ACA-related State Plan Amendments in Medicaid

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The Affordable Care Act (ACA) brought significant changes to the Medicaid program, including: expanded coverage opportunities for adults under 65 with incomes under 138 percent of the Federal Poverty Level (FPL);[1] new methodologies for determining and renewing eligibility;[2] and a streamlined single application process coordinating Medicaid with other insurance affordability programs such as eligibility for premium tax credits and cost sharing reductions.[3]

States must update their existing Medicaid state plans to implement these changes, regardless of whether they choose to implement the adult Medicaid expansion.[4] To facilitate the amendment process, the Centers for Medicare & Medicaid Services (CMS) created a repository of pre-printed Medicaid State Plan Amendments (SPAs) presented in an electronic, rather than paper, format. The SPAs address ACA-related consolidation of existing optional and mandatory eligibility categories, new coverage options, and required administrative changes to state Medicaid programs.[5]

These ACA-related SPAs require states to make important policy decisions which may expand or limit coverage for their Medicaid beneficiaries. This issue brief highlights some of the key state-policy decision points under the SPAs, and provides recommendations for advocates seeking to expand Medicaid eligibility in their states. For a complete list of ACA-related SPAs, please see the attached chart.

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[1] 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII). The ACA provides that the federal government pays 100% of the costs of covering these newly eligible adults through 2016, scaling down to 90% by 2020. 42 U.S.C. § 1396d(y)(1). These individuals must be under age 65, not pregnant, and not eligible under a disability category.

[2] 42 U.S.C. § 1396a(e)(14); 42 C.F.R. § 435.603.

[3] 42 U.S.C. § 18083; 45 C.F.R. § 155.405; CMCS Informational Bulletin, *Model Eligibility Application and Guidance on State Alternative Applications,* April 30, 2013, *available at* http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-30-2013.pdf.

[4] In *National Federation of Independent Business v. Sebelius (NFIB)*, the Supreme Court limited the federal government's enforcement authority if a state fails to implement the expansion. *NFIB*, 132 S.Ct. 2566 (2012).

[5] *See* CMS, Medicaid and CHIP Form Repository, Medicaid State Plan Eligibility PDF Forms (hereinafter CMS Repository), *available at* http://157.199.113.99/MMDLDOC/mac.html.

I. Background - State Medicaid Plans and Amendments

Medicaid is jointly administered by states and the federal government.[6] As part of this collaboration, states are required to develop state plans describing their Medicaid programs and compliance with federal law.[7] CMS must review and approve state plans, and any amendments to those plans (e.g. SPAs).[8]

A SPA consists of relevant excerpts from the existing state plan that the state wishes to modify, along with the proposed changes.[9] As part of the SPA evaluation process, CMS reviews the materials submitted with the SPA and any related provisions in the existing State Plan that may be impacted by the amendment(s).[10] CMS has 90 days to approve or disapprove the SPA or request additional information.[11] If CMS does not act within the specified time, the SPA is considered approved.[12] Alternatively, if CMS requests supplementary materials, the 90-day review period restarts from the day the state submits the additional information.[13] Once CMS approves a SPA, all documents related to it are posted on CMS' website.[14] Members of the public can request to review the entire administrative record.[15] SPAs become effective (and thus eligible for Federal Financial Participation (FFP)) either the first day of the quarter in which an approvable SPA is submitted or on the effective date approved by CMS.[16]

II. Opportunities for Stakeholder Participation in SPA process

Although CMS posts approved SPAs on its website, no federal requirements exist for public notice and comment for SPAs under development or review.[17] Some states require legislative review or approval for changes to the state Medicaid program, particularly if a fiscal impact exists, which may provide some opportunity for stakeholders to participate and provide feedback.[18]

