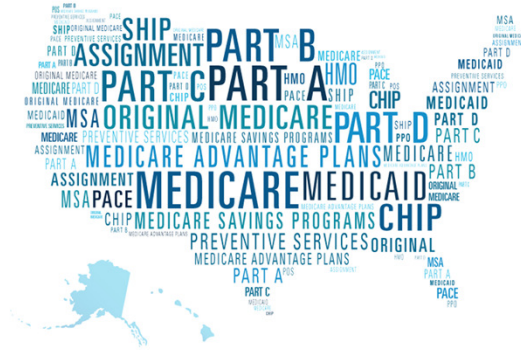




2017 National Training Program



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 June 2017. 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.

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The lessons in this module explain Medicaid and the Children’s Health Insurance Program.

The materials are designed for information givers/trainers who are familiar with the Medicare Program, and would like to have prepared information for their presentations.

The module consists of 48 PowerPoint slides with corresponding speaker’s notes and check-your-knowledge questions. 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.

NOTE: This module provides information at the national level. When presenting, you may want to provide state-specific information.

Session Objectives

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

This session should help you

- 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

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

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Lesson 1, “Medicaid Overview” explains the following:

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

Medicaid Overview

- Federal and state entitlement program
- Medical assistance for people with limited income and resources
- Covers about 69 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.

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-and-chip-enrollment-data/report-highlights/index.html](https://www.Medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html)

Medicaid Administration

- Jointly financed entitlement program
- Federally established national guidelines
- States get federal matching funds
 - Known as the Federal Medical Assistance Percentage (FMAP)
 - Used to calculate amount of federal share of state costs
 - Varies from state-to-state
 - Based on state per capita income

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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 its own plan
 - Establishes its own eligibility standards
 - Determines the type, amount, duration, and scope of services
 - Sets the payment rate for services
 - Partners with CMS to administer its program
 - Administers its own program once approved by the federal government
- States may change eligibility, services, and reimbursement during the year

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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. 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

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

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](https://www.Medicaid.gov/about-us/contact-us/contact-state-page.html), or contact your local State Health Insurance Assistance Program (SHIP) at www.shiptacenter.org. 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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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 get federal matching funds for covered services.

Medicaid Eligibility

- To be eligible for Medicaid, you must belong to one of these groups:
 - Pregnant
 - A child under a certain age (can be different depending on the state)
 - Disabled
 - Over 65
 - An adult in a state that expanded the Affordable Care Act
- States have to cover certain groups, like children and pregnant women, and have the option to cover other groups
- Financial and non-financial requirements

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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/by-topics/eligibility/eligibility.html](https://www.Medicaid.gov/Medicaid-chip-program-information/by-topics/eligibility/eligibility.html) for more information about Medicaid eligibility.

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

Eligibility—Medicaid Expansion

- Affordable Care Act's Eligibility Groups
 - 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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Starting January 1, 2014, the Affordable Care Act (ACA) established 3 new Medicaid eligibility groups:

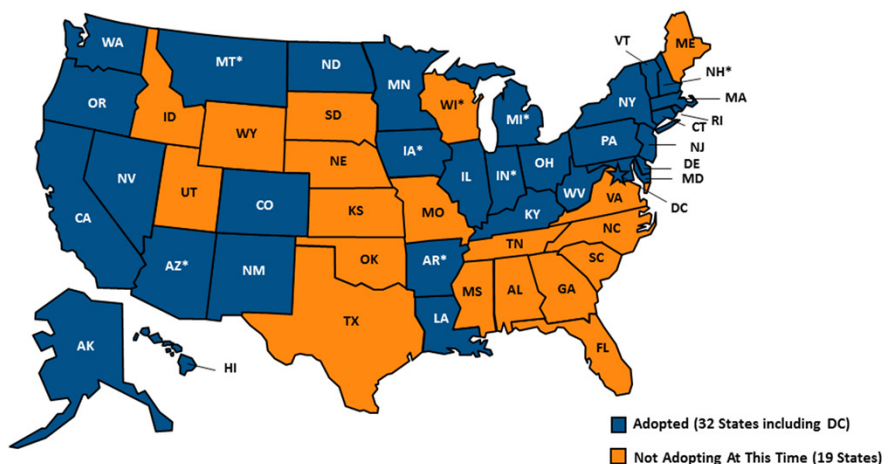
1. The adult group covers individuals 19–64 with income below 133% of the Federal Poverty Level (FPL), including 19- and 20-year-olds (children under 19 aren't included in this group because they're covered under other eligibility groups). To be eligible, individuals must meet non-financial requirements 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-learning-collaboratives/downloads/primer-for-eligibility-workers.pdf](https://www.Medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/primer-for-eligibility-workers.pdf).

