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**Medicaid and CHIP FAQs: Funding for the New Adult Group,  
Coverage of Former Foster Care Children and CHIP Financing**

*December 2013*

**Funding for the New Adult Group**

**Q1: What do states need to do to assure availability of federal funding for the new adult group in 2014?**

**A1:** We are working with states to help them complete all of the steps needed to implement the new adult group on January 1, 2014. States need to make changes and updates to their Medicaid state plan (and sometimes waiver programs) as expeditiously as possible, so they can accurately determine who is eligible, assist individuals with enrollment, contract with health care plans, provide access to quality care health care for their beneficiaries, and receive federal financial assistance for these costs. They will also need to submit state plan amendments (SPAs) describing how they will claim the appropriate federal medical assistance percentage (FMAP) for expenditures for the new adult group. In addition, states will need to submit their budget estimates related to the new adult group, so CMS can provide funding at the appropriate levels.

**Q2: Can you describe the process for providing funding for the new adult group?**

**A2:** As states compile their budget estimates for the first calendar quarter of 2014, or for future quarters, states that will adopt the new adult group should include in those estimates the impact of the increased newly eligible FMAP rates available for the new adult group. CMS typically issues quarterly grant awards prior to the beginning of the quarter, so that states can make payments to Medicaid providers during the quarter. We will issue grant awards associated with expenditures related to the new adult group once eligibility SPAs reflecting the new adult group have been approved and the associated FMAP SPAs have been submitted.

For states that have not yet reached these milestones, CMS can quickly issue supplemental grant awards once the new adult group SPA is approved and the FMAP SPA is submitted. States expanding coverage are likely to achieve these milestones early in the quarter but, as always, SPAs do not need to be submitted until the end of the quarter to be made effective retroactively to the beginning of the quarter. CMS is working with states to secure approval of new adult group eligibility SPAs on an expedited basis, and will provide technical assistance as needed so that states can submit their FMAP SPAs in a timely manner.

After the grant award reflecting estimated new adult expenditures is issued, states will be able to draw down federal funds during the quarter, in advance of submitting claims for such expenditures. Finally, as is our regular process, states can begin claiming for expenditures made during the quarter following the close of the quarter, subject to approval of all required eligibility, benefit, and FMAP SPAs. States that do not have approved SPAs can claim retroactively after approval is granted, as long as timely filing requirements are met.

States with waivers should note that, as always, waivers are prospective only – so any waiver changes need to be submitted and approved by January 1, 2014 if a state is trying to make coverage effective on that date.

**Q3: How will the grant funding process accommodate delays related to the milestones referenced above for the new adult group with respect to the SPAs or the funding requests?**

**A3:** Typically, grant awards exclude any amounts associated with unapproved SPAs. If the eligibility SPA for a state is approved after the initial grant award to the state was issued (and which, therefore, would not have included amounts for the new adult group), the state could subsequently submit a request for additional funds at any time during the quarter once the eligibility SPA was approved. We consider the approval of the eligibility SPA for the new adult group to provide the necessary basis and authority for this grant action. However, to ensure that states demonstrate they will be able to claim federal funds properly, grant awards will also be contingent upon the submission (but not approval) of an FMAP claiming SPA. These steps will enable states to draw down federal funds during the quarter. However, states must still have all applicable SPAs (eligibility, benefits, and FMAP) approved before they claim expenditures on the CMS-64 after the quarter has closed. If they don't, they can claim retrospectively once approval is granted, as long as timely filing requirements are met. It is important to note that retroactive claiming is not possible when eligibility is triggered by a section 1115 waiver.

