Medicaid and CHIP MAC Learning Collaboratives

Coverage Expansion Learning Collaborative

First Time "MAGI Renewal": Model Renewal Form & Considerations in 2013-2014

All-State Webinar

July 8th, 2013

3:00-5:00pm ET

Registration Link:
https://chcs.webex.com/chcs/onstage/g.php?t=a&d=717534162

Agenda

- Introduction and Roll Call
- Project Approach and Overview
- Regulatory Requirements for Renewal
- Unique Considerations for Renewal Form in 2014
- Model 2014 Renewal Form
- Process & Timeline for Regularly Scheduled Renewals in 4th Quarter 2013 & 1st Quarter 2014
- Questions & Answers
- Appendix: Renewal Process Flows

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Project Approach

Of the 62.7 million* current Medicaid beneficiaries, the majority will need to be renewed for coverage using the Modified Adjusted Gross Income (MAGI) methodology for the first time

States must gather household and income information they do not currently have to calculate eligibility based on the MAGI methodology. Today we will present both a tool (the Renewal Form) to collect this information for the first time and discuss unique considerations for some current beneficiaries' renewal process and timing

Goals of this Project:

- To support states' conversion to MAGI
- Draft a Model 2014 Renewal Form as a tool for states
- Identify best practices in implementing first-time "MAGI renewal" and targeted enrollment

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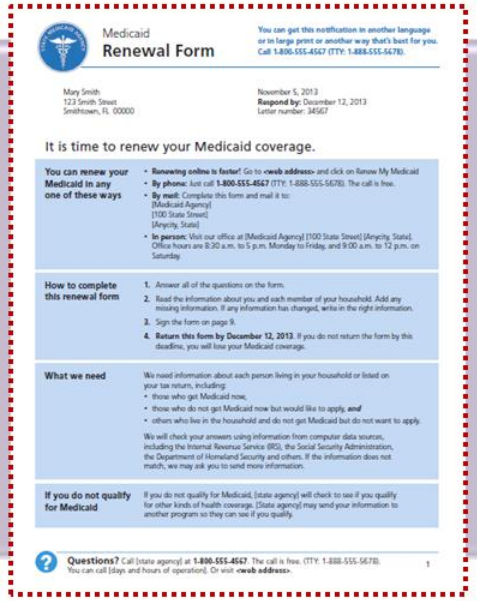
*Source: Kaiser Family Foundation, State Health Facts. Data from FY 2009.

Model Renewal Form

Model 2014 Renewal Form:

- Modeled on the Single Streamlined Application for both content and formatting
- Drafted a *paper* Model Renewal Form
  - A dynamic online version would only show beneficiaries questions they need to answer or validate
- Length of the form will decrease after the first year
- Developed as a collaboration between CMS, Manatt Health Solutions, Maximus, SIS and the Expanding Coverage Learning Collaborative states



Medicaid
Renewal Form

You can get this notification in another language or in large print or another way that's best for you. Call 1-800-555-4567 (TTY: 1-888-555-5678).

Mary Smith
123 Smith Street
Smithtown, FL 00000

November 5, 2013
Respond by: December 12, 2013
Letter number: 34567

It is time to renew your Medicaid coverage.

You can renew your Medicaid in any one of these ways

- **Renewing online is faster!** Go to **<web address>** and click on Renew My Medicaid
- **By phone:** Just call **1-800-555-4567** (TTY: 1-888-555-5678). The call is free.
- **By mail:** Complete this form and mail it to:
  [Medicaid Agency]
  [100 State Street]
  [Anycity, State]
- **In person:** Visit our office at [Medicaid Agency] [100 State Street] [Anycity, State]. Office hours are 8:30 a.m. to 5 p.m. Monday to Friday, and 9:00 a.m. to 12 p.m. on Saturday.

How to complete this renewal form

1. Answer all of the questions on the form.
2. Read the information about you and each member of your household. Add any missing information. If any information has changed, write in the right information.
3. Sign the form on page 9.
4. **Return this form by December 12, 2013.** If you do not return the form by this deadline, you will lose your Medicaid coverage.

What we need

We need information about each person living in your household or listed on your tax return, including:

- those who get Medicaid now,
- those who do not get Medicaid now but would like to apply, ***and***
- others who live in the household and do not get Medicaid but do not want to apply.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, we may ask you to send more information.

If you do not qualify for Medicaid

If you do not qualify for Medicaid, [state agency] will check to see if you qualify for other kinds of health coverage. [State agency] may send your information to another program so they can see if you qualify.

Questions? Call [state agency] at **1-800-555-4567**. The call is free. (TTY: 1-888-555-5678). You can call [days and hours of operation]. Or visit **<web address>**.

1

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Process & Timing for Renewal of Current Beneficiaries in 4th Quarter 2013 & 1st Quarter 2014

Challenges:

- States must **maintain rules using 2013 methodologies and standards** for new enrollments prior to January 1, 2014 and for regularly scheduled renewals prior to April 1, 2014
- States must have **new household composition and MAGI income information** to redetermine eligibility using 2014 MAGI methodologies and standards
- Special **challenges to implementation during Open Enrollment Period**:
  - From October 1 – December 31, 2013 states will be renewing current beneficiaries using 2013 methodologies and standards while also determining new applicants' eligibility using both 2014 MAGI methodologies and standards and 2013 methodologies and standards
  - From January 1 – March 31, 2014, states must ensure no current beneficiaries being renewed lose their eligibility due to the change to MAGI

CMS is offering States optional tools to help manage the transition to new eligibility and enrollment systems while states must both renew current beneficiaries and accept new applicants

Goal of this Presentation:

- To discuss states' policy and operational considerations for renewing current beneficiaries whose regularly scheduled coverage termination date falls between October 1, 2013 and March 31, 2014
- To discuss issues related to change reporting during 2014

Regulatory Requirements for Renewal

Regulatory Requirements for Renewal of MAGI Medicaid/CHIP Beneficiaries

42 CFR 435.916
42 CFR 457.343

As of January 1, 2014, Medicaid beneficiaries whose eligibility is determined using MAGI methodologies must have their eligibility renewed once every 12 months

Unless the agency receives information about a change that may affect eligibility

Renewal must be made with information available to the agency, either contained in the account or more current information in accessible databases

ABLE TO RENEW

If the agency is **able to renew** based on available information, the consumer must be notified of the determination and its basis

If all of the **information** used to make the determination **is accurate**, the beneficiary does nothing and renewal takes place

If any of the **information** used to make the determination **is inaccurate**, the beneficiary must inform the agency

UNABLE TO RENEW

If the agency is **unable to renew** with current information, a pre-populated renewal form must be sent to the beneficiary

The **beneficiary has 30 days** from the date of the renewal form **to submit any necessary information, sign and return the form.** The agency must then verify the information provided and notify the beneficiary of their decision

If the beneficiary **fails to submit the renewal form** or necessary information by the deadline, the agency will reconsider the eligibility of the beneficiary in a timely manner without requiring a new application if they submit the form **within 90 days (or a later date set by the state)** after the date of termination

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Unique Considerations for Renewal Form in 2014

Key Issues for Renewal Form in 2014

First time need to collect MAGI and household information

Pre-population of information known to the state

Opportunity to add newly applying household members

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New Information States Must Collect

Starting in 2014, states need additional household composition and MAGI income information to determine current enrollees' eligibility using 2014 MAGI methodology

- **Tax information**:
  - Whether each beneficiary is filing taxes next year for income earned this year
    - Whether that beneficiary is claiming dependents
  - Whether each beneficiary is being claimed as a dependent
- **Number of babies expected if pregnant**
- **Former foster care child status** (if beneficiary is 18-26 years old)
- **Income information**:
  - Align current questions and calculations with MAGI
  - Add income deduction questions
- **Employer sponsored insurance coverage offer**
- **Permission to review tax information**

Other APTC-specific Questions in Year 1 :

- If a person appears APTC-eligible, the state is required to transfer them to the Marketplace, where they will be asked other APTC-related questions for eligibility determination for Qualified Health Plan (QHP) coverage with Advanced Premium Tax Credits (APTC) and Cost Sharing Reductions (CSR)

Renewal Form in 2014 to Bridge Conversion to MAGI, Transition Waiver Populations, and Add Newly Applying Household Members

2014 Renewal Form

A "2014 Renewal Form" would be sent to non-ABD beneficiaries

- Pre-populated with eligibility information the state already has, to the extent possible
- Requesting missing eligibility information necessary to effectuate a MAGI evaluation
- Requesting eligibility information for newly applying household members (e.g. parents of Medicaid children)

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Model 2014 Renewal Form

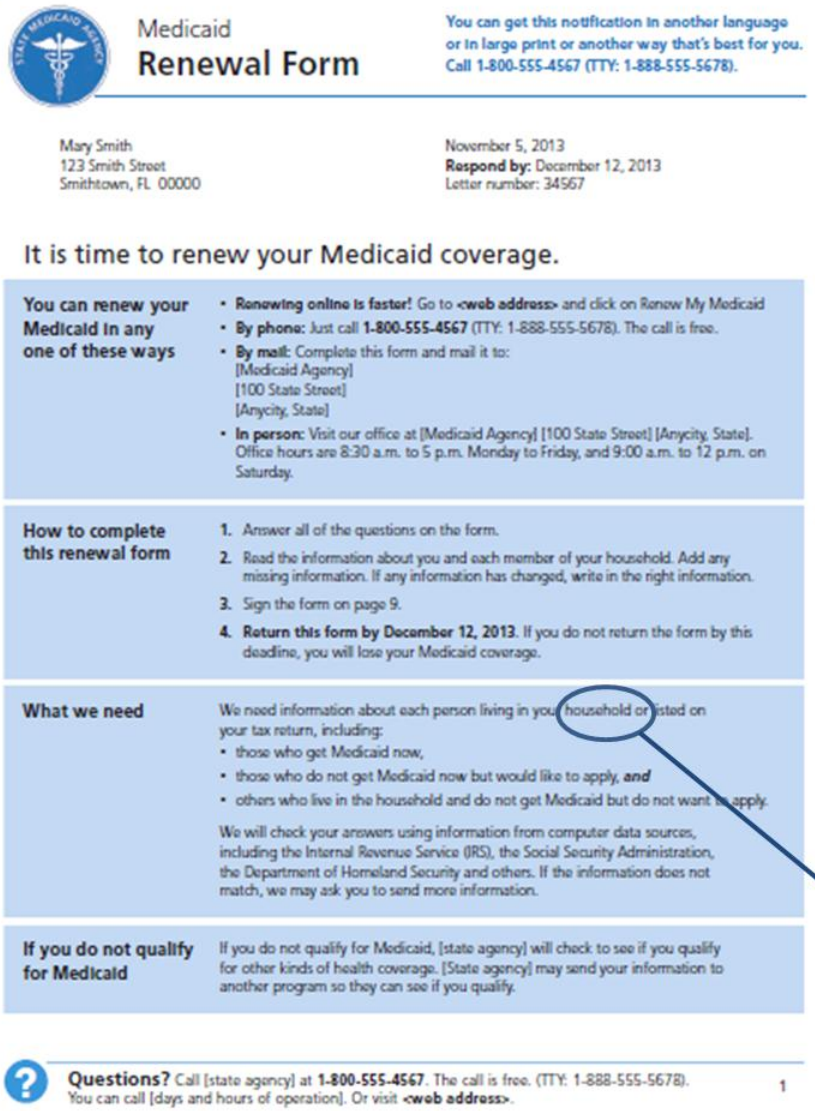
Consumer-Tested Model Renewal Form

Testing Methodology:

