U.S. DIGITAL SERVICE

Medicaid 101

U.S. DIGITAL SERVICE // FFS RENEWALS TEAM // JULYISH, 2023

DISCLAIMER

This presentation was **NOT** made by Medicaid experts.

It's geared towards the group of USDS folks working on Medicaid PHE renewals, but shouldn't be used as official guidance! This is introductory and not authoritative.

What is Medicaid?

WHAT IS MEDICAID?

Medicaid is health insurance from the government.

- Medicaid is **health insurance** for certain groups of people, provided by the government.
- **1 in 4 Americans** are on Medicaid; with **93 million recipients**, it's the largest public safety net benefit.
- Not everyone is eligible for Medicaid. People get Medicaid by **applying to their state Medicaid agency**.

WHAT IS MEDICAID?

- Medicaid is **federally funded, state administered**. This means that the Federal Government (CMS) provides **funding, oversight, and structure** to the states for the purpose of running a Medicaid program. The states then **run a Medicaid program**.
  - States submit a **State Medicaid Plan** to CMS detailing how their Medicaid program will work.
  - CMS can provide **waivers** on a case-by-case basis to allow states flexibility with respect to rules.
  - Some states **further delegate administration to counties**. In these states, counties administer the program in coordination with the state.

Types of Medicaid

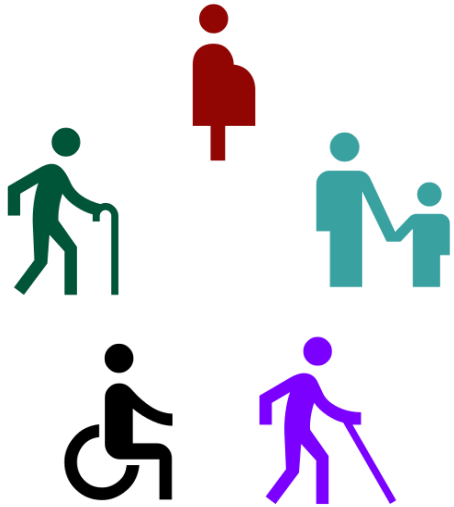
But first: Some history

- Medicaid was established in 1965. Up to 2010, the program was iterated on and adjusted, but remained **largely the same during those 45 years.**
- In 2010, Medicaid was **drastically expanded** under the **Affordable Care Act (ACA).** Many of the rules were altered, and huge numbers of people became eligible.
- In 2012, a Supreme Court decision declared that states **do not have to operate under some of the expansion rules.** These states are called "non-expansion" states.

TYPES OF MEDICAID

Prior to the ACA, the following groups were eligible for Medicaid:

- Aged (65+), blind, and/or disabled
- People with low incomes in the following categories:
  - Parents/caretakers
  - Pregnant people
  - Children
- Various smaller groups (foster care, people who are working with disabilities, etc.)
- Other groups the state chooses to cover



TYPES OF MEDICAID

After the ACA, the low-income group was expanded to include **any person with a household income below 138% of the federal poverty line.**

As a result, expansion states typically have **much higher levels of enrollment** in this group.

Non-expansion states still operate under the pre-ACA eligibility rules.

TYPES OF MEDICAID

- **MAGI [MAJ-eye]** - Any group that requires an income check based on **Modified Adjusted Gross Income (MAGI)**
  - Low-income parents/caretakers
  - Low-income children
  - Low-income pregnant people
  - Low-income adults (expansion states)
  - Any other group the state optionally covers that **requires a MAGI check**

- **Non-MAGI –** Any group that **DOES NOT** require a MAGI income check
  - Aged/Blind/Disabled (SSI, unless 209(b))
  - Smaller groups (foster care, people working with disabilities, etc.)
  - Waiver programs
  - Any other group the state optionally covers that **does not** require a MAGI check

MAGI Medicaid

MAGI Medicaid

When a person's **Modified Adjusted Gross Income (MAGI)** is used to qualify them for Medicaid, they are said to be on "MAGI" Medicaid.