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



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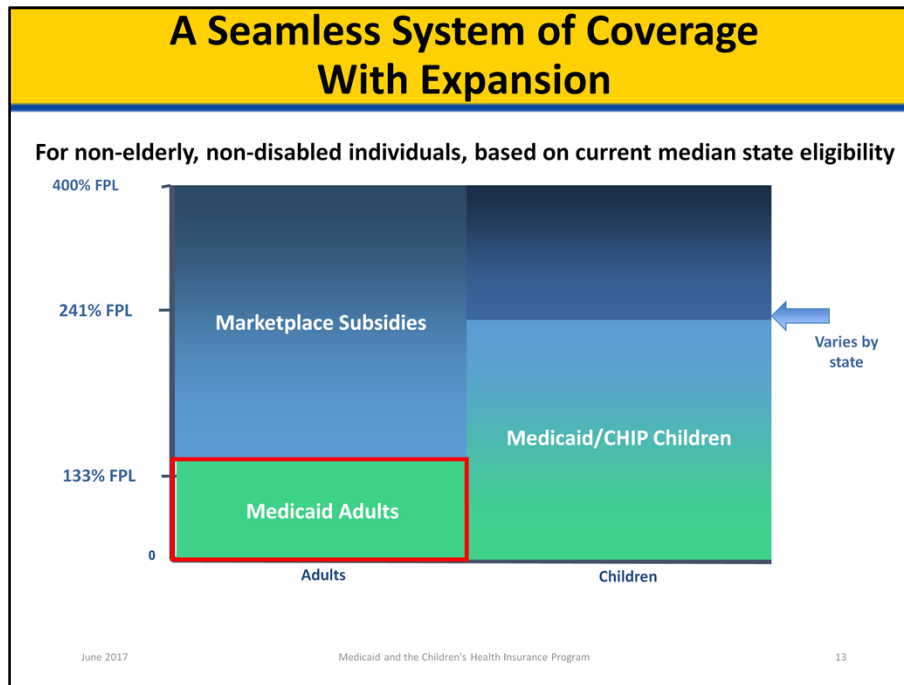
As of January 2017, 32 states (including the District of Columbia) elected to expand Medicaid coverage for the adult group with income below 133% FPL including Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, 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 1, 2017.

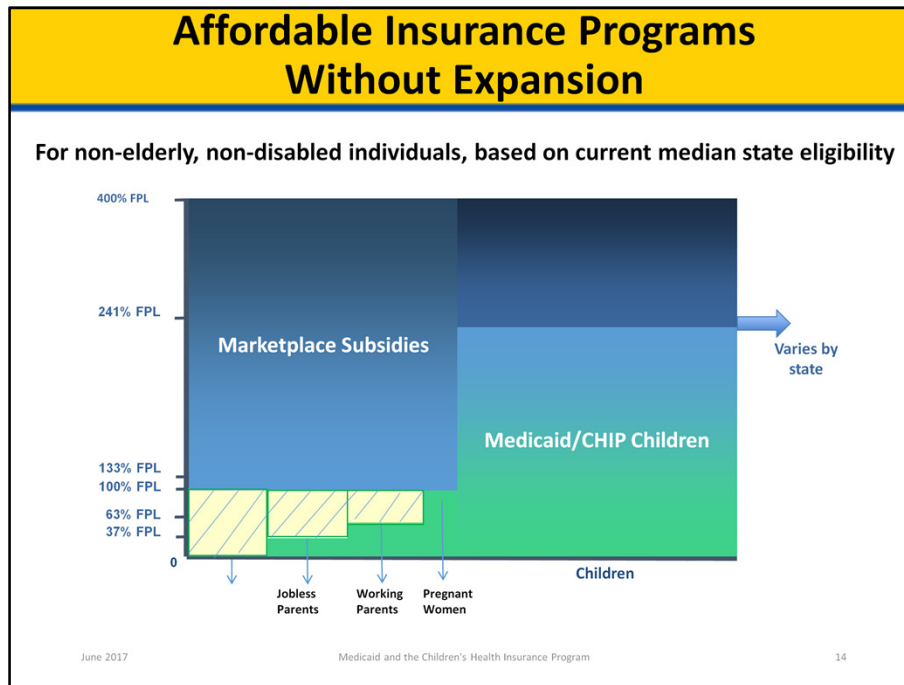


This chart is a visual display of coverage in states that expand coverage.

