

**Centers for Medicare & Medicaid Services
National Training Program
Instructor Information Sheet**

Module 12 - Medicaid and the Children's Health Insurance Program

Module Description

The lessons in this module explain Medicaid and the Children's Health Insurance Program (CHIP). The materials—up-to-date and ready-to-use—are designed for information givers/trainers who are familiar with the Medicare program, and would like to have prepared information for their presentations.

Objectives

- Describe eligibility, benefits, and administration of Medicaid
- Define eligibility, benefits, and administration of CHIP
- Summarize implications of the Affordable Care Act on Medicaid and CHIP

Target Audience

This module is designed for presentation to trainers and other information intermediaries.

Time Considerations

The module consists of 42 PowerPoint slides with corresponding speaker's notes and knowledge checks. It can be presented in 50 minutes. Allow approximately 10 more minutes for discussion, questions, and answers. Additional time may be added for add-on activities. It has a resource guide and National Training Program contact slide for reference. Appendices A-D provide the presenter with an opportunity to research and present local information.

Course Materials

Most materials are self-contained within the module.

Module 12: Medicaid and the Children’s Health Insurance Program

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2014 National Training Program

Module 12

Medicaid and the Children's Health Insurance Program



Module 12 explains Medicaid and the Children's Health Insurance Program (CHIP).

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, CHIP, and the Federally-facilitated Health Insurance Marketplace (also known as Exchanges).

The information in this module was correct as of May 2014.

To check for updates on the new health care legislation, visit healthcare.gov.

To view the Affordable Care Act, visit healthcare.gov/law/index.html.

To check for an updated version of this training module, visit cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html.

This set of CMS National Training Program materials isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Session Objectives

- This session will help you
 - Describe eligibility, benefits, and administration of Medicaid
 - Define eligibility, benefits, and administration of the Children's Health Insurance Program (CHIP)
 - Summarize implications of the Affordable Care Act on Medicaid and CHIP

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Medicaid and the Children's Health Insurance Program

This session will help you:

- Describe eligibility, benefits, and administration of Medicaid
- Define eligibility, benefits, and administration of the Children's Health Insurance Program (CHIP)
- Summarize implications of the Affordable Care Act on Medicaid and CHIP

Lesson 1 – Medicaid Overview

- Federal and state entitlement program
- Medical assistance for people with limited income and resources
- Covers 60 million adults and children
- Supplements Medicare for 9 million people who are aged and/or disabled

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Medicaid and the Children's Health Insurance Program

The Medicaid program is a federal and state entitlement* program that pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid is not a cash support program; it pays medical providers directly for your care.

Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Medicaid and the Children's Health Insurance Program provide health coverage to nearly 60 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities.

The program became law in 1965 (Title XIX (19) of the Social Security Act) as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons.

* Entitlement—a government program that guarantees certain benefits to a particular group or segment of the population.

Medicaid Administration

- Federal/state partnership
 - Jointly financed entitlement program
 - Federally established national guidelines
 - States receive federal matching funds
 - Known as the Federal Medical Assistance Percentage
 - Used to calculate amount of federal share of state expenditures
 - Varies from state-to-state
 - Based on state per capita income

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Medicaid and the Children's Health Insurance Program

Medicaid is a joint federal/state partnership program with federally established national guidelines.

States receive federal matching funds for covered services.

- The federal matching rate, also known as the Federal Medical Assistance Percentage (FMAP) is used to calculate the amount of the federal share of state expenditures for services.

The FMAP varies from state-to-state based on state per capita income.

State Medicaid Administration

- Within broad federal guidelines, each state
 - Develops its own programs
 - Develops and operates its own plan
 - Establishes its own eligibility standards
 - Determines the type, amount, duration and scope of services
 - Sets the rate of payment for services
 - Partners with CMS to administer its program
- States may change eligibility, services, and reimbursement during the year

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Medicaid and the Children's Health Insurance Program

Within broad federal guidelines, each state

- Develops its own programs.
- Develops and operates a Medicaid State Plan outlining the nature and scope of services. The state plan is a contract between the Centers for Medicare & Medicaid Services (CMS) and the state, and any amendments must be approved by CMS.
- Establishes its own eligibility standards. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. A person who is eligible for Medicaid in one state may not be eligible in another state.
- Determines the type, amount, duration, and scope of services covered within federal guidelines. Also, the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state.
- Sets the rate of payment for services with CMS approval.
- Partners with CMS to administer its program.
- Administers its own program once approved by the federal government.

State legislatures may change Medicaid eligibility, services, and reimbursement during the year.

The Single State Medicaid Agency

- Administers the Medicaid State Plan
 - May delegate some administrative functions
- Local office names may vary
 - Social Services
 - Public Assistance
 - Human Services

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Medicaid and the Children's Health Insurance Program

The “single state agency” is strictly a statutory (legal) concept that defines responsibility for administration of the Medicaid State Plan. The single state agency isn’t required to administer the entire Medicaid program. It may delegate some administrative functions to other state (or local) agencies or private contractors (or both). However, all final eligibility determinations must be made by state (or local) agency personnel.

Local office names may vary. These offices are sometimes called Social Services, Public Assistance, or Human Services, depending on where you live.

For more information about eligibility requirements, contact the Medicaid Director in your state. To apply for Medicaid, contact your local Medical Assistance office.

Need more information?

For more information, visit: [medicaid.gov/medicaid-chip-program-information/by-state/by-state.html](https://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html).



Medicaid Eligibility

- Eligibility tied to one of the main eligibility groups under the federal Medicaid law
 - Pregnant women
 - Children
 - People with disabilities
 - Seniors
- Financial and non-financial requirements

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Medicaid and the Children's Health Insurance Program

Historically, to qualify for Medicaid you must belong to one of the main eligibility groups under the federal Medicaid law. States must cover people in these groups up to federally defined income thresholds, but many states have expanded Medicaid beyond these thresholds, mainly for children. There are also other financial and non-financial requirements that must be met, such as resource requirements as well as residency and citizenship requirements.

