THE HENRY J. KAISER FAMILY FOUNDATION

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Medicaid and the Uninsured

ISSUE BRIEF

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Financing Medicaid Coverage Under Health Reform:

What is in the Law and the New FMAP Rules

Under the Affordable Care Act (ACA), Medicaid plays a major role in covering more uninsured people. Most notably, the ACA expands Medicaid to nearly all low-income individuals under age 65 with incomes up to 138% FPL ($15,856 for an individual or $26,951 for a family of three in 2013). The June 2012 Supreme Court decision limited the ability of the federal government to enforce the requirement to expand Medicaid, effectively giving states the option whether to adopt the expansion. If all states implement the expansion, an estimated 21.3 million additional people could be covered by Medicaid and CHIP by 2022.[1] The expansion largely affects adults without children who could not qualify for Medicaid prior to the ACA (except in a handful of states with waivers) and many low-income parents. Due to provisions in the ACA to simplify enrollment and coordinate applications across health programs, more individuals who already are eligible for Medicaid under current rules may participate in the program.

Under the ACA, the federal government will finance 100% of the costs of those newly eligible for Medicaid from 2014 through 2016 and then the federal contribution phases down to 90 percent by 2020 and beyond. States would continue to pay the traditional Medicaid match rate for increased participation among those currently eligible. If all states adopted the expansion, total costs would be about $1 trillion over the 2013-2022 period, with the federal government paying 93 percent of the costs. State costs are expected to be small relative to increases in federal funds and relative to other state spending on Medicaid.[2] In addition, many states estimate net state savings relative to other offsets such as reductions in uncompensated care costs, shifts in state funded spending to Medicaid and positive economic effects.[3]

This brief examines the law and new regulations related to the match rates for coverage under the ACA.

» **Medicaid Matching Rates Under the ACA**: The ACA specifies match rates for different populations in Medicaid and CHIP. Overall, the regular Medicaid match rate applies to individuals eligible for Medicaid using rules in place on December 1, 2009; the higher newly eligible match rate applies to individuals made newly eligible for coverage under the ACA; a special expansion state match rate applies to certain states that had expanded coverage to adults statewide up to at least 100 percent FPL as of March 23, 2010, when the ACA was enacted. Special rates apply for CHIP and certain states with no new eligibles.

» **Proposed FMAP Claiming Regulations:** On August 17, 2011 CMS issued a proposed regulation that included key principles and a choice of three methodologies for states to use in identifying the applicable match rate for Medicaid enrollees without conducting shadow eligibility systems that would indicate if an applicant were newly eligible or eligible under rules in effect on December 1, 2009 (and therefore eligible for the regular match rate.)

» **Final Regulations:** Beginning January 1, 2014, the rule requires states to use the "threshold methodology" to claim the appropriate FMAP. The rule also addresses other factors that are applicable in determining the applicable FMAP such as benefits, timing of disability determinations, spend-down populations, enrollment caps as well as other special criteria. States are required to submit a State Plan Amendment to implement the threshold methodology. While the rule was issued as final, several elements are open for comments.

Medicaid Financing Under the ACA

The traditional Medicaid program is jointly funded by states and the federal government. The federal matching percentage (FMAP) varies by state (ranging from a statutory floor of 50 percent up to 73.4 percent for FFY 2013.) The FMAP is based on a formula in the law that relates the FMAP to a state's average personal income; states with lower per capita incomes on average receive a higher matching rate. For every $2 that states pay for a Medicaid-covered service, they receive at least $1 back from the federal government. The ACA specifies match rates for different populations in Medicaid and CHIP with much higher rates for adults made newly eligible for Medicaid by the ACA. These different rates are described below:

» **Regular Medicaid Matching Rate**: The regular Medicaid matching rate is determined by a formula that has been in place since the program was enacted in 1965. It ranges from 50 percent to 73.4 percent, and is designed to provide more federal support to states with lower per capita incomes. In 2014, it will continue to be used for individuals who qualified for Medicaid under the rules in effect on December 1, 2009.

