DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 433

[CMS-2327-FC]

RIN 0938-AR38

Medicaid Program; Increased Federal Medical Assistance Percentage Changes under the Affordable Care Act of 2010

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with request for comments.

SUMMARY: This final rule implements the provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) relating to the availability of increased Federal Medical Assistance Percentage (FMAP) rates for certain adult populations under states' Medicaid programs. This final rule implements and interprets the increased FMAP rates that will be applicable beginning January 1, 2014 and sets forth conditions for states to claim these increased FMAP rates.

DATES: Effective Date: These regulations are effective [OFR Insert Date 60 days after date of publication of the rule in the **Federal Register**.]

Comment Date: To be assured of consideration, comments on §433.10(c)(8), §433.206(c)(4), §433.206(d), §433.206(e), §433.206(f), and §433.206(g) must be received at one of the addresses provided below, no later than 5 p.m. on **[**OFR--insert date 60 days after date of publication in the **Federal Register]**.

ADDRESSES: In commenting, please refer to file code CMS-2327-FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways

listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2327-FC,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-2327-FC,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Richard Strauss, (410) 786-2019.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been

received: http://regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

We are providing additional opportunity for comment on the threshold methodology. In order to operationalize the methodology, the final rule contains significantly more detail about various aspects of the threshold methodology than originally included in the August 17, 2011 proposed rule. For example, the proposed rule included basic language regarding the treatment of disability status, resource (or asset) criteria, enrollment caps in states with section 1115 demonstrations, and spend-down eligibility provisions and we solicited public comments on how to account for these factors in assigning the appropriate FMAP. This increased detail in this final rule resulted in large part from our consideration of comments received from the public, including requests for additional clarity with respect to some of these matters. While we believe that this additional detail will assist states in implementing the threshold methodology, we recognize the complexity surrounding these issues. 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.

Although this final rule is effective 60 days from publication, the increased FMAPs authorized by the Affordable Care Act and codified here do not become effective until January 1, 2014. We are proceeding with the issuance of a final rule in light of the time constraints for states to implement system changes to implement the FMAP claiming methodology described in this rule. To the extent that any revisions to the final rule are warranted by new public comment,

we will make necessary revisions well before the effective date.

In summary, while we are issuing these rules as final, we are providing the opportunity for further comment on parts of this rule to ensure transparency and allow for further clarifications that might be necessary. We are thus issuing certain provisions as final but are soliciting comments. These provisions are specifically listed in the "Comment Date" section of this final rule.

Table of Contents

I. Executive Summary

This final rule implements sections 2001(a)(3)(B) and 10201(c) of the Patient Protection and Affordable Care Act (Pub. L. 111-148, enacted on March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, enacted on March 30, 2010), and together referred to as the Affordable Care Act of 2010 (Affordable Care Act).

Specifically, this final rule implements the provisions of the Affordable Care Act related to the availability of increased FMAP rates under the Medicaid program with respect to the new adult eligibility group. The rule also describes a temporary general increase in FMAP rates for certain expansion states that meet required statutory criteria.

Although this rule is being issued in final, we remain interested in considering comments

from the public on the following provisions:

§433.10(c)(8) – Expansion State FMAP

§433.206(c)(4) – Components of Threshold Methodology; Treatment of Disability

§433.206(d) – Optional Resource Criteria Proxy Adjustment

§433.206(e) – Enrollment Caps Adjustment

§433.206(f) – Application of Spend-down Income Eligibility Criteria

§433.206(g) – Special Circumstances

II. Background

In the August 17, 2011 **Federal Register** (76 FR 51148), we published a proposed rule entitled "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010" (Medicaid Eligibility proposed rule). After considering public comments, we finalized many provisions of the proposed rule in the March 23, 2012 **Federal Register** (77 FR 17144). That final rule, in conjunction with other proposed and final rules published by the Department of Health and Human Services implemented provisions of the Affordable Care Act that expand access to health coverage through improvements in Medicaid and the Children's Health Insurance Program (CHIP) and the establishment of the new Affordable Insurance Exchanges (also called Health Insurance Marketplaces). In addition, those rules simplified and streamlined the enrollment and renewal processes for Medicaid and CHIP and created alignment and coordination across insurance affordability programs.

This final rule addresses certain provisions that were included in the August 17, 2011 Medicaid Eligibility proposed rule but not included in the March 23, 2012 final rule. These provisions include implementation of statutory increases in the FMAP rates for state medical assistance expenditures relating to certain individuals described in the new adult eligibility group (new adult group) set forth at section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the

Act), as amended by the Affordable Care Act, and a temporary general increase in FMAP rates in certain states that meet the definition of "expansion states."

In particular, amendments made by section 2001(a)(3) of the Affordable Care Act added section 1905(y) to the Act effective January 1, 2014 to provide for an increased FMAP rate for expenditures for medical assistance for individuals who are defined as "newly eligible." The statutory definition of newly eligible individuals at section 1905(y)(2) of the Act requires that such individuals be: (1) described in the new adult eligibility group at section 1902(a)(10)(A)(i)(VIII) of the Act and not under age 19 or such higher age as the state may have elected; (2) not eligible for full benefits, benchmark coverage described in subparagraphs (A), (B) or (C) of section 1937(b)(1) or benchmark-equivalent coverage under section 1937(b)(2) under the provisions of the state plan or under a waiver of the plan as of December 1, 2009; or (3) eligible but not enrolled (or on a waiting list) for such benefits or coverage under a waiver under the plan that has capped or limited enrollment that is full. Therefore, not all individuals enrolled in the eligibility group described in section 1902(a)(10)(A)(i)(VIII) of the Act (and in our corresponding regulation at §435.119) will be "newly eligible" for FMAP purposes. Note that the newly eligible FMAP is available only for the 50 states and the District of Columbia; the United States territories are not included in the scope of the newly eligible FMAP under section 1905(y)(1) of the Act, which provides that the increased FMAP is at 100 percent for calendar years (CYs 2014, 2015, and 2016) and gradually declines to 90 percent by 2020, where it remains permanently.

Furthermore, amendments made by section 10201(b) of the Affordable Care Act added section 1905(z) to the Act effective January 1, 2014 to provide for an increased FMAP for expenditures for childless nonpregnant individuals in the new adult eligibility group in a defined "expansion state." The expansion state FMAP is initially lower than the newly eligible FMAP; however it increases to be the same as the newly eligible FMAP effective January 1, 2019.

Section 1905(z) also provides for certain expansion states to receive a 2.2 percentage point increase in FMAP rates for the medical assistance expenditures of all individuals who are not considered newly eligible (under the definition at section 1905(y) as summarized above) during the period January 1, 2014 through December 31, 2015. The August 17, 2011 proposed rule included provisions to implement these increased FMAP rates, and set forth options for states to quantify expenditures that would qualify for the increased FMAP rate.

The August 17, 2011 proposed rule included three possible methodologies for states to use in documenting claims for the increased FMAP for medical assistance expenditures for newly eligible individuals. The purpose of these proposed methodologies was to ensure that states would not need to operate dual eligibility determination systems, one to determine Modified Adjusted Gross Income (MAGI)-based financial eligibility, and the other to determine the appropriate FMAP based on the pre-2014 eligibility rules. Each of these three methods was intended to capture the expenditures that would be claimed in accordance with the requirements of the statute. We also solicited comment on whether other methods would accomplish these goals.

In this issuance, we discuss our consideration of public comments on the FMAP calculation issues included in the August 17, 2011 proposed rule, and set forth final rules to define the increased FMAP rates and set out the threshold methodology which states will be required to use to document claims for the increased FMAP rates. As described in more detail below, the threshold methodology begins with a simplified method for determining the individuals who are and are not newly eligible, comparing their MAGI-based income (as calculated for purposes of eligibility determination) to the effective income thresholds for relevant eligibility categories in effect in December 2009, converted to a MAGI-based equivalent. 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. To complete

the transition to the MAGI-based methodology, CMS is also working with states to develop MAGI-based income eligibility standards for the applicable eligibility groups that are not less than the effective income levels that were used to determine Medicaid and CHIP income eligibility as of the enactment of the Affordable Care Act, and as of December 1, 2009 for Medicaid for FMAP determination purposes for the new adult eligibility group. The conversion of income eligibility standards to equivalent MAGI-based income eligibility standards should take into account income disregards that factor into the effective income eligibility standard.

III. Summary of Proposed Provisions and Analysis of and Responses to Public Comments

The following summarizes the FMAP-related provisions that were discussed in more detail in the Medicaid Eligibility proposed rule (76 FR 51172 through 51178):

- Newly Eligible Increased FMAP §433.10(c)(6). Indicated the increased FMAP rates applicable for states' medical assistance expenditures in their Medicaid program for individuals in the new adult group who meet the definition of "newly eligible" individual for the period beginning January 1, 2014.

- Temporary Increase to FMAP §433.10(c)(7). Indicated the conditions applicable for a state to be eligible for a 2.2 percentage point increase in its FMAP rates for the medical assistance expenditures of individuals who are not newly eligible during the period January 1, 2014 through December 31, 2015.

- Increased Expansion State FMAP §433.10(c)(8). Indicated the conditions, requirements, rate calculation formula, and the applicable "expansion state" definition for states to be eligible for an increase in their FMAP rates for certain childless adults in the new adult group who do not meet the definition of newly eligible individual for the period beginning January 1, 2014.

- Definition of Newly Eligible Individual §433.204. Indicated the definition of newly eligible individual for purposes of the availability of the newly eligible FMAP referenced in §433.10(c)(6) for the medical assistance expenditures of such individuals.

- Methodology §433.206. Described three possible approaches in §433.208, §433.210, or §433.212 for states to use for purposes of claiming federal funding for the expenditures for individuals in the new adult eligibility group at the appropriate FMAPs. The rule proposed that a state could choose one of the three indicated alternative methods and indicated that in the final rule we might modify, narrow, or combine these approaches based on comments received and the results of a feasibility study.

- Threshold Methodology §433.208. Described the "threshold methodology" under which there would be a determination of "newly eligible" and not "newly eligible" on an individual specific basis through the application of simplified eligibility criteria, including income eligibility standards for each eligibility group in effect in each state's December 1, 2009 Medicaid program, and as appropriate, proxies for disability and resources, if applicable to such eligibility groups.

- Statistically Valid Sampling Methodology §433.210. Described an alternative methodology under which states would use sampling to extrapolate the amount of expenditures to be claimed at the applicable FMAPs for newly and not newly eligible individuals in the new adult group.

- CMS Established FMAP Proportion §433.212. Described an alternative methodology under which states would develop appropriate applicable proportions based on reliable data sources; this would provide a basis for determining the amount of expenditures for the adult group to be claimed at the applicable FMAPs for newly and not newly eligible individuals.

Responses to General Comments

We received 813 comments from state Medicaid and CHIP agencies, policy and advocacy organizations, health care providers and associations, Tribes, Tribal organizations, and individual citizens regarding the August 17, 2011 eligibility proposed rule, including 87 comments on the FMAP provisions. In addition, to support the goal of transparency, we conducted a number of webinar and other consultation sessions with states and interested parties in which we presented the FMAP provisions of the proposed rule and participants were afforded an opportunity to ask questions and make comments. At these consultation sessions, the public was reminded to submit written comments before the close of the public comment period that was announced in the August 2011 Medicaid Eligibility proposed rule. In addition, we worked more intensively with 10 pilot states to discuss and test different elements of the proposed regulation, with a particular emphasis on income conversion and application of appropriate FMAP claiming methodologies. Because of the technical aspects of the FMAP provisions related to the new adult group, in addition to evaluating the comments received on the proposed rule, we performed additional research on this topic to better understand which approaches would maximize the accuracy of the increased FMAP and further the simplification goals of the Affordable Care Act. We have revised the proposed regulation to respond to public comments and reflect our final policies.

We received a number of comments concerning the proposed FMAP methodologies for newly eligible individuals and for the expansion state provisions. The majority of comments on the three methodologies described in the proposed rule supported the "threshold methodology," described in section IV of this final rule, and did not support certain aspects of the other proposed methodologies. Consistent with these comments, as discussed below, this final rule adopts the threshold methodology as the methodology to be used to document claims for the increased FMAPs. Summaries of the public comments that are within the scope of the proposals and our responses to those comments follow; more detailed summaries of the key changes in the

final regulation are also included in section IV of this final rule, "Provisions of the Final Rule." Some of the comments received were outside the scope of the FMAP provisions contained in the Medicaid Eligibility proposed rule and, therefore, are not addressed in this final rule. In some instances, commenters raised policy or operational issues that will be addressed through regulatory and subregulatory guidance subsequent to this final rule.

A. Comments on General Issues

Some commenters addressed items of a general nature in their comments, as described below. Numerous commenters requested clarification about whether expenditures for certain categories of individuals will be matched at the increased newly eligible or expansion state FMAP. We reiterate in the preamble and in the provisions of this final rule that under the statute the increased newly eligible and expansion state FMAPs are only available to individuals enrolled in the new adult group described at §435.119. Therefore, for example, former foster care children enrolled in the new group described in proposed regulation at §435.150 (78 FR 4687) are not eligible for the newly eligible FMAP because they will not be enrolled under §435.119. As our proposed regulation explains (78 FR 4604), we proposed that eligibility under the adult group at §435.119 will not take precedence over coverage under the mandatory group of former foster care children. This position was in accordance with subclause (XVII) in the matter following subparagraph (G) of section 1902(a)(10) of the Act, as added by section 10201(a)(2) of the Affordable Care Act, which states that individuals eligible for both the former foster care group and the adult group should be enrolled in the former foster care group. Similarly, in general individuals who receive Supplemental Security Income benefits based on a determination of a disability would not be enrolled under §435.119 and would not receive the newly eligible FMAP. Finally, individuals who could have been eligible for an optional Medicaid eligibility category of coverage as of December 1, 2009 may in some cases become eligible for the new adult group at §435.119, effective January 1, 2014, but they will not be

newly eligible (as defined in §433.204(a)(1)). This is because they were previously eligible for full state plan benefits as of December 1, 2009. These and other scenarios are discussed in more detail below.

Comment: Many commenters endorsed the goal that CMS articulated in the August 17, 2011 proposed rule to avoid creating a shadow eligibility system that states would have to implement to determine who was and who was not newly eligible. Commenters opposed any methodology or system that would require applicants to provide information that is not necessary to determine their eligibility under the new Affordable Care Act eligibility criteria.

Response: As described in more detail below, the threshold methodology which we are adopting in the final rule is designed to provide for a simplified 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.

Comment: One commenter noted that the proposed definition of "newly eligible" at §433.204 only refers to individuals eligible under the new adult group, even though the Affordable Care Act expanded Medicaid eligibility from 100 percent of the Federal Poverty Level (FPL) to 133 percent of the FPL for children aged 6-18, making some children newly eligible for Medicaid in 2014. As such, the commenter suggested that the increased newly eligible FMAP also should be available to children who may not have been covered by Medicaid before January 1, 2014 (including children previously eligible under CHIP). Another commenter requested clarification with respect to the applicable FMAP for children between 100 and 133 percent FPL who were not eligible for Medicaid prior to 2014.

Response: The commenter is correct that the Affordable Care Act increased the minimum eligibility income standard for children in Medicaid, although in all states these children were already eligible for Medicaid or CHIP. The Affordable Care Act did not provide for the same increased FMAP for the expanded population of children since the newly eligible

FMAP is available only for individuals enrolled in the new adult group (as codified at §435.119), which does not include individuals eligible under mandatory coverage groups previously listed in the statute, including groups for children. For children, the Affordable Care Act revised section 1902(l)(2)(C) of the Act to extend Medicaid coverage of children aged 6-18 from 100 to 133 percent of the FPL, making them eligible for coverage under section 1902(a)(10)(A)(i)(VII) of the Act, a mandatory coverage group. However, states may be able to claim the enhanced FMAP available through CHIP under Title XXI of the Act for expenditures relating to children. The state will be able to claim the CHIP enhanced match, consistent with §433.11, for children who would not have been covered under Medicaid before July 1, 1997 (including children covered by a separate CHIP before 2014 who will move to Medicaid) to the extent that the state has available CHIP allotment funding.

Comment: One commenter requested clarification as to whether the newly eligible FMAP would be available for childless adults who were eligible for Medicaid prior to 2014 based upon disability but in 2014 choose to apply for Medicaid under the new adult group.

Response: In general, individuals with disabilities who are eligible for Medicaid under a mandatory eligibility category based on receipt of Supplemental Security Income (SSI), are not within the definition of the new adult group, and should not be enrolled in that group. Some states may have covered individuals with disabilities under an optional Medicaid category as of December 1, 2009 but may choose to eliminate such categories after January 1, 2014. In these cases, individuals with disabilities who were enrolled in the optional eligibility group would retain Medicaid eligibility under the new adult group (assuming they met the eligibility standards for the new adult group), but expenditures for their coverage would not be subject to the newly eligible FMAP. Individuals who would have been eligible for full benefits, benchmark benefits, or benchmark equivalent benefits under Title XIX of the Act as of December 1, 2009 are not newly eligible under the definition in 1905(y)(2)(A) of the Act, which is codified in

§433.204(a)(1) (as revised in this final rule). CMS will be providing technical assistance to states to identify relevant disability groups for FMAP claiming purposes, based on states' optional disability categories in effect in 2009.

Comment: Several commenters raised issues related to American Indian and Alaska Native (AI/AN) populations enrolled in Medicaid. First, the commenters requested that the regulation explicitly state that all existing AI/AN specific protections continue to apply (such as for cost sharing). Second, the commenters suggested that the regulation explicitly indicate that services provided through an IHS facility are claimed at 100 percent FMAP, whether or not they are provided as part of an expansion.

Response: The final eligibility rule published on March 23, 2012 as well as a proposed rule published on January 22, 2013 both address beneficiary protections for AI/AN populations and, as they do not relate to FMAP specifically, are outside the scope of this regulation. We understand that the commenters are concerned about the continued availability of the 100 percent FMAP for services provided through an IHS facility for individuals eligible under the new adult eligibility group. We are currently reviewing this issue and intend to issue guidance on this at a later date.

B. Rates of FFP for Program Services (§433.10)

The August 17, 2011 proposed rule would have amended part 433 to add new provisions at §433.10(c) to indicate the increases to the FMAPs available to states under the Affordable Care Act. We received numerous comments on these provisions and are revising the final rule to account for many of the comments.

