

Centers for Medicare & Medicaid Services (CMS)
National Training Program (NTP)
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.”

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 the Children’s Health Insurance Program (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 45 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 allocated for add-on activities. It has a resource guide and NTP 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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2016 National Training Program

Module 12

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

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.

The information in this module was correct as of May 2016. To check for an updated version, visit [CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html).

The CMS National Training Program provides this as an informational resource for our partners. It’s not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

Session Objectives

- This session should help you
 - Describe eligibility, benefits, and administration of Medicaid including state assistance for Medicare-Medicaid enrollees
 - Define eligibility, benefits, and administration of the Children’s Health Insurance Program (CHIP)

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Medicaid and the Children's Health Insurance Program

This session should help you

- Describe eligibility, benefits, and administration of Medicaid including state assistance for Medicare-Medicaid enrollees
- Define eligibility, benefits, and administration of the Children’s Health Insurance Program (CHIP)

Lesson 1—Medicaid Overview

- What is Medicaid?
- Medicaid Administration
- Eligibility
- Medicaid Expansion
- Enrollment
- Modified Adjusted Gross Income
- Coverage
- Waivers
- Medicare Savings Programs

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Medicaid and the Children's Health Insurance Program

Lesson 1, “Medicaid Overview” explains the following:

- What is Medicaid?
- Medicaid Administration
- Eligibility
- Medicaid Expansion
- Enrollment
- Modified Adjusted Gross Income
- Coverage
- Waivers
- Medicare Savings Programs

Medicaid Overview

- Federal and state entitlement program*
- Medical assistance for people with limited income and resources
- Covers about 71 million adults and children
- Supplements Medicare for more than 10 million people who are aged and/or disabled

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

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Medicaid and the Children's Health Insurance Program

Medicaid is a federal and state entitlement program* that pays for medical assistance for certain individuals and families with limited income and resources. Medicaid isn't a cash support program; it pays medical providers directly for care.

Medicaid is the largest source of funding for medical and health-related services for those with limited income and resources. Medicaid and the Children's Health Insurance Program provide health coverage to an estimated 71 million people, 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 help states provide medical assistance to eligible needy persons.

*Entitlement program—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
- FMAPs are updated every fiscal year and can be found at aspe.hhs.gov/federal-medical-assistance-percentages-or-federal-financial-participation-state-assistance-expenditures.

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's 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, subject to federal approval.

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.

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

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).

Check Your Knowledge—Question 1

Medicaid is _____.

- a. For people with high incomes
- b. Funded solely by states
- c. A federal program
- d. A joint federal/state partnership

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Medicaid and the Children's Health Insurance Program

Check Your Knowledge—Question 1

Medicaid is _____.

- a. For people with high incomes
- b. Funded solely by states
- c. A federal program
- d. A joint federal/state partnership

Answer: d. A joint federal/state partnership

Medicaid is a joint federal/state partnership program with federally established national guidelines. States receive federal matching funds for covered services.

Medicaid Eligibility

- Eligibility tied to groups specified under the federal Medicaid law
 - Pregnant women
 - Children
 - People with disabilities
 - Seniors
 - Adult Group in states with Affordable Care Act expansion
- States must cover certain groups, such as children and pregnant women, and have the option to cover other groups
- Financial and non-financial requirements

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Medicaid and the Children's Health Insurance Program

To qualify for Medicaid, you must belong to one of the eligibility groups specified under the federal Medicaid law and chosen to be covered in the state in which you live. To be eligible for federal funds, states must cover people in certain groups up to federally defined income thresholds. However, many states have expanded Medicaid beyond these thresholds and have extended coverage to other optional groups. There are financial and non-financial requirements that must be met. Non-financial requirements include residency, citizenship requirements, and certain program requirements such as spousal impoverishment, estate recovery, and third-party liability and coordination of benefits. Detailed eligibility content is located at [Medicaid.gov/Medicaid-chip-program-information/by-topics/eligibility/eligibility.html](https://www.Medicaid.gov/Medicaid-chip-program-information/by-topics/eligibility/eligibility.html).

Because of the Affordable Care Act, states now have options to cover additional groups, which we'll discuss next.

