



Medicaid and CHIP FAQs: Funding for the New Adult Group

December 2013

Q1: What do states need to do to assure availability of federal funding for the new adult group in 2014?

A1: We are working with states to help them complete all of the steps needed to implement the new adult group on January 1, 2014. States need to make changes and updates to their Medicaid state plan (and sometimes waiver programs) as expeditiously as possible, so they can accurately determine who is eligible, assist individuals with enrollment, contract with health care plans, provide access to quality care health care for their beneficiaries, and receive federal financial assistance for these costs. They will also need to submit state plan amendments (SPAs) describing how they will claim the appropriate federal medical assistance percentage (FMAP) for expenditures for the new adult group. In addition, states will need to submit their budget estimates related to the new adult group, so CMS can provide funding at the appropriate levels.

Q2: Can you describe the process for providing funding for the new adult group?

A2: As states compile their budget estimates for the first calendar quarter of 2014, or for future quarters, states that will adopt the new adult group should include in those estimates the impact of the increased newly eligible FMAP rates available for the new adult group. CMS typically issues quarterly grant awards prior to the beginning of the quarter, so that states can make payments to Medicaid providers during the quarter. We will issue grant awards associated with expenditures related to the new adult group once eligibility SPAs reflecting the new adult group have been approved and the associated FMAP SPAs have been submitted.

For states that have not yet reached these milestones, CMS can quickly issue supplemental grant awards once the new adult group SPA is approved and the FMAP SPA is submitted. States expanding coverage are likely to achieve these milestones early in the quarter but, as always, SPAs do not need to be submitted until the end of the quarter to be made effective retroactively to the beginning of the quarter. CMS is working with states to secure approval of new adult group eligibility SPAs on an expedited basis, and will provide technical assistance as needed so that states can submit their FMAP SPAs in a timely manner.

After the grant award reflecting estimated new adult expenditures is issued, states will be able to draw down federal funds during the quarter, in advance of submitting claims for such expenditures. Finally, as is our regular process, states can begin claiming for expenditures made during the quarter following the close of the quarter, subject to approval of all required eligibility, benefit, and FMAP SPAs. States that do not have approved SPAs can claim retroactively after approval is granted, as long as timely filing requirements are met.

States with waivers should note that, as always, waivers are prospective only – so any waiver changes need to be submitted and approved by January 1, 2014 if a state is trying to make coverage effective on that date.

Q3: How will the grant funding process accommodate delays related to the milestones referenced above for the new adult group with respect to the SPAs or the funding requests?

A3: Typically, grant awards exclude any amounts associated with unapproved SPAs. If the eligibility SPA for a state is approved after the initial grant award to the state was issued (and which, therefore, would not have included amounts for the new adult group), the state could subsequently submit a request for additional funds at any time during the quarter once the eligibility SPA was approved. We consider the approval of the eligibility SPA for the new adult group to provide the necessary basis and authority for this grant action. However, to ensure that states demonstrate they will be able to claim federal funds properly, grant awards will also be contingent upon the submission (but not approval) of an FMAP claiming SPA. These steps will enable states to draw down federal funds during the quarter. However, states must still have all applicable SPAs (eligibility, benefits, and FMAP) approved before they claim expenditures on the CMS-64 after the quarter has closed. If they don't, they can claim retrospectively once approval is granted, as long as timely filing requirements are met. It is important to note that retroactive claiming is not possible when eligibility is triggered by a section 1115 waiver.

Q4: What FMAP applies to women enrolled in the new adult group who become pregnant?

A4: We noted in a previous FAQ released on May 22, 2012 (available at: <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>), states are not required to track the pregnancy status of women enrolled in the adult group, and are not required to move them to the eligibility group for pregnant women if the state becomes aware of their pregnancy outside of the regular redetermination process. Women who become pregnant must be given the option of moving to the pregnancy-related coverage category, and states must inform women of the differences in coverage between the adult group and pregnancy-related coverage (including any differences in benefits, premiums and cost sharing) so that pregnant women can make an informed choice about reporting the pregnancy and changing their eligibility status between regular renewals. We clarify that, at a regularly scheduled renewal, states must determine whether a current beneficiary enrolled in the adult group meets all eligibility criteria to remain eligible in the adult group. If at that time the state is aware that a woman is pregnant (either because of ex parte information confirmed during the renewal process by the state or through the return of a pre-populated renewal form from the woman), she no longer would meet the requirements for eligibility under the new adult group and, if otherwise eligible for coverage based on pregnancy, must instead be enrolled in the pregnant women's group.

The state may give a pregnant woman the option to remain enrolled in the same alternate benefit package she is enrolled in through the new adult group, to minimize any disruption to

her coverage or access to providers. Note that if the state covers any additional benefits for pregnant women under 42 CFR 440.250(p) not provided to other individuals eligible under the state plan, such benefits also must be provided to pregnant women enrolled in such alternative benefit package.

Between regular renewals, if a woman enrolled in the adult group who becomes pregnant does not elect to switch groups and remains in the adult group, her status for FMAP purposes (as newly eligible or not) is unchanged until her next regularly scheduled redetermination. If, consistent with the policy described above, her enrollment is transferred to the pregnant women's group either prior to or at the point of her regular renewal, regular FMAP would apply because she would no longer be in the adult group.

Q5: What is the FMAP applicable for medical assistance authorized under section 1903(v)(2) of the Social Security Act that may be provided to low-income adults with income up to 133 percent FPL?

Q5: Section 1903(v)(2) of the Social Security Act limits the availability of federal Medicaid matching funds for states' expenditures for medical assistance for certain individuals to expenditures for services furnished to treat an emergency medical condition. If such individuals meet the eligibility criteria for the Medicaid new adult group in the state to be considered "newly eligible" under the state's FMAP methodology for the new adult group, state expenditures consistent with section 1903(v) are matched at the newly eligible FMAP described in section 1905(y). This treatment for purposes of federal reimbursement is consistent with current law and regulation.