Because of the Affordable Care Act, Medicaid groups were simplified beginning in 2014. This is discussed in greater detail in Lesson 3, starting on slide 26.

Mandatory Medicaid State Plan Benefits

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing facility services
- Home health services
- Physician services
- Rural Health Clinic services
- Federally Qualified Health Center services
- Laboratory and X-ray services

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Medicaid and the Children's Health Insurance Program

Mandatory Medicaid State Plan benefits include the following services:

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment services
- Nursing facility services
- Home health services
- Physician services
- Rural Health Clinic services
- Federally Qualified Health Center services
- Laboratory and X-ray services

Continued on the next slide.

Mandatory Medicaid State Plan Benefits - Continued

- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women
- Tobacco cessation

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Medicaid and the Children's Health Insurance Program

- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women
- Tobacco cessation

Need more information?

For more information, visit: [medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html](https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html).



Medicaid Waivers

- Allow states to test alternative delivery of care
 - Certain federal laws “waived”
- Types of waivers
 - Section 1915(b) Managed Care Waiver
 - Section 1915(c) Home and Community-Based Services Waiver
 - Section 1115 Research and Demonstration Waiver
 - Concurrent Section 1915(b) and 1915(c) Waivers

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Medicaid and the Children's Health Insurance Program

Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children’s Health Insurance Program (CHIP). There are four primary types of waivers and demonstration projects:

- Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems or otherwise limit people’s choice of providers.
- Section 1915(c) Home and Community-Based Services Waivers: States can apply for waivers to provide long-term care services in home and community settings rather than institutional settings.
- Section 1115 Research and Demonstration Projects: States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement two types of waivers to provide a continuum of services.

Need more information?

For more information, visit: [medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers.html](https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers.html).



Check Your Knowledge—Question 1



Medicaid is administered by state governments within state rules.

- a. True
- b. False



Refer to page 43 to check your answers.

How Are Medicare and Medicaid Different?

Medicare	Medicaid
National program that is consistent across the country	Statewide programs that vary among states
Administered by the federal government	Administered by state governments within federal rules (federal/state partnership)
Health insurance for people 65 or over, with certain disabilities, or with End-Stage Renal Disease (ESRD)	Health insurance for people based on need; financial and non-financial requirements
Nation's primary payer of inpatient hospital services for the elderly and people with ESRD	Nation's primary public payer of mental health and long-term care services (nursing home)

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Medicaid and the Children's Health Insurance Program

Medicare and Medicaid are different in the following ways:

- While Medicare is a national program that is consistent across the country, Medicaid consists of statewide programs that vary among states.
- While Medicare is administered by the federal government, Medicaid is administered by state governments within federal rules (federal/state partnership).
- While Medicare eligibility is based on age, disability, or End-Stage Renal Disease (ESRD), Medicaid eligibility is based on limited income and resources, as well as other non-financial requirements.

While Medicare is the nation's primary payer of inpatient hospital services for the elderly and people with ESRD, Medicaid is the nation's primary public payer of mental health and long-term care services (nursing home care).

Medicare - Medicaid Enrollees

- Referred to as “dual eligibles”
 - 9 million nationally
- Medicaid may partially or fully cover
 - Part A and/or Part B premiums
 - Other Medicare cost-sharing
 - Long-term care
- Medicaid benefits provided to dual eligibles are also known as Medicare Savings Programs

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Medicaid and the Children's Health Insurance Program

Over 9 million people covered by Medicaid are “dual-eligible” beneficiaries—low-income seniors and younger people with disabilities who are also covered by Medicare. These people have limited income and resources and may get help paying for their Medicare Part A and Part B premiums and out-of-pocket medical expenses from Medicaid. Medicaid may also cover additional services beyond those provided under Medicare for dual eligibles—most important, long-term care. Medicaid benefits provided to dual-eligible beneficiaries are sometimes referred to as Medicare Savings Programs.

Need more information?

The “*Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) at a Glance*” factsheet (ICN 006977 March 2013) is available at:

[cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf](https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf)



Medicare Savings Programs (MSP)

- MSP benefits are categorized into groups
 - *Full Benefit* enrollees receive the full array of benefits available in the state
 - *Partial Benefit* enrollees
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-Income Medicare Beneficiary (SLMB)
 - Qualified Individuals (QI)
 - Qualified Disabled and Working Individuals (QDWI)
- Automatically qualify for Extra Help

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Medicaid and the Children's Health Insurance Program

Assistance is based on income. Based on the level of benefit, Medicare Savings Programs (MSPs) are categorized into the following groups:

- Full Benefit enrollees receive the full array of Medicaid benefits in the state and coverage for Medicare premiums and cost-sharing.
- Partial dual eligible enrollees only receive assistance with Medicare costs.
 - Qualified Medicare Beneficiaries are partial-benefit enrollees who receive assistance from Medicaid to pay their Medicare premiums and cost-sharing obligations such as deductibles, coinsurance, and copayments (except Part D).
 - Specified Low-Income Medicare Beneficiaries, Qualified Individuals, and Qualified Disabled and Working Individuals are Partial-Benefit enrollees who receive assistance from Medicaid to pay Medicare premiums only.
- If you qualify for any of these MSPs, you automatically qualify to get Extra Help paying for Medicare prescription drug coverage.

Who Can Qualify for a Medicare Savings Program?