MAGI is a value calculated for a person's **household**, and must be under an **individual's personal income threshold** in order for them to be determined eligible.

The MAGI population is **much larger** than the non-MAGI population.

MAGI MEDICAID

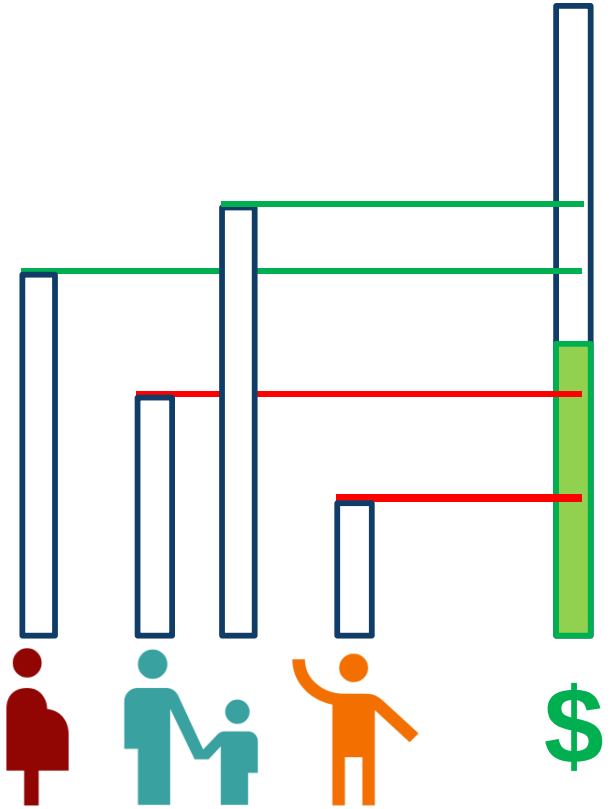
MAGI is calculated as follows:

- For each person in the household:
  - Start with their **Adjusted Gross Income (AGI)**. This is available on their tax return (1040) or can be calculated by summing up sources of income.
  - Add **modifications** to the AGI to get their individual MAGI (non-taxable interest, etc.)
- Sum the MAGI values for all household individuals to get the **household MAGI value**

MAGI MEDICAID

Once a household has a MAGI value, it's compared to that person's **individual MAGI threshold**. The threshold is **NOT** the same for everyone in the household!

- Children often have **higher** thresholds than adults, meaning it is possible for a **child to eligible for Medicaid,** but their parents are **not eligible**.
- Thresholds are expressed as **percentages of the Federal Poverty Line (FPL)**. The FPL itself varies depending on the household size (four people have a higher FPL than one)



Non-MAGI Medicaid

Non-MAGI Medicaid

Non-MAGI Medicaid consists of several groups of Medicaid eligibility, **none of which require a MAGI check.**

Depending on the category of eligibility, **income may still be a factor** in a non-MAGI determination, but it does not follow the MAGI rules.

NON-MAGI MEDICAID

The biggest non-MAGI group is the **Aged (or Elderly), Blind, and Disabled (ABD/EBD)** group.

- Being aged (65+), blind, and/or disabled qualifies people for **Supplemental Security Income (SSI)**. SSI, in turn qualifies people for Medicaid.
    - In most states, this is literal; they give Medicaid **automatically** to anyone on SSI. But a few states (called **209(b)** states) do not automatically give Medicaid to SSI recipients.
- If a person does **not** receive SSI, they may **still be eligible** for ABD Medicaid.
- ABD Medicaid typically requires both an **asset/resource** test, and a non-MAGI income test.

NON-MAGI MEDICAID

- Beyond the ABD group, there are lots of **smaller groups** contained within the non-MAGI group. Below are some examples, but there are **many more**:
  - **Waiver Programs** - These programs provide Medicaid to individuals receiving long-term care at home. These are individuals who would likely require institutionalized care otherwise.
  - **Foster Care** - Individuals in foster care and those who have recently aged out are eligible for Medicaid.
  - **Ticket to Work –** ABD Medicaid is predicated on a person being unable to work due to disability. A Ticket to Work program provides Medicaid to people with disabilities who are working.

