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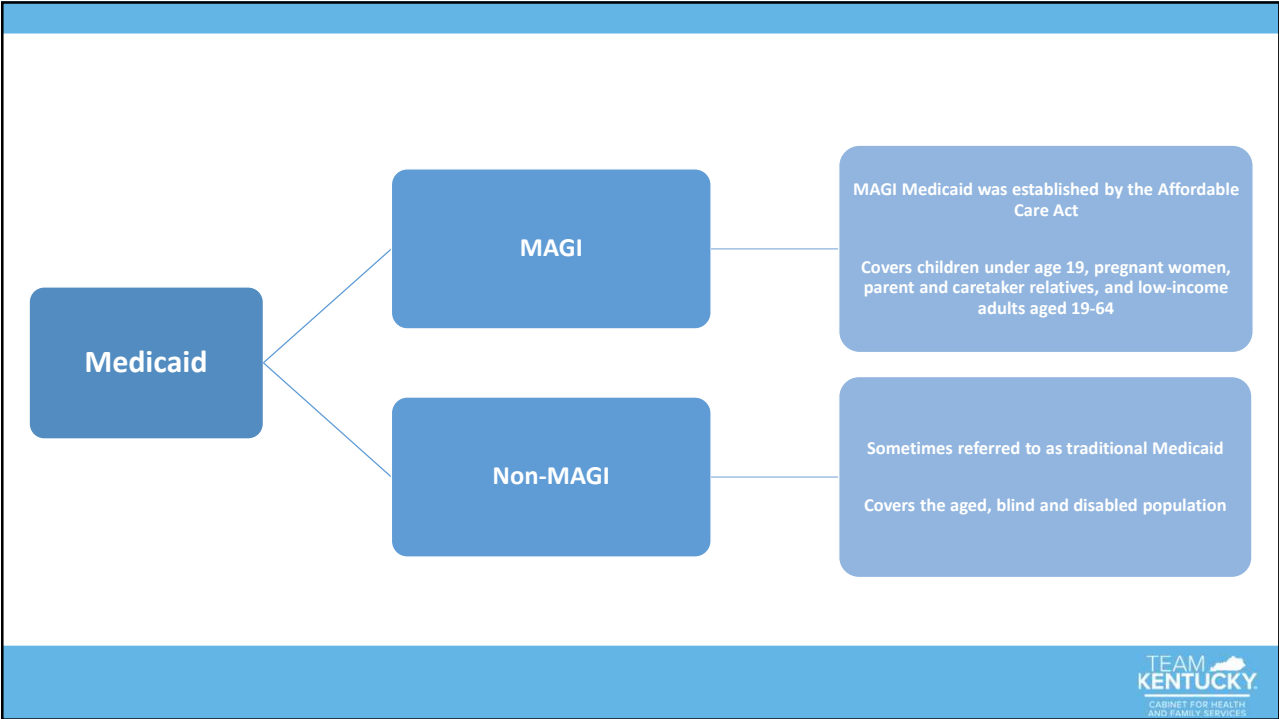
CABINET FOR HEALTH AND FAMILY SERVICES

Medicaid Overview

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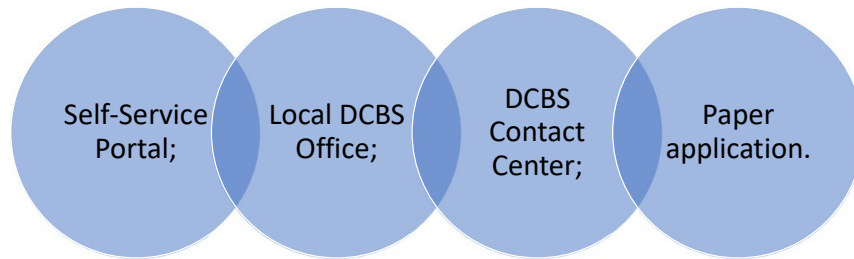AND FAMILY SERVICES

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Medicaid

MAGI

MAGI Medicaid was established by the Affordable Care Act

Covers children under age 19, pregnant women, parent and caretaker relatives, and low-income adults aged 19-64

Non-MAGI

Sometimes referred to as traditional Medicaid

Covers the aged, blind and disabled population

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Application Process

Four ways to apply:

Self-Service Portal;

Local DCBS Office;

DCBS Contact Center;

Paper application.

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Who Can Apply?

1 Client;

2 Spouse;

3 Authorized Representative;

4 Legal Guardian/POA; or

5 Statutory Payee.

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MAGI Medicaid/KCHIP

MAGI stands for **M**odified **A**djusted **G**ross **I**ncome

Financial eligibility for MAGI Medicaid/KCHIP is determined using the same methodology that is used to determine the Modified Adjusted Gross Income for Federal Tax purposes.