1. Newly Eligible FMAP (§433.10(c)(6))

In §433.10(c)(6), we proposed to add a new paragraph to indicate the increased FMAP rates available to states beginning January 1, 2014 for the medical assistance expenditures of individuals determined eligible under the new adult group who are considered to be newly

eligible as defined in section 1905(y)(2)(A) of the Act.

Comment: Several commenters noted, in their comments on §433.10(c)(6), that the definition of "newly eligible" in proposed §433.204 did not accurately reflect the language of the Act, omitting key elements of the statutory definition. They urged revisions to resolve ambiguity with respect to the application of the newly eligible FMAP described in §433.10(c)(6).

Response: We agree with the commenters, as is described below under comments regarding §433.204, and have made changes to the regulation text accordingly to ensure that the increased FMAP described at §433.10(c)(6) can be applied properly. Please see the discussion below on the revised §433.204.

Comment: One commenter noted a typographical error in §433.10(c)(6)(ii), observing that a reference to §422.206 should be to §433.206 (choice of methodology).

Response: We acknowledge the typographical error. Because this final rule is not finalizing all proposed sections of new subpart E of §433, §433.206 now describes the threshold methodology and it remains the correct cross-reference.

2. Expansion State FMAP (§433.10(c)(7) and §433.10(c)(8))

CMS proposed new regulatory text to indicate the availability of additional FMAP rates for states that expanded eligibility prior to enactment of the Affordable Care Act. CMS did not receive any comments about the temporary increased FMAP reflected in proposed §433.10(c)(7), which describes a 2.2 percentage point increase available only to a state that meets very specific criteria established in section 1905(z)(1) of the Act. CMS received numerous comments regarding the definition and methodology to apply the expansion state FMAP set forth in §433.10(c)(8), which seeks to codify section 1905(z)(2) of the Act. The expansion state FMAP is available for expansion states for the expenditures of certain nonpregnant childless adults who are determined eligible under the adult group, and who are not considered to be newly eligible, as defined in section 1905(y)(2)(A) of the Act. For this purpose, in this final rule, we define a

nonpregnant, childless adult as an individual who is not determined eligible for Medicaid on the basis of pregnancy and who does not meet the definition of a parent caretaker relative in §435.4.

Comment: Several commenters, in noting the aforementioned omissions of statutory language in the proposed newly eligible definition (described in more detail in the discussion of §433.204, below), also suggest that the proposed definition of "expansion state" in §433.10(c)(8)(iii) be revised to include a reference to enrollment caps and/or freezes.

Response: We are revising the proposed definition at §433.204(a)(1) to reflect the statutory language regarding both the scope of benefits and enrollment caps and/or freezes. However, we do not agree with the commenters that the definition of expansion states needs to be revised to include similar language regarding enrollment caps. Such language is not included in the statutory definition of expansion states and we do not think it is necessary to revise the proposed definition. We have moved that definition, proposed in §433.10(c)(8)(iii), to §433.204(b) in this final rule, so that all definitions are grouped together for ease of reference.

Comment: Several comments urged CMS to strike the phrase "who are nonpregnant childless adults for whom the state may require enrollment in benchmark coverage under section 1937 of the Act" from proposed regulation text at §433.10(c)(8)(i) and (iv). Several commenters noted that language in proposed §433.10(c)(8)(iv) could be interpreted to permit the expansion state FMAP only in states that provide section 1937 benchmark benefits, and not for non-benchmark medical assistance expenditures. The commenters asserted that this interpretation would improperly limit the availability of the expansion state FMAP to a narrow subset of individuals not deemed newly eligible. They suggest striking the language to align with congressional intent to provide the expansion state FMAP to all individuals in the new adult group (§435.119) who are not determined to be newly eligible.

Response: To clarify the availability of the expansion state FMAP, we have restructured §433.10(c)(8) of the final rule to explicitly reflect section 1905(z) of the Act, including the

provisions related to benchmark coverage. With respect to the concern expressed by the commenters, section 1902(k)(1) of the Act provides that benchmark coverage, for individuals in the adult group who would otherwise be considered exempt from the limits on such coverage, is not defined by the requirements of section 1937 of the Act. States will provide state plan benefits or they can allow such individuals to voluntarily enroll in benchmark coverage, consistent with our rules. As a result, the provision in section 1905(z) of the Act relating to individuals for whom the state may require enrollment in benchmark coverage does not limit the availability of the expansion FMAP for the expenditures for such individuals.

C. Definitions (§433.204)

In the August 17, 2011 proposed rule, CMS proposed only one new FMAP-related definition, that of "newly eligible." We proposed to define "newly eligible" to mean an "individual eligible for Medicaid in accordance with the requirements of the new adult group and who would not have been eligible for Medicaid under the state's eligibility standards and methodologies for the Medicaid state plan, waiver or demonstration programs in effect in the state as of December 1, 2009." Numerous commenters suggested revisions to our proposed definition to more accurately reflect the statutory definition and to avoid improperly denying certain states the increased FMAP. In this final rule, we are revising the proposed definition and providing other related definitions in final §433.204 as described below.

Comment: Numerous commenters noted correctly that the proposed "newly eligible" definition omitted statutory language included in section 1905(y)(2)(A) of the Act. Commenters recommended that the proposed regulatory definition of newly eligible at §433.204 be revised to correct these omissions and follow the statutory definition found at 1905(y)(2)(A); in particular, they recommended two changes: (1) specify that a newly eligible individual could not have been eligible for full benefits, benchmark, or benchmark-equivalent coverage as of December 1, 2009; and (2) specify that if the state had a cap or limitation on enrollment through a section 1115

demonstration, those who could have been eligible but were not enrolled in coverage as a result of the cap should be considered as newly eligible.

Response: The final rule has been revised to include the statutory language that was omitted in the proposed rule. The definition of newly eligible at §433.204(a)(1) now includes a reference to eligibility for full benefits, benchmark benefits, or benchmark equivalent benefits, as well as a reference to an individual who may have been "eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full." Additional information about applying the threshold methodology in states that had capped or limited enrollment is included in §433.206(e), as revised. In addition, §433.204(a)(2) now includes a definition of "full benefits" (consistent with section 1905(y)(2)(B) of the Act) and clarifies that individuals who were eligible to receive "full benefits" (or benchmark or benchmark equivalent benefits) are not considered to be "newly eligible." Thus, in the event that a state covered an optional Medicaid eligibility category as of December 1, 2009 but eliminates that category after January 1, 2014, individuals previously eligible for the optional category will be eligible for the new adult group described in §435.119 of this chapter but will not be eligible to receive the newly eligible FMAP because they would previously have been eligible for full state plan benefits. These changes should ensure that the increased newly eligible FMAP is available as set forth in the Affordable Care Act.

Comment: One commenter suggested adding the phrase "under the provisions of §435.119" to the definition of newly eligible proposed in §433.204. The commenter suggested that this revision would clarify the reference in our proposed definition to the new adult group, as defined in §435.119 in the March 23, 2012 final rule. Another commenter suggested that the definition should be revised to explicitly reference the age requirements of the new adult group.

Response: We have revised §433.204(a)(1) to more accurately link the definition of newly eligible to the new adult group created by section 1902(a)(10)(A)(i)(VIII) of the Act and

defined in §435.119. Including this cross-reference also addresses the suggestion that we include age ranges in the definition of "newly eligible" since §435.119 explicitly defines the new adult group as including individuals age 19 or older and under age 65.

Comment: One commenter suggested that CMS should clarify that individuals whose coverage is funded under a Title XXI demonstration project will be considered "newly eligible" for Medicaid in 2014. The commenter stated that the fact that a state's CHIP program operates through a Medicaid state plan or demonstration program does not convert CHIP to Medicaid and that, therefore, adults whose coverage is so funded must be considered newly eligible.

Response: Under section 1905(y)(2) of the Act, in general, if through the application of a state's Title XIX Medicaid state plan or demonstration as in effect on December 1, 2009 an individual would be considered eligible under Medicaid, the individual will not be considered to be a newly eligible individual. However, the commenter refers to a situation in which through a state plan or demonstration under Title XXI, certain adults were made eligible and funded under Title XXI as of December 1, 2009. If through the application of such demonstration(s) an individual would not be considered eligible under Title XIX as of December 1, 2009, such individual would be considered to be a newly eligible individual. CMS will work with states for which this may be an issue to address unique circumstances and application of the requirements of the state plans and demonstrations.

Comment: One commenter requested clarification about whether parents and caretaker relatives with income at or below 133 percent of the FPL who are eligible under the mandatory eligibility category for parents and other caretaker relatives at §435.110 can qualify for the newly eligible FMAP if it is determined that they would not have been eligible as of December 1, 2009.

Response: The newly eligible FMAP described in §433.10(c)(6) is only available for expenditures of individuals enrolled in the new adult group described in §435.119 who meet the definition of newly eligible codified in §433.204(a)(1). Under the related statute at section

1902(a)(10)(A)(i)(VIII) of the Act, and the regulation at §435.119, individuals such as parents and caretaker relatives who are eligible under §435.110 are precluded from eligibility under the new adult group.

If effective January 1, 2014 the state lowers the eligibility income standards used to determine eligibility for the parent and caretaker relative group below the levels in effect on December 1, 2009 for that group, resulting in certain individuals who would have been eligible for the group as of December 1, 2009, having income greater than the revised standard, such individuals may become eligible under the new adult group and some could potentially be newly eligible. For example, if the state's eligibility category for parent/caretaker relatives had a resource test in December 2009, and such individuals would have failed that test, the state could factor such individuals into its claim for newly eligible FMAP in accordance with §433.206(d).

In addition, if the state had raised its income standard for its mandatory eligibility category for parents and other caretaker relatives after December 2009, the individuals now covered in the new adult group whose incomes are above the December 2009 standards would be newly eligible.

D. FMAP Methodology (§433.206 through §433.212)

The August 17, 2011 proposed rule (76 FR 51148) provided for three possible methodologies that could potentially be available to states to claim expenditures at the appropriate FMAP for individuals determined eligible in the new adult group. As proposed, §433.206 set out principles for these methodologies; enumerated the methodologies described in more detail in proposed §433.208, §433.210, and §433.212; proposed to permit states to select any of these methodologies; and set out a process for states to make their initial and subsequent selections of methodology. The proposed rule indicated the possibility that these three approaches could be modified, narrowed, or combined based on comments received and the results of a feasibility study, including site visits to, and discussions with, 10 pilot states. We

requested comment on the methodologies themselves, whether other options should be considered, and whether states should be able to choose from such alternatives or different methods, or whether a single method should be used by all states. We received numerous comments on these issues. After assessment of the comments received, we are continuing to apply the following principles as expressed in the proposed rule:

- Any methodology must provide as accurate and valid application of the applicable FMAPs to actual expenditures as possible in the determination of the appropriate amounts of federal payments for such expenditures. The methodology must not include a systemic bias in favor of either the states or the federal government.

- Any allowable methodology should minimize administrative burdens and costs to states, the federal government, individuals, and the health care system.

- Any methodology must be developed and applied transparently by both the federal government and states.

- Any methodology must take into consideration the practical, programmatic and operational goals of the Medicaid program.

- To ensure that the states claim expenditures at the correct FMAP, any methodologies should include sufficient data to identify, associate and reconcile expenditures with the related eligibility group to which the FMAPs apply. The increased newly eligible and expansion state FMAPs are only available for individuals enrolled under §435.119 of this chapter.

On the basis of the comments received and the analysis of the feasibility of each of the alternatives, including input from pilot states and analyses of pilot states' information, we believe that the threshold methodology best addresses these principles and is the method identified in this final rule as the one that shall be used by states for purposes of claiming expenditures at the appropriate FMAP for individuals determined eligible in the new adult group.

As described briefly above and in more detail in section IV of this rule, in general, under

the threshold methodology, states will compare income levels of individuals eligible for the new adult group to equivalent December 2009 standards to determine if that individual could have qualified for Medicaid under the State's December 2009 income standards. More specifically, the threshold methodology proposed using MAGI-converted income thresholds (as described in CMS' 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)) across categorical eligibility groups, taking into account the December 2009 eligibility standards under state plans, waivers or demonstrations and applicable disregards and adjustments, to approximate, in the aggregate, the December 2009 standards for each such group. After individuals are determined eligible for the new adult group described in §435.119 of this chapter, their current income will be compared to these eligibility group or demonstration MAGI-converted standards to determine if such individual could have been income eligible, as of December 1, 2009, for an eligibility group for which they would have otherwise been eligible (for example, mandatory coverage for parents and caretaker relatives, or an optional eligibility category).

Since we are finalizing only one methodology, some of the provisions of the proposed §433.206 are inapplicable. Below is a summary of the public comments that we received with respect to proposed §433.206 through §433.212. The discussion begins with the general comments about the choice of methodology, focusing on the threshold methodology since that is the methodology being finalized and is relevant to our responses to other comments discussed throughout this section.

1. General Comments on Choice of Methodology (§433.206)

Comment: Some commenters supported the flexibility offered by the three proposed approaches in the proposed §433.208, §433.210, and §433.212, and, noting that Medicaid programs vary from state to state, urged CMS not to implement only one approach. Other

commenters suggested that states should have the flexibility to propose an alternative methodology and that each state should be allowed to establish its best and least biased methodology for application of the appropriate FMAP rates, in collaboration with CMS. Other commenters instead urged CMS to finalize one approach so that a single, consistent approach will be used to determine which adult enrollees qualify as newly eligible. Commenters noted that applying a single methodology would also help ensure that audits and other program integrity activities could assess whether payments were determined accurately.

Response: We have determined that it is more administratively feasible and consistent with the guiding principles to adopt a uniform methodology for applying the applicable FMAP. Although some commenters supported flexibility in concept, the overall position favored in the comments and other analyses and input from states supported the use of the threshold methodology. An essential characteristic of the threshold methodology is that, in general, it allows states to determine the appropriate FMAP on an individual-specific basis. In that regard, the threshold methodology most directly addresses the explicit statutory definition of newly eligible individual and allows for the most accurate application of FMAP as it relies on actual data related to the individual. For example, the FMAP for expenditures for an individual determined during the eligibility process to be a parent or caretaker relative will be assessed relative to the MAGI-converted income level in effect in 2009 for parents and caretaker relatives. We note flexibilities given to states in establishing the threshold under both the MAGI conversion process under §435.603 and the options given to states in this final rule. As we discuss below, we have modified our proposed threshold methodology to include certain population-based adjustments to reflect factors such as resource limits or enrollment caps in effect on December 1, 2009.

Comment: Numerous commenters wrote to support the threshold methodology. One commenter stated that the threshold methodology could be the most accurate and efficient of the

options provided in the proposed rule. The commenter noted that for states that can create clear upper thresholds and proxies for non-income related criteria, the newly eligible adult population could be categorized for the proper FMAP under this methodology.

Response: Based on comments, consultation with states, and other analyses, we agree that the threshold methodology, modified to clarify adjustments to increase accuracy, is the most accurate and efficient method and least burdensome for states to implement. Therefore, we are finalizing the threshold methodology in a revised §433.206. That methodology begins with a simplified method for determining the individuals who are and are not newly eligible based on MAGI-based income (as already determined for purposes of establishing eligibility under §435.119) and then offers states options for how they will address other factors. In this final rule, as part of the threshold methodology we include alternatives for states to address criteria that are not directly related to income but that may have an impact on the validity of the threshold results, such as criteria related to resources and section 1115 demonstration enrollment caps that will permit a simplified application of the methodology. We will work with states to facilitate their proper application of the methodology.

Comment: One commenter suggested that, when finalizing a methodology to determine FMAP, CMS consider the potential for each of the alternatives to impose additional burdens on beneficiaries, Medicaid health plans, and states in determining whether these or other alternatives should be included in the final rule.

Response: Our choice to finalize the threshold methodology reflects our assessment, consistent with the comments received, that it is the least burdensome of the proposed options for both states and beneficiaries, for the reasons described throughout this section and in section IV of this rule, which provides more details about the provisions of the final rule.

Comment: One commenter criticized all of the proposed methodologies, noting that the proposed regulations contemplate an apparent estimation of the population and associated

expenditures in perpetuity. The commenter suggested that at some point both CMS and states need to move away from using estimates in the FMAP methodologies. The commenter suggested that CMS convene a group of state stakeholders to develop best practices on this issue.

Response: The threshold methodology is not based on estimates but is instead based on individualized comparisons to December 1, 2009 eligibility standards. Therefore, it best addresses the goals of accuracy and simplicity. We are adopting the threshold methodology in this final rule because it provides a simplified yet largely individualized way to apply the appropriate FMAP to expenditures for those enrolled in the new adult group. While the final threshold methodology includes population-based adjustments that are not the result of individualized determinations, those adjustments are to increase the accuracy of the result.

Comment: One commenter raised concerns about one of the principles that CMS articulated as the basis for any methodology to be used to assign FMAP. The commenter finds the fifth principle, "sufficient data to identify, associate and reconcile expenditures with the related eligibility group to which the FMAPs apply," to be potentially problematic. Instead of retrospective reconciliation of expenditures, the commenter urged that states will need to be held harmless in any reconciliation if subsequently determined FMAP discrepancies are within a reasonable range.

Response: We understand the commenter's concern about financial stability and predictability and we have determined that the threshold methodology will provide states with the most certainty in part because it will generally not require retroactive reconciliations. Moreover, we believe the threshold methodology will best serve the interests of beneficiaries by avoiding dual eligibility rules and the unnecessary questions and procedures that dual rules would entail.

Comment: One commenter expressed concern that states will attempt to shift costs to the federal government by reducing or eliminating optional Medicaid groups. The commenter stated

that the three proposed methodologies would not prevent such cost-shifting because there are too many subjective aspects of pre-Affordable Care Act eligibility determinations (including disability determinations) to expect that the proposed methods would result in unbiased identification of the newly eligible. Instead, the commenter suggested that HHS should define a population-based method that compares pre-Affordable Care Act Medicaid take-up rates with post-Affordable Care Act Medicaid take-up rates (excluding the Affordable Care Act adult group).

Response: A key goal of the Affordable Care Act is to simplify eligibility for Medicaid and collapsing various Medicaid coverage categories helps achieve that goal. As described above, the newly eligible FMAP is only available for expenditures for individuals who would not have been eligible for full benefits, benchmark benefits, or benchmark-equivalent benefits (as further described in §433.204(a)) in either a mandatory or optional Medicaid eligibility category as of December 1, 2009 (or were unable to enroll in such coverage through a demonstration that had capped or limited enrollment that was full). Therefore, we do not share the commenter's concern that this method promotes cost-shifting. As described in more detail in section IV of this final rule, we believe that the threshold methodology will appropriately identify individuals and expenditures that are and are not subject to the newly eligible FMAP.