Eligibility—Medicaid Expansion

- Affordable Care Act's Eligibility Groups effective 1/1/2014
 - Adult group
 - 19–64 with income below 133% of Federal Poverty Level (FPL)
 - Former foster care group
 - Under 26 and enrolled in Medicaid while in foster care at 18 or aged out of foster care
 - Optional eligibility group for individuals with income above 133% of FPL
 - Under 65

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Medicaid and the Children's Health Insurance Program

Starting January 1, 2014, the Affordable Care Act (ACA) established 3 new Medicaid eligibility groups that made health insurance available to millions of people who weren't previously eligible:

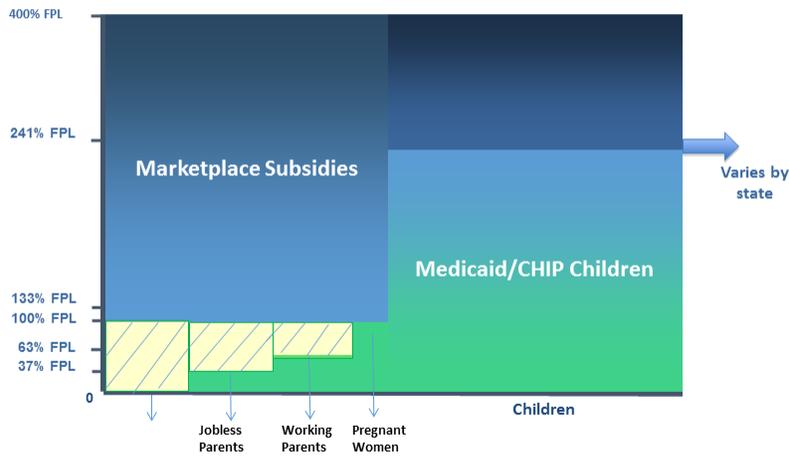
- The adult group covers individuals 19–64 with income below 133% of the Federal Poverty Level (FPL), including 19- and 20-year-olds. Children under 19 aren't included in this group because they're covered under other mandatory eligibility groups. To be eligible, individuals may not be entitled to or 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 can elect to cover.
- A second eligibility group created under the ACA established 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's no income or resource test for this eligibility group.
- The third group is similar to the aforementioned adult group. Individuals in this group must be under 65, with income above 133% of the FPL, and can't otherwise be eligible for another Medicaid group. Unlike the eligibility requirements for the first 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 a state is expanding Medicaid, individuals will probably qualify if they make up to about \$16,100 a year for 1 person (\$32,900 for a family of 4). Coverage started as early as January 1, 2014.

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

Affordable Insurance Programs Without Expansion

For non-elderly, non-disabled individuals, based on current median state eligibility



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Medicaid and the Children's Health Insurance Program

This chart shows Medicaid coverage gaps in states that don't expand coverage. While the adult group is a mandatory group, the Supreme Court ruled that there can be no penalty for states that don't adopt the new group.

Medicaid and Children's Health Insurance Programs (CHIP) vary by state, with eligibility ranging from 0% to 400% of the Federal Poverty Level (FPL). Under the Affordable Care Act's (ACA) 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.

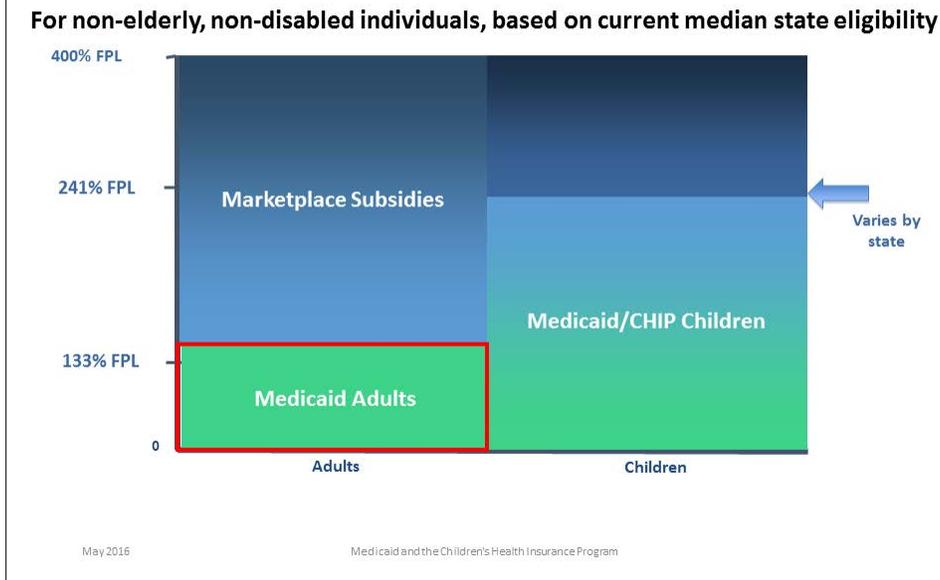
In states that don't expand, the groups potentially continuing without Medicaid coverage or eligibility for Marketplace subsidies include childless adults from 0% to 100% of the FPL, jobless parents from 37% to 100% of the FPL, and working parents from 63% to 100% of the FPL.

States have the option under the ACA to create a Basic Health Program (BHP), a health benefits coverage program for low-income residents who'd otherwise be eligible to purchase coverage through the Health Insurance Marketplace.