Other Eligibility Pathways

OTHER ELIGIBILITY PATHWAYS

Aside from **MAGI** and **non-MAGI,** there is one other pathway to Medicaid eligibility: **Categorical Eligibility**.

Being a recipient of another benefit (like SNAP) can make an applicant **automatically eligible** for Medicaid. Usually this requires a waiver from CMS. However, this skips all other eligibility steps required for MAGI and non-MAGI Medicaid.

SSI and ABD Medicaid can be thought of as categorical eligibility.

Non-Income Eligibility Factors

NON-INCOME ELIGIBILITY FACTORS

- **Residency** - Medicaid beneficiaries must be residents of the state running the program they are participating in.
- **Citizenship and Immigration Status** - Beneficiaries must be citizens of the United States, or have an immigration status that qualifies them for Medicaid.
- **Assets/Resources** - ABD Medicaid recipients are subject to an asset or resource test; this can include bank accounts, retirement savings, vehicles, and more.

NON-INCOME ELIGIBLITY FACTORS

Immigration status (applicable when a person is not a citizen) is a complicated factor. Most migrants are qualified for Medicaid after they have been in the United States for **five years**; this is also called the "five year ban". In the meantime, they may have access to **emergency Medicaid** or benefits through the state's plan.

Certain countries are not subject to the ban; **COFA states, Cuba, and Haiti**.

NON-INCOME ELIGIBLITY FACTORS

Resources/assets are used to determine eligibility for ABD Medicaid. This can include bank accounts, retirement accounts, vehicles, properties, etc.

Applying for (and getting) Medicaid

APPLYING FOR (AND GETTING) MEDICAID

Apply

Applicants submit applications to their state Medicaid agency

Determination

The state Medicaid agency makes a determination of eligibility

Usage

The beneficiary uses their coverage throughout the year

Renewal

Once per year, the beneficiary renews their coverage

Applying

APPLYING FOR MEDICAID

All states provide **paper applications** for Medicaid. These can be filled out and submitted to a local office or mailed.

Most states provide at least one **other modality of application**, including:

- Fax
- Website
  - Without an account (guest user)
  - With an account (username + password)
- Phone

STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

1. First Name, Middle Name, Last Name, & Suffix

2. Home Address (Leave blank if you don't have one.) | 3. Apartment or Suite Number

4. City | 5. State | 6. ZIP code | 7. County

8. Mailing Address (if different from home address) | 9. Apartment or Suite Number

10. City | 11. State | 12. ZIP code | 13. County

14. Phone Number | 15. Other Phone Number

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address:

17. Preferred spoken or written language (if not English)

STEP 2 Tell us about your family.

Who do you need to include on this application?

Complete the Step 2 pages for every person in your family and household, even if the person has health coverage already. The information in this application helps us make sure everyone gets the best coverage they can. The amount of help or type of program you qualify for is based on the number of people in your family and their incomes. If you don't include someone, even if they already have health coverage, your eligibility could be affected.

For adults who need coverage:

Include these people **even if they aren't applying for health coverage themselves:**

- Any spouse
- Any son or daughter under age 21 they live with, including stepchildren
- Any other person on the same federal income tax return (Including any children over age 21 that are claimed on a parent's tax return). You don't need to file taxes to get health coverage.

For children under age 21 who need coverage:

Include these people **even if they aren't applying for health coverage themselves:**

- Any parent (or stepparent) they live with
- Any sibling they live with
- Any son or daughter they live with, including stepchildren
- Any other person on the same federal income tax return. You don't need to file taxes to get health coverage.