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[6] 42 U.S.C. §1396.
[7] 42 U.S.C. §§ 1396-1, 1396a; 42 C.F.R. § 435.10.
[8] 42 C.F.R. §§ 430.10, 430.12(c)(2), 430.14. *See also* Jane Perkins, National Health Law Program, *Q & A – State Medicaid Plans* at 1 (Apr. 2006), *available at* http://healthlaw.org/images/stories/QA_State_Medicaid_Plans_2006.pdf.
[9] 42 C.F.R. § 430.12; CMS, *Dear State Medicaid Director* (Oct. 1, 2010) at 1 (Revised State Plan Amendment Review Process).
[10] *Id*.
[11] 42 U.S.C. § 1316(a)(1). A regional CMS office has the authority to approve a SPA, but only the CMS Administrator can deny a SPA. 42 U.S.C. § 1316(a)(1); 42 C.F.R. § 430.15(b), (c). *See also* Perkins, *supra* note 8, at 4-5.
[12] 42 C.F.R. § 430.16(a).
[13] *Id*.
[14] CMS posts SPAs approved after June 1, 2009 on its website. *See* CMS, *Medicaid State Plan Amendments*, *available at* http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Medicaid-State-Plan-Amendments.html.
[15] 42 C.F.R. § 430.18.
[16] 42 C.F.R. § 430.20(b).
[17] CMS, *supra* note 14.
[18] Perkins, *supra* note 8.

In the absence of transparency and public notice requirements, stakeholders must monitor their state Medicaid agencies to learn of SPAs in development and provide input. A state's Medical Care Advisory Committee (MCAC) may serve as a source of information and provide opportunities for stakeholder input on SPAs. Each state Medicaid agency must establish an MCAC to advise the agency about health and medical care services.[19] MCACs must include consumer groups and Medicaid enrollees.[20] Although no specific requirements exist for MCAC review of SPAs, under federal law MCACs must have "opportunity for participation in policy development and program administration."[21]

Separate rules apply to SPAs establishing Alternative Benefits Plans (ABPs), including a required "reasonable" public comment period.[22] The Deficit Reduction Act of 2005 allowed states the option of developing ABPs for certain Medicaid-eligible individuals. Only a few states selected this option, but under the ACA most of the newly eligible adult Medicaid expansion population will receive ABP coverage.[23]

III. Key Issues and Recommendations for Stakeholder Action

ACA-related changes provide states flexibility to either limit or expand coverage in their Medicaid programs. The following sections discuss several key provisions that states must implement and opportunities for expanded coverage.[24]

A. Pregnant Women

The ACA gives states flexibility about how to count pregnant women under the new income methodology (Modified Adjusted Gross Income or MAGI) required for the Children's Health Insurance Program (CHIP) and most Medicaid eligibility categories.[25] When a pregnant woman seeks coverage for herself, she is counted as one person plus the number of children she is expected to deliver.[26] However, under the new MAGI rules, if a pregnant woman is in the household of someone else seeking coverage,

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[19] 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.12.
[20] 42 C.F.R. § 431.12(d).
[21] 42 C.F.R. § 431.12(e).
[22] 42 C.F.R. §§ 440.305(d), 440.386. For more information on administrative procedures related to ABPs, see CMS, *Dear State Medicaid Director* (Nov, 20, 2012) at 4-5 (Essential Health Benefits in the Medicaid Program).
[23] 42 C.F.R. § 440.305(b). *See also* Michelle Lilienfeld, National Health Law Program, *Overview of HHS' proposed rule on benefits for the Medicaid Expansion population: A Step Guide for Advocates*, April 13, 2013, *available at* http://www.healthlaw.org/about/staff/michelle-lilienfeld/all-publications/overview-of-hhs-proposed-rule-on-benefits-for-the-medicaid-expansion-population-a-ste-guideffor-advocates#.UuvxcbTOTzA.
[24] For additional ACA-related SPAs, see CMS Repository, *supra* note 5.
[25] 42 U.S.C. §1396a(e)(14)(A); 42 C.F.R. §§ 435.603, 457.315.
[26] 42 C.F.R. § 435.603(b). *See also* Dipti Singh, National Health Law Program, *Q & A on Pregnant Women's Coverage under Medicaid and the ACA*, Nov. 8, 2013, *available at* http://www.healthlaw.org/publications/browse-all-publications/QA-Pregnant-Women-Coverage-Medicaid-and-ACA#.U0QEW1cVDzA.

