State Plan Under Title XIX of the Social Security Act

State: District of Columbia

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 03/04/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

TN – 13-20 Approval Date APR 25 2014 Effective Date – 01/01/2014

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Subject to Attachment D, refer to Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan.	N/A	N/A	Yes	
Disabled Persons, non-institutionalized	Subject to Attachment D, refer to Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan.	N/A	N/A	Yes	
Disabled Persons, institutionalized	Subject to Attachment D, refer to Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan.	N/A	N/A	Yes	
Children Age 19 or 20	Subject to Attachment D, refer to Attachment A, Column C, Line 4 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan.	N/A	N/A	Yes	
Childless Adults	Subject to Attachment D, refer to Attachment A, Column C, Line 5 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI conversion plan.	No	Yes	Yes	
				Yes	

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

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

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

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

1. ☒ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ☐ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☒ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☒ Applies a special circumstances adjustment(s).

   ☐ Does not apply a special circumstances adjustment.

2. The state:

   ☒ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ☐ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

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

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☐ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☒ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 08/06/2013.

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

The state:

☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will 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.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☒ Attachment C – Enrollment Cap Methodology
- ☒ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

Most Recent Updated Summary Information

for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan *

DISTRICT OF COLUMBIA

11/22/2013

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	Parents/Caretaker Relatives FPL %	200%	216%	yes	Part 1 of approved state MAGI conversion plan	SIPP
2	Non-institutionalized Disabled Persons FPL %	100%	102%	n/a	new SIPP conversion	SIPP
3	Institutionalized Disabled Persons SSI FBR%	300%	300%	n/a	gross standard	n/a
4	Children Age 19-20 FPL %	200%	216%	yes	Part 1 of approved state MAGI conversion plan	SIPP
5	Childless Adults FPL %	50%	$0	no	n/a	n/a

n/a: Not applicable.

* The numbers in the summary chart will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan.

Attachment A

Attachment D

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

District of Columbia Specific Methodology

For Claiming Expansion State and Newly Eligible FMAP

Using Proportional Claiming Methodology

December 12, 2014, as revised March 25, 2014

I. Purpose

The purpose of this proposal is to establish an approved, District of Columbia specific methodology to identify District of Columbia Medicaid program expenditures for individuals in the new adult group which qualify for enhanced "expansion state" and "newly eligible" FMAP in accordance with the Affordable Care Act (ACA) and 42 C.F.R. Part 433. As is more thoroughly discussed below, the District of Columbia's Medicaid program has long provided coverage to children up to age 19 to 300% of the Federal Poverty Level (FPL), 19 and 20 year olds up to 200% of FPL, pregnant women up to 300% FPL, and parents and caretakers up to 200% of FPL. Neither children up through age 20, pregnant women, nor parent/caretakers are eligible for Medicaid in the new adult group and therefore are not newly eligible and will not be claimed as such. Further, following enactment of the Affordable Care Act, the District expanded coverage to childless adults. Today, as an early expansion State, we provide Medicaid coverage to approximately 45,000 childless adults with incomes below 133% FPL. In addition, on December 1, 2009, the District operated two small waivers for a subset of childless adults. These two waivers had a combined enrollment cap of 2,322. Based upon these special circumstances, the District is submitting this proposed methodology pursuant to 42 C.F.R. § 433.206(g), which permits States to submit additional proxy methodologies when special circumstances exist.

The District's proposed methodology, consistent with the principles outlined by the Centers for Medicare and Medicaid Services (CMS) in the final FMAP methodology rule, is designed to meet the following goals:

- 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 without systematic bias in favor of either the state or the federal government.

- Promote administrative simplicity and minimize administrative burdens and costs to the states, the federal government, individuals and the health care system.

- Take into consideration the practical, programmatic and operational goals of the Medicaid program

- Be based upon sufficient data to identify, associate and reconcile expenditures with the related eligibility groups to which the FMAP's apply.

