2013 National Training Program

Workbook

# Module: 12

# Medicaid and the Children's Health Insurance Program (CHIP)

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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**Module 12: Medicaid and the Children's Health Insurance Program (CHIP)**

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## Contents



This module can be presented in 1 hour. Allow approximately 30 more minutes for discussion, questions and answers, and the learning activities.

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Module 12 explains *Medicaid & 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, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace (also known as Exchanges).

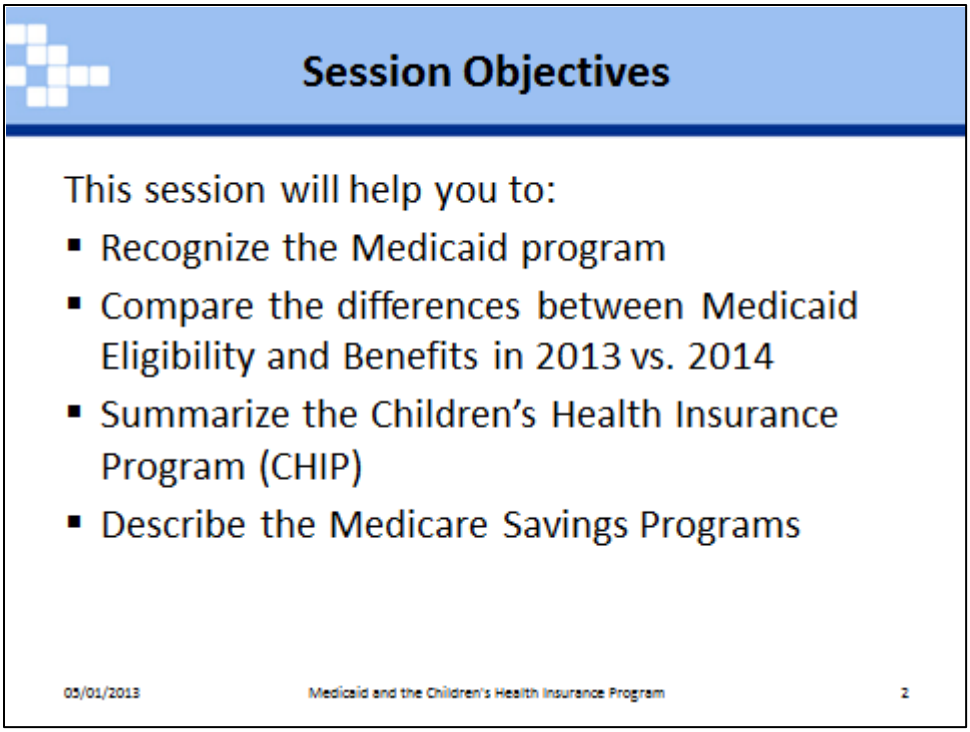
The information in this module was correct as of May 2013.

To check for updates on the new health care legislation, visit www.HealthCare.gov. To view the Affordable Care Act, visit http://www.HealthCare.gov/law/index.html.

To check for an updated version of this training module, visit http://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 are contained in the relevant statutes, regulations, and rulings.

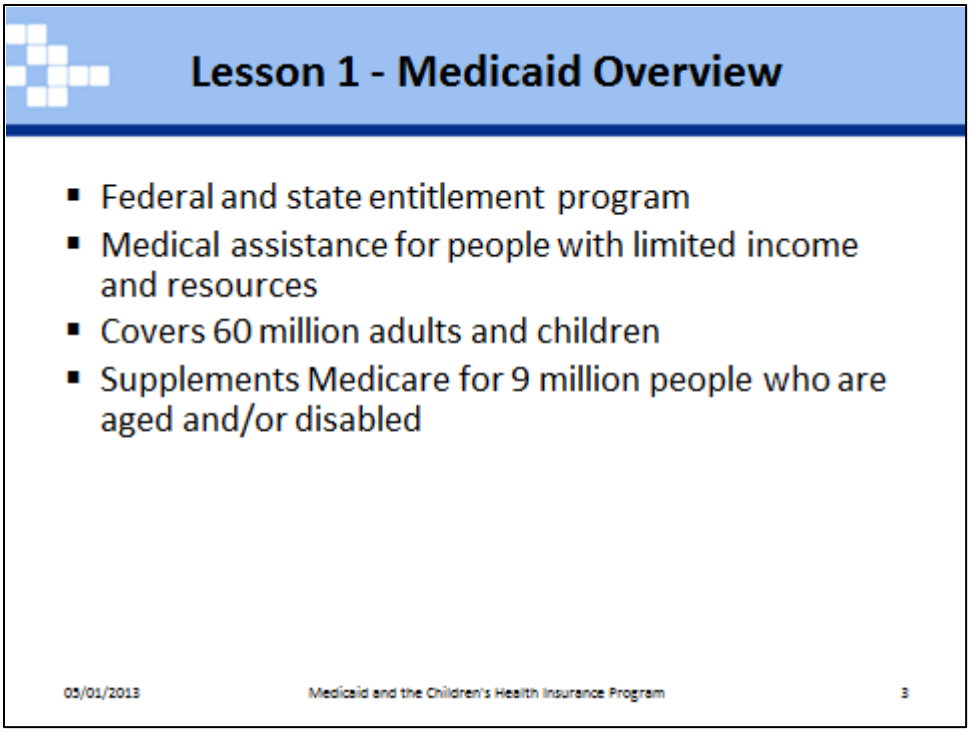
**NOTE:** Presenters may want to fill in Appendices A-D with local information.




Session Objective

This session will help you:

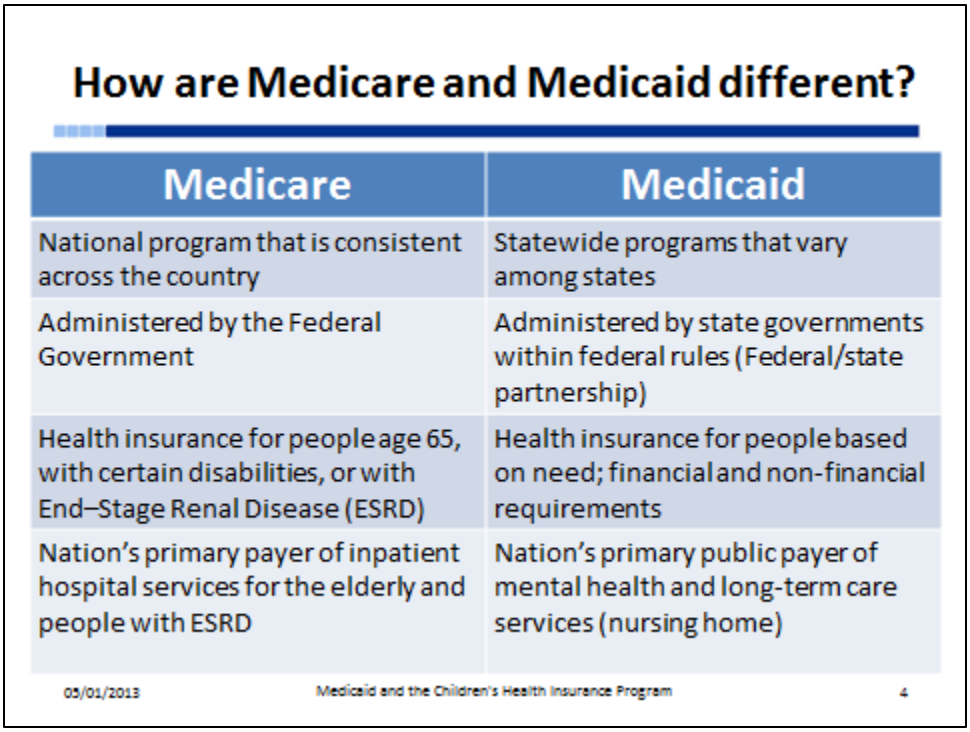
- Recognize the Medicaid program
- Compare the differences between Medicaid Eligibility and Benefits in 2013 vs. 2014
- Summarize the Children's Health Insurance Program (CHIP)
- Describe the Medicare Savings Programs




- 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 the largest source of funding for medical and health-related services for America's poorest people. Medicaid and the Children's Health Insurance Program (CHIP) 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.

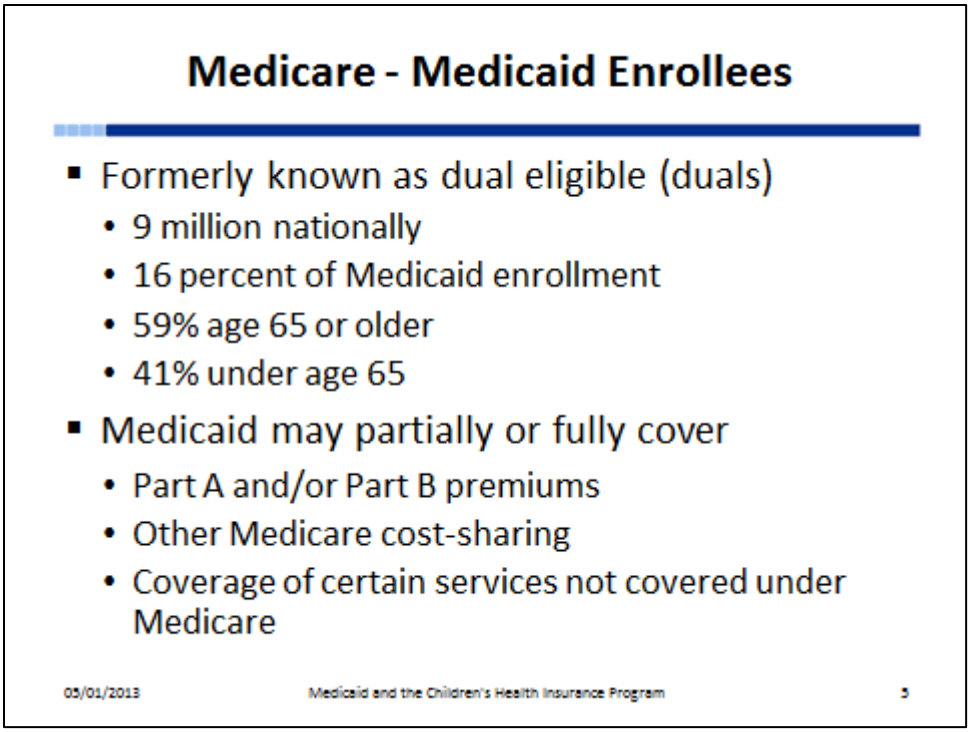
*Entitlement - a Government program that guarantees certain benefits to a particular group or segment of the population.

**NOTE:** Medicaid is not a cash support program but rather pays medical providers directly for your care.




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 income, resources, and non-financial requirements such as belonging to one of the eligibility groups.
- 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).




People who are enrolled in both Medicare and Medicaid were formerly known as dual eligible.

There are approximately 9 million low-income elderly and disabled individuals who are both Medicare and Medicaid eligible. They comprise 16 % of Medicaid enrollment - 59% are age 65 or older, and 41% are under age 65.

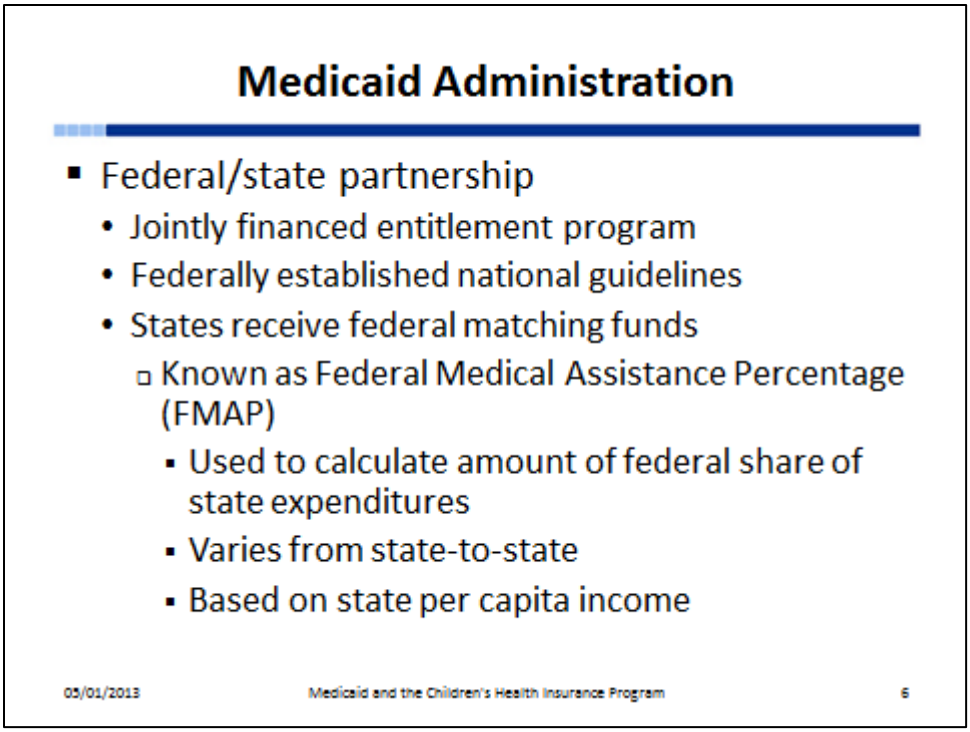
Medicare covers their acute care services, while Medicaid covers Medicare premiums and cost sharing. For those below certain income and asset thresholds, Medicaid also covers their long-term care services. People who are enrolled in both Medicare and Medicaid may receive:

- Payment by Medicaid of Part A and/or Part B premiums, and sometimes other Medicare cost-sharing like Part A and Part B deductible, coinsurance, and/or copayment.
- Medicaid coverage of certain services not covered under Medicare.



**Need More Information?**

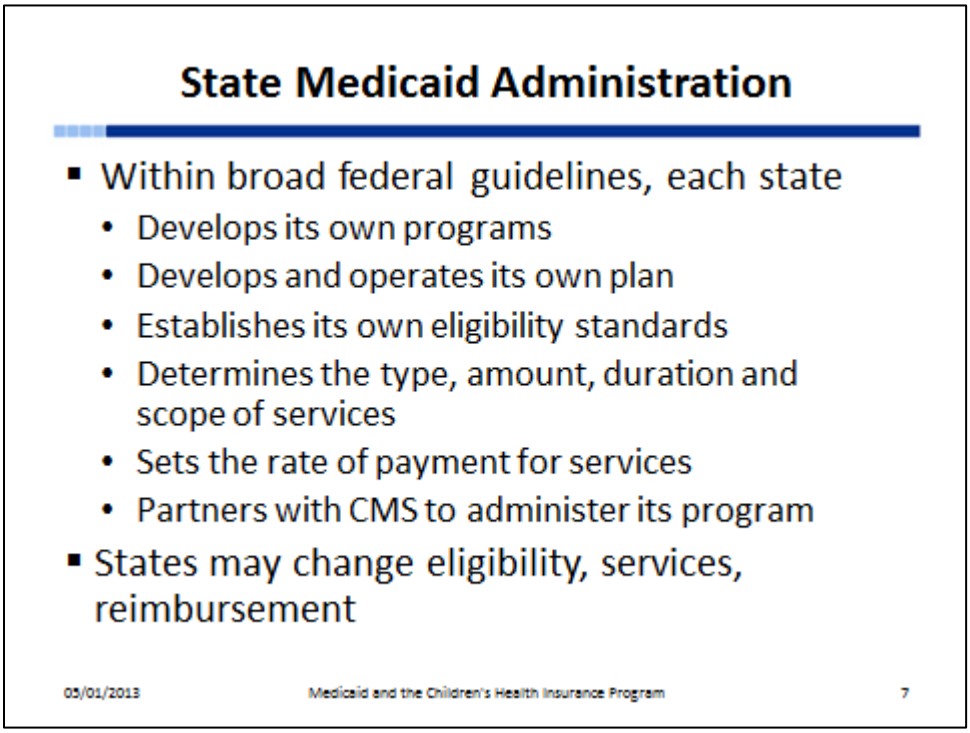
Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) at a Glance fact sheet is available at the Medicare Learning Network product downloads (ICN 006977 January 2012).



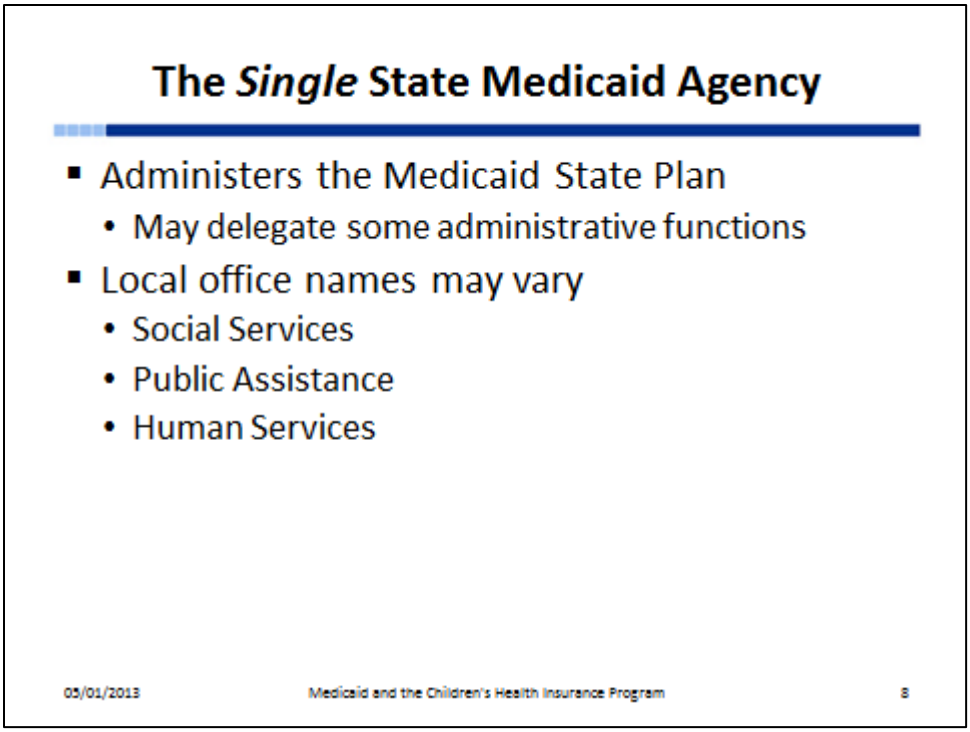

Medicaid is a joint federal/state partnership program with federally established national guidelines.

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.




- 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 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 agency"* is strictly a statutory (legal) concept that defines responsibility for administration of the Medicaid State Plan. The single state agency is not 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, and Human Services depending on where you live.



**Need More Information?**

For more information about eligibility requirements in your state, you may contact the Medicaid Director in your state. To apply for Medicaid, you'll need to contact your local Medical Assistance office.

For more information you may also visit: http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html.