NOTE: This doesn't display the state option for the BHP for uninsured individuals with incomes between 133% and 200% of the FPL who'd otherwise be eligible to receive premium subsidies in the Health Insurance Marketplace. Individuals with incomes between 133% and 200% of the FPL in states creating BHP aren't eligible for subsidies in the Marketplace.

Both Minnesota and New York implemented BHPs in 2015.

A Seamless System of Coverage With Expansion



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

Currently, 32 states including the District of Columbia have adopted the adult group with income below 133% of the FPL. Six states are participating through an alternative expansion model:

- Marketplace subsidies for individuals from 138% to 400% of the federal poverty level (FPL).
- The adult group with income below 133% of the FPL (displayed with the red rectangle above)—Medicaid for adults from 0% to 138% of the FPL (allows for 5% disregard).
- For children, Medicaid and the Children's Health Insurance Program (CHIP) vary by state, up to 241% of the FPL. Marketplace subsidies are available above the applicable state limit up to 400%.

For more information on Medicaid and the Affordable Care Act, visit [Medicaid.gov/affordablecareact/affordable-care-act.html](https://www.Medicaid.gov/affordablecareact/affordable-care-act.html).

States Not Expanding Medicaid

- If you live in a state that's NOT expanding Medicaid you may
 - Have fewer coverage options
 - Not qualify for either Medicaid or reduced costs on a private insurance plan in the Marketplace
 - Be able to get a hardship exemption and won't have to pay a fee if you don't have 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 hasn't expanded Medicaid to adults with income below 133% the Federal Poverty Level (FPL), 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% of FPL—about \$11,670 a year as a single person, or about \$23,850 for a family of 4, 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 4, 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% FPL fall into a coverage 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 apply for a hardship exemption so they don't have to pay a fee (the shared responsibility payment required by the Affordable Care Act) if they don't get health coverage.

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

For more information on Medicaid expansion, visit [HealthCare.gov/medicaid-chip/medicaid-expansion-and-you/](https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/).

Streamlined Application

- One application for Marketplace health plans, Medicaid, and the Children’s Health Insurance Program (CHIP)
 - Advance premium tax credits and cost-sharing reductions
 - Online, by phone, by mail, or in person
- May be able to enroll immediately once eligibility determination is complete
 - Depending on the program for which the applicant is eligible
- You can apply for Medicaid and CHIP at any time
 - At [HealthCare.gov](https://www.healthcare.gov), or
 - Through your state agency

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Medicaid and the Children’s Health Insurance Program

States use a streamlined application for coverage through the Marketplace, Medicaid, and the Children’s Health Insurance Program (CHIP). The application may lead seamlessly from eligibility, to plan selection, and enrollment. Individuals can submit one application for all programs. Online applications are available in nearly every state, along with traditional paper applications that may be sent by mail. 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—tax credits that can reduce what you pay for insurance
 - Cost-sharing reductions—discounts that lower the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments

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.

You can apply for Medicaid and CHIP any time of year. If you qualify, you can enroll immediately.

To find out if your children qualify for CHIP coverage, visit insurekidsnow.gov or call 1-877-543-7669. If you apply for Medicaid coverage to your state agency, you’ll also find out if your children qualify for CHIP. If you qualify, coverage can begin immediately.

Application and Enrollment Process

- Application process
 - Relies primarily on electronic data
 - Reduces need for paper documentation
 - 12-month eligibility period for most
 - Adults
 - Parents
 - Children

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Medicaid and the Children's Health Insurance Program

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

- Eligibility verification procedures rely primarily on electronic data sources. States have flexibility to determine the usefulness of available data before requesting additional information from applicants.
- 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.
- Movement toward real-time eligibility determinations.

For Medicaid only, you may be able to qualify for up to 3 months prior to application if you'd have qualified had you applied.

Modified Adjusted Gross Income (MAGI) Methodology

- MAGI is a methodology for how income is counted and how household composition and family size are determined
- MAGI is not a number on a tax return
- MAGI-based rules are used to determine Medicaid and Children's Health Insurance Program (CHIP) eligibility for most individuals

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Medicaid and the Children's Health Insurance Program

Modified Adjusted Gross Income (MAGI) is a methodology for how income's counted and how household composition and family size are determined. MAGI isn't a number on a tax return. MAGI-based rules are used to determine Medicaid and Children's Health Insurance Program (CHIP) eligibility for most individuals.

A state's decision whether or not to extend Medicaid coverage for low-income adults isn't related to the use of MAGI. MAGI rules create consistency and promote coordination between Medicaid and CHIP and coverage available through Qualified Health Plans.