- Be clear and be developed and applied transparently by both the federal government and State.

42 C.F.R. § 433.206(b); *See* 78 Fed. Reg. 19923 (April 2, 2013)(Increased Federal Medical Assistance Percentage Changes under the Affordable Care Act of 2010, Preamble to Final Rule with Request for Comments).

II. Background Regarding Coverage of Newly Eligible Childless Adults

The District of Columbia is an Early Expansion State. Following enactment of the Affordable Care Act on March 23, 2010, the District of Columbia developed and submitted a State Plan Amendment (SPA) to CMS to expand coverage and provide an Alternative Benefit Plan (ABP) offering a benchmark benefits package to childless adults who meet the eligibility criteria under section 1902(a)(1)(A)(i)(VIII). To be eligible for coverage under the District's "New Adult" SPA, an applicant must be an individual who has income that does not exceed 133% of FPL and is:

> [U]nder age 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under Part A of title XVIII, or enrolled for benefits under Part B of title XVIII, and not described in 1902(a)(10(A)(i)(I) through 1902(a)(10(A)(i)(VII) of the Act.

The SPA and the Alternative Benefit Plan were approved by CMS on June 22, 2010, with an effective date of May 1, 2010. (*See* District of Columbia State Plan, Attachment 2.2.-A, Page 9b and Attachment 3.1C, approved June 22, 2010, attached). All individuals enrolled under this SPA receive benefits through a combination of fee-for-service and managed care, as outlined in the District of Columbia State Plan, Attachment 3.1.F. Upon enrollment, individuals have 30 days to select a health plan or they will be auto-assigned. Until a plan is selected or assigned, the beneficiary is enrolled in fee-for-service. Individuals who meet the eligibility criteria for the "New Adult" group are assigned to a unique Program Code in the 774 Program Code series.[1] Individuals who meet the eligibility criteria for the new adult group but who are exempt from mandatory enrollment in managed care, such as individuals who are medically frail with special medical needs, may opt out of managed care enrollment. If they do, they are placed in Program Code 774F and are assigned to a different payment category. Today, approximately 45,000 individuals are enrolled in the District's Medicaid program as childless, "New Adults" under Program Codes 774 and 774F. Of these, approximately 650 have opted out of managed care and receive

[1] The District assigns Program Codes to identify beneficiaries by eligibility category. Each beneficiary is assigned to a single program code during each span of eligibility. Each beneficiary's program code is used, in conjunction with other data elements, to determine how the claim is paid and how the District claims federal financial participation.

services through fee-for-service arrangements; approximately 1250 are receiving services through fee-for-service arrangements pending assignment to an MCO. Each beneficiary's eligibility is reviewed and renewed on an annual basis. Upon renewal or upon receipt of information reporting a change in life events, individuals who no longer meet the eligibility criteria for the childless "New Adult" category under Program Codes in the 774 series are either moved to a different program code or sent a notice of termination.

Prior to the expansion of Medicaid to childless "New Adults", the District of Columbia Medicaid program operated two small demonstrations. The first demonstration, known as the "1115 Childless Adult Waiver Program" was implemented in March 2003 and targeted childless adults age 50-64 with incomes at or below 50 percent of the Federal Poverty Level (FPL). The second demonstration, known as the "Program to Enhance Medicaid Access to Low-Income HIV-Infected Individuals (HIV 1115)" was implemented on November 5, 2004 and targeted District residents with an HIV+ diagnosis and incomes below 100% FPL. To preserve budget neutrality, both programs operated with identified enrollment caps. Pursuant to 42 CFR § 433.206(e)(2), the District has elected to combine the enrollment caps in these two demonstrations. Based upon an analysis of these two demonstrations submitted to CMS on May 21, 2013, the District has been informed that CMS agrees that the combined enrollment cap for these two programs is 2,322.[2]

As of December 1, 2009, these two demonstrations were the only pathways to Medicaid for a non-disabled, childless adult. Individuals who were enrolled in the 1115 Childless Adult Waiver Program and the Program to Enhance Medicaid Access to Low-Income HIV-Infected Individuals (HIV 1115) and who met the eligibility criteria of the new, childless adult group were transitioned to the childless "New Adult" group under the District's early option SPA and assigned to Program Code 774 or 774F (for fee-for service).