## Check Your Knowledge – Lesson 1

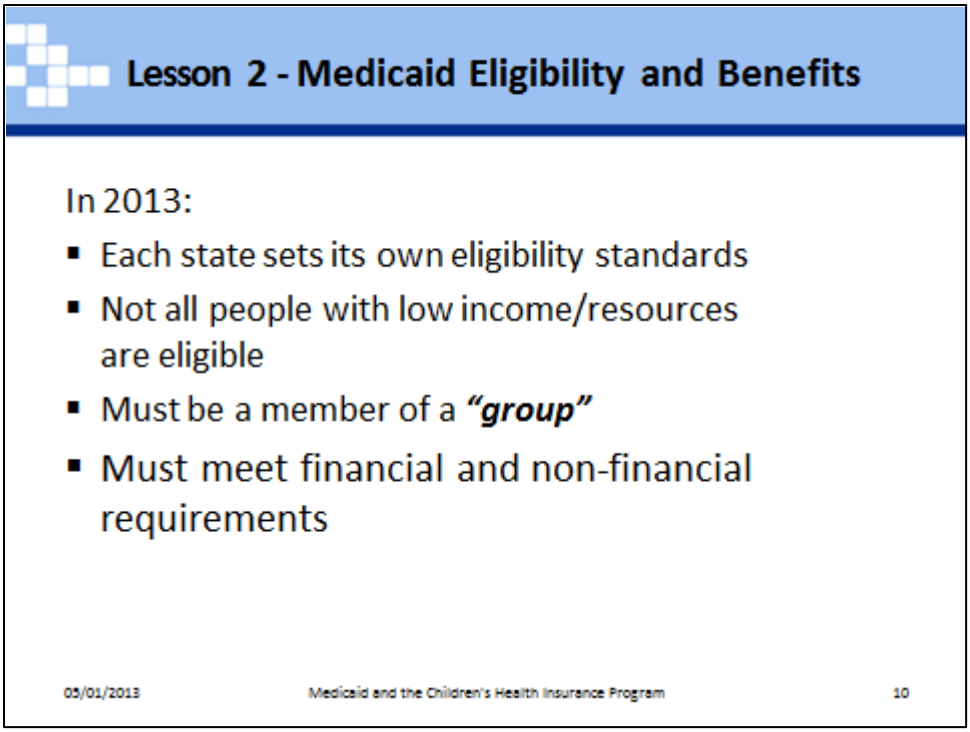
Answer the following question:

Medicaid is administered by state governments within state rules.

a. True
b. False

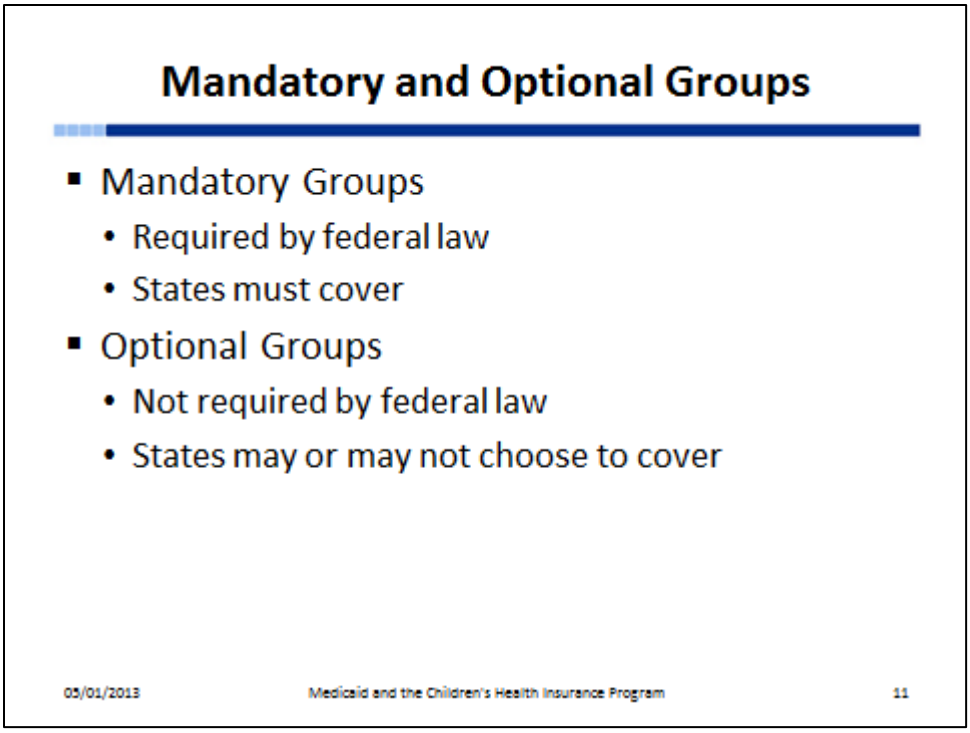


Refer to page 61 to check your answers.



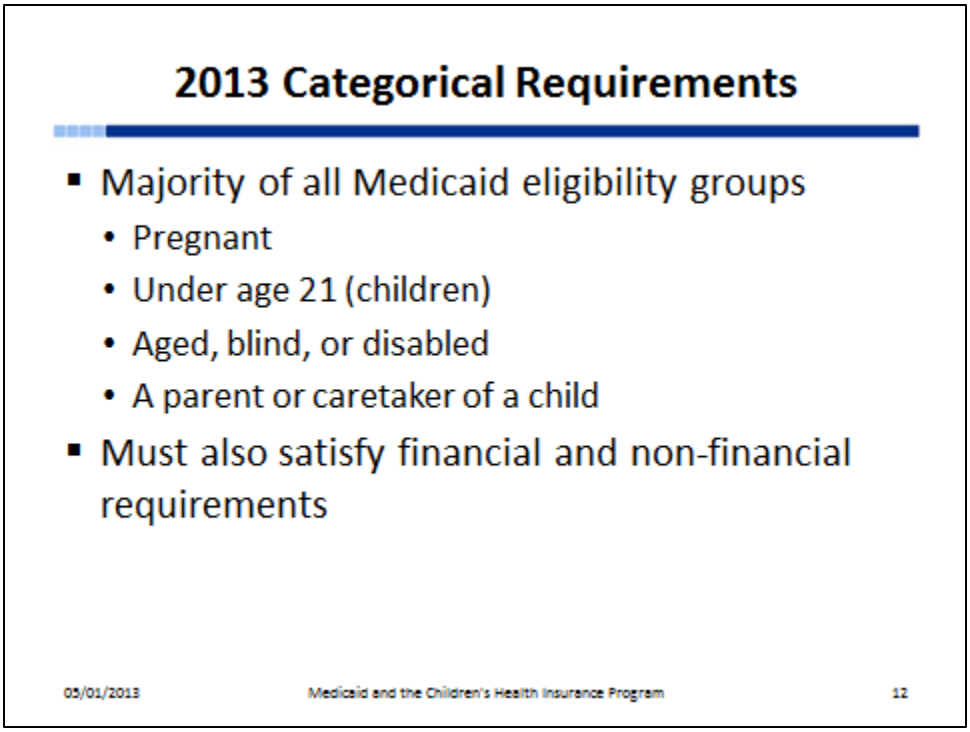

This section explains Medicaid eligibility and benefits. We will discuss who is eligible in 2013. In addition we will review mandatory and optional benefits and then discuss the newly eligible "adult group" for 2014.

In 2013, each state still sets its own eligibility standards and determines the scope of benefits provided to Medicaid beneficiaries, within federal guidelines. Not all people with low income/resources are eligible for Medicaid. To be eligible for Medicaid you must be a member of a *"group."* Individuals who fall into certain categories or categorical "groups'' are eligible for Medicaid, including low-income children, pregnant women, parents and other caretaker relatives, seniors, and people with disabilities. There are also other non-financial requirements and financial requirements that must be met.




There are mandatory groups and optional groups:

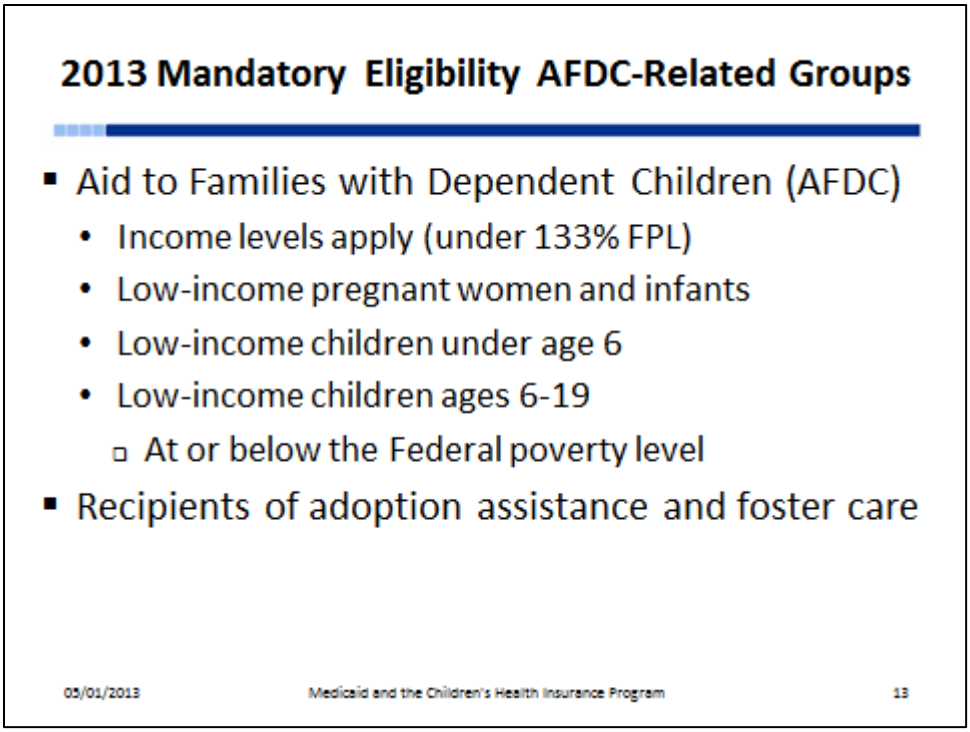
- Mandatory groups are those that federal law requires states to cover.
- Optional groups are those that federal law does not require to be covered by states, but that states may choose to cover.




The majority of all Medicaid eligibility groups consist of the following individuals:

- Pregnant women
- People under age 21 (children)
- People who are aged, blind, or disabled
- A parent or caretaker of a child

To qualify you must also satisfy financial and non-financial requirements.

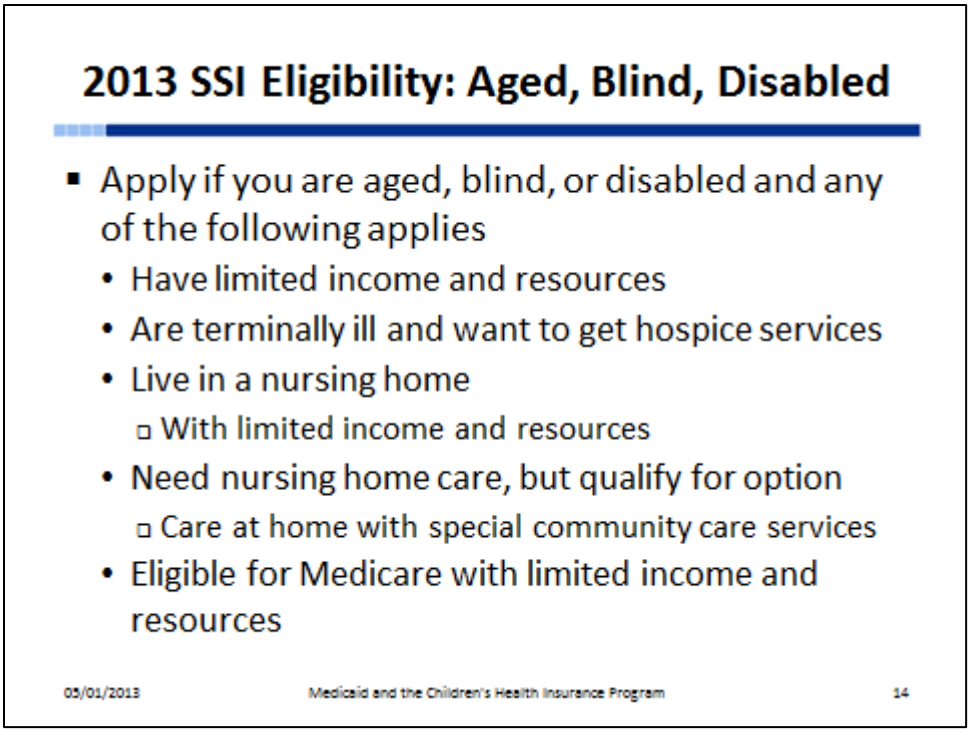



Aid to Families with Dependent Children (AFDC)-Related Groups consist of pregnant women and children under age 6, whose family income is at or below 133% of the Federal poverty level; children age 6 to age 19, in families with incomes at or below the Federal poverty level; and recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.

(An example of 133% for a family of 4 is $31,322, for an individual it is $15,282 in 2013). The minimum mandatory income level for pregnant women and infants in certain states may be higher than 133% percent if, as of certain dates, the state had established a higher percentage for covering those groups.

You should apply for Medicaid if you think you are pregnant. You can be covered whether you are married or single, and both you and your child will be covered. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income. Infant eligibility must continue throughout the first year of life so long as the infant remains in the mother's household and she remains eligible, or would be eligible if she was still pregnant.

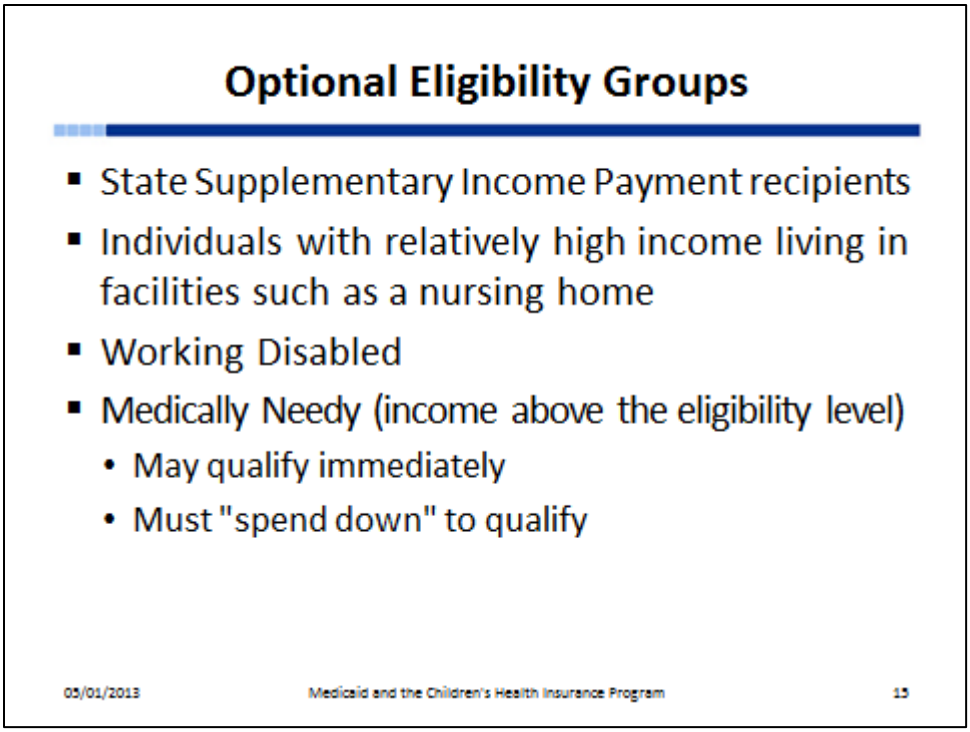
**NOTE:** The AFDC program was replaced with the Temporary Assistance for Needy Families (TANF program in 1997, but worked almost the same way as the SSI program, but for children, families with dependent children, and pregnant women. Because AFDC was the most closely related cash assistance program for this population, AFDC rules are used to establish Medicaid eligibility for AFDC-related groups (children, families with children, and pregnant women).




Eligibility is based on cash assistance programs. The SSI (Supplemental Security Income) program provides cash benefits to aged, blind or disabled people. It is a means-tested program that has specific rules, requirements, and processes for determining eligibility. Because it is the most closely related cash assistance program for this population, SSI program rules are used to establish Medicaid eligibility for SSI-related groups (persons who are aged, blind or disabled).

Apply if you are aged (65 years old or older), blind, or disabled and any one of the following applies:

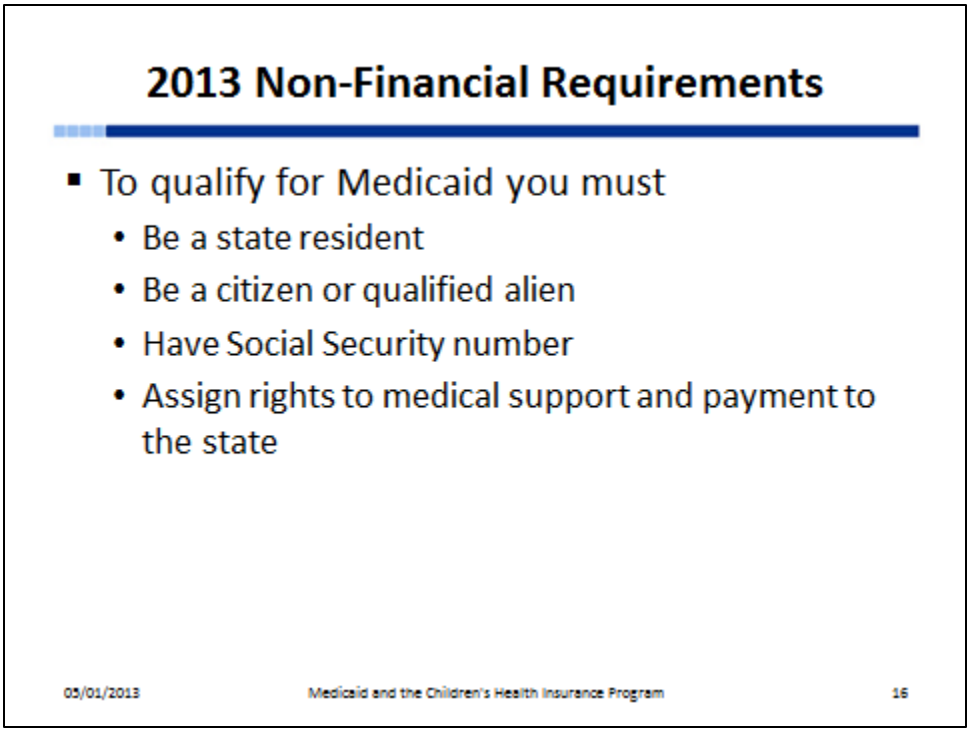
- You have limited income and resources
- You are terminally ill and want to get hospice services
- You live in a nursing home and have limited income and resources
- You need nursing home care, but qualify for care at home with special community care services
- You are eligible for Medicare and have limited income and resources




Optional groups are those that federal law does not require to be covered by states, but that states may choose to cover.

The broadest optional groups for which states will receive federal matching funds for coverage under the Medicaid program include the following:

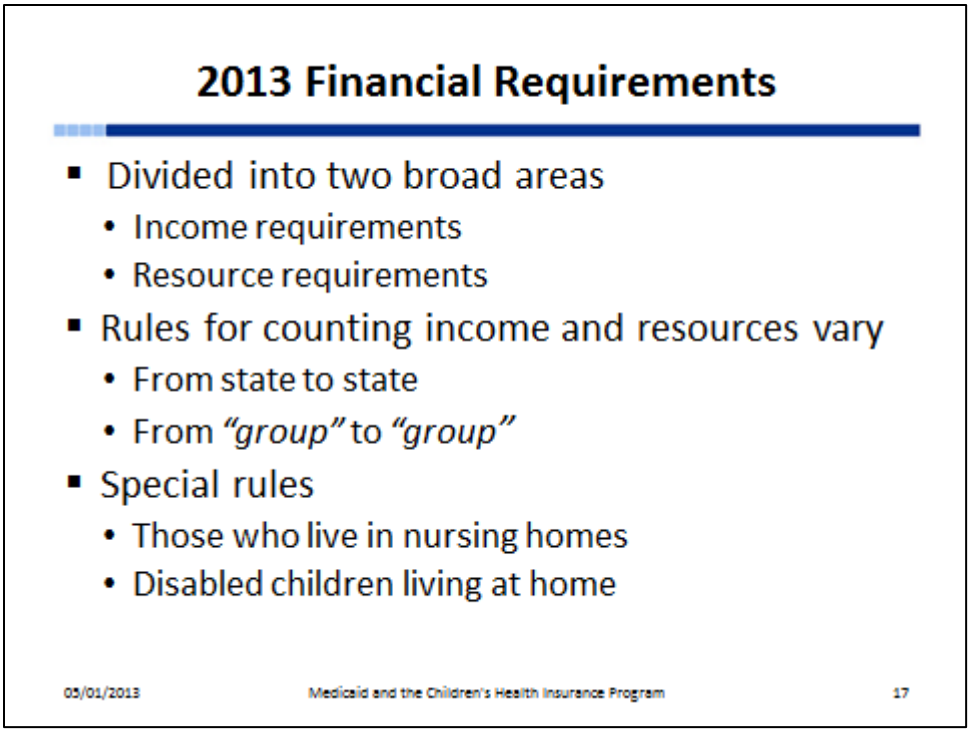
- Recipients of state supplementary income (SSI) payments. This program is the state program which augments SSI. The benefits are usually in the form of cash assistance.
- Individuals with relatively high incomes living in facilities such as a nursing home (up to 300% of the Supplemental Security Income federal benefit rate, which is $2,130 a month in 2013 ($710 x 3)).
- The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) created two new eligibility groups for working disabled individuals. Both are optional for the states, and both went into effect October 1, 2000.
- The medically-needy group is an optional group consisting of individuals who would be eligible for Medicaid, except that their income is above a level that would otherwise make them eligible for Medicaid. This can provide access to Medicaid coverage for individuals with recurring drug and medical expenses that are high in relation to their monthly income.
    - Individuals must "spend down" to qualify. Some people have too much income to qualify for Medicaid. This amount is called excess income. Some of these people may qualify for Medicaid if they spend the excess income on medical bills. This is called a spend down.




