Medicaid and the Affordable Care Act:
FMAP Final Rule Frequently Asked Questions
August 29, 2013

General Questions

1. Will there be individuals whose expenditures qualify for the "newly eligible" federal medical assistance percentage (FMAP) in states that do not elect to cover the new adult group?

No. Under the statute, the increased newly eligible FMAP is only available for expenditures for medical assistance furnished to individuals enrolled in the new adult group created by the Affordable Care Act (section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, codified at 42 C.F.R. §435.119). States that do not elect to cover the statutory new adult group (which is described in 1.b) under the approved state plan cannot claim the newly eligible FMAP.

1.a. If individuals who would not have been eligible under Medicaid requirements as of December 1, 2009 are found eligible starting in 2014 under the new modified adjusted gross income (MAGI) rules for eligibility groups other than the new adult group, would expenditures for these individuals be funded at the newly eligible FMAP?

No. Under the statute, the increased newly eligible FMAP is only available for expenditures for medical assistance for individuals enrolled in the new adult group created by the Affordable Care Act. The increased match available for expenditures for "newly eligible" individuals enrolled in the new adult group is not available for individuals receiving benefits under any other eligibility group. If a state does decide to adopt the new adult group, states have flexibility to modify existing eligibility groups, allowing individuals to qualify under the new adult group and qualify for the newly eligible FMAP if the individuals are newly eligible as defined by law. CMS will work with states to identify available options.

1.b. Is the newly eligible FMAP available for expenditures for all individuals enrolled through the new adult group?

The answer to this question will vary by state. The defined population of individuals in the new adult group may include both individuals who are "newly eligible" and individuals who are not newly eligible. The new adult group extends eligibility to non-pregnant adults up to age 65, who are not eligible for another mandatory Medicaid eligibility group, and whose income determined using the methodology based on modified adjusted gross income (MAGI-based income) does not exceed 133 percent of the poverty level. However, only individuals in this group who could not have been eligible for Medicaid full benefits, benchmark

benefits, or benchmark-equivalent benefits as of December 1, 2009 meet the definition of "newly eligible" individuals, for whom expenditures will be matched at the increased newly eligible FMAP. Expenditures would not be matched at the newly eligible FMAP for adults who could have been eligible for Medicaid as of December 1, 2009, even if they are instead enrolled in the new adult group in 2014 or later. For example, if a state had previously extended full Medicaid coverage to optional parents, these individuals would not qualify for the newly eligible FMAP.

For more details, see questions 3 and 4 in our February 2013 FAQs, available at: http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/aca-faq-bhp.pdf.

2. The FMAP rule requires an individual-based determination related to "relevant" or "applicable" categories. What does the relevant or applicable December 2009 eligibility group mean?

By this term, "the applicable December 2009 eligibility group," we mean the eligibility group for which an individual would have been eligible, based on the particular characteristics of the individual that are known to the state agency from the application or the individual's account. For example, to determine if an adult with a disability determination in 2014 is newly eligible, the current MAGI-based income of that individual would be compared against the relevant converted MAGI-based income standards in effect as of December 1, 2009 for individuals with a disability. For another example, see the response to the next question regarding eligibility for parents. The FMAP final rule is clear that, in making individual-based determinations under the threshold methodology, states shall not consider information based on factors that are not relevant to eligibility determination; for example, other than disability status, health status is generally irrelevant for purposes of applying the threshold methodology.

2a. Could you give an example of how the threshold methodology would work for parents?

To determine if a parent eligible for Medicaid in 2014 is newly or not newly eligible, that parent's current MAGI-based income would be compared against the converted MAGI-based income standards for the relevant parent/caretaker eligibility category in effect as of December 1, 2009. For example, consider a state that covered parents in a mandatory eligibility group up to a converted income standard of 45 percent of the federal poverty level (FPL), and optional coverage up to 60 percent FPL. If the state reduced parent eligibility to 45 percent FPL, while parents between 45 and 60 percent FPL would be eligible for the new adult group starting in 2014, they would not be considered newly eligible for FMAP purposes since they would have been eligible under the state's December 2009 standards.

