

## Instructions for FMAP Claiming State Plan Amendment

This new section of the Medicaid state plan applies only to states that adopt the new adult coverage group described in 42 CFR 435.119. States that wish to claim newly eligible and/or expansion state FMAP for enrollees in the adult group (42 CFR 435.119) must submit a State Plan Amendment to CMS. This State Plan Amendment is required by 42 CFR 433.206(h), which requires a state that wishes to claim expenditures at the increased FMAPs made available under the Affordable Care Act to submit a State Plan Amendment describing its methodology for determining which expenditures may be claimed at the higher FMAP rates. The final rule published in the Federal Register on April 2, 2013 (78 FR 19918) set forth allowable methods for determining which expenditures qualify for increased FMAP rates.<sup>1</sup>

For individuals enrolled in the adult group, there are three potential applicable FMAP rates: (1) the state's regular FMAP rate (as applicable with respect to the expenditures for any individuals who are not newly eligible in states that do not qualify as expansion states and for parents who are not newly eligible in states that do qualify as expansion states); (2) the expansion state FMAP rate (available only with respect to the expenditures for nonpregnant childless adults who are not newly eligible in states that qualify as expansion states); or (3) the newly eligible FMAP (as applicable with respect to the expenditures for individuals who are newly eligible in all states). For purposes of the determining the availability of the newly eligible FMAP for the expenditures of individuals in the adult group, such individuals must meet the definition of newly eligible individual at 42 CFR 433.204(a)(1).

The State Plan Amendment includes five parts as described in the table below.

Part	Description
Part 1	Adult Group Individual Income-Based Determinations
Part 2	Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap, and Special Circumstances
Part 3	One-Time Transitions of Previously Covered Populations into the New Adult Group
Part 4	Applicability of Special FMAP rates
Part 5	State Attestations Regarding Threshold Methodology for FMAP Claiming

<sup>1</sup> 78 Federal Register 19918-19947, accessible at <http://www.gpo.gov/fdsys/pkg/FR-2013-04-02/pdf/2013-07599.pdf>

## **Part 1 – Adult Group Individual Income-Based Determinations**

For individuals eligible in the adult group, the state must make an individual income-based determination for purposes of the threshold methodology by comparing individuals' income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in their approved MAGI Conversion Plan (Part 2). Under the threshold methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup will be provisionally considered as those for which the newly eligible FMAP is not available.

Because the MAGI Conversion Plans include more values than are needed for purposes of FMAP claiming for the expenditures of the adult group, Table 2 of Part 2 of the MAGI Conversion Plan consolidates the FMAP related standards into a one summary table which is applicable for states to use in completing this FMAP claiming SPA. As discussed below, this summary table should be used to complete Column B of Table 1.

Column A of Table 1 lists the potential population groups that may be covered by states under the adult group and for which there may have been relevant eligibility groups as in effect under the states' December 1, 2009 Medicaid programs. States must enter in Column B of Table 1 in the FMAP claiming SPA the appropriate reference in the MAGI Conversion Plan, as contained in the summary Table 2 of Part 2 of such plan, to the applicable relevant MAGI-equivalent income standards for each of the population groups in Column A. The entry in Column B should be explicit in identifying the applicable reference/citation from the MAGI Conversion Plan (for example, the section number or column and row from the table). Furthermore, states must also attach the summary table (that is, Table 2 of Part 2 of the MAGI conversion plan) containing the relevant income standards as Attachment A to this FMAP claiming SPA.

NOTE, there may not be a relevant income standard for each population group in Column 1 for a state; for example, your state may not have provided coverage to childless adults in 2009. For such Adult Group population groups, states should enter "N/A" in Column B. Furthermore, the Adult Group population group or groups included in Column A of Table 1 may not completely represent or reflect the group or groups covered by a state in 2009 for which the converted income standard or standards are contained in the CMS-approved MAGI conversion plan. Column A includes a blank line at the bottom which may be used to indicate such other potential population groups; however, before completing that line, states should work with CMS to determine whether such group(s) are appropriate. After working with CMS to determine the appropriateness for such groups to be included in Table 1, States should indicate such groups (or a reference to such groups) in Column A and in the other columns of Table 1 as

applicable for such group(s). Also, as appropriate, States should describe such group or groups and indicate any of the related information for the other columns in an attachment.

Columns C, D, and E in Table 1 should be completed by states to indicate whether a Resource Proxy, Enrollment Cap, or Special Circumstances population adjustment, respectively, are applicable for the state. In these columns States should enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. States should indicate additional information relating to such population adjustments in corresponding attachments discussed in Part 2 below.

## **Part 2 –Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances**

### **A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))**

Under 42 CFR 433.206(d) a resource proxy adjustment may be applied by states at their option. Every state should indicate in Section A.1 whether they do or do not apply any resource proxy. States that do not apply any resource proxy should skip Sections A.2 and A.3.