Non-financial requirements include:

- You must be a state resident
- You must be a citizen or qualified alien
- You must have a Social Security number

If parents or other adults apply for Medicaid on behalf of themselves and their children, they must assign medical support and payment rights to the states and cooperate in establishing paternity, obtaining medical support and payments, and providing information about liable third parties as a condition of their own eligibility, unless they are exempt.

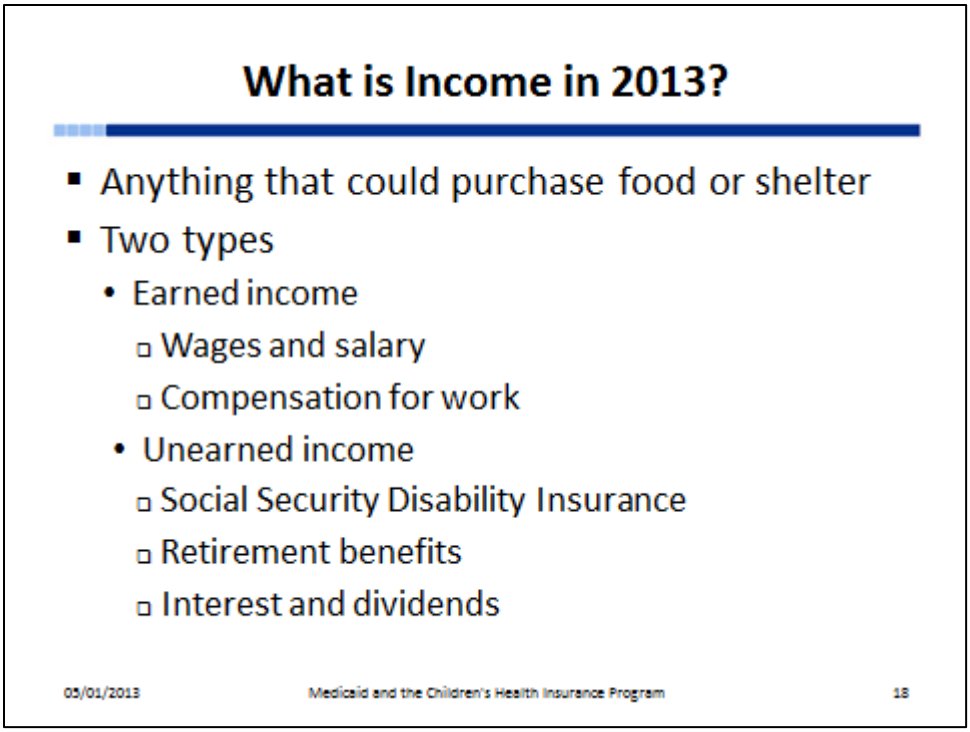



The financial requirements are divided into two broad areas:

- Income requirements
- Resource requirements

The rules for counting your income and resources vary from state to state and from *"group"* to *"group."*

There are special rules for those who live in nursing homes and for disabled children living at home.

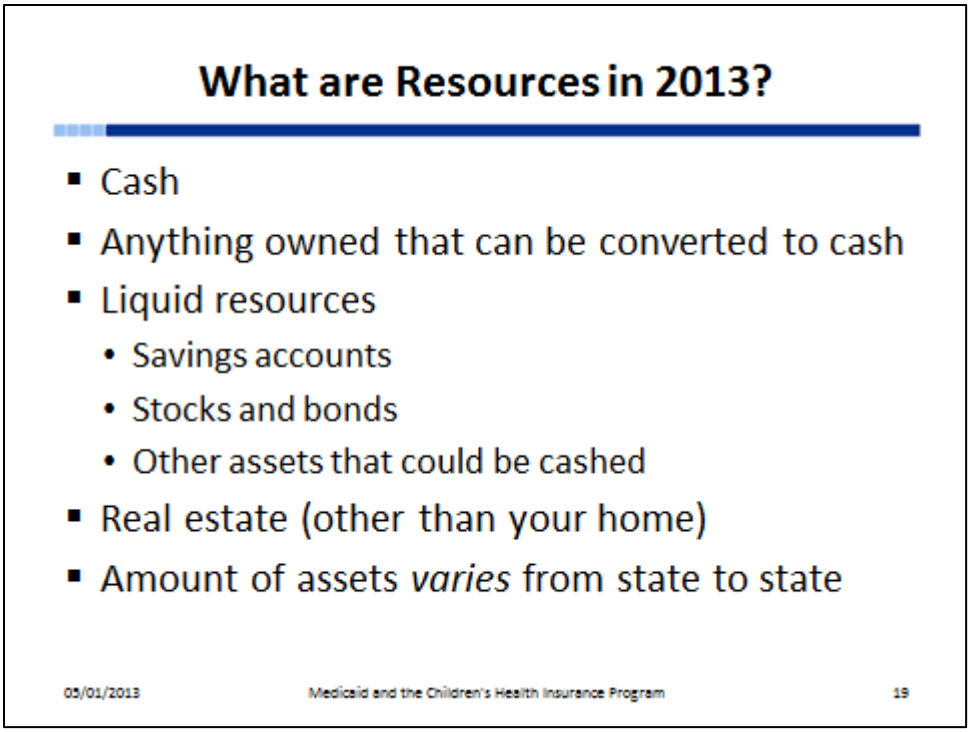



Income is anything that you could use to purchase food or shelter.

There are two types of income:

- Earned income, such as wages, salary, or any compensation for work
- Unearned income, such as Social Security Disability Insurance (SSDI), retirement benefits, and interest and dividends

**NOTE:** Most states still have some form of "income disregards" where they don't count such things as food stamps, the actuarial value of subsidized housing, some child support, and others when calculating eligibility for Medicaid. That will change in 2014.

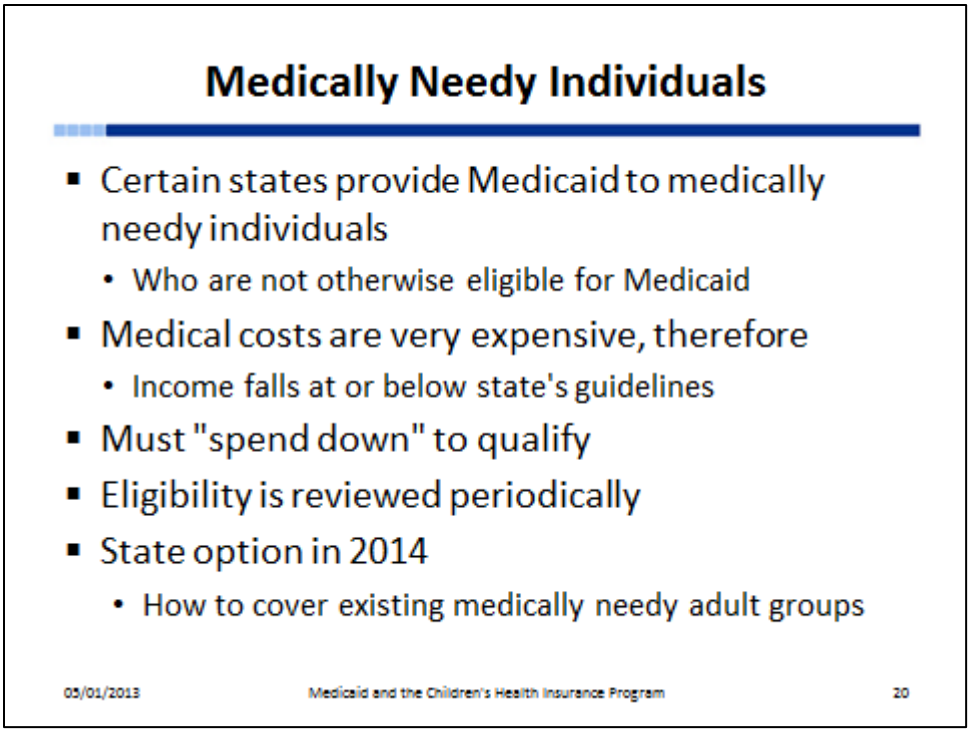



The amount of income varies by state, but is generally set at the Federal Poverty Level. The following are considered resources:

- Cash
- Anything you own that can be converted to cash
- Liquid resources like savings accounts, stocks, bonds, or anything that could be cashed
- Real estate you own, other than your home

The amount of assets you can have and still qualify for Medicaid *varies* from state to state. Assets that generally do *not* get counted for eligibility include the following:

- Your primary residence
- Your personal belongings
- One motor vehicle
- Property that is essential to self-support
- Life insurance with a face value under $1,500
- Certain burial arrangements
- Assets held in specific kinds of trusts

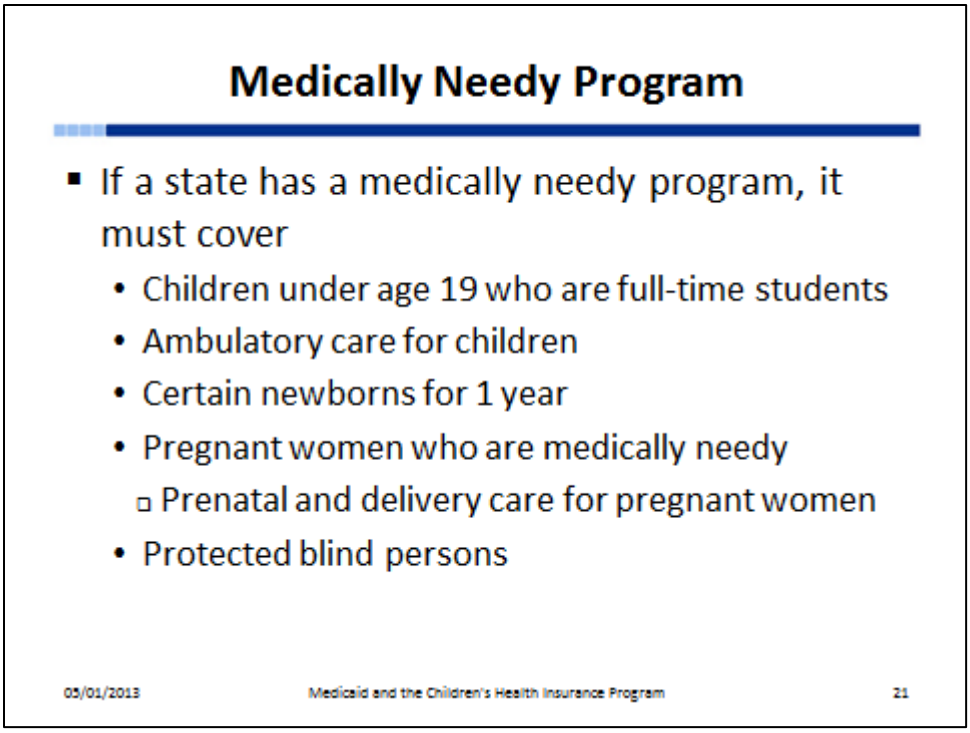



Certain states provide Medicaid to medically needy individuals who are not otherwise eligible for Medicaid. More than 30 states plus the District of Columbia currently operate medically needy programs.

If you have been denied Medicaid coverage because your income is too high, you might qualify as a "medically needy" individual based on your income and health status.

- Medically needy means someone whose medical expenses, once paid, bring that person's income to at or below the state's Medicaid income guidelines.
- Must “spend down” to qualify.
- Medically needy eligibility is reviewed periodically unlike regular Medicaid.

**NOTE:** States have the option to discontinue coverage under medically needy groups for *adults* (e.g., disabled individuals with income above the standard for categorical eligibility) in 2014, subject to Maintenance of Effort SSA §1902(gg). In states that continue to cover existing medically needy adult groups, adults who meet the categorical eligibility and resource requirements will have the ability to spend down to the medically needy income standard and receive the benefits covered for medically needy individuals in the states, or to enroll in the adult group (provided they meet the eligibility requirements for that group, including being under 65 and not eligible for Medicare).



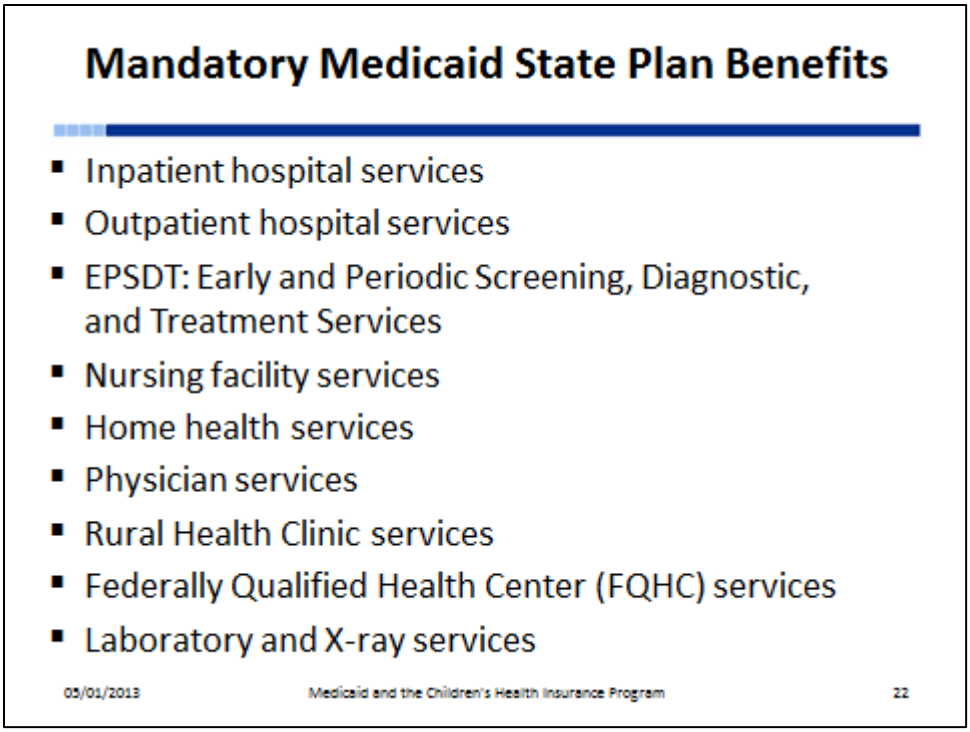

If a state elects to have a medically needy program, there are federal requirements that certain groups and certain services must be included. At present, if a state has a medically needy program it must cover the following:

- Children under age 19 who are full-time students
- Ambulatory care for children
- Certain newborns for 1 year
- Pregnant women who are medically needy
- Prenatal and delivery care for pregnant women
- Protected blind persons (those eligible as medically needy under Medicaid in December 1973 on the basis of the blindness or disability criteria and meet the current requirements for eligibility as medically needy under Medicaid except for blindness or disability criteria)

**NOTE:** The following states have medically needy programs:

Arkansas, Hawaii, Maine, Nebraska, Pennsylvania, Vermont, California, Illinois, Maryland, New Hampshire, Puerto Rico, Virginia, Connecticut, Iowa, Massachusetts, New Jersey, Rhode Island, Washington, Dist. of Columbia, Kansas, Michigan, New York, Tennessee, West Virginia, Florida, Kentucky, Minnesota, North Carolina, Texas*, Wisconsin, Georgia, Louisiana, Montana, North Dakota, and Utah.

*The medically needy program in Texas covers only the “mandatory" medically needy groups. It does not cover the aged, blind and disabled.




Some Medicaid state plan benefits are mandatory (must be covered by the state); some are optional (state may choose to cover).

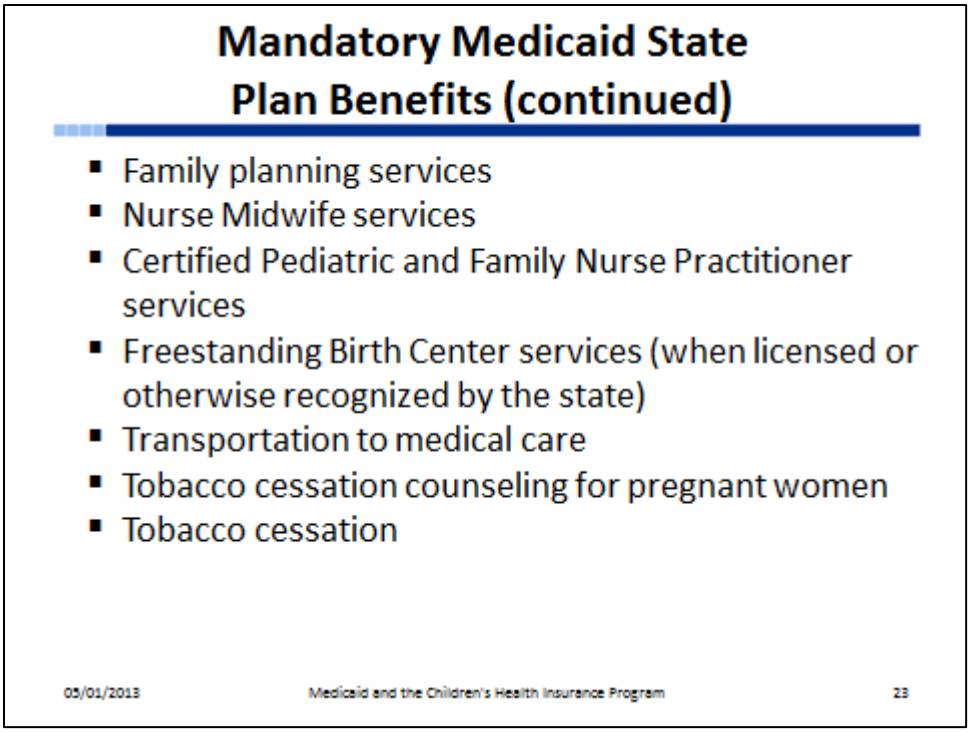
The MANDATORY benefits include:

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

Continued on the next slide.

