. 129-6-55;

(b) a person who is legally entitled to and receiving state supplemental payments from Kansas related to SSI;

(c) a person who is determined by the social security administration to retain recipient status, although the person is not currently receiving an SSI benefit;

(d) a person who is mandated to receive inpatient treatment for tuberculosis;

(e) a child born to a mother who is eligible for and receiving medicaid at the time of birth, including receiving medical assistance under K.A.R. 129-6-97, for up to one year, if the mother remains eligible for medicaid or would be eligible for medicaid if still pregnant. Eligibility for the child shall continue, unless the child dies or is no longer a resident of the state or action is taken to voluntarily terminate coverage;

(f) a child receiving foster care payments in an out-of-home placement, regardless of the state making the payments;

(g) a child for whom an adoption assistance agreement under title IV-E is in effect, even if adoption assistance payments are not being made or the adoption assistance agreement was entered into with another state. Eligibility shall begin when the child is placed for adoption, even if an interlocutory decree of adoption or a judicial decree of adoption has not been issued;

(h) a child for whom a non-title IV-E adoption assistance agreement is in effect between the state and the adoptive parents and who cannot be placed without medical assistance because the child has special needs for medical or rehabilitative care; and

(i) a child receiving title IV-E guardianship care payments. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-70. Medicaid determined eligibles; eligibility factors specific to qualifying families.** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 129-6-50 and the specific eligibility requirements in this regulation.

(b) Each family shall include a caretaker and the children of the caretaker who are under 19 years of age. Any family may also include a pregnant woman and her unborn child or children.

(c) Household income as determined under

K.A.R. 129-6-53 shall not exceed the income standard specified in K.A.R. 129-6-103(a)(3).

(d) Eligibility for medical assistance under this regulation shall continue for each person who receives medical assistance under this regulation for at least three of the six months immediately before the month in which the person became ineligible for medical assistance under this regulation as a result, in whole or in part, of collection or increased collection of spousal support. Eligibility for medical assistance shall continue for the four months immediately after the last month in which the person was eligible and legally entitled to receive medical assistance under this regulation if the person remains ineligible for medical assistance under this regulation due to collection or increased collection of spousal support.

(e) Eligibility for medical assistance under this regulation shall continue for each person who is included in the assistance plan of a family that has received medical assistance under this regulation in three of the six months immediately before the first month in which the family has lost eligibility for medical assistance under this regulation due solely to increased earned income or hours of employment of the caretaker, including an increase in the amount paid for hours of work.

Assistance shall be provided for a period not to exceed 12 months. Eligibility shall end for any individual who leaves the family and for any child who no longer meets the age requirements of subsection (b). (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-71. Medicaid determined eligibles; poverty-level pregnant women.** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 129-6-50 and the specific eligibility requirements in this regulation.

(b) Each eligible woman shall be pregnant. Assistance under this regulation shall continue for two calendar months following the month in which the pregnancy terminates. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-72. Medicaid determined eligibles; poverty-level children.** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 129-6-50 and the specific eligibility requirements in this regulation.

(b) For infants, each eligible infant shall be under one year of age. Medical assistance under this regulation shall continue according to either of the following:

(1) Through the month in which the child reaches the age of one; or

(2) if receiving inpatient services in the month in which the child reaches the age of one, according to the earlier of the following:

(A) Through the calendar month in which the inpatient care ends; or

(B) through the calendar month following the month in which the inpatient care begins. If the inpatient care will exceed this time period, eligibility for the child under this regulation shall end on the last day of the calendar month in which the child reaches the age of one.

(c) For young children, each eligible child shall be at least one year of age, but no older than five years of age. Medical assistance under this regulation shall continue according to either of the following:

(1) Through the month in which the child reaches the age of six; or

(2) if receiving inpatient services in the month in which the child reaches the age of six, according to the earlier of the following:

(A) Through the calendar month in which the inpatient care ends; or

(B) through the calendar month following the month in which the inpatient care begins. If the inpatient care will exceed this time period, eligibility for the child under this regulation shall end on the last day of the calendar month in which the child reaches the age of six.

(d) For older children, each eligible child shall be at least six years of age but under the age of 19. A child who meets the poverty income guidelines of K.A.R. 129-6-103(a)(6) shall not currently be covered under a “group health plan” or under “health insurance coverage” as defined in 42 U.S.C. 300gg-91. The child shall not be considered covered if the child does not have reasonable geographic access to care under that plan or coverage. Reasonable geographic access to care shall mean that the child routinely does not have to travel more than 50 miles to reach providers participating in the plan or coverage. Medical assistance under this regulation shall continue according to any of the following:

(1) Through the month in which the child reaches the age of 19; or

(2) if receiving inpatient services in the month

in which the child reaches the age of 19, according to the earlier of the following:

(A) Through the calendar month in which the inpatient care ends; or

(B) through the calendar month following the month in which the inpatient care begins. If the inpatient care will exceed this time period, eligibility for the child under this regulation shall end on the last day of the calendar month in which the child reaches the age of 19; or

(3) through the calendar month the child who meets the poverty-level income guidelines of K.A.R. 129-6-103(a)(6) becomes covered under a group health plan or under health insurance coverage in accordance with this subsection.

(e) A percentage of the federal poverty-level income guidelines as established in K.A.R. 129-6-103(a)(4) for infants, K.A.R. 129-6-103(a)(5) for young children, and K.A.R. 129-6-103(a)(6) for older children shall be used as the income standard for the number of persons in the assistance plan in accordance with K.A.R. 129-6-41. The total applicable income to be considered in the eligibility base period shall be compared against the poverty level for the base period. To be eligible under this regulation, the total applicable income shall not exceed the poverty level established for the base period. (Authorized by and implementing K.S.A. 2012 Supp. 64-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-73. Medicaid determined eligibility; eligibility factors specific to pregnant women.** (a) Each pregnant applicant or recipient shall meet the general eligibility requirements of K.A.R. 129-6-50. In addition, the applicant or recipient shall not be eligible for medical assistance under K.A.R. 129-6-71.

(b) Financial eligibility under this regulation shall be determined for each month as if the unborn child were already born and living with the applicant or recipient and shall be based on the number of children that the applicant or recipient is expected to deliver.

(c) Assistance under this regulation shall continue for the two calendar months following the month in which the pregnancy terminates. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-74. Medicaid determined eligibility; eligibility factors specific to children.**

Each child shall meet the applicable general eligibility requirements of K.A.R. 129-6-50 and the following requirements:

(a) The child shall be under 19 years of age.

(b) The child shall not be eligible for medical assistance under K.A.R. 129-6-72. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-77.** (Authorized by and implementing K.S.A. 2005 Supp. 75-7412; effective June 30, 2006; revoked, T-129-10-31-13, Nov. 1, 2013; revoked Feb. 28, 2014.)

**129-6-80. Medicaid determined eligibles; eligibility factors specific to children in foster care.** To be eligible for participation in the medical assistance program related to foster care, each child shall meet the following requirements:

(a) Meet the general eligibility requirements of K.A.R. 129-6-50;

(b) be under the age of 18 or be a full-time elementary or secondary school student who is qualified to receive foster care maintenance payments under title IV-E of the social security act, 42 U.S.C. 670 et seq.;

(c) be placed in a living arrangement approved by the secretary, including a foster family home, a private nonprofit child care facility, a medicaid-approved medical facility, a medicaid-accredited psychiatric hospital, or an intermediate care facility; and

(d) have a written order issued by a court giving care, custody, and control of the child to one of the following:

(1) The secretary of the department for children and families;

(2) in the case of an Indian child as defined by the federal Indian child welfare act, the four tribes social services child-placing agency; or

(3) the secretary of the department of corrections. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-81. Medicaid determined eligibles; eligibility factors specific to children living in medicaid-accredited psychiatric hospitals, intermediate care facilities, or residential treatment facilities.** To be eligible for participation in the medical assistance pro-

gram under this regulation, each child shall meet the following requirements:

(a) Meet the general eligibility requirements of K.A.R. 129-6-50; and

(b) be under the age of 21 or, if receiving inpatient psychiatric care on the person's 21st birthday and currently receiving inpatient care in either of the following, be under the age of 22:

(1) A state institution that has been approved as a medicaid-accredited psychiatric hospital or intermediate care facility; or

(2) a psychiatric residential treatment facility as defined in K.A.R. 28-4-1200. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-82. Medicaid determined eligibles; eligibility factors specific to HCBS.** (a)

To be eligible for participation in the medical assistance program under this regulation, each person shall meet the following requirements:

(1) Meet the general eligibility requirements of K.A.R. 129-6-50;

(2) be assessed as in need of long-term care services in an institutional setting pursuant to K.S.A. 39-968, and amendments thereto, and choose to receive HCBS if these services are available; and

(3) be in an approved waiver under 42 U.S.C. 1315 or 1396n, or both.

(b) Each person transitioning from a nursing facility or an intermediate care facility for people with intellectual disability to the community shall be provided HCBS if the person meets the following requirements:

(1)(A) Is 65 years of age or older in accordance with K.A.R. 129-6-85(a);

(B) is physically disabled in accordance with K.A.R. 129-6-85(c) and is 16 through 64 years of age;

(C) is five years of age or older, has an intellectual disability, and meets the level of care for an intermediate care facility for people with intellectual disability; or

(D) is between the ages of 16 and 65 and has a traumatically acquired head injury requiring care in a rehabilitation facility as determined by screening; and

(2) has been in the facility for at least 90 days and received medicaid for at least 30 days. (Authorized by and implementing K.S.A. 2012 Supp.

65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-83. Medicaid determined eligibles; eligibility factors specific to PACE.** (a) To be eligible for participation in the medical assistance program under this regulation, each person shall meet the following requirements:

(1) Meet the general eligibility requirements of K.A.R. 129-6-50;

(2) be assessed as in need of long-term care services in an institutional setting;

(3) be 55 years of age or older and residing in a PACE service area as authorized by the secretary; and

(4) meet the disability criteria of K.A.R. 129-6-85(b) or (c) if aged 55 through 64.

(b) Financial eligibility shall be determined based on the living arrangement of the individual. If services are provided in a noninstitutional living arrangement, eligibility shall be determined in accordance with the regulations applicable to the home- and community-based services program. If services are provided in an institutional living arrangement, eligibility shall be determined in accordance with the regulations applicable to persons receiving long-term care in an institutional arrangement. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-84. Medicaid determined eligibles; eligibility factors specific to work opportunities reward Kansans (WORK).** (a) To be eligible for participation in the medical assistance program under this regulation, each person shall meet the following requirements:

(1) Meet the general eligibility requirements of K.A.R. 129-6-50;

(2) be eligible for and receiving assistance under K.A.R. 129-6-88;

(3) be employed in a competitive, integrated work setting in which work is performed in the competitive labor market on a full-time or part-time basis for which individuals are compensated at or above minimum wage, but not less than the customary wage and level of benefits paid to a nondisabled individual for the same or similar work. The work shall be performed in a setting typically found in the community in which individuals with the most severe disabilities interact with nondisabled individuals according to the duties and responsibilities of the position; and

(4) be determined by an assessor authorized by the secretary to need WORK services in order to live and work in the community.

(b) The financial eligibility and premium requirements of K.A.R. 129-6-88 shall be applicable.

(c) Each individual's participation in WORK shall be based on the individual's voluntary acceptance of and agreement with the regulatory and policy requirements of the program in accordance with a participation agreement. An individual's refusal or failure to comply with the regulatory and policy requirements of the program shall be the basis for termination of the individual's participation in the program. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-85. Medicaid determined eligibles; eligibility factors specific to the aged, blind, or disabled (ABD).** Each applicant or recipient shall meet general eligibility requirements of K.A.R. 129-6-50 and one of the following specific eligibility requirements to be eligible for participation in the medical assistance program related to ABD:

(a) Age. Each individual shall have attained the age of 65 before or within the month for which eligibility is being determined.

(b) Blindness. Each individual shall be blind, based on social security administration criteria.

(c) Disability. Each individual shall be determined disabled, based on social security administration criteria. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-86. Poverty-level, low-income, and expanded low-income medicare beneficiaries; determined eligibles.** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 129-6-50 and the following specific eligibility requirements:

(1) Medicare part A beneficiary. Each individual shall be entitled to medicare part A benefits.

(2) Financial eligibility. A percentage of the official federal poverty-level income guidelines as established in K.A.R. 129-6-103 shall be used as the income standard for the number of persons in the assistance plan and any other persons whose income is considered. The total applicable income to be considered in the eligibility base period shall

be compared against the poverty level for the base period. However, the amount of an annual social security cost-of-living adjustment shall be disregarded in determining eligibility during the first quarter of the year for which the adjustment is provided.

For an individual to be eligible, the total applicable income shall not exceed the poverty level established for the base period. The individual also shall not own nonexempt real or personal property with a resource value in excess of the allowable amounts specified in K.A.R. 129-6-107(b)(1) for the number of persons whose non-exempt resources are considered available to the individual.