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

Complete Step 2 for each person in your family. Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

To be eligible for coverage, parents requesting health care coverage for themselves must provide proof that the children have creditable coverage, even if not applying for the children. Credible coverage is health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; The Federal Employees Health Benefits Program; Indian Health Service; The Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, or a foreign country); Children's Health Insurance Program (CHIP); or, a state health insurance high risk pool.

DCH-1426 (Rev. 3-20) Previous edition obsolete

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APPLYING FOR MEDICAID

- Medicaid applications contain fields for **all relevant eligibility information**. This can include any or all of the following fields and more, depending on what type of Medicaid the applicant needs:
  - SSN, Name, Date of Birth, Address
  - Jobs, income
  - Assets/Resources
  - Family relationships and/or household members
  - Citizenship, immigration status
  - Etc.

APPLYING FOR MEDICAID

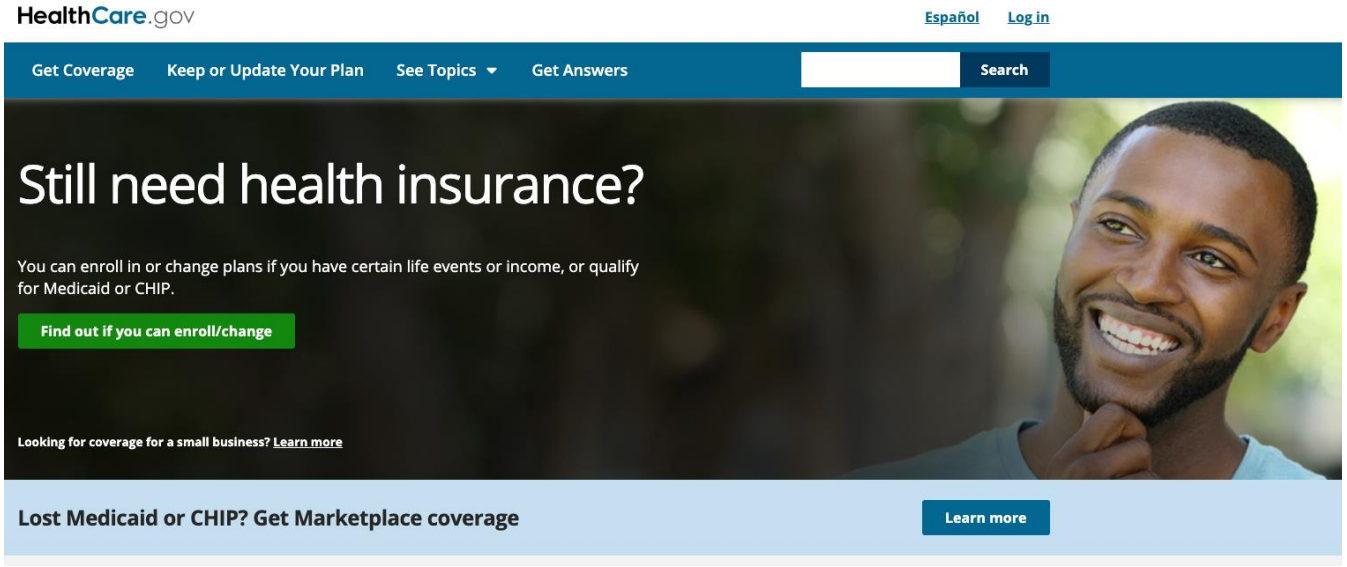
Some states provide **combined applications** for Medicaid and other benefit programs (SNAP, TANF, LIHEAP, etc.) These applications are also called **integrated applications.**

Integrated applications simplify the process for applying to multiple benefits, but can **drastically increase the length** of an application. This can be mitigated through online applications, but only if the state offers them. This can also introduce complications, as **rules and definitions vary between programs**.

APPLYING FOR MEDICAID

In addition to applying directly to Medicaid, a person can apply through their **healthcare marketplace**. For some states, this is the **Federally Facilitated Marketplace (FFM)**, also known as healthcare.gov. For other states, this is a **State Based Marketplace (SBM)**.