**Need More Information?**

For more information you may also visit:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html

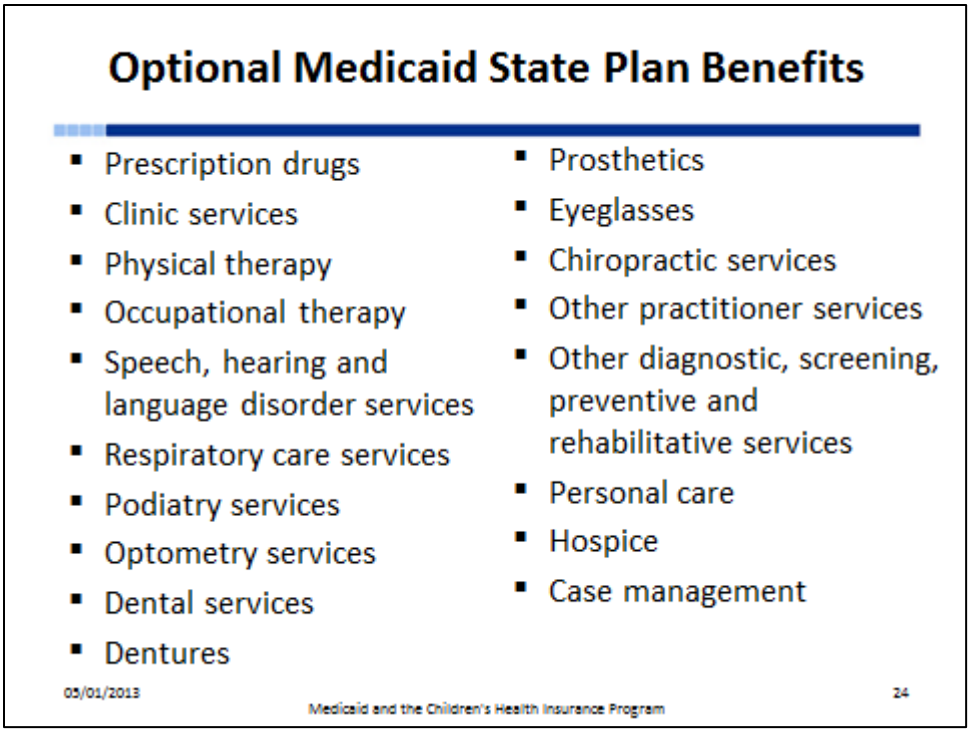



The MANDATORY benefits include (continued):

- 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

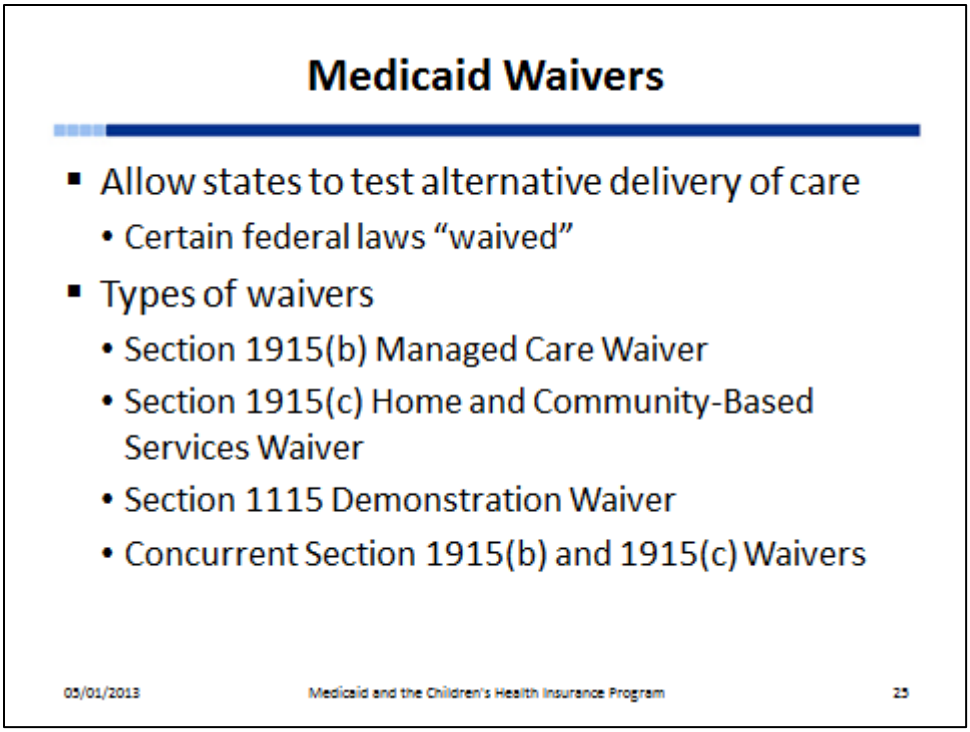
**Need More Information?**

For more information you may also visit:
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html




Optional Medicaid state plan benefits:

- Prescription drug programs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Podiatry services
- Optometry services
- Dental services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Other diagnostic, screening, preventive and rehabilitative services
- Personal care
- Hospice
- Case management




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 & 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, please visit: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html

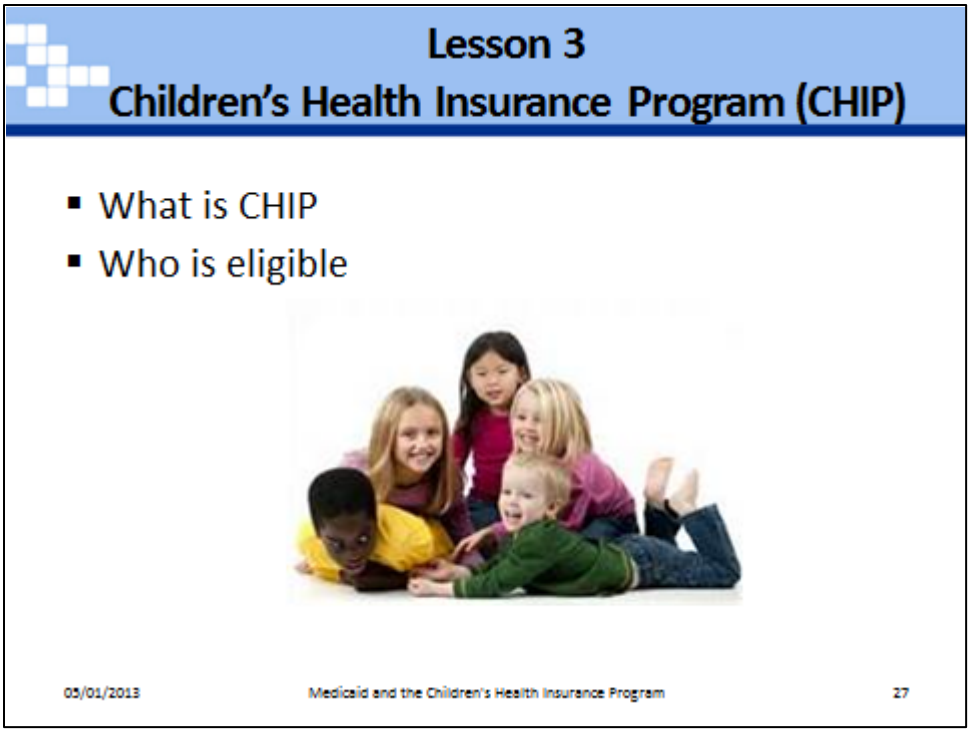
## Check Your Knowledge – Lesson 2

Answer the following question:

Which program (available in some states) considers medical expenses in determining eligibility? Applicants may "spend down" to attain eligibility.

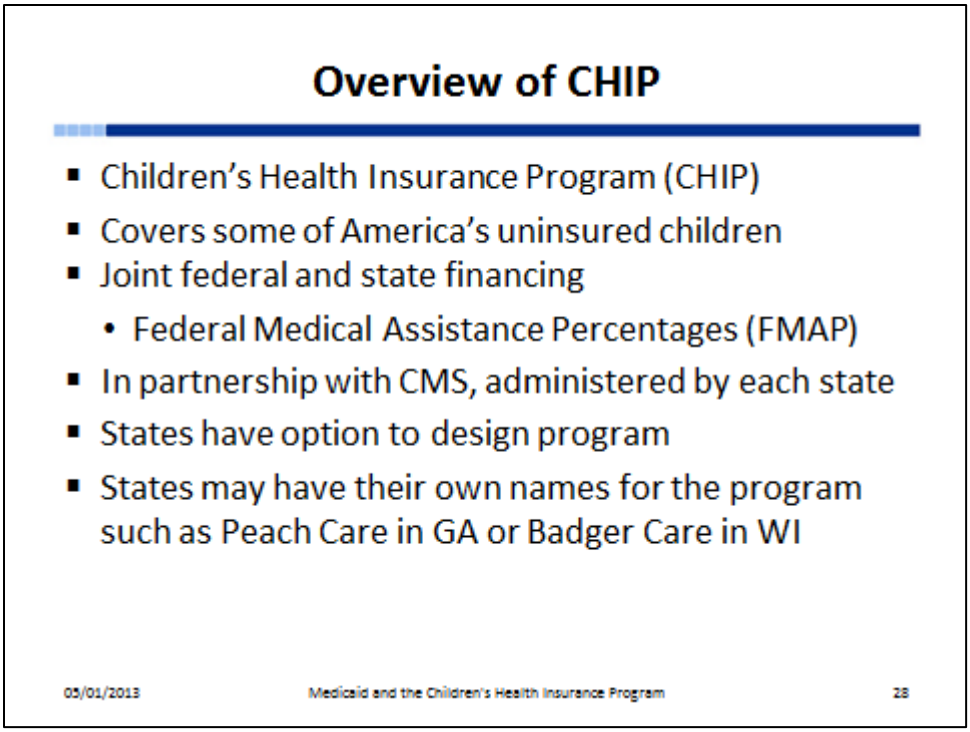
a. Medically Needy
b. Categorically Needy
c. Working Disabled
d. State Supplementary Income Payments

Refer to page 61 to check your answers.




This section explains the Children's Health Insurance Program (CHIP).

- What is CHIP?
- Who is eligible?

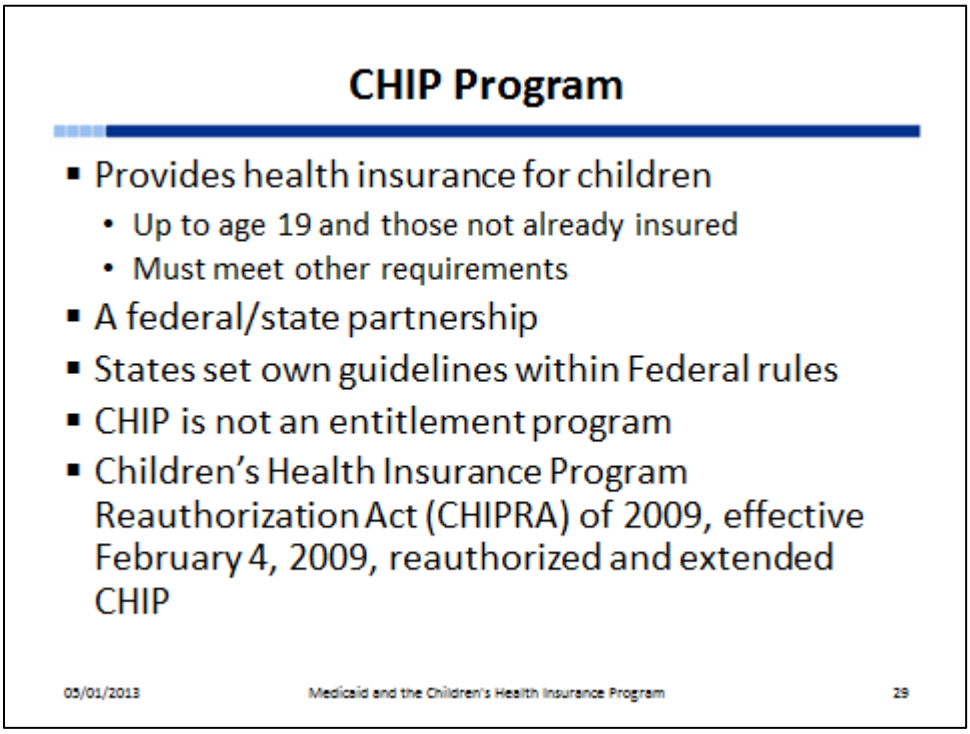



CHIP was signed into law in 1997 as part of the Balanced Budget Act as the Children's Health Insurance Program (CHIP). It is under Title XXI (21) of the Social Security Act. The Children's Health Insurance Program (CHIP) was created with strong, bi-partisan support for covering America's uninsured children. This was the largest expansion of public health insurance coverage since the creation of Medicare and Medicaid in 1965.

- CHIP is jointly financed by the federal and state governments and is administered by the states.
  - The "*Enhanced* Federal Medical Assistance Percentages" are for the Children's Health Insurance Program (CHIP) under Title XXI (21) of the Social Security Act.
- In partnership with CMS, each state administers its own program and determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. Each state has the option to expand Medicaid, create a stand-alone program, or create a combination program.
- States may have their own names for the program such as Peach Care in GA or Badger Care in WI.

**Need More Information?**

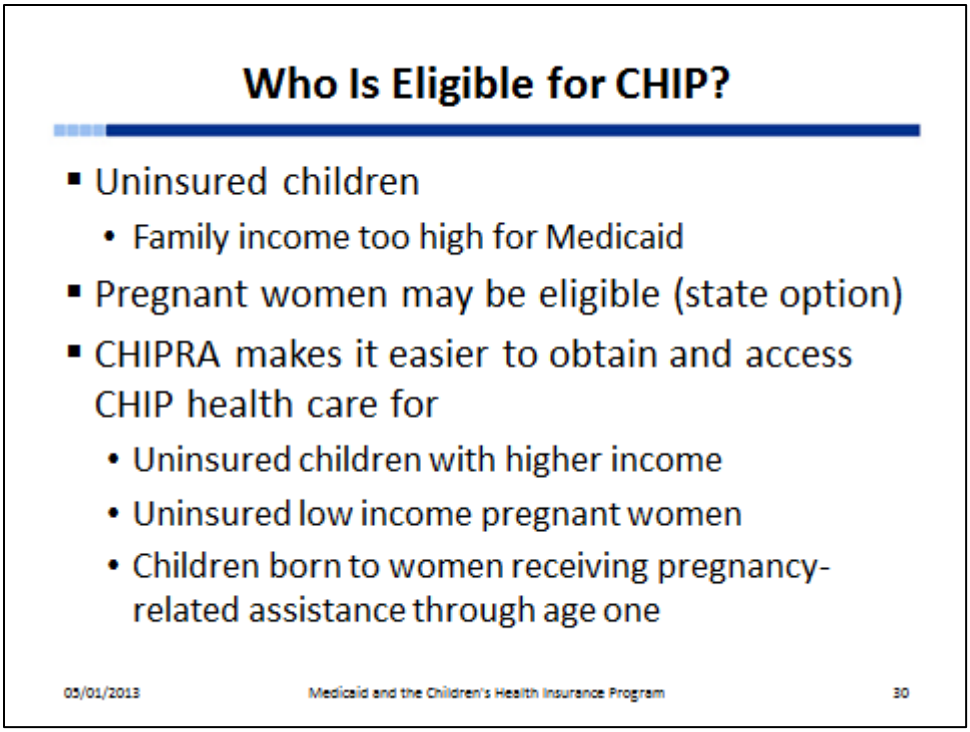
More information on CHIP is available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/CHIPRA.html




Children's Health Insurance Programs (CHIP) serve low-income, uninsured children in families who earn too much to qualify for Medicaid, but don't have private insurance coverage because they can't afford to purchase it or because their employer doesn't offer it. The program gives each state authority to provide health insurance for children, up to age 19, who are not already insured (within limitations) and who meet other requirements.

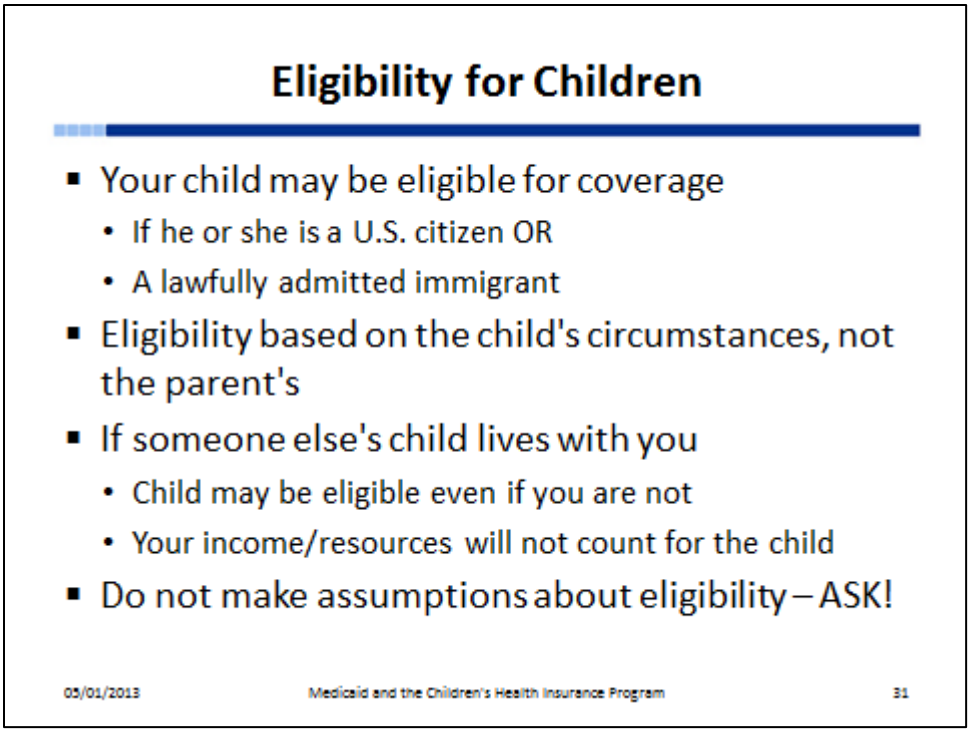
- CHIP is a partnership with the states who administer their program within the federal guidelines. Because each state sets its own guidelines, there is not one nationwide SCHIP/CHIP program but all must meet certain federal parameters.
- Unlike Medicaid, CHIP has never been an entitlement* program. CHIPRA or ACA does not change that status.
- Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 effective February 4, 2009, reauthorized and extended CHIP.

*Entitlement - A Government program that guarantees certain benefits to a particular group or segment of the population.




Who Is Eligible for CHIP?

- Uninsured children under age 19
  - Family income that is too high for Medicaid may be eligible for CHIP - up to 200% FPL or 50% higher than Medicaid level as of June 1, 1997, for age of child (many states go higher).
- Pregnant women may be eligible
  - CHIPRA gives states the option to provide coverage to targeted low-income pregnant women under the CHIP State plan if certain conditions are met. Infants born to these women are automatically eligible for Medicaid or CHIP, through age one. States may choose to apply presumptive eligibility to these pregnant women under CHIP.
- The CHIPRA legislation makes it easier for certain groups to obtain and access CHIP health care. These include:
  - Uninsured children with higher income
  - Uninsured low income pregnant women
  - Automatic enrollment in Medicaid or CHIP for children until age one born to women receiving pregnancy-related assistance



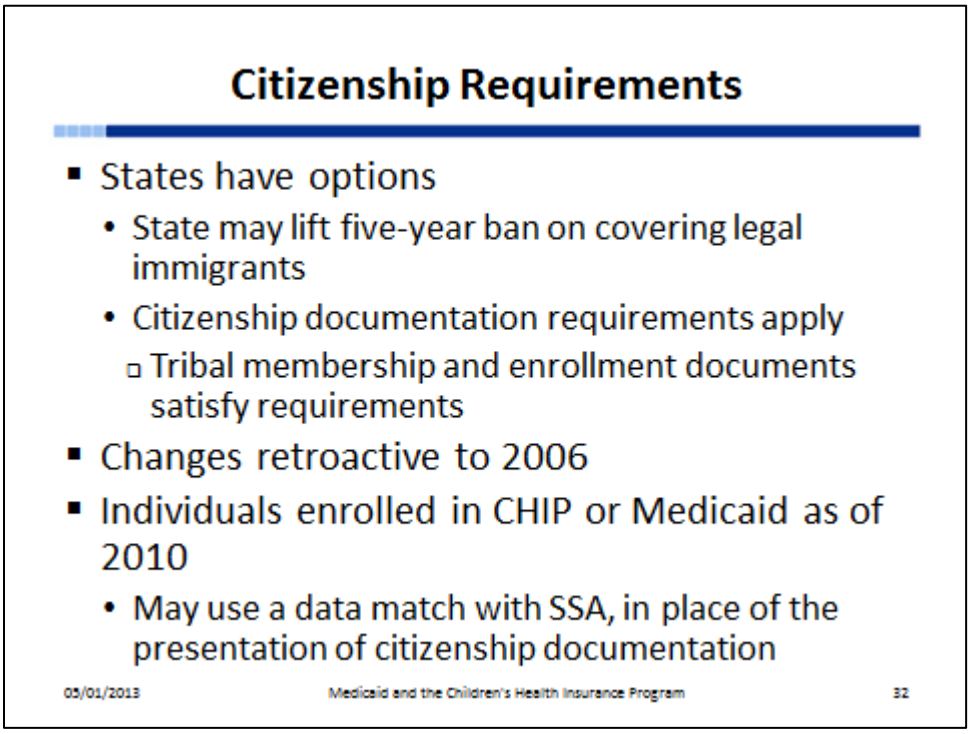

Your child may be eligible for coverage if he or she is a U.S. citizen or a lawfully admitted immigrant, even if you are not (however, there is a 5-year limit that applies to lawful permanent residents). There may be exceptions in some states.

Eligibility for children is based on the child's circumstances, not the parent's status.

If you are caring for someone else's child who lives with you, the child may be eligible even if you are not because your income and resources will not count for the child.

- Apply for Medicaid if you are the parent or guardian of a child who is 18 years old or younger and your family's income is limited, or if your child is sick enough to need nursing home care, but could stay home with good quality care at home.
- If you are a teenager living on your own, the state may allow you to apply for Medicaid on your own behalf or any adult may apply for you.
- Many states also cover children up to age 21.

