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

Section Objectives

- Describe Medicaid eligibility, benefits, and administration, including state help for Medicare-Medicaid enrollees
- Define Children's Health Insurance Program (CHIP) eligibility, benefits, and administration

Lesson 1: Medicaid Overview

Medicaid is a federal and state entitlement program that helps with medical costs for certain individuals and families with limited income and resources. An entitlement program is a government program that guarantees certain benefits to a particular group or segment of the population. 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 provides health coverage to an estimated 69 million people, including children, pregnant women, parents, seniors, and individuals with disabilities.

The program became law in 1965 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 persons.

For more information, visit Medicaid.gov/medicaid/program-information/medicaid-andchip-enrollment-data/report-highlights/index.html

Medicaid Administration

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

States get 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 costs 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 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 payment rate 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

The "single state agency" is strictly a 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 local or state agencies, private contractors, or both. However, state or local agencies make all final eligibility determinations.

Local offices may have different names. These offices are sometimes called Social Services, Public Assistance, or Human Services.

For more information about eligibility requirements and to apply for Medicaid, contact your state's Medicaid office at Medicaid.gov/about-us/contact-us/contact-state-page.html, or contact your local State Health Insurance Assistance Program (SHIP) at shiptacenter.org. For more information, visit Medicaid.gov/medicaid-chip-programinformation/by-state/by-state.html.

Medicaid Eligibility

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 have to cover people in certain groups up to federally defined income requirements. 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, third-party liability and coordination of benefits. Visit Medicaid.gov/Medicaid-chip-program-information/bytopics/eligibility/eligibility.html for information about Medicaid eligibility.

States also have options to cover additional groups, which we'll discuss next.

Eligibility – Medicaid Expansion

Starting January 1, 2014, the Affordable Care Act (ACA) established 3 new Medicaid eligibility groups:

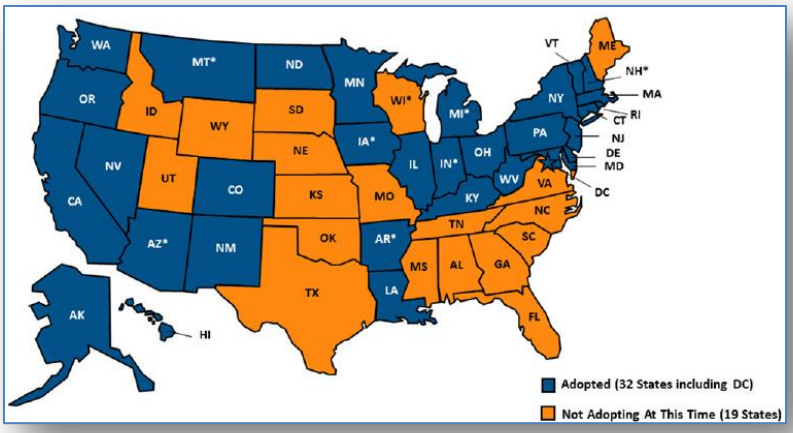
1. The adult group covers individuals 19–64 with income below 133% of the Federal Poverty Level (FPL), including 19- and 20-year-olds (children under 19 aren't included in this group because they're covered under other eligibility groups). To be eligible individuals must meet non-financial requirements and not be pregnant, not be entitled to or enrolled in Medicare Part A, and not otherwise be eligible and enrolled in a mandatory Medicaid group.
2. A second eligibility group includes 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.
3. The third group is similar to the first 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.

The number of uninsured adults who could gain Medicaid coverage if non-expansion states expand includes both individuals currently in the coverage gap (<100% FPL) and those who currently may be eligible for Marketplace coverage (100-138% FPL).

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.

For more information, visit Medicaid.gov/state-resource-center/mac-learningcollaboratives/downloads/primer-for-eligibility-workers.pdf.

Medicaid Expansion in 2017: 32 States and the District of Columbia



As of January 2017, 32 states (including the District of Columbia) elected to expand Medicaid coverage for the adult group with income below 133% FPL created under the Affordable Care Act, including Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.