(b) Medical assistance provided. Medical assistance under this regulation for each poverty-level medicare beneficiary meeting the poverty-level income guidelines of K.A.R. 129-6-103(a)(7) shall be limited to the payment of allowable medicare premiums, deductibles, and coinsurance. Medical assistance for each low-income medicare beneficiary meeting the poverty-level income guidelines of K.A.R. 129-6-103(a)(9) shall be limited to the payment of medicare part B premiums only. Medical assistance for each expanded low-income medicare beneficiary meeting the poverty-level income guidelines of K.A.R. 129-6-103(a)(10) shall be limited to the payment of medicare part B premiums only, and the person shall not seek coverage under any other type of medical assistance. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-87. Poverty-level working disabled individuals; determined eligibles.** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 129-6-50 and the following specific eligibility requirements:

(1) Medicare part A beneficiary. Each individual shall be entitled to medicare part A benefits under 42 U.S.C. 1395i-2a.

(2) Financial eligibility. A percentage of the official federal poverty income guidelines as specified in K.A.R. 129-6-103(a)(8) shall be used as the income standard for the number of persons in the assistance plan and any other persons whose income is considered. The total applicable income to be considered in the eligibility base period shall be compared against the poverty level for the base period. To be eligible under this regulation, the

total applicable income shall not exceed the poverty level established for the base period. The individual shall also not own nonexempt real or personal property with a resource value in excess of twice the allowable amount specified in K.A.R. 129-6-107 for the number of persons whose non-exempt resources are considered available to the individual.

(b) Assistance provided. Assistance under this regulation shall be limited to the payment of medicare part A premiums. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-88. Disabled individuals with earned income; determined eligibles.** (a) Each applicant and each recipient shall meet the general eligibility requirements of K.A.R. 129-6-50 and the following specific eligibility requirements:

(1) Each individual shall be at least 16 years old but less than 65 years old.

(2) Each individual shall meet the blindness or disability requirements of K.A.R. 129-6-85.

(3) Each individual shall have earned income that is subject to federal insurance contributions act (FICA) taxes.

(b) Financial eligibility shall be based on a percentage of the official poverty-level income guidelines as established in K.A.R. 129-6-103(a)(11), which shall be used as the income standard for the number of persons in the assistance plan and any other persons whose income is considered. Monthly applicable income to be considered in the eligibility base period shall be compared against the poverty level for the base period. For an individual to be eligible under this regulation, the monthly applicable income shall not exceed the poverty level established for the base period. If the individual also owns nonexempt real or personal property with a resource value in excess of \$15,000, which shall include any nonexempt resources of all family group members, that individual shall not be eligible under this regulation.

(c) For each individual whose monthly applicable income is at least 100 percent of the federal poverty-level income guidelines, a premium shall be required. This premium shall not exceed 7.5 percent of the monthly applicable income. Failure to pay the premium shall result in ineligibility.

(d) Each individual who is temporarily unemployed but intends to return to work shall con-

tinue to be eligible for coverage for not more than four months if all other eligibility factors are met. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-89. Individuals with breast or cervical cancer; determined eligibles.** (a) Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 129-6-55 and the following specific eligibility requirements:

(1) Each individual shall be screened for breast or cervical cancer under the breast and cervical cancer early detection program established under title XV of the public health service act, 42 U.S.C. 300k et seq., by the centers for disease control and prevention and shall be found to need treatment for either breast or cervical cancer.

(2) Each individual shall be uninsured and not be otherwise eligible for medical assistance under this article.

(3) Each individual shall be under the age of 65.

(b) Eligibility for coverage under this regulation shall end when the course of treatment is completed or if the individual no longer meets the eligibility requirements. There shall be no financial eligibility requirements. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-91. Youth formerly in foster care; determined eligibles.** Each applicant or recipient shall meet the general eligibility requirements of K.A.R. 129-6-50 and the following conditions:

(a) In the month of the individual's 18th birthday, be in the custody of the department for children and families or the department of corrections and be in an out-of-home placement; and

(b) be at least 18 years old but under the age of 26. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-94. Non-medicaid determined eligibles; eligibility factors specific to persons living in nursing facilities for mental health.**

(a) To be eligible for participation in the medical assistance program under this regulation, each individual shall meet the following conditions:

(1) Meet the general eligibility requirements of K.A.R. 129-6-50;

(2) be aged 21 or older and under the age of 65;

(3) have a "severe and persistent mental illness," as defined in K.A.R. 30-10-1a;

(4) be otherwise eligible for medicaid; and

(5) not meet the requirements of K.A.R. 129-6-60(b) or 129-6-81(b).

(b) Eligibility shall be determined based on the financial eligibility standards and methodologies applicable to persons in institutional arrangements as specified in K.A.R. 129-6-42(c), 129-6-54(d), and 129-6-103(b).

(c) Whether an individual has a severe and persistent mental illness shall be determined by a qualified mental health professional employed by a participating mental health center, as defined in K.S.A. 59-2946 and amendments thereto. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-95. Non-medicaid determined eligibles; eligibility factors specific to the medikan program.** (a) To be eligible for participation in the medical assistance program under this regulation, each individual shall meet the following conditions:

(1) Not be otherwise eligible for medicaid and not be rendered ineligible for medicaid by either deliberate or voluntary actions on the part of the individual;

(2) meet the general eligibility requirements of K.A.R. 129-6-50;

(3) be aged 18 or older and under the age of 65; and

(4) have a severe impairment that significantly limits physical or mental ability to do basic work activity and is expected to last at least 12 months or result in death.

(b) Each individual shall apply for social security disability benefits and cooperate in that process, to remain eligible. Each person who qualifies for social security disability benefits shall no longer be eligible for assistance under the medikan program.

(c) If the individual is married, the individual and the individual's spouse shall both qualify for medikan to be eligible for assistance.

(d) Assistance under this regulation shall be limited to 12 months in a lifetime.

(e) Temporary coverage under this regulation shall be provided to any person discharged from

a medicaid-approved psychiatric hospital, from the Larned correctional mental health facility central unit, or from the Larned state security program. Medical assistance shall be provided at the time of discharge and may continue for not more than two additional months to facilitate the person's discharge plan. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-96. Continuous eligibility for children and certain adult eligibles.** (a) Children. Except for children determined eligible for presumptive medical assistance as specified in K.A.R. 129-6-151, each child under the age of 19 who becomes eligible for medicaid under any category of medical assistance shall continue to be eligible for medical assistance for 12 months beginning with the month in which eligibility is determined or redetermined regardless of any changes in circumstances, except for any of the following:

- (1) The child reaches the age of 19.
- (2) Medical assistance for the child is voluntarily terminated.
- (3) The child no longer resides in Kansas.
- (4) The secretary determines that eligibility was granted erroneously because of fraud or department error.

(5) The child dies.

(b) Adults. Each nonpregnant adult who becomes eligible for medicaid under K.A.R. 129-6-70 shall continue to be eligible for medical assistance for 12 months beginning with the month eligibility is determined or redetermined regardless of any change in income, except for any of the following:

(1) Medical assistance for the adult is voluntarily terminated.

(2) The adult no longer resides in the state.

(3) The secretary determines that eligibility was granted erroneously because of fraud or department error.

(4) The adult dies.

(5) The adult enters a correctional or detention facility.

(6) The adult becomes eligible for coverage of nursing facility care or HCBS.

(7) The adult becomes eligible for supplemental security income. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403;

effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-97. Emergency medical services for certain noncitizens.** (a) Each noncitizen who does not meet the requirements of K.A.R. 129-6-55(b) but who is otherwise eligible for medicaid shall receive coverage as specified in subsection (b) of this regulation. The general requirements of K.A.R. 129-6-50, except for K.A.R. 129-6-55(b) and 129-6-56(c), shall be applicable.

(b)(1) Eligibility shall be limited to coverage of an emergency medical condition, as approved by the secretary, that requires emergency medical treatment after the sudden onset of a condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, so that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Serious jeopardy to the patient's health;

(B) serious impairment of bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(2) Coverage shall be limited only to treatment of the emergency condition. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-103. Determined eligibles; income standards.** (a) Independent living arrangements.

(1) The income standard for each person in an independent living arrangement shall be based on the total number of persons in the assistance plan as defined in K.A.R. 129-6-41 or 129-6-42.

(2) The income standards for independent living may also be used if an applicant or recipient meets either of the following conditions:

(A) Enters a medicaid-approved facility, except that this paragraph shall not apply if only one spouse in a married couple enters an institutional living arrangement; or

(B) is absent from the home for medical care for a period not to exceed the month in which the person left the home and the two months following to allow for maintaining the applicant's or recipient's independent living arrangements.

(3) Except as specified in paragraphs (a)(4) through (13), the following table shall be used to determine the income standard for persons in an independent living arrangement.

Persons in Independent Living (per month)		
1	2	3
\$475	\$475	\$480

The income standard for additional persons shall be the sum of the basic standard for a similar public assistance family and the maximum state shelter standard in accordance with K.A.R. 30-4-101.

(4) In determining eligibility for pregnant women under K.A.R. 129-6-71 and for infants under K.A.R. 129-6-72(b), the income standard shall be 166 percent of the official federal poverty-level income guidelines.

(5) In determining eligibility for young children under K.A.R. 129-6-72(c), the income standard shall be 149 percent of the official federal poverty-level income guidelines.

(6) In determining eligibility for older children under K.A.R. 129-6-72(d), the income standard shall be 133 percent of the official poverty-level income guidelines.

(7) In determining eligibility for poverty-level medicare beneficiaries under K.A.R. 129-6-86, the income standard shall be 100 percent of the official federal poverty-level income guidelines.

(8) In determining eligibility for working disabled individuals under K.A.R. 129-6-87, the income standard shall be 200 percent of the official federal poverty-level income guidelines.

(9) In determining eligibility for low-income medicare beneficiaries under K.A.R. 129-6-86, the income standard shall be 120 percent of the official federal poverty-level income guidelines.

(10) In determining eligibility for expanded low-income medicare beneficiaries under K.A.R. 129-6-86, the income standard shall be 120 to 135 percent of the official federal poverty-level income guidelines, subject to available federal funding.

(11) In determining eligibility for disabled individuals with earned income under K.A.R. 129-6-88, the income standard shall be 300 percent of the official federal poverty-level income guidelines.

(12) In determining eligibility for persons in the medikan program under K.A.R. 129-6-95, the income standard shall be \$250 for a single individual and \$325 for a married couple.

(13) In determining eligibility for persons in long-term care arrangements in accordance with K.A.R. 129-6-54(d)(1), the income standard shall be 300 percent of the payment standard for one

person in the SSI program. For calendar year 2013, the income standard shall be \$2,130, and this amount shall be increased at the beginning of each calendar year by any cost-of-living adjustment made to the SSI payment standard.

(b) Institutional living arrangements. For each person residing in an institutional setting, the monthly income standard for purposes of determining the client obligation shall be \$62, except as specified in paragraph (a)(2).

(c) Home- and community-based services arrangements. For each person in the HCBS program, including any person in the PACE program who is in a noninstitutional living arrangement in accordance with K.A.R. 129-6-83(b), the monthly income standard for purposes of determining the client obligation shall be \$727. (Authorized by and implementing K.S.A. 2013 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-106. General requirements for consideration of resources, including real property, personal property, and income.**

(a) For purposes of determining eligibility for medical assistance, legal title shall determine ownership. In the absence of legal title, possession shall determine ownership.

(b) Each resource shall be of a nature that the value can be defined and measured, according to the following:

(1) Real property. The value of real property shall be initially determined by the latest uniform statewide appraisal value of the property, which shall be adjusted to reflect current market value. If the property has not been appraised or if the market value determined is not satisfactory to the applicant, recipient, or department, an estimate or appraisal of the value of the property shall be obtained from an impartial real estate broker. The cost of obtaining an estimate or appraisal shall be paid by the department.

(2) Personal property. The market value of personal property shall be initially determined using a reputable trade publication. If such a publication is not available or if there is a difference of opinion between the department and the individual regarding the value of the property, an estimate from a reputable dealer shall be used. The cost of obtaining an estimate or appraisal shall be paid by the department.

(c)(1) Resources shall be considered available if the resources are actually available and the appli-

cant or recipient has the legal ability to make the resources available. A resource shall be considered unavailable if there is a legal impediment that precludes the disposal of the resource. The applicant or recipient shall pursue reasonable steps to overcome the legal impediment, unless it is determined that the cost of pursuing legal action would exceed the resource value of the property or it is unlikely the applicant or recipient would succeed in the legal action. This paragraph shall also apply to the spouse of the applicant or recipient.

(2) Real property shall be considered unavailable if the property cannot be sold for one of the following reasons:

(A) The property is jointly owned, and its sale would cause undue hardship because of the loss of housing for the other owner or owners.

(B) The owner's reasonable efforts to sell the property have been unsuccessful.

(d) The resource value of property shall be the value of the applicant's or recipient's equity in the property. Unless otherwise established, the proportionate share of jointly owned real property and the full value of jointly owned personal property shall be considered available to the applicant or recipient. Resources held jointly with a non-legally responsible person may be excluded from consideration if the applicant or recipient demonstrates that all of the following conditions exist:

(1) The applicant or recipient has no ownership interest in the resource.

(2) The applicant or recipient has not contributed to the resource.

(3) Any access to the resource by the applicant or recipient is limited to those duties performed while the applicant or recipient is acting as an agent for the other person.