3. **How would the threshold methodology apply for determining the FMAP status for individuals for whom there was no previous "relevant category" covered by a state, for example, nondisabled childless adults? Do other categories need to be checked?**

   As described above, the FMAP rule requires an individual-based determination comparing the individual's MAGI-based income to the 2009 MAGI-converted income eligibility standards in effect for relevant eligibility categories. The state would first check to confirm the individual enrolling in the adult group is not a parent or a person with a disability determination. If the person is neither and if the state did not previously cover any relevant eligibility category for comparison, the individual enrolled in the new adult group would be considered to be newly eligible. In other words, nondisabled childless adults in that state would have no relevant category as of December 1, 2009, since the state had not previously expanded coverage for the individual (through a section 1115 demonstration that provided full benefits, benchmark benefits, or benchmark-equivalent benefits). In that circumstance, it would not be necessary to compare a nondisabled childless adult's income against income standards for other categories. Instead, all nondisabled childless adults enrolled in the new adult group would be considered to be newly eligible.

4. **How will states determine an individual's MAGI income if different sources of income conflict? For example, what happens if there is a disparity between the income that someone reports and the data that a state has available for them from an alternative database? What if one data source for income shows that somebody is newly eligible and another source shows him or her to be not newly eligible? Are the same income sources to be used for eligibility and FMAP purposes?**

   FMAP determinations should rely on the income determination used to determine the individual's eligibility. No separate determination for FMAP purposes is needed or allowed. Any inconsistency in the data would be resolved through the verification and eligibility determination process followed in determining the individual's eligibility for coverage, as set forth in CMS's eligibility regulations (77 FR 17144 (March 23, 2012), available at: www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf). The same determination of income used for eligibility purposes should be used for determining status as "newly eligible" under the FMAP final rule.

5. **What is the duration of an individual's FMAP status as determined under the threshold methodology?**

   The FMAP final rule specifies that once an individual is determined to be newly or not newly eligible, the state would apply that determination until a new determination of MAGI-based income has been made in accordance with 42 C.F.R. §435.916. 42 C.F.R. §435.916 requires that eligibility must be renewed once every 12 months, and no more frequently unless a

beneficiary reports a change in circumstance or the agency receives information (for example, from a routine post-eligibility data match conducted by the state) that may affect the individual's eligibility. If such information does not affect eligibility, it would not trigger a new determination of MAGI-based income under 42 C.F.R. §435.916, and, as such, the individual's status as newly or not newly eligible would not be affected.

5a. Could you give an example of how that would work?

Yes. Consider the hypothetical state described above in Question 2a, in which the state covered parents (in an optional Medicaid category) with a converted income standard of 60 percent of the FPL as of December 1, 2009, but transitions parents between 45 percent and 60 percent FPL into the new adult group in 2014. Those parents would not be considered newly eligible for FMAP purposes (although the state could apply a population-based resource adjustment to claim a portion of expenditures at the newly eligible FMAP). Parents with incomes above 60 percent of the FPL and below 133 percent of the FPL would also be eligible for the new adult group. Those parents would be considered newly eligible for FMAP purposes.

1) A parent applies for Medicaid in 2014 and is determined to have MAGI-based income of 100 percent of the FPL. The parent is determined eligible for the new adult group and also determined to be "newly eligible" for FMAP purposes, as the parent's income is greater than the converted 60 percent FPL level in effect in 2009. If a routine data check conducted by the state suggests that the parent's income has dropped to 50 percent FPL, no redetermination of eligibility would be triggered under 42 C.F.R. §435.916, as even assuming the information received is correct, the parent's eligibility would not be affected (she would remain in the new adult group). Because no redetermination of eligibility would be conducted, the state would continue to claim the enhanced match based on the parent being considered newly eligible, until the beneficiary's next eligibility redetermination.

2) A parent applies for Medicaid and is initially determined to have MAGI-based income of 50 percent FPL. The parent is determined eligible for the new adult group and also is determined not to be newly eligible for FMAP purposes, as the parent's income is less than the converted 60 percent FPL level in effect in 2009. Expenditures on behalf of the parent are matched at the state's regular FMAP. If a routine data match suggested that the parent's income has risen to 75 percent FPL, no redetermination of eligibility under 42 C.F.R. §435.916 would be triggered, and the state would continue to claim FMAP based on the parent not being considered newly eligible, until the beneficiary's next eligibility redetermination.