Modified Adjusted Gross Income (MAGI)–Based Methodology

- Tied to taxable income
- Income disregards replaced by a single 5% disregard
- Household composition based on tax filer and tax-dependent relationships
- Child support and other assistance not counted because they're not taxable income
- Family size adjusted for pregnancy

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Medicaid and the Children's Health Insurance Program

- Modified Adjusted Gross Income (MAGI) and household income are defined in section 36B(d)(2)(A) and (B) of the Internal Revenue Code. The MAGI-based methodology under the Medicaid statute includes certain unique income counting and household composition rules reflected in CMS regulations 42 CFR 435.603. MAGI-based methodology includes taxable income. Supplemental Security Income, Temporary Assistance to Needy Families, Veterans' disability, workers' compensation, child support, federal tax credits, and cash assistance are common types of income that aren't taxable and therefore not counted under MAGI.
- The Affordable Care Act established an income disregard equal to 5 percentage points of the Federal Poverty Level "for the purposes of determining income eligibility" for individuals whose eligibility is based on MAGI. In our final rule, issued July 15, 2013, we provided that the disregard is applied to the income calculation of individuals only to the extent that the disregard matters for the purposes of determining eligibility for Medicaid or the Children's Health Insurance Plan (CHIP) under MAGI-based rules. That is, those for whom the application of the disregard means the difference between being eligible for Medicaid or CHIP and being ineligible. The final rule is available at gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf.
- An individual's Marketplace household size may differ from the Medicaid household size because of differences in the rules. For example, for purposes of calculating the Marketplace household size, a pregnant woman is counted as 1 person. However, Medicaid has special rules for counting pregnant women that include the number of babies expected to be delivered. Thus, a pregnant woman expecting twins could be counted as 1 person under Marketplace rules and as 3 people under Medicaid rules.

State Options for Coordinated Eligibility Determinations With the Marketplace

- **Determination Model**
 - Marketplace makes Medicaid/Children’s Health Insurance Program (CHIP) Modified Adjusted Gross Income eligibility determinations using state Medicaid/CHIP eligibility rules and standards
 - Must be a governmental entity
- **Assessment Model**
 - Marketplace makes initial assessment of Medicaid/CHIP eligibility; state Medicaid and CHIP agencies make the final eligibility determination

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Medicaid and the Children’s Health Insurance Program

States have options for coordinating eligibility determinations with the Marketplace. For example, the state can delegate authority to make eligibility determinations to the Marketplace, as long as the Marketplace is a government entity that maintains personnel standards on a merit basis, and is subject to safeguards.

Under this option, called the “Determination Model,” the Marketplace makes final eligibility determinations for Medicaid/Children’s Health Insurance Program (CHIP) in accordance with the state’s eligibility policies and rules using a standard set of verification procedures accepted by the state. To ensure a seamless, accurate, and timely eligibility determination, the state Medicaid/CHIP agency accepts the electronic account through a secure electronic interface and enrolls the individual in coverage as if the determination had been made by the Medicaid/CHIP agency.

Under the “Assessment Model,” the Marketplace makes an initial assessment of Medicaid/CHIP eligibility. State Medicaid and CHIP agencies make the final eligibility determination. Assessments are made using the applicable Medicaid/CHIP income standards, and other non-financial criteria such as citizenship and immigration status, using verification rules and procedures consistent with Medicaid and CHIP regulations. The Marketplace and Medicaid/CHIP agencies enter into agreements outlining the responsibilities of each entity to ensure a seamless and coordinated process.

Whose Eligibility Is Based on Modified Adjusted Gross Income (MAGI)?

Groups Using MAGI	MAGI-Excepted
Adults age 19–64	Anyone for whom agency not required to make income determination (e.g., Supplemental Security Income, federal foster care, or adoption assistance recipients)
Parents and caretakers	
Children	
Pregnant Women	
	Individuals eligible on the basis of being aged, blind, or disabled
	Individuals with long-term care needs
	Eligibility for Medicare cost-sharing assistance

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Medicaid and the Children's Health Insurance Program

The modified adjusted gross income (MAGI) methodology for determining income applies to both Medicaid and Children’s Health Insurance Program eligibility for most enrollees, including children, pregnant women, parents and other caretaker relatives, and adults age 19–64 (as applicable in a state). Under the statute, MAGI-based income methodologies don’t apply to determinations of Medicaid eligibility for elderly and disabled populations.

Verification

- Primary reliance on electronic data sources
- Supported by Federal Data Services Hub
 - Social Security
 - Internal Revenue Service
 - U.S. Department of Homeland Security
- Decreased reliance on documentation
- Increased reliance on self-attestation

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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. Verifications are supported, in part, by the federally managed Data Services Hub and real-time verification of information through Social Security, the Internal Revenue Service, and the U.S. Department of Homeland Security.

