

## **Questions and Answers: Medicaid and the Affordable Care Act**

*February 2013*

### **Basic Health Program**

#### **Q1: When will the Basic Health Program be operational?**

**A1:** Given the scope of the coverage changes that states and the federal government will be implementing on January 1, 2014, and the value of building on the experience that will be gained from those changes, HHS expects to issue proposed rules regarding the Basic Health Program for comment in 2013 and final guidance in 2014, so that the program will be operational beginning in 2015 for states interested in pursuing this option.

#### **Q2: What approaches are available to states that are interested in the Basic Health Program in the interim?**

**A2:** HHS is working with states that are interested in the concepts included in the Basic Health Program option to identify similar flexibilities to design coverage systems for 2014, such as continuity of coverage as individuals' income changes. Specifically, we have outlined options to states related to using Medicaid funds to purchase coverage through a Qualified Health Plan (QHP) on the Marketplace for Medicaid beneficiaries (<http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf>). Additionally, some states with current Medicaid adult coverage expansions are considering offering additional types of assistance with premiums to individuals who will be enrolled in QHPs through the Marketplace. HHS will review all such ideas.

### **Newly Eligible and Expansion State FMAP**

#### **Q3: What are the new FMAPs and how do states qualify for them?**

**A3:** 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.

**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.

### Pregnant Women

**Q11: Do states need to track people enrolled in the adult group who become pregnant? If a woman indicates on the application she is pregnant, do states need to enroll her as a pregnant woman if she is otherwise eligible for the adult group? Would there be a need to track pregnancy if the benefits for both groups are the same?**

**A11:** If a woman indicates on an initial application that she is pregnant, she should be enrolled in Medicaid coverage as a pregnant woman, rather than in the new adult group. However, as stated in the preamble to the March 23, 2012 Medicaid and CHIP Eligibility & Enrollment final rule (<https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010>), states are not required to track the pregnancy status of women already enrolled through the new adult group. Women should be informed of the benefits afforded to pregnant women under the state's Medicaid program and if a woman becomes pregnant and requests a change in coverage category, the state must make the change if she is eligible.

**Q12: If a woman moves to the pregnant woman group, are states then required to move former pregnant women from the pregnant women eligibility group back to the adult group when the post-partum period ends?**

**A12:** If a woman is enrolled in a group for pregnant women, before the end of the post-partum period, as specified in the definition of "pregnant woman" at 42 CFR 435.4, the state Medicaid agency will need to re-evaluate the woman's eligibility for other groups, including the low-income adult group and advance payment of premium tax credits through the Marketplace. Our regulations at 42 CFR 435.916 explain the requirements for states in connection with renewals of eligibility or determinations of ineligibility based on a change in circumstances. The procedures outlined in the regulation are intended to promote continuity of coverage.

## Transition to Modified Adjusted Gross Income (MAGI)

**Q13: How will populations that are currently eligible based on net income, but will not qualify based on MAGI in 2014, be treated? Will these individuals have an opportunity to enroll in another insurance affordability program after March 31, 2014 or their next redetermination, whichever is later?**

**A13:** As stated under section 1902(e)(14)(D)(v), if the application of the new MAGI-based methods would be the cause of an existing Medicaid beneficiary's (i.e., one determined eligible based on current methods and enrolled in the program prior to January 1, 2014) becoming ineligible for continued coverage based on income, the individual retains Medicaid eligibility until March 31, 2014 or the next scheduled renewal, whichever is later. If, at the appropriate time, an individual is determined to no longer qualify for the current eligibility group, under longstanding Medicaid rules the individual's eligibility must be assessed under other possible eligibility groups before Medicaid eligibility may be terminated (see §435.930(b) and §435.916(f)). In accordance with 435.1200, if the individual is no longer Medicaid eligible, the state agency must evaluate the individual for potential eligibility for enrollment in a qualified health plan (QHP) through the Affordable Insurance Exchange, or Marketplace, and for CHIP.

Since the eligibility rules for Medicaid, CHIP and enrollment in a QHP through the Exchange are aligned, we do not expect that the evaluation for potential eligibility for these other programs to pose a burden on state agencies. Once determined to be potentially eligible for another program, the regulations call for ensuring that the information concerning the potentially eligible individual is transferred electronically to the other program.

(<https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010>)

## Children's Coverage

**Q14: Are the expansions of Medicaid to children optional?**

**A14:** No. The extension of Medicaid coverage to the new group of former foster care children up to age 26 (see section 1902(a)(10)(A)(i)(IX)) and to all children age six and older with incomes up to 133 percent of the (FPL) (1902(a)(10)(A)(i)(VII)) are required by the Affordable Care Act and were not affected by the Supreme Court's decision. The Medicaid eligibility change for older children eliminates the confusing "stair step" federal eligibility rules that have put low-income children in the same family in different programs depending on their age. As previously indicated in our Medicaid and CHIP eligibility final rule (available at <https://www.federalregister.gov/articles/2012/03/23/2012-6560/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010>), the CHIP enhanced matching rate will continue to be available for children transferring from separate CHIP programs to Medicaid as a result of eligibility changes in the Affordable Care Act.