**Q4: What FMAP applies to women enrolled in the new adult group who become pregnant?**

**A4:** We noted in a previous FAQ released on May 22, 2012 (available at: <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>), states are not required to track the pregnancy status of women enrolled in the adult group, and are not required to move them to the eligibility group for pregnant women if the state becomes aware of their pregnancy outside of the regular redetermination process. Women who become pregnant must be given the option of moving to the pregnancy-related coverage category, and states must inform women of the differences in coverage between the adult group and pregnancy-related coverage (including any differences in benefits, premiums and cost sharing) so that pregnant women can make an informed choice about reporting the pregnancy and changing their eligibility status between regular renewals. We clarify that, at a regularly scheduled renewal, states must determine whether a current beneficiary enrolled in the adult group meets all eligibility criteria to remain eligible in the adult group. If at that time the state is aware that a woman is pregnant (either because of ex parte information confirmed during the renewal process by the state or through the return of a pre-populated renewal form from the woman), she no longer would meet the requirements for eligibility under the new adult group and, if otherwise eligible for coverage based on pregnancy, must instead be enrolled in the pregnant women's group.

The state may give a pregnant woman the option to remain enrolled in the same alternate benefit package she is enrolled in through the new adult group, to minimize any disruption to her coverage or access to providers. Note that if the state covers any additional benefits for pregnant women under 42 CFR 440.250(p) not provided to other individuals eligible under the state plan, such benefits also must be provided to pregnant women enrolled in such alternative benefit package.

Between regular renewals, if a woman enrolled in the adult group who becomes pregnant does not elect to switch groups and remains in the adult group, her status for FMAP purposes (as newly eligible or not) is unchanged until her next regularly scheduled redetermination. If, consistent with the policy described above, her enrollment is transferred to the pregnant women's group either prior to or at the point of her regular renewal, regular FMAP would apply because she would no longer be in the adult group.

**Q5: What is the FMAP applicable for medical assistance authorized under section 1903(v)(2) of the Social Security Act that may be provided to low-income adults with income up to 133 percent FPL?**

**Q5:** Section 1903(v)(2) of the Social Security Act limits the availability of federal Medicaid matching funds for states' expenditures for medical assistance for certain individuals to expenditures for services furnished to treat an emergency medical condition. If such individuals meet the eligibility criteria for the Medicaid new adult group in the state to be considered "newly eligible" under the state's FMAP methodology for the new adult group, state expenditures consistent with section 1903(v) are matched at the newly eligible FMAP described in section 1905(y). This treatment for purposes of federal reimbursement is consistent with current law and regulation.

**Eligibility for Former Foster Care Children**

**Q1: Who is eligible under the eligibility group for former foster care children?**

**A1:** Section 2004 of the Affordable Care Act added a new mandatory group for former foster care children at section 1902(a)(10)(A)(i)(IX) of the Social Security Act (the Act). Proposed 42 CFR 435.150 of the January 22, 2013 proposed rule, available at <http://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-00659.pdf>, would codify the provisions of section 1902(a)(10)(A)(i)(IX). Under the statute, states must cover individuals under age 26 who were both enrolled in Medicaid and in foster care under the responsibility of the state or tribe upon attaining either age 18 or such higher age as the state or tribe has elected for termination of federal foster care assistance under title IV-E. We are interpreting the statute also to permit states, at their option, to cover individuals who were in foster care and receiving Medicaid in another state upon turning 18 or "aging out" of foster care in the other state, but are not required to do so. There is no income test for eligibility under this group.

**Q2: Can states cover individuals who left foster care before age 18, or who were not in foster care and Medicaid either upon turning 18 or upon "aging out" of foster care at a higher age, under this group?**

**A2:** States cannot cover individuals who left foster care before aging out under the former foster care children group. Section 1902(a)(10)(i)(IX) of the Act only provides Medicaid eligibility for individuals who were in foster care when they turned 18 or such higher age when the state's foster care assistance ends. Individuals who left foster care before age 18, or who were not in foster care and Medicaid either upon turning 18 or upon "aging out" of foster care at the higher age elected by

the state, are not eligible for coverage under this group. However, these individuals may be eligible under a different eligibility group.