With increased use of electronic data sources, paper documentation isn't necessary for most applicants. States may also rely on self-attestation for many factors of eligibility.

Check Your Knowledge—Question 2

Which of the following is NOT one of the expanded Medicaid eligibility groups established by the Affordable Care Act?

- a. Under 26 and enrolled in Medicaid while in foster care
- b. U.S. military veterans
- c. Under 65 with income above 133% of the Federal Poverty Level (FPL)
- d. Ages 19–64 with income below 133% of the FPL

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Medicaid and the Children's Health Insurance Program

Check Your Knowledge—Question 2

Which of the following is NOT one of the expanded Medicaid eligibility groups established by the Affordable Care Act?

- a. Under 26 and enrolled in Medicaid while in foster care
- b. U.S. military veterans
- c. Under 65 with income above 133% of Federal Poverty Level (FPL)
- d. Ages 19–64 with income below 133% of FPL

Answer: b. U.S. military veterans

Starting January 1, 2014, the Affordable Care Act established 3 new Medicaid eligibility groups that made health insurance available to millions of people who weren't previously eligible:

- The adult group covers individuals 19–64 with income below 133% of 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, 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 can elect to cover.
- A second eligibility group created under the Affordable Care Act established 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 aforementioned adult group. Individuals in this group must be under 65, with income above 133% of the FPL, and can't otherwise be eligible for another Medicaid group. Unlike the eligibility requirements for the first 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.

Mandatory Medicaid State Plan Benefits

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment services (for children under 21 years of age)
- Nursing facility services (except for Medically Needy)
- 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 (for children under 21 years of age)
- Nursing facility services
- Home health services
- Physician services
- Rural Health Clinic services
- Federally Qualified Health Center services
- Laboratory and X-ray services

Nursing facility services aren't a mandatory service for individuals who become eligible for Medicaid as Medically Needy (which gives states the option to extend Medicaid eligibility to those with high medical expenses whose income exceeds the maximum threshold, but who would otherwise qualify).

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

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 4 primary types of waivers and demonstration projects:

1. 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.
2. 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.
3. 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.
4. Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to simultaneously implement 2 types of waivers to provide a continuum of services.

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).

The ACA Medicaid Funding Improvements and Expansion of Waivers

- The Affordable Care Act (ACA)created new opportunities
 - Health Homes for Individuals with Chronic Conditions
 - Community First Choice State Plan Option
 - Balancing Incentive Program
 - Testing Experience and Functional Tools
- ACA expanded and increased flexibility of current Medicaid programs
 - Money Follows the Person
 - 1915(i) State Plan Option
 - Home and Community-Based Services

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Medicaid and the Children's Health Insurance Program

The Affordable Care Act (ACA) includes a number of program and funding improvements to help ensure that people can receive long-term care services and supports in their home or the community. The law improves existing tools and creates new options and financial incentives for states to provide home and community-based services and supports. These expansions and improvements are expected to result in an anticipated increase in the percentage of Long-Term Services and Supports Spending (LTSS) for Home and Community-Based Services (HCBS) and a decrease in Institutional LTSS. Areas of interest for LTSS and HCBS:

- **Health Homes:** An optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects states' health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.
- **Community First Choice:** Provides enhanced federal funding to states that elect to provide person-centered home and community-based attendant services and supports to help increase individuals with disabilities' ability to live in the community.
- **State Balancing Incentive Payments Program:** Authorizes grants to states to increase access to non-institutional long-term services and supports (LTSS) as of October 1, 2011. The program offers states that undertake structural reforms to increase access to non-institutional LTSS a targeted increase in the Federal Medical Assistance Percentage (FMAP) tied to the percentage of a state's non-institutional LTSS spending, with lower FMAP increases going to states with a less-significant need for reforms.
- **Demonstration Grant for Testing Experience and Functional Assessment Tools (TEFT):** TEFT program (Demonstration Grant for Testing Experience and Functional Assessment Tools in Community-Based Long-Term Services and Supports) designed to test quality measurement tools and demonstrate e-health in Medicaid long-term services and supports.
- **Money Follows the Person (MFP):** A demonstration grant program that provides individuals with long-term services and supports, enabling them to move out of institutions and into their own homes or other community-based settings. The MFP program was set to expire in Fiscal Year 2011, but was extended by the ACA for an additional 5 years (through September 30, 2016) and offers states an approximate 50 % increase in federal matching for 1 year.
- **1915(i) State Plan Option Change:** Enables states to target home and community-based services to particular groups of people, to services accessible to more individuals, and to ensure the quality of the services provided (Home and Community-Based Services State Plan Option).