Do not assume the child is not eligible – ASK!

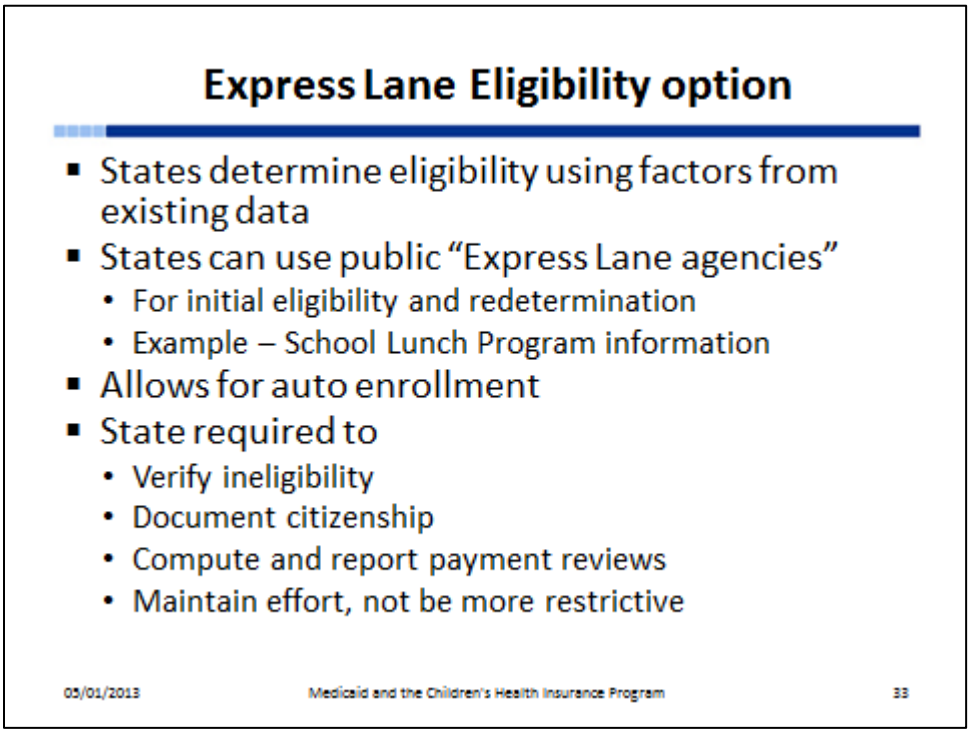



States have the option to use or not use the 5 year restriction for citizenship in cases of pregnant women and children. As of 2011, twenty-three states and the District of Columbia now offer coverage to lawfully residing immigrant children and/or pregnant women without a five-year waiting period.

Effective July 1, 2006, the Deficit Reduction Act created a new section 1903(x) of the Act which requires states to obtain satisfactory documentary evidence of citizenship or nationality when enrolling individuals in Medicaid or at the first point of eligibility redetermination. 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.

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 Administration (SSA) to confirm the consistency of a declaration of citizenship with SSA records, in lieu of the presentation of citizenship documentation.



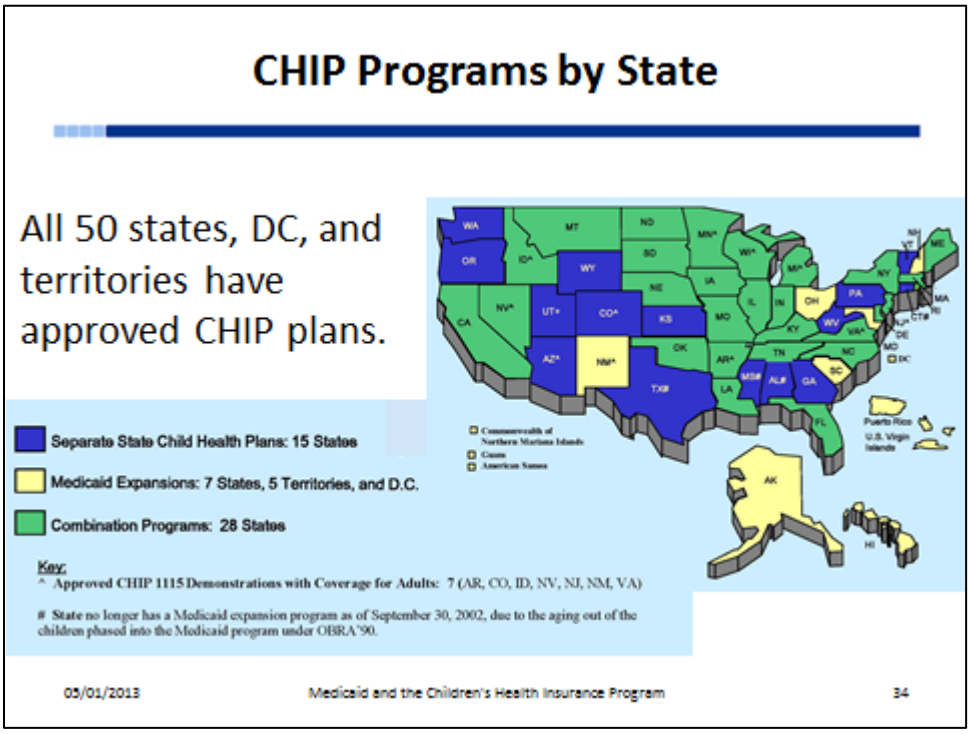

Express Lane agencies are entities identified in the state plan by the state Medicaid or CHIP agency as being capable of making a finding regarding one or more programmatic eligibility requirements, using information the Express Lane agencies already collect. A state's Medicaid and CHIP programs may use different Express Lane agencies and may select more than one agency. Express Lane Eligibility permits states to rely on findings, for things like income, household size, or other factors of eligibility from another program designated as an Express Lane agency to facilitate enrollment in health coverage. Express Lane agencies may include: Supplemental Nutrition Assistance Program (SNAP), School Lunch, Temporary Assistance for Needy Families (TANF), Head Start, and Women, Infants, and Children (WIC) among others. A state may also use information from state income tax data to identify children in families that might qualify so that families do not have to submit income information.

CHIPRA also allows for the option to auto enroll without a signature or application form. The child's parent or guardian must consent to enrollment. States are required to:

- Verify ineligibility (check the accuracy of the information provided to the Express Lane agency)
- Document citizenship (still required)
- Compute and report payment reviews
- Maintenance of Effort - states may not adopt eligibility standards and methodologies that are more restrictive than those in effect as of March 23, 2010

For more information visit: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Outreach-and-Enrollment/Express-Lane-Eligibility.html or

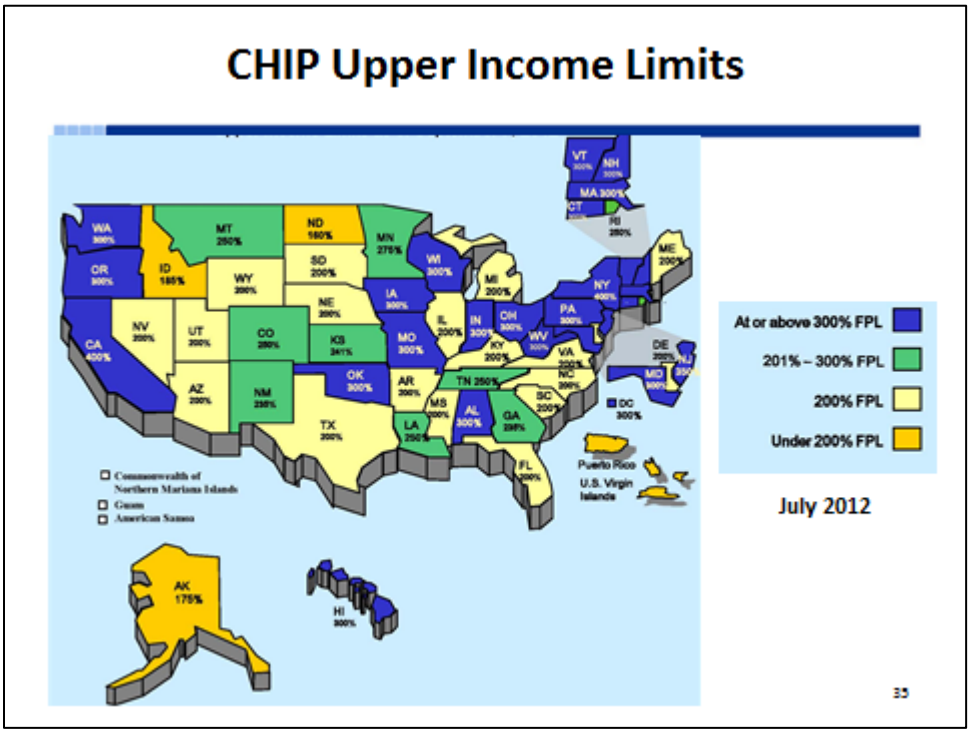
http://www.insurekidsnow.gov/professionals/eligibility/express_lane.html




This chart shows the design of the CHIP programs chosen by each state and the U.S. Territories as of January, 2013. All 50 states, DC, and territories have approved CHIP plans. States can design their CHIP program in one of 3 ways:

1. Medicaid expansion - in the states choosing to expand their Medicaid program, CHIP enrollees are regular Medicaid enrollees and they are entitled to the full range of Medicaid-covered services
2. Separate Child Health Insurance Program - creating or expanding an entirely separate program that is a state-designed program not based on Medicaid
3. Combination of the two approaches

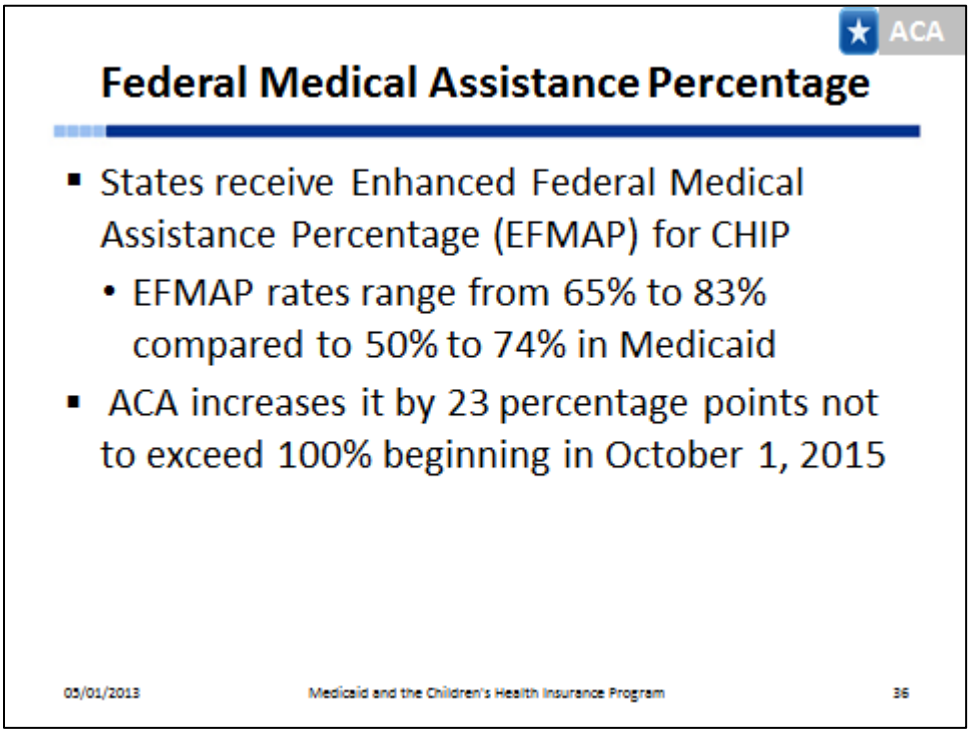
- Blue (displays dark gray in handouts) for Separate state Child Health Plan in 15 states. They include Washington, Oregon, Wyoming, Utah, Arizona, Colorado, Kansas, Texas, Mississippi, Alabama, Georgia, West Virginia, Pennsylvania, Connecticut, and Vermont.
- Yellow (displays white in handouts) for Medicaid Expansions in 7 states (New Mexico, Alaska, Ohio, South Carolina, Maryland, New Hampshire and Hawaii), 5 territories (Puerto Rico, US Virgin Islands, Guam, Marina Islands, and American Samoa), and D.C. All Medicaid state plan rules apply, including cost sharing and benefits (including EPSDT)
- Green (displays light gray in handouts) for Combination Programs in the remaining 28 states (CA, ID, MT, ND, SD, MN, IA, MO, OK, AR, LA, FL, TN, KY, IN, IL, WI, MI, VA, NC, DE, NJ, MA, RI, ME, NH, NV)



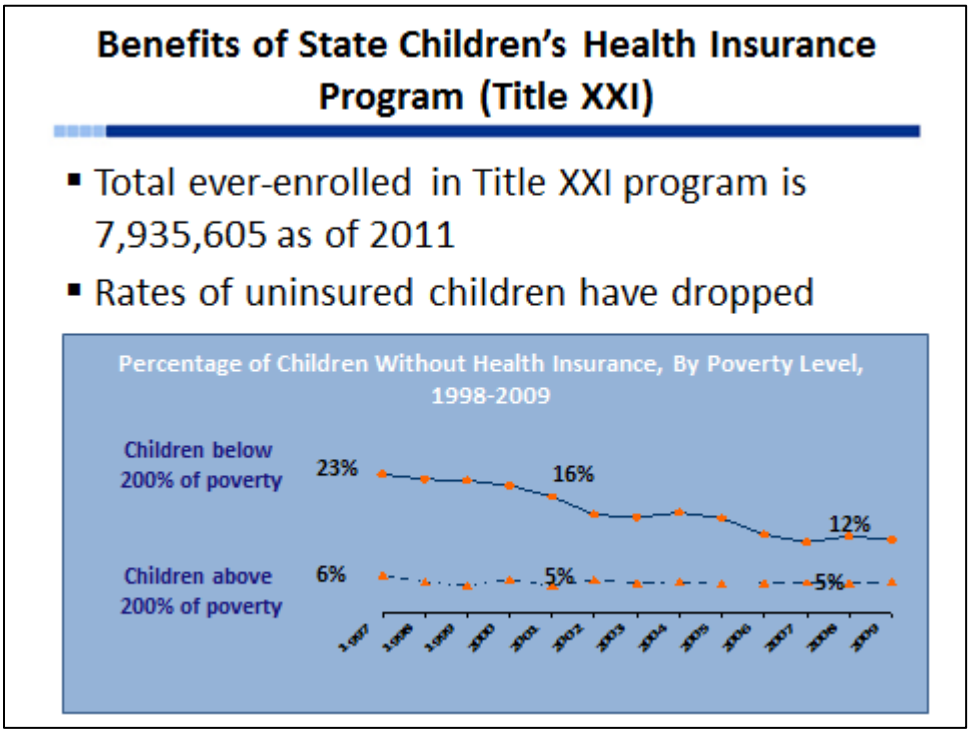

Map of CHIP Upper Income Limits by state as of July 2012 based on % of Federal Poverty Levels (FPL).

- Those states with limits at or above 300% Federal Poverty Level are shown in blue (dark gray in handouts). They include Vermont, New Hampshire, Massachusetts, Connecticut, New York, Pennsylvania, Maryland, New Jersey, Washington DC, Pennsylvania, West Virginia, Ohio, Indiana, Alabama, Missouri, Iowa, Oklahoma, Alabama, Hawaii, California, Oregon, and Washington.
- Those states with limits at or above 201-300% FPL are shown in green (medium gray in handouts). They include Montana, Minnesota, Colorado, Kansas, New Mexico, Louisiana, Georgia, and Tennessee.
- Those states with limits of 200% FPL are shown in yellow (white in handouts). They include Maine, Virginia, North Carolina, South Carolina, Florida, Kentucky, Mississippi, Arkansas, Illinois, Michigan, Texas, Nebraska, South Dakota, Wyoming, Arizona, Utah, and Nevada.
- States and territories with levels under 200% FPL are shown in gold (light gray in handouts). They include Idaho, North Dakota, Puerto Rico, US Virgin Islands and Alaska.

State-defined eligibility standards - many will change with the Health Care Law.

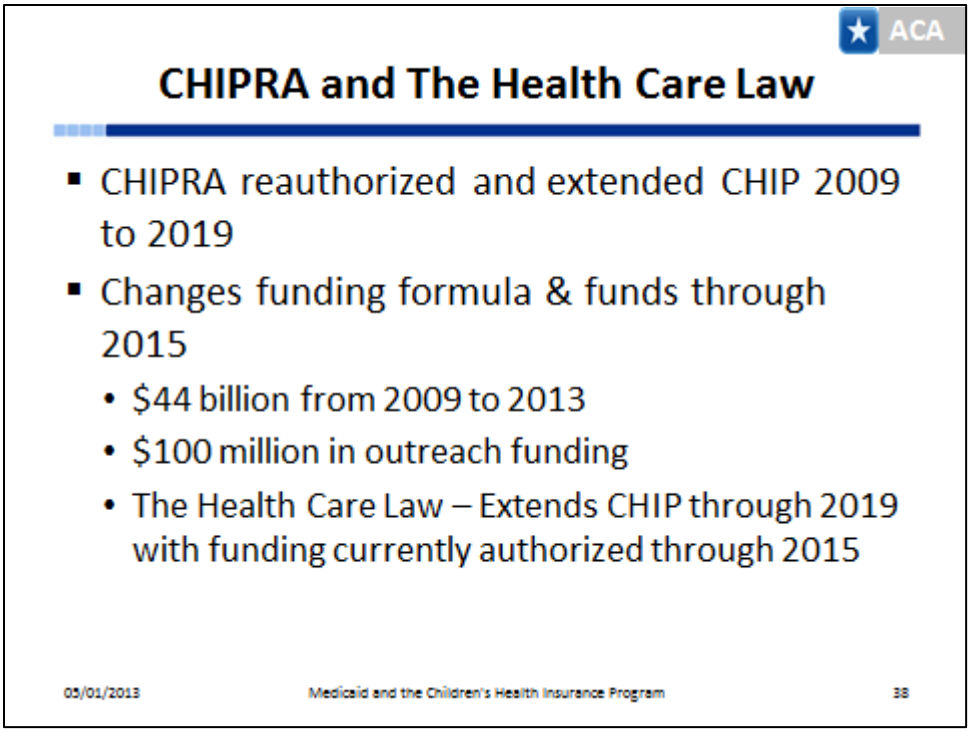



- States receive Enhanced Federal Medical Assistance Percentage (EFMAP) for CHIP.
  - EFMAP rates range from 65% to 83% compared to 50% to 74% in Medicaid.
- The enhanced FMAP for CHIP expenditures is increased by 23%, but may not exceed 100%, from October 1, 2015, through September 30, 2019, per the Health Care Law.




There are significant benefits of the CHIP program.

- Total ever-enrolled in the Social Security Title XXI - state Children's Health Insurance Program
- Rates of uninsured children have steadily dropped due to Medicaid and CHIP.




The Children's Health Insurance Program Reauthorization Act of 2009 authorized new federal funding for CHIP. CHIPRA, or the Children's Health Insurance Program Reauthorization Act, reauthorized the CHIP program effective February 4, 2009. CHIPRA is also known as Public Law (PL) 111-3.

- Reauthorized funding for CHIP to 2019
- Changes funding formula and funds through 2015
  - $44 billion from 2009 to 2013
  - CHIPRA also included a total of $100 million in outreach funding to be made available between FY 2009 and FY 2013 ($10 million-national outreach campaign, $10 million in grants Indian Tribes, health care providers serving Tribes, and $80 million in grants to execute strategies to promote enrollment and retention).
  - The Health Care Law gave authorization for extending the Children's Health Insurance Program (CHIP) through 2019. Funding is currently authorized through 2015.