- A pre-populated version of the Renewal Form was tested for consumers' use
  - Four states, 31 people
  - Participants:
    - Individuals over age 18 who have not completed high school
    - 23 of 31 testers were present or past Medicaid recipients
- Feedback from the LC and consumer testing was incorporated into the final version

Pre-Populated Form Scenario:
Father/Husband – Ernie Roberts
Mother/Wife – Samantha Roberts
Newborn Son – Benjamin Roberts

Model Renewal Form: Instructions



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- **By mail:** Complete this form and mail it to:
  [Medicaid Agency]
  [100 State Street]
  [Anycity, State]
- **In person:** Visit our office at [Medicaid Agency] [100 State Street] [Anycity, State]. Office hours are 8:30 a.m. to 5 p.m. Monday to Friday, and 9:00 a.m. to 12 p.m. on Saturday.

How to complete this renewal form

1. Answer all of the questions on the form.
2. Read the information about you and each member of your household. Add any missing information. If any information has changed, write in the right information.
3. Sign the form on page 9.
4. **Return this form by December 12, 2013.** If you do not return the form by this deadline, you will lose your Medicaid coverage.

What we need

We need information about each person living in your household or listed on your tax return, including:

- those who get Medicaid now,
- those who do not get Medicaid now but would like to apply, ***and***
- others who live in the household and do not get Medicaid but do not want to apply.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, we may ask you to send more information.

If you do not qualify for Medicaid

If you do not qualify for Medicaid, [state agency] will check to see if you qualify for other kinds of health coverage. [State agency] may send your information to another program so they can see if you qualify.

Questions? Call [state agency] at **1-800-555-4567**. The call is free. (TTY: 1-888-555-5678). You can call [days and hours of operation]. Or visit **<web address>**.

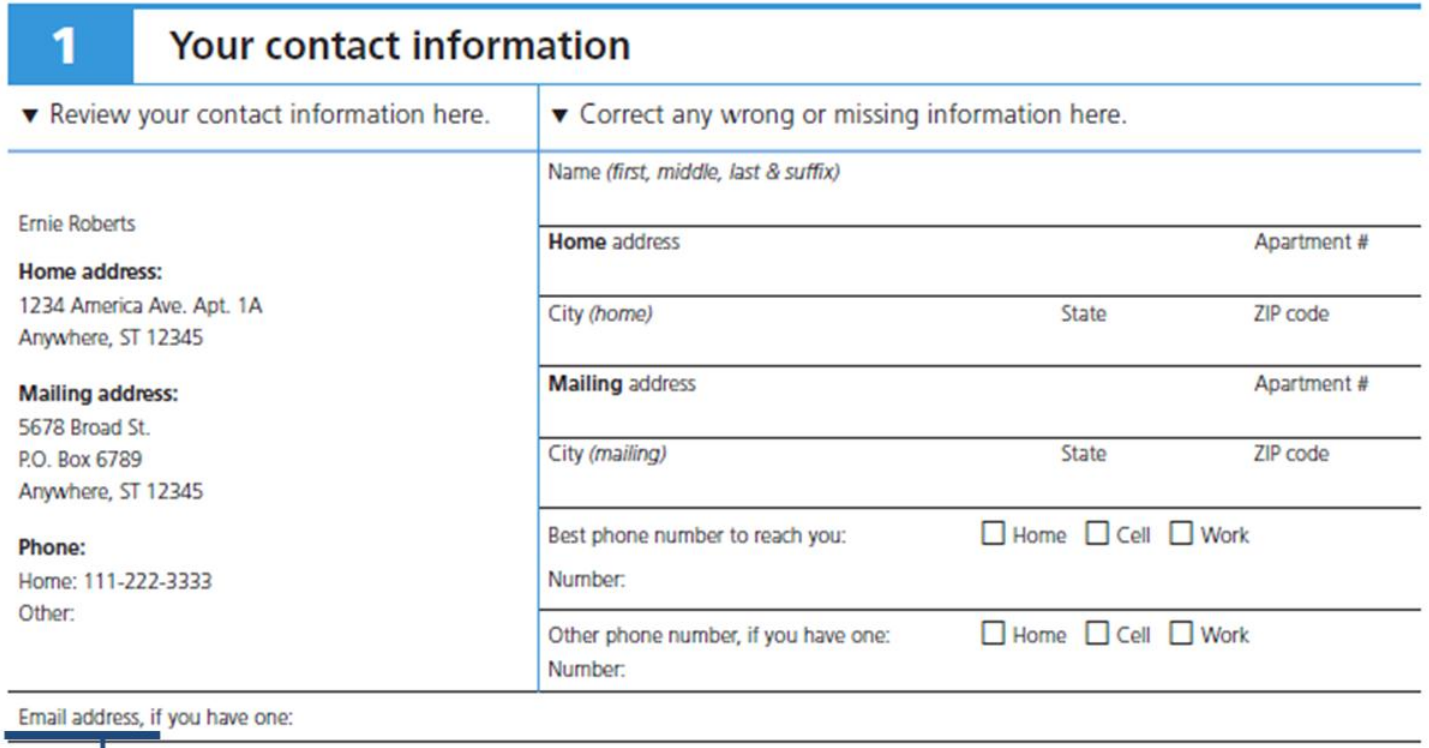
1

Beneficiaries must be able to submit the renewal form online, by phone, mail, or in-person

In an online renewal form, states can use pre-population, drop-down menus and question-level help text to assist beneficiaries. States may also filter questions so only those that are applicable to the applicant's specific situation appear

Starting in 2014, a person's "household" includes those who live with them AND those who are on a tax return, if they intend to file taxes

Model Renewal Form: Contact Information



1 Your contact information

▼ Review your contact information here.

Ernie Roberts

Home address:
1234 America Ave. Apt. 1A
Anywhere, ST 12345

Mailing address:
5678 Broad St.
P.O. Box 6789
Anywhere, ST 12345

Phone:
Home: 111-222-3333
Other:

▼ Correct any wrong or missing information here.

Name *(first, middle, last & suffix)*

Home address — Apartment #

City *(home)* — State — ZIP code

Mailing address — Apartment #

City *(mailing)* — State — ZIP code

Best phone number to reach you: ☐ Home ☐ Cell ☐ Work
Number:

Other phone number, if you have one: ☐ Home ☐ Cell ☐ Work
Number:

Email address, if you have one:

Information state already has is pre-populated

This may be new information for many states. States that have email addresses may want to also email the beneficiary with a link to the online renewal form

Model Renewal Form: Tax Filing Information

Tax filing information is needed for MAGI eligibility determinations, if anyone in the household intends to file taxes *next* year for income earned *this* year

2 **We need information about who files tax returns.**

You can still renew if you do not file tax returns.

Will anyone in the household file a **federal tax return *next year*** to report income earned ***this year***?

☐ Yes ***If yes,*** answer all of the questions below. ☐ No ***If no,*** answer the question marked with a star ★ below.

Person 1: Name (*first, middle, last & suffix*)

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

Person 2: Name (*first, middle, last & suffix*)

This is for a second tax filer in the household

If this person is filing a joint return, write the name of the spouse:

If this person will claim dependents, write the names of the dependents:

★ If anyone will be claimed as a dependent on someone else's tax return, write the name of the tax filer and the dependents. Answer only if different than what you reported above or if you did not fill in any information above.

Name of tax filer: _____

Name of dependents: _____

In an online form, these could be drop-down menus with household members known to the state, along the option to enter a new name

Model Renewal Form: Current Medicaid Beneficiaries

State agencies pre-populate this page with information they have on current beneficiaries needing to renew coverage

3 These are the people in your household who get Medicaid and need to renew now

Person 1 Samantha Roberts

☒ The [state agency name] **has** this person's Social Security number.
☐ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***
— — — – — — – — — —

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:
☐ You need to fill in the information below. ☒ You **do not** need to fill in the information below because [state Medicaid agency] has it.
☐ Check here if this person has eligible immigration status and fill in the document type: _____
and ID number: _____ . See Attachment D on page 13 for more information about eligible immigration status and document types.

State agencies pre-populate these check boxes depending on what information they already have

Benjamin is a deemed newborn, so the state does not have his Social Security number on file

Person 2 Benjamin Roberts

☐ The [state agency name] **has** this person's Social Security number.
☒ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***
— — — – — — – — — —

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:
☐ You need to fill in the information below. ☒ You **do not** need to fill in the information below because [state Medicaid agency] has it.
☐ Check here if this person has eligible immigration status and fill in the document type: _____
and ID number: _____ . See Attachment D on page 13 for more information about eligible immigration status and document types.

For a temporary or expiring immigration status, states will need an update on immigration status information

Person 3 [Name]

☐ The [state agency name] **has** this person's Social Security number.
☐ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***
— — — – — — – — — —

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:
☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because [state Medicaid agency] has it.
☐ Check here if this person has eligible immigration status and fill in the document type: _____
and ID number: _____ . See Attachment D on page 13 for more information about eligible immigration status and document types.