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 diagnosed with End-Stage Renal Disease (ESRD)	Health coverage for people who meet 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; 40% of all births
<small>May 2016</small>	<small>Medicaid and the Children's Health Insurance Program</small>

Medicare and Medicaid are different in the following ways:

- Medicare is a national program that is consistent across the country; Medicaid consists of statewide programs that vary among states.
- Medicare is administered by the federal government; Medicaid is administered by state governments within federal rules (federal/state partnership).
- 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.
- 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) and finances 40% of all births (including prenatal care, labor, delivery and 60 days of postpartum and other pregnancy-related care).

Medicare-Medicaid Enrollees

- Referred to as “dual eligibles”
 - Over 10 million nationally
 - Medicaid may provide full benefits and/or partial assistance with Medicare costs
 - The Medicare Savings Programs are partial Medicaid benefits that help pay Medicare premiums and sometimes cost-sharing
 - You can qualify for full Medicaid only, full Medicaid with a Medicare Savings Program, or just a Medicare Savings Program
 - For those with full Medicaid, Medicare pays first and Medicaid pays second for services

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Medicaid and the Children's Health Insurance Program

Over 10 million people covered by Medicaid are “dual-eligible” beneficiaries—low-income seniors and younger people with disabilities who are also covered by Medicare. Dual-eligible beneficiaries include individuals who receive full Medicaid benefits as well as those who only receive assistance with Medicare premiums or cost sharing.

The Medicare Savings Programs are partial Medicaid benefits that help pay Medicare premiums, and in some cases, deductibles, coinsurance, and copayments. Persons may have full Medicaid only, full Medicaid and a Medicare Savings Program, or just a Medicare Savings Program.

For people with Medicare who also have full Medicaid coverage, Medicare pays first and Medicaid pays second for care that Medicare and Medicaid both cover. Medicaid may cover additional services that Medicare may not or only partially covers—such as long-term care services and supports.

NOTE: The “Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs” factsheet (ICN 006977 February 2016) 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 (MSPs)

- MSPs are categorized into groups:
 - Qualified Medicare Beneficiary* (QMB)
 - Specified Low-Income Medicare Beneficiary* (SLMB)
 - Qualified Individuals* (QI)
 - Qualified Disabled and Working Individuals (QDWI)

*Automatically qualify for Extra Help for Part D

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Medicaid and the Children's Health Insurance Program

Assistance is based on income. Medicare Savings Programs are categorized into the following groups:

- Qualified Medicare Beneficiaries (QMB) are partial-benefit enrollees who receive assistance from Medicaid to pay their Medicare premiums up to the amount specified in the State Plan. QMB individuals can't be billed for Medicare deductibles, coinsurance, and copayments, or any remaining balance after the Medicaid payment.
- Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and Qualified Disabled and Working Individuals (QDWI) are partial-benefit enrollees who receive assistance from Medicaid to pay Medicare premiums only.

If you qualify for QMB, SLMB, or QI you automatically get Extra Help paying for Medicare prescription drug coverage.

Minimum Federal Eligibility Requirements for Medicare Savings Program (MSP)			
MSP	Individual Monthly Income Limit (2016)	Married Couple Monthly Income Limit (2016)	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	\$1,010	\$1,355	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	\$1,208	\$1,622	Part B premiums only
Qualifying Individual (QI)	\$1,357	\$1,823	Part B premiums only
Qualified Disabled & Working Individuals (QDWI)	\$4,045	\$5,425	Part A premiums only

These amounts are federal minimum eligibility requirements and states may have higher amounts.

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 under federal rules you must be enrolled in or enrolling in 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 under federal rules, you must be enrolled in Medicare Part A and have an income that's at least 100%, but doesn't exceed 120% 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 under federal rules, you must be enrolled in Medicare Part A, and have an income not exceeding 135% of the FPL.

To qualify for the Qualified Disabled and Working Individual program, you've lost Medicare premium-free Part A because you've returned to work (with earnings exceeding Substantial Gainful Activity); have an income not higher than 200% 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 2016); 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 your Medicare Part A premium.

In 2016, the resource limits for the QMB, SLMB, and QI programs are \$7,280 for a single person, and \$10,930 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 3

If you qualify for a Medicare Savings Program, you automatically qualify for Extra Help.

- a. True
- b. False
- c. True for QMB, SLMB, and QDWI only
- d. True for QMB, SLMB, and QI only

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Medicaid and the Children's Health Insurance Program

Check Your Knowledge—Question 3

If you qualify for a Medicare Savings Program, you automatically qualify for Extra Help.

- a. True
- b. False
- c. True for QMB, SLMB, and QDWI only
- d. True for QMB, SLMB, and QI only

Answer: d. True for QMB, SLMB and QI only.