(e) Except for persons described in K.A.R. 129-6-34(c)(1) and 129-6-34(c)(2)(A) through (I), the nonexempt resources of all persons in the assistance plan shall be considered in determining eligibility. Exempted resources as defined in K.A.R. 129-6-108(d) and 129-6-109(e) that are put in a trust that meets the requirements of K.A.R. 129-6-109(c)(1) or (c)(2)(A) shall be regarded as nonexempt, unless paragraphs (k)(4) and (6) of this regulation are applicable.

(f)(1) The combined resources of husband and wife, if they are living together, shall be considered in determining the eligibility of either individual or both individuals for the medical assis-

tance program, except as noted in subsection (e) or unless otherwise prohibited by law.

(2) A husband and wife shall be considered to be living together if they are regularly residing in the same household. Temporary absences of either the husband or the wife for education, training, working, securing medical treatment, or visiting shall not interrupt the period of time during which the couple is considered to be living together.

(3) A husband and wife shall not be considered to be living together if they are physically separated and not maintaining a common life or if one or both enter into an institutional living arrangement, including either a medicaid-approved or non-medicaid-approved medical facility or an HCBS care arrangement.

(A) If only one spouse enters an institutional living arrangement, subsection (k) shall apply.

(B) If both spouses enter an institutional living arrangement, the combined resources of the husband and wife shall be considered available to both individuals for the month in which the institutional arrangement begins.

(g) Except as noted in subsection (e), the resources of an ineligible parent shall be considered in determining the eligibility of a minor child for the medical assistance program if the parent and child are living together. However, these resources shall not be considered for any child in an institutional arrangement or an HCBS arrangement beginning with the month following the month in which the arrangement begins.

(h) Despite subsections (e), (f), and (g), the resources of an SSI beneficiary shall not be considered in the determination of eligibility for medical assistance of any other person.

(i) The conversion of real property and personal property from one form of resource to another shall not be considered to be income to the applicant or recipient, except for the proceeds from a contract for the sale of property.

(j) Income shall not be considered to be both income and property in the same month.

(k) If one spouse enters an institutional living arrangement, the other spouse remains in the community, and an application for medical assistance is made on behalf of the institutionalized spouse, an income determination according to the following requirements shall be applied first in determining eligibility:

(1) The separate income of each spouse shall not be considered to be available to the other

spouse beginning in the month in which the institutional arrangement begins. One-half of the income that is paid in the names of both spouses shall be considered available to each spouse, unless it is otherwise established that less or more than this amount is available. Income that is paid in the name of either spouse, or in the name of both spouses and the name of another person or persons, shall be considered available to each spouse in proportion to the spouse's interest, unless it is otherwise established that less or more than this amount is available.

(2)(A) A monthly income allowance for the community spouse shall be deducted from the income of the institutionalized spouse in determining the amount of patient liability for each person in an institutional living arrangement or in a spenddown status for each person in an HCBS arrangement.

(B) The income allowance for the community spouse, when added to the income already available to that spouse, shall not exceed 150 percent of the official federal poverty-level income guideline for two persons plus the amount of any excess shelter allowance. "Excess shelter allowance" shall mean the amount by which the community spouse's expenses for rent or mortgage payments, taxes and insurance for the community spouse's principal residence, and the supplemental nutrition assistance program (SNAP) standard utility allowance, 7 U.S.C. 2014(e), exceed 30 percent of 150 percent of the federal poverty-level income guideline amount specified in this paragraph.

(C) The maximum monthly income allowance that may be provided under paragraph (k)(2) shall be \$1,500. The \$1,500 limitation shall be increased at the beginning of each calendar year by the same percentage as the percentage increase in the consumer price index for all urban consumers between September 1988 and the September before the applicable calendar year.

(D) If a greater income allowance is provided under a court order of support or through the Kansas administrative hearing process, that amount shall be used in place of the limits specified in paragraph (k)(2)(C).

(3) A monthly income allowance for each dependent family member shall be deducted from the income of the institutionalized spouse in determining the 300 percent income limit as specified in K.A.R. 129-6-54(d)(1) and the amount of client obligation for each person in an institutional living arrangement or in an HCBS arrangement.

(A) "Dependent family member" shall mean a person who is a minor or dependent child, dependent parent, or dependent sibling of either spouse and who lives with the community spouse.

(B) The allowance for each member shall be equal to one-third of 150 percent of the official federal poverty-level income guideline for two persons.

(C) An allowance for a dependent family member shall not be provided if the family member's gross income exceeds 150 percent of the federal poverty-level income guideline for two persons.

(4) If the spouse is institutionalized on or after September 30, 1989, the nonexempt real property and personal property of both spouses shall be considered in determining the eligibility of the institutionalized spouse, based on the amount of property in excess of the community spouse property allowance specified in paragraph (k)(6), whether or not this allowance will be made.

(A) If the excess property is within the allowable resource standards of K.A.R. 129-6-107, the institutionalized spouse shall be eligible.

(B) In the month following the first month of eligibility for the institutionalized spouse, only the property of the institutionalized spouse shall be considered available in determining continuing eligibility, except for property to be transferred in accordance with paragraph (k)(6).

(5) If the spouse was institutionalized before September 30, 1989, the real property and personal property of each spouse shall be considered available to the other spouse in the month in which the institutional arrangement began. Thereafter, the property of each spouse shall not be considered available to the other spouse.

(6) The institutionalized spouse may make available to the community spouse a property allowance that, when added to the property already available to the community spouse, would be equal to one-half of the total value of the property owned by both spouses at the beginning of the first period of continuous institutionalization beginning on or after September 30, 1989.

(A) This property allowance shall not exceed \$60,000 and shall be at least \$12,000. Both the \$12,000 and the \$60,000 limits shall be increased at the beginning of each calendar year by the same percentage as the percentage increase in the consumer price index for all urban consumers between September 1988 and the September before the applicable calendar year.

(B) If a greater property allowance is provided

under a court order of support or through the Kansas administrative hearing process, that amount shall be used in place of the limits specified in paragraph (k)(6)(A). If a greater property allowance is required to increase the community spouse's income to the amount allowed under paragraphs (k)(2)(B) and (C), a fair hearing officer shall take into account the income-generating value of the current property allowance as well as the additional property allowance requested. The property provided shall be invested so that income is maximized, including through a single-premium annuity, and based on the salable or market value of the property.

(7) The amount of property received by the community spouse as a result of the property allowance determined in paragraph (k)(6) shall not be considered in determining the eligibility of the institutionalized spouse, except as provided in paragraph (k)(4). If the institutionalized spouse will be eligible based upon transferring sufficient property to the community spouse to equal the amount of the property allowance, the institutionalized spouse shall be given not more than 90 days from the date of application to transfer the property. Additional time may be allowed for good cause. Pending disposition of the property, the institutionalized spouse shall be eligible during this period if all other eligibility factors are met.

(l) The resources of a noncitizen's sponsor and the sponsor's spouse shall be considered in determining eligibility for the sponsored noncitizen. (Authorized by and implementing K.S.A. 2013 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-107. Property exemption.** (a) Ownership of otherwise nonexempt real property or personal property shall not affect eligibility if the aggregate resource value is not in excess of \$2,000 for one person or \$3,000 for two or more persons, including the number of persons whose nonexempt resources are considered available to a person in the assistance plan.

(b) Ownership of property with a resource value in excess of the amounts specified in subsection (a) shall render the applicant or recipient and the members of the applicant's or recipient's assistance plan ineligible for medical assistance, except for the following:

(1) For medicare beneficiaries who meet the requirements of K.A.R. 129-6-86, the resource value shall be in excess of the following standards

before the applicant or recipient and the members of the applicant's or recipient's family group shall be rendered ineligible:

(A) For calendar year 2006, \$6,000 for one person or \$9,000 for a couple; and

(B) for subsequent years, the amounts established in paragraph (b)(1)(A) increased by the annual percentage increase in the consumer price index for all items based on the United States city average as established in September of the previous year.

(2) For working disabled individuals who meet the requirements of K.A.R. 129-6-87, the resource value shall be over twice the amounts specified in subsection (a) before the applicant or recipient and the members of the applicant's or recipient's assistance plan shall be rendered ineligible.

(3) For disabled individuals with earned income who meet the requirements of K.A.R. 129-6-88, the resource value shall be over \$15,000 before the applicant or recipient and the members of the applicant's or recipient's assistance plan shall be rendered ineligible. If the applicant or recipient is making a bona fide and documented effort to dispose of the excess property at a reasonable market value, medical assistance for not more than nine months shall be provided. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-103. Real property.** (a) Definitions.

(1) "Home" shall mean the house or shelter in which the applicant or recipient is living, as well as the tract of land and contiguous tracts of land upon which the house and other improvements essential to the use or enjoyment of the home are located. Tracts of land shall be considered to be contiguous if lying side by side, except for streets, alleys, and other easements. Pieces of property that touch only at the corners shall not be considered to be contiguous.

(2) "Other real property" shall mean real property other than a home, including land and buildings.

(b) Treatment of real property. The equity value of nonexempt real property shall be deemed a resource. If a specific and discrete property interest of less than 100 percent is designated for real property, the full value shall be considered in the determination of eligibility, regardless of the exemptions specified in subsection (d).

(c) Substantial home equity. Each person who applies for long-term care on or after January 1, 2006 and has an equity interest in a home in excess of \$500,000 shall be ineligible for payment of care for a nursing facility or other institutional arrangement, HCBS arrangement, or PACE arrangement, unless one of the following persons continues to reside in the home:

- (1) The person's spouse;
- (2) the person's child, if the child meets the criteria of K.A.R. 129-6-85(b) or (c); or
- (3) the person's child, if the child is under the age of 21.

The \$500,000 limit shall be increased beginning in calendar year 2011 from year to year based on the percentage increase in the consumer price index for all urban consumers based on all items and the United States city average, rounded to the nearest \$1,000.

(d) Exempted real property. The equity value of the following classifications of real property shall be exempt, except as noted in subsections (b) and (c):

- (1) The home, except either of the following:
  - (A) A home from which an applicant or recipient has been absent and does not intend to return; or
  - (B) a home from which a person who enters an institutional living situation has been absent for at least three months, unless the absence is determined to be temporary or a spouse, dependent child, or another dependent relative remains in the home;
- (2) other real property that is essential for employment or self-employment;
- (3) income-producing other real property that is used in an individual's trade or business or that produces income consistent with its fair market value;
- (4) restricted or allotted land held by an enrolled member of an Indian tribe that cannot be sold or transferred without permission of other members of the tribe or a federal agency; and
- (5) real property that is directly related to the maintenance or use of a vehicle that is used primarily for producing income or is necessary to transport a physically disabled household member. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-109. Personal property.** (a) Defi-

nitions. For purposes of this regulation, each of the following terms shall have the meaning specified in this regulation:

(1) "Cash assets" means the following resources:

- (A) Cash surrender or loan values of life insurance policies;
- (B) investments;
- (C) money;
- (D) similar items from which a determinate amount of money can be realized; and
- (E) trust funds.

(2) "Other personal property" means the following:

- (A) Contracts from the sale of property;
- (B) equipment;
- (C) home produce;
- (D) household equipment and furnishings;
- (E) inventory;
- (F) livestock;
- (G) personal effects;
- (H) similar items from which a determinate amount of money can be realized; and
- (I) vehicles.

(3) "Personal property" means all property, excluding real property.

(b) Treatment of personal property. Personal property, unless exempted, shall be considered a resource. Each trust fund shall be subject to subsection (c).

(c) Treatment of trust funds. For purposes of determining an individual's eligibility for assistance or the amount of assistance, the requirements in this subsection shall apply to trust funds. The term "trust" shall include any legal instrument or device that is similar to a trust, including an annuity. The term "assets" shall be defined as specified in K.A.R. 129-6-57(a).

(1) For a revocable trust, the value of the trust shall be considered a resource available to the individual. Payments from the trust to or for the benefit of the individual shall be considered to be income. All other payments made from the trust shall be considered under the property transfer provisions of K.A.R. 129-6-57.

(2) For an irrevocable trust established after August 10, 1993, the following requirements shall apply:

(A) If there are any circumstances under which payment from an irrevocable trust could be made to the individual or for the benefit of the individual, the portion of the trust from which payment could be made shall be considered as a resource

available to the individual. Each payment made from the trust to the individual or for the benefit of the individual shall be considered income. All other payments made from the trust shall be considered under the property transfer provisions of K.A.R. 129-6-57.

(B) Each portion of the trust from which no payment could be made to the individual under any circumstances shall be considered under the transfer of assets provisions of K.A.R. 129-6-57 from the date of establishment of the trust or, if later, the date on which payment to the individual was restricted or foreclosed.

(C) An individual shall be considered to have established a trust if any assets of the individual were used to form all or part of the trust and if any of the following individuals established the trust, other than by will:

- (i) The individual or the individual's spouse;
- (ii) any person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
- (iii) any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(D) If the principal of the trust includes assets of any other person or persons, this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(E) This subsection shall apply without regard to the purposes for which the trust was established, whether or not the trustees have or exercise any discretion under the trust, any restrictions on when or whether distributions can be made from the trust, or any restrictions on the use of distributions from the trust.