Brackets indicate potential pre-population

In an online form, "Document type" could be a drop-down menu, and "eligible immigration status" could link to question-level help

Person 4 [Name]

☐ The [state agency name] **has** this person's Social Security number.
☐ The [state agency name] **does not** have this person's Social Security number. ***Write it in the spaces below.***
— — — – — — – — — —

☐ Check here if this person is no longer living in the household.

If this person is an immigrant, for their immigration status:
☐ You need to fill in the information below. ☐ You **do not** need to fill in the information below because [state Medicaid agency] has it.
☐ Check here if this person has eligible immigration status and fill in the document type: _____
and ID number: _____ . See Attachment D on page 13 for more information about eligible immigration status and document types.

Model Renewal Form: Other People in the "Household"

The State may know about some other people in the household already, but will want to allow space for additional people

4 We need more information about people not listed in Section 3 *(page 3)*

▶ Tell us about anybody else in your household or on your tax return.

Other person: Ernie Roberts

☒ The [state agency name] **has** this person's Social Security number. ☐ The [state agency name] **does not** have this person's Social Security number. ***Write it here*** if this person is applying for health insurance coverage: ___ ___ ___ – ___ ___ – ___ ___ ___ ___ *This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.*	☐ Check here if this person is no longer living in the household. Date of birth (month/day/year): 9/15/1973 This person is: ☒ Male ☐ Female How is this person related to you?

☐ Check here if this person **has** Medicaid.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 10.

Other person: Name (*first, middle, last & suffix*):

☐ The [state agency name] **has** this person's Social Security number. ☒ The [state agency name] **does not** have this person's Social Security number. ***Write it here*** if this person is applying for health insurance coverage: ___ ___ ___ – ___ ___ – ___ ___ ___ ___ *This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.*	☐ Check here if this person is no longer living in the household. Date of birth (month/day/year): This person is: ☐ Male ☐ Female How is this person related to you?

☐ Check here if this person **has** Medicaid.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 10.

Other person: Name (*first, middle, last & suffix*):

☐ The [state agency name] **has** this person's Social Security number. ☒ The [state agency name] **does not** have this person's Social Security number. ***Write it here*** if this person is applying for health insurance coverage: ___ ___ ___ – ___ ___ – ___ ___ ___ ___ *This person may choose not to give the Social Security number if he or she is not applying, but it helps us to have it.*	☐ Check here if this person is no longer living in the household. Date of birth (month/day/year): This person is: ☐ Male ☐ Female How is this person related to you?

☐ Check here if this person **has** Medicaid.
☐ Check here if this person **does not** have Medicaid and wants health insurance coverage, and fill out Attachment A on page 10.

Renewal forms provide the opportunity for other household members to apply for coverage, especially important in 2014 when many people will be newly eligible

If online, a state could present the questions in Attachment A as soon as this box is checked

Model Renewal Form: Other Insurance

5 Tell us about *other* health insurance coverage people have

▶ Include anyone in Sections 3 and 4 with Medicaid and anyone who is applying for health insurance coverage.

Name of insurance company: | Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance _____

List everyone who is on this policy:

Name of insurance company: | Policy number:

Type of insurance: ☐ Medicare ☐ Tricare ☐ Veteran's health coverage ☐ Other insurance _____

List everyone who is on this policy:

▶ ☐ Check here if anyone on this form is offered health insurance through a job, even if they are not enrolled in it.
☐ Check here if any of the insurance plans you listed is a state employee benefit plan.

This question will allow the Marketplace to use this form to determine eligibility for APTC/CSR without needing to request further information (if the beneficiary appears ineligible for Medicaid/CHIP AND does not have an offer of ESI)

Model Renewal Form: Other Information Needed

In an online form, some of these questions would only show up for people of certain ages or only for women

6 Tell us more about the people listed on this form

- If anyone who is renewing or applying for health insurance coverage has a medical, mental health, or substance use condition that limits his or her ability to work, go to school, or take care of daily activities (like bathing or dressing), write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

- If anyone who is renewing or applying for health insurance coverage lives in a long term care facility, group home, or nursing home, or regularly gets medical care, personal care, or health services at home or in another community setting (like adult day care), write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

- If anyone who is renewing or applying for health insurance coverage is blind or terminally ill, write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

- If anyone who is renewing or applying for health insurance coverage is between the ages of 18 and 22 and is also a full-time student, write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

- If anyone who is renewing or applying for health insurance coverage is between the ages of 18 and 26 and was in foster care at age 18, write his or her name here.

Name (*first, middle, last & suffix*):

Name (*first, middle, last & suffix*):

- If anyone listed on this form (whether renewing or applying for health insurance coverage or not) is pregnant, write her information below.

Name (*first, middle, last & suffix*): How many babies are expected?

Name (*first, middle, last & suffix*): How many babies are expected?

- ☐ Check here if anyone who is renewing or applying for health insurance coverage is an American Indian or Alaska Native, and fill out Attachment B on page 11.

Non-MAGI screening questions

The upper age limit will vary depending on state policy

Included to meet new regulations under the ACA

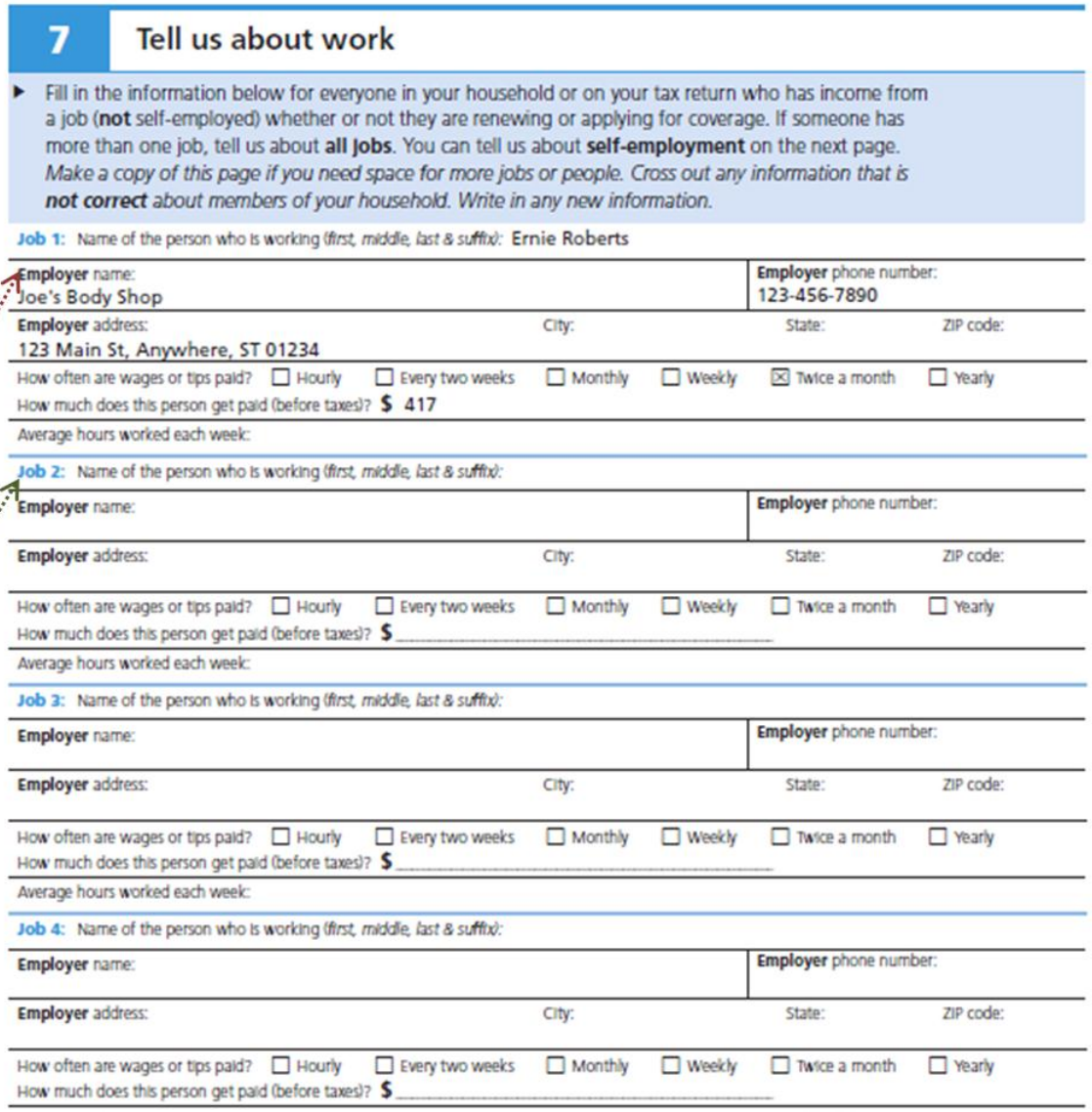
Necessary for determining the size of the household

A great way to direct a few applicants to some more detailed questions

Model Renewal Form: Employment Information

Wage information is needed to make a MAGI eligibility determination

States should pre-populate the information they have and leave space for additional employed people



7 Tell us about work

▶ Fill in the information below for everyone in your household or on your tax return who has income from a job (**not** self-employed) whether or not they are renewing or applying for coverage. If someone has more than one job, tell us about **all jobs**. You can tell us about **self-employment** on the next page. *Make a copy of this page if you need space for more jobs or people. Cross out any information that is* ***not correct*** *about members of your household. Write in any new information.*

Job 1: Name of the person who is working (*first, middle, last & suffix*): Ernie Roberts

Employer name: Joe's Body Shop | **Employer** phone number: 123-456-7890

Employer address: 123 Main St, Anywhere, ST 01234 | City: | State: | ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☒ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ 417

Average hours worked each week:

Job 2: Name of the person who is working (*first, middle, last & suffix*):

Employer name: | **Employer** phone number:

Employer address: | City: | State: | ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ _____

Average hours worked each week:

Job 3: Name of the person who is working (*first, middle, last & suffix*):

Employer name: | **Employer** phone number:

Employer address: | City: | State: | ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

How much does this person get paid (before taxes)? $ _____

Average hours worked each week:

Job 4: Name of the person who is working (*first, middle, last & suffix*):

Employer name: | **Employer** phone number:

Employer address: | City: | State: | ZIP code:

How often are wages or tips paid? ☐ Hourly ☐ Every two weeks ☐ Monthly ☐ Weekly ☐ Twice a month ☐ Yearly