When the Marketplace determines a person may be eligible for Medicaid, it is **required** to hand that person's information off to the state's Medicaid program.



APPLYING FOR MEDICAID

All Medicaid applicants apply through their state Medicaid program, **with one exception**. Recipients of ABD Medicaid who qualify by receiving SSI **apply through SSA**, who then provides a list of SSI (and therefore Medicaid) recipients to the state. These people automatically receive Medicaid upon reception.

The exception to the exception is **209(b)** states, in which SSI recipients still have to apply for Medicaid through their state (and may or may not be automatically eligible).

Eligibility Determination

ELIGIBILITY DETERMINATION

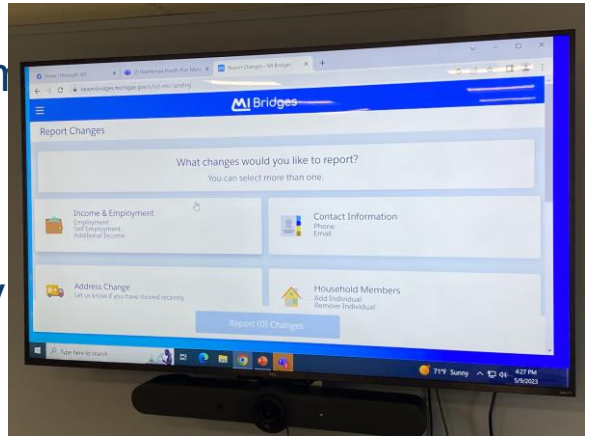
Once an application is received by a Medicaid program, the program makes an **eligibility determination**. This is a "Yes/No" decision that determines if the applicant is eligible for Medicaid.

Eligibility determinations involve **verifying the relevant information** through electronic or manual means. The methods and rules concerning how information is verifying depends on the item under scrutiny. For some items (like date of birth), **self-attestation is sufficient**. For others (like income), **electronic and paper verification methods** must be used.

ELIGIBILITY DETERMINATION

The system used to determine eligibility is called the **Eligibility and Enrollment (E&E) system**. This system manages the applications and accounts as they move through the flow.

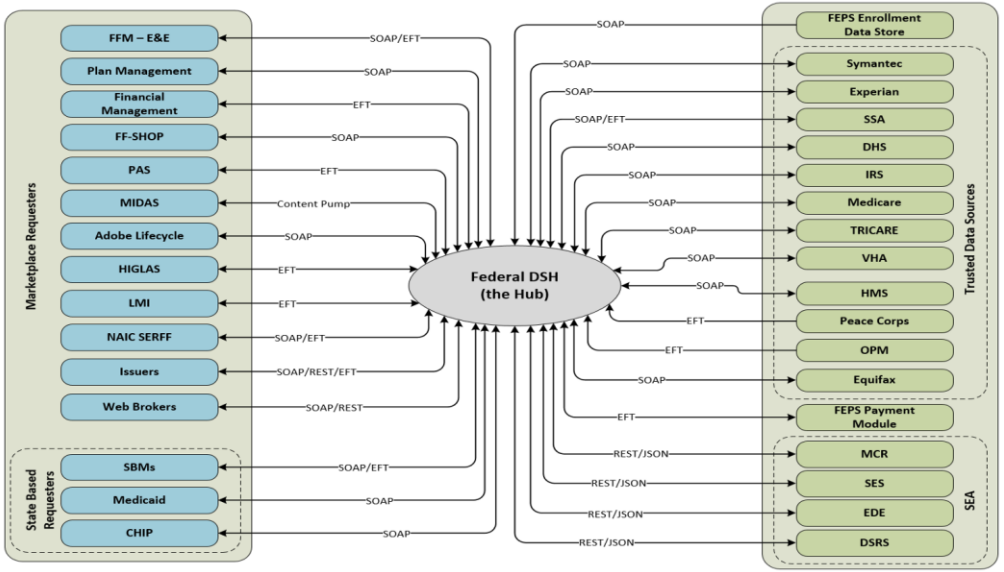
The E&E system is used by **caseworkers** (or eligibility workers) as they manager applications and cases. Caseworkers are employees of the state (or county).