states can opt to count her as one person, two people, or herself plus the number of children she is expected to deliver.[27]

How a state elects to calculate family size in its MAGI SPA can have a significant impact on eligibility. States that calculate family size by including the number of children expected to be delivered will result in a larger household size and a proportionately lower total household income, thereby facilitating Medicaid eligibility for household members.[28]

Example: John and Jane are married and expecting twins. Their combined household income totals $32,000 annually or approximately $2,700 per month. When Jane applies for Medicaid, her household size is 4 (Jane, two children she expects to deliver, and John). Thus her monthly income is 136% FPL.

John's household size will be determined according to the state's Medicaid SPA for counting pregnant women when another person in the household applies for coverage. If the state decides to count pregnant women as just one person, regardless of how many children are expected, John's Medicaid household size would be two (John, Jane). Thus, John's household income would equate to 206% FPL. However, if the state counts pregnant women as one plus the number of children expected, John's household size would be four. His income would then be at 136% FPL and he would likely qualify for Medicaid under the new adult expansion group.

Many states are still awaiting final approval of their ACA-mandated SPAs, including the method for counting pregnant women. However, states can amend their Medicaid state plans at any time, so stakeholders will have continuing opportunities to advocate for more inclusive eligibility policies.

B. Family Planning Services

Under the ACA, states have the option to offer limited-scope family planning coverage to individuals who are not pregnant and who meet income eligibility requirements established by the state.[29] These services, available to men and women, are reimbursable at a 90% federal match.[30] They include family planning services and

[27] *Id*. See also CMS Repository, *S10 MAGI-Based Income Methodologies*, *supra* note 5.
[28] The number of children a woman is expected to deliver adds to family size but does not impact the countable household income. Note the Medicaid MAGI rules for counting the household containing a pregnant woman do not apply to eligibility determinations for subsidies to help purchase health insurance through the Marketplaces. 26 I.R.C. § 36B(d)(1). Fetuses cannot be claimed as tax dependents and therefore do not count as members of the tax household. 26 I.R.C. §§ 151, 152. In the Marketplace, the birth of a child triggers a Special Enrollment Period. 45 C.F.R. § 155.420(d)(2).
[29] 42 U.S.C. § 1396a(ii).
[30] 42 U.S.C. § 1396b(a)(5).

supplies, screening and treatment for Sexually Transmitted Infections (STIs), contraceptive counseling, lab tests, and other services.[31]

The ACA allows states flexibility when considering the income and family size of an individual applying for family planning benefits.[32] Under proposed rules, states can calculate household size to include: (1) all of the members of the family; (2) only the applicant; or (3) the applicant's household size plus one, regardless of whether the state counts all the members of the family or only the applicant.[33]

In addition to household size, CMS' pre-print for this SPA presents states with a choice of whose income to count. States, using MAGI-based methodology, can consider either: (1) the income of only the applicant; or (2) the income of the applicant and all legally responsible household members.[34]

States can provide the broadest eligibility as well as confidential family planning by: (1) including every potential member in the household to determine household size; (2) increasing that household size by one; and (3) counting the income of only the applicant. Under these options, the applicant would have lowest possible income as a percentage of the federal poverty line.

Example: Tina is 17 and lives with her mother, father, and three brothers. Her family's total household income is $85,000, including the $5,000 Tina makes at her after school job.

The state where they live implemented a Family Planning SPA counting only the applicant's income. The state also elected to count all members of the applicant's household, plus one.