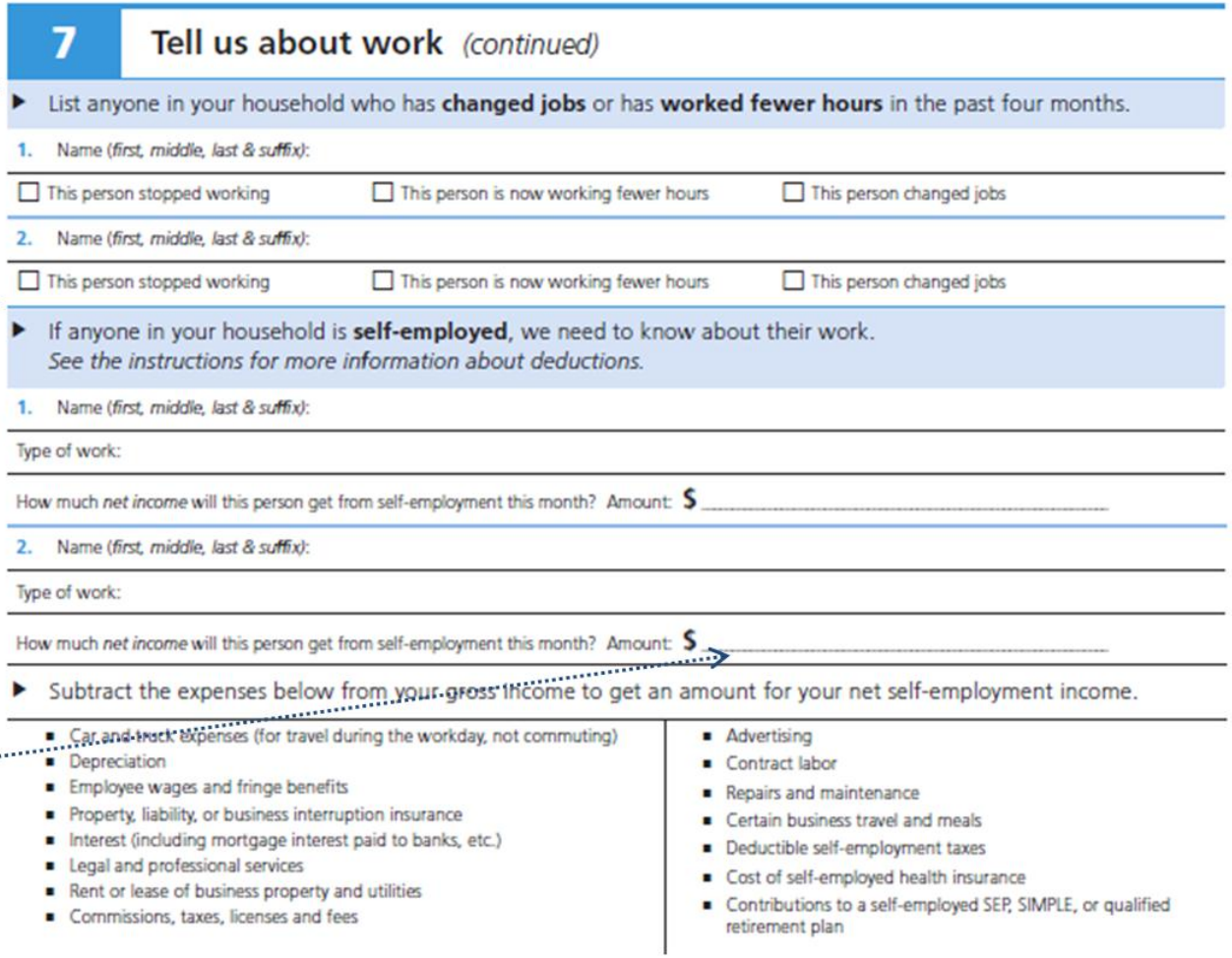
How much does this person get paid (before taxes)? $ _____

Model Renewal Form: Employment Information (cont.)

Resolving discrepancies with electronic data

Cannot pre-populate; IRS MAGI data does not break out self-employment

State could provide an income calculator in online renewal form



7 Tell us about work *(continued)*

▶ List anyone in your household who has **changed jobs** or has **worked fewer hours** in the past four months.

1. Name (*first, middle, last & suffix*):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

2. Name (*first, middle, last & suffix*):

☐ This person stopped working ☐ This person is now working fewer hours ☐ This person changed jobs

▶ If anyone in your household is **self-employed**, we need to know about their work.
See the instructions for more information about deductions.

1. Name (*first, middle, last & suffix*):

Type of work:

How much *net income* will this person get from self-employment this month? Amount: $ _____

2. Name (*first, middle, last & suffix*):

Type of work:

How much *net income* will this person get from self-employment this month? Amount: $ _____

▶ Subtract the expenses below from your gross income to get an amount for your net self-employment income.

- Car and truck expenses (for travel during the workday, not commuting)
- Depreciation
- Employee wages and fringe benefits
- Property, liability, or business interruption insurance
- Interest (including mortgage interest paid to banks, etc.)
- Legal and professional services
- Rent or lease of business property and utilities
- Commissions, taxes, licenses and fees
- Advertising
- Contract labor
- Repairs and maintenance
- Certain business travel and meals
- Deductible self-employment taxes
- Cost of self-employed health insurance
- Contributions to a self-employed SEP, SIMPLE, or qualified retirement plan

Model Renewal Form: Other Income Information

Depending on state database and computer matching agreements, states should pre-populate to the extent possible

8 Tell us about other income

▶ *Cross out any information that is **not correct** about members of your household. Write in any new information.*

Unemployment	**How much?**	**How often?**
Name (*first, middle, last & suffix*): Samantha Roberts	$ 70	☒ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Social Security	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Pensions	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Retirement accounts		
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____

***Section 8** continued on next page ▶▶▶*

8 Tell us about other income *(continued)*

▶ *Cross out any information that is **not correct** about members of your household. Write in any new information.*

Alimony received	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Farming or fishing *(profit after business expenses)*	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Rental income or royalties *(profit after business expenses)*	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Other income Type: _____	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Other income Type: _____	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____

Allow extra space for common types of income

Model Renewal Form: Other Income Information (cont.)

Adjustments to MAGI on the tax form

▶ If anyone in your household has **deductions**, tell us what kind.

Alimony paid to someone else	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Student loan interest paid	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____
Other deductions	**How much?**	**How often?**
Name (*first, middle, last & suffix*):	$	☐ Weekly ☐ Every two weeks ☐ Yearly ☐ Monthly ☐ Twice a month ☐ Other_____

Allows reporting of reasonably predictable changes in income and helps with annual income for the Marketplace

▶ List the names of anyone whose income **changes** from month to month. Also tell us how much you think their income will be for the year. *Make a copy of this page if you need space for more people.*

1. Name (*first, middle, last & suffix*):

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year**.

2. Name (*first, middle, last & suffix*):

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year**.

3. Name (*first, middle, last & suffix*):

What do you expect his or her income to be **this year**? Amount: $ ☐ Check here if you do not know what the income will be **this year**.

Model Renewal Form: Signature Page

9 Read and sign this application

Renewal of coverage in future years

▶ Read the statement below and check **one** box.

To make it easier to check my income at renewal time, I give permission to the [state agency] to use income information from my tax returns for the number of years I checked below.

I understand that the [state agency] will send me a letter with the income information they have. I can make changes to it. I can also change my mind and not allow the [state agency] to check this information.

Yes, I give permission to check my income on tax returns for (check one box):

☐ 5 years (the longest time) ☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ No, I do not give permission to use my tax returns.

Your rights and responsibilities

- I am signing this renewal form under penalty of perjury. That means that I have provided true answers to all the questions on this form to the best of my knowledge, and I know that I may be subject to penalties under federal law if I provide false or untrue information.
- I know that I must tell [state agency] if anything changes and is different from what I wrote on this form. I can call XXX-XXX-XXXX or visit [web address] to report any changes. I understand that a change in my information might affect whether someone in my household qualifies for coverage.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- If I think [state agency] has made a mistake, I can appeal its decision. To appeal means to tell someone at [state agency] that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting [state agency] at XXX-XXX-XXXX. Someone from [state agency] will explain anything about this application to me if I need that.
- I understand that if I do not qualify for Medicaid, [state agency] will check to see if I qualify for other kinds of health coverage. [State agency] may send my information to another program so they can see if I qualify. [State agency] will check my answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, [state agency] may ask me to send more information.
- I understand that, after my death, [state agency] can file a claim against my estate to recover money that the state paid for coverage provided to me. This process must happen if I am in a medical institution and not expected to return home, or if I am 55 years of age or older and the state pays for my nursing facility services, home and community based services, or related hospital and prescription drug services. The amount recovered by the [state agency] will not be more than the amount Medicaid paid for my care.
- I understand that when I send in this form, it means I have permission from everyone whose information is on the form to submit their information to [state agency] and receive any communications about their eligibility and enrollment.
- I understand that [state agency] is authorized to collect information on this form, and other supporting information including Social Security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care Education Reconciliation Act of 2010 (Public Law 111-152) and the Social Security Act.

▶ Sign and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment C on page 12.