3) A parent applies for Medicaid in 2014 and is determined to have MAGI-based income of 100 percent FPL. The parent is determined eligible for the new adult

group and also determined to be newly eligible for FMAP purposes, as the parent's income is greater than the converted 60 percent FPL level in effect in 2009. A routine data match suggested that the parent's income had increased to 150 percent FPL, triggering a redetermination of eligibility in accordance with 42 C.F.R. §435.916(d). If the increase in income is confirmed in accordance with the regulations, the parent no longer would be eligible under the new adult group. In accordance with 42 C.F.R. §435.916(d), the state would need to consider whether the parent might retain eligibility under another eligibility group and, if so eligible, the state would claim the regular FMAP for coverage under the other group. If not eligible under any other group, the state would assess the parent's eligibility for other insurance affordability programs and transfer the parent's electronic account accordingly, consistent with 42 C.F.R. §§435.916(f) and 435.1200(e).

6. How will FMAP determinations be built into Medicaid systems for reporting purposes?

The FMAP final rule generally requires individualized determinations of the applicable FMAP for individuals enrolled in the new adult group, subject to certain population-based adjustments to assure that FMAP claiming appropriately reflects the impact of enrollment caps or resource tests. It is necessary for states to determine if individuals are newly or not newly eligible so that expenditures can be matched appropriately. There are different ways that states can document these FMAP determinations. CMS has provided states with technical assistance about these options.

For example, at application when MAGI income is determined for eligibility purposes, one approach is for a state to simultaneously compare the relevant converted standards to determine if the individual is newly or not newly eligible. The FMAP status can be flagged in the eligibility system and carried over into MMIS for reporting purposes. States adopting this approach must assure that the FMAP determination does not delay the eligibility determination.

7. Is the newly eligible FMAP available for populations found presumptively eligible for the new adult group?

Individuals may be determined "presumptively eligible" for coverage under the new adult group by a qualified hospital or qualified entity under the statute and implementing regulations. In these circumstances, the newly eligible FMAP is only authorized with respect to individuals determined eligible for the new adult group by the state agency or other public entity authorized to make final Medicaid eligibility determinations. The regular FMAP applies until such time as the state (or other authorized entity) determines an individual to be eligible for the new adult group and the state confirms that they also meet the definition of a "newly eligible individual".

In appropriate circumstances, a state may retroactively adjust claiming for services provided during a presumptive eligibility period. Specifically, newly eligible status is available based on the effective date of eligibility for the new adult group, which may be as early as the third month prior to the month that the individual applied for Medicaid in accordance with 42 C.F.R. §435.914 (resdesignated at §435.915 under the March 2012 final eligibility rule), provided that the individual would have been eligible for Medicaid had he or she applied as of the earlier date. To the extent to which the presumptive eligibility period is encompassed within such retroactive eligibility period and the state determines that the individual meets the criteria for newly eligible status, the state may retroactively adjust claiming for services provided during a presumptive eligibility period. The state is not required to make such a retroactive adjustment if the state determines that an adjustment would be administratively burdensome.

Questions about Applying the FMAP Final Rule and Disability Findings

8. Why would individuals who are disabled obtain coverage under the new adult group?

There are various reasons why individuals with disabilities could be enrolled in the new adult group. An individual could be determined to have a disability but have income over the income level for coverage under an eligibility group for which being disabled is a requirement. Or someone who qualifies under an optional eligibility group for disabled individuals may decide not to pursue eligibility under that group, for example because doing so may entail a lengthy process to determine disability or require additional information regarding resources and the individual decides that the benefit package for the new adult group meets his or her needs. Such individuals could enroll in the new adult group if they meet criteria for that group, including having MAGI-based income at or below 133 percent FPL.

9. For purposes of determining eligibility, will the income eligibility standards for any blind or disabled eligibility groups that will continue to be in effect on and after January 1, 2014 need to be converted to equivalent MAGI-based income eligibility standards?