Today, in addition to coverage for childless "New Adults," the District's Medicaid program provides coverage to parents and caretakers up to 200% of the FPL. The District has provided this coverage since before December 1, 2009. Parents and caretaker relatives in this category are assigned to different Program Codes and are not eligible for coverage in the 774 Program Code Series. The District also expanded its Medicaid program to cover children up to age 19 with incomes up to 300% FPL and covers 19 and 20 year olds up with incomes up to 200% FPL -- and has done so since before December 1, 2009. These children also are assigned to different Program Codes. Parents or caretakers and children (up to age 21) are *not* "New Adults" and therefore are not newly eligible, and there are no parents, caretakers or children in the 774 Program Code Series.

In addition to the above, the District of Columbia provides Medicaid coverage to individuals who are aged, blind or disabled (ABD) who have incomes that are not greater than 100% FPL. To be eligible for ABD coverage, the individual's resources cannot exceed $4,000. Individuals who are eligible for ABD

[2] *See* Letter to Linda Elam, Deputy Director and Medicaid Director, District of Columbia Department of Health Care Finance from Kristin Fan, Acting Director, Financial Management Group, Centers for Medicare and Medicaid Services, August 6, 2013.

coverage are placed in Program Code 950. This coverage category was in existence on December 1, 2009 and notably, the income standard has not changed. Individuals who meet the criteria for Program Code 950 are not "New Adults" and therefore are not newly eligible. Individuals who meet criteria for Program Code 950 are not placed in the 774 Program Code Series.

III. Transition to MAGI Methodologies

The District opened DC Health Link, our State-based Exchange, for enrollment on October 1, 2013. To help promote efficient, coordinated enrollment in the Medicaid program through DC Health Link, the District sought and received CMS approval to implement the early adoption of the modified adjusted gross income (MAGI)-based eligibility determination methods effective October 1, 2013. Under the terms of the approved waiver as amended, the District also has permission and will extend the dates for the state's eligibility renewals scheduled for January 1, 2014 through June 30, 2014 for eligibility groups subject to MAGI methodologies. (*See* Letter to Linda D. Elam, PhD, MPH, Senior Deputy and State Medicaid Director from Marilyn Tavenner, CMS Administrator, dated June 18, 2013, and Letter to Linda D. Elam, PhD, MPH, Senior Deputy and State Medicaid Director from Cindy Mann, Director, CMCS, dated February 25, 2014, attached). Finally, the District received approval of an additional request for a waiver under 1902(e)(14) to allow for the seamless transition of "New Adult" enrollees who are currently enrolled under the early option State Plan to the "New Adult" group SPA (S32), approved on November 20, 2013, for implementation on January 1, 2014. (*See* Letter to Linda D. Elam, PhD, MPH, Senior Deputy and State Medicaid Director from Cindy Mann, Director, CMCS, dated January 20, 2013. Based upon the above, the District will transition new applicants and existing beneficiaries to MAGI- based eligibility as follows:

Table 1 – Application of MAGI Methodologies for New Applicants and Existing Beneficiaries

Effective Date	New Applicants	Medicaid Renewals
Prior to September 30, 2013	New applicants will be processed according to pre-ACA eligibility rules and processes.	Redeterminations for Medicaid beneficiaries with a renewal date on or before September 30, 2013 will be processed using pre-ACA eligibility rules and processes.
On or after October 1, 2013 – September 30, 2014	New applicants will be subject to MAGI-based eligibility rules to determine eligibility for Medicaid and Exchange Insurance Affordability Programs (IAPs). If an individual is determined eligible for MAGI-Medicaid or other IAP but has non-MAGI eligibility factors, the individual's application with be further processed as described in Section IV below.	