**Q3: The proposed rule at §435.150 discusses the option for states to cover individuals who were in foster care and receiving Medicaid in another state upon turning 18 or “aging out” of foster care in the other state. However, proposed §435.150 was not included in the July 15, 2013 rule and therefore has not been finalized. Can states exercise this option before CMS issues a final regulation for §435.150?**

**A3:** Yes, we will approve state plan amendments to cover individuals who were in foster care and receiving Medicaid when they turned age 18 or “aged out” of foster care in another state. This option is provided in the state plan amendment (SPA) page (S33) for this group. Because this provision has not yet been finalized, if §435.150 is later finalized in such a way that conflicts with the state’s approved state plan amendment, a subsequent amendment to the state plan may be necessary (see 42 CFR §430.12(c)(1)(i)). The state would be able to receive federal financial participation for expenditures under an approved SPA if the policy later changed, until the state (within a reasonable period of time) had submitted a new SPA and modified its policies and procedures to comply with such change in federal policy.

**Q4: Does the former foster care group cover individuals who turned 18 or aged out of foster care prior to January 1, 2014?**

**A4:** Yes. Effective as of January 1, 2014, coverage is available to individuals under age 26 who meet the eligibility requirements described above. For example, an applicant who is 23 years old in January 2014 and who was in foster care and receiving Medicaid at the time he or she turned 18 (back in 2009) will be eligible for coverage under the former foster care group.

**Q5: If an individual who aged out of foster care at age 18 and was receiving Medicaid in the state at that time applies for Medicaid at age 24, would she be eligible under this group?**

**A5:** Yes.

**Q6: Are individuals who were in foster care and enrolled in Medicaid when they turned age 18 or aged out of foster care in a different state eligible under this group?**

**A6:** We do not believe the statute requires states to cover, under this group, individuals who were in foster care and enrolled in Medicaid when they turned age 18 or aged out of foster care in a different state. However, we believe the statute provides states the option to do so. As noted above, pending publication of a final regulation at §435.150, states may exercise the option proposed when they complete SPA page S33 for this group.

**Q7: At what age do individuals become ineligible for, or “age out of,” Title IV-E foster care assistance?**

**A7:** Title IV-E foster care stops either when the individual attains age 21 or attains age 20, 19, or 18, as specified in the state’s IV-E state plan.

**Q8: Who is considered to have be “in foster care” for purposes of eligibility under this group? Are children placed with a relative or in another non-licensed out-of-home placement, with respect to whom foster care payments are not being made, considered to be “in foster care”?**

**A8:** According to federal regulations at 45 CFR 1355.20, “Foster care means 24-hour substitute care for children placed away from their parents or guardians and for whom the [state or tribal] agency has placement and care responsibility. This includes but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and preadoptive homes. A child is in foster care in accordance with this definition regardless of whether the foster care facility is licensed and payments are made by the State, Tribal or local agency for the care of the child, whether adoption subsidy payments are being made prior to the finalization of an adoption, or whether there is Federal matching of any payments that are made.”

Receipt of foster care maintenance payments is not required for a child to be considered “in foster care” under this definition. Thus, children placed with a relative or in another non-licensed out-of-home placement, with respect to whom foster care maintenance payments are not being provided, may be considered to be “in foster care” according to this definition if they are also under the placement and care of the state or tribal agency.

This definition of “foster care” is contained in regulations implementing titles IV-B and IV-E of the Social Security Act. However, because the federal regulations implementing titles IV-B and IV-E require state and tribal title IV-E agencies to agree to certain program requirements for all children in foster care, this definition applies to all foster care provided in a state or tribe, even that which is provided without federal financial participation.

**Q9: Are individuals with respect to whom federal guardianship payments under section 473(d) of title IV-E of the Social Security Act were being paid and who were receiving Medicaid when the individual turned 18 (or such higher age as the state elected under title IV-E) eligible for coverage under the former foster care group?**

**A9:** No. Federal guardianship assistance payments provided under section 473(d) of title IV-E of the Act are not considered federal foster care maintenance payments. Because the title IV-E agency no longer has placement and care responsibility for youth receiving such payments, these youth are not considered to be in foster care and therefore would not be eligible for coverage under the former foster care group.

