



Medicaid and CHIP Overview



October 2021

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A Note About This Presentation

This presentation applies if you are:

- A Navigator or certified application counselor (collectively, an assister) in a state with a Federally-facilitated Marketplace.
- Assisting low-income individuals, families, or children who may be uninsured or exploring different health coverage options.



Overview: Medicaid and CHIP

- Medicaid and the Children's Health Insurance Program (CHIP) are federal health coverage programs administered individually by each state and territory to provide comprehensive coverage for over 81 million eligible beneficiaries, including:
 - Medicaid
 - Parents and children
 - Pregnant individuals
 - Older consumers
 - People with disabilities
 - Other low-income adults, depending on the state
 - CHIP
 - Uninsured children up to age 19 whose household income is too high for them to qualify for Medicaid
 - In some states, low-income pregnant individuals
- Medicaid and CHIP eligibility requirements and program benefits vary by state.



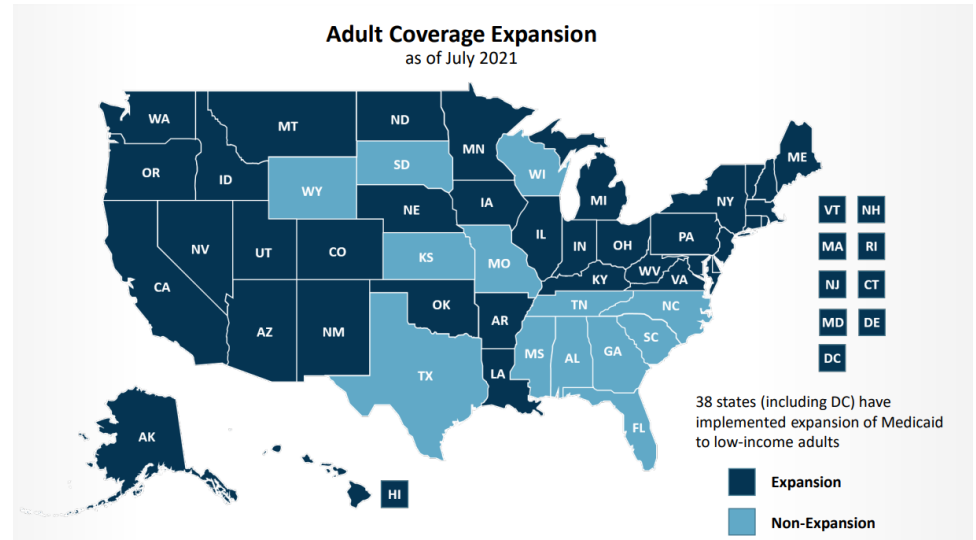
Eligibility Basics

- Medicaid and CHIP eligibility depends on several factors including:
 - A consumer's income level
 - The number of people in their household
 - Their U.S. citizenship or immigration status
 - The state in which they live
 - The consumer's age, pregnancy status, and disability status
- Modified adjusted gross income (MAGI) is used to determine most consumers' financial eligibility for Medicaid and CHIP, including most children, pregnant individuals, parents, and non-elderly adults.



Expansion for the Medicaid Adult Group

- Under the Affordable Care Act (ACA), states have the opportunity to expand Medicaid coverage to low-income adults under the age of 65 with incomes at or below 133 percent (in practice, 138 percent) of the federal poverty level (FPL). As of July 2021, 38 states including the District of Columbia have implemented this expansion.
- Assistors should be prepared to assist consumers in expansion states with their options for enrolling in Medicaid.
- Assistors can find the status of state expansion at the map provided by Medicaid at [Medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map-07-2021.pdf](https://www.Medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map-07-2021.pdf).



2021 Medicaid Eligibility Based on Medicaid Adult Group, Income, and Household Size

Number of People in the Household	Income Below 138% of the FPL
1	\$17,774
2	\$24,040
3	\$30,305
4	\$36,570
5	\$42,835
6	\$49,100
6+	For each additional person, add \$6,265

Note: These numbers represent 2021 FPLs for the 48 contiguous states and DC. FPL amounts are higher in Alaska and Hawaii.