A state that applies any resource proxy adjustment for any of the population groups covered by the state as of December 1, 2009, as listed in Table 1 of Part 1, must complete Sections A.2 and A.3 and provide more detail about the resource proxy methodology as Attachment B to this SPA.

For each population group or group described in Column A of Table 1, in Column C of the same table, indicate whether the population group will be subject to a resource proxy adjustment. Include a "Y" (Yes) or "N" (No) in each row under Column C. For any population groups listed in Column A of Table 1 that were not covered by the state as of December 1, 2009 and for which a resource proxy therefore would not be applied, enter "N/A" in Column F.

Use Attachment B to provide more details about each population group, including whether a resource test was applied to the indicated population group in Column A on December 1, 2009. For any population group or groups for which your state will apply a resource proxy (i.e., the entry in Column F is "Yes"), indicate the effective date or dates for the application of such resource proxy in Attachment B, as appropriate.

In Sections A.2 and A.3, indicate aspects of the resource test proxy related to data, data sources, and methods used for the associated adjustment made through the resource proxy and attach additional descriptive information in Attachment B. As appropriate, both items under section A.3 could be completed and described in Attachment B. Specifically, provide information that describes the data used and demonstrates that the methodology used is

statistically valid and reflects denials explicitly due to excess resources and is not due to other factors such as failure to return paperwork. If your state plans to develop a resource proxy adjustment and has not yet done so (for example, because it will implement a post-enrollment survey after January 1, 2014), indicate that you are not currently implementing a resource proxy and file a new State Plan Amendment when the information is available.

Information on data included in Attachment B should include and address:

- Eligibility Groups for which the data apply
- Sampling design
- Periods which the data represent
- Statistical validity
- Calculation of denial rates related specifically to excess resources

Information on the resource methodology and adjustment included in Attachment B should include and address and specify:

- How the adjustment is applied by eligibility group (for example, whether the groups are combined or separated)
- How the data is applied to determine the adjustment

## **B. Enrollment Cap Adjustment (42 CFR 433.206(e))**

An enrollment cap adjustment is only applicable for states that, as of December 1, 2009, provided demonstration populations with full benefits, benchmark benefits, or benchmark-equivalent benefits as described in section 1905(y)(2)(A) of the Social Security Act that had an enrollment cap and as confirmed by CMS under the established process described in letters to states issued in February 2013. States that expanded Medicaid eligibility through a demonstration prior to December 1, 2009 but offered less than full, benchmark, or benchmark equivalent benefits do not need to reflect enrollment caps as part of their FMAP SPA.

Every state should indicate in Section B.1 whether an enrollment cap adjustment is is applicable (first indicator area) or is not applicable (second indicator area) for the state. States for which an enrollment cap adjustment is not applicable should skip Sections B.2 through B.4.

Use Column D of Table 1 to describe any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to population groups that your state covers in the adult group and that received full, benchmark, or benchmark-equivalent benefits. If CMS has already indicated in separate correspondence that populations covered by a demonstration as of December 1, 2009 did not receive full benefits, benchmark benefits, or

benchmark-equivalent benefits, an enrollment cap adjustment is not necessary and you may designate “No” in Column D of Table 1 and then skip this section.

For any population group that was subject to an enrollment cap as of December 1, 2009, provide more detail about the enrollment cap in Attachment C, and attach CMS correspondence confirming the enrollment cap. It may be helpful to include some of the information in Attachment C in a chart format. Below is a sample chart that may be useful:

<b>Section 1115 Demonstration Enrollment Caps</b>			
<b>Demonstration Name</b>	<b>Demonstration Number</b>	<b>Population</b>	<b>Enrollment Cap*</b>
<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>

\*Enrollment cap is as specified in demonstration special terms and conditions as confirmed by CMS, or alternative authorized cap confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap.

The following describes the columns in the above template chart:

- Column A – Demonstration Name. Indicate in Column A the demonstration name for which an enrollment cap was applicable on December 1, 2009.
- Column B – Demonstration Number. Indicate in Column B the demonstration number for which an enrollment cap was applicable on December 1, 2009.
- Column C – Population. Indicate in Column C the population for which an enrollment cap was applicable on December 1, 2009.
- Column D – Enrollment Cap. Indicate in Column D the enrollment cap level as in effect on December 1, 2009 (as authorized and confirmed by CMS) related to the population for which the enrollment cap was applicable.

States that had separate enrollment caps in place may choose to combine them for purposes of FMAP claiming, unless such treatment would preclude claiming of Federal funding at the applicable FMAP rate required under 42 CFR 433.10(b) or (c) (such as, for example, claiming the expansion state FMAP only for childless adults, and not parents). In Section B.3 of this section, indicate whether your state will combine enrollment caps for FMAP claiming purposes. If your

state will combine some or all enrollment caps, specify the combined enrollment cap number in Attachment C.

In Section B.4 and Attachment C, states should provide a description of the methodology for applying enrollment caps under the enrollment cap adjustment. Such description should include:

- The enrollment caps as established for each group or groups and approved by CMS as in effect on December 1, 2009.
- How the enrollment caps are applied to determine the adjustment
- How the methodology is applied for separate or combined enrollment caps.
- How the methodology is applied for purposes of claiming federal funding for expenditures.