If you qualify in the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, or Qualified Individuals categories, you automatically qualify to get Extra Help paying for Medicare prescription drug coverage. However, if you qualify for the Qualified Disabled Working Individual program, you don't automatically qualify for Extra Help.

Lesson 2—Children’s Health Insurance Program (CHIP) Overview

- What is CHIP?
- State Options for CHIP
- CHIP Eligibility
- Documents and Requirements
- Authorization and Funding

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Medicaid and the Children's Health Insurance Program

Lesson 2, “Children’s Health Insurance Program (CHIP) Overview” explains the following:

- What is CHIP?
- State Options for CHIP
- CHIP Eligibility
- Documents and Requirements
- Authorization and Funding

What Is the Children's Health Insurance Program (CHIP)?

- State-federal partnership
- CMS establishes broad guidelines
- Federal government provides matching funds
 - ACA increased the matching rate by 23 percentage points effective October 1, 2015, and the Medicare and CHIP Reauthorization Act of 2015 (MACRA) maintained this increase
- States receive annual allotment determined by statute

NEW!

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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 was typically about 15 percentage points higher than the Medicaid Federal Medical Assistance Percentage (FMAP) rate for that state. For example, a state with a 50% FMAP would typically have an "enhanced" CHIP matching rate of 65%. The Affordable Care Act (ACA) authorized a 23 percentage point increase to the FMAP. The Medicare and CHIP Reauthorization Act of 2015 (MACRA) reauthorized CHIP and maintained this 23 percentage point increase. For fiscal years 2016 through 2019, the CHIP matching rate ranges from 88 to 100%. Unlike Medicaid, states receive a specific annual allotment for CHIP, determined by the statute.

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

- All 50 states, the District of Columbia, and U.S. territories have approved CHIP programs
- States can design their CHIP program in 1 of 3 ways:
 1. Medicaid expansion (8 states, the District of Columbia, and 5 territories)
 2. Separate Child Health Insurance Program (2 states)
 3. Combination of the 2 approaches (40 states)

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Medicaid and the Children's Health Insurance Program

All 50 states, the District of Columbia, and U.S. territories have approved Children's Health Insurance Program (CHIP) programs.

States can design their CHIP in 1 of 3 ways:

- Medicaid expansion (8 states, the District of Columbia, and 5 territories)—Alaska, Hawaii, Maryland, New Hampshire, New Mexico, Ohio, South Carolina, Vermont, District of Columbia, American Samoa, Commonwealth of Northern Mariana Islands, Guam, Puerto Rico, U.S. Virgin Islands
- Separate Child Health Insurance Program (2 states)—Connecticut and Washington
- Combination of the 2 approaches (40 states total; 29 considered combination programs by the state) Arkansas, California, Colorado, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Rhode Island, South Dakota, Tennessee, Virginia, and Wisconsin

Of the 40 combination states, 11 (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, and Wyoming) were historically separate programs, but are technically combination programs due to the Affordable Care Act requirement of transitioning children ages 6–18 in families earning 133% of the FPL.

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.

To see CHIP information by state, visit [Medicaid.gov/chip/state-program-information/chip-state-program-information.html](https://www.Medicaid.gov/chip/state-program-information/chip-state-program-information.html).

Children's Health Insurance Program (CHIP) Eligibility

- To be eligible for CHIP you must
 - Be under 19
 - Have income up to 200% of the Federal Poverty Level (FPL) or income 50 percentage points higher than Medicaid as of June 1, 1997
- Many states have higher limits
 - 46 states and District of Columbia cover children up to and above 200% FPL
 - 24 of these cover children at 250% FPL or higher
- States may add eligibility criteria

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Medicaid and the Children's Health Insurance Program

There are 2 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% 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. There are 46 states and the District of Columbia covering children up to and above 200% of the FPL. Of these, 24 states cover children at 250% of the FPL or higher. Some states go as high as 400% of the FPL. In addition to the federal requirements, states can add eligibility criteria such as residency requirements or income levels.

NOTE: A state can add its own eligibility criteria to CHIP, but must comply with federal 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 (ACA) changed that by allowing states the option to cover those children. Under the ACA, states also have the option to allow CHIP coverage for an unborn child of an undocumented woman.

Inmates of public institutions and non-citizens who aren't lawfully present remain ineligible for CHIP.

Documentation Requirements for Medicaid and CHIP

- U.S. citizens
 - Must provide satisfactory documentary evidence
 - Tribal membership and enrollment documents satisfy requirements
- Lawfully residing immigrant children and pregnant women otherwise eligible
 - 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

Section 1903(x) of the Deficit Reduction Act 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.