When Tina applies for family planning services provided under the SPA, her household size is seven – (Tina, plus one, her mother, father, and three brothers). However, her household income is $5,000, because the state does not count the income of the other household members when determining eligibility for family planning SPA services.

Tina's household income is 13% FPL for a household of seven.

[31] CMS, *Dear State Medicaid Director* (Apr. 16, 2014) (Family Planning and Family Planning Related Services Clarification); CMS, *Dear State Health Official* (July 2, 2010) at 1 (Family Planning Services Option and New Benefit Rules for Benchmark Plans).
[32] 42 U.S.C. § 1396a(ii)(3).
[33] 78 Fed. Reg. 4592 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. § 435.603(k)). *See also* CMS, *supra* note 31. The pre-print implements this provision even though the regulations are not yet final. *See* CMS Repository, *supra* note 5.
[34] *Id*.

There is no time limit for the enhanced federal match for the family planning state plan option; and, as an optional service, states can submit a family planning SPA at any time.

C. Former Foster Care Youth

The ACA requires states to extend Medicaid coverage to certain young adults who age out of foster care, up to age 26, who were both enrolled in Medicaid and in foster care under the responsibility of the state.[35] Youth who leave foster care prior to attaining age 18 (or a higher age established by the state) are not eligible under this category.[36] The new mandatory category differs from the existing, optional coverage known as "Independent Foster Care Adolescents."[37]

According to CMS's proposed regulation and guidance, states must extended Medicaid coverage only for those young adults who age out of a state's *own* foster care system. States may, but are not required, to provide coverage to former foster youth from other states.[38]

States that choose to cover all former foster youth help ensure that these highly vulnerable young people receive necessary medical and mental health services, even if they move from one state to another. Former foster children have significant medical and mental health needs, but are often transient and do not receive necessary care.[39] Moreover, if a former foster youth moves to a state that has not yet implemented the adult Medicaid expansion, that youth may have no coverage options at all.

D. Caretaker Relatives

States currently provide Medicaid to parents and caregivers in low-income families with a dependent child.[40] This helps ensure these individuals have access to necessary health care services for themselves and can, in turn, continue to care for their dependent child. While caretaker relatives have traditionally included parents,

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[35] 42 U.S.C. § 1396a(a)(10)(A)(i)(IX), 78 Fed. Reg. 4687 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. § 435.150).

[36] CMS, *Medicaid and CHIP FAQs: Funding for the New Adult Group, Coverage of Former Foster Care Children and CHIP Financing* at 3 (Dec. 2013), *available at* http://www.medicaid.gov/Federal-Policy-Guidance/downloads/FAQ-12-27-13-FMAP-Foster-Care-CHIP.pdf.

[37] 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XVII), 1396d(w). Sometimes referred to as the "Chafee option," states may cover individuals who are under age 21 (or at state option under 20 or 19) and were in foster care on their 18th birthday, or any reasonable classification of those individuals.

[38] 78 Fed. Reg. 4687 (proposed Jan. 22, 2013) (to be codified at 42 C.F.R. § 435.150); CMS, *Medicaid and CHIP FAQs, supra* note 36. *See also* CMS Repository, *supra* note 5.

[39] Amy Dworsky & Mark E. Courtney, *Homelessness and the Transition from Foster Care to Adulthood*, 2009, Child Welfare, vol. 88, no. 4, p. 23-56.

[40] 42 U.S.C. § 1396a(a)(10)(i)(I), 42 C.F.R. §§ 435.4, 435.110; MAGI methodologies apply to these parents and caretaker relatives.

grandparents, siblings or other relatives, states have the opportunity to expand this category.[41]

States can now extend Medicaid coverage to:

(1) domestic partners of the parent or other caretaker relatives, even after the partnership is terminated;
(2) other relatives of the child based on blood (including those of half-blood), adoption, or marriage; and
(3) any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.[42]

By expanding the definition of this category, state programs can provide services to individuals who perform the same roles as traditionally recognized caretakers, but have not had access to Medicaid coverage.