- If your income is below 138 percent of the FPL and your state has expanded Medicaid coverage to the adult group, you may qualify for Medicaid based only on your income.
- Consumers in states that have not expanded Medicaid coverage to the adult group for households with income below 100 percent of the FPL (\$12,880 for a household of one, with an increase of \$4,540 for each additional person) may not qualify for either income-based Medicaid or financial assistance for a Marketplace plan. Assistors should help consumers in this situation understand that they may still qualify for Medicaid under their current state rules.

Knowledge Check #1



States have the opportunity to expand Medicaid coverage to low-income adults under the age of 65 up to what percent of the FPL?

Knowledge Check #1 Answer

States have the opportunity to expand Medicaid coverage to low-income adults under the age of 65 up to what percent of the FPL?

Answer: 138 percent



Benefits

- States establish and administer their own Medicaid and CHIP programs in accordance with federal requirements and determine the type, amount, duration, and scope of services within federal guidelines. Medicaid benefits for children under the age of 21 must include the full range of medically necessary services.* Medicaid benefits for adults may vary but generally must be comprehensive in scope.
- CHIP provides comprehensive benefits to children. States have flexibility to design their own program within federal guidelines, so benefits vary by state and by the type of CHIP program. However, all states must provide well-baby and well-child care, dental coverage, behavioral health care, the COVID vaccine, and all other ACIP-recommended, age-appropriate vaccines.

*Including 1905(a) benefits, even if they are not covered in the state plan for individuals over the age of 21. States must minimally provide all mandatory 1905(a) benefits to all eligible beneficiaries.



Medicaid/CHIP Changes for Eligibility Based on Pregnancy

- With Medicaid coverage, pregnant individuals get help paying for care related to pregnancy and labor and delivery, as well as postpartum care.
- Pregnant individuals who are receiving Medicaid on the date their pregnancy ends continue their Medicaid coverage for a postpartum period that lasts for 60 days after the end of the pregnancy and through the end of the month in which the 60-day period ends. After the postpartum period ends, they may lose Medicaid eligibility.
- The American Rescue Plan, enacted March 11, 2021, gives states the option to extend Medicaid coverage for most pregnant individuals beyond the required 60-day postpartum period through the end of the month in which a 12-month postpartum period ends.
- If adopted for Medicaid, the extended postpartum coverage election applies automatically to CHIP in the state for most children and pregnant individuals, as applicable.
- This state option begins on April 1, 2022, and is currently authorized for five years from that date.



Out-of-Pocket Costs

Within limits, states can impose copayments, coinsurance, deductibles, and other similar charges on most Medicaid-covered benefits. Out-of-pocket amounts vary depending on a Medicaid beneficiary's income. All out-of-pocket charges are based on the specific state's defined payment amount for that service.

Maximum Allowable Copayments Determined by Eligible Population's Household Income

Services and Supplies	Less than or equal to 100% of the FPL	101-150% of the FPL	Greater than 150% of the FPL
Inpatient Hospital	\$91.60	10% of the cost the agency pays	20% of the cost the agency pays
Outpatient Services	\$4.90	10% of the cost the agency pays	20% of the cost the agency pays
Non-emergency Use of the Emergency Department	\$9.80	\$9.80	No limit; must remain within the 5% aggregate family cap
Preferred Drugs	\$4.90	\$4.90	\$4.90
Non-preferred Drugs	\$9.80	\$9.80	20% of the cost the agency pays

Applying for Medicaid or CHIP

You can help consumers find out whether they are eligible for Medicaid at any time during the year in two main ways:

- 1. Through their state's website.** Consumers can find their state's website at [HealthCare.gov/medicaid-chip/eligibility](https://www.healthcare.gov/medicaid-chip/eligibility).
- 2. Fill out a Marketplace application.** Help consumers complete a Marketplace application to learn about the programs for which they may be eligible.