Comment: As an alternative to the approaches described in the proposed regulation, one commenter asked whether states could use a single "blended FMAP" rate across the entire population, similar to the method proposed under §433.212. Noting the implementation obstacles associated with the three proposed methodologies, the commenter suggested mitigating the associated burdens by permitting a blended FMAP combined with annual floors on any downward adjustments to state rates, and 15 months advance notice of annual changes to the model.

Response: We considered the blended FMAP, and related methodologies, but concluded

that the threshold methodology is preferable for the reasons described throughout this preamble.

Comment: One commenter suggested that CMS should allow states to determine their own methodologies and procedures for tracking FMAP for the new adult population, noting that some states already have the capacity to do so.

Response: We believe it is important, and in the interest of efficient administration of the Medicaid program, to promote consistency in FMAP determinations. Therefore, we are finalizing an approach that will minimize the administrative burden on states while also ensuring accuracy and consistency across the country, and permit CMS oversight and review. We note flexibilities given to states in establishing the threshold under both the MAGI conversion process under §435.603 and the options given to states in this final rule as described below for resources and enrollment caps, for example. As we explain in our 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) regarding MAGI conversion, states will have flexibility with respect to the methodology they choose to adopt for income conversions.

Comment: A number of identical comments were submitted to urge CMS to adopt, for all states, a hybrid methodology based on the threshold and proportion methods. These commenters suggested that in the initial years of the availability of the increased newly eligible FMAP (CYs 2014-2016), the threshold methodology be used to determine which individuals are newly or not newly eligible. For 2017 and years thereafter, they suggested that the federal government would coordinate a proportion method using data from previous years related to each state's unique experience. The first 3 years' experience would represent and provide "benchmark" data for the future and would give states time to develop the administrative structure necessary for implementation. The commenters also suggested that HHS should establish approval criteria including estimated accuracy of the method and limits burdens on

enrollees.

Response: To provide for a consistent approach nationally, we are adopting the proposed threshold methodology under which states have certain options that help ensure that it reflects and claims expenditures at the appropriate FMAP. Using the elections available under these options, states will have the ability to amend their threshold methodology to further refine the methodology. As described under the provisions of the regulation, states will need to submit state plan amendments to make such elections.

2. Threshold Methodology (§433.208, redesignated §433.206)

Proposed §433.208, which is being redesignated as §433.206 in this final rule, described the first of three proposed approaches to identify newly eligible individuals for purposes of applying the correct enhanced FMAP rate. We sought comment on the methodology as proposed and on the use of proxies of eligibility criteria in place prior to CY 2014 that are not related to income, such as disability status and resource value.

a. Comments Related to Dual Eligibility Systems, Burdens on States and Applicants, and Streamlined Eligibility Procedures

In the proposed rule, CMS articulated several principles that would drive our selection of a methodology (or methodologies) to accurately reflect the appropriate FMAP. One principle was to minimize the administrative burdens and costs to states, the federal government, individuals, and the health care system. We also noted that requiring states to run two distinct eligibility systems – one for purposes of eligibility using new MAGI methodologies and one that would exactly retain all of the eligibility requirements of states' Medicaid programs as in effect on December 1, 2009 for purposes of determining which individuals are newly and not newly eligible – would pose challenges and create unnecessary burdens, inefficiencies, and administrative costs to applicants, states, and the federal government. Because retaining and applying two different sets of eligibility rules is burdensome and costly to states and the federal

government, a barrier to enrollment for eligible individuals and families, and would likely lead to inaccurate determinations, we identified possible alternative approaches for determining the appropriate FMAP rate. We proposed not to permit FFP for the costs of maintaining dual eligibility systems for the adult group and instead proposed methodologies to enable states to determine FMAP without needing to run dual eligibility systems. We remain committed to that principle in this final rule, which establishes the threshold methodology as a simplified approach to apply the eligibility criteria effective on December 1, 2009.

Comment: Numerous commenters wrote in support of the principle articulated in the proposed rule that eschewed requiring states to evaluate every applicant under both the pre-and post-Affordable Care Act eligibility criteria for purposes of both identifying individuals as newly eligible and assigning FMAP accordingly. Some commenters, however, expressed concern that the threshold methodology, as proposed in §433.208, would require dual eligibility screening for every applicant. They therefore recommended that states not be required to evaluate every applicant under both the old and new eligibility rules, nor be permitted to require every applicant to submit information not required to determine the eligibility of the applicant under the new adult category solely for the purpose of determining the appropriate FMAP for that individual. Commenters expressed concern that questions or requests for an individual to provide information related to FMAP that are not needed for the basic eligibility determination would be a burden for the applicant and the case worker and, as such could potentially be a disincentive for the individual in applying for Medicaid. To the extent that CMS permits such actions, however, commenters recommend that CMS require states first to make every effort to gather all supplemental information through electronic data matching or other processes that require no additional input from the applicant. This would require applicants to provide as little information as possible.

Response: We appreciate the support for the principle that dual eligibility systems are

neither fair nor efficient. This rule finalizes the threshold methodology to enable states to apply a methodology for purposes of the FMAP application that does not require the application of December 2009 eligibility rules. Rather, the threshold methodology provides for a method for applying the FMAP provisions based on the characteristics associated with each individual that will be determined during the newly designed eligibility process, such as whether an individual is a parent or caretaker relative or a childless adult, and the associated relevant eligibility group. The threshold methodology can be applied by employing the new MAGI-based income rules, rather than the old December 2009 income rules, and comparing MAGI-based income to the converted MAGI eligibility standards. Finally, note that the final rule includes, at §433.206(b)(1), language (originally proposed at §433.206(d)) that specifies that the threshold methodology must not impact the timing or approval of an individual's eligibility for Medicaid.

Comment: Numerous commenters urged CMS not to require applicants to submit additional information, beyond what would be required for eligibility determinations, solely for the purpose of FMAP determinations. Commenters noted that this point applied regardless of which method is adopted; one commenter noted that any proposed methodology that asks additional questions of applicants works against the expressed goal of simplification and is not preferable. Other commenters wrote that any additional questions regarding FMAP should not unduly burden applicants. Some commenters urged CMS to require states to inform applicants that failing to answer any such additional questions will not impact eligibility. Other commenters suggested that the threshold methodology regulation text should be revised to explicitly require states first to gather all necessary supplemental information through electronic data matching (as required by §435.949), or other processes that require no additional information from the applicant. Other commenters recommended adding explicit language to the regulation directing states that they may not "include a request for information from an individual unless such request is essential to determining that individual's current eligibility."

Other commenters suggested that the proposed regulation be revised to require CMS to establish standards for additional application questions and approve any additional questions asked during the application process for the purpose of the newly eligible determination.

Response: We remain committed to creating the least burdensome system – for applicants and states – to determine the appropriate FMAP. The threshold methodology generally will not require any supplemental information from applicants, beyond the information that will already be collected for purposes of the eligibility determination. For example, certain information, such as that related to income and categorical eligibility status, may be needed for both eligibility and FMAP determinations both to properly determine eligibility for the new adult group and to assign the applicable FMAP once the individual is determined eligible for the group. As noted above, in the final rule we retained language at §433.206(b)(1) that was originally included at proposed §433.206(d), which specifies that the threshold methodology must not impact the timing or approval of an individual's eligibility for Medicaid. We do not think any additional revisions are necessary to §433.206 because these principles are already reflected in the March 23, 2012 eligibility rule.

As described below, this rule provides states with the option to develop one-time sampling data to help determine the proportion of individuals enrolled under the new adult group who would qualify as newly eligible because they would have been found ineligible for Medicaid in 2009 due to excess resources. To the extent that states take advantage of a time-limited opportunity (described below) to gather sampling data to develop an accurate resource proxy, those questions will not be permissible as part of the application, cannot affect the application, and cannot delay determinations of eligibility. Effective January 1, 2014, when resources are no longer a relevant eligibility criterion for many categories of eligibility, only a post-eligibility sample (which would be for a period ending no later than December 31, 2014 with respect to states' new adult eligibility groups that are effective on January 1, 2014) would

be permissible. States taking this option must notify beneficiaries that a nonresponse would not impact their continuing eligibility.

Comment: Related to concerns that the methodology for claiming FMAP not unduly burden applicants, several commenters suggested that CMS revise the FMAP methodology regulation text to capture the intent that applicants would not be asked to provide additional information for purposes of assigning FMAP. Commenters recommended that the regulations describing the selected FMAP methodology cross-reference those at §435.907(c), which set out the standards for a streamlined eligibility application. Several commenters suggested strengthening proposed §433.206(d) by reinforcing the requirements to not unduly burden applicants with a cross-reference to §435.907 (and to rely on data matching as required by §435.949).

Response: The final March 23, 2012 eligibility rule contained various provisions regarding a single streamlined application and data matching. We affirm those provisions and the principles they embody.

b. Comments Related to Application of and Refinements to the Threshold Methodology

Comment: Several commenters wrote to support the proposal in §433.208(c)(2) that determinations under this Part remain in effect for the entire 12-month eligibility period.

Response: Both the proposed rule and the final rule now at §433.206(c)(7) indicate that for an individual who is eligible under the new adult group, the individual's status as newly or not newly eligible continues to apply until a new determination of MAGI-based income has been made in accordance with §435.916; in general, this could occur at the next scheduled periodic redetermination, or it could occur at other times related to the availability of other information, for example, as discussed in the provisions related to disability status. Additionally, §433.206(c)(7) also indicates that changes to an individual's eligibility group would require changes in the status for FMAP purposes. This approach will generally avoid any need to

reassign FMAP should an individual's income change within the year.

Comment: Several commenters suggested that the regulation should be explicit in using MAGI-equivalent standards under the threshold methodology. They note that the preamble to the proposed rule suggests this as an option but that the proposed regulatory language does not. They further note that the MAGI-equivalent standards will appropriately take into account disregards and deductions that states use in determining Medicaid eligibility currently, and could therefore be used to implement the threshold methodology.

Response: We agree with the commenters that the converted MAGI-based thresholds will serve as the basis for the threshold methodology. Individuals in the new adult group with MAGI income that is above the relevant converted MAGI-based threshold standard that is determined to apply as of December 1, 2009 would be considered as newly eligible. We do not think it is necessary to further clarify the regulation text now included at §433.206.

Comment: One commenter notes that the threshold methodology requires that many income standards would have to be applied to each eligibility category that was in effect on December 1, 2009 for purposes of determining the availability of the newly eligible FMAP rate. Therefore, the commenter asks whether the upper income standard is a blended rate or will the state be required to maintain many classes of newly eligible categories.

Response: The commenter is observing that the threshold methodology will require states to compare the income of individuals found eligible for the new adult group to the converted MAGI income levels for relevant eligibility groups for which the individual could have been eligible as of December 1, 2009. CMS has worked and continues to work extensively with states to establish converted MAGI income thresholds. We published a letter to State Medicaid Directors and Health Officials on December 28, 2012 (SHO #12-003, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf) to provide guidance about the conversion of net income standards to MAGI equivalent income standards.

As described in this regulation, in addition to income conversion required for eligibility for certain eligibility groups, these converted standards will be used as a reference point for the income eligibility levels that were applicable for eligibility groups in effect as of December 1, 2009 explicitly for the purposes of the FMAP determination. The converted standards will be applied, by eligibility group, to make FMAP determinations.

Comment: One commenter wrote to request clarification as to whether eligibility under the threshold methodology is based on the current income and household size composition, regardless of changes since December 1, 2009.

Response: Under the statute, for purposes of determining the availability of the appropriate FMAP for the expenditures of newly and not newly eligible individuals, the issue is whether the individual who is found to be eligible for the new adult group would have been eligible for full benefits, benchmark benefits, or benchmark equivalent benefits under the state's eligibility standards as of December 1, 2009. Therefore, under the threshold methodology the individual's current (that is, post-December 31, 2013) MAGI-based income would be compared to the state's applicable converted December 1, 2009 MAGI-based eligibility standards. An individual's income and household composition from December 2009 is not relevant for FMAP determinations.

Comment: In setting income thresholds for 2009, one commenter urged CMS to adjust the 2009 levels to adjust for cost of living increases, inflation, and other factors.

Response: We are currently working with states to convert December 1, 2009 income standards to the applicable MAGI-based income standards and these converted income standards will be used to determine whether individuals in the adult group qualify as newly eligible. Under the threshold methodology those MAGI-based income standards, as applicable for the relevant eligibility groups in effect in 2009 when expressed as a percentage of the FPL, will be adjusted annually as the FPL adjusts annually for inflation. Income eligibility standards in effect on

December 1, 2009 that were expressed as fixed dollar amounts will continue to be expressed in fixed dollar amounts after being converted.

Comment: One commenter suggested that the final regulation should strike the proposed paragraph §433.208(b)(2)(i), which permits states to claim the enhanced federal matching funds based on "self-declaration" from an applicant.

Response: As proposed, §433.208(b) included a number of criteria to establish thresholds. As a result of public comments and our additional research to better understand which approaches will ensure an accurate method for assigning the FMAP and further the simplification goals of the Affordable Care Act, we significantly revised the original §433.208(b)(2), now redesignated as §433.206(b), "General Principles," to revise several of the criteria included in the proposed rule. The final rule affirms that FMAP determinations will rely on information derived from the regular eligibility determination process, consistent with regulations finalized in our March 2012 final rule; in that regard, we struck the language regarding the reliance on self-declaration data in this regulation.

c. Application of Disability Criteria

In the proposed rule (76 FR 51148, 51175), we indicated we were considering using either a disability proxy methodology or using only actual disability determinations under the threshold methodology to determine if an individual may have been eligible under the state's December 1, 2009 standards based on disability. The disability status of an individual may be relevant in two ways. First, a disabled individual may be eligible under section 1902(a)(10)(A)(i)(II) of the Act for Medicaid based on receipt of supplemental security income (SSI) or such more stringent standards that a state may have under the election at section 1902(f) of the Act (the "209(b)" option), in which case the individual would not be eligible under the new adult group and should be excluded from the universe to which the threshold methodology applies. Second, a disabled individual may have been eligible in an optional eligibility category

in effect under a state's December 1, 2009 Medicaid program at higher income levels than adults without disabilities, which would mean that they would not be considered newly eligible.

We received numerous comments in response to our request for feedback on this issue. In general, commenters encouraged CMS to avoid asking applicants additional questions and urged CMS to clarify expectations in the regulation. Based on comments received, we are not finalizing a disability proxy. Rather, only an actual disability determination will be used for purposes of determining whether an individual enrolled in the new adult group will be newly eligible. This approach is described in more detail in section IV and is reflected in §433.206(c)(4).

Comment: One commenter suggested that the initial question for disability should be whether an individual has actually been determined to be disabled. The commenter asserted that the other proxies suggested in the proposed rule will disadvantage the state by counting as "disabled" individuals who never would have qualified for Medicaid but for the new adult eligibility group. Another commenter affirmed the reasonableness of using actual disability determinations to ascertain the appropriate FMAP. Numerous commenters suggested that the regulations should indicate that no additional information should be required from individuals with respect to disability status for purposes of an FMAP determination. Rather, they suggested that the state could draw from existing data. Other commenters specifically asked whether individuals would be permitted to opt not to answer such questions.

Response: We are finalizing this rule to specify that for purposes of applying the appropriate FMAP under the threshold methodology, as well as for determining whether an individual could be considered eligible under another eligibility category for which disability is a criteria, only an actual disability determination will be used to establish whether an individual is disabled. For individuals actually determined disabled, the state would need to apply the status for such individuals for any December 1, 2009 eligibility category for which such status is

applicable for purposes of determining if the individual is newly eligible; under the threshold methodology, the state would also need to apply the income test specific for such disability related eligibility categories. If the individual's income exceeds such December 1, 2009 income eligibility level for the applicable eligibility category, the individual would be considered newly eligible with respect to such eligibility category. The revised approach is described in more detail in section IV of this rule and in regulation text at §433.206(c)(4).

d. Population Adjustments to the Threshold Methodology; Application of Resource Criteria and Section 1115 Demonstration Enrollment Caps

In general, the threshold methodology is designed to properly assign the applicable FMAP to the expenditures of individuals eligible in the new adult group under §435.119. The threshold methodology provides for states to use the applicable state plan or demonstration eligibility income standard converted to a MAGI-equivalent for each eligibility group as in effect in the state on December 1, 2009 to determine whether an individual is considered to be newly eligible for purposes of assigning a federal matching rate. Although the threshold methodology is individualized, we are finalizing this rule to include certain population-based adjustments, or proxies, to account for resource standards and, as applicable, enrollment caps or limits.

In the proposed eligibility rule, we proposed several ways in which the threshold methodology could account for a resource (or asset) test that was applied to the applicants' coverage category as of December 2009, since resources will no longer be part of the eligibility determination for populations whose income will be determined using MAGI rules. We solicited comments on these various alternatives, as well as on the feasibility of using the Asset Verification System (AVS) as a tool to obtain resource information, as necessary. We received a variety of comments on these varied approaches.

Comment: Several commenters noted that, when comparing individuals' eligibility against the December 2009 criteria, only income eligibility and not resource information should

be considered. One commenter stated that resources should not be considered since verification would be confusing and burdensome to applicants, particularly since a significant proportion of low-income individuals do not have resources in excess of 2009 Medicaid resource standards. Thus, they stated that the threshold method should not include a resource test. Another commenter stated that the final regulation should clearly state that individuals who were ineligible on the basis of resources under rules in effect as of December 1, 2009 are considered to be newly eligible.

Response: As described in more detail in section IV of this rule and §433.206(d), we are giving states a choice whether or not to consider resources; for states that elect to consider resources, this rule directs the use of a proxy methodology that minimizes the need to seek information about resources from applicants. Further, to the extent that information is requested the response (or lack of a response) is not a basis for denying eligibility.

Comment: Another commenter suggested that since resources may make an individual ineligible (based on December 2009 rules), the threshold method must include a question regarding resources; otherwise the threshold methodology will not provide accurate results.

Response: As explained above, the existence of a resource test in 2009 may have made individuals ineligible for coverage, even if they met Medicaid income criteria, so these individuals should be characterized as newly eligible in 2014. To determine whether such newly eligible individuals qualify for the newly eligible FMAP, states may apply the resource methodology as described in §433.206(d) and in more detail below. However, a state may forego the application of a resource proxy test as part of the threshold methodology as some states have advised CMS that very small numbers of individuals were determined ineligible due to resources. States that choose to consider their December 2009 resource tests may apply the resource proxy methodology described in §433.206(d) and in more detail below.