ELIGIBILITY DETERMINATION

CMS provides, at no cost to states, the **Federal Data Services Hub (FDSH)** (also called "The CMS Hub", "The Hub", or just "Hub"). The FDSH provides a set of APIs services for verifying applicant information, both in real time and in batch.

All states use the Hub in some format, but not all states use all the offered Hub services.



(Some) Hub Services

- Remote Identity Proofing (RIDP) (Experian)
- SSA Information (BENDEX + BEERS)
- Citizenship and Immigration Information (DHS SAVE)
- Account Transfer (Marketplace to/from Medicaid)
- Employer-Sponsored Insurance Lookup
- Government Insurance Lookup (Medicaid, Medicare, TRICARE, Peace Corps)
- Income
  - IRS (Income and Family Size)
  - SSA (Title II income)
  - Wage data (Equifax)
- Etc.

ELIGIBILITY DETERMINATION

Income verification is required for an application to proceed. This can be done using one of the following sources, but states could use a different set:

- **IRS Data –** Often a year old, and comes with strict security requirements
- **State Quarterly Wage Data** - Often the highest quality, but every state has a different implementation
- **SSA** - Only includes unearned income (SSI, etc.)
- **Third Parties** - Most common is The Work Number. Very high quality, but very expensive
- **Pay Stubs** - Labor intensive to retrieve and review

ELIGIBILITY DETERMINATION

For non-MAGI groups subject to an **asset test,** the applicant must attest to their assets, which will then be verified by the state. This often involves a case worker making **lots of calls** to banks, mortgage companies, retirement fund managers, etc.

Verification of assets is a difficult process, so many states choose to use an **Asset Verification System (AVS)** which is an automated service provided by a 3rd party. These services take a long time to return data; **often up to two weeks.**

ELIGIBILITY DETERMINATION

Medicaid eligibility is **required** to be determined at **the individual level**. This means different people on the same case may have **different eligibility** (for example, a child may be eligible but their parents are not).

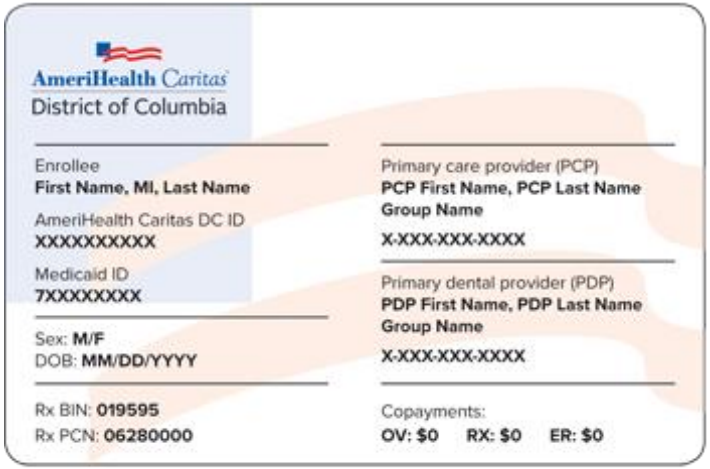
Usage

USAGE OF MEDICAID

Once a person is determined eligible for Medicaid, they choose a **Medicaid plan**. Each state has their own set of Medicaid plans, which fall into two categories:

- **Managed Care Organizations (MCO)** - These organizations handle all care related to a Medicaid client. In return, the state pays a regular, recurring fee.
- **Fee For Service (FFS)** - These organizations charge the state based on the services a client receives.

For both MCO and FFS organizations, the **state and the plan** cover the cost of healthcare, **not the client**.



USAGE OF MEDICAID

Some states charge monthly **premiums** to their clients in order for their clients to remain enrolled in Medicaid. These premiums are capped by law, and the caps vary based on the client.