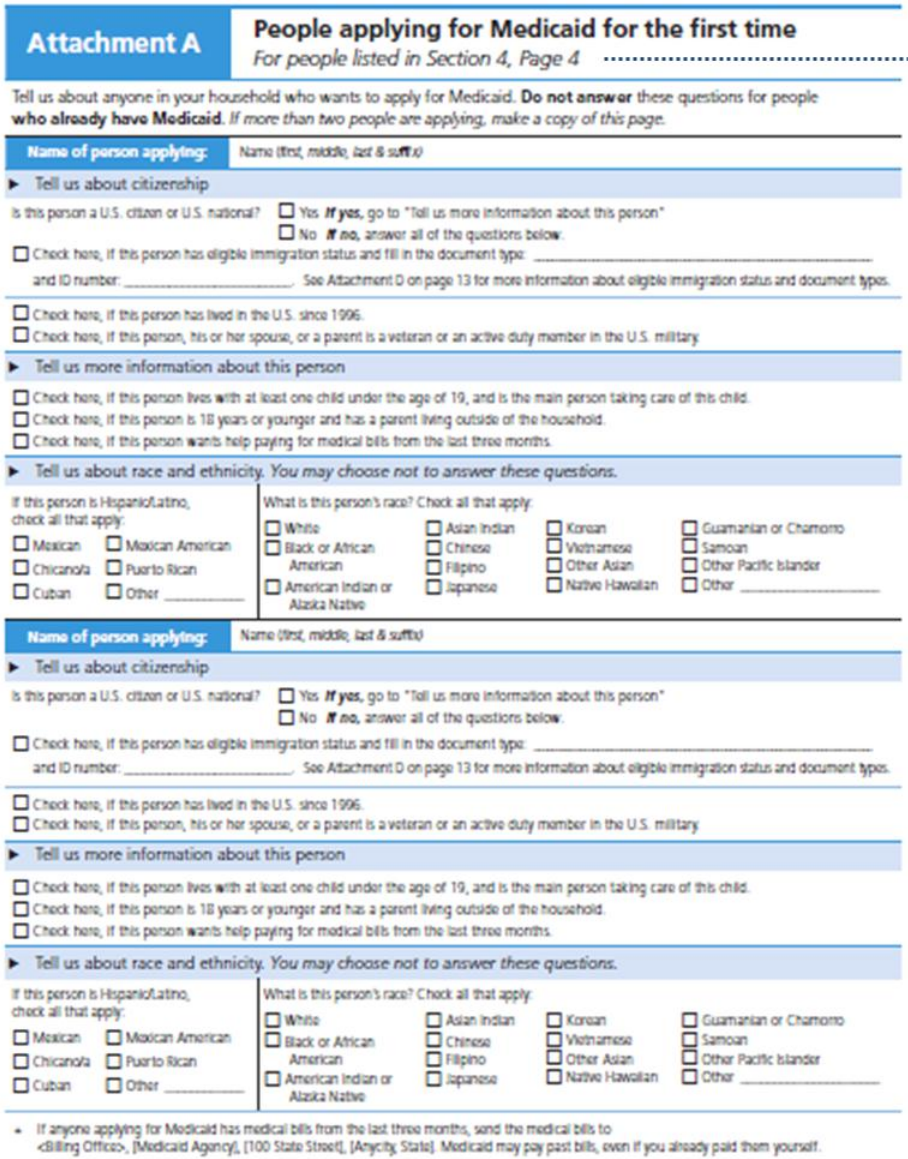
☐ Check here if you are an authorized representative. Sign below and fill out Attachment C on page 12.

Signature of household contact or authorized representative:	Date:

It's important to ensure the beneficiary and others know that their information may be transferred to CHIP or the Marketplace

Allow for digital signature online

Model Renewal Form: Attachment A for Newly Applying Individuals



Attachment A — **People applying for Medicaid for the first time**

For people listed in Section 4, Page 4

Tell us about anyone in your household who wants to apply for Medicaid. **Do not answer** these questions for people **who already have Medicaid.** *If more than two people are applying, make a copy of this page.*

Name of person applying: Name (*first, middle, last & suffix*)

▶ Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes **If yes,** go to "Tell us more information about this person" ☐ No **If no,** answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type: _____ and ID number: _____. See Attachment D on page 13 for more information about eligible immigration status and document types.

☐ Check here, if this person has lived in the U.S. since 1996.

☐ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

▶ Tell us more information about this person

☐ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.

☐ Check here, if this person is 18 years or younger and has a parent living outside of the household.

☐ Check here, if this person wants help paying for medical bills from the last three months.

▶ Tell us about race and ethnicity. *You may choose not to answer these questions.*

If this person is Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

What is this person's race? Check all that apply:

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Name of person applying: Name (*first, middle, last & suffix*)

▶ Tell us about citizenship

Is this person a U.S. citizen or U.S. national? ☐ Yes **If yes,** go to "Tell us more information about this person" ☐ No **If no,** answer all of the questions below.

☐ Check here, if this person has eligible immigration status and fill in the document type: _____ and ID number: _____. See Attachment D on page 13 for more information about eligible immigration status and document types.

☐ Check here, if this person has lived in the U.S. since 1996.

☐ Check here, if this person, his or her spouse, or a parent is a veteran or an active duty member in the U.S. military.

▶ Tell us more information about this person

☐ Check here, if this person lives with at least one child under the age of 19, and is the main person taking care of this child.

☐ Check here, if this person is 18 years or younger and has a parent living outside of the household.

☐ Check here, if this person wants help paying for medical bills from the last three months.

▶ Tell us about race and ethnicity. *You may choose not to answer these questions.*

If this person is Hispanic/Latino, check all that apply:

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

What is this person's race? Check all that apply:

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

* If anyone applying for Medicaid has medical bills from the last three months, send the medical bills to <Billing Office>, [Medicaid Agency], [100 State Street], [Anycity, State]. Medicaid may pay past bills, even if you already paid them yourself.

It is helpful for people to know which part of the form this attachment links back to

Answers to these questions are needed in addition to answers already provided so this renewal form can be used as an application

Model Renewal Form: Attachment B for American Indians/Alaska Natives

Needed for MAGI income determination

Attachment B — American Indian or Alaska Native family member (AI/AN) *To help you fill out Section 6, page 5*

Tell us about your American Indian or Alaska Native family member(s)

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They may not have to pay co-pays and may get special monthly enrollment periods.

If more than two people are American Indian or Alaska Native, make a copy of this page.

1. Name (*first, middle, last & suffix*):

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

How much income? $

How often?

☐ Weekly ☐ Twice a month
☐ Every two weeks ☐ Yearly
☐ Monthly

2. Name (*first, middle, last & suffix*):

Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian health program?

☐ Yes ☐ No

If no, does this person qualify to get these services?

☐ Yes ☐ No

List any income that includes money from these sources:

- Payments from a tribe for natural resources, usage rights, leases, or royalties
- Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
- Money from selling things that have cultural significance

How much income? $

How often?

☐ Weekly ☐ Twice a month
☐ Every two weeks ☐ Yearly
☐ Monthly

Model Renewal Form: Attachment C for Authorized Representatives

Beneficiaries are given the opportunity to change their authorized representative, update their information, or request one for the first time

Attachment C — **Assistance with completing this application**

An authorized representative is a trusted friend, partner, or lawyer you choose to sign your renewal form, get information about this renewal form, and act for you with this agency.

▶ If you have an authorized representative now, please answer these questions.

We show that you chose this person as your authorized representative:

Not applicable

Do you still want this person to be your authorized representative?
☐ Yes ☐ No

If yes, has any of his or her information changed?
☐ Yes ☐ No

If your authorized representative's information has **changed**, or if you would like a **different** authorized representative, please write the new information here:

Name of authorized representative:

Address: Apartment # City State ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other
Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: Date:

▶ If you do not have an authorized representative and want one, please answer these questions.

☐ Check here if you want an authorized representative. Answer the questions below.

Name of authorized representative:

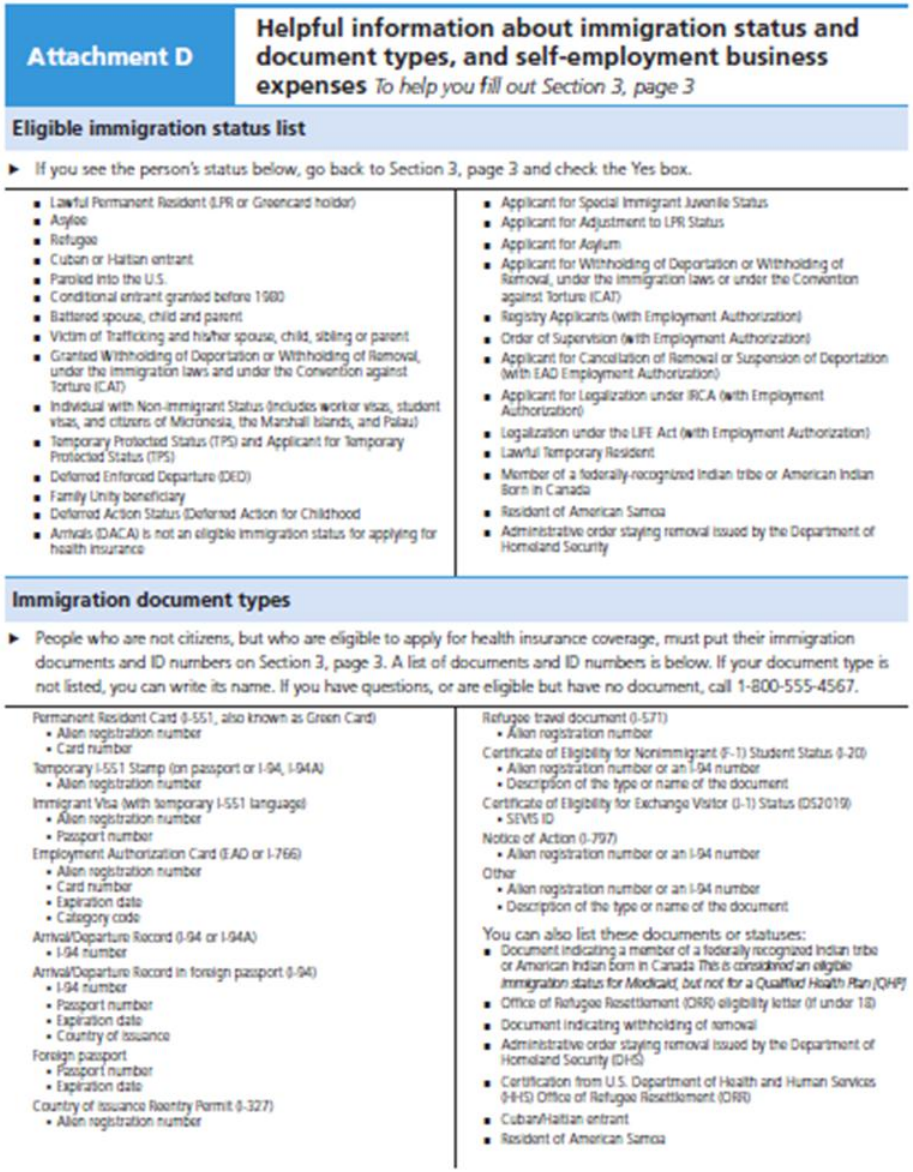
Address: Apartment # City State ZIP code

Phone number: ☐ Home ☐ Cell ☐ Work ☐ Other
Number:

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: Date:

Model Renewal Form: Attachment D for Instructions



Attachment D — **Helpful information about immigration status and document types, and self-employment business expenses** *To help you fill out Section 3, page 3*

Eligible immigration status list

▶ If you see the person's status below, go back to Section 3, page 3 and check the Yes box.