The remaining states haven't expanded their Medicaid Programs to date, but could expand Medicaid in the future.

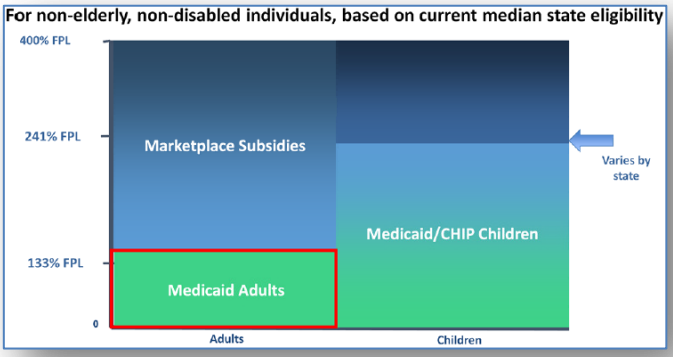
Under the law, the federal government will pay states all of the costs for newly eligible people for the first 3 years. It will pay no less than 90% of the costs in the future.

States are continuing to make coverage decisions. States may also drop their Medicaid expansion coverage at a later time without a federal penalty.

Source: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 3, 2017.

A Seamless System of Coverage With Expansion

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



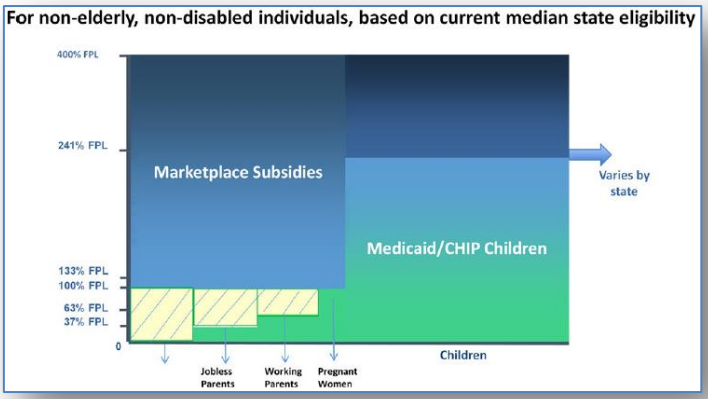
Currently, 32 states including the District of Columbia have adopted the adult group with income below 133% of the FPL. Six states are participating through an alternative expansion model:

- 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.

Affordable Insurance Programs Without Expansion

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). 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 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 get premium subsidies in the Health Insurance Marketplace. Individuals with incomes between 133% and 200% of the FPL in states creating a Basic Health Program aren't eligible for subsidies in the Marketplace.

Both Minnesota and New York implemented BHPs in 2015.

States Not Expanding Medicaid

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% of 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 $12,060 a year as a single person, or about $24,600 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 $12,060 a year as a single person or about $24,600 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/.

Streamlined Application

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 get eligibility determinations for the following:

- Medicaid and CHIP
- Enrollment in Qualified Health Plans (QHP) in the Marketplace
    - Advance premium tax credits – tax credits that can reduce what you pay for QHPs
    - 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 plan 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, you can also visit insurekidsnow.gov or call 1-877-543-7669. If you apply for Medicaid coverage through 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

Medicaid and Children's Health Insurance Program (CHIP) application, enrollment, and renewal processes have been simplified in these 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.
- States have the option to provide continuous eligibility to children who remain eligible for CHIP.
- States have the option to provide children with 12 months of continuous coverage through Medicaid and CHIP, even if the family experiences a change in income during the year.
- 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, if you would have qualified earlier, but didn't apply, your coverage start date may go back (retrocactivly) 3 months.