Different **categories** of client may have different premiums based on the state; children may have different premiums than adults, for example.

The caps enforced by law are **very low**; however, numerous studies have shown that premiums are **extraordinarily detrimental** to Medicaid recipients and **inordinately expensive** for programs to maintain.

USAGE OF MEDICAID

While a person has Medicaid, they **must report any life changes** that may impact their eligibility. These can include (but are not limited to):

- Marriages
- Pregnancies
- Birth/death of a household member
- Change in immigration/citizenship status
- New employment, sources of income, or assets

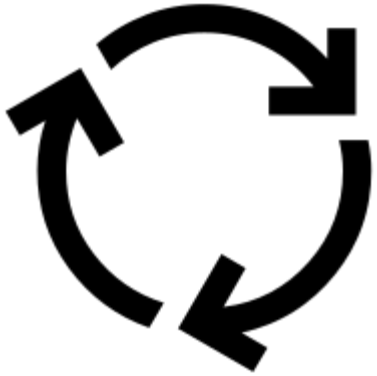
Once reported, the Medicaid agency **must act on the information** if it constitutes a change in eligibility.

Renewal

RENEWING MEDICAID

Once per year, Medicaid recipients **must renew their coverage**. This process is initiated by the state, who tracks their Medicaid population and when they must renew.

The exception here is the **SSI Medicaid** population, which renews through SSA.



RENEWING MEDICAID

When a person's renewal is due, the state **must first** attempt to renew the person **without contacting them**. This process is called "ex parte", "administrative renewal", "automatic renewal", or "passive renewal".

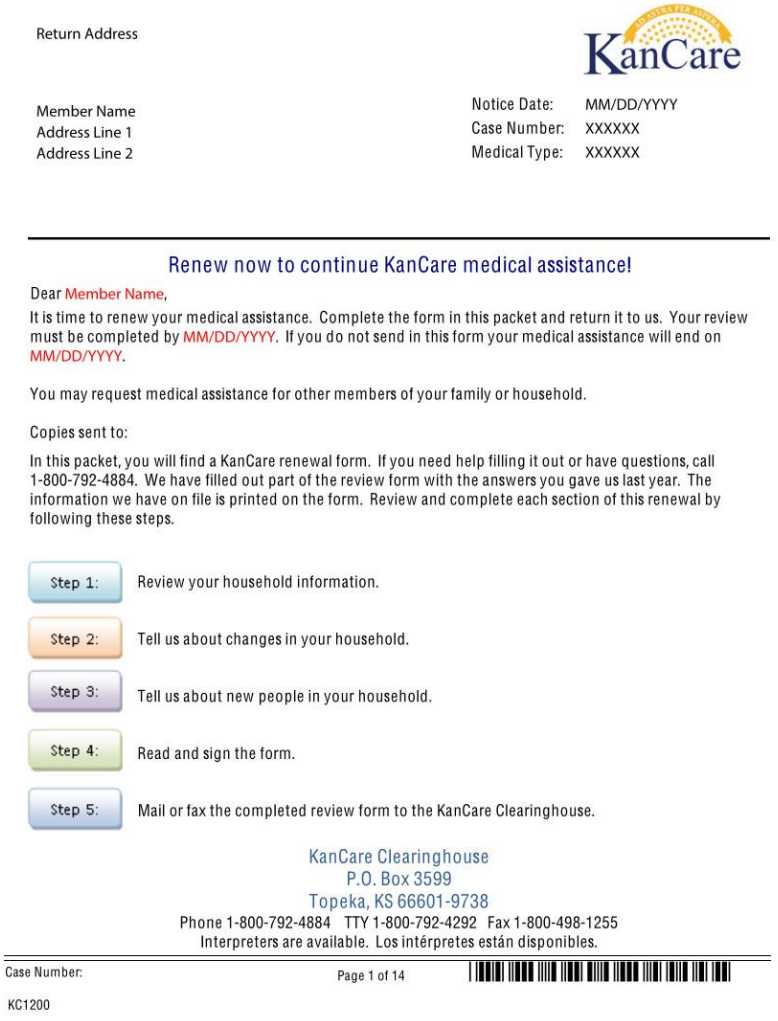
During an ex parte renewal, the state uses **prior information, research, and electronic data sources** to re-determine the recipient's eligibility. If successful, the recipient is renewed and the state sends a letter.