(F) This subsection shall not apply to a trust that contains the assets of an individual under the age of 65 who meets the blindness or disability criteria of K.A.R. 129-6-85 and that is established for the benefit of the individual by a parent, grandparent, or legal guardian of the individual, or a court. The state shall receive all amounts remaining in the trust upon the death of the individual, up to an amount equal to the total medical assistance paid on behalf of the individual;

(G) This subsection shall not apply to a trust that contains the assets of an individual who meets the blindness or disability criteria of K.A.R. 129-6-85 if the trust meets all the following conditions:

(i) The trust is established by a nonprofit association.

(ii) A separate account is maintained for each beneficiary of the trust.

(iii) Accounts in the trust are established solely for the benefit of individuals who meet the blindness or disability criteria of K.A.R. 129-6-85.

(iv) Each account in the trust is established by that individual; the parent, grandparent, or legal guardian of the individual; or a court. The state shall receive all amounts remaining in the individual's account upon the death of the individual, up to an amount equal to the total medical assistance paid on behalf of the individual.

Establishment of a trust under paragraph (c)(2)(G) for an individual who is at least 65 shall be subject to the transfer of assets provisions of K.A.R. 129-6-57.

(H) The requirements of K.A.R. 129-6-109(c)(2) shall be waived if the secretary determines that a waiver is necessary to avoid undue hardship on the individual. A finding of undue hardship may be granted if the individual verifies that all of the following conditions have been met:

(i) The individual has exhausted all legal remedies for gaining access to the principal or income of the trust.

(ii) All otherwise available assets have been expended to meet living and medical expenses.

(iii) The individual's health or life would be endangered if the individual were deprived of medical care.

(3) For an irrevocable trust established with the individual's own assets on or before August 10, 1993, the following provisions shall apply:

(A) The trust shall be considered available up to the maximum value of the funds that can be made available under the terms of the trust on behalf of the individual if both of the following conditions are met:

(i) The individual is a beneficiary.

(ii) The trustees are permitted to exercise any discretion with respect to distribution to the individual.

(B) The trust may be established by the individual, the individual's spouse or parent, a legal guardian, or a legal representative who is acting on behalf of the individual.

(C) The amount from the trust that shall be considered as an available resource is the amount that could have been distributed but was not distributed within an eligibility base period. Each amount actually distributed shall be regarded as

income. Each portion of the trust that is unavailable to the individual or is not used for the benefit of the individual shall be considered a transfer of property for less than fair market value in accordance with K.A.R. 129-6-57.

(D) K.A.R. 129-6-109(c)(3) shall not be applicable to any trust established before April 7, 1986 if the individual is a developmentally disabled individual who is residing in an intermediate care facility for people with intellectual disability and the trust is solely for the benefit of the individual.

(4) For any other trust, including a trust established with assets of someone other than the individual, the trust shall be considered available to the individual only if the individual has the ability to revoke or terminate the trust or to direct the use of the trust assets for the individual's own support and maintenance. Mandatory periodic payments received from a trust by the individual shall be considered an available resource equal to the present value of the anticipated payments, unless there is a valid spendthrift clause or other language in the trust that specifically prohibits anticipation of payments. If a valid spendthrift clause or other restrictive language exists, the periodic payments shall be considered countable unearned income.

(d) Treatment of annuities. The term "annuity" shall include any contract or device that conveys a right to receive a fixed, periodic source of income for a specified period of time. For purposes of determining an individual's eligibility for assistance or the amount of assistance, the following requirements shall apply:

(1) Each individual requesting medical assistance shall disclose any interest in an annuity. Failure to meet this requirement shall result in ineligibility for medical assistance due to noncooperation in accordance with K.A.R. 129-6-56.

(2) Retirement annuities, including civil service and railroad retirement annuities, shall be exempt as a resource, but the income received shall be countable unearned income.

(3) All other revocable and irrevocable annuities, including those reported to be nonassignable, shall be presumed to be an available resource. The right to either the principal or the income stream from an annuity shall be considered a countable resource. If the annuity can be sold, assigned, encumbered, or structured so that the benefit of the annuity can be received by someone other than the designated beneficiary, the annuity shall be considered available and shall be assigned a value.

(4) The fair market value of a revocable annuity shall be the cash value of the annuity. The fair market value of an irrevocable annuity shall be the amount yet to be paid out under the terms of the contract.

(5) If the individual can furnish evidence from a reliable source that the annuity or the income stream from the annuity is not able to be received by someone other than the designated beneficiary, the annuity shall be reevaluated. Reliable sources concerning the availability of the annuity or income stream shall include banks and other financial institutions, insurance companies, and brokers.

(e) Exempted personal property. The resource value of the following types of personal property shall be exempt:

(1) Personal effects;

(2) household equipment and furnishings in use or only temporarily not in use;

(3) tools in use and necessary for the maintenance of a house or a garden;

(4) the stock and inventory of any self-employed person that are reasonable and necessary in the production of goods and services;

(5) items for home consumption, which shall consist of the following:

(A) Produce from a garden consumed from day to day and any excess that can be canned or stored; and

(B) a small flock of fowl or herd of livestock that is used to meet the food requirements of the family;

(6) cash assets that are traceable to income exempted as income and as a cash asset;

(7) any contract for the sale of property, if the proceeds from the contract are considered as income and the income is consistent with the repayment terms and conditions specified in the written contract;

(8) one vehicle for each family group receiving medical assistance if the primary purpose of the vehicle is to serve the needs of that family group. If someone who is not a member of that family group has the primary use, enjoyment, and possession of the vehicle, the vehicle shall not be exempted under this paragraph. Additional vehicles may be exempt if used over 50 percent of the time for employment or self-employment, if used as the family's home, if needed for medical treatment of a specific medical problem, or if specially equipped for use by a handicapped person;

(9) any individual development account (IDA) that meets the following requirements:

(A) The account shall be established by or on behalf of a temporary assistance for needy families (TANF) recipient or by or on behalf of an individual participating in the assets for independence demonstration program (AFIA) and shall be used for a qualified purpose. A qualified purpose shall mean one or more of the following: postsecondary education expenses for college or vocational-technical school, excluding learning quest and other 529 accounts; first home purchase, if the person has not owned a home within three years of acquisition; or business capitalization, if the business plan has been approved by a financial institution or nonprofit loan fund. All funds withdrawn from an IDA and used for any purpose other than one of those listed in this paragraph shall count as unearned income in the month withdrawn; and

(B) the IDA shall be a trust funded through periodic contributions by the establishing individual and may be matched by or through a qualified entity for a qualified purpose. A qualified entity to match IDA funds for a TANF recipient shall be either a not-for-profit organization described in 8 U.S.C. 501(c)(3) and exempt from taxation under 8 U.S.C. 501(a) or a state or local government agency acting in cooperation with a 501(c)(3) organization. For AFIA participants, matching contributions shall be made by the federal government through a grantee;

(10) low-income family postsecondary savings accounts incentive program established pursuant to K.S.A. 2012 Supp. 75-650, and amendments thereto;

(11) life insurance that is owned by an applicant or recipient if one of the following conditions is met:

(A) The policy has no potential cash surrender value;

(B) the policy does not exceed \$1,500 face value. The face value shall not include and shall not be increased by accumulated dividends, but shall be decreased by any outstanding policy loan. If the total face value of insurance policies owned by any one individual exceeds \$1,500, the total cash surrender value of those policies shall be a nonexempt resource; or

(C) the policy is in excess of \$1,500 face value and has been irrevocably collaterally assigned to the state. The assignment shall be for an amount not to exceed the amount of benefits paid under the medical assistance program for the individual;

(12) any personal property of a blind or disabled person that is covered by an approved plan of self-support;

(13) burial spaces in accordance with the following:

(A) "Burial spaces" shall mean conventional grave sites, crypts, mausoleums, caskets, urns, and other repositories that are traditionally used for the remains of deceased persons. This term shall include vaults, headstones, and grave markers, as well as monies set aside for opening and closing the grave; and

(B) burial spaces purchased through a revocable or irrevocable prepaid contract shall be exempt under this paragraph, including the account in which the funds are deposited under the contract and the interest that accrues on the funds;

(14) burial funds of up to \$1,500 each, plus any interest that has accumulated in that fund beginning with the month of application but no earlier than November 1, 1984, for members of the assistance plan that are separately identifiable and clearly designated as set aside for each member's burial expenses. "Burial funds" shall mean revocable burial contracts and trusts as well as other revocable burial arrangements:

(A) The fund shall be considered separately identifiable if it is set up in a separate account and not commingled with any other funds, except funds for burial purposes including a prepaid contract fund for burial merchandise in accordance with paragraph (e)(13);

(B) the fund shall be considered as clearly designated if the account is noted "for burial purposes only" or if the client provides a signed, written statement attesting to the fact that the funds have been set aside and are intended for burial purposes only;

(C) if the fund is exempted and the client withdraws all or a portion of the funds, the amount withdrawn shall be considered as a nonexempt resource and, if transferred, shall be subject to the transfer provisions of K.A.R. 129-6-57;

(D) the \$1,500 amount that can be exempted under paragraph (e)(14) shall be reduced by the amount of any irrevocable burial agreements established under K.S.A. 16-303 and amendments thereto, except to the extent that the irrevocable burial agreement represents excludable burial spaces under paragraph (e)(13), as well as the face value of all life insurance policies that do not exceed the \$1,500 face value limitation in accordance with paragraph (e)(11). The face value of life

insurance policies that exceed this \$1,500 limit shall not reduce the amount that can be exempted for burial purposes;

(15) proceeds from the sale of a home if the proceeds are conserved for the purchase of a new home and the funds so conserved are expended or committed to be expended within three months of the sale;

(16) a retroactive social security payment received by the applicant or recipient or an ineligible legally responsible person for the nine months following the month of receipt;

(17) the cash value of pension plans or funds under any of the following conditions:

(A) The person is employed and would have to terminate employment in order to obtain any payment. Each pension plan or fund that can be converted to periodic payments shall be exempt if the plan or fund is converted to periodic payments by the month following the month in which the plan or fund is eligible for conversion;

(B) the person is not retired or claiming permanent disability; or

(C) the applicant's or recipient's spouse or parent has funds in a work-related pension plan or fund, including Keogh plans, and IRAs and is not applying for or receiving medical assistance;

(18) retirement accounts and pensions of any employed individual who meets the requirements of K.A.R. 129-6-88;

(19) income-producing personal property, other than cash assets, that is essential for employment or self-employment or producing income consistent with its fair market value. Income-producing property may include any of the following items:

- (A) Tools;
- (B) equipment;
- (C) machinery; or
- (D) livestock;

(20) escrow accounts established for families participating in the family self-sufficiency program through the U.S. department of housing and urban development. Interest earned on the accounts shall also be exempted as income; and

(21) monies paid as part of a contract or agreement to receive medical or assistive services from an unlicensed individual or entity if all of the following conditions are met:

(A) A written contract is executed before providing or paying for any service. The contract shall specify services to be provided and the rates for these services;

(B) the contracted amount paid for services is consistent with the market rate for the services. If there is no established rate, the federal minimum wage shall be used;

(C) the provider of the service is reporting all monies as income to the appropriate state and federal governmental revenue agencies as required by law;

(D) any amounts due under the contract are paid after the services are rendered;

(E) the agreement is revocable; and

(F) upon the death of the individual, the contract ceases. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-110. Income.** (a) Treatment of income for MAGI-based coverage groups. For purposes of this regulation, "prospective monthly amount" shall mean an amount that is projected for purposes of determining an applicant's or recipient's monthly income. For those groups specified in K.A.R. 129-6-34(c)(1), all earned income and unearned income expected to be received in the month of application shall be used to determine a prospective monthly amount. This amount shall be used in the determination of both eligibility in the prior three months and current eligibility. For changes in earned income and unearned income, an estimate of those changes shall be used to determine a prospective monthly amount. For self-employment income, a prospective monthly amount shall be based on annual federal tax information from the most recent tax year. In the absence of federal tax information from the most recent tax year, an estimate shall be used to determine a prospective monthly amount.

(b) Treatment of income for MAGI-excepted coverage groups. For those groups specified in K.A.R. 129-6-34(c)(2), income shall be classified as income in the eligibility base period in which the income is received and as a cash asset following this eligibility base period.

(1) Prior eligibility. For individuals in independent living, current income as defined in paragraph (b)(2) shall be considered in the determination of eligibility for the prior three months. For individuals in long-term care arrangements, income received in the prior three months shall be considered in the determination of eligibility for the prior three months, except that self-employment income shall be averaged.

(2) Current eligibility. Income shall be considered prospectively to determine eligibility, beginning with the month of application. All income received or reasonably expected to be received shall be considered in determining the applicable income for the eligibility base period. Income from self-employment and intermittent income shall be considered and averaged. Intermittent income shall be divided by the applicable number of months to establish the monthly amount. Intermittent income shall be considered as income beginning with the eligibility base period in which this income is received. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-111. Applicable income.** “Applicable income” shall mean the amount of earned and unearned income that is compared with the appropriate income standard to establish financial eligibility.