Comment: We received numerous comments in response to our request for feedback

about using the Asset Verification System (AVS). Multiple commenters suggested using the AVS for electronic resource verification and one commenter suggested that the regulation be revised to explicitly require use of the AVS. Other commenters suggested that the threshold methodology regulation should be revised to indicate that resources will be determined using the AVS. One commenter noted that using the AVS for electronic verification would help permit a resource test while maintaining the Affordable Care Act goal of a simplified streamlined process.

Response: We agree that the AVS can be a good tool to verify resources but we are not requiring its use for individuals enrolled in the new adult group under §435.119. The approach we outline in this rule provides states with greater flexibility and is consistent with MAGI-based income determinations that will be in effect starting January 1, 2014. States may continue to use AVS for non-MAGI populations.

Comment: One commenter requested clarification about how to account for the current resource tests in Medicaid eligibility determinations. The commenter noted that states will need to adjust the threshold methodology to reflect relative resource values and recommended freezing resource levels at the 2009 threshold.

Response: Subject to the requirements of §433.206(d) of this final rule with comment period, to the extent a state elects to incorporate a resource proxy methodology under its applied threshold methodology, the resource criteria should reflect the states' December 1, 2009 resource eligibility levels. Referencing resource levels at the 2009 value will most accurately reflect eligibility as of December 1, 2009, which is the relevant criterion for determining whether or not an applicant shall be considered newly eligible.

e. Application of Spend-down Income Eligibility Criteria

The August 17, 2011 proposed rule stated that CMS does not believe that, for FMAP determination purposes, states need to consider whether an individual enrolled in the new adult group would have been eligible under a spend-down for a medically needy category under

section 1902(a)(10)(C) of the Act in considering whether someone would have been eligible under standards in effect in December 1, 2009. We explained that this is because we believe there is an inherent uncertainty in determining whether and when a spend-down would have been met. An individual who is eligible for the new adult group and whose income is above the December 1, 2009 medically needy income standard would be considered newly eligible. If an individual would have qualified by meeting the medically needy income standard without a spend-down, the state could not claim newly eligible FMAP for that individual. We requested comment on this analysis and received numerous responses, which we have used to add more detail to the final threshold methodology regulation at §433.206(f).

Comment: Multiple commenters raised issues with respect to how the threshold methodology will account for medically needy determinations. Some noted that the final rule should explicitly indicate that if spend-down criteria are not met, the individual should be considered newly eligible. Commenters noted that this principle should also extend to "209(b)" states, which are states in which the Medicaid eligibility criteria for the elderly and people with disabilities are more restrictive than the federal SSI program standards. We take these comments to mean that if an individual's income is above the medically needy income level, he or she would be assumed not to be eligible under the December 2009 standards and therefore newly eligible for purposes of FMAP, even if it might have been possible for that person to spend-down and qualify in a medically needy eligibility category.

Response: In section IV below, and §433.206(f), we address how the threshold methodology will account for the treatment of individuals in 209(b) states. Individuals eligible for SSI are enrolled in the eligibility group specified in §435.120, and, as such, are not eligible for the newly eligible FMAP, which is only available to individuals enrolled in the new adult group at §435.119.

f. Timeframes and Parameters for Notice to CMS

In light of the proposed rules that identified potential alternate FMAP claiming methodologies, §433.206(b) of the August 2011 proposed rule proposed that a state provide notice to CMS of which methodology it plans to use at least two calendar years prior to the first day of the calendar year in which the state would have used the particular method. For 2014, we proposed that states would give notice to CMS no later than one year prior to the beginning of the CY, which is January 1, 2013.

Comment: Numerous commenters expressed concern about the amount of notice that CMS proposed states must give CMS with respect to choice of methodology or with respect to changes in methodology. They requested additional time to notify CMS of the selected methodology and noted that the proposed timeframe is insufficient to make an informed decision.

Response: As indicated in responses to previous comments and in section IV of this rule, the threshold methodology is the selected permissible methodology and, as such, there is no longer the need for states to provide notice to CMS as to their choice of methodology. We provide, at §433.206(h), that states must revise their state plans under the provisions of subpart B of part 430. States will submit, as an attachment to their state plan, a threshold methodology plan that outlines how the threshold methodology will be applied. CMS will review and approve this plan pursuant to the timeframes that otherwise govern review of state plan amendments.

Comment: Several commenters noted that the regulations should define a timeline for states to submit and CMS to approve the threshold methodology prior to implementation. One commenter wrote to support proposed §433.208(b), which proposed that each state submit a proposed methodology to CMS and receive CMS approval for that methodology prior to its implementation.

Response: As discussed previously and as indicated in revised §433.206(h), states must amend their state plans under the provisions of subpart B of part 430 to reflect the threshold

methodology the state implements in accordance with the provisions of this part 433. The threshold methodology, which will be reviewed and approved by CMS, will be included as an attachment to the state plan and will include details about the manner in which the state will apply the methodology to FMAP determinations.

g. Comments Regarding Need for Technical Assistance for States

Comment: Several commenters suggested that CMS should provide technical assistance to states as they implement approaches to properly identify the FMAP associated with individuals in the new adult group. One commenter suggested that CMS should assist states upon request with determining individuals newly eligible for Medicaid as of 2014, particularly with respect to treatment of previously excluded income in determining Medicaid eligibility. Another commenter believes that states need specific guidance from CMS to operationalize the approach used to determine the appropriate FMAP. Another commenter requested more examples to illustrate how the three alternate methods would work and requested additional guidance about the appropriate sample size necessary to test each methodology.

Response: We will be working to provide states with technical assistance as they implement the final methodology and are already providing technical assistance in the context of the conversion process which is a component of the methodology. One of the concerns raised by commenters about the treatment, under MAGI rules, of income previously excluded in determining Medicaid eligibility, has been addressed by a legislative change included in section 401 of Pub. L. 112-56, which revised the MAGI rules to include as income an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d) of the Internal Revenue Code) that is not included in gross income under section 86 for the taxable year.

h. Comments Regarding Transparency

Comment: Multiple commenters suggested that states should use an open and transparent process to determine the methodology they will use to claim the appropriate FMAP. Another

commenter noted that given the significant budgetary and beneficiary implications of any methodology, negotiations between states and CMS on the proposed methodological approach should be public (including any documents submitted by the state and any question posed by CMS in response). In addition, the process should allow for input from beneficiaries and consumer advocates to ensure that the proposals do not unduly burden applicants.

Response: CMS is adopting the threshold methodology in this final regulation, in part to support the goals of transparency and simplicity. The methodology does offer states certain options and states that take them must clearly and transparently describe to CMS how they will implement the threshold methodology. The proposed rule, at §433.208(b) indicated that to implement the threshold methodology, states must submit a methodology and receive CMS approval of such methodology prior to its application to new FMAP determinations. As described in more detail in section IV of this final rule, we have revised that provision, now included at §433.206(h), to instead require states to submit a state plan amendment reflecting the manner in which they will implement the threshold methodology. This will achieve the goals of transparency that commenters supported.

i. Other General Methodology Comments

Comment: One commenter suggests that CMS should require states to take into account whether public entities other than the state, such as counties, provide the non-federal share of Medicaid payments when developing an FMAP methodology. The commenter further suggested that CMS could require the state to demonstrate that its methodology results in a distribution of funds among the public entities providing the non-federal share that reflect the actual enrollment of newly eligible adults.

Response: States have significant flexibility to finance their Medicaid programs consistent with existing federal laws and regulations. This final rule does nothing to change the regulatory requirements set forth in subpart B of part 433, including §433.53, which permits

entities other than the state to contribute up to 60 percent of the non-federal share of total expenditures under the plan and requires state and federal funds to be apportioned among political subdivisions of the state on a basis that ensures that individuals in similar circumstances will be treated similarly and that a lack of local financial participation will not result in lowering the amount, duration, scope, or quality of services available to beneficiaries. Nor does this rule address the provisions of section 1905(cc) of the Act, added by section 10201(c)(6) of the Affordable Care Act, which offer some protection to political subdivisions from increased requirements to contribute the non-federal share. We further note that due to the significantly increased FMAP rates available for the newly eligible adults, there will be no non-federal share for the medical assistance expenditures for such adults in calendar years 2014-2016 and a small non-federal share (no more than 10 percent of costs) thereafter.

Comment: Commenters recommended that CMS require that any claiming methodology include the total cost of providing care to patients, including supplemental payments such as disproportionate share hospital (DSH) or upper payment limit payments (UPL). The commenter notes that the proposed rule described the statistically valid sampling methodology as excluding Medicaid supplemental payments from medical expenditures paid to providers when providers are paid under a managed care capitated payment arrangement. The commenter believes that all payments should be in the claiming methodologies including costs associated with patients for whom supplemental payments such as DSH or UPL are made to reflect providers' total cost of care.

Response: The threshold methodology as contained in this final rule with comment period is not intended to revise the definition of or requirements for determining the amounts of the expenditures that may be claimed by a state as medical assistance provided to individuals. In that regard, Medicaid DSH payments are considered payments that are required under section 1923 of the Act and are payments made to hospitals to take into account the situation of hospitals

which serve a disproportionate number of low income patients. Accordingly, DSH payments are not considered to be medical assistance expenditures for an eligible individual such as those in the new adult group. Therefore, the new increased FMAPs would not be available for any DSH payments.

Supplemental payments made by a state under its Medicaid state plan that are based on the upper payment limit (UPL) are always identifiable with specific services furnished to individuals not enrolled in managed care. Accordingly, a state could claim the new increased FMAPs for such supplemental payments when identified with a service furnished to a newly eligible individual (or a qualified nonpregnant childless adult in expansion states). We note that a state may need to work with CMS to develop such a UPL demonstration.

3. Statistically Valid Sampling Methodology (§433.210)

As originally proposed in §433.210, one methodology to assign FMAP would have used a sampling methodology across individuals in the adult group and related Medicaid expenditures to make a statistically valid extrapolation of who is newly eligible and their related expenditures.

Comment: Numerous commenters criticized the sampling methodology as unworkable. Among the objections provided by states, advocates, and other Medicaid stakeholders is the concern that sampling would create a scenario under which a state would operate a shadow eligibility system, requiring actual eligibility determinations under 2009 rules and would thus be counter to HHS' principle of avoiding two separate eligibility systems.

Other commenters noted that the sampling methodology would be administratively burdensome to develop and would place additional burdens on enrollees, including requests for information not required for eligibility. Other commenters noted that the proposed regulation appropriately required verification of the sampling results, but it is not clear how results can be verified without states retaining December 1, 2009 standards. Commenters also noted that if enrollees refused to undergo a full eligibility determination for purposes of FMAP, states would

face additional administrative burdens in creating the statistically valid sample. Furthermore, other commenters noted that, at least for states that had not previously expanded Medicaid using section 1115 demonstrations, the statistically valid sampling methodology would not be applicable during the initial years of the Medicaid expansion (2014 through 2019) because states would not have applicable data for sampling purposes. Another commenter noted that the level of accuracy of the sampling method would depend on whether or not "newly eligibles" are more or less expensive than other adults.

One commenter noted that the sampling methodology would require a highly complex system to create a readily reviewable audit trail between the individual claim transaction and corresponding disposition on the CMS-64. Another commenter also noted that use of data sources like the Medical Expenditure Panel Survey (MEPS) or Medicaid Statistical Information Statistics (MSIS) will take some time to establish as reliable data elements.

Response: CMS agrees with commenters' concerns about administrative feasibility and accuracy, and therefore, we are not finalizing the proposed sampling methodology.

Comment: Commenters note that because the sampling results would apply retroactively, this methodology creates the potential for sizeable retroactively adjusted federal payments, which would make it difficult for states to budget. One commenter expressed concern about such retroactive adjustments to correct federal funds and noted that the proposed rule did not include any language that would hold states harmless from retroactive adjustments. The state also noted that the proposed rule could be revised to design an approach to create an incentive for states to correct the federal claiming if to their advantage to claim additional federal funds. Other commenters noted the statistically valid sampling methodology would hinder state budget planning and that it is not feasible to retroactively adjust the FMAP rates and adjust prior period CMS-64 claims.

Response: We understand the commenters' concerns about retroactive adjustments and

this concern contributed to our decision not to finalize the sampling methodology.

Comment: One commenter supports the use of statistical sampling to ensure that the expanded Medicaid population is accounted for in the sampling methodology. Absent this basic statistical tool, the commenter is concerned that states may underestimate the significant numbers of Latinos who are expected to participate in the Affordable Care Act's various insurance affordability programs.

Response: We share the commenter's interest in promoting and accurately tracking participation in the Medicaid program. The purpose of the proposed methodologies is to properly designate the FMAP, and we believe that the threshold methodology does this most efficiently.

Comment: One commenter endorsed the sampling methodology as the best option available at this time, despite concerns about the burden for applicants/beneficiaries and the financial risk to states due to potentially inaccurate sampling. Nonetheless, the commenter concluded that the sampling method could be the least burdensome to states.

Response: We agree with the commenter's concerns and reach a different conclusion after weighing the considerations. Therefore, we are finalizing the threshold methodology instead of the sampling methodology.

4. CMS-Established FMAP Proportion Methodology (§433.212)

As originally proposed in §433.212, the proportion methodology would have used an extrapolation from available data sources to determine the proportion of individuals covered under the new adult group who would not have been eligible under the eligibility category in effect under the state plan or applicable waiver as of December 1, 2009, validating and adjusting the estimate, based on sampling or some other mechanism going forward.

Comment: Several commenters opposed the use of the proportion methodology, noting that reliable data sources have limited experience with newly eligible populations and new rules

under the Affordable Care Act, making it difficult to accurately estimate the proportion of individuals covered under the new adult group who would have been eligible under eligibility categories that would have been in effect as of December 1, 2009. Furthermore, the commenter noted that many newly eligible individuals will have insurance coverage for the first time and their actual utilization will be varied. Another commenter noted concerns about the proportion methodology in light of uncertainty regarding the fundamental restructuring of the Medicaid program resulting from the Affordable Care Act. Therefore, the commenter noted that it would be difficult for any model to accurately predict allocation of expenses on a state-by-state basis. This uncertainty would lead to the need for large annual adjustments of state-specific rates, particularly once the proportion methodology is tested in 2016. A commenter questioned the reliability of the estimates of proportions of enrollees who would be newly eligible, especially because this methodology would not provide an opportunity for retroactive adjustments.

Response: We agree with the commenters and for these reasons we are not including the proportion methodology in the final rule.

Comment: Many commenters noted that the proportion methodology could provide a consistent and administratively simple approach to determine the newly eligible FMAP, especially if statistical modeling cannot provide a reliable basis for FMAP determinations. Commenters specifically encouraged CMS to consider the Congressional Budget Office, the Urban Institute, and the Agency for Healthcare Research and Quality as credible sources of information on effective modeling techniques. Several other commenters supported the proportion methodology as the most appropriate since it appears to best fit the requirements of a streamlined process and is least likely to place an undue and unnecessary burden on applicants, states, and CMS.

Some commenters further qualified their support for the proportion methodology by noting some data concerns. They noted that while they support the use of Medical Expenditure

Panel Survey (MEPS), MSIS and Current Population Survey (CPS) data as the foundation for the implementation of the proportion method, they had concerns, especially for smaller states, with MEPS and CPS data. One commenter warned about survey margins of error and noted that the MEPS does not provide individual estimates for the 50 states, thus requiring additional imputation of the survey.

Response: We appreciate the commenters' thoughtful concerns about methodology and data related to the proportion methodology. Because we are not adopting the proportion methodology for the reasons stated in our prior response, we have not pursued these recommendations.

IV. Provisions of the Final Rule

This final rule incorporates certain provisions set forth in the Medicaid Eligibility proposed rule and reflects revisions made based on comments received on the proposed rule. The following describes the provisions of this final rule:

A. Availability of FMAP Rates for the Adult Group (§433.10(c)).

1. Newly Eligible FMAP (§433.10(c)(6))

The provisions of §433.10(c)(6) describe the availability and amounts of the increased FMAP for newly eligible adults, as defined in §433.204(a)(i), who are enrolled in the new adult group described in §435.119 of this chapter. In response to comments and questions from the public about whether states that meet the definition of expansion states (which this rule redesignates from §433.10(c)(8)(iii) in the proposed rule and codifies at §433.204(b)) may receive the newly eligible FMAP, we revised §433.10(c)(6)(i) to clarify that the increased FMAP for newly eligible individuals can be applied in states that meet the definition of expansion state. As discussed in the proposed rule (76 FR 51147, 51173 (August 17, 2011)), 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 expenditures for that

population. The expansion state match is designed to help states that expanded coverage to adults prior to enactment of the Affordable Care Act to the extent that a particular expansion population does not qualify as newly eligible.

2. Temporary FMAP Increase (§433.10(c)(7)).

In accordance with section 1905(z)(1)(A) of the Act, §433.10(c)(7) describes the availability of a temporary 2.2 percentage point increase in the regular FMAP for a state that meets three conditions specified in the regulation:

- The state meets the definition of expansion state in §433.204(b);
- The state does not qualify for any payments for the medical assistance expenditures of newly eligible individuals under the newly eligible FMAP in §433.10(c)(6); and
- The state has not been approved to divert a portion of its disproportionate share hospital allotment under a demonstration in effect on July 1, 2009.

Although in this final rule we are not making any substantive revisions to §433.10(c)(7) as was contained in the proposed rule, the following provides clarification regarding this provision. If a state meets the three indicated conditions, then the regular FMAP in §433.10(b) is increased as follows:

- Medical assistance expenditures for individuals who are not eligible under the new adult group. The regular FMAP in §433.10(b), which is available for the medical assistance expenditures of individuals eligible under any eligibility group other than the new adult group, would be increased by 2.2 percentage points.
- Medical assistance expenditures of individuals who are eligible under the new adult group, but who do not meet the definition of newly eligible individual in §433.204(a)(1). For these individuals:

++ Increase in Expansion State FMAP. The regular FMAP component of the expansion state FMAP formula is increased by 2.2 percentage points for the medical assistance

expenditures of individuals in the new adult group who are not newly eligible and for whom the expansion state FMAP is available.

++ Increase in Regular FMAP. The 2.2 percentage point increase in the regular FMAP would also be available for the medical assistance expenditures of individuals in the new adult group who are not newly eligible and for whom the expansion state FMAP is not available, for example pregnant women or parents.