Coverage for Certain Adults Below 100 Percent of the FPL

- In states that have not expanded Medicaid, many adults with incomes below 100 percent of the FPL do not qualify for Medicaid or savings on Marketplace coverage.
- These adults should still fill out a Marketplace application in order to explore all available coverage options. In addition, you could discuss the following options:
 - **Obtain health care services at federally-qualified community health centers.** Use the following tool to find a community health center near the consumer: [HealthCare.gov/community-health-centers](https://www.healthcare.gov/community-health-centers).
 - **Purchase Catastrophic coverage**, which is available for people under 30 years old and people granted a hardship or affordability exemption. For more information, visit [HealthCare.gov/choose-a-plan/catastrophic-health-plans](https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans).
 - **Find out what pharmaceutical assistance programs may be available.** You can help consumers find out if assistance is available for the medications they take by visiting [Medicare.gov/pharmaceutical-assistance-program](https://www.medicare.gov/pharmaceutical-assistance-program).
 - **Other coverage options, including short-term, limited-duration insurance.**
 - For more resources, please refer to the Resources for the Uninsured webinar at [Marketplace.cms.gov/technical-assistance-resources/connecting-uninsured-to-health-care-resources.pdf](https://www.marketplace.cms.gov/technical-assistance-resources/connecting-uninsured-to-health-care-resources.pdf) and the Health Coverage Options for the Uninsured fact sheet at [Marketplace.cms.gov/technical-assistance-resources/health-coverage-options-for-uninsured.pdf](https://www.marketplace.cms.gov/technical-assistance-resources/health-coverage-options-for-uninsured.pdf).

Medicaid/CHIP and Minimum Essential Coverage

- Most Medicaid and CHIP coverage qualifies as minimum essential coverage (MEC).
- However, certain types of limited Medicaid coverage are not recognized as MEC, including limited coverage offered by some states that only pays for family planning services or treatment for an emergency medical condition for non-citizens who do not have satisfactory immigration status, or limited services to treat a specific condition.
- Consumers who are determined eligible for or are enrolled in coverage through Medicaid or CHIP that counts as MEC are ineligible for advance payments of the premium tax credit (APTC) for themselves and for income-based cost-sharing reductions (CSRs) to help pay for the cost of their Marketplace coverage. If they are enrolled in both Medicaid or CHIP and Marketplace coverage with APTC and CSRs, the consumer should visit [HealthCare.gov/medicaid-chip/cancelling-marketplace-plan](https://www.healthcare.gov/medicaid-chip/cancelling-marketplace-plan) or contact the Marketplace Call Center at 1-800-318-2596 for instructions on how to end their Marketplace coverage with APTC and CSRs.

Medicaid Eligibility and Citizenship

- To be eligible for full Medicaid benefits, individuals must be U.S. Citizens, U.S. nationals, or have a satisfactory immigration status.
- Individuals who are non-citizens and who have a “qualified non-citizen” immigration status are eligible to enroll in Medicaid or CHIP, if they are otherwise eligible for Medicaid or CHIP in the state.
- Federal law requires that many qualified non-citizens meet a five-year waiting period (also called the “five-year bar”) before becoming eligible for Medicaid or CHIP.
 - This five-year waiting period begins when consumers receive their qualifying immigration status, not when they first enter the United States.
- Consumers with certain immigration statuses are exempt from the five-year waiting period (e.g., refugees and asylees). “Qualified non-citizen” immigration statuses exempt from the five-year waiting period can be found at [HealthCare.gov/immigrants/lawfully-present-immigrants](https://www.healthcare.gov/immigrants/lawfully-present-immigrants).
- States have the option to remove the five-year waiting period and cover lawfully residing children and/or pregnant individuals in Medicaid or CHIP through the [CHIPRA 214 program](#). A child or pregnant woman is "lawfully residing" if they're "lawfully present" and otherwise eligible for Medicaid or CHIP in the state.
- Medicaid provides payment for treatment of an emergency medical condition for people who meet all Medicaid eligibility criteria in the state (such as income and state residency) but don't have an eligible immigration status.