**Q10: Do MAGI-based methodologies apply to determining eligibility for the group for former foster care children up to age 26? Will states need to consider their parents' income?**

**A10:** There is no income test for eligibility under this new mandatory group for former foster care children. Therefore, MAGI-based methodologies are not relevant and states do not need to consider the parents' (or even the individual's own) income for purposes of Medicaid eligibility.

**Q11: Are states permitted to apply an asset test for eligibility under the group for former foster care children?**

**A11:** No. States may not impose an asset test for eligibility under the former foster care group.

**Q12: What is the difference between the mandatory group for former foster care children under section 1902(a)(10)(A)(i)(IX) (proposed §435.150) and the optional group for independent foster care adolescents under section 1902(a)(10)(A)(ii)(XVII) (proposed §435.226)? Can states that currently cover the optional group delete it from their state plan?**

**A12:** While there is significant overlap in eligibility under the two groups, the mandatory group for former foster care children does not completely subsume or replace coverage under the optional group, and states that currently cover the optional group for independent foster care adolescents must continue to do so until the maintenance of effort for individuals under age 21 has expired in accordance with section 1902(gg) of the Act.

The coverage of former foster care individuals ages 18-25, set forth at proposed §435.150, covers individuals who were either receiving IV-E or non-IV-E foster care and were enrolled in Medicaid either when they turned age 18 or aged out of foster care. As noted in an earlier question, states have the option, but are not required, to cover individuals who were in foster care and enrolled in Medicaid in another state when they turned 18 or aged out of foster care.

The optional coverage for independent foster care adolescents, set forth at proposed §435.226, covers individuals age 18-20 who were in IV-E or, at state option, non-IV-E foster care when they turned age 18. Eligibility under the optional group does not require the individual to have been enrolled in Medicaid when they turned 18, nor are they required to have been in foster care in the same state in which they are seeking coverage under this group. Unless the state has elected to eliminate the income test for this group (by disregarding all income under section 1902(r)(2) of the Act), eligibility for this optional group is subject to the MAGI-based methods described at §435.603.

As noted, the mandatory group will largely subsume the optional group, but there are some differences:

- The mandatory group at §435.150 must be applied to individuals who were in state-only funded or IV-E foster care. The optional group at §435.226 applies to individuals who were receiving IV-E foster care and, at state option, individuals who were in state foster care.
- The mandatory group requires that the individual have been enrolled in Medicaid while in foster care when s/he turned 18 or aged out of foster care; the optional group only requires that the individual have been in foster care when they turned 18.
- Eligibility for the mandatory group goes up to age 26; the optional group goes up to age 19,

- 20, or 21 (state option).
- There is no income test for the mandatory group. There is an income test for the optional group. Currently, the income standard for the optional group is based on the AFDC payment standard, although most states that cover this group apply a block of income disregard under section 1902(r)(2) of the Act to raise the effective income standard, and in some cases to eliminate it. This standard will be converted to a MAGI-equivalent standard effective in 2014, and additional disregards will no longer be permitted. States that have effectively eliminated any income test for this optional group may continue that policy in 2014.

**Q13: Are individuals eligible for Medicaid under the former foster care group eligible for EPSDT?**

**A13:** Individuals under age 21 who are eligible under the group for former foster care children are covered for EPSDT services. Individuals ages 21 – 25 who are eligible under this group are not covered for EPSDT services.

**Q14: Does this eligibility category effectively impose a requirement on states to maintain a roster of former foster care young adults receiving Medicaid when they turned age 18 or “aged out” at a higher age, which states would need to check for all applicants under age 26? If not, how can states operationalize eligibility under this group?**

**A14:** States have broad flexibility under the final regulations at §435.956 regarding verification of non-financial eligibility requirements, other than citizenship and immigration status. States may, for example, accept self-attestation of the former foster care status and enrollment in Medicaid required for eligibility under this group.