MAGI-based methodologies do not apply to eligibility categories in which disability or blindness is an element of eligibility. Therefore, for *eligibility purposes*, the income eligibility standards for blind and disabled eligibility groups that continue in 2014 will not need to be converted to equivalent MAGI-based income eligibility standards. However, for purposes of claiming the appropriate FMAP for the new adult eligibility group, conversion of such income standards is required (see question below).

10. For purposes of determining the FMAP rates that are applicable for the expenditures of individuals determined eligible under the new adult group in 2014, will the income

eligibility standards for any blind or disabled eligibility groups in effect on December 1, 2009 need to be converted to equivalent MAGI-based income eligibility standards?

Generally, yes. For purposes of determining the FMAP applicable for the expenditures on behalf of individuals determined eligible under the new adult eligibility group, states must determine whether individuals with a disability determination meet the definition of "newly eligible", that is, would the individuals have been determined eligible under the applicable income eligibility standards for any relevant eligibility groups as were in effect on December 1, 2009. This requires the state to compare the MAGI-based income of such individuals against the income eligibility standards for any relevant optional eligibility groups (and in some circumstances the mandatory aged, blind, or disabled (ABD) group in 209(b) states) for which they may have qualified that were in effect on December 1, 2009, regardless of whether any such eligibility groups continue on or after January 1, 2014. In order to make this determination, the income eligibility standards for the relevant blind and disabled groups as in effect on December 1, 2009, will need to be converted to equivalent MAGI-based income eligibility levels.

CMS is already working with states on such conversions. CMS has requested that all states complete the "FMAP Template for Aged, Blind and Disabled Groups," which requests the identification of the income eligibility standards for ABD categories covered under the states' December 2009 state plans.

Generally, the SSI-related eligibility group will not be a relevant group unless the state applies new standards to the group (for example, by switching to the "209(b)" option under section 1902(f) of the Act) because individuals who would have qualified for the SSI-related group will still qualify under that group and will never be included in the new adult group.

11. How does an individual's disability status affect the individual's eligibility status for the new adult eligibility group and other eligibility categories?

An individual with disabilities may or may not be eligible for the new adult group, depending on whether the individual is eligible for Medicaid based on another Medicaid eligibility category related to their disability.

As discussed in a May 22, 2012 FAQ (see Question 6 at: http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf) adults with disabilities who otherwise meet the criteria for eligibility under the new adult group described in §435.119 of the March 2012 Medicaid eligibility final rule may be determined eligible for Medicaid under that group.

However, individuals who are eligible for mandatory coverage as an SSI recipient or deemed SSI recipients under section 1902(a)(10)(A)(i)(II) of the Act and 42 C.F.R. §435.120 et seq.

of the regulations must be enrolled for coverage under the mandatory eligibility group for aged, blind and disabled individuals. These individuals are not eligible under the new adult group. Note that, in 209(b) states, individuals, including SSI recipients, who must meet a spenddown in order to qualify for coverage under the mandatory group for aged, blind and disabled individuals are not required to spenddown to the income standard applied to that group, but may elect to enroll for coverage under the new adult group. Similarly, an SSI recipient who must meet other more restrictive criteria for mandatory coverage under Medicaid in a 209(b) state is not required to undergo further evaluation to determine such eligibility, but may be determined eligible under the new adult group.

In the case of coverage under an optional eligibility group based on disability, applicants and beneficiaries may elect to complete a full determination of eligibility under such group. Once determined to meet all requirements for eligibility based on disability (including the applicable income and resource tests as well as a determination of disability), the individual would be exempt from application of MAGI-based methodologies and therefore ineligible for the new adult group. Unless and until the state finds that the applicant or beneficiary meets all requirements for eligibility based on disability, the individual may obtain coverage under the new adult group (provided that the eligibility requirements for the new adult group are met).

12. What happens when a disability determination is made for an individual after they are enrolled in the new adult group?

The FMAP regulation made clear that a person without an actual determination of disability is considered not disabled for purposes of this analysis. If a person is awaiting a disability determination, and this individual qualifies for the new adult group, the person will be considered newly eligible with respect to any 2009 eligibility category for which disability is a criterion (because they are not disabled).