- Expansion State FMAP (§433.10(c)(8)). Section 433.10(c)(8) in general refers to the availability of the expansion state FMAP for certain individuals who are not newly eligible. This FMAP is only available for expenditures in states that meet the definition of an expansion state in §433.204(b)(1).

In response to comments and for purposes of clarification, proposed §433.10(c)(8)(iv) was deleted as redundant. As discussed above, §433.10(c)(6)(i) as revised clarifies that the newly eligible FMAP is available for newly eligible individuals in an expansion state. However, §433.10(c)(8)(iv), as contained in the proposed rule, also referred to the availability of the newly eligible FMAP for certain individuals in an expansion state. We believe the reference in the revised §433.10(c)(6)(i) makes clear that the newly eligible FMAP is available for newly eligible individuals in expansion states.

B. Scope of Regulation (§433.202).

Section 433.202, which sets out the scope of the FMAP provisions for the new adult eligibility category in §435.119, is revised to indicate explicitly in regulation the increased or regular FMAP rates that are potentially available, as applicable, for the medical assistance expenditures associated with individuals in the new adult eligibility group: the regular FMAP, the increased newly eligible FMAP, or the increased expansion state FMAP, as indicated in §433.10(b) and (c).

C. Definitions (§433.204).

1. Newly Eligible Individual (§433.204(a)(1)).

Section 433.204 is revised to include the definition of newly eligible individual in the renumbered §433.204(a)(1), which now indicates that the determination of an individual as newly eligible is in accordance with the requirements of §433.206, the revised and renumbered threshold methodology.

- The definition of newly eligible individual in §433.204(a)(1) is clarified to follow the statutory definition in section 1905(y)(2)(A) of the Act and, in particular, to refer to individuals who would not have been eligible for full benefits, benchmark coverage, or benchmark equivalent coverage as of December 1, 2009. Section 433.204(a)(1) as revised refers to the regulations in §440.330 and §440.335, referring to benchmark and benchmark equivalent coverage, respectively. These changes were necessary to more accurately reflect the statutory language of the Affordable Care Act, which was not included in the proposed rule. Individuals enrolled in §435.119 who could have previously received full Medicaid state plan benefits (either under an optional coverage category under the Medicaid state plan or a waiver of the plan), benchmark benefits, or benchmark equivalent benefits will not satisfy the definition of newly eligible in §433.204(a)(1) and their medical assistance expenditures will not be matched at the newly eligible FMAP provided in §433.10(c)(6)(i). Medical assistance expenditures for other populations in these states, however, may be matched at either of the increased FMAP rates described in §433.10(c)(7) or (8).

As described in §433.204(a)(3), states with section 1115 demonstrations that provided benefits to adult populations that are more limited than standard state plan benefits will need to analyze the benefit package that was offered so that CMS can determine the appropriate FMAP to apply to specific populations who were enrolled in Medicaid as of December 1, 2009. As CMS explained in FAQ guidance issued in February 2013 at http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf and in letters to

states following this guidance, CMS will work with each state to ensure that the correct FMAP is applied to medical assistance expenditures for individuals enrolled under §435.119. We are requesting that states that expanded eligibility through section 1115 demonstrations provide CMS with an analysis of the eligibility levels and scope of benefits available under demonstrations as of December 1, 2009 to enable CMS to confirm the applicable FMAP. CMS has provided states with guidance about the manner in which benefits should be analyzed to substantiate claims for the increased newly eligible FMAP; states are expected to utilize a consistent methodology and provide CMS with sufficient data to substantiate the states' analyses. In addition, 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. CMS will use the benefit analysis provided by states to determine the appropriate FMAP. States that do not qualify for the newly eligible FMAP but appear to meet the criteria to be an expansion state should provide CMS with information about coverage in effect as of the date of enactment of the Affordable Care Act, if they wish to claim the expansion state FMAP for qualified populations.

- The definition of newly eligible at §433.204(a)(1) has also been clarified to include the provision in statute that describes as newly eligible those individuals in the new adult group who, as of December 1, 2009, would have been eligible but not enrolled (or could have been on a waiting list) for benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

2. Full Benefits (§433.204(a)(2)).

Section 433.204 is revised to add a new §433.204(a)(2) to include the statutory definition of "full benefits" from section 1905(y)(2)(B) of the Act, which describes "full benefits" to mean those benefits required to be provided to mandatory adult populations under the state plan, or such benefits that are not less in amount, duration, or scope than the benefits offered to the

mandatory populations, or benefits that are determined by the Secretary to be substantially equivalent to the medical assistance available for the mandatory populations. Adult populations covered by a state under a section 1115 demonstration under which any associated waivers of state plan requirements did not provide for any reduction of the benefits relative to those offered to the mandatory populations under the state plan are presumed to have received full benefits under the demonstration; that is, full benefits are presumed unless approved terms and conditions of the demonstration explicitly provided for a lesser benefit package.

3. Expansion State (§433.204(b)).

A new §433.204(b)(1) is added to include the definition of "expansion state," moving the definition from the proposed §433.10(c)(8)(iii). We also clarified in a new §433.204(b)(2), for purposes of applying the expansion state FMAP in §433.10(c)(8) that a "nonpregnant childless adult" is an individual who is not eligible based on pregnancy and who does not meet the definition of a caretaker relative in §435.4.

D. Choice of Methodology (§433.206 in proposed rule)

In the proposed rule §433.206 referred to the "Choice of Methodology." This regulatory provision is deleted in this final rule and the remaining sections are renumbered accordingly.

E. Threshold Methodology (§433.206, was §433.208 in proposed rule)

Previously numbered as §433.208 "Threshold Methodology" in the proposed rule, this final rule redesignates this section of the regulation as §433.206. Under the threshold methodology, for individuals enrolled under §435.119, the applicability of the newly eligible FMAP is determined, in part, by comparing individuals' MAGI-based income to converted MAGI-based income eligibility levels for each appropriate eligibility group as in effect on December 1, 2009 (this conversion process was described in a State Health Official letter #12-003, dated December 28, 2012).

The following highlights, by section, revisions to provisions of the proposed rule and, as

appropriate, provides further description of revised provisions. The following provisions are being issued as final with an opportunity for comment: §433.206(c)(4), §433.206(d), §433.206(e), §433.206(f), and §433.206(g).

1. Overview (§433.206(a)).

This paragraph specifies that the threshold methodology must be used by states to document claims for the newly eligible FMAP specified in §433.10(b) and (c). The threshold methodology encompasses an individualized analysis of whether individuals determined eligible under §435.119 are newly or not newly eligible individuals for purposes of determining the appropriate federal share of medical assistance expenditures. We note that for certain aspects of the threshold methodology, such as the treatment of resources and enrollment caps, states have options in applying the methodology, which may be based on either population or total medical assistance expenditures. Such options are addressed in the related regulation sections.

In general, this rule clarifies that the threshold methodology is designed to assign the applicable FMAP to the medical assistance expenditures only for individuals determined eligible under §435.119. The methodology begins with a simplified method for determining the individuals who are and are not newly eligible based on MAGI-based income (as already determined for purposes of establishing eligibility under §435.119) and disability status, and then offers states options for how they will adjust the results to take into account other factors that may be relevant to assess the appropriate FMAP; in particular, resources, and enrollment caps and limits to the extent that a cap or limit was in effect in a state for an applicable eligibility group in December 2009. These factors will not be accounted for in MAGI-converted income standards but have bearing on determining whether claims for individuals enrolled under §435.119 can be matched at the newly eligible FMAP. Therefore, although the threshold methodology is individual based, to ensure a simplified procedure, we are finalizing a rule to include some population-based adjustments, or proxies, to account for certain eligibility factors

that may have been in place in a state in December 2009. As noted, the final rule includes options for how states might calculate or apply these adjustments and proxies.

2. General Principles (§433.206(b)).

This section of the threshold methodology regulation indicates general principles underlying the establishment and application of the threshold methodology. In accordance with these principles, the threshold methodology: must not affect the timing of any individual's eligibility determination; must not be biased; must provide for a valid and accurate accounting of medical assistance expenditures and claims for federal funding for Medicaid claims; and operate efficiently, without further review, once an individual has been determined not to be newly eligible based on the December 1, 2009 standards for any eligibility category.

3. Components for Threshold Methodology (§433.206(c)).

To clarify the threshold methodology, the final §433.206(c) now indicates the basic components of the methodology. This section references the use of individuals' MAGI-based income determinations as established under the 2014 eligibility requirements; the threshold methodology does not require determining individuals' income under the income rules in effect as of December 1, 2009:

- The threshold methodology applies for individuals determined eligible and enrolled under §435.119; the regulation clarifies that the threshold methodology is not applicable for individuals who have been determined eligible and enrolled under any other mandatory or optional Medicaid eligibility category.

- Under the threshold methodology, the individuals' MAGI-based income (as determined under the rules in effect as of January 1, 2014) is compared to converted MAGI-based income eligibility levels for each appropriate eligibility group as in effect on December 1, 2009. Appropriate eligibility groups include, for example, parent/caretaker relative groups, section 1115 demonstration expansion populations, and optional disabled groups. CMS is

currently working with states to convert those standards. If an individual in the new adult group would only have qualified for a December 1, 2009 eligibility group which did not offer full benefits, benchmark coverage, or benchmark equivalent coverage, they will be considered newly eligible for FMAP determination purposes regardless of income;

- Finally, states must ensure that for purposes of the availability and applicability of the applicable FMAPs for individuals, the determination of such individuals' status as newly or not newly eligible continues until a new determination of MAGI-based income has been made, in accordance with §435.916, or until the individual has been otherwise determined not to be covered under the adult group set forth at §435.119 of this chapter. Section 433.206(c)(4) describes, for example, the treatment of individuals for whom a determination of disability alters the applicable FMAP.

Under this process, an individual enrolled in the new adult group with income at or below the converted MAGI-based income eligibility standard for a relevant December 1, 2009 eligibility group related to that individual's characteristics and who would have been eligible to receive full benefits, benchmark benefits, or benchmark-equivalent benefits as of December 1, 2009 would be considered as not newly eligible and the FMAP applicable to such individuals would apply; this would be the regular FMAP or the expansion FMAP for applicable individuals, in expansion states. An individual in the new adult group whose income is greater than the converted income eligibility standard for December 1, 2009 for the relevant eligibility group related to that individual's characteristics would be considered as newly eligible and the newly eligible FMAP applicable to such individuals may apply.

Disability Status. A new §433.206(c)(4) is included in the components of the threshold methodology section of the regulation to clarify the role an individual's disability status plays in determining the availability of increased FMAP for the expenditures of the new adult eligibility group under the definition of newly eligible. This final rule with comment period clarifies that to

the extent disability status is applicable to the determination of newly eligible, an individual will not be considered to be disabled during the period of a pending disability determination, and would be considered disabled for purposes of determining FMAP availability only effective with the actual determination of disability.

The disability status of an individual may be relevant with respect to establishing whether the individual would have been eligible under an eligibility category that was in effect on December 1, 2009 for which disability is a criteria. In that case, if the individual could be determined eligible based on disability and the financial criteria applicable for such December 1, 2009 eligibility category, the individual would not be considered to be newly eligible for purposes of applying the appropriate FMAP for the expenditures associated with such individual. For this reason, to establish the applicable FMAP, it is necessary to establish whether the individual met the appropriate definition of disability applicable for a state.

For purposes of establishing disability status with respect to determining whether an individual meets the definition of newly eligible, in the proposed rule we indicated we were considering using either a disability proxy methodology or using actual disability determinations under the threshold methodology. In recognition of the disability determination process currently used by states and the Social Security Administration, we have concluded that for purposes of applying the appropriate FMAP under the threshold methodology, only an actual disability determination can be used to establish whether an individual should be considered to be disabled as relates to meeting the definition of newly eligible. That is, absent an actual determination of disability made in accordance with the disability definition applicable for the state under Title XIX of the Act, an individual enrolled in the new adult group should be considered not disabled for any FMAP determination purpose, regardless of any indication of disability provided by the individual. Therefore, in general, with respect to any eligibility categories in effect on December 1, 2009 for which a disability determination was required,

individuals eligible for the new adult group who do not have an actual determination of disability would be considered newly eligible.

Individuals who are disabled have an incentive to seek a disability determination to receive financial support based on disability; therefore, an actual disability determination under the established disability determination process may be initiated by and for such individuals. In circumstances in which a disability determination process is initiated, the individual will be considered not to be disabled for FMAP determination purposes while the disability determination is pending. This means that the newly eligible FMAP will apply until the date on which the individual is actually determined to be disabled. On the date of the disability determination, the individual may shift, if eligible, to an eligibility category other than the new adult group, in which case the determination of newly or not newly eligible would no longer be relevant; or, if still enrolled in the new adult eligibility group, the individual might then be considered as not newly eligible (depending on the individual's income level), and, if no longer newly eligible, the state must adjust FMAP claiming from the date the disability determination is made. The determination relative to newly eligible status will depend on both the disability status and the individual's income: if the individual's income exceeds the converted MAGI threshold for any December 1, 2009 category of coverage related to disability status, expenditures for the individual would continue to be matched at the newly eligible FMAP.

In determining which expenditures can be claimed under the newly eligible matching rate relative to expenses for an individual who eventually is determined disabled, the application of the FMAP methodology is not intended to revise existing claiming rules. In particular, the FMAP applicable for provider claims paid by a state is generally determined based on when the state made the payment to the service provider; the application of the appropriate FMAP is not generally based on the date the service is provided. Therefore, the FMAP applicable for payments made by a state subsequent to the date of the disability determination would reflect any

change in the individual's status as newly eligible and/or the individual's actual eligibility status; for example, if receiving a disability determination results in the individual becoming eligible under an eligibility category other than the new adult group, any FMAPs associated with the new adult group would not be applicable to claims paid after the change in status.

We developed this approach to support our general principle of providing states with certainty and avoiding retroactive recoupment of dollars from states. Numerous commenters also reinforced the concept that any selected methodology should minimize the need for retroactive financial adjustments to avoid subjecting states to financial uncertainty; this approach is consistent with those comments. While current practice requires states to adjust claiming back to the date of onset of the disability determination, we think creation of the new adult group gives us an alternative because individuals have a way to receive services during the period of the pending disability determination.

Finally, although we recognize that under normal circumstances the disability process may take a significant period of time to be completed, we do not wish to incentivize states to prolong this process – to the extent they play a role in conjunction with the Social Security Administration in determining disability – by providing the increased newly eligible FMAP during the period when the disability determination is pending. Therefore, 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. We will work with the Social Security Administration to continue to consider ways to expedite such determinations.

4. Application of Resource Criteria (§433.206(d)).

In this final rule, a new §433.206(d) is added to indicate how resource criteria may be applied for purposes of determining the availability of an increased FMAP for the expenditures

of newly eligible individuals (as described in §433.204(a)(1)).

For the new adult group under §435.119, which is effective beginning January 1, 2014, there is no resource test (sometimes called an "asset test") applied in determining individuals' eligibility. However, some individuals in the new adult group might have had income below the applicable income standards in effect in December 2009 but would not have been eligible due to resources. Under the threshold methodology, for FMAP purposes a state can account for the effect of resource standards in effect in December 2009.

To promote simplification and flexibility, in this final rule CMS is providing states the option of not applying a resource proxy. A number of states have indicated that resources did not keep many individuals from qualifying for Medicaid, and imposing a resource proxy for purposes of determining the applicable FMAP might be administratively burdensome and yet not yield a very different result than if no resource proxy were used. Therefore, §433.206(d)(1) allows states to choose whether to apply a resource proxy methodology under the threshold methodology. For a state that elects not to impose a resource proxy methodology, the increased FMAP under §433.10(c)(6)(i) would not apply to the medical assistance expenditures of individuals determined eligible under the adult group whose incomes are at or below the applicable income levels for the eligibility categories in effect on December 1, 2009.

For states that elect to apply a resource proxy methodology, as described in greater detail below, this rule also provides for two options for states to address the application of resource criteria which were applied to applicable eligibility groups under a state's Medicaid program as in effect on December 1, 2009:

- A state could elect to collect and use existing state data prior to January 1, 2014 related to denials of eligibility explicitly due to excess resources; or

- A state could elect to obtain similar data through sampling of beneficiaries in eligibility categories relevant to the adult group (for periods prior to January 1, 2014), or eligible

and enrolled in the new adult group (for periods on or after January 1, 2014).

A state may elect to apply a resource proxy methodology under the threshold methodology with respect to a particular eligibility category that had a resource test in effect on December 1, 2009, or the state could apply the resource proxy methodology to all relevant eligibility categories that had a resource test in effect on December 1, 2009.

Consistent with previously issued regulations, the development of a resource proxy methodology must not delay or interfere with the eligibility determination for an individual nor rely on information from applicants or beneficiaries if such information is available electronically. Particularly for states that undertake a resource proxy sample on or after January 1, 2014, when new MAGI methodologies are in effect and resources are no longer a criteria for eligibility determinations, states may not require individuals to provide information that is not necessary for the determination of eligibility, such as resource information for purposes of determining FMAP. However, states are not precluded from asking for such information, if it is not available electronically through an accessible data base or through electronic means, for example, after an applicant has completed an application. Such requests may not be part of the formal application process, and states must provide applicants or beneficiaries with clear notice that the information solicited is not required for purposes of eligibility determination and will not affect such determination.

Section 433.206(d)(2) describes the standards for the resource proxy methodology. In particular, the resource proxy methodology must be based on state-level data, which would be used to identify the percentage of denials of Medicaid eligibility over a period of time due to excess resources. The state data must either be existing data from and for periods before January 1, 2014 related to denials of eligibility explicitly due to excess resources, or data obtained through a statistically valid sample of beneficiaries in eligibility categories relevant to the new adult group (for periods prior to January 1, 2014) or eligible and enrolled in the new adult group

(for periods on or after January 1, 2014).

Whether the state data is based on actual resource criteria determinations prior to January 1, 2014 or based on statistically valid post-eligibility sampling (whether prior to or on or after January 1, 2014), the data that will be used for the resource criteria proxy must represent sampling results for a period of sufficient length to be statistically valid. States who use data based on actual resource criteria determinations prior to January 1, 2014 must ensure the data validly reflects eligibility denials explicitly due to excess resources. Eligibility denials that were not explicitly related to excess resources, such as denials based on failure to return paperwork or other administrative issues, shall not be included as they would inappropriately inflate the number of people for whom the resource requirement was a bar to eligibility.