Medicare Savings Program	Individual Monthly Income Limit (2014)	Married Couple Monthly Income Limit (2014)	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	\$993	\$1,331	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	\$1,187	\$1,593	Part B premiums only
Qualifying Individual (QI)	\$1,333	\$1,790	Part B premiums only
Qualified Disabled & Working Individuals (QDWI)	\$3,975	\$5,329	Part A premiums only

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Medicaid and the Children's Health Insurance Program

If you qualify for the Qualified Medicare Beneficiary (QMB) program, you get help paying your Part A and Part B premiums, deductibles, coinsurance, and copayments. To qualify for QMB you must be eligible for Medicare Part A, and have an income not exceeding 100 percent of the federal poverty level (FPL). This will be effective the first month following the month QMB eligibility is approved. Eligibility can't be retroactive. To qualify for the Specified Low-Income Medicare Beneficiary (SLMB) program, you must be eligible for Medicare Part A and have an income that is at least 100 percent, but doesn't exceed 120 percent of the FPL. If you qualify for SLMB, you get help paying for your Part B premium.

To qualify for the Qualified Individual (QI) program, which is fully federally funded, you must be eligible for Medicare Part A, and have an income not exceeding 135 percent of the FPL. If you qualify for QI, and there are still funds available in your state, you get help paying your Part B premium. Congress only appropriated a limited amount of funds to each state.

To qualify for the Qualified Disabled and Working Individual program, you must be entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding Substantial Gainful Activity; have an income not higher than 200 percent of the FPL, and resources not exceeding twice the maximum for Supplemental Security Income (\$4,000 for an individual, and \$6,000 for married couple in 2014); and not be otherwise eligible for Medicaid. If you qualify, you get help paying your Part A premium. If your income is between 150 percent and 200 percent of the FPL, the state can ask you to pay a part of your Medicare Part A premium.

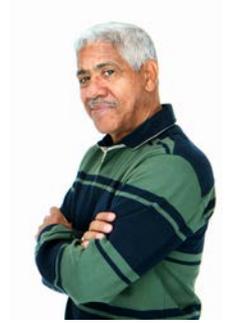
In 2014, the resource limits for the QMB, SLMB, and QI programs are \$7,160 for a single person, and \$10,750 for a married person living with a spouse and no other dependents. These resource limits are adjusted on January 1 of each year, based on the change in the annual consumer price index since September of the previous year.

Check Your Knowledge—Question 2



If you qualify for a Medicare Savings Program, you automatically qualify for

- a. Medicaid
- b. Free Medicare premiums
- c. Extra Help paying for Medicare prescription drug coverage
- d. The Children's Health Insurance Program



Refer to page 43 to check your answers.

Lesson 2 - Children's Health Insurance Program (CHIP) Overview

- Works with Medicaid
- Insures low-income children
- Signed into law in 1997

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Medicaid and the Children's Health Insurance Program

Medicaid and the Children's Health Insurance Program (CHIP) work together to provide health insurance coverage to more than 43 million children, including half of all low-income children in the United States. CHIP provides health insurance to nearly 8 million children in families whose incomes are too high to qualify for Medicaid, but who can't afford private health insurance coverage.

Children's Health Insurance Program (CHIP) and the States

- State-federal partnership
- CMS establishes broad guidelines
- Federal government provides matching funds
- CHIP funding typically 15 percentage points above Medicaid funding
- States receive annual allotment determined by statute

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Medicaid and the Children's Health Insurance Program

Like Medicaid, the Children's Health Insurance Program (CHIP) is a partnership between the states and the federal government. States administer CHIP within broad guidelines established by the Centers for Medicare & Medicaid Services, and the federal government provides matching funds to states to provide the coverage.

The federal matching rate for CHIP is typically about 15 percentage points higher than the Federal Medicaid Matching Rate (FMAP) for that state. For example, a state with a 50 percent FMAP would typically have an "enhanced" CHIP matching rate of 65 percent. Unlike Medicaid, states receive a specific annual allotment for CHIP, determined by the statute.

State Options for the Children's Health Insurance Program (CHIP)

- States can design their CHIP program in one of three ways
 - Medicaid expansion (seven states, the District of Columbia, and five territories)
 - Separate Child Health Insurance Program (17 states)
 - Combination of the two approaches (26 states)
- Income and resource standards and eligibility vary by state

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Medicaid and the Children's Health Insurance Program

States can design their Children's Health Insurance Program (CHIP) in one of three ways:

- Medicaid expansion (seven states, the District of Columbia, and five territories)
- Separate Child Health Insurance Program (17 states)
- Combination of the two approaches (26 states)

If a state integrates CHIP into its Medicaid Program, the services provided to CHIP-eligible children must be the same as those provided to Medicaid-eligible children, and the eligibility and enrollment processes must be consistent. Under a separate CHIP, the state may establish different standards and processes within the federal guidelines. Like Medicaid, CHIP has income and resource standards, and eligibility varies by state.

Children's Health Insurance Program (CHIP) Eligibility

- To be eligible for CHIP you must
 - Be under 19
 - Have income up to 200 percent of the federal poverty level or income 50 percentage points higher than Medicaid as of June 1, 1997
- Many states have higher limits
- States may add eligibility criteria

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Medicaid and the Children's Health Insurance Program

There are two minimum-income eligibility standards for the Children's Health Insurance Program (CHIP), depending on the state of residence. States may cover children with incomes up to 200 percent of the federal poverty level (FPL), or 50 percentage points higher than Medicaid level on June 1, 1997, for the age of the child. Many states have higher income limits. Some states go as high as 400 percent of the FPL. In addition to the federal requirements, states can add eligibility criteria such as residency requirements, age, or income levels.

NOTE: A state can add its own eligibility criteria to CHIP, but still must comply with several prohibited eligibility standards, including the prohibition that the state can't cover children in higher-income families over lower-income families.