Modified Adjusted Gross Income (MAGI) Methodology

Modified Adjusted Gross Income (MAGI) is a methodology for how income is 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) and household income are defined in the Internal Revenue Code (IRC). The MAGI-based methodology includes income counting and household rules. Supplemental Security Income (SSI), Temporary Assistance to Needy Families (TANF) , 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 (or income deduction) of 5% of the Federal Poverty Level (FPL). The disregard helps people who may be slightly above the eligibility income requirement to qualify. These people should still need to meet the other requirements to be eligible. 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 be different from the Medicaid household size because of differences in the rules. For example, to calculate the Marketplace household size, a pregnant woman is counted as one person. However, Medicaid has special rules for counting pregnant women that include the number of babies expected to be delivered. Meaning, a pregnant woman expecting twins could be counted as one person under Marketplace rules and as 3 people under Medicaid rules. For more information, you can visit Medicaid.gov/medicaid/programinformation/medicaid-and-chip-eligibility-levels/index.html#footnote4.

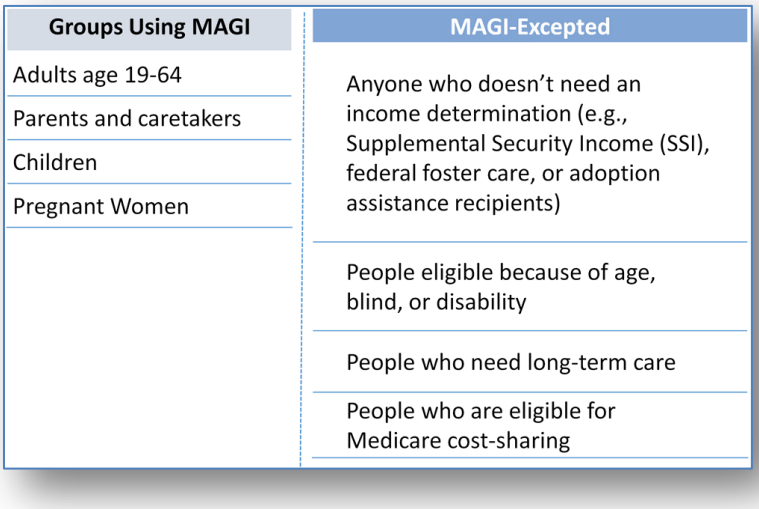
State Options for Coordinated Eligibility Determination With the Marketplace

States have 2 options for making eligibility determinations with the Marketplace. For example, the state can delegate eligibility determination to a government agency that maintains personnel standards on a merit basis, and subject to safeguards.

Under this option, called "Determination Model," the state can let the Marketplace make eligibility determinations for Medicaid and the Children's Health Insurance Program (CHIP) using the state's eligibility rules. To ensure a seamless, accurate, and timely eligibility determination, the state Medicaid/CHIP agency accepts the electronic account through a secure electronic interface and follows the Medicaid/CHIP enrollment procedures to the same extent as if the application had been submitted to the Medicaid/CHIP agency.

Under the "Assessment Model," the Marketplace makes the first Medicaid and CHIP eligibility determination using Medicaid and CHIP requirements. The Marketplace and Medicaid/CHIP agencies work together to make a smooth process.

Whose Eligibility Is Based on MAGI?



Groups Using MAGI	MAGI-Excepted
Adults age 19-64	Anyone who doesn't need an income determination (e.g., Supplemental Security Income (SSI), federal foster care, or adoption assistance recipients)
Parents and caretakers	People eligible because of age, blind, or disability
Children	People who need long-term care
Pregnant Women	People who are eligible for Medicare cost-sharing

Verification

When you apply online, information through Social Security, the IRS, and the Department of Homeland Security can verify eligibility quickly. Most people who apply don't need paper documentation. States may also use self-attestation to verify eligibility.

Mandatory Medicaid State Plan Benefits

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)
- Nursing facility services
- Home health services
- Physician services
- Rural Health Clinic services
- Federally Qualified Health Center services
- Laboratory and X-ray services
- 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

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 requirement, but who would otherwise qualify).

For more information, visit Medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html.