States that have not changed their resource eligibility criteria since December 1, 2009, that have valid state data, as described above, available from and for a statistically valid period prior to January 1, 2014 or that can collect such state data before January 1, 2014 (when resource tests will no longer be permissible), may rely on that data for the resource proxy. Alternatively, for states that do not have such data or cannot collect it before January 1, 2014, this rule permits states to develop a resource proxy based on data derived through a post-eligibility review of the resource information for a one-time sample of beneficiaries. Such sample would be with respect to applicable resources as assessed against standards for eligibility groups in effect on December 1, 2009, collected through a statistically valid sample obtained during the one year period that begins on the first day of the quarter in which eligibility for individuals under the new adult group is initially effective for the state (for example, by December 31, 2014, for states that adopt the new adult group effective January 1, 2014), and ends on the last day of the one year period. For example, denial data for a determined statistically valid period January to March 2014 could be used for claims beginning with January 1, 2014, subject to CMS approval of an amendment to the state plan submitted during the first calendar quarter of 2014, retroactive to the beginning of

such quarter in which the SPA was submitted.

Because we believe that it is important to have consistent processes, we would provide for a one-time opportunity to elect to implement a resource proxy methodology. States may elect to implement a resource proxy methodology through submission of a state plan amendment no later than one year from the first day of the quarter in which eligibility for individuals under the new adult group under §435.119 is initially effective for the state. For example, for states choosing to adopt the new adult group effective January 1, 2014, this would be by December 31, 2014. State claims for federal funding in accordance with the resource proxy could be allowable no earlier than the beginning of the quarter in which the state plan was submitted, subject to CMS approval. The state plan amendment would describe the data upon which the resource proxy is based. CMS will review such amendments to ensure all requirements both methodological and related to data are met.

Under the resource proxy, states would apply the proportion of denials with respect to the expenditures of individuals in the new adult group who would otherwise be considered not to be newly eligible based only on their income being at or below the applicable converted MAGI standard; this would allow such expenditures to be claimed at the increased newly eligible FMAP. To illustrate this approach, if based on the state data there was a 5 percent denial rate due to excess resources for an applicable eligibility group or groups in effect on December 1, 2009 for which resource criteria was applicable, then 5 percent of the new adult eligibility group expenditures related to such applicable group or groups, which would otherwise have been claimed at the FMAP for individuals who were not newly eligible, would be claimed at the newly eligible FMAP rate. That is, the amounts of such expenditures would be considered to be newly eligible expenditures. CMS will work with the states to ensure that the resource proxy methodology is appropriately determined and applied.

5. Enrollment Cap Adjustment (§433.206(e)).

Under section 1905(y)(2)(A) of the Act, the definition of a newly eligible individual includes individuals who would be eligible for full benefits, benchmark coverage, or benchmark equivalent coverage provided through a demonstration under the authority of section 1115 of the Act (1115 demonstration) as in effect on December 1, 2009 but would not have been enrolled (or would have been placed on a waiting list) based on the application of an enrollment cap or limit determined in accordance with such demonstration. As discussed above, the definition of newly eligible individual in §433.204(a)(1) is clarified in this final rule to include a reference to this enrollment cap provision. For purposes of applying an enrollment cap, limit, or waiting list provision under the threshold methodology, individuals who would have been on a waiting list are considered as not enrolled under the demonstration. Proposed §433.208(a)(2) of the August 17, 2011 proposed rule required the threshold methodology to incorporate any enrollment caps under section 1115 demonstrations programs that were in place in the state on December 1, 2009. In this final rule, §433.206(e) is added to more fully describe the treatment of enrollment caps under the threshold methodology.

Section 433.206(e) indicates the underlying principles for applying an enrollment cap provision under the threshold methodology and describes how these principles are used for calculating the amount of federal funding to be claimed by states that had an enrollment cap or limit in effect on December 1, 2009, subject to the definition of newly eligible individual in §433.204(a)(1). The main objective of the enrollment cap provision, added here to reflect the previously described revision to the definition of "newly eligible" contained in §433.204(a)(1), is to establish the appropriate amount of federal funding available for the medical assistance expenditures that would be claimed at the FMAP applicable for individuals enrolled in the new adult group who are newly eligible individuals due to enrollment caps, and the amount of such expenditures that would be claimed at the FMAP applicable for individuals who are not newly eligible. Recognizing that enrollment limits or caps were designed differently in different

section 1115 demonstrations, §433.206(e) includes flexibility for states to reflect enrollment caps in a manner consistent with the demonstration terms and conditions and with the policies in place in the state as of December 1, 2009.

In accordance with the goal of administrative simplicity, and as described below, for purposes of determining the applicable FMAP and appropriate level of federal funding for the medical assistance expenditures of the new adult group, under the threshold methodology the treatment of enrollment caps is based on the following three elements associated with the eligibility categories of individuals for which an enrollment cap/limit provision was applicable on December 1, 2009:

- Beginning in quarters ending after January 1, 2014, the total unduplicated number of individuals eligible and enrolled under the adult eligibility group for the applicable claiming period, that is, the period for which expenditures are being made.
- Beginning in quarters ending after January 1, 2014, the total state medical assistance expenditures for the new adult group for the applicable claiming period.
- The enrollment cap or limit in effect on December 1, 2009.

For purposes of the third element above, this final rule indicates that the enrollment cap/limit would be the level of such enrollment cap/limit as authorized under the approved demonstration in effect on December 1, 2009; or, if the state had affirmatively set the cap at a lower level consistent with flexibility provided by the demonstration terms and conditions, the state may elect to apply the lower cap as in effect in the state on December 1, 2009. To the extent that states imposed enrollment limits in accordance with the approved terms and conditions, this regulation seeks to assure that the newly eligible FMAP will be available to states for enrollment above such defined limits, as verified by CMS. Whether the state uses the enrollment cap specifically authorized in the demonstration or a lower, verifiable cap as in effect in the state that was consistent with the demonstration special terms and conditions, under the

methodology described here, the amount of expenditures multiplied by the proportion of the 2009 enrollment cap to the total number of currently enrolled people in the group would be claimed at the regular FMAP (or, if applicable, at the expansion state FMAP); and the amount of expenditures multiplied by 100 percent minus the proportion (expressed as a percentage) would be claimed at the newly eligible FMAP.

In §433.206(e)(2), under the threshold methodology, states may simplify application of enrollment caps/limits by electing to combine such enrollment caps as were in effect on December 1, 2009, unless such treatment would preclude claiming of federal funding at the applicable FMAP rates required under §433.10(b) or (c). Combining enrollment caps would be precluded in certain circumstances when separate treatment of enrollment caps is necessary to distinguish claims for which different FMAP rates apply. For example, in an expansion state the applicable FMAP for childless adults who are not newly eligible is the expansion state FMAP, and the applicable FMAP for parents who are not newly eligible is the regular FMAP. This difference in the FMAP rates for individual who are not newly eligible in an expansion state necessitates separately capturing the number of parents and childless adults to whom the expansion state FMAP would apply. In all cases, all states can elect to apply the enrollment caps separately, even when combining such caps/limits is not precluded.

Whether the treatment is to combine or separate the applicable enrollment caps, for states that had enrollment caps in effect on December 1, 2009, using the three elements listed above, federal funding will be determined based on the proportion of the enrollment cap to the total number of individuals in the applicable demonstration coverage group who are eligible under the adult eligibility group. In particular, the total expenditures multiplied by the proportion would be claimed at the FMAP for individuals who are not newly eligible individuals; and the total expenditures multiplied by the difference between 100 percent and the proportion would be claimed at the increased newly eligible FMAP.

EXAMPLE 1:

On December 1, 2009 the State had in effect a demonstration applicable only for childless adults for individuals with incomes up to 133 percent of FPL; the approved enrollment cap (C) for such childless adults in effect on December 1, 2009 under the demonstration was 1,000. The State is not an expansion state. The regular FMAP (F) for the State is 60.00 percent.
For the quarter ending after January 1, 2014, there are $10 million in total expenditures for the new adult group consisting of 4,000 childless adults with incomes up to 133 percent of FPL. Since the state is not an expansion State, the 60.00 percent regular FMAP would be applied for the amount of the total expenditures of individuals who are not newly eligible. The enrollment cap (C) for this group as applicable on December 1, 2009 is 1,000. Since all of the individuals have income up to 133 percent of FPL, they would otherwise be considered as not newly eligible. However, in accordance with the FMAP methodology for enrollment caps, the following describes how these expenditures would be claimed: P = C/T = 1,000/4,000 = 25% E = $10 million total expenditures F = 60.00% (100% -P) = 75%
Not Newly Eligible Claims for Childless Adults (at 60.00% regular FMAP): = P x E x F = 25% x $10 million x 60.00% = **$1.5 million**.
Newly Eligible Claims for Childless Adults (at 100% newly eligible FMAP): = (100% – P) x E x Newly Eligible FMAP = 75% x $10 million x 100.00% = **$7.5 million**
SUMMARY: The total federal dollars for the new adult group comprised of childless adults in this example is **$9.0 million**, calculated as $1.5 million (not newly eligible) + $7.5 million (newly eligible).

Section 433.206(e)(4)specifies that each state for which the enrollment cap/limit provision applies will be required to indicate the treatment of such provisions in the state plan amendment submission required by new §433.206(h), described below.

6. Application of Spend-down Income Eligibility Criteria (§433.206(f)).

States' Medicaid programs as in effect on December 1, 2009 may have included eligibility categories for which deduction of incurred medical expenses from income (referred to as spend-down) under the provisions of sections 1902(a)(10)(C) and/or 1902(f) of the Act was applied in determining individuals' Medicaid eligibility. Under the provisions of section

1902(a)(10(C) of the Act, and in regulations at part 435, subparts D and I, states had and continue to have the option of establishing a "medically needy" program under which the income of an individual above the spend-down income eligibility standard (referred to as the medically needy income level) could become eligible for Medicaid by applying incurred medical expenses to reduce the excess income to the medically needy income level. States could choose the categories of individuals who would be covered by the medically needy program. Under the authority of section 1902(f) of the Act, and in regulations at §435.121, a similar eligibility spend-down process is also applied under which certain states (referred to as "209(b) states"), in determining the Medicaid eligibility of aged, blind and disabled individuals, may apply certain more restrictive requirements than are applied under the Supplemental Security Income program to provide mandatory categorically needy coverage to such individuals. In certain circumstances, 209(b) states must use a spend-down process to determine eligibility of such affected individuals whose income is in excess of the applicable 209(b) mandatory categorically needy income level. 209(b) states may also elect to have a medically needy program in addition to covering the mandatory categorically needy aged, blind, and disabled individuals.

In general, the medically needy spend-down process and the 209(b) state spend-down process are the same with respect to the application of incurred medical expenses to reduce the excess income of individuals to the respective income eligibility levels. In that regard, as indicated in the August 17, 2011 proposed rule, for purposes of the determination of the applicable FMAP for individuals in the new adult group, individuals whose income is greater than the applicable respective medically needy or 209(b) spend-down levels as in effect on December 1, 2009 would be considered to be newly eligible individuals. Essentially, a state will only consider the income level of individuals in the new adult group, and not their potential spend-down amounts, in determining if they are newly eligible or not. However, based on comments received on the proposed rule on this issue, there continues to be confusion about the

application of the spend-down provision in determining the appropriate FMAP for the adult group. Accordingly, to clarify the application of the spend-down provision under the threshold methodology, a new §433.206(f) is being added in this final rule.

Section 433.206(f)(1) generally describes the spend-down process as applied in determining eligibility. Section 433.206(f)(2) and (3) describe the determination under the threshold methodology of an individual as not newly eligible or newly eligible, respectively, under the definition indicated in §433.204 and the availability of the appropriate FMAP under §433.10(b) or (c) for the medical assistance expenditures of such individual for which a spend-down eligibility category of a state effective on December 1, 2009 is applicable. As indicated in §433.206(f)(2), if an individual's income before any deductions for incurred medical expenses are made is less than or equal to the applicable spend-down income level in the state, whether a medically needy or 209(b) spend-down level, the individual would be considered as not newly eligible and the medical assistance expenditures related to such individual would be claimed at the FMAP applicable to not newly eligible individuals in the state. As indicated in §433.206(f)(3), if an individual's income before any deductions for incurred medical expenses is greater than the applicable spend-down income level in the state, whether a medically needy or 209(b) spend-down level, the individual would be considered as newly eligible, and the medical assistance expenditures related to such individual would be claimed at the newly eligible FMAP.

7. Special Circumstances (§433.206(g)).

As states implement the threshold methodology, we recognize and anticipate that special circumstances may necessitate the potential need to consider additional adjustments to provide a basis for states to properly claim federal funding for the expenditures of individuals enrolled in the new adult group at the appropriate FMAP. The final rule provides a basis at new §433.206(g) for addressing such circumstances and to assure efficient transitions to the new

eligibility and FMAP provisions. Subject to CMS approval, this provision will apply such as in the case of the operation of a waiver authorized under section 1902(e)(14)(A) of the Act or, to the extent that a section 1115 demonstration in effect as of December 1, 2009 applied non-financial eligibility criteria for demonstration eligibility that are otherwise not accounted for in the general rule. To the extent that such criteria are difficult to verify or unknowable in 2014 and beyond, this approach is intended to provide a basis for states to claim federal funding for the expenditures of individuals enrolled in the adult group at the appropriate FMAP. CMS will work with states to develop an appropriate proxy methodology, process, and the appropriate documentation for submission to and approval by CMS.

8. Threshold Methodology State Plan Requirements (§433.206(h)).

The proposed rule generally indicated that states would submit a threshold methodology plan to CMS for approval. In this final rule, states are directed to submit a threshold methodology state plan amendment to their Medicaid state plan for approval by CMS. The threshold methodology plan, which will be included as an attachment to the state plan, would indicate that the state will implement such methodology in accordance with the provisions of this section and include details about the methodology. The threshold methodology attachment to the state plan will include any options or alternatives the state elects with respect to:

- Treatment of resources, in accordance with (§433.206(d));
- Treatment of enrollment caps or waiting lists, in accordance with (§433.206(e));
- Any applicable special circumstances, as approved by CMS ((§433.206(g)); and
- Treatment of other aspects of the threshold methodology as approved by the CMS.

The process for submission and the format of the threshold methodology plan will be provided through guidance issued by CMS.

F. Statistically valid sampling methodology (§433.210))

In the proposed rule, §433.210 referred to the statistically valid sampling methodology. This regulatory provision is deleted in this final rule.

G. CMS established FMAP proportion (§433.212)

In the proposed rule, §433.212 referred to the CMS established FMAP proportion. This regulatory provision is deleted in this final rule.

V. Collection of Information Requirements

In the Medicaid Eligibility proposed rule (RIN 0938–AQ62, 76 FR 51148), we solicited public comments for 60 days on the rule's information collection requirements but none were received. As described in this final rule, we are clarifying and finalizing the provisions of the threshold methodology for states to use in the claiming of federal funding at the appropriate FMAP rates for expenditures related to the new adult eligibility group. In that regard, and as previously explained, states will need to submit state plan amendments to reflect their implementation of the threshold methodology. States will also need to submit expenditure and other information in their submissions of their quarterly Medicaid expenditure reports. Any information collection requirements for states related to the state plan amendment or expenditure report submission will be described separately.

This final rule implements provisions of the Affordable Care Act that relate to the availability of increased FMAP rates under states' Medicaid programs. This final rule codifies the increased FMAP rates and the related conditions and requirements that will be applicable beginning January 1, 2014, for the expenditures of certain individuals determined eligible under the new adult eligibility group. In particular, with respect to the new adult eligibility group, increased FMAP rates will be available for state Medicaid expenditures associated with medical assistance for two groups of adults: certain individuals who are "newly eligible" and certain individuals who are in defined "expansion states" and are not "newly eligible." This final rule selected one of the three methodologies described in the proposed rule and finalizes it as the

methodology that states will use to determine the appropriate FMAP in claiming federal funding for the expenditures related to individuals determined eligible in the new adult group. In general, the threshold methodology offers a simplified approach that compares individuals' MAGI-based income, as already established through the basic eligibility process, to the income levels as were in effect under states' Medicaid programs on December 1, 2009. To further ease and simplify administration, the threshold methodology also provides for potential population-based adjustments in the federal claims to account for resources and enrollment caps that may have applied in the states' December 1, 2009, Medicaid programs. As specified in §433.206(h), states must amend their state plans to reflect the threshold methodology the states will implement.

Although there are short-term burdens associated with implementation of these provisions, over time the Medicaid program will be made substantially easier for states to administer by simplifying the determinations of the applicable FMAP. The policies finalized in this final rule are intended to reduce or eliminate the burden on states seeking to determine the appropriate FMAP for claims as well as on individuals applying for Medicaid. The regulation makes clear that any additional information potentially requested from individuals for FMAP purposes cannot delay or otherwise affect the eligibility determination; nor can any individual be required to provide such information needed solely for FMAP purposes.

We recognize that there are information collection requirements related to the implementation of this regulation, particularly with respect to the state plan amendments required by §433.206(h). CMS will seek OMB approval of those amendments at a later time under OCN 0938-1148. In addition, CMS will be making changes to its quarterly financial reporting form (CMS-64) to facilitate claiming under this final rule. CMS will seek public comment and OMB approval of those changes at a later time under OCN 0938-0067.

VI. Regulatory Impact Analysis

A. Introduction

We have examined the impact of this final rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). This final rule does not reach the economic threshold and thus is not considered a major rule. In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

This final rule concerns the technical aspects of applying the appropriate FMAP to the expenditures of individuals in the new adult group (described at §435.119) who are either newly eligible or, if not, meet the criteria for the increased expansion state FMAP. This final rule simply provides guidelines and a process by which states can claim the appropriate FMAP in a streamlined manner. The economic impacts of the Medicaid expansion are entirely attributable to the Affordable Care Act; the economic impact of this rule concerns the additional costs of the methodology described in §433.206, but not the costs of the expansion or the IT costs of the systems, which are contained in other implementation rules. As such, the costs of this rule are not economically significant, particularly when considered relative to the alternatives CMS

considered in developing this rule; the process described here is less costly and more equitable than the alternatives described below.