When an individual awaiting a disability determination is determined to be disabled, their FMAP status will need to be reevaluated by comparing their income to the relevant MAGI-converted income standard for individuals with disabilities. If the disability finding is rendered as part of a favorable determination of SSI eligibility, no comparison of income will have to be made, because the individual will not be eligible for the new adult group from that point in time.

The following examples may be illustrative:

- Continued Newly Eligible. If the individual is not eligible for a mandatory or optional disability-based eligibility category covered under the state's plan at the time of the disability determination (i.e., in 2014 or after), and if the individual's income is *greater* than the income standard(s) for the relevant disability-related mandatory or

optional eligibility categories(s) in effect on December 1, 2009, the individual would continue to be eligible for the new adult group and would continue as newly eligible.

- Not Newly Eligible. If the individual is not eligible for a mandatory or optional disability-based eligibility category covered under the state's plan at the time of the determination, but the individual's income is *less* than the income standard(s) for the relevant disability-related mandatory or optional category in effect on December 1, 2009, the individual will continue to be eligible for the new adult group and would not be considered newly eligible.
- Eligible for Another Eligibility Group. If the individual is determined eligible for an eligibility group other than the new adult group at the time of the disability determination, the individual will be enrolled in that group. For example, if the individual has income *and* resources that are less than the standards for a disability-related category covered under the state's plan, the individual enrolled under that group and would not continue to be eligible for the new adult group.

Finally, as we stated in our April 2, 2013 final rule, we recognize that availability of the increased FMAP while a disability determination is pending should not result in a delay processing disability determinations, to the extent the state plays a role in determining disability. To ensure timely determinations of disability status, we will closely monitor state implementation of the threshold methodology and develop safeguards, such as performance standards related to timeliness of disability determinations, and work with states to ensure that such performance standards are satisfied.

13. Beginning in 2014, can states eliminate previous optional disability-related eligibility categories? How would this change impact FMAP for individuals in the new adult group?

Yes, beginning in January 2014, states may eliminate or limit the scope of optional eligibility groups that are not specific to children (or families with children), including optional disability-related eligibility categories. This could result in more individuals becoming eligible for coverage under the new adult eligibility group. Ultimately, however, the preservation or elimination of optional disability-related categories generally will not impact the FMAP states receive. As described above, a person with a disability determination will have his or her income compared to a disability-related category covered under the state's December 2009 state plan for purposes of FMAP, regardless of whether that category remains covered in the state's plan after 2014. Therefore, most individuals with a disability determination who could have been eligible under an optional eligibility group for disabled individuals as of December 1, 2009, should, under the FMAP final rule, be determined not to be newly eligible. See Question 2, which describes the "relevant" eligibility categories. To the extent that the state discontinues state-only disability determinations for an optional eligibility group in effect in December, 2009, the state may need to make a population-based

adjustment to reflect the special circumstance resulting from a change in disability determination procedures.

14. Does a state that retains all of its 2009 disability-related eligibility categories for adults need to establish MAGI-equivalent income eligibility thresholds for such eligibility categories? Can it comply with the FMAP final rule simply by ensuring that after someone has been found by an actual determination to be disabled and to qualify for disability-based coverage under current rules that they are moved out of the new adult group and into the disability category?

When an individual otherwise eligible for the new adult group is determined to have a disability and is found eligible for a separate disability-related category covered under the individual's state plan, the individual must be enrolled in that separate category. However, regardless of whether states that adopt the new adult group retain all 2009 disability categories, they still need to convert their 2009 ABD income standards to MAGI-equivalent thresholds. As described above, this is necessary because some people who have been determined to have a disability will be enrolled in the new adult group because, for example, they do not meet all of the state's disability-related category eligibility requirements. In such a situation, states will have to compare the individual's MAGI-based income and the converted income standard applicable to a 2009 disability-related category to determine the applicable FMAP.

15. If a beneficiary has been receiving Medicaid in an existing group for disabled people and that person loses eligibility due to acquiring excess resources, once the state moves that individual to the new adult group, would that individual be considered newly eligible as it relates to excess resources. Can the state claim the newly eligible FMAP for the expenditures of that individual?