Medicaid Waivers

Waivers are ways 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:

1. Section 1915(b) Managed Care Waivers: States can apply for waivers to provide services through managed care delivery systems for people with limited choices 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 paying for and providing Medicaid and CHIP care.
4. Concurrent Section 1915(b) and 1915(c) Waivers: States can apply to use 2 waivers at the same time.

For more information, visit 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 includes a number of program and funding improvements to help ensure that people can get 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.

Areas of interest under this provision:

- **Health Homes**: An optional Medicaid State Plan benefit to help coordinate care for people with Medicaid who have chronic conditions. Health Homes providers will coordinate primary care, acute care, behavioral health, and long-term services and supports.
- **Community First Choice**: Provides more federal funding to states that choose to give person-centered home and community-based services and supports to help people with disabilities live in the community.
- **State Balancing Incentive Payments Program:** Gives grants to states that give people better access to non-institutional long-term services and supports (LTSS). It offers states that give more access to non-institutional LTSS more Federal Medical Assistance Percentage (FMAP). A state's FMAP depends on its non-institutional LTSS spending, with lower amounts going to states that need less change.
- **Demonstration Grant for Testing Experience and Functional Assessment Tools in Community-Based Long Term Services and Supports (TEFT)**: Tests quality measurements and e-health in Medicaid long-term services and supports.

- **Money Follows the Person (MFP)**: Provides long-term services and supports to people to help them move out of institutions and into their own homes or the community. Final funding for the MFP demonstration was awarded to states in 2016 for continued implementation of grantee programs through September 30, 2020. MFP grantees have identified and are implementing actions necessary to sustain key components of the demonstration beyond the period of performance.
- **1915(i) State Plan Option Change**: Helps states target home and community-based services groups of people, find services more accessible to more people, and to check the quality of the services provided.

For more information, visit Medicaid.gov/affordable-care-act/cb-ltss/index.html.

How Are Medicare and Medicaid Different?

Medicare	Medicaid
National program that is the same across the country	Statewide programs that are different between 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; covers 40% of all births/prenatal and postpartum

Medicare – Medicaid Enrollees

Over 10 million people with 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 get full Medicaid benefits and those who only get help 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. People may have full Medicaid only, full Medicaid and a Medicare Savings Program, or just a Medicare Savings Program.

For people with Medicare that 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—like long-term care services and supports.

NOTE: For more information, "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 and at Medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html

Medicare Savings Programs (MSP)

You can get help from your state paying your Medicare premiums. In some cases, Medicare Savings Programs may also pay Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) deductibles, coinsurance, and copayments if you meet certain conditions. There are 4 kinds of Medicare Savings Programs:

- Qualified Medicare Beneficiaries (QMB) get some help from Medicaid to pay their Medicare premiums up to an amount set by their state. Federal law bars Medicare and Medicare Advantage providers from balance billing a QMB beneficiary under any circumstance.
- Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and Qualified Disabled and Working Individuals (QDWI) get some help 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 MSP

Medicare Savings Program	Individual Monthly Income Limit (2017)	Married Couple Monthly Income Limit (2017)	Helps Pay Your
Qualified Medicare Beneficiary (QMB)	$1,025	$1,374	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
Specified Low-Income Medicare Beneficiary (SLMB)	$1,226	$1,644	Part B premiums only
Qualifying Individual (QI)	$1,377	$1,847	Part B premiums only
Qualified Disabled & Working Individuals (QDWI)	$4,105	$5,499	Part A premiums only

See also www.Medicare.gov/Contacts/staticpages/msps.aspx to access your state's Medicare Savings Program website.

NOTE: The Medicare Savings Program Income/Resource Limits information is typically released in January/February each year.