On or after October 1, 2014[3]	New applicants will be subject to MAGI-based eligibility rules to determine eligibility for Medicaid and Exchange Insurance Affordability Programs (IAPs). If an individual is determined eligible for MAGI-Medicaid or other IAP but has non-MAGI eligibility factors, the individual's application with be further processed in the automated eligibility system to determine eligibility for non-MAGI based Medicaid.	
On or after October 1, 2013 – December 31, 2013		If a current Medicaid beneficiary has a renewal date between October 1, 2013 and December 31, 2013, they will be redetermined based on pre-ACA Medicaid eligibility rules and processes. .
On or after January 1, 2014 – June 30, 2014	.	Pursuant to the District's amended approved waiver for early MAGI and deferral of renewals[4], if a current Medicaid beneficiary has a renewal date between January 1, 2014 – June 30, 2014, their renewal will be deferred for six (6) months. Renewals will be passive and will use post-ACA processes.
On or after July 1, 2014		For current beneficiaries with renewal dates on or after July 1, 2014, renewals with be passive and will use post-ACA processes.

[3] DHCF's timetable for the design, build and implementation of MAGI methodologies in the automated eligibility system has been extended due to the need to address system defects and to defer expected functionality to later releases. Consequently, the timetable for deployment of non-MAGI eligibility functionality in the automated system also needs adjusting. DHCF anticipates revising this timetable and will be submitting a formal plan to CMS. Until the District is able to process non-MAGI eligibility through the automated system, applications or renewals for MAGI individuals who indicate non-MAGI factors will be further processed in accordance with Section IV.

[4] See Letter to Linda D. Elam, PhD., MPH, Senior Deputy and State Medicaid Director from Marilyn Tavenner, CMS Administrator, dated June 18, 2013, and Letter to Linda D. Elam, PhD, MPH, Senior Deputy and State Medicaid Director from Cindy Mann, Director, CMCS, dated February 25, 2014, attached.

As part of its transition planning, the District has identified all program codes for eligibility categories that will transition to MAGI-based methods effective October 1, 2013. Effective October 1, 2013, new applicants who are screened using MAGI-based methodologies and that meet the eligibility criteria as "New Adults" under 42 C.F.R. § 435.119 will be assigned to Program Code 774D. DHCF will begin MAGI-based methodologies on October 1, 2013 and passive renewals effective July 1, 2014. Current beneficiaries will be screened for continuing eligibility as they come up for annual renewal or renewal based upon life event changes (change in income, status, household composition, etc.). Only those that continue to meet the eligibility criteria as childless "New Adults" will be assigned to Program Code 774D.[5]

IV. Processing Applications that Indicate Non-MAGI Factors

As noted above, beginning October 1, 2013, the District will begin processing new eligibility applications through an automated eligibility portal called DC Health Link. During Release 1, DC Health Link will have the capacity only to process MAGI –based eligibility and the new former foster care youth[6] and will assign appropriate program codes based upon eligibility factors and attributes. Because this system is automated, the assignment to a MAGI program code will happen automatically and in real time, in most cases. If a *new applicant* is found eligible based upon MAGI eligibility factors but also indicates non-MAGI factors (such as blindness, disability, need for long-term care), the individual will receive a notice informing them of the Medicaid eligibility determination and of the opportunity to apply for Medicaid under an optional eligibility group. At the same time, the individual's case will be flagged, and the case will be sent automatically to the Special Processing Unit for further manual processing for non-MAGI Medicaid coverage.