(a) MAGI-based coverage groups. For those groups specified in K.A.R. 129-6-34(c)(1), all earned income and unearned income shall be considered applicable, unless exempted in accordance with K.A.R. 129-6-53(a)(2), and shall be determined as follows:

(1) Applicable income shall be based on the methodologies used to determine modified adjusted gross income, as specified in K.A.R. 129-6-53(a), for persons in the household, as specified in K.A.R. 129-6-53(b).

(2) An amount equivalent to five percentage points of the federal poverty level for the applicable family size shall be deducted from the combined household income in accordance with K.A.R. 129-6-53(a) when determining eligibility for the MAGI-based coverage groups under K.A.R. 129-6-34(c)(1) with the highest income standard for which the individual's eligibility is being determined.

(b) MAGI-excepted coverage groups. For those groups specified in K.A.R. 129-6-34(c)(2), all earned income and unearned income shall be considered applicable income, unless exempted in accordance with K.A.R. 129-6-112 and 129-6-113. For all aged, blind, and disabled groups, applicable income shall be determined as follows:

(1) Wages. All earned income shall be considered applicable income, except that K.A.R. 129-6-112 and 129-6-113 shall apply to persons in an independent living arrangement or in the HCBS

program. The applicable earned income shall be gross income less income deductions, if applicable.

(2) Self-employment. The applicable earned income for a self-employed person shall equal the modified adjusted gross earned income less the income deductions of paragraph (b)(4), if applicable. Paragraph (b)(1) regarding modified adjusted gross earned income shall apply to calculations made pursuant to this paragraph. Annual tax information from the most recent tax year shall be converted to a monthly prospective amount. This amount shall be used in the determination of both eligibility in the prior three months and current eligibility. In the absence of tax information from the most recent tax year, the most current income shall be used to determine a monthly amount.

(3) Unearned income. All net unearned income shall be considered to be applicable income, except that K.A.R. 129-6-112 and 129-6-113 shall apply to persons in an independent living arrangement or in the HCBS program. K.A.R. 129-6-113 (a), (m), (n), (w), (bb), (cc), (ff), (kk), (nn), and (oo) shall apply to persons in long-term care arrangements. Net unearned income shall equal gross unearned income less the costs of the production of the income. Income-producing costs shall include only those expenses directly related to the actual production of income.

(4) Income deductions.

(A) For persons in an independent living arrangement or in the HCBS program, the following deductions shall apply:

(i) The first \$20 of any nonexempt unearned income; and

(ii) an applicable earned income deduction calculated as follows: gross earned income minus any portion of the unearned income deduction that exceeds monthly earned income, plus \$65 of monthly earned income, plus one-half of the remainder of the monthly earned income.

(B) For persons in long-term institutional arrangements who are employed, an applicable earned income deduction shall be calculated as follows: gross earned income minus \$65 of monthly earned income, plus one-half of the remainder of the monthly earned income. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-112. Income exempt from con-**

**sideration as income and as a cash asset for MAGI-excepted groups.**

For those groups specified in K.A.R. 129-6-34(c)(2), exempted income shall be the following: (a) Grants, scholarships, and loans provided for educational purposes;

(b) the value of benefits provided under the federal supplemental nutrition assistance program;

(c) the value of any food donated by the United States department of agriculture;

(d) benefits received under title V, community services employment program, or title VII, nutrition program for the elderly, of the older Americans act of 1965, as amended by public law 109-365;

(e) Indian funds distributed or held in trust by the secretary of the interior, including interest and investment income accrued on these funds while held in trust and initial purchases made with these funds;

(f) distributions to natives under the Alaska native claims settlement act;

(g) payments provided to individual volunteers serving as foster grandparents, senior health aides, and senior companions under title II of the domestic volunteer service act of 1973 as amended by public law 106-170;

(h) any payments provided through americorps, except that volunteers in service to America (VISTA) payments shall be exempt only as income;

(i) relocation payments received under public law 91-646;

(j) death benefits from social security administration (SSA), veterans administration (VA), railroad retirement, or other burial insurance policy if the benefits are used toward the cost of burial. This shall include payments occasioned by the death of another person to the extent that the payments have been expended or committed to be expended for purposes of the deceased person's last illness and burial;

(k) money held in trust by the VA for a child that the VA determines shall not be used for subsistence needs;

(l) retroactive corrective assistance payments in the month received or in the following month;

(m) maintenance income directly provided by rehabilitation services of the Kansas department for children and families;

(n) mandatory deductions from military pay for educational purposes while the individual is enlisted in the armed services;

(o) reimbursements for out-of-pocket expenses in the month received and the following month;

(p) proceeds from any bona fide loan requiring repayment;

(q) payments granted to certain United States citizens of Japanese ancestry and resident Japanese aliens under title I of public law 100-383;

(r) payments granted to certain eligible Aleuts under title II of public law 100-383;

(s) agent orange settlement payments;

(t) federal major disaster and emergency assistance and comparable disaster assistance provided by state or local government agencies or by disaster-assistance organizations in conjunction with a presidentially declared disaster;

(u) payments granted to the Aroostook band of Micmac Indians under public law 102-171;

(v) payments from the radiation exposure compensation trust fund made by the department of justice;

(w) special federal allowances paid monthly to children of Vietnam veterans who are born with spina bifida, under public law 104-204, or other certain birth defects, under public law 106-419;

(x) payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer corporation*, except for interest or other investment income earned on the payments;

(y) except for aged, blind, and disabled persons, a one-time payment or a portion of a one-time payment from a cash settlement for the repair or replacement of property or for legal services, medical costs, or other required obligations to a third party, if the payment is expended or committed to be expended for the intended purpose within six months of its receipt;

(z) cash donations that are based on need, do not exceed \$300 in any calendar quarter, and are received from one or more private, nonprofit, charitable organizations;

(aa) foster care and adoption support payments;

(bb) the amount of any earned income tax credit received. This credit shall not be regarded as a cash asset in the month of receipt and in the following 12 months;

(cc) for aged, blind and disabled persons, a one-time payment or a portion of a one-time payment from a cash settlement for the repair or replacement of property or for legal services, medical costs, or other required obligations to a third party, if the payment is expended or committed to be expended for the intended purpose within

nine months of its receipt. This time period may be extended for good cause;

(dd) for blind and disabled persons, income necessary for fulfillment of a plan to achieve self-support established for a blind or disabled person, as approved by the social security administration;

(ee) any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become a part of that burial fund, according to K.A.R. 129-6-109;

(ff) housing assistance from federal housing programs operated by state and local subdivisions;

(gg) family subsidy payments provided through the mental health and developmental disabilities commission or family support payments provided through the prevention and protection services commission;

(hh) relocation assistance provided by a state or local government that is comparable to assistance provided under title II of the uniform relocation assistance and real property acquisitions act of 1970, public law 91-646;

(ii) interest on an allowable individual development account (IDA) that meets the requirements of K.A.R. 129-6-109(e)(9), including authorized matching contributions and accrued interest. Earnings deposited in an individual development account shall also be exempted for a person who meets the requirements of K.A.R. 129-6-88;

(jj) the portion withheld to repay a prior overpayment received from a program not based on financial need, including certain programs administered by the SSA, VA, and the division of workers compensation or the division of employment security in the Kansas department of labor; and

(kk) payments made pursuant to the Ricky Ray hemophilia relief fund act, public law 105-369. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-113. Income exempt as applicable income for MAGI-excepted groups.** For those groups specified in K.A.R. 129-6-34(c)(2), the following types of income shall be exempt as applicable income in the determination of eligibility:

(a) Income-in-kind;

(b) shelter cost participation payments. In shared living arrangements in which two families contribute toward the shelter obligations, cash

paid toward the shared shelter obligation by one family to the second family in the shared arrangement shall not be considered as income to the second family. This exemption shall not be applicable in a bona fide, commercial landlord-tenant arrangement;

(c) hostile-fire pay received while in active military service;

(d) payments made pursuant to the crime victims fund, public law 103-322, as amended, and by the Kansas crime victims compensation board pursuant to K.S.A. 74-7301 et seq., and amendments thereto;

(e) payments received through the senior community service employment program;

(f) payments or allowances made under federal laws for the purpose of providing energy assistance. Home energy assistance furnished on the basis of need by a federally regulated or state-regulated entity whose revenues are primarily derived on a rate-of-return basis, by a private non-profit organization, by a supplier of home heating oil or gas, or by a municipal utility company that provides home energy shall also be exempted;

(g) income received from the workforce investment act of 1998, public law 105-220. However, earnings received by individuals who are participating in on-the-job training programs shall be countable unless the individual is under the age of 19;

(h) the values of any services or monies received for support or transitional services paid directly to the customer through work programs as defined in article 4 of the regulations of the department for children and families;

(i) income of an SSI recipient, including a deemed recipient, and retroactive SSI benefits. This subsection shall not be applicable to any person residing in a long-term institutional arrangement in accordance with K.A.R. 129-6-111(b)(3);

(j) incentive payments received by renal dialysis patients;

(k) irregular, occasional, or unpredictable monetary gifts that do not exceed \$50 per month per family group;

(l) tax refunds and rebates, except for earned income tax credits in accordance with K.A.R. 129-6-112 (bb);

(m) VA aid and attendance and housebound allowances;

(n) VA payments resulting from unusual medical expenses;

(o) up to \$2,000 per year of income received by

an individual Indian that is derived from leases or other uses of an individually owned trust or restricted lands;

(p) lump sum income;

(q) earned income of a child who is under the age of 19 if the child is a student in elementary or secondary school or is working towards attainment of a G.E.D.;

(r) interest and dividend income that does not exceed \$50 per month per family group;

(s) child care payments made to persons other than a child care provider;

(t) child support pass-through payments;

(u) payments from any bona fide loan;

(v) the amount of any child support arrearage payment paid for a child under the age of 18;

(w) reparation payments made to holocaust survivors;

(x) vendor payments that are not payable directly to a household but are paid to a third party for a household expense, as follows:

(1) Each payment made in money on behalf of a household shall be considered a vendor payment whenever a person or organization outside of the household uses its own funds to make a direct payment to either the household's creditors or a person or organization providing a service to the household;

(2) each assistance payment financed by state or local funds that is not made directly to the household but is paid to a third party on behalf of the household to pay a household expense shall be considered a vendor payment if the payment is for medical care, child care, or temporary housing assistance;

(3) each assistance vendor payment financed by state or local funds that is made on behalf of migrants in the labor stream pursuant to 7 C.F.R. 273.9(c)(1) shall be exempt and not counted as income, regardless of the purpose of the vendor payment;

(4) each payment in money that is not made to a third party, but is made directly to the household, shall be counted as income and shall not be excludable as a vendor payment; and

(5) each payment or other assistance financed by state or local funds that is provided over and above the normal grant or other assistance payment and would not normally be provided in a money payment to the household shall be considered emergency or special assistance and exempted as income if provided directly to a third party for a household expense;

(y) payments provided through youth service corps;

(z) allocation payments made to individuals under a WORK plan according to K.A.R. 129-6-84;

(aa) for aged, blind, and disabled persons, one-third of the child support payments received by an eligible child from an absent parent;

(bb) for blind and disabled persons, work expenses of a blind recipient. The first \$300 of earned income or verified actual average expenses, if in excess of this amount, shall be exempted under this subsection;

(cc) for blind and disabled persons, impairment-related work expenses of a disabled recipient. The first \$100 of earned income or verified actual average expenses, if in excess of this amount, shall be exempted under this subsection;

(dd) for aged, blind, or disabled persons, the difference between the social security benefit entitlement in August 1972 and the entitlement in September 1972 for persons who were receiving cash assistance through the programs of aid to the aged, blind, or disabled (AABD) or aid to dependent children (ADC) in September 1972 and who were entitled to a social security benefit in September 1972. This exemption shall apply only if the exemption establishes eligibility without a spenddown;

(ee) for aged, blind, or disabled persons, the amount of all social security cost-of-living adjustments for a person who was concurrently receiving SSI and social security after April 1977 and who would be eligible for SSI if the cost-of-living adjustments received since that person was last eligible for SSI were not considered as income;

(ff) for aged, blind, or disabled persons, income allocated and expended by an adult in an institutional living arrangement for the support of the adult's minor children if the adult does not have a spouse who continues to live in the community. The income allocation shall not exceed the amount necessary to bring the children's income up to the appropriate income standard described in K.A.R. 129-6-103(a)(3);

(gg) for aged, blind, and disabled persons, SSI payments that the person is not legally entitled to receive and that are subject to SSI recovery;

(hh) for aged, blind, and disabled persons, the amount of the December 1983 increase in social security disabled widow or widower benefits resulting from the changes in the actuarial reduction formula, and all subsequent cost-of-living adjustments, for a person who was concurrently receiving

ing SSI and social security disabled widow and widower benefits under section 202(e) or 202(f) of the social security act, if the person meets all of the following conditions:

(1) The person became ineligible for SSI due solely to the 1983 actuarial increase;

(2) the person has continually received social security disabled widow or widower benefits since the 1983 actuarial increase was first received;

(3) the person would be currently eligible for SSI if it were not for the 1983 actuarial increase and all subsequent cost-of-living adjustments; and

(4) the person applied for medical assistance before July 1, 1988;