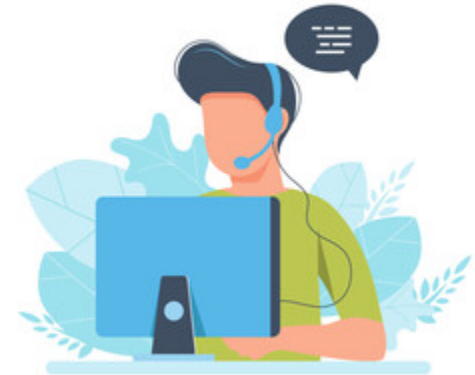
Medicaid Eligibility Changes for COFA Migrants

- Compacts of Free Association (COFA) are agreements between the United States and the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau that permit certain citizens of those nations to lawfully work, study, and reside in the U.S.
- Effective December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) requires states and the District of Columbia to provide all Medicaid benefits covered under a state's Medicaid program to COFA migrants who otherwise meet all of the eligibility requirements in the state. Extension of Medicaid eligibility to COFA migrants is optional for the U.S. Territories (American Samoa, Guam, the Northern Mariana Island, Puerto Rico, and the U.S. Virgin Islands).
- Prior to the passage of the CAA, COFA migrants were considered lawfully present non-citizens, but not qualified non-citizens (QNCs), so they were eligible for qualified health plans (QHP), APTC, and CSRs, but were generally not eligible for Medicaid, although they may have been eligible for the treatment of an emergency medical condition.
- As a result of this new legislation, COFA migrants are now defined as QNCs and exempted from the five-year waiting period ("five-year bar") for purposes of Medicaid eligibility only.
- COFA Medicaid extension provided under the CAA does not extend to separate CHIP programs. However, states and territories can cover COFA migrants in a separate CHIP under the CHIPRA 214 option.

Knowledge Check #2

All Medicaid is minimum essential coverage.

True or False?



Knowledge Check #2 Answer

All Medicaid is minimum essential coverage.

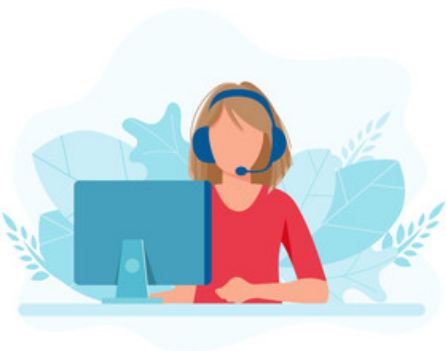
False

Most Medicaid programs are considered MEC or qualifying health coverage. However, certain types of limited Medicaid coverage are not recognized as MEC, including coverage that only pays for family planning, the treatment of an emergency medical condition for non-citizens who do not have satisfactory immigration status, and tuberculosis services.



Knowledge Check #3

What should a consumer do if they receive a Medicaid/CHIP Periodic Data Matching (PDM) notice from the Marketplace?



- A. Update their online Marketplace application to indicate they are not enrolled in Medicaid or CHIP coverage that is considered MEC, as applicable.
- B. Nothing.
- C. End their Marketplace coverage with APTC and CSRs if they are enrolled in Medicaid or CHIP coverage that is considered MEC; otherwise, they will have to pay full cost for their share of the Marketplace plan premium and covered services.

Knowledge Check #3 Answer

What should a consumer do if they receive a Medicaid/CHIP Periodic Data Matching (PDM) notice from the Marketplace?

Consumers should either:

- A. Update their online Marketplace application to indicate they are not enrolled in Medicaid or CHIP coverage that is considered MEC, as applicable;

OR

- C. End their Marketplace coverage with APTC and CSRs if they are enrolled in Medicaid or CHIP coverage that is considered MEC; otherwise, they will have to pay full cost for their share of the Marketplace plan premium and covered services.



Complex Case Scenario

- On April 16, 2021, Joanne came in to meet with an assister and reported that she enrolled herself in a QHP and thought she enrolled her two-year-old son in CHIP during the Marketplace's Open Enrollment (OE) with an effective date of January 1, 2021.
- Joanne stated that her son was hospitalized on January 27, 2021, and that her insurance claims for his hospitalization were rejected. She did not realize her son had been denied CHIP coverage. Joanne did receive a CHIP denial on March 9, 2021. Therefore, her son is eligible for an SEP for QHP coverage because the CHIP denial occurred after OE ended, but the CHIP application was submitted during OE.