Restrictions on Eligibility

- Children of public employees (state option)
- Inmates of public institutions
- Some non-citizens

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Medicaid and the Children's Health Insurance Program

Historically, children who had access to public employee coverage haven't been eligible for Children's Health Insurance Program (CHIP) coverage. The Affordable Care Act changed that by allowing states the option to cover those children. Inmates of public institutions and non-citizens who aren't lawfully present remain ineligible for CHIP.

Documentation Requirements

- U.S. Citizens
 - Must provide satisfactory documentary evidence
 - Tribal membership and enrollment documents satisfy requirements
- Lawfully residing children and pregnant women
 - States may choose to lift 5-year ban
 - Legal immigration documentation requirements apply
- Individuals enrolled as of 2010 may use Social Security data match

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Medicaid and the Children's Health Insurance Program

Effective July 1, 2006, the Deficit Reduction Act created a new section 1903(x) of the Act that requires states to obtain satisfactory documentary evidence of citizenship or nationality when enrolling individuals in Medicaid, or at the first point of eligibility re-determination. Eligible individuals who declare to be U.S. citizens or nationals must be provided a reasonable opportunity to present satisfactory documentation of citizenship or nationality, and must be enrolled in coverage pending the reasonable opportunity to document that claim.

Tribal enrollment or membership documents issued from a federally recognized Tribe must be accepted as verification of citizenship; no additional identity documents are required.

States have the option to use or not use the 5-year restriction for citizenship in cases of pregnant women and children. Section 214 of the Children's Health Insurance Program Reauthorization Act grants states the option to provide Medicaid and Children's Health Insurance Program (CHIP) coverage to all children and pregnant women (including women covered during the 60-day postpartum period) "who are lawfully residing in the United States..." and who are otherwise eligible for such assistance. States may elect to cover these groups under Medicaid only, or under both Medicaid and CHIP. The law doesn't permit states to cover these new groups only in CHIP, without also extending the option to Medicaid. As of 2014, 25 states, the District of Columbia, and the Mariana Islands now offer coverage to lawfully residing immigrant children and/or pregnant women without a 5-year waiting period under Medicaid, or Medicaid and CHIP (visit medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/lawfully-residing.html for the list of states).

Another state option, as of January 1, 2010, allows verification of a declaration of citizenship for individuals newly enrolled in CHIP or Medicaid using a data match with Social Security (SSA) to confirm the consistency of a declaration of citizenship with SSA records, in lieu of the presentation of citizenship documentation.

Authorization and Funding

- Affordable Care Act
 - Maintenance of Effort authorizes Children's Health Insurance Program (CHIP) through 2019
 - Provides CHIP funding through September 30, 2015
 - Increases CHIP federal matching rate by 23 percentage points in October 2015
 - Provides funding for outreach efforts

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Medicaid and the Children's Health Insurance Program

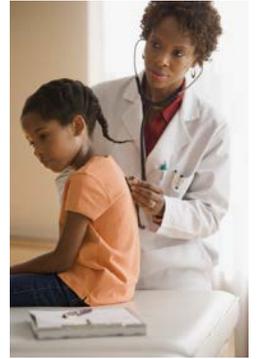
The Affordable Care Act (which we'll discuss in the next lesson) Maintenance of Effort authorizes the Children's Health Insurance Program (CHIP) through 2019, and extends CHIP funding through September 30, 2015, when the already enhanced CHIP federal matching rate will be increased by 23 percentage points. Because CHIP matching rates vary from state to state, the additional 23 percentage points will lead to different totals in different states. The Affordable Care Act also provides an additional \$40 million in federal funding to continue efforts to promote enrollment of children in CHIP and Medicaid.

Check Your Knowledge—Question 3



Each state can add its own eligibility criteria to its Children’s Health Insurance Program (CHIP).

- a. True
- b. False



Refer to page 43 to check your answers.

Lesson 3 – Health Care Reform

- Provides a seamless system of health coverage
 - Medicaid and the Children’s Health Insurance Program (CHIP) serve as the foundation
 - Qualified health plans in the Marketplace serve slightly higher incomes
 - All programs are aligned with a unified application
- Offers a new opportunity for states to expand Medicaid
- Improves access to Medicaid and CHIP

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Medicaid and the Childrens Health Insurance Program

The Affordable Care Act established a seamless system of health coverage to improve access to health care. Medicaid and the Children’s Health Insurance Program (CHIP) serve as the foundation for this new system, providing coverage for most low-income adults and children, with qualified health plans in the Health Insurance Marketplace serving individuals with slightly higher incomes. The new eligibility rules for all three programs are aligned. Everyone can enroll in coverage using a unified application and find out whether they’re eligible for Medicaid, CHIP, or a private insurance plan at the same time.

The Affordable Care Act provides states with additional federal funding to expand their Medicaid programs, and improves access to Medicaid and CHIP for individuals:

- Medicaid eligibility groups are simplified.
- Streamlined enrollment processes make it easier for qualified individuals to apply for and enroll in coverage.
- Eligibility determinations are based on modified adjusted gross income, creating consistency across programs for most individuals.
- Medicaid and CHIP renewals occur on an annual basis for most beneficiaries to reduce unnecessary interruptions in coverage.
- CHIP waiting periods and premium lockout periods are limited to no more than 90 days.