(ii) for aged, blind, and disabled persons, the amount of the social security adult disabled child benefit for an otherwise eligible SSI person aged 18 or older who meets both of the following conditions:

(1) The person was receiving SSI benefits that began before the age of 22; and

(2) the person lost SSI eligibility due solely to the person's becoming eligible for the adult disabled child benefits or to an increase in the adult disabled child benefits;

(jj) for aged, blind, and disabled persons, the amount of social security early or disabled widow or widower benefits under section 202(e) or (f) of the social security act, if the person meets all of the following conditions:

(1) The person became ineligible for SSI because of the receipt of the benefits;

(2) the person would be currently eligible for SSI in the absence of the benefits; and

(3) the person is not entitled to hospital insurance benefits under part A of title XVIII of the social security act;

(kk) for aged, blind, and disabled persons, the income of an SSI recipient that exceeds the income standard for institutionalized persons for three months following the month of admission, if the social security administration determines that the stay in the institution is temporary and the person needs to continue to maintain and provide for the expenses of the home or another living arrangement to which the person could return;

(ll) for aged, blind, and disabled persons, the income of an applicant's or recipient's spouse or parent that was counted or excluded in determining the amount of a public assistance payment, if the spouse or parent is not an applicant for or

recipient of medical assistance for aged, blind, and disabled persons;

(mm) for aged, blind, and disabled persons, the income of an applicant's or recipient's spouse or parent that is used to make support payments under a court order or title IV-D support order, if the spouse or parent is not an applicant for or recipient of medical assistance for aged, blind, and disabled persons;

(nn) for aged, blind, and disabled persons, the amount of VA pension received by a single veteran with no dependents or by a surviving spouse with no children, if the pension has been reduced to \$90 or less because the veteran or spouse resides in a medicaid-approved nursing facility; and

(oo) for aged, blind, and disabled persons, Austrian social insurance payments based, in whole or in part, on wage credits granted under the Austrian general social insurance act. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-120. Eligibility before the month of application.** The eligibility of an applicant for the medical assistance program shall be determined for the three months immediately before the month of application if the applicant requests this determination.

(a) Automatic eligibles. The applicant shall be eligible for medical assistance in any of the three months in which the applicant would have been automatically eligible for medical assistance if the applicant would have applied for medical assistance during the month.

(b) Determined eligibles. The prior eligibility base period shall begin on the first day of the first month in which all eligibility factors other than financial are met without regard to current eligibility. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-140. Correction and discontinuance of medical assistance.** (a) Overpayments. Each recipient who receives an overpayment, whether caused by the department or the individual, shall repay the amount of the overpayment, either by voluntary action or through administrative processes including recoupment and legal action.

(b) Welfare fraud penalty. Each person convicted of medical assistance program fraud, pur-

suant to 42 U.S.C. 1320a-7b, shall be ineligible to participate in the medical assistance program for one year from the date of the conviction.

(c) Discontinuance of medical assistance. A recipient's participation in the medical assistance program shall be discontinued if the recipient no longer meets one or more of the applicable eligibility requirements. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-150. Estate recovery.** (a) Pursuant to K.S.A. 39-709 and amendments thereto and this regulation, each recipient's real and personal property or estate shall be subject to the recovery of the cost of all medical assistance provided on the recipient's behalf. By applying for and receiving medical assistance, the recipient shall agree to the department's use of liens against the recipient's property, claims against the recipient's estate, agreements with heirs, and any other collection method allowed by Kansas statutes.

(b) The amount of any medical assistance paid on behalf of a recipient after June 30, 1992 shall be a claim against the property or estate of a deceased recipient, subject to whether the medical assistance was correctly paid on behalf of an eligible recipient.

(1) If the medical assistance was correctly paid on behalf of an eligible recipient, the department's claim against the recipient's estate shall be restricted to medical assistance paid when the recipient met either of the following conditions:

(A) Was 55 years of age or older; or

(B) was admitted as an inpatient in a long-term care facility, including a PACE institutional arrangement.

(2) If the medical assistance was incorrectly paid on behalf of an ineligible recipient, the department's claim shall be the total amount of assistance paid on behalf of the ineligible recipient.

(c) The recipient's estate shall not be subject to the department's claim for correctly paid medical assistance benefits if one of the following individuals survives for at least six months after the recipient's death:

(1) A spouse; or

(2) a child who is under 21 years of age or who meets the disability criteria of K.A.R. 129-6-85(b) or (c).

(d) If a deceased recipient is survived by a spouse, all claims for correctly paid medical assis-

tance benefits that have been paid on behalf of the deceased recipient shall be filed against the estate of the surviving spouse.

(e) The recipient may be subject to the imposition of a lien by the department on the recipient's real property before the recipient's death pursuant to K.S.A. 39-709, and amendments thereto.

(f) For a deceased recipient, the real property of the recipient may be subject to the imposition of a lien by the department for up to one year after the death of the recipient, pursuant to K.S.A. 39-709 and amendments thereto.

(g) Pursuant to K.S.A. 39-709 and amendments thereto, a deceased recipient's real and personal property may be subject to recovery of the recipient's medical assistance costs if the deceased recipient's interest in the property ended or was transferred due to the recipient's death. The department's recovery shall be limited to the recipient's interest in the property as that interest existed immediately before the death of the recipient. (Authorized by K.S.A. 2013 Supp. 39-709, 65-1,254, and 75-7403; implementing K.S.A. 2013 Supp. 39-709, K.S.A. 59-3504, K.S.A. 2013 Supp. 65-1,254, and K.S.A. 2013 Supp. 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-6-151. Presumptive eligibility.** A presumptive period of eligibility shall be provided if a qualified entity, designated by the department in accordance with K.A.R. 129-6-152, determines that the individual meets the presumptive eligibility requirements as follows. (a) Pregnant women.

(1) Each woman shall be at least 18 years of age.

(2) Each woman shall meet the general eligibility requirements of K.A.R. 129-6-52 and 129-6-55 and the determined eligible requirements of K.A.R. 129-6-71.

(3) Financial eligibility shall be based on the requirements of K.A.R. 129-6-53.

(b) Children.

(1) Each child shall be under the age of 19.

(2) Each child shall meet the general eligibility requirements of K.A.R. 129-6-52 and 129-6-55 and the determined eligible requirements of K.A.R. 129-6-72.

(3) Financial eligibility shall be based on the requirements of K.A.R. 129-6-53.

(4) The child shall not be living in a public institution, as specified in K.A.R. 129-6-60.

(c) The presumptive period.

(1) The presumptive period shall begin on the date on which the qualified entity makes an eligibility determination. The presumptive period shall end on the last day of the month following the month in which the determination is made, unless an application for medical assistance is received. If an application is filed in accordance with K.A.R. 129-6-35 before this date, the presumptive period shall end on the last day of the month in which a full determination is made according to this regulation.

(2) Each individual shall be eligible for only one period of presumptive eligibility within a 12-month period under this regulation or under K.A.R. 129-14-51. The 12-month period shall begin on the first day of presumptive eligibility under either of these regulations. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective June 30, 2006; amended, T-129-10-31-13, Nov. 1, 2013; amended Feb. 28, 2014.)

**129-6-152. Presumptive eligibility when determined by qualified entities other than qualified hospitals.** (a) Except for qualified hospitals pursuant to K.A.R. 129-6-153, each qualified entity shall be designated by the department to make determinations of presumptive eligibility as specified in K.A.R. 129-6-151.

(b) Each qualified entity shall meet the requirements of 42 C.F.R. 435.1101 and 435.1103.

(c) For each determination of presumptive eligibility under this regulation, a qualified entity shall perform the following:

(1) Make a finding of presumptive eligibility pursuant to K.A.R. 129-14-51(b) or 129-6-151;

(2) notify the pregnant woman or the child's parent or caretaker, by written or electronic means, of the results of the determination at the time of the determination;

(3) provide the pregnant woman or the parent or caretaker of the child with an application for ongoing medical assistance. For an individual determined to be presumptively eligible, the qualified entity shall provide notification that this application shall be required to be submitted before the last day of the month following the month of the presumptive determination or eligibility shall end on that date;

(4) assist the pregnant woman or the child's par-

ent or caretaker in completing and filing an application for ongoing medical assistance; and

(5) notify the department of the presumptive determination within five working days after the determination. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective June 30, 2006; amended, T-129-10-31-13, Nov. 1, 2013; amended Feb. 28, 2014.)

**129-6-153. Presumptive eligibility when determined by qualified hospitals.** (a) Each hospital that meets the following requirements shall be approved to make determinations of presumptive eligibility as specified in K.A.R. 129-6-151:

(1) Participates as a medicaid provider in Kansas;

(2) indicates interest in writing to the department to make determinations of presumptive eligibility;

(3) enters into a formal written agreement with the secretary to make determinations of presumptive eligibility in accordance with department regulations and policies;

(4) uses forms and other tools approved by the secretary for determining eligibility;

(5) satisfactorily completes state-provided training; and

(6) meets the performance standards established by the secretary, which shall include the following:

(A) Processing applications for presumptive eligibility within prescribed time limits; and

(B) achieving an accuracy rate of at least 90 percent in eligibility determinations made by the hospital.

(b) Presumptive eligibility determinations shall be made for pregnant women and children as specified in K.A.R. 129-6-151 and for qualifying families as specified in K.A.R. 129-6-70.

(c) For each determination of presumptive eligibility, the qualified hospital shall perform the following:

(1) Make a finding of presumptive eligibility pursuant to K.A.R. 129-6-151;

(2) notify the family, the pregnant woman, or the child's parent or caretaker of the results of the determination at the time of the determination;

(3) provide the family, the pregnant woman, or the parent or caretaker of the child with an application for ongoing medical assistance. For an individual determined to be presumptively eligible, the qualified hospital shall provide notifica-

tion that this application shall be required to be submitted before the last day of the month following the month of the presumptive determination or eligibility shall end on that date;

(4) assist the family, the pregnant woman, or the child's parent or caretaker in completing and filing an application for ongoing medical assistance; and

(5) notify the department of the presumptive determination within five working days after making the determination.

(d) Each qualified hospital shall be required to be recertified by the department each year to determine if the qualified hospital continues to meet the requirements in this regulation. The qualified hospital's certification shall be terminated by the department under either of the following circumstances:

(1) The qualified hospital is not making, or is incapable of making, presumptive eligibility determinations in accordance with the agreement established in accordance with subsection (a).

(2) The qualified hospital is failing to meet the performance standards specified in this regulation. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

#### **Article 10.—ADULT CARE HOME PROGRAM**

**129-10-31. Responsibilities of, assessment of, and disbursements for the nursing facility quality care assessment program.** (a) In addition to the terms defined in K.S.A. 2013 Supp. 75-7435 and amendments thereto, the following terms shall have the meanings specified in this subsection, unless the context requires otherwise.

(1) "High medicaid volume skilled nursing care facility" means any facility that provided more than 25,000 days of nursing facility care to medicaid recipients during the most recent calendar year cost-reporting period.

(2) "Kansas homes and services for the aging," as used in K.S.A. 2013 Supp. 75-7435 and amendments thereto, means leadingage Kansas.

(3) "Nursing facility quality care assessment program" means the determination, imposition, assessment, collection, and management of an annual assessment imposed on each licensed bed in

a skilled nursing care facility required by K.S.A. 2013 Supp. 75-7435, and amendments thereto.

(4) "Skilled nursing care facility that is part of a continuing care retirement facility" means a provider who is certified as such by the Kansas insurance department before the start of the state's fiscal year in which the assessment process is occurring.

(5) "Small skilled nursing care facility" means any facility with fewer than 46 licensed nursing facility beds.

(b) The assessment shall be based on a state fiscal year. Each skilled nursing facility shall pay the annual assessment as follows:

(1) The assessment amount shall be \$325 annually per licensed bed for the following:

(A) Each skilled nursing care facility that is part of a continuing care retirement facility;

(B) each small skilled nursing care facility; and

(C) each high medicaid volume skilled nursing care facility.

(2) The assessment amount for each skilled nursing care facility other than those identified in paragraphs (c)(1)(A) through (C) shall be \$1,950 annually per licensed bed.

(3) The assessment amount shall be paid according to the method of payment designated by the secretary of the Kansas department of health and environment. Any skilled nursing care facility may be allowed by the secretary of the Kansas department of health and environment to have an extension to complete the payment of the assessment, but no such extension shall exceed 90 days. (Authorized by and implementing K.S.A. 2013 Supp. 75-7435; effective Feb. 18, 2011; amended Dec. 27, 2013.)

#### **Article 14.—CHILDREN'S HEALTH INSURANCE PROGRAM**

**129-14-2. Definitions.** The terms defined in K.A.R. 129-1-1 shall be applicable to this article. In addition and for purposes of this article, each of the following terms shall have the meaning specified in this regulation, unless the context clearly indicates otherwise:

(a) "Capitated managed care" means health care services provided by a contracted provider for which payment is made on an approved contracted rate for each enrolled person assigned to the provider, regardless of the number or nature of the services provided.