This final rule sets out a simplified methodology and process for determining the applicable FMAP, which will lessen the burden on states implementing the provisions described in the Affordable Care Act. In the absence of the threshold methodology being finalized by this regulation, states would have to conduct an individualized determination based on the eligibility rules in effect in 2009, or would be subject to uncertainty (and potentially ongoing and costly disputes) in their efforts to claim the increased FMAP. Instead, under this final rule, the threshold methodology simply requires a basic comparison of an individual's current income against converted MAGI income thresholds for applicable categories of eligibility, subject to a limited number of adjustments that states may elect to increase the accuracy of the methodology. Therefore, the approach being finalized in this rule provides relief from the burden that would otherwise accrue to states seeking to determine the applicable FMAP. Indeed, the key objective of this final rule, as described in the preamble to the proposed rule and as reaffirmed here, is to alleviate the need to conduct complicated and unnecessary eligibility determinations simply for the purpose of applying the appropriate FMAP. The costs of implementing other aspects of the Affordable Care Act have been accounted for elsewhere and the impacts described here reflect the incremental costs of applying a process to claim the increased FMAPs available to individuals enrolled in the new adult group. We do not find this final rule to be economically significant because states are already undertaking related activity pursuant to the March 23, 2012 final eligibility rule and the December 28, 2012 letter to State and Health Officials (SHO #12-003, available at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf), regarding the conversion of net income standards to MAGI equivalent income standards. These converted income standards will provide the basis for applying the threshold methodology

described in this rule; states will then use standard Medicaid claiming procedures (using the CMS-64 and MBES systems as modified by CMS) to claim the applicable FMAP.

B. Statement of Need

This final rule will implement provisions of the Affordable Care Act related to Medicaid, specifically provisions about the increased FMAPs and related provisions. It provides states with a simplified, less burdensome approach by which to identify the appropriate FMAP and alleviates the need for states to maintain a shadow eligibility system based on eligibility rules in effect in 2009. Instead, the regulation sets out a fair and accurate methodology by which to assess whether individuals seeking coverage in 2014 and beyond could have qualified for coverage under the state's eligibility standards as of December 1, 2009. Applying this methodology, individuals for whom it is determined could not have been eligible for specified coverage as of December 1, 2009 will be deemed newly eligible and the higher FMAP will apply.

C. Anticipated Effects

1. Effects on State Medicaid Programs

The final rule sets out standards for claiming the increased FMAPs created by the Affordable Care Act. Following the process and methodology outlined in this final rule will provide states that elect to expand coverage to the new adult group access to the increased FMAPs, resulting in a significant economic benefit to states. The threshold methodology approach will require minimal incremental increases in states' spending relative to the alternatives we considered in finalizing this rule, as described below.

Although state Medicaid programs will have to invest in administrative costs to implement the threshold methodology described in this rule, they will ultimately receive significant federal matching payments for the costs of new Medicaid beneficiaries. As described elsewhere in this section, the threshold methodology will minimize the costs to state Medicaid

agencies relative to the costs that they would otherwise bear in claiming the increased Affordable Care Act FMAPs. For example, this rule provides a transparent and uniform process for states to use, eliminating the uncertainty they would experience with respect to federal funds claiming in the absence of this guidance. Most significantly, the threshold methodology provides an efficient and streamlined alternative to avoid indefinitely applying 2009 eligibility standards to every applicant (in addition to current standards) simply for the purposes of determining the applicable FMAP. Numerous state and other commenters wrote to express particular concern about the burden that any methodology might impose on states and on applicants if additional information is requested for FMAP purposes.

D. Alternatives Considered

We considered various alternative methodologies to determine the applicable FMAP in developing the proposed rule and in finalizing the provisions of this regulation, ultimately revising our approach from the proposed rule to finalize the threshold methodology. First, with regard to the increased FMAP rates available for state medical assistance expenditures relating to "newly eligible" individuals, in developing the proposed rule we considered requiring all states to complete a second, full eligibility determination on all Medicaid eligibles using the state's December 2009 eligibility standards to determine the appropriate FMAP rate based upon whether or not each individual was newly eligible. We determined that such a requirement would be overly burdensome to states and to beneficiaries and would likely lead to errors and unnecessary costs. We do not believe such an approach would result in an economic and efficient outcome in administering the program; rather, it would be significantly more burdensome than the approach we are adopting. In addition, such a requirement would directly contradict the principles of the Affordable Care Act to streamline and simplify eligibility and enrollment into health care programs. We did not propose this approach in the proposed rule and

are not revisiting that decision in this final rule to avoid imposing unnecessary and unwarranted burdens on states or beneficiaries.

Second, we considered as an alternative approach the statistically valid sampling methodology (originally proposed in §433.210). This alternative approach would use a sampling methodology across individuals in the adult group and related Medicaid expenditures to derive a statistically valid extrapolation of who is newly eligible and their related expenditures. We received numerous comments about the potential burdens associated with this methodology and concluded that it could require states to make actual eligibility determinations under 2009 rules and therefore maintain precisely the type of shadow eligibility system that the rule seeks to avoid. We also shared commenters' concerns that this alternative could place additional burdens on enrollees, including requests for information not required for eligibility. Such a result would not only be burdensome to beneficiaries but also inconsistent with standards established in the March 23, 2012 final rule that prevent states from asking applicants additional questions, when they apply for Medicaid, that are not related to the eligibility determination. Furthermore, we concluded that addressing concerns about burden on applicants could compromise the accuracy of the statistical sampling methodology.

We also determined that the statistically valid sampling methodology would not produce accurate results in states that had not expanded coverage through section 1115 demonstrations prior to 2014 because those states would not have applicable data for sampling purposes. Finally, we agreed with commenters' concerns that, because the sampling results would apply retroactively, this methodology would create the potential for sizeable retroactively adjusted federal payments, which would make it difficult for states to budget accurately and would introduce financial uncertainty for states. Given all of these concerns, we determined that the statistically valid sampling methodology would be more burdensome, less administratively feasible, and less accurate than the approach we elected, the threshold methodology.

A third alternative methodology considered was the CMS-established FMAP proportion methodology (originally described in §433.212). This alternative approach would have used an extrapolation from available data sources to determine the proportion of individuals covered under the new adult group who would not have been eligible under the eligibility category in effect under the state plan or applicable waiver as of December 1, 2009, validating and adjusting the estimate, based on sampling or some other mechanism going forward. Public comments and our ongoing analysis cast doubt on the accuracy of this methodology, in part because available data sources have limited experience with newly eligible populations and new rules under the Affordable Care Act, making it difficult to accurately estimate the proportion of individuals covered under the new adult group who would have been eligible under the eligibility category that would have been in effect as of December 1, 2009. Some commenters particularly noted data accuracy concerns for smaller states. Finally, other commenters pointed out that the proportion methodology could require large annual adjustments of state-specific rates, introducing uncertainty and potentially fiscal burden to states. Although some commenters supported this alternative methodology, we concluded that equity, accuracy, and administrative simplicity mitigated against its selection and that the threshold methodology would be a less burdensome alternative.

Finally, numerous commenters provided comments with respect to the provision (included in the proposed rule at §433.206) regarding the choice of FMAP methodologies. Some commenters urged us to select one methodology for nationwide use while other commenters urged flexibility. In response to the various comments, particularly those noting concerns with the accuracy, equity, burden, and lack of certainty related to the statistically valid sampling methodology and the proportion methodology, we are finalizing one methodology, the threshold methodology. Our view is that the threshold methodology (originally proposed in §433.208 and being finalized in §433.206), particularly as modified in this final rule, is the least burdensome,

most transparent, and most accurate approach relative to the other alternatives. We have worked and continue to work extensively with states to develop the converted MAGI income thresholds that will be the basis of this methodology. As noted above, we published a letter to State and Health Officials on December 28, 2012 (SHO #12-003, available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf) to provide guidance about the conversion of net income standards to MAGI equivalent income standards. The threshold methodology builds on this work and, relative to the other alternatives that we considered, will be less burdensome to implement.

In finalizing the threshold methodology, we accounted for various comments about specific elements of the threshold methodology, including how the methodology should account for past denials based on resources and how the methodology should treat individuals eligible for Medicaid based on disability status and/or spend-down rules. We revised this final rule to provide states with various options to account for these adjustments to the threshold methodology to enable accurate FMAP claiming. With respect to resources, for example, states may – but are not required to – undertake additional data analysis to develop a resource proxy to help determine additional expenditures eligible for the increased newly eligible FMAP. Rather than require all states adopting the new adult group to develop and apply a resource proxy, only states wishing to claim additional FMAP for populations that might not appear to be newly eligible in the absence of the consideration of resources will pursue the additional (but time-limited and minimal) administrative costs of doing so. We believe this approach strikes an appropriate balance that avoids increasing the burden on all states.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2013,

that threshold is approximately $141 million. However, it is important to understand that the UMRA does not address the total cost of a rule. Rather, it focuses on certain categories of cost, mainly costs resulting from (A) imposing enforceable duties on state, local, or Tribal governments, or on the private sector, or (B) increasing the stringency of conditions in, or decreasing the funding of, state, local, or Tribal governments under entitlement programs.

Because of the favorable Affordable Care Act increased FMAPs and the availability of 90 percent federal match for systems improvements to facilitate upgrades to accommodate the Affordable Care Act eligibility changes, we believe that states can take actions that will have limited effects on state costs. The extensive consultation with states we describe below was aimed at the requirements of both UMRA and Executive Order 13132 on Federalism.

1. State and Local Governments

As noted previously, the Affordable Care Act creates a new mandatory eligibility group to cover adults with incomes below 133 percent of the FPL. The recent Supreme Court decision gives states the option not to cover this eligibility group but, for states that elect to provide such coverage, Title XIX now provides substantial new federal support to nearly offset the costs of covering that population. States will have to undertake some work to properly apply the threshold methodology, including developing procedures to properly identify and claim the appropriate FMAP for newly eligible and/or certain non-newly eligible populations in expansion states, but this work builds on existing work they are already undertaking as part of the conversion of income standards to MAGI-based standards. Furthermore, claiming expenditures will be done in accordance with current claiming requirements.

The Affordable Care Act changes the Medicaid and CHIP programs to improve coordination between programs and reduce the administrative burden on states by simplifying and streamlining systems. Following publication of the August 17, 2011 proposed eligibility rule, we received input from states about the FMAP provisions in that rule. In addition to

analyzing the feasibility of each of the proposed alternatives, we solicited input from a group of states working intensively to prepare to implement the new Medicaid adult group, including the transition to MAGI, and analyzed the data from these states.

We have received input from states on how the various Affordable Care Act provisions codified in this final rule will affect them. We have participated in a number of conference calls and in person meetings with state officials since the law was enacted. These discussions have enabled the states to share their thinking and questions about how the Medicaid changes in the legislation would be implemented. The conference calls and meetings also furnished opportunities for State Medicaid Directors to comment informally on implementation issues and plans (although to be considered comments on the Medicaid Eligibility proposed rule, written comments using the process described in the Medicaid Eligibility proposed rule were required). Based on the input we received, we believe that the threshold methodology best addresses state concerns about burden and simplification for those states that elect to adopt the new adult coverage group.

2. Private Sector and Tribal Governments

We do not believe this final rule will impose any unfunded mandates on the private sector. As we explain in more detail in the Regulatory Flexibility Act analysis, the provisions of the Affordable Care Act implemented by this final rule deal with FMAP rates for individuals in the new adult group, and as such are directed toward state governments rather than toward the private sector. Since the final rule will impose no mandates on the private sector, we conclude that the cost of any possible unfunded mandates would not meet the threshold amounts discussed previously that would otherwise require an unfunded mandate analysis for the private sector. We also conclude that an unfunded mandate analysis is not needed for Tribal governments since the final rules will not impose mandates on Tribal governments.

F. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small entities if a final rule will have a significant economic impact on a substantial number of small entities. We are not preparing an RFA because the Secretary has determined that this final rule would not have a significant economic impact on a substantial number of small entities. Few of the entities that meet the definition of a small entity as that term is used in the RFA (for example, small businesses, nonprofit organization, and small governmental jurisdictions with a population of less than 50,000) will be impacted directly by this final rule. Individuals and states are not included in the definition of a small entity. There are some states in which counties or cities share in the costs of Medicaid. To the extent that states require counties to share in these costs, some small jurisdictions could be affected by the requirements of this final rule, especially beginning in 2017 when the newly eligible FMAP is no longer 100 percent. However, nothing in this rule will constrain states from making changes to alleviate any adverse effects on small jurisdictions.

Because this final rule is focused on the appropriate FMAP to reimburse the expenditures of individuals enrolled in Medicaid, it does not contain provisions that would have a significant direct impact on hospitals, and other health care providers that are designated as small entities under the RFA. However, the provisions in this final rule, like the provisions in the final March 23, 2012 eligibility rule, may have a substantial, positive indirect effect on hospitals and other health care providers due to the substantial increase in the prevalence of health coverage among, and Medicaid reimbursement for, populations who are currently unable to pay for needed health care, leading to lower rates of uncompensated care at hospitals.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a final rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of

a metropolitan statistical area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because the Secretary has determined that this final rule will not have a direct economic impact on the operations of a substantial number of small rural hospitals. As indicated in the preceding discussion, there may be indirect positive effects from reductions in uncompensated care.

G. Conclusion

In conclusion, we are not preparing analysis for either the RFA or section 1102(b) of the Act, because we have determined that this final rule will not have a direct significant economic impact on states, small entities, or small rural hospitals. Relative to the alternatives considered, we determined the threshold methodology to be less burdensome to states and beneficiaries, more equitable, and more transparent than other approaches considered. The threshold methodology provides a uniform, streamlined process for states that adopt to extend Medicaid to the new adult group to claim the higher FMAPs provided by the Affordable Care Act. Finalizing this methodology thereby eliminates the comparatively more burdensome approaches of either uncertainty about federal claiming standards or requiring states to indefinitely determine new applicants' eligibility using new standards as well as the eligibility rules in effect in 2009 simply for the purposes of assigning the FMAP. The incremental costs of implementing the threshold methodology process are therefore relatively small compared to the alternatives considered. This analysis, together with the remainder final rule, provides a final Regulatory Impact Analysis.

VIII. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct effects on states, preempts state law, or otherwise has Federalism implications. We have reviewed this rule under the threshold criteria of Executive Order 13132, Federalism, and have determined it will not have substantial direct effects on the rights, rules, and responsibilities of states, local or tribal governments.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Child support Claims, Grant programs-health, Medicaid, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amend 42 CFR chapter IV as set forth below:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

2. Section 433.10 is amended by --

A. In paragraph (a), removing the phrase "and 1905(b)," and adding in its place the phrase "1905(b), 1905(y), and 1905(z)"

B. Adding new paragraphs (c)(6), (c)(7), and (c)(8).

The additions read as follows:

§433.10 Rates of FFP for program services

* * * * *

(c) * * *

(6)(i) Newly eligible FMAP. Beginning January 1, 2014, under section 1905(y) of the Act, the FMAP for a State that is one of the 50 States or the District of Columbia, including a State that meets the definition of expansion State in §433.204(b), for amounts expended by such State for medical assistance for newly eligible individuals, as defined in §433.204(a)(1), will be an increased FMAP equal to:

(A) 100 percent, for calendar quarters in calendar years (CYs) 2014 through 2016;

(B) 95 percent, for calendar quarters in CY 2017;

(C) 94 percent, for calendar quarters in CY 2018;

(D) 93 percent, for calendar quarters in CY 2019;

(E) 90 percent, for calendar quarters in CY 2020 and all subsequent calendar years.

(ii) The FMAP specified in paragraph (c)(6)(i) of this section will apply to amounts

expended by a State for medical assistance for newly eligible individuals in accordance with the requirements of the methodology applied by the State under §433.206.

(7)(i) Temporary FMAP increase. During the period January 1, 2014, through December 31, 2015, under section 1905(z)(1) of the Act for a State described in paragraph (c)(7)(ii) of this section, the FMAP determined under paragraph (b) of this section will be increased by 2.2 percentage points.

(ii) A State qualifies for the targeted increase in the FMAP under paragraph (c)(7)(i) of this section, if the State:

(A) Is an expansion State, as described in §433.204(b) of this section;

(B) Does not qualify for any payments on the basis of the increased FMAP under paragraph (c)(6) of this section, as determined by the Secretary; and

(C) Has not been approved by the Secretary to divert a portion of the disproportionate share hospital allotment for the State under section 1923(f) of the Act to the costs of providing medical assistance or other health benefits coverage under a demonstration that is in effect on July 1, 2009.

(iii) The increased FMAP under paragraph (c)(7)(i) of this section is available for amounts expended by the State for medical assistance for individuals that are not newly eligible as defined in §433.204(a)(1).

(8) Expansion State FMAP. Beginning January 1, 2014, under section 1905(z)(2) of the Act, the FMAP for an expansion State defined in §433.204(b), for amounts expended by such State for medical assistance for individuals described in §435.119 of this chapter who are not newly eligible as defined in §433.204(a)(1), and who are nonpregnant childless adults with respect to whom the State may require enrollment in benchmark coverage under section 1937 of the Act, will be determined in accordance with the expansion State FMAP formula in paragraph (c)(8)(i).

(i) Expansion State FMAP.

F + (T x (N – F))

F = The base FMAP for the State determined under paragraph (b) of this section, subject to paragraph (c)(7) of this section.

T = The transition percentage specified in paragraph (c)(8)(ii) of this section.

N = The Newly Eligible FMAP determined under paragraph (c)(6) of this section.

(ii) Transition percentage. For purposes of paragraph (c)(8)(i) of this section, the transition percentage is equal to:

(A) 50 percent, for calendar quarters in CY 2014;

(B) 60 percent, for calendar quarters in CY 2015;

(C) 70 percent, for calendar quarters in CY 2016;

(D) 80 percent, for calendar quarters in CY 2017;

(E) 90 percent, for calendar quarters in CY 2018; and

(F) 100 percent, for calendar quarters in CY 2019 and all subsequent calendar years.

3. Subpart E is added to part 433 to read as follows:

Subpart E—Methodologies for Determining Federal Share of Medicaid Expenditures for Adult Eligibility Group

Sec.

Subpart E—Methodologies for Determining Federal Share of Medicaid Expenditures for Adult Eligibility Group

§433.202 Scope.

This subpart sets forth the requirements and procedures that are applicable to support State claims for the increased FMAP specified at §433.10(c)(6) for the medical assistance expenditures for individuals determined eligible as specified in §435.119 of this chapter who meet the definition of newly eligible individual specified in §433.204(a)(1). These procedures will also identify individuals determined eligible as specified in §435.119 of this chapter for whom the State may claim the regular FMAP rate specified at §433.10(b) or the increased FMAP rate specified at §433.10(c)(7) or (8), as applicable.

§433.204 Definitions.