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).



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 Basic Health Plan (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

- 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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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/](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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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

- 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 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 (retroactively) 3 months.

For more information, visit [Medicaid.gov/chip/eligibility-standards/chip-eligibility-standards.html](https://www.Medicaid.gov/chip/eligibility-standards/chip-eligibility-standards.html) and [Medicaid.gov/medicaid/outreach-and-enrollment/continuous-eligibility/index.html](https://www.Medicaid.gov/medicaid/outreach-and-enrollment/continuous-eligibility/index.html).

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

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) Methodology (continued)

- 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 determining eligibility of a pregnant woman

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- 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](https://www.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/program-information/medicaid-and-chip-eligibility-levels/index.html#footnote4](https://www.Medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html#footnote4).

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

Under this option, called the “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 enrolls the individual in coverage as if the determination had been made by 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	
Children	
Pregnant Women	
	People eligible because of age, blind, or disability
	People who need long-term care
	People who are eligible for Medicare cost-sharing

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The Modified Adjusted Gross Income (MAGI) methodology for determining income applies to both Medicaid and Children's Health Insurance Program eligibility for most people, like children, pregnant women, parents, relative caretakers, and adults 19-64 (as applicable in a state). People who enroll in Medicaid because of age, blindness, or a disability won't use the MAGI. Medicaid eligibility for these individuals is generally determined using the income methodologies of the supplemental security income (SSI) program administered by the Social Security Administration. Some states, known as 209(b) states, use certain more restrictive eligibility criteria than SSI's, but still largely apply SSI's methodologies.

For more information about Medicaid eligibility and MAGI, visit [Medicaid.gov/medicaid/eligibility/index.html](https://www.Medicaid.gov/medicaid/eligibility/index.html).

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

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 documents. States may also use self-attestation to verify eligibility.

Check Your Knowledge—Question 2

Which of the following is NOT one of the expanded Medicaid eligibility groups?

- a. Under 26 and enrolled in Medicaid while in foster care
- b. U.S. Veterans
- c. Under 65 with income above 133% of FPL
- d. Ages 19–64 with income below 133% of FPL

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Check Your Knowledge—Question 2

Which of the following is NOT one of the expanded Medicaid eligibility groups?

- a. Under 26 and enrolled in Medicaid while in foster care
- b. U.S. Veterans
- c. Under 65 with income above 133% of the FPL
- d. Ages 19–64 with income below 133% of FPL

Answer: b. U.S. Veterans

Starting January 1, 2014, the Affordable Care Act 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-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.
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 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.
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.

Mandatory Medicaid State Plan Benefits

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment services (for children under 21)
- 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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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

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).

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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Mandatory Medicaid State Plan benefits also include

- 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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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 [Medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers.html](https://www.Medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers.html).

ACA Medicaid Funding Improvements & Expansion of Waivers

- 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 (TEFT)
- ACA expanded and increased flexibility of current Medicaid Programs
 - Money Follows the Person (MFP)
 - 1915(i) State Plan Option
 - Home and Community Based Services

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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](https://www.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
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Medicare and Medicaid are different in these ways:

- Medicare is a national program that is the same across the country; Medicaid consists of statewide programs that are different between 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, and 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 covered services

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Over 10 million people with Medicaid are “dual-eligible”—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](https://www.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](https://www.Medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html).

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

NOTE: Federal law bars Medicare and Medicare Advantage providers from balance billing a QMB beneficiary under any circumstances.

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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

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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, you must be eligible for Medicare Part A and have an income not more than 100% of the federal poverty level (FPL). This will be effective the first month after the month QMB eligibility is approved (can't be retroactive).

If you qualify for the Specified Low-income Medicare Beneficiary (SLMB) program you get help paying for your Part B premium. To qualify, you must be eligible for Medicare Part A and have an income that's at least 100%, but isn't more than 120% of the FPL.

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

If you qualify for the Qualified Disabled and Working Individual (QDWI) you get help paying your Part A premium. To qualify, you must be entitled to Medicare Part A because of a loss of disability-based Part A due to earnings exceeding substantial gainful activity (SGA), have an income not higher than 200% of the FPL and resources not exceeding twice maximum for Supplemental Security Income (\$4,000 for an individual and \$6,000 for married couple in 2017), and not be otherwise eligible for Medicaid. If your income is between 150% and 200% of the FPL, the state can ask you to pay a part of the Medicare Part A premium. The resource limits are \$4,000 (individual) and \$6,000 (married couple).