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

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

Like Medicaid, the Children's Health Insurance Program (CHIP) is a partnership between the states and the federal government that provides health coverage to eligible children, through both Medicaid and separate CHIP Programs. 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 ACA created a 23 percentage point increase to the FMAP. MACRA kept CHIP and the 23% increase. For 2016-2019, the CHIP matching rate ranges from 88 to 100%. Unlike Medicaid, the money states get every year depends on 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 Children's Health Insurance Program (CHIP) Programs. States can design their CHIP in 1 of 3 ways:

1. Medicaid expansion—Alaska, Hawaii, Maryland, New Hampshire, New Mexico, Ohio, South Carolina, Vermont, DC, American Samoa, Commonwealth of Northern Mariana Islands, Guam, Puerto Rico, U.S. Virgin Islands.
2. Separate Child Health Insurance Program—Connecticut and Washington
3. Combination of the 2 approaches—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 states (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, and Wyoming) had historically separate programs but are technically combination programs due to transitioning children ages 6–18 in families earning 133% of the FPL.

If a state adds CHIP into its Medicaid Program, the services given to CHIP-eligible children must be the same as those provided to Medicaid-eligible children, and the eligibility and enrollment processes must be the same. If a state has a separate CHIP, the state can have 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.

Children's Health Insurance Program (CHIP) Eligibility

There are 2 minimum-income eligibility requirements for the Children's Health Insurance Program (CHIP), depending on the state where you live. States may cover children with incomes up to 200% of the federal poverty level (FPL), or 50% higher than Medicaid 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% FPL or higher. Some states go as high as 400% of the FPL. In addition to the federal requirements, states can add eligibility requirements like residency requirements or income levels.

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

Restrictions on Eligibility

States have the option to cover children of public employees and unborn children of undocumented woman under the CHIP Program.

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

Documentation Requirements for Medicaid and CHIP

States have to obtain satisfactory documentary evidence of citizenship or nationality when enrolling individuals in Medicaid, or at the first point of eligibility re-determination. States have to give people an opportunity to prove they're a U.S. citizen or national, and let them continue coverage while their claim is reviewed. Tribal enrollment or membership documents issued from a federally recognized tribe must be accepted as verification of citizenship; no additional identity documents are required.

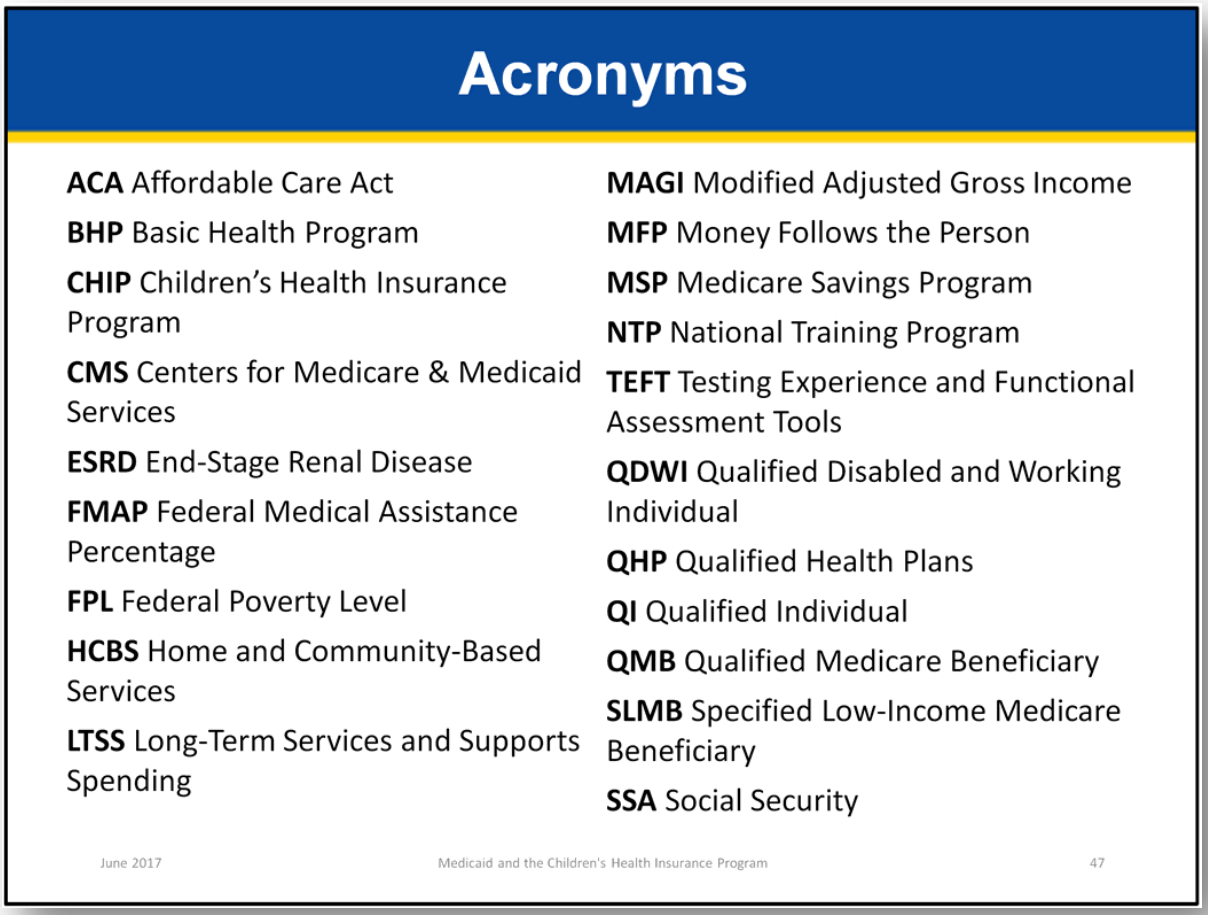
States have the option to give Medicaid and Children's Health Insurance Program (CHIP) coverage to all children and pregnant women (including women covered during the 60-day postpartum period) "who are lawfully residing in the United States…" and who are otherwise eligible. States may choose to cover these groups under Medicaid only, or under both Medicaid and CHIP. The law doesn't let states cover these new groups in CHIP without also extending the option to Medicaid. Twenty-nine 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. States use 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