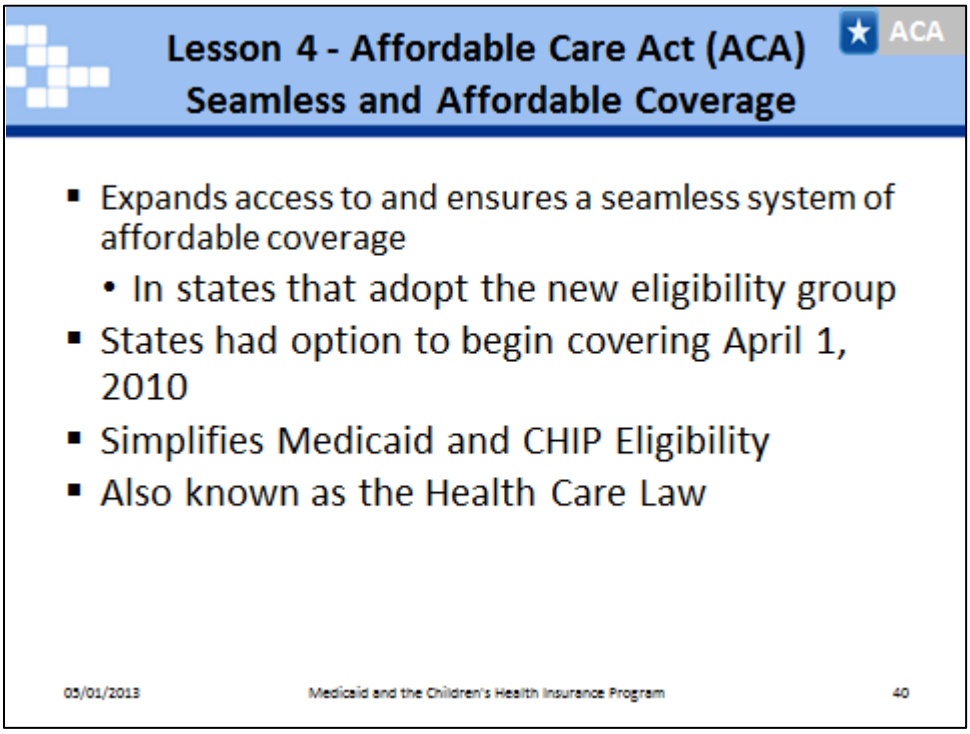
## Check Your Knowledge – Lesson 3

Answer the following question:

CHIP eligibility for children up to age 19 is based on the child's circumstances, not the parent's status.

a. True
b. False

Refer to page 61 to check your answers.



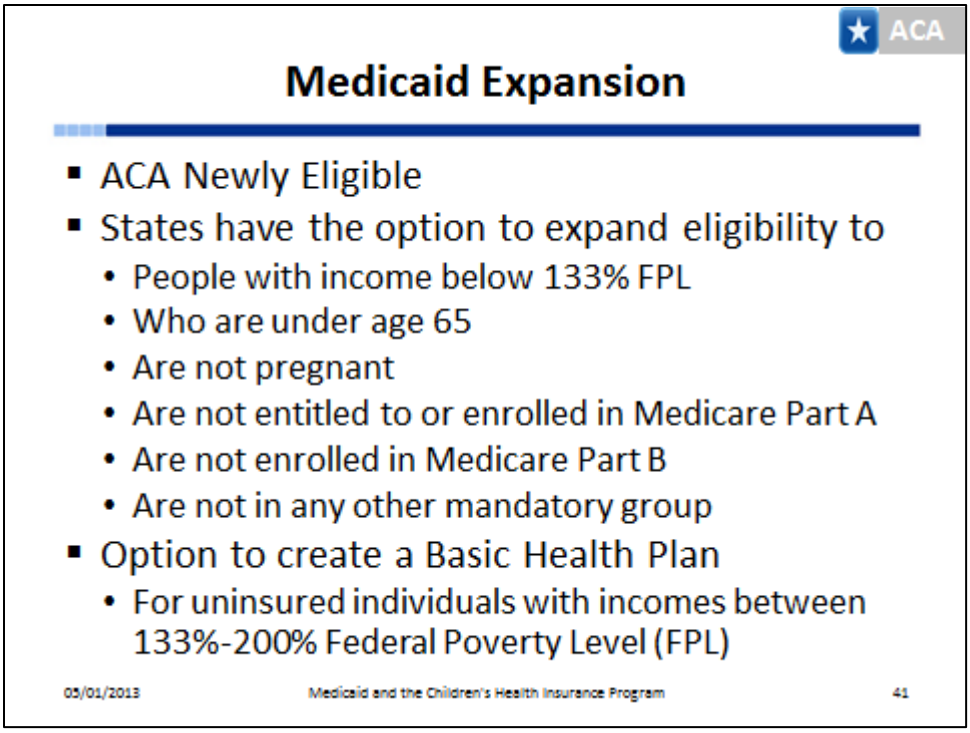

The Patient Protection and Health Care Law of 2010, amended by the Health Care and Education Reconciliation Act of 2010, are referred to collectively as the "Affordable Care Act." (ACA). It is also known as the Health Care Law.

In states that adopt the new eligibility group:

- Expand access to affordable coverage, ensures a seamless system of coverage and implements a more straightforward structure of four major eligibility groups: children, pregnant women, parents and caretaker relatives, and the new *optional* adult group not currently covered. (See chart on p. 49). In addition, people with disabilities or in need of long-term services and supports may enroll in an existing Medicaid eligibility category to ensure that they are quickly enrolled in coverage that best meets their needs.
- Can begin covering this group or to phase-in coverage of the group based on income starting April 1, 2010.
- Simplify Medicaid & CHIP eligibility and enrollment by relying on a single "Modified Adjusted Gross Income" (MAGI) standard for determining eligibility for most Medicaid and CHIP enrollees (children and non-disabled adults under age 65).

For more information on Medicaid and CHIP Affordable Care Act (ACA), please visit: http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation.html

**NOTE:** As used in this lesson, the Patient Protection and Health Care Law of 2010, amended by the Health Care and Education Reconciliation Act of 2010, are referred to collectively as the "Affordable Care Act." (ACA) or the "Health Care Law."

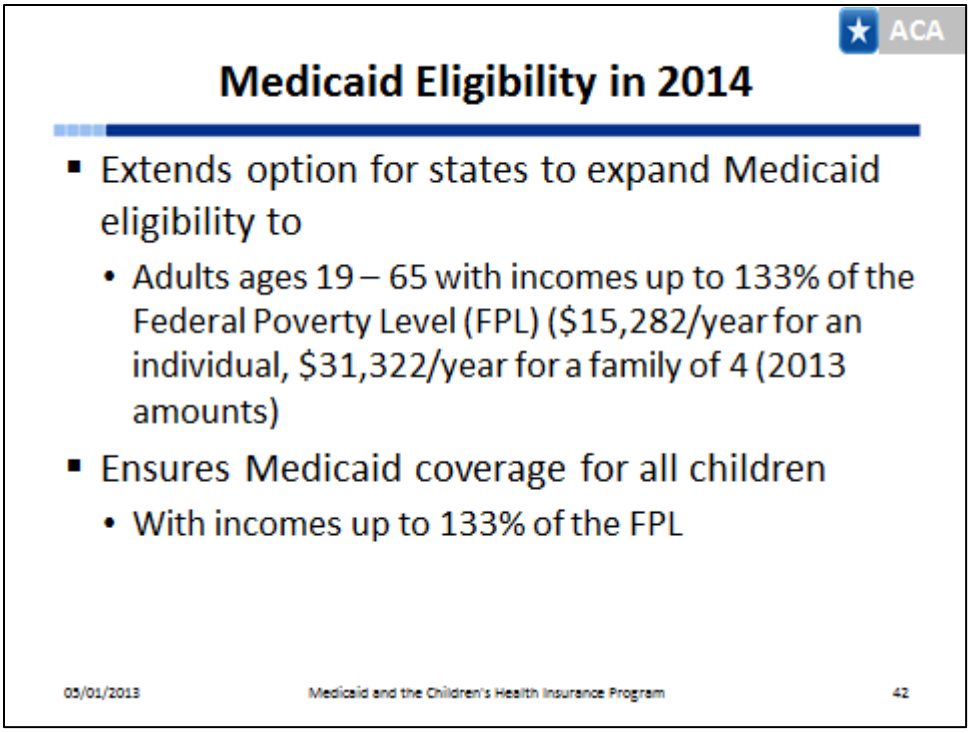



ACA established a new eligibility group that all states participating in Medicaid could optionally begin to cover April 1, 2010. States may adopt the following expansion at any time. This new group would fill in the gaps in existing Medicaid eligibility.

- It makes eligible very-low income individuals (those under 133% FPL who aren't otherwise eligible under mandatory eligibility categories). It would include those who are not age 65 or older; pregnant; entitled to or enrolled in benefits under Medicare Part A; enrolled in Medicare Part B; or described in any of the other mandatory groups in the statute, such as certain parents, children, or people eligible based on their receipt of benefits under the Supplemental Security Income (SSI) program.
- In 2014, it permits states the option to create a Basic Health Plan for uninsured individuals with incomes between 133%-200% FPL who would otherwise be eligible to receive premium subsidies in the Health Insurance Marketplace. States opting to provide this coverage will contract with one or more standard plans to provide at least the essential health benefits and must ensure that eligible individuals do not pay more in premiums than they would have paid in the Marketplace and that the cost-sharing requirements do not exceed those of the platinum plan for enrollees with income less than 150% FPL or the gold plan for all other enrollees. States will receive 95% of the funds that would have been paid as federal premium and cost-sharing subsidies for eligible individuals to establish the Basic Health Plan. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Marketplace.

**Need More Information?**

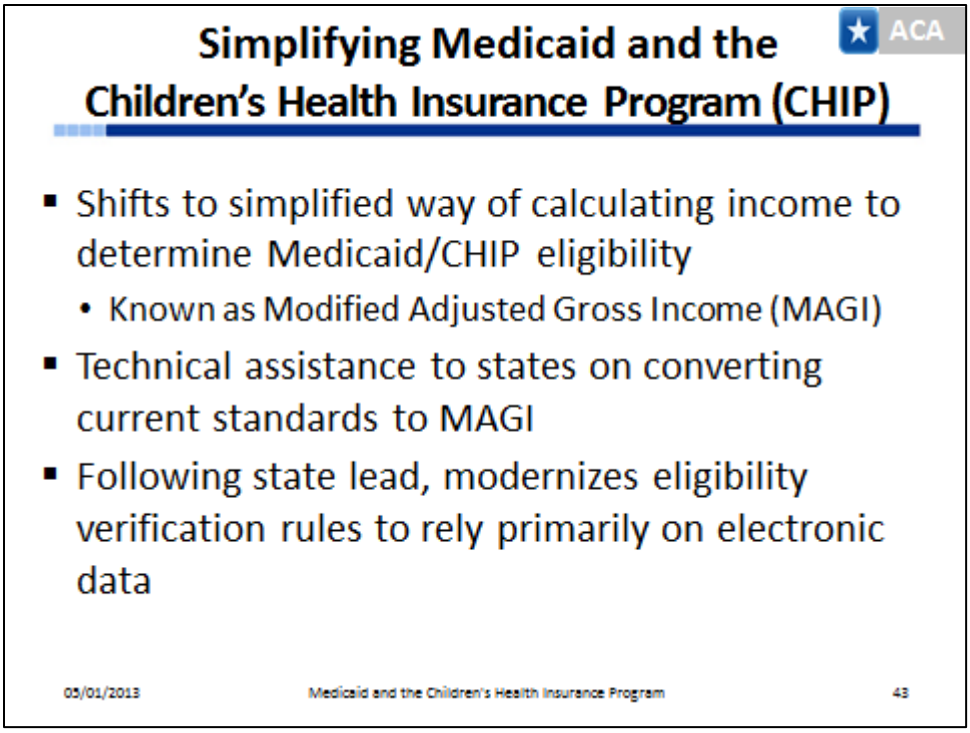
For more information on the Health Insurance Marketplace, please visit: www.HealthCare.gov




Prior to the implementation of the Affordable Care Act, as previously discussed, individuals who fall into certain categories or categorical "groups'' are eligible for Medicaid. Medicaid expansion will replace categorical "groups".

- For the first time, low-income adults without children may be able to obtain coverage through Medicaid *if* their state chooses to expand coverage with federal support. This Medicaid eligibility expansion goes into effect on January 1, 2014, but states could have chosen to expand coverage with federal support before this date.
- If adopted, beginning in January 2014, the new adult group - individuals under 65 years of age with income below 133 percent of the Federal Poverty Level (FPL) may be eligible for Medicaid if their state chooses to expand coverage with federal support. These are adults ages 19 – 65 with incomes up to 133% of the Federal Poverty Level (FPL) ($15,282/year for an individual, $31,322/year for a family of 4 (2013 amounts).
- Ensures Medicaid coverage for all children with incomes up to 133% of the FPL.

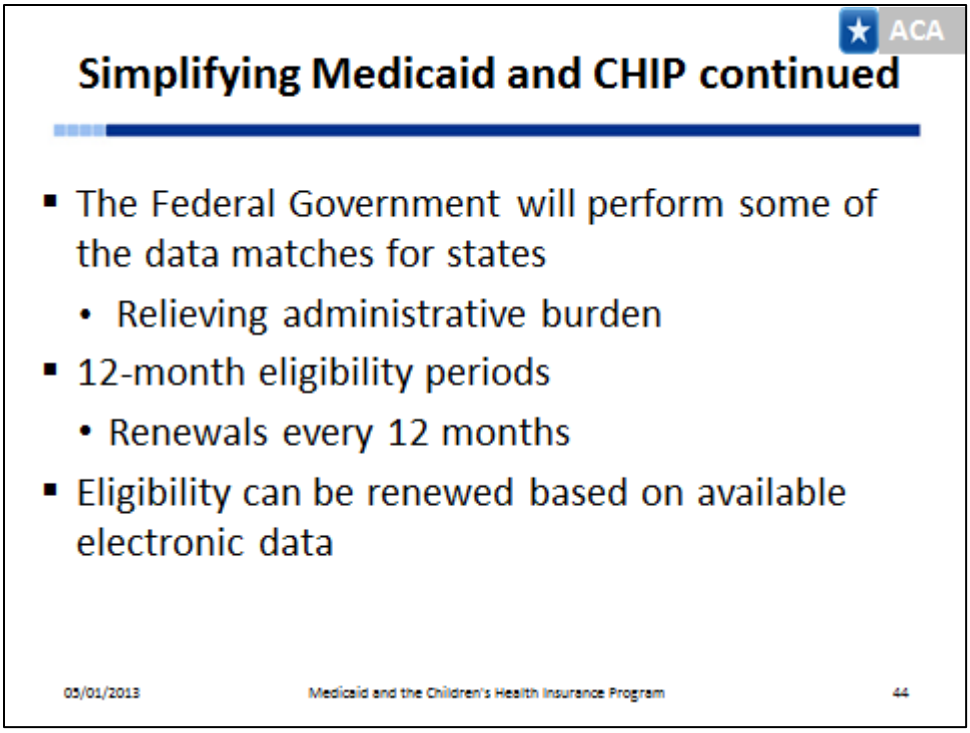
**NOTE:** Under the Affordable Care Act, the Federal Government would pay 100 percent of the cost of expansion for the first three years. After that the federal match would gradually drop to 90 percent by 2020.




The new rule simplifies the Medicaid and CHIP eligibility, enrollment and renewal process in the following ways:

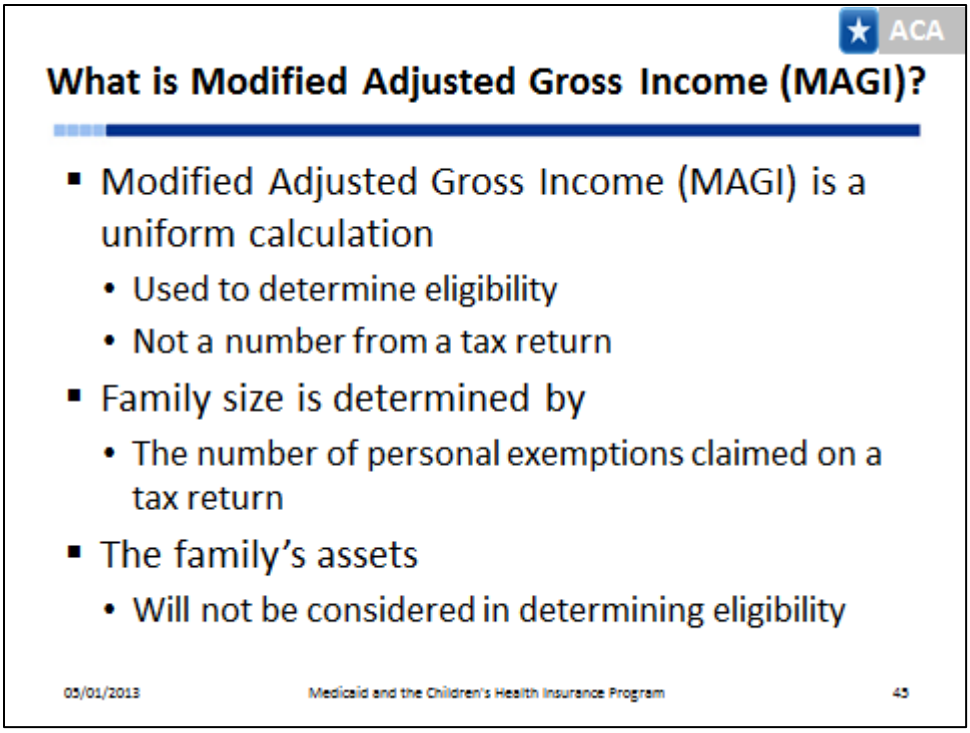
- The rules for counting income for purposes of determining Medicaid and CHIP eligibility will be much simpler and easier for families to understand. By moving to Modified Adjusted Gross Income (MAGI), it replaces the complex rules in place today, ensuring that individuals eligible under the MAGI-based category will be promptly enrolled in Medicaid.
- Will provide technical assistance (TA) to states on converting current standards to MAGI.
- Following state lead modernizes eligibility verification rules to rely primarily on electronic data and simplifies verification procedures for states through the operation of a federal data services "Hub" that will link states with federal data sources such as Social Security.

**NOTE:** CHIP, like Medicaid and the Marketplace will use MAGI and be part of a streamlined and coordinated system.



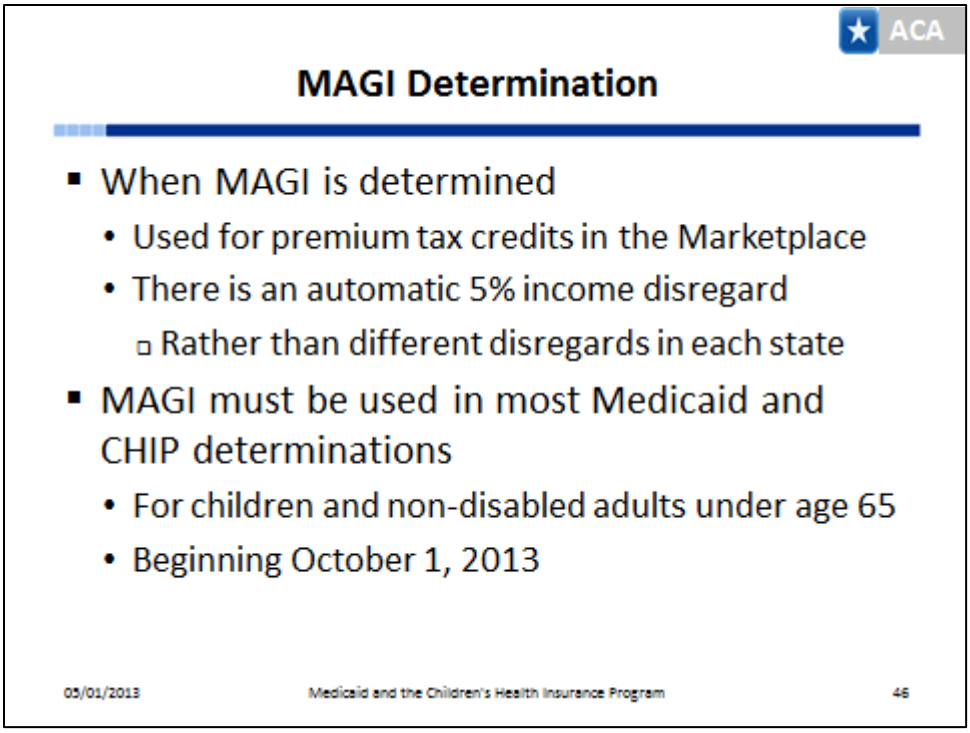

The new rule simplifies the Medicaid and CHIP eligibility, enrollment and renewal process in the following ways:

- The Federal Government will perform some of the data matches for states, relieving administrative burden.
- 12-month eligibility periods - renewals every 12 months.
- If eligibility can be renewed based on available data, such as wage data, no paperwork is needed. Eligibility will be reevaluated if the individual reports a change or the agency has information to prompt a reassessment of eligibility.