» **Newly-Eligible Matching Rate**: The ACA provides 100 percent federal financing for those made newly eligible for Medicaid under the law. The federal match rate falls to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and then 90 percent in 2020 and beyond. Beginning in 2014, it is available for non-elderly adults with income up to 138 percent of the FPL who are not eligible for Medicaid under the rules that a state had in place on December 1, 2009. Since April 1, 2010, states have had the option of moving early to provide Medicaid coverage through a state plan amendment or through a waiver to people up to 133 percent of the FPL. States that take up the early option will receive the regular Medicaid matching rate for this population until January 1, 2014, and then still qualify for even more generous federal support.[4]

» **"Expansion" States Matching Rate**: The "expansion" or "transition" matching rate is designed to provide some additional federal help to "expansion" states (states that had expanded coverage to adults statewide up to at least 100 percent FPL as of March 23, 2010, when the ACA was enacted). These states can receive a phased-in increase in their federal matching rate for adults without children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults.[5] (Table 1)

Table 1. Enhanced Matching Rates for Parents and Childless Adults, 2014 and Beyond

Year	Newly-Eligible Parents & Childless Adults (up to 138% FPL)	Medicaid-Eligible Childless Adults in "Expansion" States Only (I.e., States that Had Already Expanded to Adults >100% FPL as of March 23, 2010)		
		Transition Percentage used to Calculate Enhanced Match	Example: State with 50% Original FMAP *Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]*	Example: State with 60% Original FMAP *Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]*
2014	100%	50%	75%	80%
2015	100%	60%	80%	84%
2016	100%	70%	85%	88%
2017	95%	80%	86%	88%
2018	94%	90%	89.6%	90.6%
2019	93%	100%	93%	93%
2020 on	90%	100%	90%	90%

» **Special Match Rate for States with No Newly-Eligible Individuals:** Expansion states that do not have any newly-eligible Medicaid beneficiaries because they already cover people up to 138 percent of the federal poverty level or higher will also (in addition to the expansion state match rate) receive a temporary (January 1, 2014 through December 31, 2015) 2.2 percentage point increase in their federal matching rate for all populations. It is likely that these states will include at least Massachusetts and Vermont, which already use Medicaid to provide coverage to people with income at or above 138 percent of the federal poverty level.

» **CHIP Matching Rate:** The CHIP matching rate is available for children who are covered through a Medicaid expansion or through a separate CHIP program. It ranges from 65 percent to 83 percent, and, in effect, it reduces the cost to a state of covering a child by 30 percent when compared to the regular Medicaid matching rate. It will remain available to states through the end of fiscal year 2015, and then assuming Congress extends funding for CHIP past that date, it will increase by an additional 23 percentage points (capped at 100 percent).

In addition, the ACA changes how financial eligibility is determined for Medicaid. Beginning January 2014, financial eligibility for many groups will be based on MAGI methods, as defined in the Internal Revenue Code. The move to MAGI aligns Medicaid financial eligibility determinations with the standards used to determine eligibility for premium tax credits and cost-sharing reductions through the Exchanges. Under the new ACA, states are not allowed to impose an asset or resource test.

Proposed FMAP Claiming Rules

On August 17, 2011 CMS issued a proposed regulation related to Medicaid eligibility, enrollment simplification and coordination under the ACA.[6] The proposed rule specified the federal matching rates for newly eligible individuals as well as the increased FMAP for expansion states. The goal was to establish a system for determining the appropriate matching rates for states without interfering with other goals of simplifying and streamlining the enrollment process. The guiding principles in the proposed regulation state that the selected methodology must provide accurate and valid application of the FMAP without systematic bias, minimize administrative burdens, take into account the programmatic and operational goals of the program and include data to tie expenditures to the related eligibility group for the appropriate FMAP.

CMS originally proposed to allow states to choose among three methodologies to identify newly eligible individuals whose expenditures qualify for increased FMAP. The first proposed methodology assessed whether individuals are "newly eligible" based on an approximation of the state's 2009 eligibility standards that have been converted to a MAGI-equivalent standard (the threshold method). The second proposal used a statistically valid sampling methodology across individuals in the new adult group and their related Medicaid expenditures to extrapolate which individuals are newly eligible. The third proposal calculated the proportion of individuals covered under the new adult group who are newly eligible, as compared to the state's December 2009 eligibility standards, by extrapolating from reliable data sources, such as the MEPS or MSIS.