RENEWING MEDICAID

If ex parte fails, the state must provide the recipient with **a pre-populated renewal form**. This form should allow the recipient to modify any information, and include instructions on how to provide verification. **The state cannot terminate coverage at this stage.**

In addition to the form, states may provide **alternative methods of renewal**. These can include:

- Over the phone
- In person at an office
- Through a web portal



Return Address

Member Name
Address Line 1
Address Line 2

KanCare

Notice Date: MM/DD/YYYY
Case Number: XXXXXX
Medical Type: XXXXXX

Renew now to continue KanCare medical assistance!

Dear Member Name,

It is time to renew your medical assistance. Complete the form in this packet and return it to us. Your review must be completed by MM/DD/YYYY. If you do not send in this form your medical assistance will end on MM/DD/YYYY.

You may request medical assistance for other members of your family or household.

Copies sent to:

In this packet, you will find a KanCare renewal form. If you need help filling it out or have questions, call 1-800-792-4884. We have filled out part of the review form with the answers you gave us last year. The information we have on file is printed on the form. Review and complete each section of this renewal by following these steps.

Step 1: Review your household information.

Step 2: Tell us about changes in your household.

Step 3: Tell us about new people in your household.

Step 4: Read and sign the form.

Step 5: Mail or fax the completed review form to the KanCare Clearinghouse.

KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601-9738
Phone 1-800-792-4884 TTY 1-800-792-4292 Fax 1-800-498-1255
Interpreters are available. Los intérpretes están disponibles.

Case Number:

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KC1200

RENEWING MEDICAID

Once the renewal form is returned, the state **verifies any new information** and uses it to determine eligibility. If additional documentation is required, the state will reach back out to the recipient.

If the form is returned, and the recipient is eligible, their Medicaid coverage will be renewed.

If the form is returned but the recipient is **not** eligible, the state is **required to hand them off to their Marketplace**.

If the renewal form is **not** returned within the deadline, the state will **terminate the recipient's Medicaid coverage**.

The Public Health Emergency (PHE)

THE PUBLIC HEALTH EMERGENCY (PHE)

During the COVID-19 pandemic, Congress authorized **increased funding** to Medicaid programs that followed new rules. **All states** implemented the new rules, and received funding.

One of the most important rules was **continuous coverage**. Under continuous coverage, states were **prevented from terminating any Medicaid recipients**, regardless of that person's circumstance. As a result, Medicaid counts grew rapidly during the PHE.

THE PUBLIC HEALTH EMERGENCY (PHE)

At the end of the PHE on May 11th, 2023, the new rules were **ended**. As a result, every state had **one year to redetermine eligibility for all Medicaid recipients on their rolls**.

This process is called **"unwinding"**.

Odds and Ends

CHIP

- In addition to Medicaid, states **have the option** of running a **Children's Health Insurance Program (CHIP)**. CHIP programs are largely the same as MAGI Medicaid, but can allow for **much higher income thresholds** (in practice, up to 400% FPL).
- CHIP programs come in three types:
  - **Medicaid Expansion** - The Medicaid program is simply altered to allow the higher thresholds
  - **Separate CHIP** - The CHIP program is separate from the Medicaid program
  - **Combination** - Some combination of the two

TERRITORIES

This presentation applies to Medicaid programs run by the **50 states and DC**.

Medicaid in Puerto Rico, Guam, the United States Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands works **completely differently**. These are generally block grant programs with their own rules.

Because **each territory works differently**, they are not expanded upon here. Medicaid.gov contains profiles of their various programs.


U.S. DIGITAL SERVICE
Thank you