Under the Health Care Law, the system for determining eligibility will be streamlined and unified across the states.

- MAGI is a calculation used to determine eligibility that is uniform.
- MAGI is not a number from a tax return. MAGI is based on federal tax rules for determining adjusted gross income (with some modification).
- Family size is determined by the number of personal exemptions claimed on a tax return.
- The family's assets will not be considered in determining eligibility.



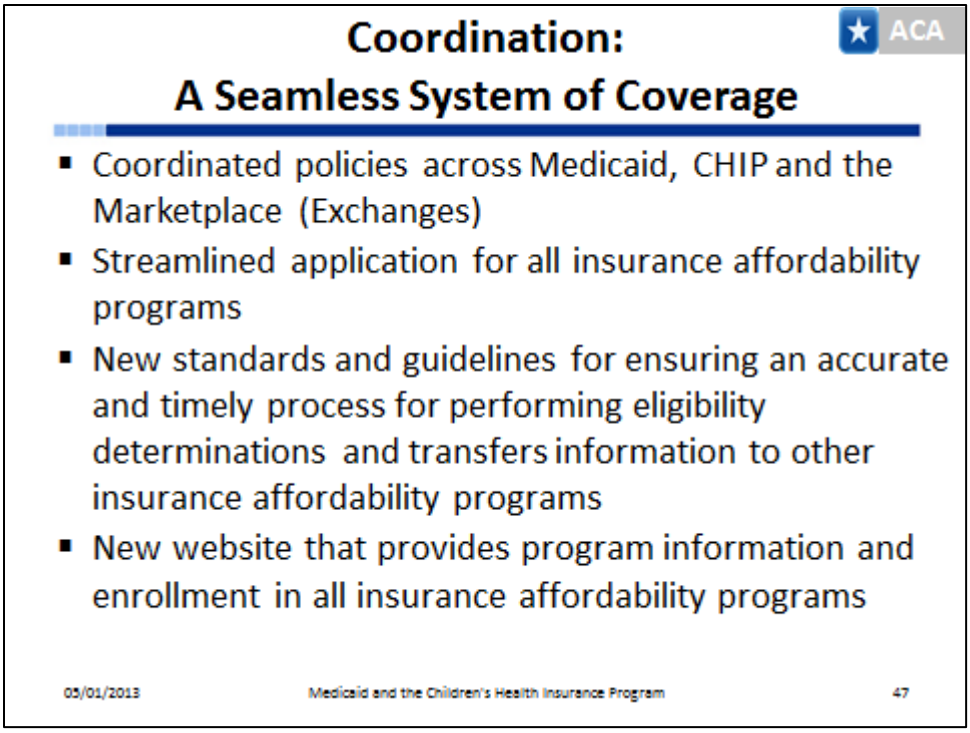

Under the Health Care Law (ACA), the system for determining eligibility will be streamlined and unified across the states.

- When MAGI is determined, it will be used to also determine eligibility for premium tax credits. There is an automatic 5% income disregard, rather than different disregards in each state. That means that a person's income can be up 138% FPL, but since 5% of income will be ignored, it will effectively meet the 133% threshold.
- MAGI must be used in most determinations beginning October 1, 2013, for children and non-disabled adults under age 65, whether or not they expand adult Medicaid coverage.

**NOTE:** The health care law does *not* change Medicaid eligibility rules for beneficiaries who are *65 or older* or those in eligibility categories based on *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; age 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 modified adjusted gross income, please visit: http://www.medicaid.gov/state-Resource-Center/Frequently-Asked-Questions/Downloads/MAGI-Conversion-2-28-13.pdf




The new rules implement the following:

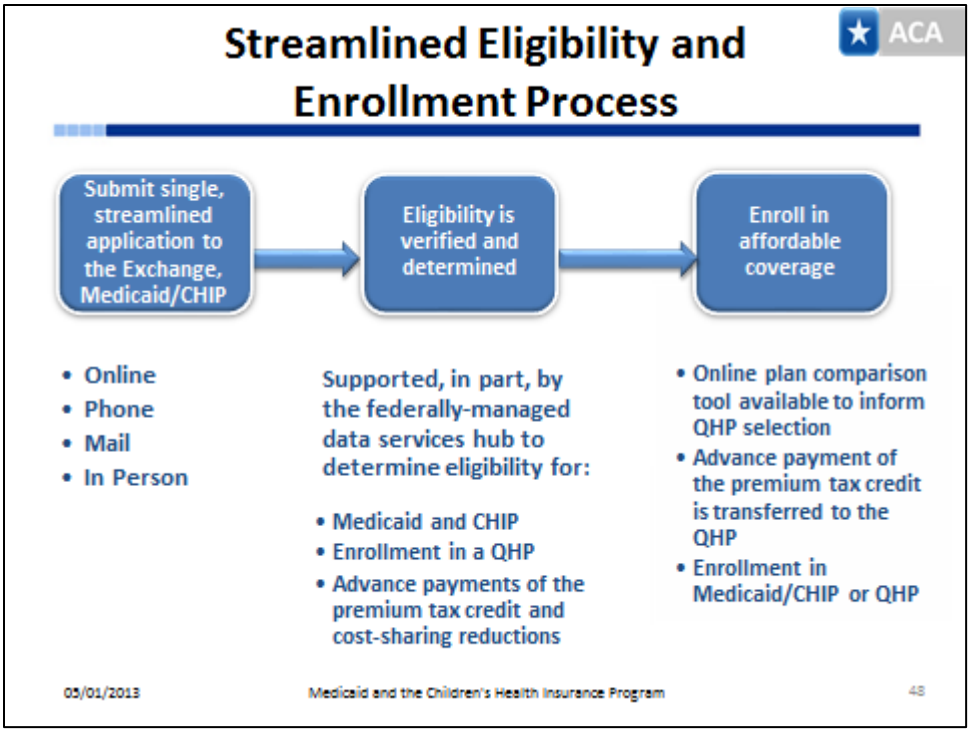
- Coordinated verification policies across Medicaid, CHIP and the Marketplace (e.g. income, state residency, requesting Social Security Numbers)
- Streamlined application for all insurance affordability programs
- Set new standards and guidelines for ensuring a coordinated, accurate and timely process for performing shared eligibility service, eligibility determinations and transferring information to other insurance affordability programs

The Insurance Finder on www.HealthCare.gov is a tool that can help you identify both private and public health coverage options available in your area. The Finder sorts through available options to help identify the ones that may be right for you. For more information, please visit: http://finder.HealthCare.gov/

**NOTE:** State Medicaid agencies must also begin transferring to the exchange electronic accounts of applicants who are not eligible for Medicaid but may be for premium tax credits as of October 1, 2013.

**Need More Information?**

For more information, please visit: http://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Events-and-Announcements.html




States will 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 CHIP. The application leads seamlessly to comparing the Qualified Health Plans (QHP) and then actual enrollment.

Applications will be selected based on your circumstances (single, family, etc.) and may be submitted online, by phone, by mail, and in person.

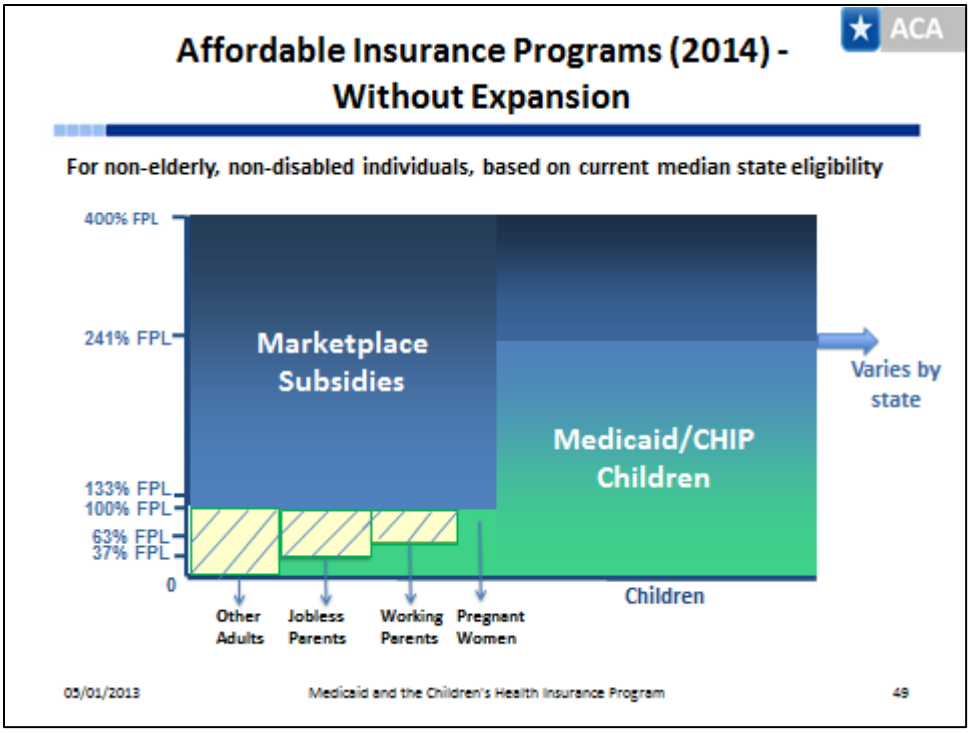
States may use another type of application if approved by the Secretary of HHS.

**Need More Information?**

Need more information about the Health Insurance Marketplace?

Sign up to get email and text alerts at signup.HealthCare.gov.

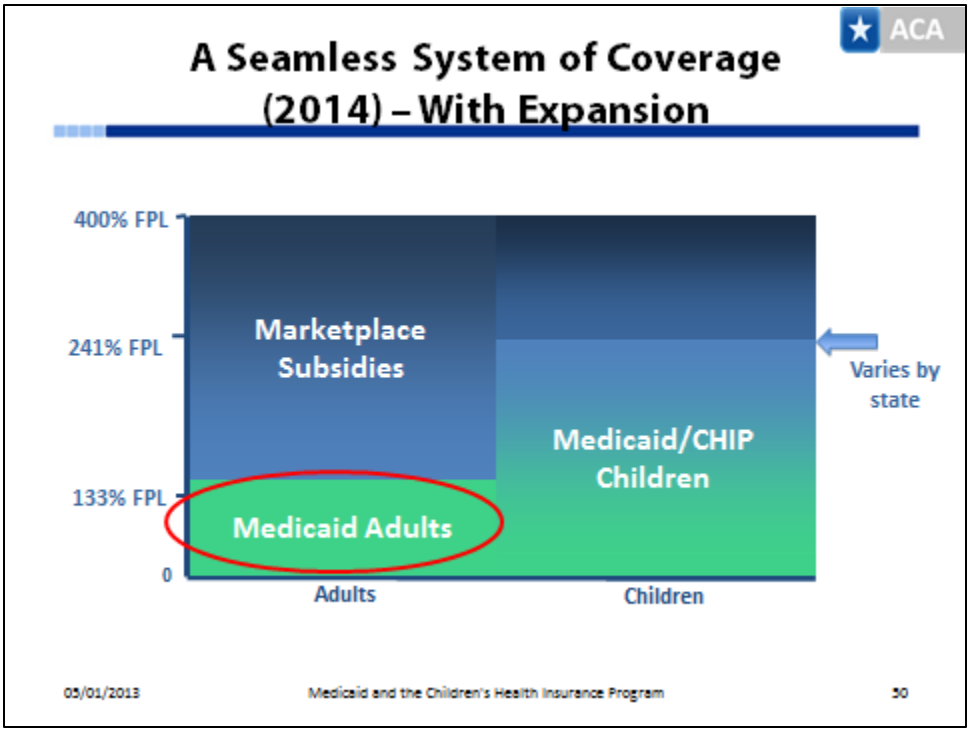
Updates and resources for partner organizations are available at: http://marketplace.cms.gov/index.html




This chart visually displays Medicaid coverage gaps in 2014 in states that do not expand coverage.

- Medicaid and CHIP varies by state at 0% to 241% Federal Poverty Level (FPL). It may cover pregnant women, some working or jobless parents, but not most adults. Under the ACA's maintenance of effort provision, states are not 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 at 0%-100% of FPL, jobless parents 37%-100% FPL, and working parents 63%-100%.

**NOTE:** This does not display the state option for the Basic Health Plan (BHP) for uninsured individuals with incomes between 133%-200% FPL who would otherwise be eligible to receive premium subsidies in the Health Insurance Marketplace. Individuals with incomes between 133-200% FPL in states creating Basic Health Plans *will not* be eligible for subsidies in the Marketplace.




This chart shows Medicaid coverage in 2014 in states that do expand coverage.

As of May 2013, 26 states and the District of Columbia are participating in expansion efforts. Four states are participating through an alternative expansion model.

This chart is a visual display for Medicaid coverage in 2014 in states that do expand coverage.

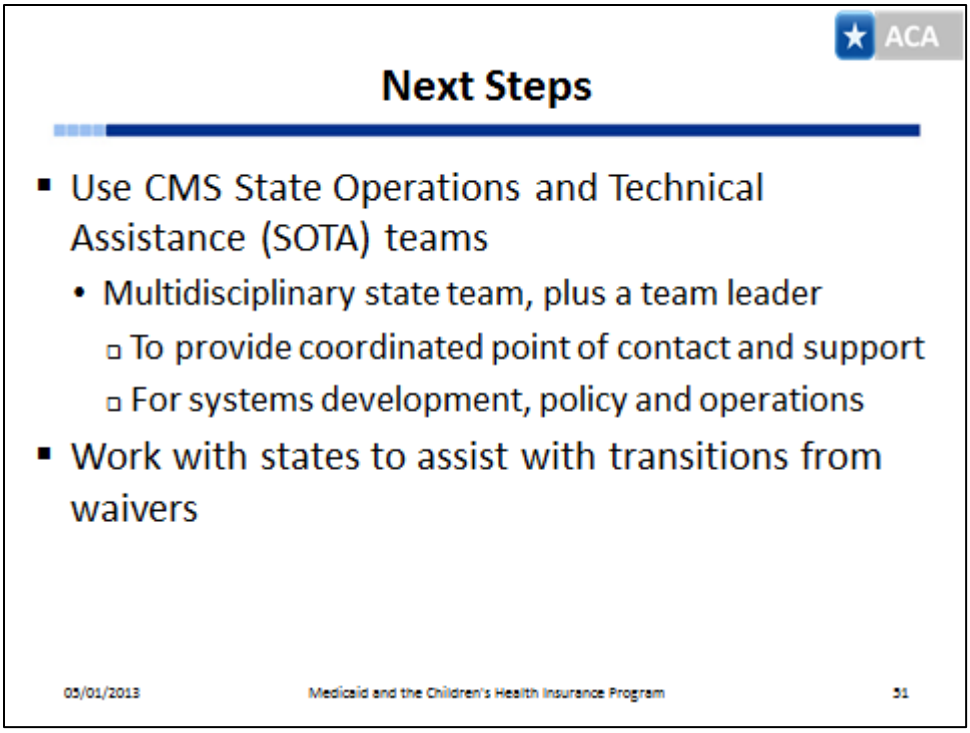
- Marketplace Subsidies for 138% to 400% Federal Poverty Level (FPL)
- The New Expansion Group - Medicaid Adults 0% to 138% FPL are displayed with the red circle (allows for 5% disregard)
- Medicaid and CHIP varies by state 0% to 241% FPL

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

http://www.medicaid.gov/AffordableCareAct/Affordable-Care-Act.html

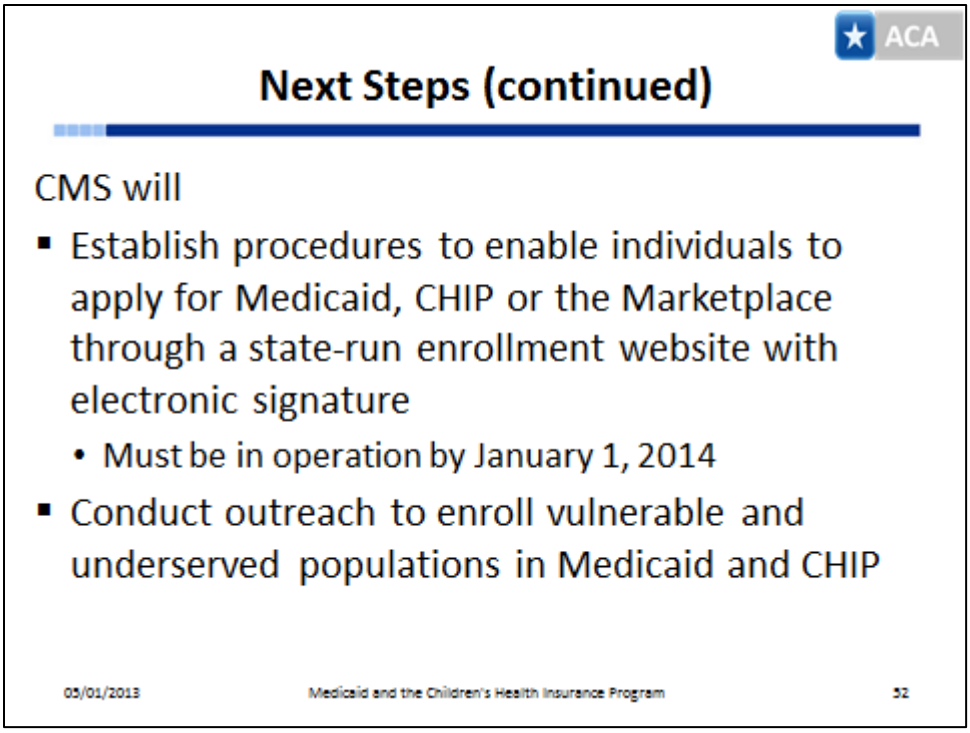
For more information on eligibility and enrollment, please visit

http://www.medicaid.gov/State-Resource-Center/Eligibility-Enrollment-Final-Rule/Eligibility-and-Enrollment-Final-Rule-Webinars.html




The CMS State Operations and Technical Assistance (SOTA) initiative was designed to promote communication and information sharing with states and to facilitate their Health Care Law implementation efforts. The SOTA teams are made up of a multidisciplinary state team, plus a team leader, who serve as coordinated points of contact to assist states with 2014 implementation. Moving forward CMS goals are to work in partnership with states to develop the state based Marketplaces:

- Use State Operations and Technical Assistance (SOTA) teams
  - To provide coordinated point of contact and support
  - For systems development, policy and operations
- Work with states to assist with transitions from waivers.




CMS will

- Establish procedures to enable individuals to apply for Medicaid, CHIP or the Exchange through a state-run enrollment website with electronic signature which must be in operation by January 1, 2014.
- Conduct outreach to enroll vulnerable and underserved populations in Medicaid and CHIP.