Under the final FMAP rule, resource criteria are not applied on an individual basis because in many cases the state will not have resource or asset information from individuals and asking for this information (which is not relevant for MAGI-based income determinations) is not permissible. The expenditures specific to that individual would not be claimed at the newly eligible FMAP. However, states have the option to apply a population-based resource adjustment to reflect that some individuals could not have been eligible as of December 1, 2009 based on excess resources. As described in the final FMAP rule, resource criteria are not applied on an individual basis but there may be some states that will have information available to them about individuals' non-MAGI income and assets; in those cases CMS will work with states to develop reasonable approaches to determine FMAP in a manner consistent with the FMAP final rule.

16. The FMAP final rule is clear that the threshold methodology will consider only an actual disability determination for purposes of determining the applicable FMAP. What if a beneficiary had a disability determination at one point but it has lapsed by the time the individual applies for eligibility under the new adult group?

Different states have different policies about the duration of the applicability of a disability determination. For purposes of determining the applicable FMAP status of the individual under the threshold methodology, only a disability determination that is considered current (as determined in accordance with the state's operational policies) is relevant; a disability determination that is not considered current could not be the basis for concluding that someone is disabled. Instead, the individual would be considered not to be disabled for purposes of determining the applicable FMAP. To the extent that the state changes its disability policies from those in effect in December 2009, the state would need to make a population-based adjustment to reflect the special circumstance resulting from a change in disability determination procedures. CMS will work with states to provide technical assistance in advance of FMAP SPA submissions.

Questions about Other Populations

17. Does the newly eligible FMAP rate affect the 100 percent FMAP rate that is set forth in 1905(b) of the Act and is available for services received through IHS facilities and tribal health facilities, to the extent funded by IHS pursuant to Public Law 93-638?

No. The second sentence of section 1905(b) of the Social Security Act provides that the FMAP for services received through an IHS or tribal facility is 100 percent, notwithstanding the application of the newly eligible FMAP under the first sentence of 1905(b). So the 100 percent IHS FMAP rate continues to apply to expenditures for services received through IHS or tribal facilities for the new adult group, whether or not the individual is newly eligible.

18. The FMAP final rule appears to require that states exclude individuals from the newly eligible FMAP if their incomes are at or below the spend-down income eligibility level. Wouldn't this disqualify a significant portion of individuals in the new adult group from being determined newly eligible?

Only individuals who *could* have been eligible under a spenddown-related category covered under a state's 2009 plan will have their income compared to the state's medically needy income level (MNIL). In a state that did not offer medically needy coverage to people with disabilities, an individual with a disability who is enrolled in the new adult group will not have his or her income compared to the state's MNIL, because the person could not have been eligible in the state's medically needy category.

Where an individual enrolled in the new adult group could have been eligible in December 2009 in a state's medically needy category, the individual's income will be compared to the

MNIL, and where it is *above* the MNIL, the person will be considered newly eligible (assuming there are not any other categories the individual would have qualified under in December 2009). While it is possible that such an individual could have qualified for Medicaid in 2009 by meeting his or her spenddown through the deduction of incurred medical expenses, only where the individual would have qualified in the state's medically needy category *without* needing to deduct any expenses (i.e., medically needy without spenddown) will the new adult group enrollee be considered not newly eligible.

19. What FMAP applies to individuals with breast or cervical cancer beginning in 2014?

States have the option to provide Medicaid to individuals who have been screened for breast or cervical cancer by the Centers for Disease Control and Prevention (CDC) Breast and Cervical Cancer Treatment Program (BCCTP). No income test is applied by the state Medicaid agency in determining an individual's eligibility under this optional eligibility group, however, individuals must have been screened by the state's CDC program as needing treatment for one of those conditions and meeting the eligibility requirements for the state's screening program (e.g., income no more than 250 percent FPL, age).

Once the maintenance of effort required under section 1902(gg) of the Act expires for adults (January 1, 2014), states that currently provide Medicaid under the optional eligibility group for individuals screened by the BCCTP are not required to continue to do so.