Effective October 1, 2013, the Special Processing Unit will be responsible for contacting the applicant and helping the applicant complete supplemental forms to determine eligibility for non-MAGI coverage. In evaluating ABD eligibility, the Special Processing Unit will first determine whether an individual meets financial eligibility standards for ABD coverage. If the individual meets financial eligibility standards, including the resource test, and has a current disability determination by the Social Security Administration, the individual will be found eligible for ABD coverage and will be disenrolled from Program Codes in the 774 series and placed Program Code 950.[7] If the individual does not have a

---

[5] DHCF will use Program Code 774H to identify "New Adults" who are determined eligible under rules for hospital-based presumptive eligibility.

[6] The District will begin processing applications for former foster care youth on January 1, 2014.

[7] This process is consistent with the process delineated in CMS' final eligibility rules published on March 23, 2012. As noted in the preamble, individuals who meet the eligibility requirements for coverage based on the applicable MAGI standard and who also meet the requirements for coverage under an optional eligibility group excepted from MAGI methods may first enroll in a MAGI eligibility group.

> However, while no individual may be required to provide additional information needed to determine eligibility based on disability or another MAGI-excepted basis, once eligibility on such basis is established, the individual would no longer be eligible for Medicaid on the basis of

current disability determination by the Social Security Administration, the applicant will also be referred for evaluation by the Medical Review Team (MRT) which is responsible for evaluating and determining disability using SSA standards for individuals. If the individual has met financial eligibility standards (income and resources) and the MRT finds that the individual is disabled, the individual will be found eligible for ABD coverage and will be disenrolled from Program Codes in the 774 series and placed Program Code 950. As noted above, individuals who qualify for coverage in Program Code 950 are not considered "New Adults."

If the individual meets all ABD coverage criteria but has income above 100% FPL or does not meet the resource test, the individual will remain in a 774 Program Code. Further, these individuals will be considered "New Adults" without further evaluation of their income. This is because the income standard for the ABD coverage category has remained at 100% FPL since December 1, 2009. While the income standard has remained the same, FPL levels have continued to rise annually. In 2009, 100% FPL for a household of one was equal to $10,830. In 2013, 100% of FPL for a household of one is equal to $11,490. Accordingly, an individual who is over 100% FPL in 2013 could never be under 100% FPL for 2009. Therefore, the District has determined that there is no need to compare the individual's MAGI-based current income to the income standard in effect for the ABD eligibility category in effect on December 1, 2009, converted to the equivalent MAGI-based income standard for the ABD eligibility category. Renewal for these individuals will be completed in accordance with the timetables in the District's transition plan.

Based upon the above, Program Code 774, 774F, 774H and 774D will include only childless "New Adults" who are newly eligible as defined by CMS.

V. Proposed Threshold Methodology Using Proportional Claiming

As an Early Expansion State the District of Columbia is already providing Alternative Benefit Plan coverage to approximately 45,000 childless adults in the 774 Program Code series. On January 1, 2014, the District must be able to apply a methodology that accurately identifies the program expenditures associated with individuals who are and are not newly eligible. Pursuant to 42 CFR §433.204(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 the Chapter and who, as determine 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 demonstrations 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

---

MAGI (unless his or her circumstances changed), but would enroll in the program on the MAGI-excepted basis.

77 Fed. Reg. 17167 (March 23, 2012).

> §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.

Pursuant to the terms of the District's approved SPA, all childless adults in the 774 Program Code series have been determined eligible in accordance with the requirements of the adult group described in 42 C.F.R. §435.119. Thus, the issue of whether individuals in the "New Adult" group would not have been eligible for Medicaid under the State's eligibility standards and methodologies in effect on December 1, 2009 is ultimately controlled by the combined enrollment cap of the two small demonstrations that were in effect on that date. Assuming that all 45,000 childless adults currently enrolled in the 774 Program Code series are not newly eligible by virtue of the fact they are all childless adults who meet the income, age and HIV criteria for the demonstrations that were in effect on December 1, 2009, the District could never enroll more than 2,322 because of the combined enrollment cap. Accordingly, within the 774 Program Code series, the District's enrollment cap controls who is not newly eligible.[8]

According to CMS' final rule, when claiming FMAP for an eligibility category for which an enrollment cap or limit is applicable, the State must account for:

> (i) The total unduplicated number of individuals eligible and enrolled under 42 C.F.R. §435.119 (the new adult group) for the applicable claiming period.
>
> (ii) The total State medical assistance expenditures for individuals eligible and enrolled under 435.119 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, 2009.