**Need More Information?**

For more information, please visit: http://www.medicaid.gov/state-Resource-Center/Eligibility-Enrollment-Final-Rule/Eligibility-and-Enrollment-Final-Rule-Webinars.html

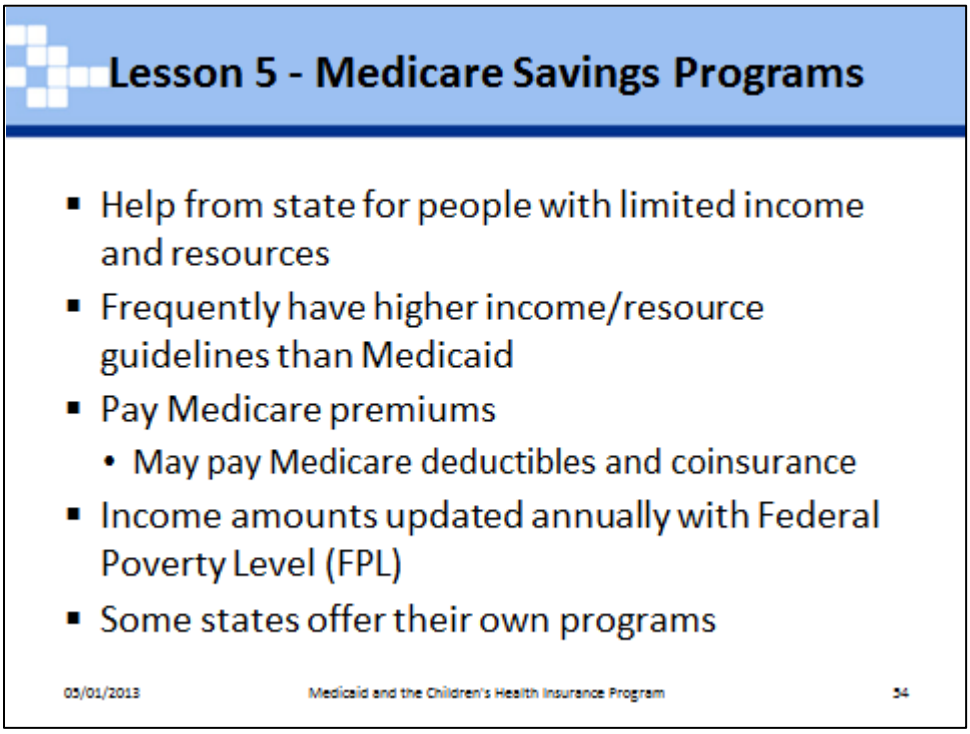
## Check Your Knowledge – Lesson 4

Answer the following question:

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

a. States have the option to expand eligibility to the new adult group
b. It would cover adults with income below 133% FPL, under age 65, who are not pregnant
c. There will be a streamlined application for all insurance affordability programs
d. All of the above

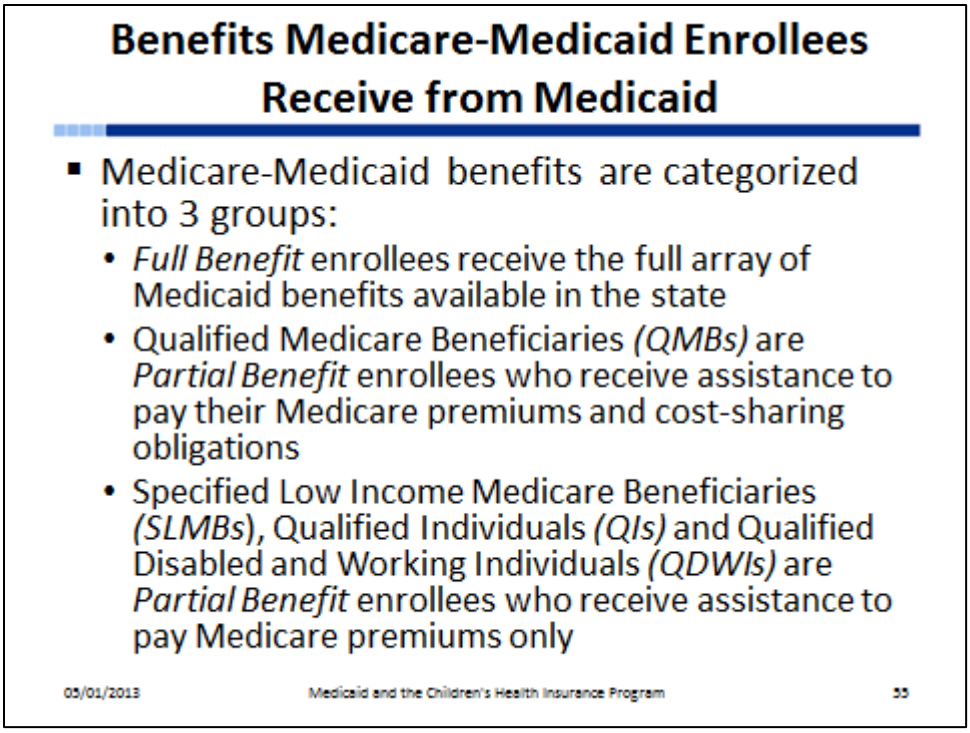
Refer to page 61 to check your answers.




- States have other programs that help pay Medicare premiums for people with limited income and resources that are called Medicare Savings Programs.
- These programs frequently have higher income and resource guidelines than Medicaid and eligibility for these programs is determined by income and resource levels.
- They may pay Medicare premiums and, in some cases, may also pay Medicare deductibles and coinsurance.
- The income amounts are updated annually with the Federal Poverty Level.
- Additionally, some states offer their own programs to help people with Medicare pay the out-of-pocket costs of health care, including State Pharmacy Assistance Programs (SPAPs).

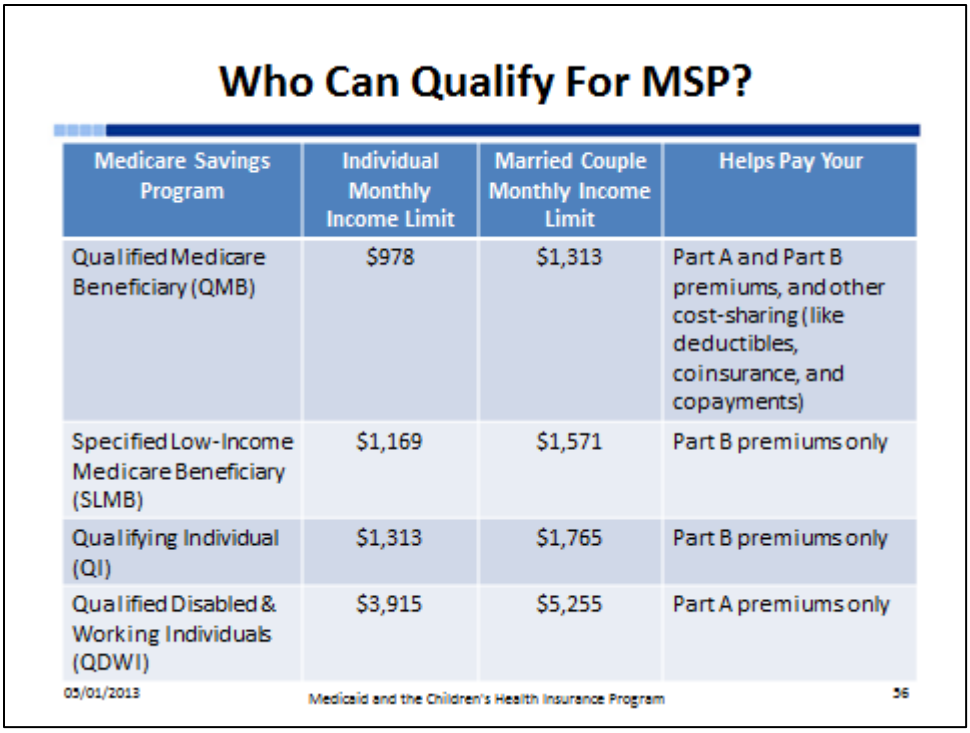
You can contact your local Medicaid office or the State Health Insurance Assistance Program (SHIP) in your state to find out which programs may be available to you. You can find the contact information for your local SHIP by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**NOTE:** Federal Poverty Level amounts are available at http://aspe.hhs.gov/poverty/ 13poverty.cfm




Assistance is based on income. Based on the level of benefit, Medicare-Medicaid enrollees are categorized into 3 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 (QMBs) are Partial Benefit enrollees who receive assistance from Medicaid to pay their Medicare premiums and cost-sharing obligations such as deductibles, co-insurance and co-pays (except Part D).
  - Specified Low Income Medicare Beneficiaries (SLMBs), Qualified Individuals (QIs) and Qualified Disabled and Working Individuals (QDWIs) are Partial Benefit enrollees who receive assistance from Medicaid to pay Medicare premiums only.



## Who Can Qualify For MSP?

| Medicare Savings Program | Individual Monthly Income Limit | Married Couple Monthly Income Limit | Helps Pay Your |
|---|---|---|---|
| Qualified Medicare Beneficiary (QMB) | $978 | $1,313 | Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments) |
| Specified Low-Income Medicare Beneficiary (SLMB) | $1,169 | $1,571 | Part B premiums only |
| Qualifying Individual (QI) | $1,313 | $1,765 | Part B premiums only |
| Qualified Disabled & Working Individuals (QDWI) | $3,915 | $5,255 | Part A premiums only |

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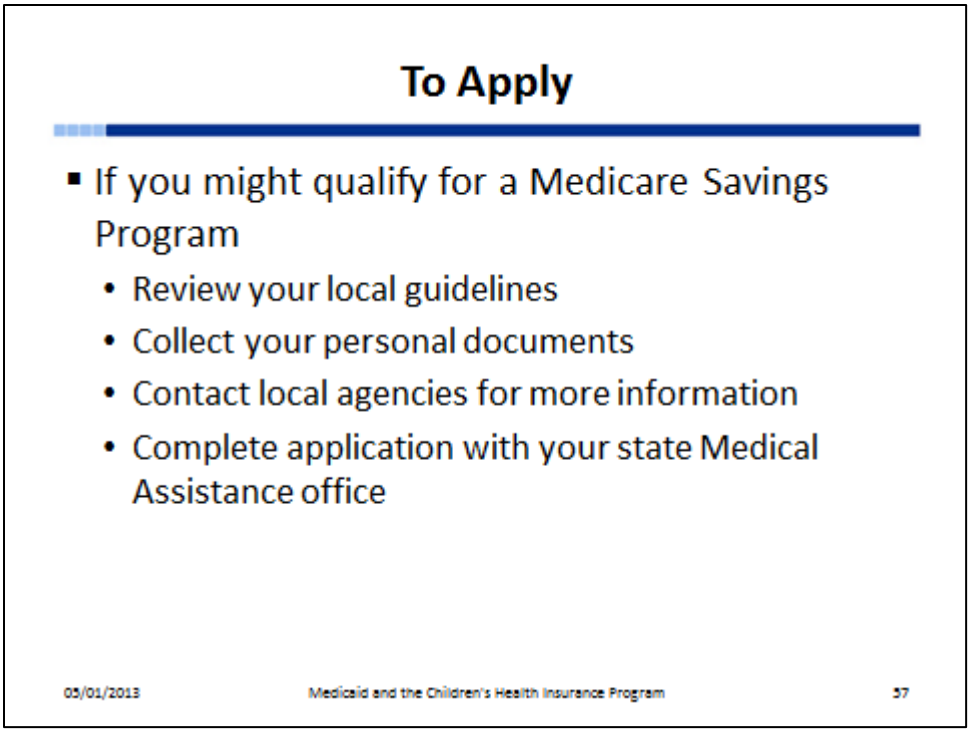
If you qualify for The Qualified Medicare Beneficiary (QMB) program, you get help paying your Part A and Part B premiums, deductibles, co-insurance, and co-pays. To qualify for QMB you must be eligible for Medicare Part A, and have an income not exceeding 100% of the Federal Poverty Level (FPL). This 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%, but does not exceed 120% of the Federal Poverty Level (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 federal funded, you must be eligible for Medicare Part A, and have an income not exceeding 135% of the Federal Poverty Level (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 (QDWI) 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 (SGA); have an income not higher than 200% of the FPL and resources not exceeding twice maximum for SSI ($4,000 for an individual and $6,000 for married couple in 2013); and not be otherwise eligible for Medicaid. If you qualify you get help paying your Part A premium. If your income is between 150% and 200% of the FPL, the state can ask you to pay a part of the Medicare Part A premium.

In 2013, the resource limits for the QMB, SLMB and QI programs are $7,080 for a single person and $10,620 for a married person living with a spouse and no other dependents. These resource limits are adjusted on January 1 of each year, based upon the change in the annual consumer price index (CPI) since September of the previous year.




Here are some steps you can take to find out if you qualify for help with your Medicare out-of-pocket expenses:

- First, review the income and resource (or asset) guidelines for your area.
- If you think you may qualify, collect the personal documents the agency requires for the application process. You will need the following:
  - Medicare card
  - Proof of identity
  - Proof of residence
  - Proof of any income, including pension checks, Social Security payments, etc.
  - Recent bank statements
  - Property deeds
  - Insurance policies
  - Financial statements for bonds or stocks
  - Proof of funeral or burial policies
- You can get more information by contacting your state Medical Assistance office, your local State Health Insurance Assistance Programs (SHIP), or your local Area Agency on Aging.
- Finally, complete an application with your state Medical Assistance office.

## Check Your Knowledge – Lesson 5

Answer the following question:

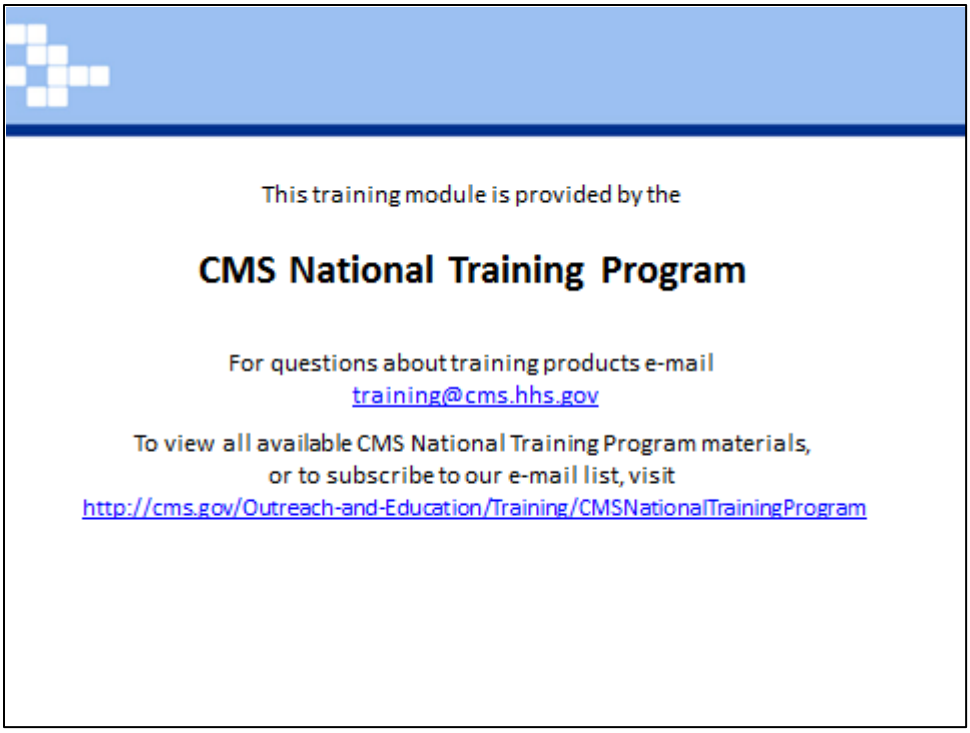
There are several programs available to assist people with limited incomes. Which program helps pay your Part A and Part B premiums, deductibles, coinsurance and co-pays?

a. Medicare Savings Program (MSP)
b. Specified Low-income Medicare Beneficiary (SLMB)
c. Qualified Medicare Beneficiary (QMB)
d. Qualified Individual (QI)



Refer to page 61 to check your answers.

| Information Sources for Medicaid & CHIP | | |
|---|---|---|
| **Government Resources** | **Industry Resources** | **Medicare Products** |
| **Centers for Medicare & Medicaid Services (CMS)**<br>1-800-MEDICARE<br>(1-800-633-4227)<br>1-877-486-2048 for TTY users<br>**www.medicare.gov**<br>**http://www.medicaid.gov/**<br>**http://www.cms.gov/Center/Special-Topic/ Ombudsman-Center.html**<br>**http://www.healthcare.gov/**<br>**Social Security Administration**<br>1-800-772-1213<br>(TTY 1-877-486-2048)<br>**www.socialsecurity.gov** | **State Health Insurance Assistance Programs (SHIPs)***<br>**State Office on Aging**<br>*For telephone numbers call CMS<br>1-800-MEDICARE (1-800-633-4227)<br>1-877-486-2048 for TTY users<br>**CMS Medicaid Integrity Group** has created 6 toolkits for states to use with providers and beneficiaries. You can email the Education Medicaid Integrity Contractor at:<br>MedicaidProviderEducation@cms.hhs.gov<br>For more information on Medicaid Integrity you can visit: **http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/What_is_New.html** | ***Medicare & You Handbook***<br>CMS Product No. 10050<br><br>***Your Medicare Benefits***<br>CMS Product No. 10116<br>**To access these products:**<br>View and order single copies at Medicare.gov<br>Order multiple copies (partners only) at productordering.cms.hhs.gov.<br>You must register your organization.<br>Frequently Asked Questions (FAQ) to address Affordable Care Act implementation questions:<br>**http://www.medicaid.gov/State-Resource-Center/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation/FAQ-Medicaid-and-CHIP-Affordable-Care-Act-ACA-Implementation.html** |

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# Answer Key

## Check Your Knowledge

**Lesson 1- From p. 9**

Medicaid is administered by state governments within state rules.

a. True
b. False

**ANSWER**: 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

**Lesson 2- From p. 26**

Which program (available in some states) considers medical expenses in determining eligibility? Applicants may "spend down" to attain eligibility.

a. Medically Needy
b. Categorically Needy
c. Working Disabled
d. State Supplementary Income Payments

**ANSWER**: a. Medically Needy

**Lesson 3- From p. 39**

CHIP eligibility for children up to age 19 is based on the child's circumstances, not the parent's status.

a. True
b. False

**ANSWER:** a. True

**Lesson 4- From p. 53**

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

a. States have the option to expand eligibility to the new adult group

b. It would cover adults with income below 133% FPL, under age 65, who are not pregnant

c. There will be a streamlined application for all insurance affordability programs

d. All of the above

**ANSWER:** d. All of the above

**Lesson 5- From p. 58**

There are several programs available to assist people with limited incomes, which program helps pay your Part A and Part B premiums, deductibles, coinsurance and co-pays?

a. Medicare Savings Program
b. Specified Low-income Medicare Beneficiary
c. Qualified Medicare Beneficiary
d. Qualified Individual

**Answer**: c. Qualified Medicare Beneficiary

# Appendix A – Medicaid Agencies

| State/Agency | Web Site | Application Format |
|---|---|---|
| | | |
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| | | |
| | | |

**NOTE:** You may wish to fill in the blanks based on the information for the Medicaid Agency in your state/region.

# Appendix B - Medicaid/CHIP Enrollment

| State | Medicaid Enrollment | CHIP Enrollment |
|---|---|---|
| | | |
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| | | |
| | | |

**NOTE:** You may wish to fill in the blanks for the information on Medicaid and CHIP enrollment numbers in your state/region.

# Appendix C – Medicaid Eligibility

| State | Children | Pregnant Women | Parents | Adults |
|---|---|---|---|---|
| | | | | |
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NOTE: You may wish to fill in the blanks with the Medicaid eligibility FPL percentages for your state/region.

# Appendix D – State Medicaid FMAP Rates

| State | FMAP | Enhanced FMAP |
|---|---|---|
| | | |
| | | |
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| | | |

The Federal Medical Assistance Percentages (FMAPs) are used in determining federal share of expenditures for assistance payments for certain social services, and state medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

The "Federal Medical Assistance Percentages" are for Medicaid. Section 1905(b) of the Act specifies the formula for calculating Federal Medical Assistance Percentages.

"Enhanced Federal Medical Assistance Percentages" are for the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. Section 2105(b) of the Act specifies the formula for calculating Enhanced Federal Medical Assistance Percentages.

**NOTE:** You may wish to fill in the blanks with the Medicaid FMAP rates for your state/region.

## Acronyms

| | |
|---|---|
| ACA | Affordable Care Act |
| AFDC | Aid to Families with Dependent Children |
| CHIP | Children's Health Insurance Program |
| CHIPRA | Children's Health Insurance Program Reauthorization Act |
| EFMAP | Enhanced Federal Medical Assistance Percentage |
| FMAP | Federal Medical Assistance Percentage |
| FPL | Federal Poverty Level |
| MAGI | Modified Adjusted Gross Income |
| MSP | Medicare Savings Program |
| QDWI | Qualified Disabled and Working Individual |
| QI | Qualified Individual |
| QMB | Qualified Medicare Beneficiary |
| SHIP | State Health Insurance Assistance Program |
| SLMB | Specified Low Income Medicare Beneficiary |
| SOTA | State Operations and Technical Assistance |
| SPAP | State Pharmacy Assistance Program |
| SSI | Supplemental Security Income |
| TANF | Temporary Assistance for Needy Families |

## Index

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Website: cms.gov/www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram

E-mail training@cms.hhs.gov

Centers for Medicare & Medicaid Services

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