Expanding Medicaid

- Millions of newly-eligible individuals
 - Ages up to 65
 - Income to 133 percent of the federal poverty level
- New Eligibility Groups
 - Adult group
 - Former foster care group
 - Optional eligibility group

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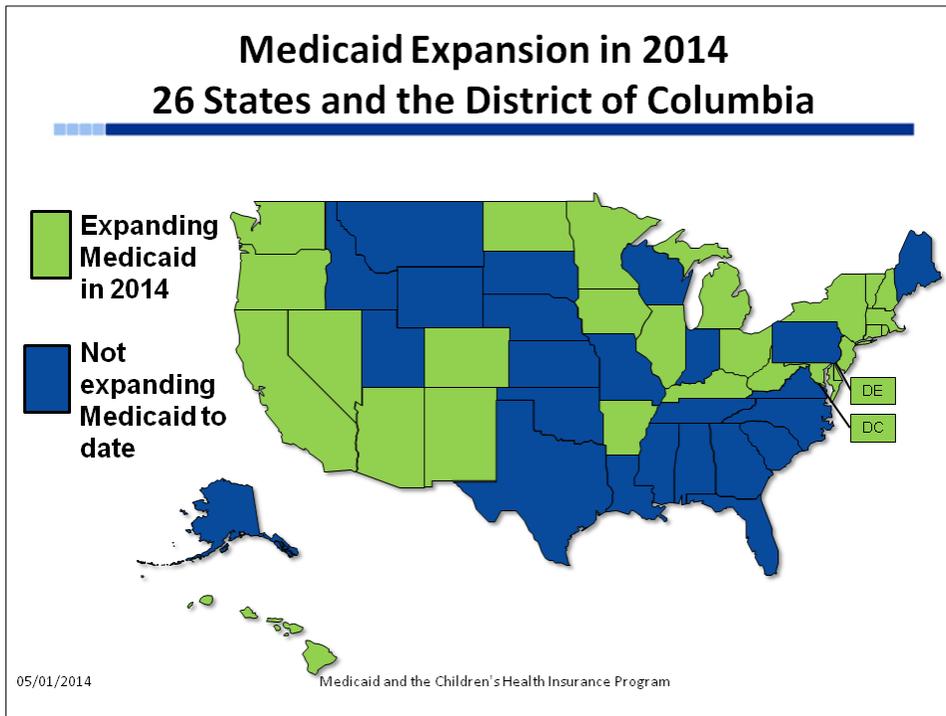
Medicaid and the Children's Health Insurance Program

Starting January 1, 2014, the Affordable Care Act established three new Medicaid eligibility groups that made health insurance available to millions of people who weren't previously eligible. Medicaid eligibility expanded to most individuals under 65 whose income is below 133 percent of the federal poverty level (FPL):

- The New Adult Group covers individuals 19-64 with income below 133 percent of the FPL, including 19- and 20-year-old children. Children under 19 aren't included in this group because they're covered under other mandatory eligibility groups. To be eligible for the New Adult Group, individuals may not be entitled to or enrolled in Medicare, they can't be eligible for any other mandatory Medicaid eligibility group, and they may not be pregnant at the time of enrollment. This group is a mandatory eligibility group that states elect to cover.
- A second eligibility group created under the Affordable Care Act establishes new Medicaid coverage for individuals under 26 who were enrolled in Medicaid while they were either in foster care at 18 or when they "aged out" of foster care. There is no income or resource test for this eligibility group. States have the option to cover individuals who were in foster care and in Medicaid in another state.
- The third group is similar to the New Adult Group. Individuals in this group must be under 65, with income above 133 percent of the FPL, and can't otherwise be eligible for another Medicaid group. Unlike the eligibility requirements for the New Adult Group, individuals in this optional group may be pregnant or may be eligible for Medicare. In addition, this group covers both children and adults who aren't otherwise eligible.

If your state is expanding Medicaid, you'll probably qualify if you make up to about \$16,100 a year for one person (\$32,900 for a family of four). Coverage started as early as January 1, 2014.

NOTE: The Medicaid expansion up to 133 percent of the FPL resulted in a number of states needing to transition children 6-18 between 100-133 percent of the FPL that were previously covered in separate Children's Health Insurance Programs to Medicaid.



As of April 2014, 26 states and the District of Columbia are moving forward to expand Medicaid coverage in 2014, including Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia.

The remaining 24 states have not expanded their Medicaid programs to date, but could expand Medicaid in the future, including Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

Under the law, the federal government will pay states all of the costs for newly eligible people for the first 3 years. It will pay no less than 90 percent of the costs in the future.

States are continuing to make coverage decisions, and additional states could expand Medicaid in the future. States may also drop their Medicaid expansion coverage at a later time without a federal penalty.

Simplified Medicaid Eligibility

- Four main eligibility groups and minimum eligibility levels
 - Children – average 241 percent federal poverty level (FPL) (varies by state)
 - Pregnant women – 133 percent FPL (varies by state)
 - Parents – 133 percent FPL
 - Other adults – 133 percent FPL

05/01/2014

Medicaid and the Children's Health Insurance Program

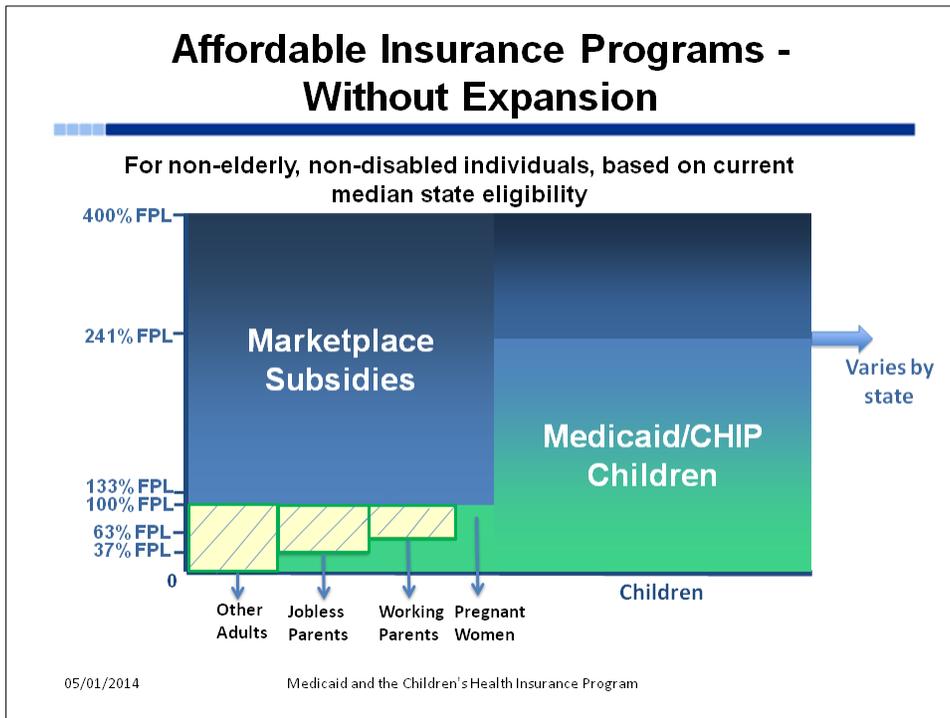
Recent Medicaid regulations consolidate eligibility categories into four main groups: children, pregnant women, parents, and other adults. For those states that are expanding a Medicaid program, the following income eligibility levels apply for 2014:

- For children, the income eligibility threshold is, at a minimum, wherever a state was in March 2010, the date of enactment. On average, that level is about 241 percent of the federal poverty level (FPL).
- For pregnant women, the minimum threshold is 133 percent of the FPL. However, this level will be higher in some states.
- For parents and other adults, the minimum threshold is 133 percent of the FPL in a state that takes up the New Adult Group.
- People with disabilities will also be eligible below 133 percent of the FPL based on income, either through the New Adult Group or a group specifically for people with disabilities at that income level.

Need more information?

For state Medicaid and Children's Health Insurance Program income eligibility standards effective January 1, 2014, visit: www.medicaid.gov/affordablecareact/medicaid-moving-forward-2014/downloads/medicaid-and-chip-eligibility-levels-table.pdf.



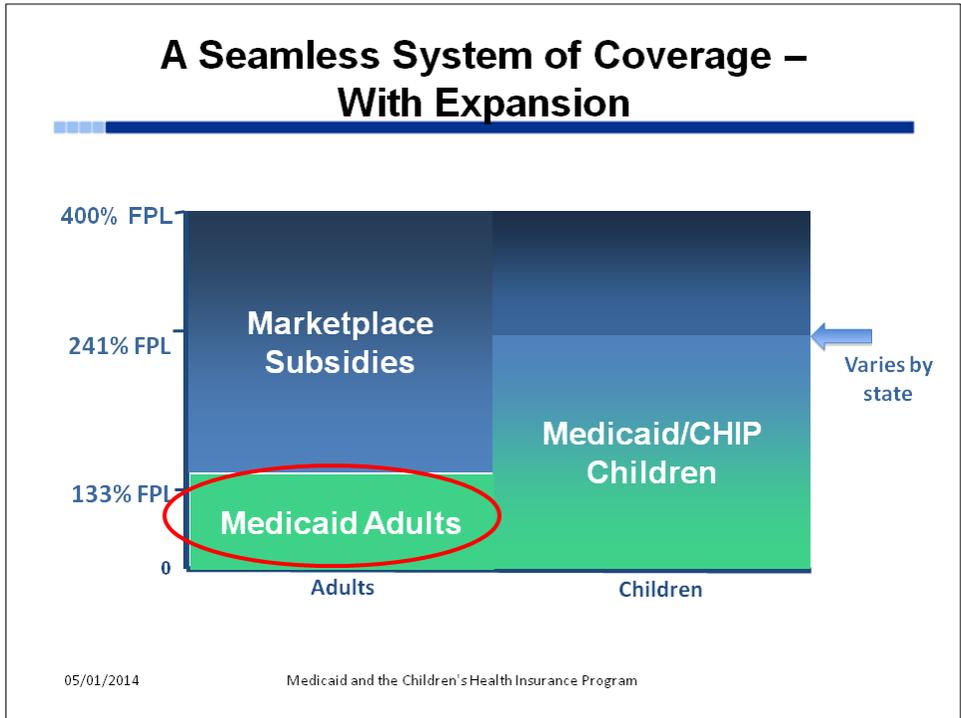


This chart shows Medicaid coverage gaps in states that do *not* expand coverage. The Supreme Court made this optional.

Medicaid and Children’s Health Insurance Programs (CHIP) vary by state, at 0 percent to 241 of the percent federal poverty level (FPL). It may cover pregnant women, some working or jobless parents, but not most adults. Under the Affordable Care Act’s Maintenance of Effort provision, states aren’t permitted to use standards, procedures, or methodologies that reduce eligibility for children in either CHIP or Medicaid until after September 30, 2019.

The groups potentially continuing without coverage or eligibility for Marketplace subsidies include adults from 0 percent to 100 percent of the FPL, jobless parents from 37 percent to 100 percent of the FPL, and working parents from 63 percent to 100 percent of the FPL.

NOTE: This doesn’t display the state option for the Basic Health Plan (BHP) for uninsured individuals with incomes between 133 percent and 200 percent of the FPL who would otherwise be eligible to receive premium subsidies in the Health Insurance Marketplace. Individuals with incomes between 133 and 200 percent of the FPL in states creating BHPs aren’t eligible for subsidies in the Marketplace.



This chart is a visual display for Medicaid coverage in states that expand coverage.

Currently, 26 states and the District of Columbia are participating in expansion efforts. Four states are participating through an alternative expansion model.

- Marketplace subsidies for from 138 percent to 400 percent of the federal poverty level (FPL)
- The New Expansion Group - Medicaid Adults from 0 percent to 138 percent of the FPL are displayed with the red circle (allows for 5 percent disregard)
- Medicaid and Children's Health Insurance Program vary by state, from 0 percent to 241 percent of the FPL

These individuals may also have the option to purchase a catastrophic plan in the Marketplace.