Conclusion

The ACA provides states flexibility when implementing new eligibility rules, categories, and processes. That flexibility provides consumer advocates and other stakeholders an opportunity to push for expanded coverage by urging states to opt for more inclusive eligibility policies. Although opportunities for stakeholder participation in the SPA process remain limited, the CMS Repository of pre-printed SPAs can serve as resource to evaluate SPA options and advocate for more inclusive policies.

[41] 42 C.F.R. § 435.4.
[42] 42 C.F.R. § 435.4. *See also* 77 Fed. Reg. 17194 (March 23, 2012); CMS Repository, *supra* note 5.

ACA-related State Plan Amendments

This chart summarizes the pre-printed State Plan Amendments (SPAs) available in the CMS repository.*

State Plan Eligibility Form	Summary of Options Available to States	Statute/Regulation
Mandatory categories and amendments		
Medicaid Administration: Single State Agency **(SPAs A1-A3)**	• Designation of single state agency • Delegation of authority to conduct eligibility determinations • Delegation of authority to conduct fair hearings	42 C.F.R. §§ 431.10, 431.11, 431.12, 431.50
MAGI-Based Income Methodologies **(SPA S10)**	• How to count a pregnant woman as a member of a household • Determining financial eligibility for current beneficiaries based on current monthly or projected annual income • Reasonable methods to determine income including a prorated portion of a reasonably predictable increase in future income and/or family size or account for a reasonably predictable decrease in future income and/or family size • The age used for children with respect to determining the Medicaid MAGI household under 42 C.F.R. § 435.603(f)(3)(iv)** • Option to include available cash support, exceeding nominal amounts, provided by the person claiming the individual as a tax dependent	42 U.S.C. § 1396a(e)(14) 42 C.F.R. § 435.603
Presumptive Eligibility by Hospitals **(SPA S21)**	• Identifying eligibility groups or populations for which hospitals will determine presumptive eligibility (PE) • Limits on PE time periods • Option to apply PE to other categories	42 C.F.R. § 435.1110

* *See* CMS, Medicaid and CHIP Form Repository, Medicaid State Plan Eligibility PDF Forms, *available at* http://157.199.113.99/MMDLDOC/mac.html.

** *See* NHeLP, *The Advocate's Guide to MAGI*, Sec. IV.C.2. (Feb. 14, 2014) *available at* http://www.healthlaw.org/publications/agmagi#.U3pA8CjyTzA.

Eligibility Groups-Mandatory Coverage: Parents and Other Caretaker Relatives **(SPA S25)**	• Options for defining caretaker relative • Options for defining dependent child • Income standard for eligibility • Option to apply PE to these categories • Additional qualified entities that may make PE determinations for these categories	42 U.S.C. § 1396a (a)(10)(A)(i)(I) 42 U.S.C. § 1396u–1(b), (d) 42 C.F.R. § 435.110
Eligibility Groups-Mandatory Coverage: Pregnant Women **(SPA S28)**	• Sets income standard for eligibility • Designates whether state will provide full scope or limited benefits for individuals who qualify in this eligibility group • Option to apply PE to these categories • Identifies additional qualified entities that may make PE determinations for this category	42 U.S.C. § 1396a (a)(10)(A)(i)(III), (IV) 42 U.S.C. § 1396a (a)(10)(A)(ii)(I), (IV), (IX) 42 U.S.C. § 1396u–1(b), (d) 42 U.S.C. § 1396r–1 42 C.F.R. § 435.116
Eligibility Groups-Mandatory Coverage: Infants and Children under Age 1 **(SPA S30)**	• Sets income standards for eligibility • Option to apply PE to these categories	42 U.S.C. § 1396a (a)(10)(A)(i)(III), (IV), (VI), (VII) 42 U.S.C. § 1396a (a)(10)(A)(ii)(IV), (IX) 42 U.S.C. § 1396u–1(b), (d) 42 C.F.R. § 435.118
Eligibility Groups-Mandatory Coverage: Adult Group **(SPA S32)**	• Describes eligibility group • Option to apply PE to these categories	42 U.S.C. § 1396a (a)(10)(A)(i)(VIII) 42 C.F.R. § 435.119
Eligibility Groups-Mandatory Coverage: Former Foster Care Children **(SPA S33)**	• Describes eligibility group • Option to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system • Option to apply PE to these categories	42 U.S.C. § 1396a (a)(10)(A)(i)(IX) 42 C.F.R. § 435.150