Taxable income is countable in the eligibility determination and non-taxable income is excluded.
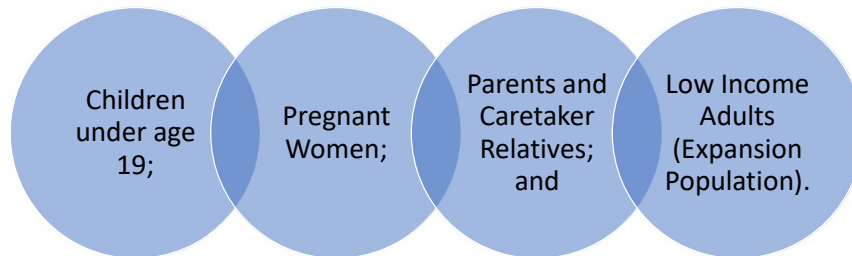
Resources are not counted for MAGI Medicaid .

The MAGI Medicaid Household is determined based on tax filing status and/or relationship rules.
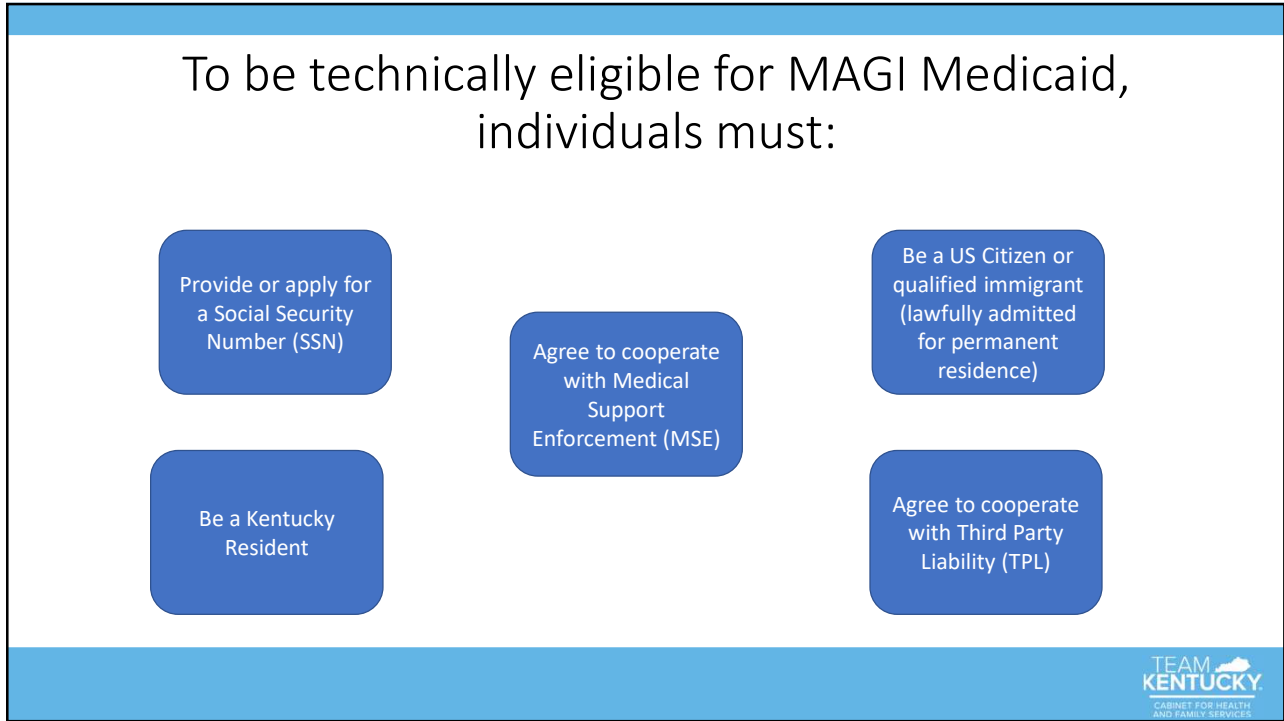
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Categories of MAGI Medicaid

MAGI Medicaid is divided into four categories of assistance

Children under age 19;

Pregnant Women;

Parents and Caretaker Relatives; and

Low Income Adults (Expansion Population).

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To be technically eligible for MAGI Medicaid, individuals must:

Provide or apply for a Social Security Number (SSN)

Be a Kentucky Resident

Agree to cooperate with Medical Support Enforcement (MSE)

Be a US Citizen or qualified immigrant (lawfully admitted for permanent residence)

Agree to cooperate with Third Party Liability (TPL)

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Financial Eligibility for MAGI Medicaid

MAGI Medicaid income calculations are based on federal tax rules.