Need more information?

For more information on Medicaid and the Affordable Care Act, visit:

www.medicaid.gov/affordablecareact/affordable-care-act.html.

For more information on eligibility and enrollment, visit: www.medicaid.gov/state-resource-center/eligibility-enrollment-final-rule/eligibility-and-enrollment-final-rule-webinars.html.



States that Aren't Expanding Medicaid

- If you live in a state that is NOT expanding Medicaid, you
 - May have fewer coverage options
 - May not qualify for either Medicaid or reduced costs on a private insurance plan in the Marketplace
 - May be able to get a hardship exemption and won't have to pay a fee if you don't obtain minimum essential health coverage

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Medicaid and the Children's Health Insurance Program

Some states haven't expanded their Medicaid programs. In these states, some people with limited incomes may have fewer coverage options.

If you live in a state that isn't expanding Medicaid, you may not qualify for either Medicaid or reduced costs on a private insurance plan in the Marketplace; it depends on where your income falls.

- If your income is **more** than 100 percent of the federal poverty level (FPL) - about \$11,670 a year as a single person, or about \$23,850 for a family of four - you **can** buy a private health insurance plan in the Marketplace and may get lower costs based on your household size and income.
- If you make **less** than about \$11,670 a year as a single person or about \$23,850 for a family of four, you **may not** qualify for lower costs for private insurance based on your income. However, you may be eligible for Medicaid, even without the expansion, based on your state's existing rules.

Many adults in those states (that aren't expanding Medicaid) with incomes below 100 percent of the FPL fall into a gap. Their incomes may be too high to get Medicaid under their state's current rules, but their incomes are too low to qualify for help buying coverage in the Marketplace. However, these individuals can get hardship exemption and won't have to pay a fee if they don't get health coverage.

Streamlined Application

- One application for all programs
- Application leads seamlessly from comparing Qualified Health Plans in the Marketplace to enrollment
- May be able to enroll immediately once eligibility determination is complete
 - Depending on the program for which the applicant is eligible

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Medicaid and the Children's Health Insurance Program

States use a streamlined application for coverage through the Marketplace for health insurance from private plans, the new premium tax credit, reduced cost sharing, Medicaid, and the Children's Health Insurance Program (CHIP). The application leads seamlessly to comparing the Qualified Health Plans and then actual enrollment. Individuals can submit one application for all programs. Online applications are available in every state, along with traditional paper applications that may be mailed in. And people continue to have the option to apply in person or over the phone.

Through the single streamlined application, individuals and families receive eligibility determinations for the following:

- Medicaid and CHIP
- Enrollment in Qualified Health Plans in the Marketplace
 - Advance premium tax credits
 - Cost-sharing reductions

Once the eligibility determination is complete, applicants may be able to enroll in affordable coverage immediately, depending on the programs for which they're eligible and the model established in their state.

Simplified Eligibility Determinations

- Eligibility process has been simplified
 - Relies primarily on electronic data
 - Reduces need for paper documentation
- Apply on-line, by phone, by mail, or in person
- 12-month eligibility period for
 - Adults
 - Parents
 - Children
- Simplified process for renewing coverage

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Medicaid and the Children's Health Insurance Program

The Medicaid and Children's Health Insurance Program (CHIP) eligibility, enrollment, and renewal processes have been simplified in the following ways:

- Eligibility verification procedures have been modernized to rely primarily on electronic data sources. States have flexibility to determine the usefulness of available data before requesting additional information from applicants.
 - Verification procedures have also been simplified through the creation of a federal data services hub that links states with federal data sources, including the Internal Revenue Service, Social Security, and the U.S. Department of Homeland Security.
 - Renewals are limited (for people enrolled through the simplified, income-based rules) to once every 12 months, unless you report a change or the agency has information to prompt a reassessment.
- States can work with the Federally-facilitated Marketplace (FFM) regarding Medicaid and CHIP eligibility determinations in one of two ways. The state may either establish an Assessment model, an agreement whereby the FFM assesses applicants for Medicaid/CHIP eligibility based on their Modified Adjusted Gross Income (MAGI) and then transfers the applicants' electronic accounts to the state Medicaid or CHIP agency to complete the eligibility determination. Or the state may elect to use a Determination model, and accept MAGI-based eligibility determinations completed by the FFM as final determinations. Regardless of the approach, the process should be as seamless as possible for the applicant, with most eligibility determinations completed in near real-time as specified in our eligibility final rule at 435.912.
- States can take up to 45 days to determine Medicaid or CHIP eligibility, but enrollment may be retroactive up to 3 months.

Modified Adjusted Gross Income (MAGI) Methodology

- New methodology to count income
- Creates consistency
- Used to evaluate eligibility for
 - Medicaid
 - CHIP
 - Premium tax credits
 - Cost-sharing reductions
- Replaced complex rules
- States required to use MAGI

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Medicaid and the Children's Health Insurance Program

To create consistency across Medicaid, the Children's Health Insurance Program (CHIP) and the Marketplaces, the Affordable Care Act established a new methodology for determining how income is counted, based on federal tax rules. This methodology is called the Modified Adjusted Gross Income (MAGI). MAGI is used to evaluate eligibility for most Medicaid groups, CHIP, and premium tax credits and cost-sharing reductions (that may lower your monthly premiums and out-of-pocket costs in the Health Insurance Marketplace). This simplified system replaced many complex rules, as states were required to convert their income standards to MAGI equivalent standards.