CMS requested comments on alternative methods that should be considered, if it is advisable to allow states to choose a method or if HHS should identify a single method for all states and on methods or proxies that could be used to identify new versus current eligible beneficiaries for matching purposes related to asset limitations and disability determinations. The final rule related to eligibility, enrollment and coordination published on March 23, 2012 did not include specifications related to the FMAP provisions.[7]

Final FMAP Claiming Rules

On April 2, 2013, HHS issued a final regulation that implements and interprets the increased FMAP rates that will be applicable beginning on January 1, 2014.[8] The final rule address comments submitted related to the proposed rule but maintains the original goals and principles stated in the proposed regulation. The rule was issued as "final," but some sections are open for public comments through June 3, 2013. CMS will evaluate the comments and may make some revisions to the rule. Specific sections that are open for comment include the expansion state match rates, the treatment of disability, the resource criteria adjustment, the enrollment caps adjustment, the spend-down income eligibility criteria and the special circumstances wherein states may submit additional proxy methodologies to CMS for approval. The following summary outlines the major provisions of the rule:

FMAP Rates:

In accordance with the statutory provisions, the final rule outlines the newly eligible FMAP, the temporary 2.2 percentage point FMAP for certain states without any newly eligible individuals and the expansion state FMAP (the FMAP rates are described earlier in Table 1). An expansion state is defined as a state that as of March 23, 2010, offered health benefits coverage statewide to parents and non-pregnant, childless adults whose income is at least 100 percent FPL. Health benefits coverage must: have included inpatient hospital services; not have been dependent on access to employer coverage, employer contribution, or employment; and 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.

The preamble to the final regulation clarifies that CHIP funding is available for children ages six to 18 with family income between 100 percent and 133 percent of the FPL who are moved from separate CHIP programs into Medicaid under the ACA. There is also a clarification that foster care children up to age 26 who are eligible for Medicaid as former foster care children cannot receive the increased FMAP. Instead, states will receive their regular Medicaid match rate for this population.

"Threshold" Methodology:

Beginning January 1, 2014, the rule requires states to use the "threshold methodology" to claim the appropriate FMAP in a streamlined manner without requiring states to use shadow eligibility systems to determine if an individual also was eligible for Medicaid based on rules in effect in 2009. CMS determined that using a uniform methodology was more administratively feasible and consistent with guiding principles than allowing for a choice. The threshold methodology was determined to be the most accurate, efficient and least burdensome to administer. It also provides states with the most certainty because there is generally no retroactive adjustment process.

Under this method a state evaluates an individual's current income against converted MAGI income thresholds to determine if an individual could have been eligible for coverage as of December 1, 2009.
States are required to submit a state plan amendment (SPA) to implement the threshold methodology that includes the income-based determination and other adjustments such as enrollment caps in effect on December 1, 2009.[9]
The threshold method applies to the new adult eligibility category and not to other individuals eligible for Medicaid under other mandatory or optional eligibility categories.[10]

Other Key Elements:

Other elements that are applicable in determining the applicable FMAP include the following:

- **Benefit Criteria:** Individuals eligible for full Medicaid benefits, benchmark coverage or benchmark equivalent coverage as of December 1, 2009 will be eligible for the regular match rate and others will be considered newly eligible and eligible for the higher FMAP. Full benefits are defined as "not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an adult individual". To determine if an individual would 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 and CMS will review the state analysis and confirm the applicable FMAP. Individuals eligible for full benefits under a waiver or demonstration as of December 2009 are not newly eligible individuals and instead will receive the state's regular matching rate.
- **Income-Based Determination:** The individual income-based determination is based on a comparison of the individual's MAGI-based income to the income standard in effect on December 1, 2009, converted to an equivalent MAGI-based income standard. Individuals with MAGI-based income at or below the converted MAGI-based income standard will not be considered newly eligible and individuals with MAGI-based income that is greater than the converted MAGI-based income standard are newly eligible and eligible for the enhanced match rate.
- **Treatment of Disability-Related Eligibility Determinations:** The rule specifies that states must account for disability-related eligibility categories in effect in December 1, 2009 when determining the applicable match rates. However, if an individual meets the income threshold as a newly eligible adult, the state can claim the newly eligible match rate for that individual while the disability determination is being conducted. Once there is an actual determination of disability, the individual will be considered disabled effective on the date of the disability determination so the new FMAP rates would apply prospectively without any retroactive adjustments. The preamble of the regulation notes that CMS will need to work with the Social Security Administration to expedite determinations and will monitor states to ensure timely determinations of disability (given the incentives to delay the process to claim higher match rates).