In addition, §435.952(c)(2)(ii) provides that the state may not require paper documentation unless electronic data to verify the individual’s status as a former foster care individual is not available and establishing such a data match would not be effective. States that do not currently have an electronic data base that could be used for verifying an applicant’s former status as a foster care child receiving Medicaid should consider the effectiveness of developing such capability in accordance with the regulations. The 90/10 federal match for systems development would be available for this purpose through December 2015, as outlined in 42 CFR Part 433, available at <http://www.gpo.gov/fdsys/pkg/FR-2011-04-19/pdf/2011-9340.pdf>.

We note that, over time, verification of former foster care status may become less important at the point of application because, in accordance with sections 471(a)(16) and 475(1)(D) and (5)(H) of the Act, Title IV-E/B agencies are required to assist and support a foster youth in developing a transition plan during the 90-day period before the youth attains age 18, or if applicable, before the later age elected by the state or tribe, that addresses specific options for the youth, including health insurance coverage. We encourage child welfare agencies and state Medicaid agencies to begin incorporating coverage under this group in the transition planning for foster care youth as soon as practicable. More information about transition planning requirements for youth in foster care can be found in Section C of ACYF-CB-PI-10-11, available at [http://archive.acf.hhs.gov/programs/cb/laws\\_policies/policy/pi/2010/pi1011.htm](http://archive.acf.hhs.gov/programs/cb/laws_policies/policy/pi/2010/pi1011.htm).

**Q15: Can individuals who meet the requirements both for the group for former foster care children and the new adult group at 42 CFR 435.119 be enrolled in either group?**

**A15:** No. In accordance with section 1902(a)(10)(G) of the Social Security Act, eligibility under the group for former foster care children takes precedence over eligibility under the new adult group. Thus, individuals who meet the requirements for both of these groups must be enrolled under the group for former foster care children.

**Q16: Is the 100% federal matching rate (FMAP) available for individuals who are newly-eligible under the former foster care group?**

**A16:** No. Under the law, the state's regular federal matching rate applies for individuals eligible under the former foster care group.

### **CHIP Financing**

**Q1: How did the Affordable Care Act (ACA) revise funding for the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act?**

**A1:** Section 2101(a) of the Affordable Care Act amended section 2104(a) of the Social Security Act to extend title XXI funding for states' CHIP fiscal year allotments through September 30, 2015, the end of federal fiscal year (FY) 2015. The new law also amended section 2105(b) of the Social Security Act to increase the enhanced Federal Medical Assistance Percentage (Enhanced FMAP) rate by 23 percent applicable for certain expenditures for the period FY 2016 through FY 2019, but in no case will the enhanced FMAP exceed 100 percent. In the absence of additional legislation, the FY 2015 allotments would continue to be available through September 30, 2016. The Secretary also has the authority to redistribute prior unexpended allotments to states experiencing shortfalls.

**Q2: Will states have an opportunity to expand CHIP eligibility coverage levels above 200 percent of the Federal Poverty Level (FPL) not to exceed 300 percent of the FPL using block disregards before December 31, 2013, the date for which Modified Adjusted Gross Income (MAGI) applies?**

**A2:** Yes. States have a limited opportunity to expand CHIP eligibility without a section 1115 demonstration (through the use of a block of income disregard) that will then get incorporated into a MAGI converted eligibility level. Any state interested in expanding CHIP eligibility above 200 percent of the FPL must submit a state plan amendment (SPA) before December 31, 2013. After such time, states could expand eligibility through a demonstration. (Of course, if a state has not already expanded eligibility to 50 percentage points above the MAGI-converted Medicaid income level that was in effect in 1997, that option for expansion without demonstration authority will remain available after December 31, 2013.)