(b) "Caretaker" means the person who is as-

signed the primary responsibility for the care and control of the child and who is any of the following persons:

(1) Parent, including parent of an unborn child;  
 (2) guardian, conservator, legal custodian, or person claiming the child as a tax dependent;

(3) sibling;

(4) nephew;

(5) niece;

(6) aunt;

(7) uncle;

(8) person of a preceding generation who is denoted by a term that includes any of the following prefixes: "grand," "great-," "great-great-," or "great-great-great-";

(9) stepfather, stepmother, stepbrother, or stepsister;

(10) legally adoptive parent or another relative of adoptive parents as listed in this subsection; or

(11) spouse of any person listed in this subsection or former spouse of any of those persons, if marriage is terminated by death or divorce.

(c) "Child" means natural or biological child, adopted child, or stepchild, if the child is under the age of 19.

(d) "Earned income" means all income, in cash or in kind, that an applicant or recipient currently earns through the receipt of wages, salary, or profit from activities in which the individual engages as an employer or as an employee.

(e) "Family group" means the applicant or recipient and all individuals living together in which there is a relationship of legal responsibility or a caretaker relationship.

(f) "Household size" means the number of persons counted as members of an individual's tax household in accordance with K.A.R. 129-14-33. For each pregnant woman in the household, the household size shall include the woman and the number of children she is expected to deliver.

(g) "Legally responsible relative" means the person who has the legal responsibility to provide support for the person in the assistance plan.

(h) "Modified adjusted gross income" and "MAGI" mean income as defined in 26 U.S.C. 36B(d).

(i) "Parent" means natural or biological parent, adoptive parent, or stepparent.

(j) "Sibling" means natural or biological sibling, adopted sibling, half sibling, or stepsibling.

(k) "Tax dependent" means a dependent under 26 U.S.C. 152 for whom another individual claims

a deduction for a personal exemption under 26 U.S.C. 151 for a taxable year.

(l) "Unearned income" means all income that is not earned income. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-3. Providers.** (a) Subject to provider availability, any recipient may be required to be enrolled in a managed care option in order to access covered program services.

(b) Managed care contractors shall be selected by the secretary from willing providers, as determined by the secretary or designees.

(c) Before signing a contract to provide services, each provider of capitated managed care shall demonstrate the ability to meet contract requirements, including providing or maintaining the following:

(1) Financial solvency;

(2) a panel of service providers, who shall meet the following requirements:

(A) Have professional credentials required by the state in which the services are provided;

(B) be in active practice;

(C) be available to provide services to program enrollees; and

(D) be able to provide services sensitive to the needs of a diverse population, including individuals of any race, ethnicity, or disability;

(3) a quality management process under 42 C.F.R. Part 438; and

(4) any other relevant requirements as determined by the secretary.

(d) Penalties for failure to abide by the contract provisions shall be imposed by the secretary, or other appropriate actions, as specified in the contract, may be taken.

(e) Each capitated managed care contractor shall be reimbursed at a rate agreed to by the secretary. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-20. Application process.** (a) An application for kancare-CHIP shall be made by an applicant or by another person authorized to act on the applicant's behalf.

(b) An application for kancare-CHIP shall be made using a department-approved form. The applicant or person authorized to act on behalf of the applicant shall sign the application. Electronic

signatures, including telephonically recorded signatures, and handwritten signatures transmitted by any other electronic transmission shall be acceptable. If any person signs by mark, the names and addresses of two witnesses shall be required.

Each application shall be submitted on the state application web site or the federally facilitated exchange web site, by telephone, in person, by mail, by electronic mail, or by fax.

(c) If the department denies an application within 45 days of receipt of the application and the applicant reapplies or provides required information within this 45-day period, the application shall be reactivated. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-21. Reenrollment process.** (a) Each recipient shall reenroll for the program by providing the department with information on the recipient's current situation and having an opportunity to review the eligibility factors so that the department can redetermine the recipient's eligibility for coverage under the program.

(b) Each recipient shall complete the reenrollment process by either of the following:

(1) Reviewing and, if necessary, responding to information provided from the department's records, including information obtained through electronic data matching with other state or federal agencies; or

(2) completing and returning information on the recipient's current situation requested by the department.

(c) Each recipient shall reenroll for coverage at least once each 12 months or as often as a need for review is indicated. Coverage under the program shall not be provided for more than 12 months, unless the recipient completes the required reenrollment process. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-22.** (Authorized by K.S.A. 2005 Supp. 75-7412; implementing K.S.A. 2005 Supp. 75-7412 and 75-7413, as amended by L. 2006, ch. 4, § 2; effective Aug. 11, 2006; revoked, T-129-10-31-13, Nov. 1, 2013; revoked Feb. 28, 2014.)

**129-14-23. Responsibilities of applicants and recipients.** Each applicant or recipient shall meet the following requirements:

(a) Submit an application for medical assistance on a department-approved form. Any applicant may withdraw the application between the date the application is submitted and the date of the notice of the department's decision;

(b) supply information essential to the determination of initial and continuing eligibility, insofar as the applicant or recipient is able to do so;

(c) give written permission for release of information, when needed;

(d) report each change in circumstances that could affect eligibility within 10 calendar days of the change or as otherwise required by the program. Changes to be reported shall include changes to income, living arrangement, household size, family group members, residency, alienage status, health insurance coverage, and employment;

(e) take all necessary action to obtain any income due the person; and

(f) except for children for whom a determination under presumptive medical assistance as defined in K.A.R. 129-14-51 has been made, request a fair hearing in writing if the individual is dissatisfied with any department decision or lack of action in regard to the application for or the receipt of assistance. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-25. Act on own behalf.** (a) For purposes of this regulation, each of the following terms shall have the meaning specified in this subsection:

(1) "Emancipated minor" means either of the following:

(A) A person who is aged 16 or 17 and who is or has been married; or

(B) a person who is under the age of 18 and who has been given or has acquired the rights of majority through court action.

(2) "Medical facilitator" means a person authorized to help complete the application or reenrollment process on behalf of an applicant or recipient under written authorization made by the applicant or recipient. The medical facilitator may help with completing and submitting the application or reenrollment form, providing necessary information and verifications, and receiving copies of notices or other official communications from the department to the applicant or recipient. A medical facilitator shall not be authorized to apply

for medical assistance on behalf of another person.

(3) "Medical representative" means a person who is authorized to act on behalf of an applicant or recipient under a written authorization made by the applicant or recipient and who is knowledgeable of the applicant's or recipient's financial holdings and circumstances.

(b) Each applicant or recipient shall be legally capable of acting on that individual's own behalf.

(1) An incapacitated person aged 18 for whom a court has named a guardian or conservator shall not be eligible for kancare-CHIP, unless the named legal guardian or conservator applies for assistance on the person's behalf.

(2) An incapacitated person aged 18 for whom a court has not named a guardian or conservator shall not be eligible for kancare-CHIP, unless a representative payee for the person's social security benefits, a person with durable power of attorney for financial decisions for the individual, or a medical representative applies for assistance on the person's behalf.

(3) Each emancipated minor shall be eligible to apply for and receive assistance under kancare-CHIP on that individual's own behalf.

(4) An unemancipated minor shall not be deemed capable of acting on that individual's own behalf and shall not be eligible to apply for or receive assistance under kancare-CHIP on that individual's own behalf, except as specified in this paragraph. An unemancipated minor shall not be eligible unless a caretaker, representative payee for social security benefits, or other nonrelated responsible adult who is approved by the parent or legal guardian and who resides with the child applies for assistance on the minor's behalf. However, an unemancipated minor may apply for or receive assistance on that individual's own behalf if one of the following conditions exists:

(A) The parents of the minor are institutionalized.

(B) The minor has no parent who is living or whose whereabouts are known, and there is no other caretaker who is willing to assume parental control of the minor.

(C) The health and safety of the minor has been or would be jeopardized by remaining in the household with the minor's parents or other caretakers. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-26. Residence.** Each applicant or recipient shall be a resident of Kansas. Temporary absence from a state with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, shall not be considered to interrupt continuity of residence. Residence shall be considered to be retained until abandoned or established in another state. Residence shall be established as follows:

(a) For each individual who is not residing in an institution, capable of stating intent, and either is emancipated from the individual's parents or is married, the individual shall choose the state of residence based on either of the following:

(1) The state in which the individual is living and intends to reside, including without a permanent address; or

(2) the state that the individual has entered with a job commitment or for seeking employment, whether or not the individual is currently employed.

(b) For each individual who is not residing in an institution and who does not meet the conditions of subsection (a), the state of residence shall be either of the following:

(1) The state in which the individual is residing, including without a permanent address; or

(2) the state in which the individual's parent or caretaker resides, if the individual is living with the parent or caretaker.

(c) For each individual residing in an institution, the state of residence shall be one of the following, whether or not the individual is capable of stating intent:

(1) The state in which the individual's parent or guardian resides, if the individual became incapable of stating intent before the age of 21;

(2) the state that placed the individual in an out-of-state institution; or

(3) for any other institutionalized individual, the state in which the individual is living and intends to reside. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-27. Citizenship and alienage.** (a) Each applicant or recipient shall be a citizen of the United States or shall be a noncitizen who meets either of the following conditions:

(1) The individual entered the United States before August 22, 1996 and meets one of the following conditions:

(A) Is a refugee, as specified in 8 U.S.C. 1101, including any person who is a Cuban or Haitian entrant as defined in public law 96-422 or is admitted as an Amerasian immigrant as defined in public law 100-202;

(B) is granted asylum, pursuant to 8 U.S.C. 1158;

(C) has deportation withheld under 8 U.S.C. 1253(h) as in effect before April 1, 1997 or under 8 U.S.C. 1231(b)(3);

(D) is a lawful, permanent resident;

(E) is an honorably discharged veteran or is on active duty in the armed forces or is the spouse or unmarried dependent child of the veteran or the person on active duty;

(F) has been paroled into the United States for at least one year under 8 U.S.C. 1182(d)(5);

(G) has been granted conditional entry under 8 U.S.C. 1157;

(H) has been battered or subjected to extreme cruelty by a United States citizen or lawful permanent spouse or parent and has a pending or approved violence against women act (VAWA) case or petition before the department of homeland security pursuant to 8 U.S.C. 1641(c); or

(I) is a certified victim of severe forms of trafficking, as defined in 22 U.S.C. 7105; or

(2) the individual entered the United States on or after August 22, 1996 and meets one of the following conditions:

(A) Is a refugee, as specified in 8 U.S.C. 1101, including any person who is a Cuban or Haitian entrant as defined in public law 96-422 or is admitted as an Amerasian immigrant as defined in public law 100-202;

(B) is granted asylum, pursuant to 8 U.S.C. 1158;

(C) has deportation withheld under 8 U.S.C. 1253(h) as in effect before April 1, 1997 or under 8 U.S.C. 1231(b)(3);

(D) is an honorably discharged veteran or is on active duty in the armed forces or is the spouse or unmarried dependent child of the veteran or the person on active duty;

(E) is an Iraqi or Afghani special immigrant under the 2006 national defense authorization act, public law 109-163;

(F) is a certified victim of severe forms of trafficking, as defined in 22 U.S.C. 7105;

(G) is a lawful, permanent resident who has resided in the United States for at least five years;

(H) has been paroled into the United States under 8 U.S.C. 1182(d)(5) for at least one year and

has resided in the United States for at least five years;

(I) has been granted conditional entry under 8 U.S.C. 1157 and has resided in the United States for at least five years; or

(J) has been battered or subjected to extreme cruelty by a United States citizen or lawful permanent spouse or parent, has a pending or approved violence against women act (VAWA) case or petition before the department of homeland security pursuant to 8 U.S.C. 1641(c), and has resided in the United States for at least five years.

(b) Each applicant or recipient declaring to be a citizen or national of the United States shall present evidence of citizenship or nationality in accordance with the department's policy memo titled "KDHE-DHCF policy no. 2013-10-01," dated October 4, 2013 and hereby adopted by reference. This requirement shall not apply to any of the following:

(1) Newborn children who meet the provisions of K.A.R. 129-6-65(e);

(2) individuals receiving SSI benefits;

(3) individuals entitled to or enrolled in any part of medicare;

(4) individuals receiving disability insurance benefits under 42 U.S.C. 423 or monthly benefits under 42 U.S.C. 402, based on the individual's disability; or

(5) individuals who are in foster care and who are assisted under title IV-B of the social security act as amended by public law 109-288 and individuals who are recipients of foster care maintenance or adoption assistance payments under title IV-E.

(c) Each individual declaring to be a noncitizen shall present evidence of that individual's status in accordance with "KDHE-DHCF policy no. 2013-10-01," which is adopted by reference in subsection (b). Each noncitizen who has provided evidence of qualified noncitizen status that has been verified with the department of homeland security shall be eligible for medical assistance.

(d) Each applicant or recipient shall have 90 days from the date the application is approved to supply the evidence described in subsections (b) and (c). (Authorized by and implementing K.S.A. 2013 Supp. 65-1,254 and 75-7403; effective June 30, 2006; amended, T-129-10-31-13, Nov. 1, 2013; amended Feb. 28, 2014.)