In 2017, the asset limits for the QMB, SLMB, and QI programs are \$7,390 for a single person and \$11,090 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 (official in April of each year).

See also [Medicare.gov/Contacts/staticpages/msps.aspx](https://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.

Check Your Knowledge—Question 3

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

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

Check Your Knowledge—Question 3

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

- a. True for QMB only
- b. True for QMB and SLMB
- 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

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 that provides health coverage to eligible children
- CMS establishes broad guidelines
- Federal government provides matching funds
 - ACA increased the matching rate by 23% effective October 1, 2015, and the Medicare and CHIP Reauthorization Act of 2015 (MACRA) maintained this increase
- States get money every year

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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 CHIP Programs
- States can design their CHIP Program in one 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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All 50 states, the District of Columbia, and U.S. territories have 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](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% higher than Medicaid
- Many states have higher limits
 - 46 states and DC 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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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

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

States have the option to cover children of public employees and unborn children of undocumented women 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

- 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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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](https://www.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

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

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 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.

Check Your Knowledge—Question 4

States have complete flexibility in designing their CHIP Programs.

a. True

b. False

Check Your Knowledge—Question 3

States have complete flexibility in determining their 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 that states can't cover children in higher-income families over lower-income families.

Medicaid and CHIP Resource Guide

Resources	Medicare Products
<p>Centers for Medicare & Medicaid Services</p> <ul style="list-style-type: none"> • CMS.gov • Medicaid.gov <p>Social Security</p> <ul style="list-style-type: none"> • Call 1-800-772-1213. TTY: 1-800-325-0778 • socialsecurity.gov <p>Federal Medical Assistance Percentages</p> <ul style="list-style-type: none"> • ASPE.hhs.gov/health/fmap.cfm <p>Health Care Expansion and Medicaid</p> <ul style="list-style-type: none"> • HealthCare.gov/medicaid-chip/medicaid-expansion-and-you/ <p>InsureKidsNow</p> <ul style="list-style-type: none"> • InsureKidsNow.gov <p>Local State Offices can be found using:</p> <ul style="list-style-type: none"> • Medicaid.gov/Medicaid-chip-program-information/by-state/by-state.html 	<ol style="list-style-type: none"> 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)
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Medicaid and CHIP Resource Guide (continued)

Medicare Products (continued)

- | | |
|--|---|
| <p>4. National Training Program Job Aids
(CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/National-Training-Program-Resources.html)</p> <p>5. “Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs”
(CMS Product No. 006977)</p> <p>6. “4 Programs that Can Help Pay Your Medical Expenses” (CMS Product No. 11445)</p> <p>7. “Medicaid: Getting Started” (CMS Product No. 11409)</p> <p>8. “What is Medicare? What is Medicaid?” (CMS Product No. 11306)</p> | <p>9. CMS Partner Tip Sheets
(CMS.gov/publications-for-partners.html)</p> <p>10. “Medicaid Spend Down” (CMS Product No. 11249-P)</p> <p>11. “The Limited Income NET Program for People With Retroactive Medicaid & SSI Eligibility” (CMS Product No. 11401-P)</p> <p>To access these products:</p> <ul style="list-style-type: none"> • View and order single copies at Medicare.gov/publications. • Order multiple copies (partners only) at Productordering.cms.hhs.gov.
<i>You must register your organization.</i> |
|--|---|

Appendix A—Medicaid Agencies

State	Website	Application Format

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

State	Medicaid Enrollment Numbers

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

State	Children	Pregnant Women	Parents	Adults

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

State	FMAP	Enhanced FMAP

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

Acronyms

ACA Affordable Care Act	MAGI Modified Adjusted Gross Income
BHP Basic Health Program	MFP Money Follows the Person
CHIP Children’s Health Insurance Program	MSP Medicare Savings Program
CMS Centers for Medicare & Medicaid Services	NTP National Training Program
ESRD End-Stage Renal Disease	TEFT Testing Experience and Functional Assessment Tools
FMAP Federal Medical Assistance Percentage	QDWI Qualified Disabled and Working Individual
FPL Federal Poverty Level	QHP Qualified Health Plans
HCBS Home and Community-Based Services	QI Qualified Individual
LTSS Long-Term Services and Supports Spending	QMB Qualified Medicare Beneficiary
	SLMB Specified Low-Income Medicare Beneficiary
	SSA Social Security

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