**Q3: Will the expenditures for children currently enrolled in a separate CHIP whose income is up to 133 percent of the FPL, who are transitioned to the Medicaid program beginning January 1, 2014 under the mandatory eligibility group for poverty-level related children required under section 1902(a)(10)(A)(i)(VII) of the Act, be eligible for the CHIP enhanced FMAP after such transition?**

**A3:** Yes. The CHIP enhanced FMAP will continue to be available for the expenditures for children shifted from CHIP to Medicaid, as long as their income is greater than the state's March 31, 1997 Medicaid income standard for children. In other words, if CHIP funding was available for this group of children when they were covered in a separate CHIP, it will continue to be available when the children are covered under Medicaid. The CHIP enhanced FMAP is available for uninsured children whose income exceeds that income standard, whether the children previously qualified for or were enrolled in a separate CHIP program or not.

**Q4: Are states required to cover new applicants who have insurance under the mandatory coverage level for children ages 6-18 in Medicaid up to 133 percent FPL?**

**A4:** Yes, consistent with Medicaid coverage rules. States must cover children ages 6-18 in the new mandatory Medicaid group and Medicaid is the secondary payer to other insurance. All children must be covered without regard to their insurance status but title XIX funds must be used to cover such children who have creditable health insurance.

**Q5: Will states be eligible to receive the enhanced CHIP FMAP for children who were previously eligible for CHIP but will now be enrolled in Medicaid as a result of the 5 percent disregard (applied to the Medicaid upper income threshold for children)?**

**A5:** Yes. As with children who move from a separate CHIP to Medicaid because of the change in Medicaid eligibility to 133 percent FPL, children moving from CHIP to Medicaid because of the application of the 5 percent disregard may also be funded through title XXI.

**Q6: Will states be eligible to receive the enhanced CHIP FMAP for children who lose Medicaid eligibility due to the elimination of income disregards as a result of the conversion to MAGI under 2101(f)?**

**A6:** Yes. As stated in the Frequently Asked Questions pertaining to this provision posted on April 25, 2013, states may claim the enhanced match available under title XXI for children who lose Medicaid eligibility due to the elimination of income disregards as a result of the conversion to MAGI. These children now meet the definition of a targeted low-income child and will be enrolled in a separate CHIP in accordance with section 2101(f) of the ACA. If states choose the option to maintain Medicaid eligibility for such children, as described in Frequently Asked Questions posted on August 9, 2013, title XIX funds and regular FMAP must be used to provide coverage.

**Q7: Are states allowed to claim enhanced FMAP for enrollees whose family income is above 300 percent of the FPL?**

**A7:** Generally, no. Section 2105(c) (8) of the Social Security Act limits enhanced FMAP to the expenditures associated with children whose effective family income is at or below 300 percent FPL. Expenditures for children whose effective family income exceeds 300% of the FPL are matched at the regular Medicaid FMAP rate rather than the enhanced FMAP. However, the enhanced matching rate continues to be available for expenditures on populations whose income exceeds 300% FPL in states in which the income standard exceeds 300 percent as a result of MAGI conversion, as well as for states with approved income limits for CHIP above 300% of the FPL prior to the passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA).

**Q8: At state option, are states allowed to claim title XIX funding instead of title XXI for services provided under a Medicaid expansion program?**

**A8:** Yes. Section 115 of CHIPRA gives states the option to claim expenditures for Medicaid expansion program populations under section 1905(u)(2)(B) of the Act, either at the enhanced FMAP rate using title XXI funds or at the regular FMAP rate using title XIX funds. States that elect to claim expenditures under title XXI will receive the enhanced FMAP rate. However, states that elect to claim expenditures under title XIX will receive the regular Medicaid FMAP rate. Claims submitted at the enhanced FMAP rate will be paid from the state's CHIP allotment.

**Q9: Will states be allowed to continue to cover parents and receive the enhanced CHIP FMAP for those expenditures?**

**A9:** States are no longer allowed to cover parents in CHIP after September 30, 2013 and therefore, are no longer eligible to receive the enhanced CHIP FMAP for expenditures for parents.