Modified Adjusted Gross Income (MAGI) Determination

- When MAGI is determined
 - Used for premium tax credits in the Marketplace
 - There is an automatic 5percent income disregard
 - Rather than different disregards in each state
- MAGI must be used in most Medicaid and all CHIP determinations
 - For children and non-disabled adults under 65
 - Began October 1, 2013

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Medicaid and the Children's Health Insurance Program

Under the Affordable Care Act, the system for determining eligibility is streamlined and unified across the states.

When a person's Modified Adjusted Gross Income (MAGI) is determined, it is used to also determine eligibility for premium tax credits. There is an automatic 5 percent income disregard, rather than different disregards in each state. That means that a person's income can be up 138 percent of the federal poverty level (FPL), but since 5 percent of income is ignored, it effectively meets the 133 percent threshold.

MAGI must be used in most determinations for children and non-disabled adults under 65, whether or not their state expanded adult Medicaid coverage.

NOTE: The Affordable Care Act does *not* change Medicaid eligibility rules for beneficiaries who are *65 or older* or those in eligibility categories based on a *disability*. The Medicaid categories *exempt* from the MAGI methodology are those categories covering individuals who are *categorically eligible* (without need for an income determination); blind; disabled; 65 or over, where age is a condition of eligibility; or seeking coverage based on the need for long-term services and supports, Medicare cost-sharing assistance, or medically needy coverage.

Need more information?

For more information on conversion to MAGI, visit:

[medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/magi-conversion-2-28-13.pdf](https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/magi-conversion-2-28-13.pdf)



Verification

- Real time
- Supported by Federal Data Services Hub
- Data from
 - Social Security
 - Internal Revenue Service
 - Department of Homeland Security

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Medicaid and the Children's Health Insurance Program

For those who apply online, verifications for eligibility may occur in real or near real time. Supported, in part, by the federally managed Marketplace Data Services Hub, real-time verification of information is available through Social Security, the Internal Revenue Service, and the U.S. Department of Homeland Security.

Check Your Knowledge—Question 4



Which statement(s) is/are TRUE about Medicaid Expansion?

- a. States have the option to expand eligibility to the New Adult Group.
- b. The Medicaid expansion covers adults with income below 133 percent federal poverty level, under 65 and not pregnant.
- c. There is a streamlined application process for all insurance affordability programs.
- d. All of the above.



Refer to page 43 to check your answers.

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Appendix A - Optional

Medicaid Agencies

State	Website	Application Format

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Medicaid and the Children's Health Insurance Program

This slide can act as a template to report Medicaid agency details by state, depending on the audience. It can be hidden when not applicable.

Appendix B - Optional

Medicaid Enrollment

State	Medicaid Enrollment Numbers

05/01/2014

Medicaid and the Children's Health Insurance Program

This slide can act as a template to report Medicaid enrollment numbers by state, depending on the audience. It can be hidden when not applicable.

Appendix C - Optional

Medicaid Eligibility

State	Children	Pregnant Women	Parents	Adults

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Medicaid and the Children's Health Insurance Program

This slide can act as a template to report Medicaid eligibility by state, depending on the audience. It can be hidden when not applicable.

Appendix D - Optional State Medicaid FMAP Rates

State	FMAP	Enhanced FMAP

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Medicaid and the Children's Health Insurance Program

This slide can act as a template to report Federal Medical Assistance Percentages (FMAPs) by state, depending on the audience. It can be hidden when not applicable.

FMAPs are used in determining the federal share of expenditures for assistance payments for certain social services, and state medical and medical insurance expenditures. The Social Security Act requires the U.S. Secretary of Health and Human Services to calculate and publish MAPs each year. FMAPs are for Medicaid. Section 1905(b) of the Act specifies the formula for calculating FMAPs.

“Enhanced FMAPs” are for the Children’s Health Insurance Program under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating Enhanced FMAPs.



Need more information?

To view FMAPs visit:

aspe.hhs.gov/health/fmap.cfm.



Check Your Knowledge Answer Key

Question 1 (page 11)

Medicaid is administered by state governments within state rules.

ANSWER: b

b. False. Medicaid is administered by state governments within federal rules (federal/state partnership). A state administers its own eligibility and program once approved by the federal government.

Question 2 (page 16)

If you qualify for a Medicare Savings Program, you automatically qualify for:

ANSWER: c

c. Extra Help paying for Medicare prescription drug coverage. If you qualify for a Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, or Qualified Individuals program, you automatically qualify to get Extra Help paying for Medicare prescription drug coverage.

Question 3 (page 24)

Each state can add its own eligibility criteria to its Children's Health Insurance Program (CHIP).

ANSWER: a

a. True. A state can add its own eligibility criteria to CHIP, but still must comply with several prohibited eligibility standards, including the prohibition that the state can't cover children in higher-income families over lower-income families.

Question 4 (page 37)

Which statement(s) is/are TRUE about Medicaid Expansion?

ANSWER: d

- a. States have the option to expand eligibility to the New Adult Group.
- b. The Medicaid expansion covers adults with income below 133 percent federal poverty level, under 65 and not pregnant.
- c. There is a streamlined application process for all insurance affordability programs.
- d. All of the above.

d. All of the above. States have the option to expand eligibility to the New Adult Group. The Medicaid expansion covers adults with income below 133 percent of the FPL, under 65 and not pregnant. Also, there is a streamlined application process for all insurance affordability programs.

Acronyms

ACA	Affordable Care Act
BHP	Basic Health Plan
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
ESRD	End-Stage Renal Disease
FFM	Federally-facilitated Marketplace
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
MAGI	Modified Adjusted Gross Income
MSP	Medicare Savings Program
NTP	National Training Program
QDWI	Qualified Disabled and Working Individual
QI	Qualified Individual
QMB	Qualified Medicare Beneficiary
SLMB	Specified Low-Income Medicare Beneficiary
SSA	Social Security

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