- However, when Joanne called the Marketplace on April 15, 2021, she was told that the effective date of her son's QHP coverage via the SEP would be April 15, 2021. Joanne wants to know if it would be possible to get her son's coverage date set back to January 1, 2021, so that his hospitalization would be covered.

Applicable Rules

- Consumers may be eligible for an SEP to enroll in a QHP through the Marketplace if they:
 - Applied for coverage through the Marketplace or their state Medicaid/CHIP agency during OE or during an SEP for which they were eligible;
 - Were assessed potentially Medicaid/CHIP-eligible and referred to their state's Medicaid agency for a final eligibility determination; and
 - Received a Medicaid/CHIP denial from the state after OE or their other SEP window ended.
- The SEP is available for 60 days from the date of the denial by the state.

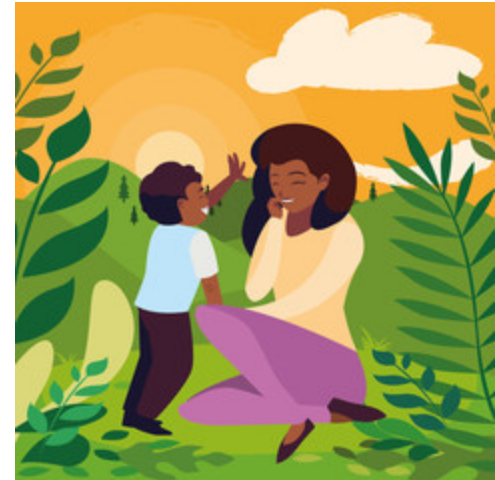


Applicable Rules (Cont.)

- Such consumers who first applied at the Marketplace during OE or during an SEP for which they were eligible have the option to request a retroactive coverage effective date back to the effective date they would have received based on the date of their original Marketplace application, so long as they pay any outstanding premiums.
- Every time a consumer applies to the Marketplace and indicates they want to see if they can get help paying for coverage, their eligibility for Medicaid or CHIP will be reassessed based on factors including their household size and income, unless they attest to a Medicaid/CHIP denial by the state in the last 90 days and also attest to no changes since the denial.
- For applications submitted to the Marketplace that include consumers who may be Medicaid/CHIP-eligible, some states make the final Medicaid/CHIP eligibility determination, while some states allow the Marketplace to determine Medicaid/CHIP eligibility.

Helpful Tips

- Remember, for Joanne to receive the SEP with a retroactive coverage effective date in this specific scenario, she and her son had to have applied through the Marketplace during OE and received the Medicaid/CHIP denial from the state agency outside of OE.



Helpful Tips (Cont.)



- In this scenario, once consumers have received their Medicaid or CHIP denial from the state agency, they should update their Marketplace application, including checking the box to indicate they have received a Medicaid or CHIP denial in the past 90 days and attest that they haven't had any changes, as applicable, and answer related questions to see if they are eligible for an SEP.
- Consumers should never select the box on the Marketplace application stating they have received a Medicaid or CHIP denial before they actually receive notice of the denial. This is to ensure the consumer or the consumer's family member are not later determined eligible for and enrolled in Medicaid or CHIP and dually enrolled in Marketplace coverage.

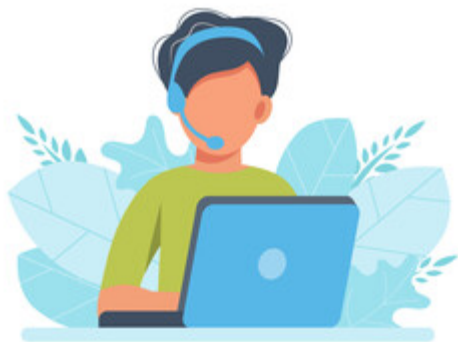
Applying the Rules to Joanne's Situation

- Joanne could request to have her son added to her original application for a QHP, which was effective January 1, 2021, but she will be liable for any outstanding premiums from January 1, 2021, to April 15, 2021.
- If she can pay the outstanding premiums from January, February, March, and April, the effective date can be changed to January 1, 2021, through the Marketplace casework system, and her son's hospitalization may be covered if the hospital providers are in-network.