If income is taxable, it is countable in the MAGI Medicaid income calculation.

In most cases, income that is not taxable is not counted in the MAGI Medicaid income calculation.

Social Security payments for Retirement, Survivors, Disability Insurance (RSDI) are an exception.

RSDI of adult household members is countable.

RSDI of children is only countable when they are required to file taxes.

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MAGI Income Scales

- Income is compared to the appropriate Federal Poverty Level (FPL) when determining eligibility for children, pregnant women, and expansion adults.
- Income is compared to the traditional Medicaid income scale when determining eligibility for the Parent and Caretaker Relative category of assistance.

MAGI Income Limits

Age Group	At or below a Federal Poverty Level of…	Limit for a Household of 2
Infants, up to age 1	$200% FPL	$3,287
Children between 1-19	147% FPL	$2,416
KCHIP Children up to age 19	218% FPL	$3,582
Pregnant Women	200%	$3,287
Low Income Adults	138% FPL	$2,268

MAGI Income Limits

- Parents or Caretaker Relatives may be eligible if the countable income for their Medicaid household is at or below the MAGI Medicaid income scale. ($358 for a household of 2)
- Parents or Caretaker Relatives who have income more than the traditional Medicaid income scale, but below 138% of the FPL, may be eligible for expanded Medicaid as a Low Income Adult.

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MAGI Income Limits, Special Considerations

Infants whose mothers received Medicaid in the birth month are considered deemed eligible regardless of income until age 1.

Children who are covered by other health insurance are not eligible for KCHIP.

A pregnant woman's unborn child(ren) is considered as part of the Medicaid household.

Lawfully present pregnant women no longer must meet qualified immigrant status to be eligible to receive Medicaid as a pregnant woman. If they meet all other technical and financial criteria, they may be approved during their pregnancy and the 12-month postpartum period. Their baby will also be considered deemed eligible.

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The Medicaid Household

MAGI Medicaid household composition is determined based on either tax filer or non-filer rules.

- Each individual is identified as a tax filer or non-filer based on how they plan to file taxes for the current year.
- The Medicaid household can be a combination of tax filers and non-filers.

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The Medicaid Household

Filer
Non-Filer

- If an individual intends to file taxes, they are considered a **tax filer**.
- Anyone they claim on their return, is considered a **tax dependent**.
- Both tax filers and their dependents are included in the MAGI Medicaid household.
- Spouses are *always* included in the Medicaid household regardless of their tax filing status.

Note: Some dependents may fall under Non-Filer rules.

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The Medicaid Household

Filer

Non-Filer

- Non-Filers are individuals who..
  - Do not intend to file taxes, OR
  - Meet on of the following exceptions:
    - The individual expects to be claimed as a dependent by someone other than a spouse or a biological, adopted, or step-parent.
    - A child under the age of 19 living with both parents and the parents do not intend to file jointly; or
    - A child under age 19 who will be claimed by a non-custodial parent.
- The MAGI Medicaid Household for non-filers is established based on relationship and traditional relative responsibility rules.

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Non-MAGI Medicaid

Traditional Medicaid is also referred to as Non-MAGI Medicaid.

Non-MAGI Medicaid primarily refers to the aged, blind, and disabled population.

Non-MAGI Medicaid categories of assistance include:

- Regular Medicaid
- Long Term Care Medicaid
- Medicare Savings Program
- Medicaid Works

Medicare Savings Program

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Non-MAGI Categories of Assistance

Regular Non-MAGI Medicaid

Long Term Care Medicaid

Pass Through Medicaid

Medicaid Works

- Regular Non-MAGI Medicaid is for individuals who have income below the Income Scale.
- Individuals who are potentially eligible for Supplemental Security Income (SSI) must apply for the benefit. A separate Medicaid application is not required for SSI recipients.

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Non-MAGI Categories of Assistance

Regular Non-MAGI Medicaid

Long Term Care Medicaid

Pass Through Medicaid

Medicaid Works

- Long Term Care (LTC) Medicaid is for individuals who reside in a nursing facility (or other institution), receive waiver services, or receive Hospice.
- LTC Medicaid has a higher income limit than regular Medicaid. (3 x the SSI standard)
- Individuals who transfer assets in order to become resource eligible may be disqualified from receiving LTC Medicaid.

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Non-MAGI Categories of Assistance

Regular Non-MAGI Medicaid

Long Term Care Medicaid

Pass Through Medicaid

Medicaid Works

- Pass Through Medicaid is for certain individuals who lose their Supplemental Security Income (SSI) due to entitlement to, or increase in, RSDI Social Security benefits.
- For Pass Through Medicaid, the increase which caused the loss of SSI can be disregarded when determining income eligibility for Medicaid.
- The income limit for Pass Through Medicaid is the SSI standard, which is higher than regular Medicaid.