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, 29 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 only or in both 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 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 (ACA)**
 - Maintenance of Effort authorizes Children's Health Insurance Program (CHIP) through 2019
 - Increases CHIP federal matching rate by 23 percentage points in October 2015
 - Provides funding for outreach efforts
- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
 - Extends CHIP funding through September 30, 2017

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Medicaid and the Children's Health Insurance Program

The Affordable Care Act (ACA) Maintenance of Effort authorizes the Children's Health Insurance Program (CHIP) through 2019, and extended CHIP funding through September 30, 2015, when the already enhanced CHIP federal matching rate was increased by 23 percentage points. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 extended CHIP funding through September 30, 2017.

Because CHIP matching rates vary from state to state, the additional 23 percentage points lead to different totals in different states. The ACA 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 4

States have complete flexibility in designing their Children’s Health Insurance Program (CHIP) programs.

- a. True
- b. False

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Medicaid and the Children’s Health Insurance Program

Check Your Knowledge—Question 3

States have complete flexibility in determining their Children’s Health Insurance Program (CHIP) programs.

- a. True
- b. False

Answer: b. False

A state can add its own eligibility criteria to CHIP, but must comply with federal eligibility standards, including the prohibition that the state can’t cover children in higher-income families over lower-income families.

Medicaid and CHIP Resource Guide

Resources	Resources	Medicare Products
<p>Websites Centers for Medicare & Medicaid Services (CMS) Medicaid.gov CMS.gov</p> <p>Federal Medical Assistance Percentages ASPE.hhs.gov/health/fmap.cfm</p> <p>Health Care Expansion and Medicaid HealthCare.gov/medicaid-chip/medicaid-expansion-and-you/</p> <p>InsureKidsNow – Information for children’s health and dental coverage options insurekidsnow.gov</p> <p>Local State Offices can be found using: Medicaid.gov/Medicaid-chip-program-information/by-state/by-state.html</p> <p>Social Security Administration’s Medicaid.information</p> <p>Contacts: CMS Medicaid.gov/about-us/contact-us/contact-us.html</p> <p>Social Security 1-800-772-1213 socialsecurity.gov</p>	<p>Manuals/Guidance “The State Medicaid Manual” CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html</p> <p>“Medicaid Integrity Program (MIP)” CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1238527.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending</p> <p>“Medicaid State Children’s Health Insurance Program” CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1249728.html?DLPage=2&DLEntries=10&DLSort=0&DLSortDir=ascending</p> <p>National Training Program – Partner Job Aids Visit the Training Library at CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram.</p> <p>CMS Publications “Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs” (CMS Product No. 006977) CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf</p>	<p>“4 Programs That Can Help Pay Your Medical Expenses” (CMS Product No. 11445) Medicare.gov/Publications/Search/results.asp?PubID=11445&PubLanguage=1&Type=PubID</p> <p>“Medicaid: Getting Started” (CMS Product No. 11409) Medicare.gov/Publications/Search/results.asp?PubID=11409&PubLanguage=1&Type=PubID</p> <p>“What is Medicare? What is Medicaid?” (CMS Product No. 11306) Medicare.gov/Publications/Search/results.asp?PubID=11306&PubLanguage=1&Type=PubID</p> <p>To view or order these products: Single copies-Medicare.gov/Publications; Multiple copies (partners only) productordering.cms.hhs.gov</p> <p>CMS Partner Tip Sheets – CMS.gov/publications-for-partners.html</p> <p>“Medicaid Spend Down” CMS Publication ID 11249-P CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11249-P.pdf</p> <p>“The Limited Income NET Program for People With Retroactive Medicaid & SSI Eligibility” CMS Publication ID 11401-P CMS.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/11401-P.pdf</p>

Medicaid and the Children’s Health Insurance Program

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Appendix A—Medicaid Agencies

Appendix A—Medicaid Agencies		
State	Website	Application Format

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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—Medicaid Enrollment

Appendix B—Medicaid Enrollment	
State	Medicaid Enrollment Numbers

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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—Medicaid Eligibility

Appendix C—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—State Medicaid Federal Medical Assistance Percentages (FMAP) Rates

Appendix D—State Medicaid Federal Medical Assistance Percentages (FMAP) Rates		
State	FMAP	Enhanced FMAP

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

Acronyms

ACA	Affordable Care Act
BHP	Basic Health Program
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
ESRD	End-Stage Renal Disease
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
HCBS	Home and Community-Based Services
LTSS	Long-Term Services and Supports Spending
MAGI	Modified Adjusted Gross Income
MFP	Money Follows the Person
MSP	Medicare Savings Program
NTP	National Training Program
TEFT	Testing Experience and Functional Assessment Tools
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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education/training/cmsnationaltrainingprogram/](https://www.cms.gov/outreach-and-education/training/cmsnationaltrainingprogram/).