

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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FACT SHEET

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Increased Federal Medical Assistance Percentage through the Affordable Care Act of 2010

On March 29, 2013, the Centers for Medicare & Medicaid Services CMS issued a final rule with request for comment to implement provisions of the Affordable Care Act on increased Federal Medical Assistance Percentage (FMAP), or matching, rates for certain Medicaid beneficiaries in states. This rule codifies the increased FMAP rates that will be applicable beginning January 1, 2014 and outlines a simplified methodology states will use to claim the appropriate matching rates.

Overview

An increased FMAP rate is available for medical services provided to people defined as “newly eligible” who are enrolled in the new eligibility group for adults up to 133 percent of poverty. In general, individuals are “newly eligible” if they are enrolled in the new adult group and would not have been eligible for full benefits, benchmark benefits, or benchmark-equivalent benefits under the eligibility rules in that state in effect in December 2009. The rule also describes the increased FMAP available under the Affordable Care Act in a defined “expansion state” if the state had expanded coverage to the adult group prior to enactment of the Affordable Care Act.

Based on public comments on the proposed rule and additional CMS analysis, the final rule selects the threshold methodology, one of the three methodologies described in the proposed rule, as the methodology that states will use to determine the appropriate FMAP related to “newly eligible” Medicaid beneficiaries in the new eligibility group for adults. Supported by states and other commenters, the threshold methodology is designed to provide for a simplified, individualized methodology for determining the appropriate FMAP that does not require states to maintain two

sets of eligibility rules or to solicit information from applicants that is not necessary to determine eligibility.

Provisions of the Final Rule

The final rule implements the increased FMAP rates provided by the Affordable Care Act. It establishes a structure and process for their application, setting out applicable definitions and describing the threshold methodology that states will use to claim the new FMAP rates.

Increased FMAP rates through the Affordable Care Act

The final rule establishes the following increased FMAP rates:

- *Newly Eligible FMAP* – The rule describes the increased FMAP available to states that expand to 133 percent of the federal poverty level under the Affordable Care Act for the expenditures of the “newly eligible” individuals enrolled in the new adult group created by the Affordable Care Act. The newly eligible FMAP 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.
- *Expansion State FMAP* – The rule describes an increased FMAP for expenditures for nonpregnant, childless individuals in the new adult eligibility group in a defined “expansion state.” The expansion state FMAP is the regular FMAP rate increased by the number of percentage points equal to a “transition percentage” (that 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.

Threshold Methodology

The final rule also describes the threshold methodology, which states will use to claim expenditures at the appropriate FMAP. The threshold methodology begins with a simplified method for determining the individuals who are and are not newly eligible, comparing their modified adjusted gross income (MAGI) based income (as calculated for purposes of eligibility determination) to converted modified MAGI-based income thresholds for relevant eligibility categories in effect in December 2009. It then describes, and in some cases, offers states options, regarding the treatment of other factors that may be relevant for purposes of claiming the appropriate FMAP. This final rule reaffirms CMS’ overall policy interest in promoting simplicity as states implement the Affordable Care Act.

Parallel eligibility rules will not be needed or permitted. The threshold methodology is a simplified method that avoids the need for a shadow eligibility system wherein states would determine individuals eligible under both their current, MAGI-based rules as well as eligibility rules in effect as of December 1, 2009 in order to determine if an individual is newly eligible for

FMAP purposes. The threshold methodology provides a simple, accurate approach to determining the newly or not newly eligible status of individuals enrolled in the new adult group. The final regulation reaffirms principles included in our March 23, 2012 final eligibility rule, which sought to promote a streamlined eligibility experience for individuals seeking new coverage options under the Affordable Care Act.

The final threshold methodology rule:

- Clarifies that only an actual disability determination will establish whether an individual is disabled, allowing states to treat individuals who are enrolled in the new adult group as newly eligible for FMAP purposes during the period that a disability determination is pending. Once the determination is made, states will adjust claiming prospectively.
- Describes states' options for how they will address other factors that may be relevant such as resource criteria, section 1115 demonstration enrollment caps, and spend-down requirements.
- Recognizes special circumstances may require additional adjustments, subject to CMS approval, to provide a basis for states to claim federal funding for expenditures of individuals enrolled in the adult group at the appropriate FMAP.
- Directs states to submit a threshold methodology state plan amendment for CMS approval prior to claiming the increased FMAP rates. CMS will provide states with additional guidance, and an updated state plan amendment template.

To complete the transition to the MAGI-based methodology, and to facilitate implementation of the threshold methodology, CMS is already working with states to develop MAGI-based income eligibility standards for the applicable eligibility groups as of December 1, 2009. More information about the income conversion process can be found in CMS's December 28, 2012 letter to State Medicaid Directors and Health Officials (SHO #12-003, available at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf>).

CMS is seeking comment on selected provisions of this final rule through June 3, 2013. We are seeking additional comment on these provisions so that we can determine whether additional clarification would assist states to implement these aspects of the threshold methodology more effectively.

The rule can be found at <http://www.ofr.gov/inspection.aspx>

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