**129-14-28. Cooperation.** (a) Establishment of eligibility. Each applicant or recipient

shall cooperate with the department in the establishment of the applicant's or recipient's eligibility by providing all information necessary to determine eligibility as provided in K.A.R. 129-14-23. Failure to provide all information necessary shall render the members of the assistance plan, as defined in K.A.R. 129-14-33, ineligible for medical assistance.

(b) Social security number. Except as noted in this subsection, each applicant or recipient shall cooperate by providing the department with the applicant's or recipient's social security number. Failure to provide the number, or failure to apply for a number if the applicant or recipient has not previously been issued a social security number, shall render the applicant or recipient ineligible for medical assistance. The following individuals shall be exempt from this requirement:

(1) Any individual who is not eligible to receive a social security number;

(2) any individual who does not have a social security number and can be issued a number only for a valid non-work reason; and

(3) any individual who refuses to obtain a social security number because of well-established religious objections. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-30. Public institution.** (a) Definitions. For purposes of this regulation, each of the following terms shall have the meaning specified in this subsection:

(1) "Institution" means an establishment that furnishes food, shelter, and some form of treatment or services to four or more persons who are unrelated to the proprietor.

(2) "Public institution" means any institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(b) Living arrangement. Each applicant or recipient meeting one of the following conditions shall be ineligible for assistance:

(1) Lives in a public institution, unless one of the following conditions is met:

(A) The individual is in a public educational or vocational training institution for purposes of completing education or vocational training; or

(B) the individual is in the public institution for a temporary period not to exceed the month of entrance and the following two months;

(2) resides in a state intermediate care facility for diagnosis, treatment, or rehabilitation of persons with intellectual disabilities or related conditions that has been approved for medicaid coverage of inpatient services;

(3) receives inpatient care in either of the following:

(A) A state psychiatric hospital that has been approved for medicaid coverage of inpatient services; or

(B) a nursing facility for mental health that has been approved for medicaid coverage of inpatient services;

(4) receives inpatient care in a psychiatric residential treatment facility as defined in K.A.R. 28-4-1200;

(5) resides in a correctional facility; or

(6) is in the custody of the department of corrections as an accused or convicted criminal and does not meet any of the following conditions:

(A) Is on probation, parole, bail, or bond;

(B) has been released on the individual's own recognizance; or

(C) is participating in a prison diversion program operated by a privately supported facility. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-31. Insurance coverage.** (a) An applicant or recipient shall not currently be covered under a "group health plan" or under "health insurance coverage" as defined in 42 U.S.C. 300gg-91. The applicant or recipient shall not be considered covered if the applicant or recipient does not have reasonable geographic access to care under that plan or coverage. Reasonable geographic access to care shall mean that the applicant or recipient routinely does not have to travel more than 50 miles to reach providers participating in the group health plan or health insurance coverage.

(b) For family groups with income over 200 percent of the official federal poverty-level income guidelines, the applicant or recipient shall not have had health insurance coverage in the three-month period before the effective date of coverage and terminated this coverage without good cause.

(c) For family groups with income less than or equal to 200 percent of the official federal poverty-level income guidelines, the applicant or recipient shall not have had health insurance cov-

erage in the prior three months and terminated this coverage without good cause.

(d) An applicant or recipient shall not be eligible for enrollment in the Kansas state employee health plan.

(e) The standards for good cause shall include the loss of health insurance due to the involuntary loss of employment, the death of the policy holder, and the elimination of coverage by the applicant's or recipient's employer. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-32. Premium payment requirement.** (a) If the total monthly applicable income in a family group exceeds 166 percent of the official federal poverty-level income guidelines, the family shall pay a monthly premium for coverage in kancare-CHIP.

(b) Each family who fails to pay the monthly premium for two consecutive months shall be considered delinquent, which shall result in the ineligibility of that family. The period of ineligibility shall not exceed 90 days. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-33. Assistance plan.** (a) The assistance plan shall consist of those persons in the household as determined in subsections (b) through (f).

(b) For each person who is not claimed as a tax dependent by any other taxpayer and is expected to file a tax return, the household shall consist of the person and all of the person's tax dependents, except as noted in subsection (e). If a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which assistance is determined, the inclusion of the individual in the household of the taxpayer shall be determined in accordance with subsections (d) and (e).

(c) For each person claimed as a tax dependent by another taxpayer, the household shall consist of that taxpayer and the taxpayer's dependents, except as noted in subsection (e).

(d) For each person who neither files a tax return nor is claimed as a tax dependent, the household shall consist of the person and, if living with the person, the following:

(1) The person's spouse;

(2) the person's natural children, adopted children, and stepchildren under the age of 21;

(3) the person's natural parents, adopted parents, and stepparents, if the person is under the age of 21; and

(4) the person's natural siblings, adopted siblings, and stepsiblings under the age of 21, if the person is under the age of 21.

(e) For each person who is claimed as a tax dependent by another taxpayer, the household shall be determined in accordance with subsection (d) if the person meets the following conditions:

(1) Is not a spouse of the taxpayer and is not a biological child, an adopted child, or a stepchild of the taxpayer;

(2) is claimed by one parent as a tax dependent and is living with both parents who do not expect to file a joint tax return; or

(3) is under the age of 21 and expected to be claimed as a tax dependent by a noncustodial parent.

(f) For any married couple living together, each spouse shall be included in the household of the other spouse, whether both spouses expect to file a joint tax return under 26 U.S.C. 6013 or whether one spouse expects to be claimed as a tax dependent by the other spouse. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-34. Financial eligibility.** (a) Definitions. For purposes of this regulation, each of the following terms shall have the meaning specified in this subsection:

(1) "Household income" means the sum of the MAGI-based income of every individual included in the individual's household minus an amount equivalent to five percentage points of the federal poverty level for the applicable family size, for purposes of determining the individual's eligibility under the highest income standard for which the individual is eligible.

(2) "MAGI-based income" means income calculated using the same financial methodologies used to determine MAGI as defined in 26 U.S.C. 36B(d)(2), with the following exceptions:

(A) Each amount received as a lump sum shall be counted as income only in the month received;

(B) scholarships, awards, and fellowship grants used for education purposes and not for living expenses shall be excluded from income; and

(C) for American Indian or Alaska native funds, the following shall be excluded from income:

(i) Distributions from Alaska native corporations and settlement trusts;

(ii) distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the secretary of the interior;

(iii) distributions and payments from rents, leases, rights-of-way, royalties, usage rights, or natural resource extraction and harvest from rights of ownership or possession in any lands described in this paragraph or federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(iv) distributions either resulting from real property ownership interests related to natural resources and improvements located on or near a reservation or within the most recent boundaries of a prior federal reservation or resulting from the exercise of federally protected rights relating to these real property ownership interests;

(v) payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom; and

(vi) student financial assistance provided under the bureau of Indian affairs education programs.

(b) Determination of financial eligibility. Financial eligibility for families and children shall be based on household income, except for the following:

(1) The MAGI-based income of an individual who is included in the household of the individual's natural parent, adoptive parent, or stepparent and is not expected to be required to file a tax return under 26 U.S.C. 6012(a)(1) for the taxable year in which eligibility is being determined shall not be included in household income whether or not the individual files a tax return.

(2) The MAGI-based income of a tax dependent described in K.A.R. 129-14-33(e)(1) who is not expected to be required to file a tax return under 26 U.S.C. 6012(a)(1) for the taxable year in which eligibility is being determined shall not be included in household income whether or not the tax dependent files a tax return.

(c) Income deductions. No other deductions shall be applied in determining household income.

(d) Budget periods. Each household's financial eligibility shall be based on the current monthly income and family size of the household, unless a change in circumstances is expected. In these instances, financial eligibility shall be based on the projected monthly income and family size of the household.

(e) Exclusion of resources. The value of the household's resources shall not be taken into consideration in determining financial eligibility.

(f) Poverty-level determination. The total monthly income limits for the poverty-level determination shall be established by the secretary and converted to MAGI-equivalent numbers in accordance with 42 C.F.R. 457.300 et seq. If the department determines that the program funds appropriated are insufficient to fund up to this income level, a lower income level shall be implemented by the department, and the notice of the lower income level shall be published by the department in the Kansas register.

(g) Continuous eligibility. Except for children determined eligible for presumptive medical assistance as specified in K.A.R. 129-14-51, each child under the age of 19 who becomes eligible for kancare-CHIP shall continue to be eligible for assistance for 12 months beginning with the month of enrollment or reenrollment regardless of any changes in circumstances, unless one of the following conditions is met:

(1) The child reaches the age of 19.

(2) Assistance is voluntarily terminated for the child.

(3) The child no longer resides in the state.

(4) The state determines that eligibility was granted erroneously because of fraud or agency error.

(5) The child dies. (Authorized by and implementing K.S.A. 2013 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-35. Treatment of income.** (a)

For purposes of this regulation, "prospective monthly amount" shall mean an amount that is projected for purposes of determining an applicant's or recipient's monthly income. All earned income and unearned income received or expected to be received in the month of application shall be used to determine a prospective monthly amount.

(b) For changes in earned income and unearned income, an estimate of those changes shall

be used to determine a prospective monthly amount.

(c) For self-employment income, a prospective monthly amount shall be determined based on annual federal tax information from the most recent tax year. In the absence of federal tax information from the most recent tax year, an estimate shall be used to determine a prospective monthly amount. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-36. Applicable income.** For purposes of this regulation, “applicable income” shall mean the amount of earned income and unearned income that is compared with the appropriate income standard to establish financial eligibility. All earned income and unearned income shall be considered applicable income, unless exempted in accordance with K.A.R. 129-14-34(a)(2), and shall be determined as follows:

(a) Applicable income shall be based on the methodologies used to determine modified adjusted gross income, as specified in K.A.R. 129-14-34(a)(2), for persons in the household, as specified in K.A.R. 129-14-34(b).

(b) An amount equivalent to five percentage points of the federal poverty level for the applicable family size shall be deducted from the combined household income, for purposes of determining the individual’s eligibility under the highest income standard for which the individual is eligible, in accordance with K.A.R. 129-14-34(a)(1). (Authorized by and implementing K.S.A. 2013 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-37. Overpayments.** Each recipient who receives an overpayment, whether caused by the department or the individual, shall repay the amount of the overpayment, either by voluntary action or through administrative processes including recoupment and legal action. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-40. Discontinuance of assistance.** A recipient’s participation in kancare-CHIP shall be discontinued if the recipient no longer meets one or more of the applicable eligibility requirements. (Authorized by and imple-

menting K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-50. Scope of services.** The services provided to children enrolled in kancare-CHIP shall be Kansas medicaid services as specified in K.A.R. 30-5-58 through 30-5-310 and K.A.R. 129-5-1 through 129-5-118b. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective, T-129-10-31-13, Nov. 1, 2013; effective Feb. 28, 2014.)

**129-14-51. Presumptive eligibility.** (a) Each child, as defined in K.A.R. 129-14-2, shall be eligible for a presumptive period if a qualified entity, as specified in K.A.R. 129-14-52, designated by the department determines that the child meets the presumptive eligibility requirements.

(b) Each child shall meet the following requirements:

(1) The child shall be under the age of 19.

(2) The child shall meet the general eligibility requirements of K.A.R. 129-14-25, 129-14-26, 129-14-27, and 129-14-28.

(3) The child shall be financially eligible according to K.A.R. 129-14-34.

(4) The child shall be uninsured as specified in K.A.R. 129-14-31.

(5) The child shall not be living in a public institution, as specified in K.A.R. 129-14-30.

(c) The presumptive period shall begin on the date on which the qualified entity makes an eligibility determination. The presumptive period shall end on the last day of the month following the month in which the determination is made, unless an application for medical assistance is received. If an application is filed in accordance with K.A.R. 129-14-20 before this date, the presumptive period shall end on the last day of the month in which a full determination is made.

(d) Each child shall be eligible for only one period of presumptive eligibility within a 12-month period under this regulation or under K.A.R. 129-6-151. The 12-month period shall begin on the first day of presumptive eligibility under either of these regulations. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective June 30, 2006; amended, T-129-10-31-13, Nov. 1, 2013; amended Feb. 28, 2014.)

**129-14-52. Presumptive eligibility to be determined by qualified entities.** (a) Each

qualified entity shall be designated by the department to make determinations of presumptive eligibility as specified in K.A.R. 129-14-51.

(b) Each qualified entity shall meet the requirements of 42 C.F.R. 435.1100.

(c) For each determination of presumptive eligibility, a qualified entity shall perform the following:

(1) Make a finding of presumptive eligibility pursuant to K.A.R. 129-14-51 or 129-6-151;

(2) notify the child's parent or caretaker, by written or electronic means, of the results of the determination at the time of the determination;

(3) provide the child's parent or caretaker with an application for regular medical assistance. For

a child determined to be presumptively eligible, the qualified entity shall notify the child's parents or caretaker that, unless a regular medical assistance application is submitted before the last day of the month following the month of the presumptive determination, eligibility shall end on that date;

(4) assist the child's parent or caretaker in completing and filing a regular medical assistance application; and

(5) notify the department of the presumptive determination within five working days after the determination. (Authorized by and implementing K.S.A. 2012 Supp. 65-1,254 and 75-7403; effective June 30, 2006; amended, T-129-10-31-13, Nov. 1, 2013; amended Feb. 28, 2014.)