- Lawful Permanent Resident (LPR or Greencard holder)
- Asylee
- Refugee
- Cuban or Haitian entrant
- Paroled into the U.S.
- Conditional entrant granted before 1980
- Battered spouse, child and parent
- Victim of Trafficking and his/her spouse, child, sibling or parent
- Granted Withholding of Deportation or Withholding of Removal, under the immigration laws and under the Convention against Torture (CAT)
- Individual with Non-immigrant Status (includes worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS) and Applicant for Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Family Unity beneficiary
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) is not an eligible immigration status for applying for health insurance
- Applicant for Special Immigrant Juvenile Status
- Applicant for Adjustment to LPR Status
- Applicant for Asylum
- Applicant for Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT)
- Registry Applicants (with Employment Authorization)
- Order of Supervision (with Employment Authorization)
- Applicant for Cancellation of Removal or Suspension of Deportation (with EAD Employment Authorization)
- Applicant for Legalization under IRCA (with Employment Authorization)
- Legalization under the LIFE Act (with Employment Authorization)
- Lawful Temporary Resident
- Member of a federally-recognized Indian tribe or American Indian Born in Canada
- Resident of American Samoa
- Administrative order staying removal issued by the Department of Homeland Security

Immigration document types

▶ People who are not citizens, but who are eligible to apply for health insurance coverage, must put their immigration documents and ID numbers on Section 3, page 3. A list of documents and ID numbers is below. If your document type is not listed, you can write its name. If you have questions, or are eligible but have no document, call 1-800-555-4567.

Permanent Resident Card (I-551, also known as Green Card)
- Alien registration number
- Card number

Temporary I-551 Stamp (on passport or I-94, I-94A)
- Alien registration number

Immigrant Visa (with temporary I-551 language)
- Alien registration number
- Passport number

Employment Authorization Card (EAD or I-766)
- Alien registration number
- Card number
- Expiration date
- Category code

Arrival/Departure Record (I-94 or I-94A)
- I-94 number

Arrival/Departure Record in foreign passport (I-94)
- I-94 number
- Passport number
- Expiration date
- Country of issuance

Foreign passport
- Passport number
- Expiration date

Country of issuance Reentry Permit (I-327)
- Alien registration number

Refugee travel document (I-571)
- Alien registration number

Certificate of Eligibility for Nonimmigrant (F-1) Student Status (I-20)
- Alien registration number or an I-94 number
- Description of the type or name of the document

Certificate of Eligibility for Exchange Visitor (J-1) Status (DS2019)
- SEVIS ID

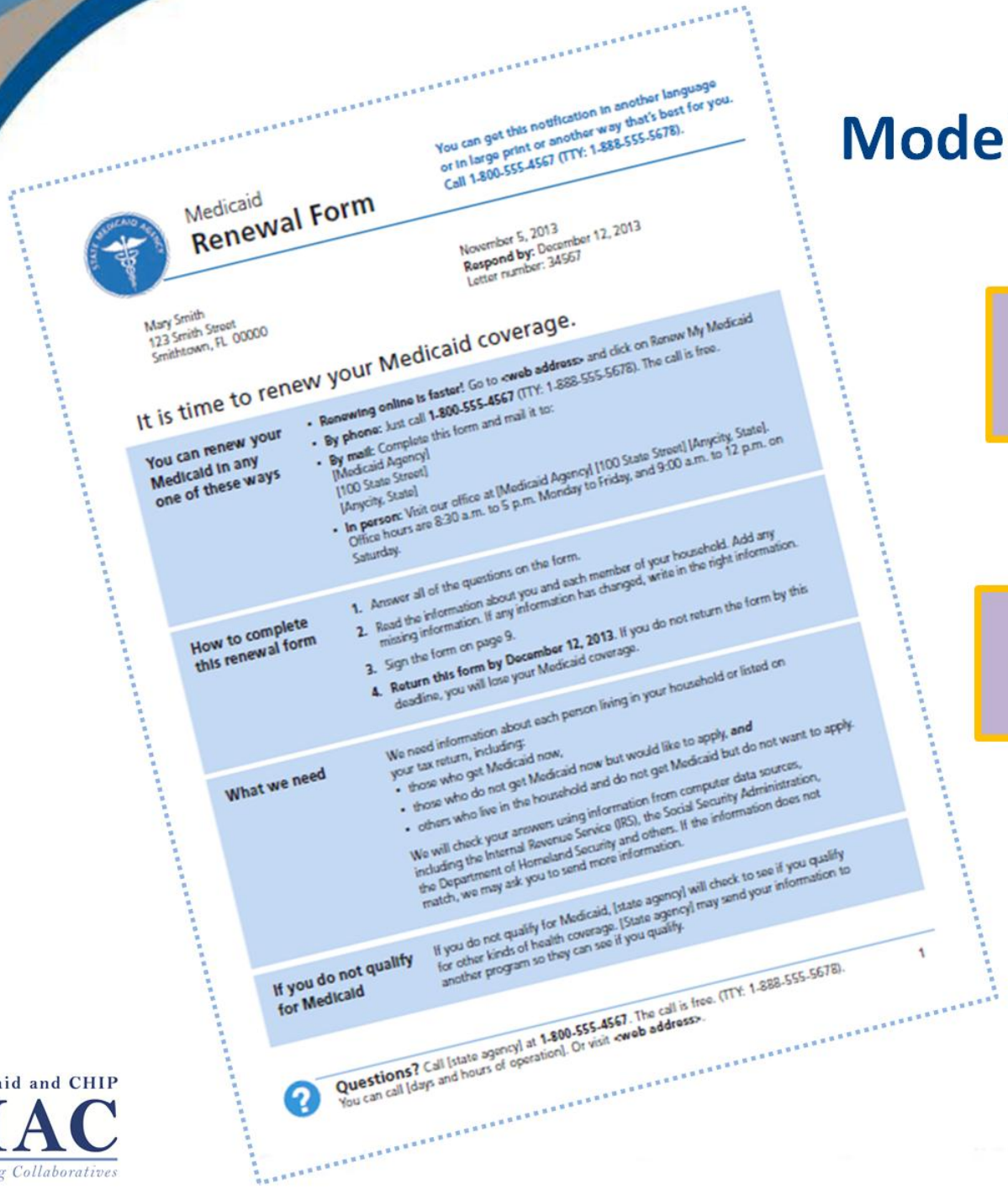
Notice of Action (I-797)
- Alien registration number or an I-94 number

Other
- Alien registration number or an I-94 number
- Description of the type or name of the document

You can also list these documents or statuses:
- Document indicating a member of a federally recognized Indian tribe or American Indian born in Canada *This is considered an eligible immigration status for Medicaid, but not for a Qualified Health Plan (QHP)*
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security (DHS)
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Cuban/Haitian entrant
- Resident of American Samoa

Throughout the Renewal form, beneficiaries are instructed to turn to Attachment D for help with more difficult concepts

Model Renewal Form



Medicaid
Renewal Form

You can get this notification in another language or in large print or another way that's best for you. Call 1-800-555-4567 (TTY: 1-888-555-5678).

November 5, 2013
Respond by: December 12, 2013
Letter number: 34567

Mary Smith
123 Smith Street
Smithtown, FL 00000

It is time to renew your Medicaid coverage.

You can renew your Medicaid in any one of these ways

- **Renewing online is faster!** Go to **<web address>** and click on Renew My Medicaid
- **By phone:** Just call **1-800-555-4567** (TTY: 1-888-555-5678). The call is free.
- **By mail:** Complete this form and mail it to:
  [Medicaid Agency]
  [100 State Street]
  [Anycity, State]
- **In person:** Visit our office at [Medicaid Agency] [100 State Street] [Anycity, State]. Office hours are 8:30 a.m. to 5 p.m. Monday to Friday, and 9:00 a.m. to 12 p.m. on Saturday.

How to complete this renewal form

1. Answer all of the questions on the form.
2. Read the information about you and each member of your household. Add any missing information. If any information has changed, write in the right information.
3. Sign the form on page 9.
4. **Return this form by December 12, 2013.** If you do not return the form by this deadline, you will lose your Medicaid coverage.

What we need

We need information about each person living in your household or listed on your tax return, including:

- those who get Medicaid now,
- those who do not get Medicaid now but would like to apply, **and**
- others who live in the household and do not get Medicaid but do not want to apply.

We will check your answers using information from computer data sources, including the Internal Revenue Service (IRS), the Social Security Administration, the Department of Homeland Security and others. If the information does not match, we may ask you to send more information.

If you do not qualify for Medicaid

If you do not qualify for Medicaid, [state agency] will check to see if you qualify for other kinds of health coverage. [State agency] may send your information to another program so they can see if you qualify.

1

Questions? Call [state agency] at **1-800-555-4567**. The call is free. (TTY: 1-888-555-5678). You can call [days and hours of operation]. Or visit **<web address>**.