Knowledge Check #4

Consumers who receive a Medicaid denial outside of OE are eligible for an SEP ONLY if they applied for coverage during OE or during another SEP window and were denied Medicaid or CHIP coverage after OE or their original SEP window ended. How long do these consumers have to sign up for a Marketplace plan after they receive their denial?



- A. 30 days
- B. 45 days
- C. 60 days
- D. 90 days

Knowledge Check #4 Answer

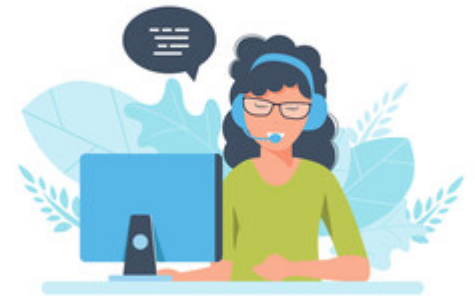
Consumers who receive a Medicaid denial outside of OE are eligible for an SEP ONLY if they applied for coverage during OE or during another SEP window and were denied Medicaid or CHIP coverage after OE or their original SEP window ended. How long do these consumers have to sign up for a Marketplace plan after they receive their denial?

- C. 60 days The SEP eligibility period for most qualifying events is 60 days. This includes post-enrollment-period Medicaid denials.



Knowledge Check #5

Consumers who qualify for an SEP to purchase a Marketplace plan due to a post-OE (or post-SEP) Medicaid/CHIP denial are not eligible to receive Marketplace coverage back to the effective date they would have received based on the date of their original Marketplace application.



True or False?

Knowledge Check #5 Answer

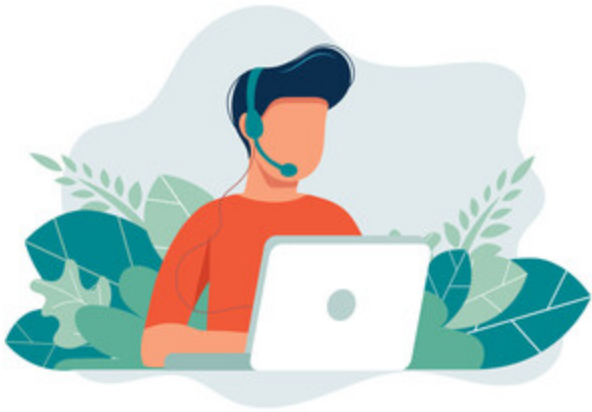
Consumers who qualify for an SEP to purchase a Marketplace plan due to a post-OE (or post-SEP) Medicaid/CHIP denial are not eligible to receive Marketplace coverage back to the effective date they would have received based on the date of their original Marketplace application.

False



If they originally applied at the Marketplace during OE or during an SEP window, consumers who qualify for an SEP to purchase a Marketplace plan due to a post-OE (or post-SEP) Medicaid/CHIP denial may be eligible to receive a retroactive coverage effective date back to the effective date they would have received based on the date of their original Marketplace application.

Knowledge Check #6



In order to receive coverage retroactively, what must the consumer do?

- A. Nothing
- B. Call the Marketplace
- C. Pay any outstanding premiums

Knowledge Check #6 Answer

In order to receive coverage retroactively, what must the consumer do?

Both:

B. Call the Marketplace

AND

C. Pay any outstanding premiums



Consumers will not get retroactive coverage if they do not first call the Marketplace Call Center to request it. The system will default to coverage that is effective per accelerated prospective effective rules; that is, coverage will start the first of the month following their date of plan selection.

Additional Resources

For more information, visit:

- [Medicaid.gov](https://www.Medicaid.gov)
- [Insurekidsnow.gov](https://www.Insurekidsnow.gov)
- HealthCare.gov: Getting Medicaid & CHIP Coverage
[HealthCare.gov/medicaid-chip/getting-medicaid-chip](https://www.HealthCare.gov/medicaid-chip/getting-medicaid-chip)
- Medicaid and CHIP Eligibility
 - [Medicaid.gov/medicaid/eligibility/index.html](https://www.Medicaid.gov/medicaid/eligibility/index.html)
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