- **Resource Criteria Proxy Adjustment:** The MAGI methodology prohibits asset limits, therefore some people who would otherwise not qualify based on December 1, 2009 rules could be newly eligible. The rule allows states to use a resource proxy methodology to adjust and account for individuals who would not have been eligible for Medicaid because of the application of resource criteria (asset test) in effect on December 1, 2009. The proxy must be based on existing state data related to denial rates due to excess resources or a one-time statistical sampling of resources of newly eligible beneficiaries. The proxy only applies to the "newly eligible group" (not to other groups) so this proxy has a very narrow application.
- **Enrollment Caps Adjustment:** Some states applied enrollment caps, limits or waiting lists in their Medicaid waiver programs as of December 1, 2009. The rule specifies that these caps must be accounted for in claiming the appropriate FMAP. The FMAP the state can claim is based on the ratio of those subject to the enrollment cap relative to the total enrolled in the new adult eligibility group. The regulation provides an example: if the total expenditures are $10 million for the new adult group of 4,000 childless adults and the cap in place on December 1, 2009 was 1,000 then the state would claim the regular match rate for 25 percent of the enrollees ($2.5 million) and newly eligible match rate for 75 percent of the enrollees ($7.5 million).
- **Application of Spend-Down Income Eligibility Criteria:** The final rule also clarifies the treatment of Medicaid programs in effect on December 1, 2009 that included eligibility categories that accounted for deductions of incurred medical expenses from income (referred to as spend-down). The rule specifies states can make FMAP claiming decisions based on income before the deduction of incurred medical expenses in determining if an individual qualifies for the regular or newly eligible FMAP.
- **Special Circumstances:** To allow for additional flexibility, states may submit additional proxy methodologies for approval by CMS.

Looking Ahead

Overall, the FMAP rule provides a process for states to claim the applicable FMAP under the ACA without the administrative burden of having to operate shadow eligibility determination systems. Beneficiaries should experience a more streamlined and coordinated enrollment process in applying for health coverage and the determination of the specific match rates should be determined behind the scenes. However, oversight and education will be important in ensuring that beneficiaries are enrolled in the category where they can receive a benefits package that matches their needs and not the category that draws down the best matching rate for the states.

Compared to the proposed rule with multiple options for states to choose among, the final rule specifies that states must use the threshold methodology but still allows for some state flexibility in the methodology related to accounting for assets and other special circumstances. Looking ahead, states will need to continue to work with CMS to file SPAs to implement the threshold methodology, apply for any other special proxies in making FMAP determinations and will also need to work with CMS to determine which state demonstration programs qualify as offering full benefits. In conclusion, CMS's FMAP rule still allows for public comment on key areas but marks an important step forward in the ACA implementation process.

This issue brief was prepared by Robin Rudowitz of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

Endnotes

[1] John Holahan, Matthew Beuttgens, Caitlin Carroll and Stan Dorn, The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis. Kaiser Commission on Medicaid and the Uninsured, November 2012. http://www.kff.org/medicaid/8384.cfm

[2] Ibid

[3] Data Note: Understanding the 50-State Cost and Coverage Estimates of the ACA Medicaid Expansion: Why Do They Vary from State Specific Estimates? Kaiser Commission on Medicaid and the Uninsured, January 2013. http://www.kff.org/medicaid/8384.cfm

[4] CMS released guidance on the new option on April 9, 2010. The letter is available at: http://www.cms.gov/SMDL.

[5] For estimates in The Cost and Coverage Implication of the ACA Medicaid Expansion: National and State-by-State Analysis cited above, Arizona, Delaware, Hawaii, Massachusetts, Maine, New York and Vermont were assumed to be eligible for the expansion state match rate. Under the regulations, CMS will evaluate demonstration waiver coverage meeting the expansion state definition to determine if they meet the "full benefits" criteria for purposes of determining the applicable FMAPs. States with waivers or state-funded programs that do not meet the "full benefits" criteria would not be eligible for the expansion state match rate and individuals in these coverage categories would qualify under the new adult group and receive the newly eligible match rate.

[6] Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010. A Proposed Rule by the Centers for Medicare & Medicaid Services on 08/17/2011. https://www.federalregister.gov/articles/2011/08/17/2011-20756/medicaid-program-eligibility-changes-under-the-affordable-care-act-of-2010.

[7] Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule. Kaiser Commission on Medicaid and the Uninsured, December 2012. http://www.kff.org/medicaid/8391.cfm

[8] Increased Federal Medical Assistance Percentage Changes Under the Affordable Care Act of 2010; Rule. http://www.gpo.gov/fdsys/pkg/FR-2013-04-02/pdf/2013-07599.pdf

[9] Conversion of Net Income Standards to MAGI Equivalent Income Standards, December 28, 2012. http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO12003.pdf

[10] The new adult eligibility category is found at Section 1902(a)(10)(A)(i)(VIII) of the Act.

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