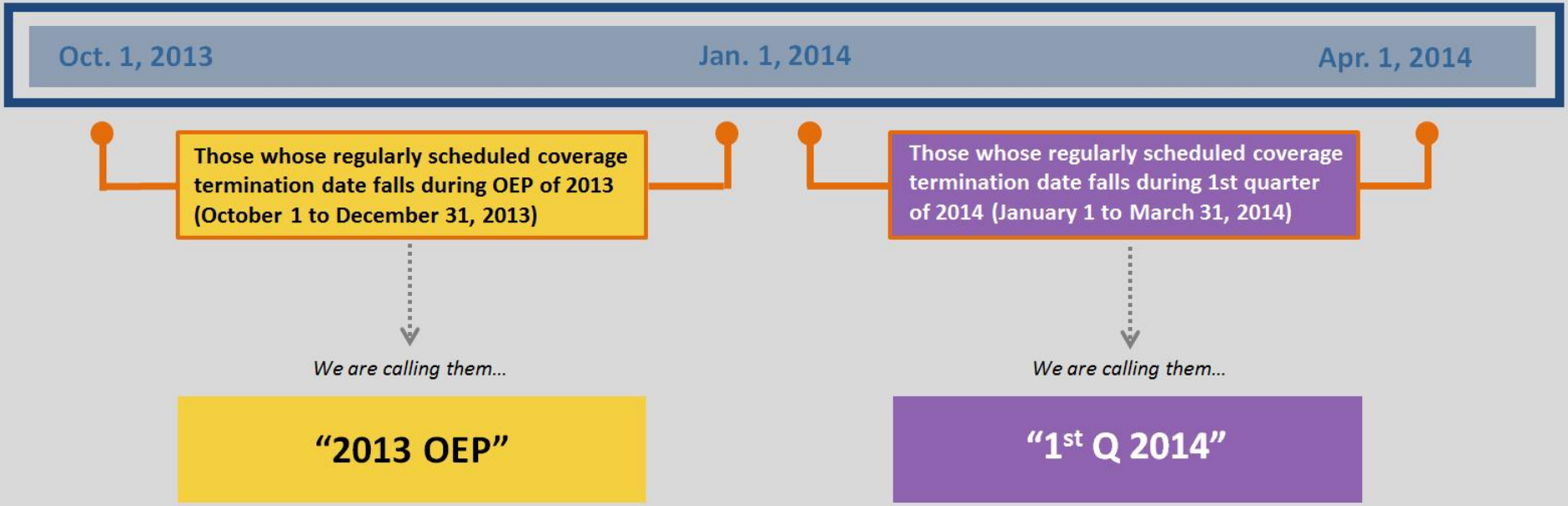
Comments?

Tell us about your state's approach to renewal

Process & Timing of Regularly Scheduled Renewals in 4th Q 2013 & 1st Q 2014

Medicaid and CHIP MAC Learning Collaboratives

Current Beneficiaries with Unique Renewal Considerations



Medicaid and CHIP MAC Learning Collaboratives

Renewal of 2013 OEPs

For current beneficiaries, states are using:
- *2013 methodologies and standards*

For new applicants, states are using:
- *2014 MAGI methodologies and standards*
- *2013 methodologies and standards*

Scheduled termination date is Nov. 1, 2013

State agency redetermines eligibility using 2013 methodologies and standards

If found eligible…

State renews Medicaid coverage for 12 months – until Nov. 1, 2014

If found ineligible…

State terminates Medicaid coverage on Nov. 1, 2013;
What Happens Next?

What happens next?
- Could the State offer the opportunity for a determination using 2014 MAGI methodologies and standards, which new applicants are receiving?
- If this person will become eligible on January 1, 2014 for coverage under Medicaid:
  - Terminating coverage leads to a temporary gap in coverage
  - Could the state offer a new effective coverage date of January 1, 2014 at the time of termination?
  - Could the state apply for a waiver to extend the renewal date or coverage to December 31, 2013 to avoid the gap in coverage?
  - Are there other strategies to avoid the gap in coverage that might occur?
- How does the State notify the beneficiary of the next steps?

Process flow assumes state has no waiver

Renewal of 1st Q 2014

Currently enrolled beneficiaries are protected from loss of eligibility due to the application of MAGI methodologies through March 31, 2014 or an individual's regularly-scheduled renewal, whichever is later.

SSA 1902(a)(14)(D)(v) as added by Section 2002 of the ACA; 42 CFR 435.603

Scheduled termination date is Feb. 1, 2014

State agency redetermines eligibility using 2014 MAGI methodologies and standards

If found eligible…

State renews Medicaid coverage for 12 months – until Feb. 1, 2015

If found ineligible…

State redetermines eligibility using 2013 methodologies and standards

If found eligible…

State renews Medicaid coverage until April 1, 2014; State assesses for other IAPs and transfers account as appropriate

If found ineligible…

State terminates Medicaid coverage, assesses for other IAPs and transfers account as appropriate

For current beneficiaries, states are using:
- *2014 MAGI methodologies and standards*
- *2013 methodologies and standards*

For new applicants, states are using:
- *2014 MAGI methodologies and standards*

Process flow assumes state has no waiver

Timeline for Regularly Scheduled Renewal in 4th Q 2013 & 1st Q 2014

No Waivers

State Considerations:

- Applying 2014 MAGI methodologies and standards and 2013 methodologies and standards through April 1, 2014 requires maintaining two sets of eligibility rules
- Disruptions of coverage for beneficiaries in 2013 OEP if found ineligible

Medicaid and CHIP MAC Learning Collaboratives

Process & Timing of Regularly Scheduled Renewals in 4th Q 2013 & 1st Q 2014

For States Applying For Waivers

Medicaid and CHIP MAC Learning Collaboratives

Renewal Strategies for States' Consideration

On Friday, May 17, 2013, CMS released the State Health Official (SHO) Letter #13-003: "Facilitating Medicaid and CHIP Enrollment and Renewal in 2014" to help states meet operational and system demands for determining new applicants and renewing current beneficiaries

The SHO Letter identifies two waiver options to simplify renewal for state agencies

TODAY'S FOCUS: Waiver Strategies for Renewal of Current Beneficiaries

1. Implementing the early adoption of Modified Adjusted Gross Income (MAGI)-based rules (could also apply to new applicants)

2. Extending the Medicaid renewal period* so that renewals otherwise occurring during the first quarter of calendar year 2014 (January 1-March 31) occur later**

Medicaid and CHIP MAC Learning Collaboratives

*42 CFR 435.916(a)(1) states that individuals whose eligibility is based on MAGI must be renewed once every 12 months

** Extension of renewals that would otherwise occur on or after April 1, 2014 to ease administrative burden also possible

Early Adoption of MAGI-Based Rules

From October 1 to December 31, 2013:

Without a waiver

- For current beneficiaries, states are using:
  - 2013 methodologies and standards
- For new applicants, states are using:
  - 2014 MAGI methodologies and standards
  - 2013 methodologies and standards
- **States run two sets of eligibility rules**

With a waiver*

- For current beneficiaries and new applicants, states are using:
  - MAGI methodologies and standards
- **States only run one set of eligibility rules - MAGI methodologies and standards**

**States waive Section 1902(a)(17) through a Section 1115 waiver*

Medicaid and CHIP MAC Learning Collaboratives

Extending the Renewal Period

From January 1 to March 31, 2014:

Protection Provision

Currently enrolled beneficiaries are protected from loss of eligibility due to the application of MAGI methodologies through March 31, 2014 or an individual's regularly-scheduled renewal, whichever is later.

Social Security Act 1902(a)(14)(D)(v) as added by Section 2002 of the ACA; 42 CFR 435.603

Without a waiver

For current beneficiaries, states are using:

- 2014 MAGI methodologies and rules
- If determined ineligible, 2013 methodologies and rules to determine if the individual remains eligible through March 31, 2014 (due to the protection provision in the ACA)

For new applicants, states are using:

- 2014 MAGI methodologies and rules

States run two sets of methodologies and standards

States must process cases for current beneficiaries and new applicants during this time

With a waiver*

For current beneficiaries:

- States would not be performing renewals, because states extend beneficiaries' renewal dates (within a reasonable timeframe) so they occur on or after April 1, 2014**

For new applicants, states are using:

- 2014 MAGI methodologies and rules

States only run MAGI methodologies and standards

States only process new applicants, reducing total number of cases and administrative burden during this time

*States waive Section 1902(e)(14)(A)

**Extension of renewals that would otherwise occur on or after April 1, 2014 to ease administrative burden also possible

Renewal of 2013 OEPs with Early Application of MAGI Waiver

Scheduled termination date is Nov. 1, 2013

State agency redetermines eligibility using 2014 MAGI methodologies and 2013 standards converted

If found eligible…

State renews Medicaid coverage for 12 months – until Nov. 1, 2014

If found ineligible…

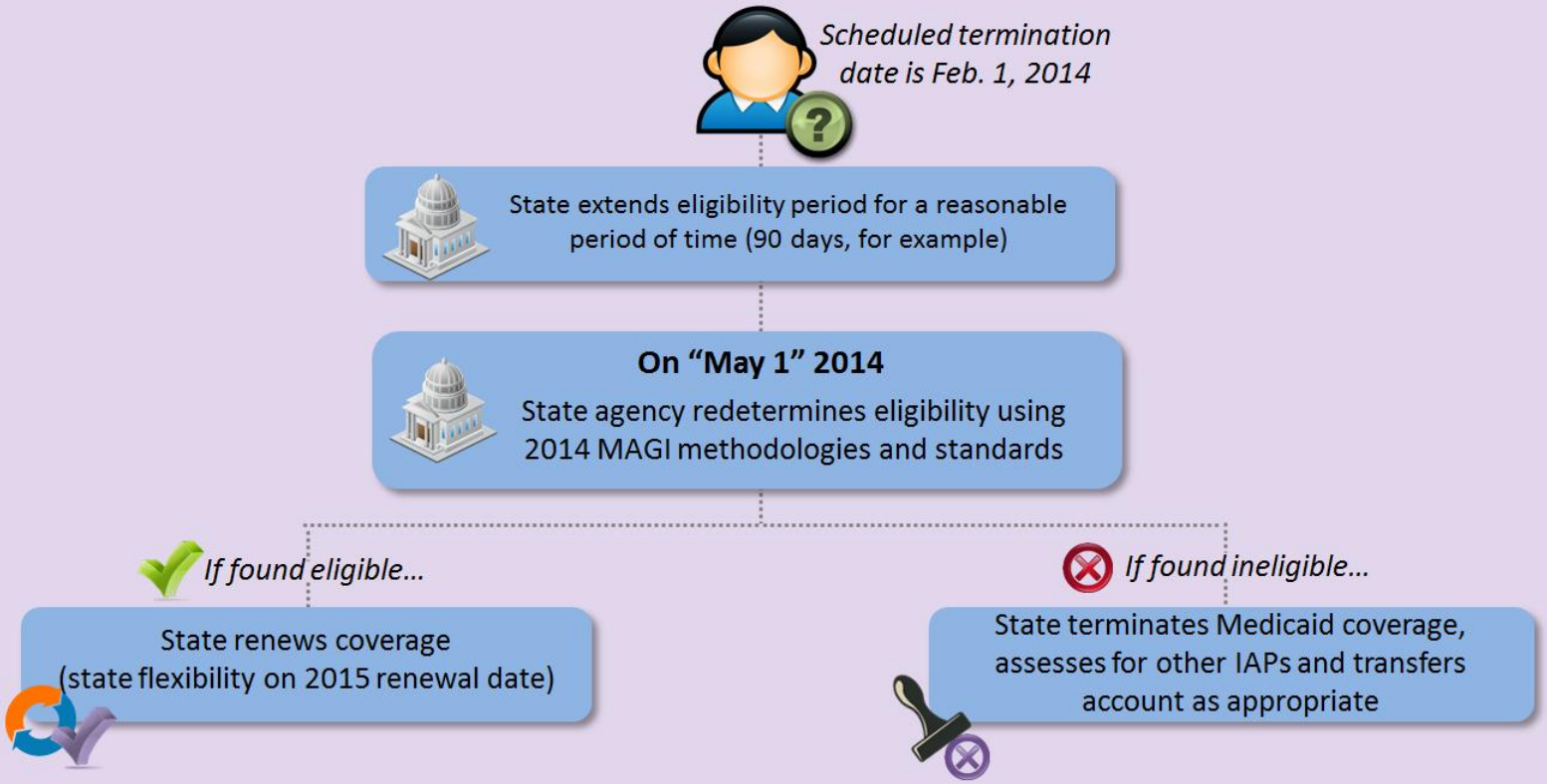
State terminates Medicaid coverage on Nov. 1, 2013;
What Happens Next?