(a)(1) Newly eligible individual means an individual determined eligible for Medicaid in accordance with the requirements of the adult group described in §435.119 of this chapter, and who, as determined by the State in accordance with the requirements of §433.206, would not have been eligible for Medicaid under the State's eligibility standards and methodologies for the Medicaid State plan, waiver or demonstration programs in effect in the State as of December 1, 2009, for full benefits or for benchmark coverage described in §440.330 (a), (b), or (c) of this chapter or benchmark equivalent coverage described in § 440.335 of this chapter that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in §440.330 (a), (b), or (c) of this chapter, or would have been eligible but not enrolled (or placed on a waiting list) for such benefits or coverage through a waiver under the plan that had a capped or limited enrollment that was full.

(2) Full benefits means, for purposes of paragraph (a)(1) of this section, with respect to an adult individual, medical assistance for all services covered under the State plan under Title XIX of the Act that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i) of the Act.

(3) For purposes of establishing under paragraphs (a)(1) and (2) of this section whether

an individual would not have been eligible for full benefits, benchmark coverage, or benchmark equivalent coverage under a waiver or demonstration program in effect on December 1, 2009, the State must provide CMS with its analysis, in accordance with guidance issued by CMS, about whether the benefits available under such waiver or demonstration constituted full benefits, benchmark coverage, or benchmark equivalent coverage. CMS will review such analysis and confirm the applicable FMAP. Individuals for whom such benefits or coverage would have been available under such waiver or demonstration are not newly eligible individuals.

(b)(1) Expansion State means a State that, as of March 23, 2010, offered health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the Federal Poverty Level. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence will not be considered to be an expansion State. Such health benefits coverage must:

(i) Have included inpatient hospital services;

(ii) Not have been dependent on access to employer coverage, employer contribution, or employment; and

(iii) Not have been limited to premium assistance, hospital-only benefits, a high deductible health plan, or benefits under a demonstration program authorized under section 1938 of the Act.

(2) For purposes of paragraph (b)(1) of this section and for §433.10(c)(8), a nonpregnant childless adult means an individual who is not eligible based on pregnancy and does not meet the definition of a caretaker relative in §435.4 of this chapter.

§433.206 Threshold methodology.

(a) Overview. Effective January 1, 2014, States must apply the threshold methodology described in this paragraph for purposes of determining the appropriate claiming for the Federal

share of expenditures at the applicable FMAP rates described in §433.10(b) and (c) for medical assistance provided with respect to individuals who have been determined eligible for the Medicaid program under §435.119 of this chapter. Subject to the provisions of this paragraph, States must apply the CMS-approved State specific threshold methodology to determine and distinguish such individuals as newly or not newly eligible individuals in accordance with the definition in §433.204(a)(1), and in accordance with States' Medicaid eligibility criteria as in effect on December 1, 2009 and to attribute their associated medical expenditures with the appropriate FMAP. The threshold methodology must not be applied by States for the purpose of determining the applicable FMAP for individuals under any other eligibility category other than §435.119 of this chapter.

(b) General principles. The threshold methodology should:

(1) Not impact the timing or approval of an individual's eligibility for Medicaid.

(2) Not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

(3) Provide a valid and accurate accounting of individuals who would have been eligible in accordance with the December 1, 2009 eligibility standards and applicable eligibility categories for the benefits described in §433.204(a)(1), and subject to paragraphs (d), (e), and (g) of this section, by incorporating simplified assessments of resources, enrollment cap requirements in place at that time, and other special circumstances as approved by CMS, respectively.

(4) Operate efficiently, without further review once an individual has been determined not to be newly eligible based on the December 1, 2009 standards for any eligibility category.

(c) Components of the threshold methodology. Subject to the submission of a threshold methodology State plan amendment as specified in paragraph (h) of this section, the provisions of the threshold methodology consist of two components, the individual income-based

determination and population-based non-income adjustments to reflect resource criteria, enrollment caps in effect on December 1, 2009, and other factors in accordance with paragraph (g) of this section.

(1) Scope. The threshold methodology shall apply with respect to the population, and the associated expenditures for such population, which has been determined eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) of the Act and in accordance with §435.119 of this chapter. This population and associated expenditures must not include individuals who have been determined eligible for Medicaid under any other mandatory or optional eligibility category.

(2) Benefit criteria for newly eligible. An individual eligible for and enrolled under §435.119 of this chapter is considered newly eligible if, with respect to the applicable eligibility category in effect on December 1, 2009, the benefits did not meet the criteria described in the newly eligible definition at §433.204(a)(1).

(3) Individual income-based determination. The individual income-based determination shall be a comparison of the individual's MAGI-based income to the income standard in effect on December 1, 2009, as converted to an equivalent MAGI-based income standard for each applicable eligibility category as in effect on that date, as follows.

(i) The amount of an individual's income under the threshold methodology is the MAGI-based income determined in accordance with §435.603 of this chapter.

(ii) For each individual, the equivalent MAGI-based income eligibility standard is the applicable income eligibility standard for the applicable category of eligibility as in effect on December 1, 2009 that is converted to an equivalent MAGI-based income standard. For example, as applicable, a separate MAGI-based income standard will be applied for individuals determined to be disabled who would have been eligible under an optional eligibility category in effect on December 1, 2009 that was based on disability. For these purposes, the applicable

equivalent MAGI-based standard is the standard as submitted by the State and approved by CMS in accordance with CMS guidance.

(iii) With respect to income eligibility criteria, if the individual's MAGI-based income is at or below the applicable converted MAGI-based income standard for the relevant eligibility category or group, then the individual is included in the population that is not newly eligible;

(iv) With respect to income eligibility criteria, if the individual's MAGI-based income is greater than the applicable converted MAGI-based income standard for the relevant eligibility category or group, then the individual is included in the population that is newly eligible;

(v) Treatment of spend-down programs. Treatment of medically needy or spend-down programs under the threshold methodology is described in paragraph (f) of this section.

(vi) For purposes of comparing the individual's MAGI-based income to the applicable converted MAGI-based income standard in effect on December 1, 2009, an individual will not be considered disabled absent an actual disability determination for the individual that is in accordance with the disability definition applicable for the State under Title XIX of the Act.

(4) Treatment of disability. For purposes of applying the appropriate FMAP under §433.10(b) or (c) for the medical assistance expenditures of an individual in applying the definition of newly eligible under §433.204(a)(1), for eligibility categories or groups as in effect on December 1, 2009 for which disability was an eligibility criteria:

(i) During the period of a disability determination. During the period for which a disability determination is pending, including during the period of any appeal process, and absent an actual disability determination for the individual that is in accordance with the disability definition applicable for the State under Title XIX of the Act, the individual is not considered to be disabled.

(ii) Following a disability determination. With respect to an individual for which a disability determination was pending, following the actual determination of disability, the

individual will be considered disabled effective with the date of the disability determination, or, if later, the disability onset date, as determined.

(5) Population-based adjustments to the populations of newly eligible and not newly eligible.

(i) The State may elect a resource criteria proxy adjustment described in paragraph (d) of this section.

(ii) States that had a waiver or demonstration program with an enrollment cap in effect as of December 1, 2009 must apply an adjustment based on enrollment caps, subject to the definition of newly eligible individual in §433.204(a)(1) and paragraph (e) of this section.

(iii) States that have special circumstances may need to submit associated proxy methodologies to CMS for approval by CMS as described in paragraph (g) of this section.

(6) Application of FMAP rates to adult group expenditures. Subject to population adjustments under paragraphs (d), (e), or (g) of this section, federal funding for a State's expenditures for medical assistance provided to individuals determined eligible under §435.119 of this chapter, including individuals determined eligible under that eligibility group during the evaluation for another eligibility category, must be claimed using the applicable FMAP as follows:

(i) The newly eligible FMAP under §433.10(c)(6) is applicable for the medical assistance expenditures for individuals determined to be newly eligible, as defined in §433.204(a)(1).

(ii) The applicable FMAP under §433.10(b) or §433.10(c)(7) or (8) is applicable for the medical assistance expenditures for individuals determined not to be newly eligible.

(7) Status as newly or not newly eligible. Under the threshold methodology States must provide that once individuals are determined under the threshold methodology to be either newly or not newly eligible individuals in accordance with the applicable December 1, 2009 eligibility criteria, the State would apply that determination until a new determination of MAGI-based

income has been made in accordance with §435.916 of this chapter, or the individual has been otherwise determined not to be covered under the adult group set forth at §435.119 of this chapter.

(d) Optional resource criteria proxy adjustment. (1) General. Under an election under this paragraph (d), the State may use a resource proxy methodology for purposes of adjusting the claims for the expenditures of the population enrolled under §435.119 of this chapter to account for individuals who would not have been eligible for Medicaid because of the application of resource criteria as in effect for such population as of December 1, 2009, and therefore would meet the newly eligible individual definition at §433.204(a)(1). Under this paragraph (d), a State may elect to apply a resource proxy methodology with respect to the resource criteria as in effect on December 1, 2009 and applied to the expenditures for a specific eligibility category or categories of individuals as in effect on December 1, 2009, or applied to the expenditures of the entire population enrolled under §435.119 of this chapter. As provided in paragraph (d)(4) of this section, the State must indicate any resource proxy election in the threshold methodology State plan amendment submitted under paragraph (h) of this section. The use of a resource proxy methodology must not delay or interfere with the eligibility determination for an individual.

(2) A State's resource proxy methodology must:

(i) Describe each eligibility group or groups for which an individual eligible under §435.119 would have been eligible on December 1, 2009, subject to resource criteria, and a methodology to apply those resource criteria as an adjustment to the total expenditures to adjust determinations of the newly eligible population under paragraph (c) of this section.

(ii) Be auditable.

(iii) Be based on statistically valid data, which is either:

(A) Existing State data from and for periods before January 1, 2014 on the resources of

individuals who had applied and received a determination with respect to Medicaid eligibility, including resource eligibility under the State's applicable December 1, 2009 eligibility criteria. The existing State data must be specifically related to resource eligibility determinations, indicate the number and types of individuals for whom resource determinations were made, and establish the denial rates specifically identified as due to excess resources; or

(B) Post-eligibility State data on the resources of individuals described in paragraph (d)(2)(iii)(B)(1) and (2) of this section, based on and obtained through a post-eligibility statistically valid sample of such individuals with respect to the applicable Medicaid eligibility categories and resource eligibility criteria under the State's applicable December 1, 2009 eligibility criteria:

(1) State data from and for periods before January 1, 2014 must be for individuals in eligibility categories relevant to §435.119 of this chapter who apply and receive a determination with respect to Medicaid eligibility, including both approvals and denials, to establish denial rates specifically due to excess resources and identify numbers and types of individuals.

(2) State data from and for periods on or after January 1, 2014 must only be for individuals determined eligible and enrolled under §435.119 of this chapter, must compare individuals' resources to the applicable December 1, 2009 resource criteria to establish denial rates specifically due to excess resources, and identify numbers and types of individuals.

(iv) Describe the State data on individuals' resources used and the application of such data. Whether such State data is based on data described in paragraph (d)(2)(iii)(A) or (B) of this section, such State data must represent sampling results for a period of sufficient length to be statistically valid.

(v) Provide that the resource proxy methodology will account for the treatment of resources in a statistically valid manner when there is a lack of sufficient information to make a resource determination for a particular individual in a sampled population.

(vi) Describe the application of the resource proxy methodology in establishing the amount and submission of claims for Federal funding by the State for the medical assistance expenditures of the applicable eligibility group(s). Such claims submitted under the resource proxy methodology must reflect the appropriate FMAP for the medical assistance expenditures of the affected eligibility group(s).

(vii) As appropriate, describe and demonstrate the statistical validity of the resource proxy methodology and the use of data under such methodology.

(3) Effective date for application of resource proxy. The resource proxy shall not be effective prior to the beginning of the quarter in which such resource proxy is submitted to CMS under the threshold methodology State plan in paragraph (h) of this section.

(4) One time election for resource proxy. The election, application, and description of a resource proxy methodology under this paragraph for individuals determined eligible under §435.119 must be included in a one-time submission of a State plan amendment submitted under paragraph (h) of this section no later than one year from the first day of the quarter in which eligibility for individuals under §435.119 of this chapter is initially effective for the State.

(e) Enrollment caps adjustment. (1) Scope. Certain States may have applied enrollment caps, limits, or waiting lists in their Medicaid programs as in effect on December 1, 2009. Under the definition of newly eligible individual in §433.204(a)(1), such States must consider as newly eligible those individuals eligible under §435.119 of this chapter who would otherwise be eligible for full benefits, benchmark coverage, or benchmark equivalent coverage provided through a demonstration under the State plan effective December 1, 2009, but would not have been enrolled (or would have been on a waiting list) based on the application of an enrollment cap or limit determined in accordance with the approved demonstration as in effect on that date. Such States must only apply such enrollment cap, limit or waiting list provisions with respect to eligibility category or categories for which such provisions were applicable (for example,

nonpregnant childless adults or parents/caretaker relatives) and in effect under the State's Medicaid program on December 1, 2009. For this purpose, individuals who would have been on a waiting list are considered as not enrolled under the demonstration.

(2) A State for which multiple enrollment caps or limits were in effect under its December 1, 2009 Medicaid program may elect to combine such enrollment caps or limits, unless such treatment would preclude claiming of Federal funding at the applicable FMAP rate required under §433.10(b) or (c) (for example, to distinguish claims for childless adults and parents in an expansion State) for the medical assistance expenditures of individuals determined eligible and enrolled under §435.119 of this chapter; a State with enrollment cap or limit provisions that would preclude combining enrollment caps or limit provisions must use separate caps; or, the State, at its option, may elect to use separate caps.

(3) For purposes of claiming Federal funding, with respect to each claiming period for which the State claims Federal funding for an eligibility category for which an enrollment cap or limit is applicable and in effect on December 1, 2009, the State must account for:

(i) The total unduplicated number of individuals eligible and enrolled under §435.119 of this chapter for the applicable claiming period.

(ii) The total State medical assistance expenditures for individuals eligible and enrolled under §435.119 of this chapter for the applicable claiming period.

(iii) The enrollment cap or limit in effect on December 1, 2009 for the eligibility category, determined in accordance with the approved demonstration as in effect on December 1, 2009.

(A) For States that elect under paragraph (e)(2) of this section to combine the enrollment caps, the enrollment cap is the sum of the enrollment caps for each eligibility group which is being combined.

(B) For States that elect to treat the enrollment caps separately under paragraph (e)(2) of

this section, each enrollment cap will be accounted for separately.

(C) The level of the enrollment cap will be as authorized under the demonstration in effect on December 1, 2009; or, if the State had affirmatively set the cap at a lower level consistent with flexibility provided by the demonstration terms and conditions, the State may elect to apply the lower cap as in effect in the State on December 1, 2009. If a State elects to use such an alternate State-specified enrollment cap, the State will provide CMS with evidence, in its State plan amendment submitted to CMS under paragraph (h) of this section, that it had affirmatively implemented such a cap. Whether the State uses the authorized cap or a lower, verifiable cap as in effect in the State consistent with the demonstration special terms and conditions, the amount of expenditures up to the proportion of the 2009 enrollment cap to the total number of currently enrolled people in the group would not be claimed at the newly eligible FMAP.

(4) States for which an enrollment cap, limit, or waiting list was applicable under their Medicaid programs as in effect on December 1, 2009, must describe the treatment of such provision or provisions in the submission to CMS for approval by CMS in accordance with the State plan requirements outlined in §433.206(h).

(f) Application of spend-down income eligibility criteria. (1) General. Certain States' Medicaid programs as in effect on December 1, 2009 may have included eligibility categories for which deduction of incurred medical expenses from income (referred to as spend-down) under the provisions of sections 1902(a)(10)(C) or 1902(f) of the Act was applied in determining individuals' Medicaid eligibility. Paragraphs (f)(2) and (3) of this section apply, for purposes of determining whether an individual enrolled under §435.119 of this chapter meets the definition of newly eligible under §433.204(a)(1), and for purposes of applying the appropriate FMAP under §433.10(b) or (c) for the medical assistance expenditures of the individual for which a spend-down eligibility category of a State effective on December 1, 2009 is applicable.

(2) Not newly eligible individual. For purposes of a State's spend-down provision, an individual enrolled under §435.119 of this chapter whose income before the deduction of incurred medical expenses is less than or equal to the applicable December 1, 2009 State spend-down eligibility income level that would have resulted in full benefits is considered not newly eligible. The FMAP applicable for the medical assistance expenditures of such an individual is the appropriate FMAP under §433.10(b) and (c) as applicable for an individual who is not newly eligible.

(3) Newly eligible individual. For purposes of a State's spend-down provision, an individual enrolled under §435.119 of this chapter whose income before the deduction of incurred medical expenses is greater than the applicable State spend-down eligibility income level is considered newly eligible. The FMAP applicable for the medical assistance expenditures of such an individual is the appropriate FMAP under §433.10(b) and (c) as applicable for an individual who is newly eligible.

(g) Special circumstances. States may submit additional proxy methodologies to CMS for approval by CMS in accordance with the State plan requirements outlined in §433.206(h).

(h) Threshold methodology State plan requirements. To claim expenditures at the increased FMAPs described in §433.210(c)(6) of (c)(8), the State must amend its State plan under the provisions of subpart B of part 430 to reflect the threshold methodology the State implements in accordance with the provisions of this section. The threshold methodology will be included as an attachment to the State plan and, explicitly and by reference, must:

(1) Specify that the threshold methodology the State implements is in accordance with this section;

(2) Specify that the threshold methodology the State implements accounts for the individuals determined eligible under the adult group in §435.119 of this chapter as a newly eligible individual or not newly eligible individual; and, on that basis, the State implements

appropriate tracking for purpose of claiming Federal Medicaid funding for the associated medical assistance expenditures.

(3) Reference the converted MAGI-based December 1, 2009 income eligibility standards and the associated eligibility groups, describe how the State will apply such standards and methodologies, and include other relevant criteria in the assignment of FMAP.

(4) Indicate any required provisions, or options and alternatives the State elects, with respect to:

(i) Treatment of resources, in accordance with paragraph (d) of this section;

(ii) Treatment of enrollment caps or waiting lists, in accordance with paragraph (e) of this section; and

(iii) Special circumstances as approved by CMS in accordance with paragraph (g) of this section.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: March 20, 2013.

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Marilyn Tavenner,

Acting Administrator,

Centers for Medicare & Medicaid Services.

Approved: March 26, 2013.

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Kathleen Sebelius,

Secretary,

Department of Health and Human Services.

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