See 42 C.F.R. § 433.206(e)(3).

States submit claims to CMS thirty (30) days after the end of the quarter using the CMS-64. However, total enrollment figures are not typically finalized for months after the end of the quarter. To minimize administrative burden for the District and CMS, apply the applicable FMAPs to actual expenditures as accurately as possible without bias in favor of either the state or the federal government, take into account the practical, programmatic and operational goals of the Medicaid program and base claims upon sufficient data to identify, associate and reconcile expenditures with the related eligibility groups to which the FMAPs apply, the District proposes the following:

---

[8] While the threshold methodology requires that States first undertake an individual screen of each applicant's income, individuals in Program Codes in the 774 series are already receiving Medicaid and based upon the terms of our waiver, will not be subject to renewal until July 1, 2014 at the earliest. The District does not have the system capacity to undertake these individual screens prior to January 1, 2014. Yet, even if we were able to do so, once we found 2,322 individuals who met the income criteria, all other childless adults will be newly eligible, regardless of whether they meet the eligibility criteria of either waiver. Accordingly, given the size of the "New Adult" Program Group, the enrollment cap is controlling with respect to defining who is not newly eligible.

1. To meet the requirements of 42 C.F.R. §433.206(e)(i), use the total unduplicated number of individuals eligible and enrolled under 42 C.F.R. §435.119 as of the last month of the quarter ending six (6) months prior to the first day of the quarter for which claims are filed. The Table below details the applicable dates for CY 14. The same dates would be used in subsequent years. The total unduplicated number of individuals eligible and enrolled is represented by "T" in the formula below.

Quarter	Applicable Date for Identification of Enrollment
January 1 – March 31, 2014	June 30, 2013
April 1 – June 30, 2014	September 30, 2013
July 1 – September 30, 2014	December 31, 2013
October 1 – December 31, 2014	March 31, 2014

2. To meet the requirements of 42 C.F.R. §433.206(e)(ii), use the State medical assistance expenditures for individuals eligible and enrolled in Program Codes 774, 774F, 774H and 774D under 42 C.F.R. §435.119 for the applicable claiming period. The medical assistance expenditures for the applicable claiming period is represented by "E" in the formula below.

3. To meet the requirements of 42 C.R.F. §433. 206(e)(iii), use an enrollment cap of 2,322, representing the combined enrollment cap of the two demonstrations. The enrollment cap is represented by "C" in the formula below.

The proportion (P) of claims eligible to be claims at the expansion state FMAP would be equal to the enrollment cap divided by the total unduplicated enrollment for the period defined above, or P = C/T. The remaining claims for individuals enrolled pursuant to 42 C.F.R. §435.119 would be claimed at 100% (the newly eligible FMAP). The District then proposes to use CMS' formula to arrive at the total amount of expenditures to be claimed by the District for individuals enrolled pursuant to 42 C.F.R. §435.119. Specifically:

Newly Eligible Claims for Childless Adults at 100% newly eligible FMAP = (1-P) x E x Newly Eligible FMAP

The remainder would be claimed at the applicable expansion state FMAP.

The above formula achieves the objectives of the threshold methodology established in CMS' final rule, promotes administrative simplicity and minimizes administrative burdens and costs to the states and to the federal government. It further is based upon sufficient data to identify, associate and reconcile expenditures with the related eligibility groups to which the FMAP's apply. Accordingly, the District of Columbia respectfully requests approval of this methodology.

Attachment D