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Center for Medicaid and CHIP Services

Medicaid and CHIP FAQS: Newly Eligible and Expansion State FMAP

Q1: What are the new Federal matching rates (FMAPs) available under the Affordable Care Act and how do states qualify for them?

A1: Beginning in 2014, the Affordable Care Act authorizes two types of increased federal medical assistance percentages (FMAPs) for state expenditures for low-income individuals in the new adult group (that is, the group described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act)) – the newly eligible FMAP and the expansion state FMAP. Under the statute, these two increased federal matching rates are only available to states that adopt the new adult group.

The newly eligible FMAP is available for medical assistance expenditures on behalf of "newly eligible" individuals, who are defined (in section 1905(y)(2) of the Act) as individuals between the ages of 19 and 64 who are enrolled in the new adult group and who would not have been eligible for full benefits, benchmark coverage (described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act), or benchmark-equivalent coverage (described in section 1937(b)(2) of the Act) as of December 1, 2009. An individual may also be "newly eligible" if he or she would have been eligible but could not have been enrolled for such benefits or coverage because the applicable Medicaid waiver or demonstration had limited or capped enrollment as of December 1, 2009.

The newly eligible FMAP (described in section 1905(y)(1) of the Act) is 100 percent in calendar years 2014-2016, 95 percent in calendar year 2017, 94 percent in calendar year 2018, 93 percent in calendar year 2019, and 90 percent in calendar years 2020 and beyond. The expansion state FMAP (described in section 1905(z)(2) of the Act) is an alternate increased FMAP available to match the expenditures for certain adults in states that previously expanded Medicaid and, as a result, may not qualify for the newly eligible FMAP. More details about the expansion state FMAP are included in Question 5.

In our August 17, 2011 eligibility NPRM (http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf), we proposed that methods for assigning the appropriate FMAP would not require that states undertake the process of using their old eligibility rules to determine if someone would have been eligible under December 2009 rules. We have been consulting with states to test different methodologies for accuracy and simplicity.

Q2: How does CMS define the term "Expansion State"? Which States are "expansion States"?

A2: Under the Affordable Care Act, an Expansion State is one that had eligibility standards for parents and non-pregnant childless adults (under either the State plan or a demonstration project) to at least 100 percent of the FPL as of the date of enactment of the Affordable Care Act. Specifically, a State is an expansion State if, on March 23, 2010, the State offered health benefits coverage Statewide to parents and non-pregnant, childless adults whose income is at least 100 percent of the poverty line, that includes inpatient hospital services, is not dependent on access to employer coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits under a demonstration program authorized under section 1938 of the act. A State that offers health benefits coverage to only parents or only non-pregnant childless adults described in preceding sentence will not be considered to be an expansion State; both groups must have been covered as described above.

The law established a special Federal medical assistance percentage (FMAP) for expansion States. Expansion States are able to claim a special FMAP for the non-pregnant childless adults who are not "newly eligible." These States can also claim the enhanced FMAP for individuals who are "newly eligible" in 2014. CMS is in the process of a 50-State review of State coverage as of March 23, 2010.

Q3: Can a State claim enhanced FMAP for parents in the new adult group?

A3: Yes, in order to be eligible for enhanced FMAP for "newly eligible" individuals, an individual must be in the new adult group. The adult group is comprised of individuals that could include parents. Specifically, the group is comprised of individuals described in section 1902(a)(10)(A)(i)(VIII) of the Act who beginning January 1, 2014:

- Are under age 65
- Are not pregnant
- Not entitled to/enrolled for benefits under Medicare (Part A and B)
- Not described in the "(I) to (VII) Groups" (referring to individuals described in section 1902(a)(10)(I) - (VII) of the Act)
- Whose income is determined using MAGI and does not exceed 133% of the FPL

This list does not preclude parents from being in the adult group, but whether the State can claim enhanced FMAP depends on whether the parents are considered "newly eligible" ; that is, an individual who is not under 19 years of age (or higher age as the State may have elected) and who is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage or benchmark equivalent coverage under State rules in effect as of December 2009, or is eligible but would not have been enrolled for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment.

Thus, for any parents who are in the adult group because, for example, their income is greater than the income standard for parents in the State's parent/caretaker relative group in January 2014, the State will be able to claim enhanced FMAP if they would not have been eligible under the eligibility criteria in effect under the plan or waiver as of December 1, 2009.

Our proposed rules on this definition were issued in August 2011 (available at http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/html/2011-20756.htm); final rules are forthcoming. As discussed in the proposed rule, CMS intends to establish a methodology for States to claim enhanced FMAP without having to maintain and apply its December 1, 2009 eligibility rules to each individual.