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Non-MAGI Categories of Assistance

Regular Non-MAGI Medicaid

Long Term Care Medicaid

Pass Through Medicaid

Medicaid Works

- Disabled Adult Children
- Correct/Concurrent
- Disabled or early widows/widowers or disabled surviving divorced spouses

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Non-MAGI Categories of Assistance

Regular Non-MAGI Medicaid

Long Term Care Medicaid

Pass Through Medicaid

Medicaid Works

- Medicaid Works is for the working disabled
- Not otherwise eligible for Medicaid
- Unearned income must be less than the SSI limit.
- Earned income must be less than 250% FPL

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Non-MAGI Medicaid

- Income eligibility for Non-MAGI Medicaid is determined based on monthly gross income.
- Resources are considered in the Non-MAGI Medicaid eligibility determination.
- The Non-MAGI Medicaid household is determined based on relationship and relative responsibility.

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To be technically eligible for Non-MAGI Medicaid, individuals must:

Provide or apply for a Social Security Number (SSN)	Agree to cooperate with Medical Support Enforcement (MSE)	Agree to cooperate with Third Party Liability (TPL)
Be a Kentucky Resident	Be a US Citizen or qualified immigrant (lawfully admitted for permanent residence)	Be **aged, blind, or disabled.**

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Aged, Blind, Disabled Criteria

An aged individual must be age 65 or older.

A blind individual must be determined blind by the Social Security Administration (SSA).

A disabled individual must be determined disabled by the SSA.

Note: In some cases, blindness and disability are determined by the Medical Review Team (MRT) using the SSA definition of blindness and disability.

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Non-MAGI Medicaid Income

The Medicaid Income Scale is used when determining eligibility for Regular Medicaid. The income limit is $235 for an individual and $291 for a couple.

When determining eligibility for Long Term Care Medicaid the special income standard of 3 X the SSI standard is used. ($2,742)

For Pass Through Medicaid, countable income is compared to the current SSI standard. ($914)

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Non-MAGI Medicaid Resources

- Resources must be verified at application and recertification to determine Non-MAGI Medicaid eligibility.
- Resources may be countable or excluded depending on ownership, how the resources are used, and the category of Medicaid assistance received.

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Non-MAGI Resource Limit

- The resource limit for regular Medicaid is $2,000 for a single individual and $4,000 for a couple.
- The resource limit for the Medicare Savings Program is $9,090 for a single individual and $13,630 for a couple.

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Medicare Savings Program

- The Medicare Savings Program (MSP) can assist individuals in paying for their Medicare premiums. The categories of MSP are:
  - Qualified Medicare Beneficiaries (QMB)
  - Specified Low-Income Medicare Beneficiaries (SLMB)
  - Medicare Qualified Individuals Group 1 (QI1)

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Medicare Savings Program

Category	QMB	SLMB	QI-1
Benefit Received	• SMI Premium Buy-In • Medicare Deductibles and co-insurance	• SMI Premium Buy-In Only	• SMI Premium Buy-In Only
Income Limits	Single: $1235 Couple: $1663	Single: $1478 Couple: $1992	Single: $1660 Couple: $2239
Medicare Requirement	Must receive Part A	Must receive Medicare Parts A and B	Must receive Medicare Parts A and B
Dually Eligible? (MSP + Other Medicaid)	May be Dually Eligible	May be Dually Eligible	No Dual Eligibility
Backdated Eligibility?	No retroactive coverage	Yesby up to 3 months	Yesby up to 3 months

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Medicaid Renewal

MAGI and Non-MAGI Medicaid cases require a recertification every 12 months to determine ongoing Medicaid eligibility.

The recertification process begins on the 1st day of the month prior to the recertification month.

Recertification's are completed through either the active or passive renewal process.

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Passive Renewal

- Cases selected for the passive renewal process do not require any action to initiate the recertification process; it is initiated automatically by the eligibility system.
- During passive renewal, the eligibility system checks trusted data sources to verify income and/or resources.
    - If income and/or resources are verified by trusted data sources the case is renewed without any action by the member.
    - If income and/or resources cannot be verified by trusted data sources, a Request for Information (RFI) is issued to the member.

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Active Renewal

- An active renewal is required when the case has income and/or resources other than those that can be verified by trusted data sources.
- For cases not eligible for passive renewal, form EDB-087, Renewal Form for Medical Coverage is issued.
    - Members may complete and return the form to initiate recertification, or they may recertify in person, by phone, or on the benefind self-service portal.
    - If the renewal is not initiated by the 15th of the renewal month, form EDB-088, Renewal Reminder Form for Medical Coverage, is issued.

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