State Options:

- State terminates Medicaid coverage with appropriate notice
- State terminates Medicaid coverage and determines eligibility for January 1, 2014
  - If the person is eligible for Medicaid or subsidized QHP coverage on January 1, 2014:
    - Could they be enrolled in their new coverage option with an effective coverage date of January 1, 2014 with the termination notice?
    - Could the state apply for a waiver to extend the renewal date or coverage through December 31, 2013 to avoid the gap in coverage?

Example of Beneficiary: A childless adult previously covered at 50% FPL (just under the state's threshold) whose income raises to 75% FPL is now ineligible for current Medicaid but newly eligible for the new adult group

Renewal of 1st Q 2014 with Renewal Period Extension Waiver



Timeline for Regularly Scheduled Renewal in 4th Q 2013 & 1st Q 2014

Targeted Waiver Strategies 1 & 2

Change Reporting

For change reporting prior to a regularly scheduled renewal date in 2014, states must use 2013 methodologies and standards if individual is not eligible based on MAGI rules

CMS is developing a strategy to allow the disregard of income changes during the renewal extension period to ensure states are not required to maintain two sets of eligibility rules for change reporting since same grandfathering protection applies

Questions & Answers

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Thank You!

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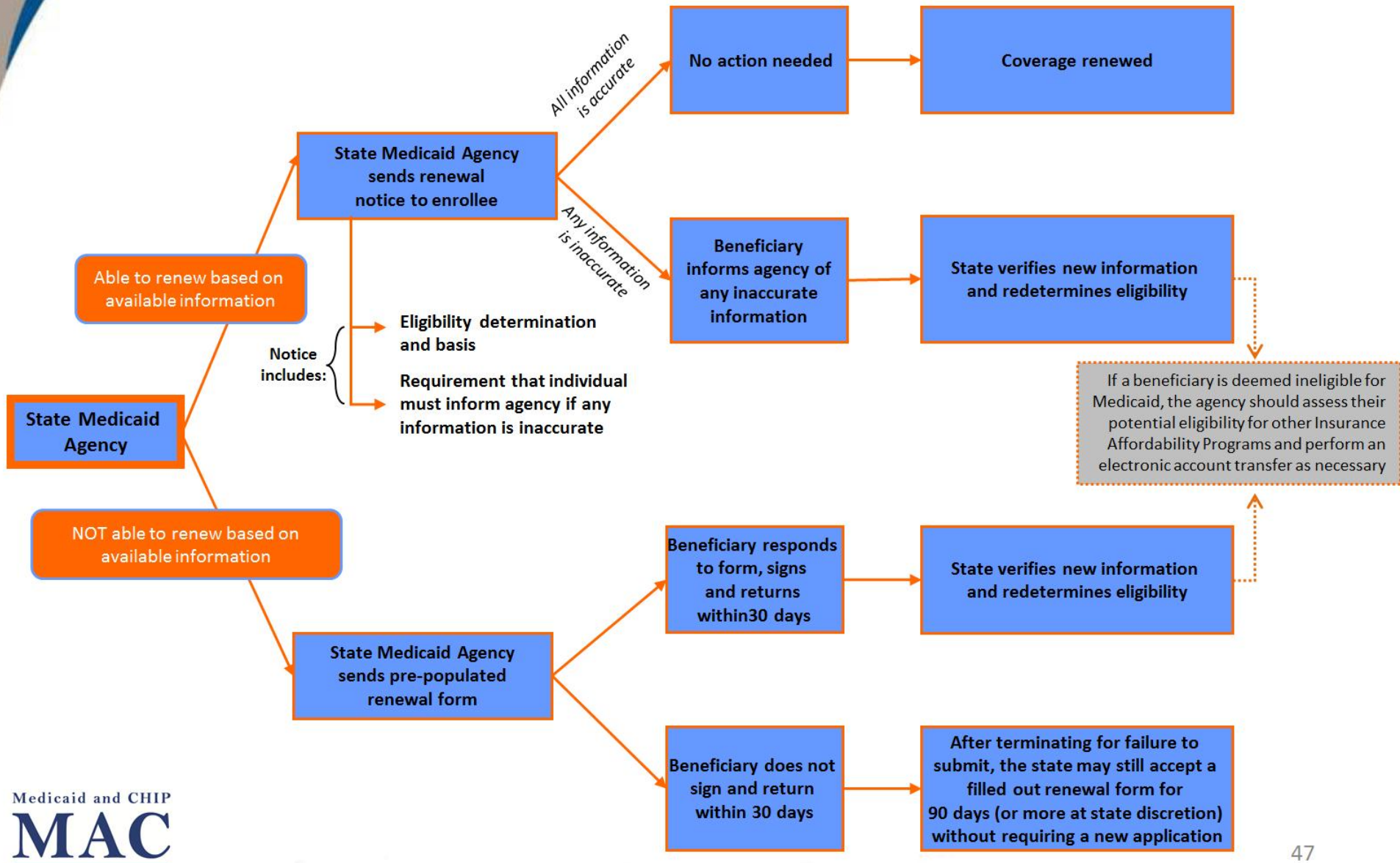
Appendix: Renewal Process Flows

Medicaid Process Flow for Renewal



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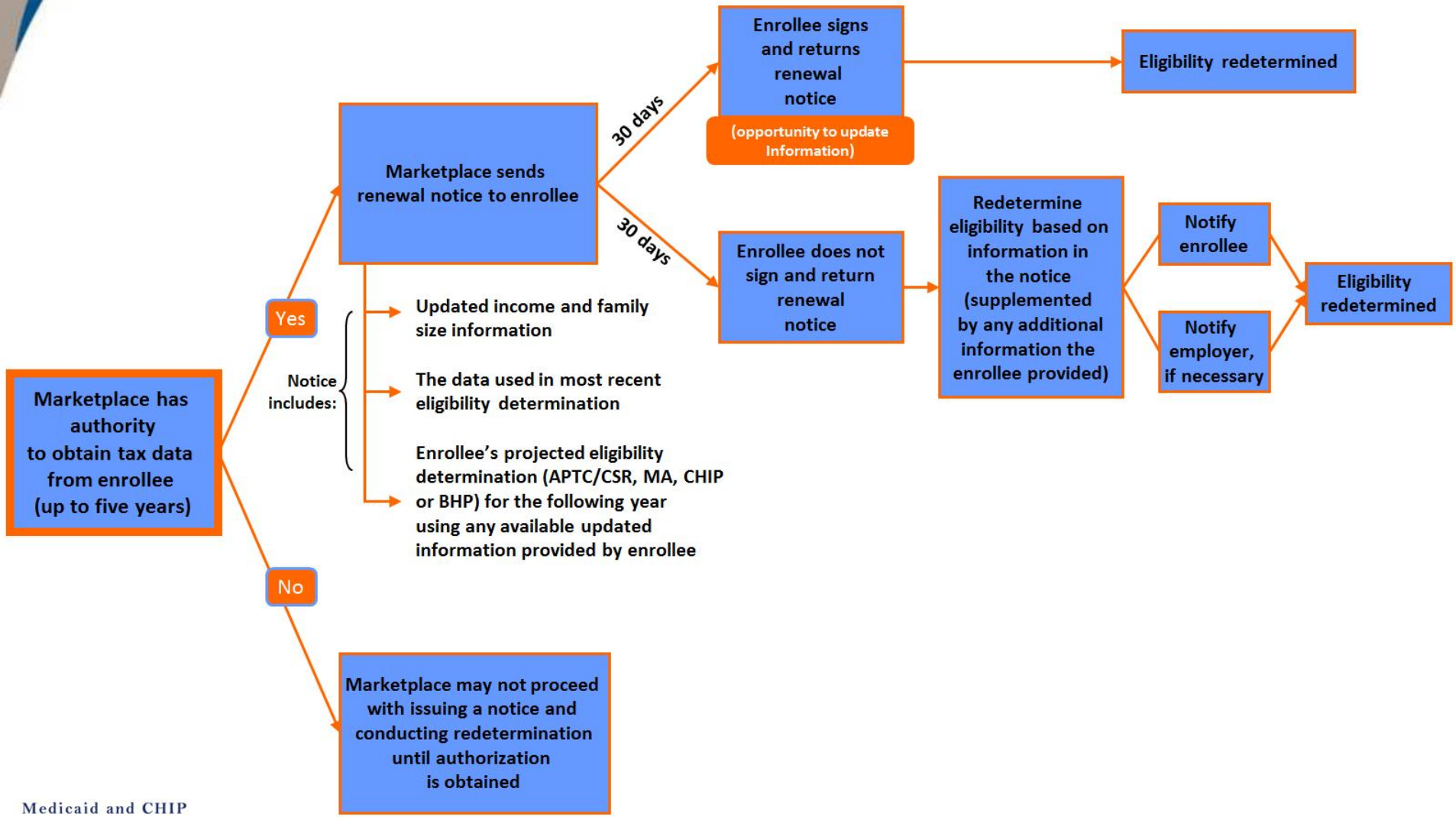
APTC/CSR Process Flow for Renewal



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