The Affordable Care Act (ACA) Maintenance of Effort authorizes the Children's Health Insurance Program (CHIP) through 2019 and increased the CHIP federal matching rate was by 23 %. 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.



Medicaid and CHIP Resource Guide

Resources	Medicare Products
Centers for Medicare & Medicaid Services • CMS.gov • Medicaid.gov **Social Security** • Call 1-800-772-1213. TTY: 1-800-325-0778 • socialsecurity.gov **Federal Medical Assistance Percentages** • ASPE.hhs.gov/health/fmap.cfm **Health Care Expansion and Medicaid** • HealthCare.gov/medicaid-chip/medicaid-expansion-and-you/ **InsureKidsNow** • InsureKidsNow.gov **Local State Offices can be found using:** • Medicaid.gov/Medicaid-chip-program-information/by-state/by-state.html	1. **"The State Medicaid Manual"** (CMS.gov/Regulations-and-Guidance/guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html) 2. **"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) 3. **"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)

Medicaid and CHIP Resource Guide (continued)

Medicare Products (continued)

4. **National Training Program Job Aids** (CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/National-Training-Program-Resources.html)
5. **"Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs"** (CMS Product No. 006977)
6. **"4 Programs that Can Help Pay Your Medical Expenses"** (CMS Product No. 11445)
7. **"Medicaid: Getting Started"** (CMS Product No. 11409)
8. **"What is Medicare? What is Medicaid?"** (CMS Product No. 11306)
9. **CMS Partner Tip Sheets** (CMS.gov/publications-for-partners.html)
10. **"Medicaid Spend Down"** (CMS Product No. 11249-P)
11. **"The Limited Income NET Program for People With Retroactive Medicaid & SSI Eligibility"** (CMS Product No. 11401-P)

To access these products:

- View and order single copies at Medicare.gov/publications.
- Order multiple copies (partners only) at Productordering.cms.hhs.gov. *You must register your organization*.