### **C. Special Circumstances (§ 433.206(g))**

In Section C.1, indicate whether or not your state applies special circumstances adjustment(s). For each population group described in Column A of Table 1, designate in Column E whether or not a special circumstances adjustment will apply by entering “Y” or “N” in each relevant row.

If your state applies any special circumstances adjustments, describe them in Attachment D. The methodologies for any such adjustments are subject to CMS review and approval. CMS will be working with any states for which special circumstances adjustments may apply.

If your state has adopted a targeted enrollment strategy (as described in our May 17<sup>th</sup> letter to State Health Officials (<http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-003.pdf>) that requires a special circumstances adjustment (such as administrative transfers from SNAP to Medicaid, or Medicaid continuous eligibility for adults), details of the special circumstances adjustment should be included in Attachment D as well.

## **Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group**

States must also describe in the FMAP SPA how individuals who are in existing Medicaid coverage will be transitioned to the new adult group described in 42 CFR 435.119, particularly with respect to how the states will be claiming federal funds for these transitioned populations under the new adult group and whether any new authorities will be required as part of the transition.

States that are transitioning populations from preexisting Medicaid coverage provided under a section 1115 demonstration or a Medicaid state plan group should so indicate by checking the

first line in Part 3, Section A. All states with 1115s will have a CMS-approved transition plan covering all changes the state will be making on January 1, 2014 (even those changes that are state plan to state plan). The approved transition plan should be attached to the SPA as part of Attachment E. States that do not have an approved transition plan but who will be administratively transferring any coverage groups into the VIII group should attach a description of that transition, including the methodology the state will use for claiming FMAP during the time period between the transfer and the MAGI redetermination.

The state's transition plan will describe (1) the manner in which individuals' eligibility will be redetermined, using MAGI methodologies, to ensure their continued eligibility for the new adult group; (2) the manner in which the threshold methodology will be applied to determine the appropriate FMAP; and (3) the state's plans, if any, to retroactively adjust FMAP following the MAGI determination and application of the threshold methodology. States that do not have any relevant populations requiring a transition plan should so indicate in of the second line of Part 3.

## **Part 4 - Applicability of Special FMAP Rates**

### **A. Expansion State Designation**

Complete this section to indicate whether your state is an expansion state, as determined by CMS in accordance with the process established by CMS for identifying such States and based on state-submitted information. In Section A, indicate whether your state qualifies as an expansion state and insert the date of the letter from CMS confirming this status. If your state does not qualify as an expansion state skip Section B, and go to Part 5.

### **B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP**

Under 42 CFR 433.10(c)(7), under very restrictive criteria, an expansion state may qualify for a temporary 2.2 percentage point increase in its regular FMAP rate.<sup>2</sup> This 2.2 percentage point increase in the regular FMAP applies with respect to the amounts of expenditures incurred by the qualifying state during the period January 1, 2014 through December 1, 2015 for the medical assistance for individuals who are not eligible under the adult group, and for calculating

---

<sup>2</sup> In particular, in order to qualify for this increase in the FMAP rate, a state must:

- Meet the definition of expansion state as determined by CMS;
- Not qualify for any increased FMAP funding for newly eligible individuals under 42 CFR 433.10(c)(6); and
- Not have been approved by the Secretary to divert a portion of the disproportionate share hospital allotment for the State under section 1923(f) of the Social Security Act to the costs of providing medical assistance or other health benefits coverage under a demonstration in effect on July 1, 2009.

the amount of the expansion state FMAP which is applicable for the expenditures for individuals eligible under the adult group. Any states wishing to claim the temporary 2.2 percentage point FMAP increase must certify that they are not eligible for and will not claim the increased newly eligible FMAP described in 42 CFR 433.10(c)(6).

Expansion states should indicate in Section B whether they qualify for the 2.2 percentage point FMAP increase, as determined by CMS. CMS has previously provided states that meet the criteria for the 2.2 percentage point increase with confirmation of this status.

### **Part 5 - State Attestations**

The last section of the SPA includes two attestations to indicate that the state understands and will comply with the requirements for claiming newly eligible or expansion state FMAP for the new adult group. The assurances relate to compliance with the threshold methodology as described in 42 CFR 433 Part 206. CMS will review submitted SPAs for compliance with the regulation and ongoing financial management reviews will also assure that FMAP claiming proceeds in compliance with federal laws and regulation.

#### **ATTACHMENTS**

**Note**, not all of the following attachments will apply to all states and that some attachments may describe methodologies for multiple population groups within the new adult group.

- Attachment A – Conversion Plan Standards Referenced in Table 1
- Attachment B – Resource Criteria Proxy Methodology
- Attachment C – Enrollment Cap Methodology
- Attachment D – Special Circumstances Adjustment Methodology
- Attachment E – Transition Plans