States that retain coverage under the optional BCCTP group. If the state retains coverage under this optional group in 2014, individuals who have been screened by the BCCTP and referred to the Medicaid agency must be enrolled in that group, as they are exempt from application of MAGI-methods under the statute and regulations and may not be enrolled in the new adult group. Expenditures for individuals enrolled under the optional BCCTP eligibility group will be matched at the CHIP enhanced FMAP (the same match that is provided today). Individuals who have breast or cervical cancer but have not been screened by the CDC program could be determined eligible under the new adult group and may be considered newly eligible (if their income is above the converted thresholds for other relevant groups).

States that discontinue coverage under the optional BCCTP group. States that discontinue coverage under the optional BCCTP group are not required to collect information to determine whether an individual determined eligible under the new adult group would have been eligible under the BCCTP group; indeed, the single streamlined application developed by the Secretary does not request information relating to the need for breast or cervical cancer treatment services or screening by the CDC-funded program. Therefore, an individual enrolled in the new adult group and, using the threshold methodology, not found eligible for another category of coverage in effect as of December 1, 2009, would be considered to be newly eligible and the increased FMAP would apply.

Questions About Applying the FMAP Final Rule

20. What FMAP would be applicable beginning January 2014 for the expenditures for individuals covered by an "early option SPA" that went into effect after the date of enactment of the Affordable Care Act? What approach do states need to use when moving individuals from the early option SPA into the new adult group?

Individuals who could not have been eligible for Medicaid as in effect on December 1, 2009, but who are eligible after that date through December 31, 2013, under an early option adult coverage SPA could be considered newly eligible in 2014; accordingly, their expenditures would be matched at the newly eligible FMAP. CMS is available to work with states to efficiently transfer these early option populations into the new adult group and, prior to the next regularly scheduled redetermination, states should submit for CMS approval as part of the FMAP SPA a description of how they will move individuals into the new adult group and apply the applicable FMAP. We will not require a new eligibility determination before the regularly scheduled renewal. Effective with the next regularly scheduled redetermination, eligibility and FMAP would need to be reviewed.

21. What FMAP would be applicable beginning January 2014 for the expenditures for individuals who, prior to January 1, 2014, are enrolled in section 1115 demonstrations; and in particular, would the treatment differ based on whether the demonstration was in effect on, or after, December 1, 2009?

The application of the FMAP would differ based on whether the demonstration was in effect on, or after, December 1, 2009.

Enrollees who would have been eligible for a demonstration eligibility category that was *not* in effect on December 1, 2009, would be considered to be newly eligible.

For a Medicaid demonstration that was in effect on December 1, 2009, states will need to consider the benefits provided under the demonstration (as described in Frequently Asked Questions released in February 2013 and available at: http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/aca-faq-bhp.pdf) and apply the threshold methodology to determine the newly eligible status for individuals in the new adult group who could have been eligible for coverage under the demonstration as in effect on December 1, 2009. A state may apply a population-based adjustment based on any approved enrollment cap methodology applied under the threshold methodology, if applicable.

22. Do states have flexibility to apply the FMAP final rule in a manner that reflects unique state circumstances that might make straightforward application of the threshold methodology difficult or inefficient?

Yes. The final rule includes a provision that permits CMS to authorize a population-based adjustment to reflect "special circumstances" (see 42 C.F.R. §433.206(g)). Any such adjustment must be consistent with the general principles set forth in the regulation at 42 C.F.R. §433.206(b) with respect to validity, accuracy and efficiency. CMS is interested in working with states to identify such special circumstances to develop appropriate state-specific protocols, as long as we can validate the accuracy of the methodology as applied. These special circumstances adjustments will be memorialized in states' threshold methodology FMAP SPAs.

23. What steps will CMS be taking to ensure that states are properly claiming the increased match?

CMS has issued technical guidance to states to assist them in tracking individuals and expenditures that are eligible for the increased match. States will also be submitting state plan amendments to describe their FMAP methodologies. CMS will review expenditures for increased match, including sampling specific claims to audit against the state's approved FMAP claiming methodologies and procedures, to identify any errors and sources of errors. Based on those results, states will make any needed corrections and CMS will continue reviews in subsequent quarters to assure proper claiming.