Optional categories		
Eligibility Groups-Options for Coverage: Individuals above 133% FPL **(SPA S50)**	• Describes eligibility group • Sets income standards for eligibility • Option to apply PE to these categories	42 U.S.C. § 1396a (a)(10)(A)(ii)(XX) 42 U.S.C. § 1396a(hh) 42 C.F.R. § 435.218
Eligibility Groups-Options for Coverage: Optional Coverage of Parents and Other Caretaker Relatives **(SPA S51)**	• Describes eligibility group • Sets income standards for eligibility	42 U.S.C. § 1396a (a)(10)(A)(ii)(I) 42 C.F.R. § 435.220
Eligibility Groups-Options for Coverage: Reasonable Classification of Individuals Under Age 21 **(SPA S52)**	• Describes eligibility group for one or more reasonable classifications of individuals under 21 who are not eligible under a mandatory category • Sets standards for eligibility	42 U.S.C. § 1396a (a)(10)(A)(ii)(I) 42 U.S.C. § 1396a (a)(10)(A)(ii)(IV) 42 C.F.R. § 435.222
Eligibility Groups-Options for Coverage: Children with Non IV-E Adoption Assistance **(SPA S53)**	• Describes eligibility group for children enrolled in non IV-E adoptions • Sets age limit on eligibility	42 U.S.C. § 1396a (a)(10)(A)(ii)(VIII) 42 C.F.R. § 435.227
Eligibility Groups-Options for Coverage: Optional Targeted Low Income Children **(SPA S54)**	• Describes eligibility group for Targeted Low Income Children • Sets income standard for eligibility	42 U.S.C. § 1396a (a)(10)(A)(ii)(XIV) 42 U.S.C. § 1396d (u)(2)(B) 42 C.F.R. §§ 435.229, 435.4

Eligibility Groups-Options for Coverage: Individuals with Tuberculosis **(SPA S55)**	• Describes eligibility group for individuals with tuberculosis • Sets income standard for eligibility	42 U.S.C. § 1396a (a)(10)(A)(ii)(XII) 42 U.S.C. § 1396a(z)
Eligibility Groups-Options for Coverage: Independent Foster Care Adolescents **(SPA S57)**	• Describes eligibility group for Independent Foster Care Adolescents • Sets age limit on eligibility	42 U.S.C. § 1396a (a)(10)(A)(ii)(XVII) 42 C.F.R. § 435.226
Eligibility Groups-Options for Coverage: Individuals Eligible for Family Planning Services **(SPA S59)**	• Describes eligibility for individuals seeking family planning services • Sets income standard for eligibility • Options for household size • Options for income counting methodology	42 U.S.C. § 1396a (a)(10)(A)(ii)(XXI) 42 C.F.R. § 435.214
Non-Financial Eligibility		
Non-Financial Eligibility: Citizenship and Non-Citizenship Eligibility **(SPA S89)**	• Options to extend reasonable opportunity to verify citizenship or immigration status • Option to furnish benefits on a date earlier than the date the notice is received by the individual (during the reasonable opportunity period) • Coverage for lawfully present pregnant women and individuals under 21	42 U.S.C. § 1396a (a)(46)(B) 8 U.S.C. §§ 1611,1612, 1613,1641 42 U.S.C. § 1396b (v)(2)-(4) 42 C.F.R. §§ 435.4, 435.406, 435.956