Q4: For purposes of determining if the newly eligible FMAP applies, how will CMS decide if benefits offered through a section 1115 demonstration meet a benchmark or benchmark equivalent standard?

A4: As described above, the newly eligible FMAP applies to adults in the new low-income adult eligibility group who would not have been eligible for full benefits, benchmark benefits, or benchmark-equivalent benefits under the state's rules as of December 1, 2009. At the time of approval of the section 1115 demonstrations in effect as of that date, neither CMS nor states explicitly designated the coverage offered under demonstrations as "benchmark" or "benchmark-equivalent" coverage, even though the coverage offered to demonstration beneficiaries may have met such standards. Therefore, CMS is requesting that states that used section 1115 demonstrations to expand coverage to low-income adults as of December 1, 2009 provide CMS with an analysis of the benefit package that was offered so that CMS can determine whether the benefits provided could have met a benchmark or benchmark- equivalent standard, as in effect in December 2009. A separate analysis should be undertaken for each demonstration benefit package, if different demonstration populations received different benefits under the demonstration.

In conducting the benefit analysis, it will be important for states to utilize a consistent methodology and provide CMS with sufficient data to substantiate their analyses. States' benchmark-equivalence analyses must be certified by a qualified actuary and must include information on the data, assumptions, and methodology used to calculate actuarial values, in accordance with regulations implementing section 1937 of the Act, which are already in effect at 42 C.F.R. 440.330-340. CMS is working with all affected states (that is, states with demonstrations covering adults in effect on December 1, 2009) and will provide them with guidance about the form and manner in which to provide information about eligibility and benefits in effect as of December 1, 2009. CMS will use the benefit analysis that states provide to determine the appropriate FMAP. If any state has questions about this process, they should contact their State Operations and Technical Assistance (SOTA) team representative.

It is also important to note that if the benefit analysis described above indicates that the newly eligible FMAP is not available for a particular population, states may nevertheless be able to claim the expansion state FMAP for certain non-pregnant adults enrolled in the new adult group (as described in Question 5). CMS will work with each state that expanded coverage to adults prior to the enactment of the Affordable Care Act to address questions and to ensure that the correct FMAP is applied to expenditures for each population.

Q5: What is the difference between the expansion state FMAP and the newly eligible FMAP and which states qualify for the expansion state FMAP?

A5: When Congress enacted the Affordable Care Act, some states had already expanded coverage to adults at higher incomes. The expansion state designation under the statute provides an alternate increased FMAP to states that adopt the new adult group but where some individuals in the new group do not qualify for the newly eligible FMAP because they would have qualified for full benefits, benchmark benefits, or benchmark-equivalent benefits under the state's rules as of December 1, 2009. The expansion state FMAP may be available to qualifying states for expenditures for certain non-pregnant childless adults (those who are enrolled in the new adult group and who the state may require to enroll in benchmark coverage), to the extent that such individuals do *not* qualify for the newly eligible FMAP.

A qualifying expansion state (described in section 1905(z)(3) of the Act) is a state that, as of March 23, 2010 (the date of enactment of the Affordable Care Act), provided "health benefits coverage" either through Medicaid or a fully state-funded program to parents and non- pregnant childless adults up to at least 100 percent of the Federal Poverty Level (FPL). For purposes of this statutory definition, such health benefits coverage as of March 23, 2010 must have:

- Included inpatient hospital services.
- Not been dependent on access to employer coverage, employer contribution, or employment.
- Not been limited to premium assistance, hospital-only benefits, a high deductible health plan, or a health opportunity account.

States seeking to confirm their status as expansion states should provide CMS with an analysis of the scope of coverage provided as of March 23, 2010, citing applicable demonstration special terms and conditions or state-based policies to establish eligibility levels and the coverage provided. As we have explained in a previously released FAQ, (available at http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf), if a population covered by a state that qualifies as an expansion state meets the criteria for the newly eligible matching rate, the state will receive the newly eligible matching rate for that population. A state will always receive the more favorable FMAP if two FMAPs might be applicable for a particular population. For example, states that qualify as expansion states may be eligible for the newly eligible FMAP if the expansion offered less than full benefits, benchmark benefits, or benchmark-equivalent benefits, or if the expansion started after December 1, 2009. In such an instance, expenditures for adults in the new adult coverage group will be subject to the newly eligible FMAP.

The expansion state FMAP (described in section 1905(z)(2) of the Act) is the regular FMAP rate increased by the number of percentage points equal to a "transition percentage" (which ranges from 50-100 percent) of the gap between the regular Medicaid FMAP and the increased "newly eligible" FMAP. In 2019 and beyond, the expansion state FMAP will be equal to the newly eligible FMAP, which means it will be 93 percent in 2019 and 90 percent in 2020 and thereafter.

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