DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

JAN 13 2014

Theresa Arcangel
Administrator
Guam Department of Public Health and Social Services
123 Chalan Kareta
Mangilao, GU96913-6304

Dear Ms. Arcangel:

The Affordable Care Act contains provisions for increases to federal medical assistance percentage (FMAP) rates that may be available for matching the expenditures that are incurred by jurisdictions in their Medicaid programs, potentially including commonwealths and territories. Such increased FMAPs include those available to help pay for coverage of low-income adults who are enrolled in Medicaid as part of the new low income adult group described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act), for jurisdictions that cover individuals under such new group. This letter describes these increased matching rates that may be available to territories and describes the process by which Guam may establish eligibility to claim expenditures at the applicable increased FMAPs. Please note that eligibility for the increased FMAPs does not alter otherwise applicable spending limits for Guam under section 1108 of the Act.

Territories are not eligible to receive the increased FMAP specified under section 1905(y)(1) of the Act, which by statute is only available to the 50 states and the District of Columbia for "newly eligible" individuals covered under the new Medicaid adult eligibility group. However, territories that adopt the new adult eligibility group may qualify to have certain expenditures for individuals enrolled in that group matched at the increased FMAP specified under section 1905(z)(2) of the Act, if they meet the definition of "expansion state" described in section 1905(z)(3) of the Act. Furthermore, as described in section 1905(z)(1) of the Act and discussed further below, territories that meet the expansion state definition in section 1905(z)(3) of the Act may qualify for a temporary 2.2 percentage point increase in their regular FMAP rate.

The increased "expansion state" FMAP described in section 1905(z)(2) is available to qualifying states (including the territories) for expenditures for certain nonpregnant childless adults (those who are enrolled in the new adult group and receive benchmark or benchmark-equivalent coverage). A qualifying state is one that, as of March 23, 2010 (the date of enactment of the Affordable Care Act), had provided a specified level of health benefits coverage, which we refer to as "specified" coverage,[1] (whether through Medicaid or a fully territory-funded program)

[1] The standards for specified coverage are set forth in section 1905(z)(3) of the Act. Specified coverage is statewide coverage that included inpatient hospital services, was not dependent on access to employer coverage, employer contribution, or employment, and was not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits authorized under a demonstration program authorized under section 1938 of the Act.

statewide to both low-income parents and nonpregnant childless adults up to at least 100 percent of the poverty line. As indicated in our letter to State Health Officials dated December 10, 2012, while the federal poverty line (FPL) is applicable to the 50 states and the District of Columbia, we have recognized for the territories local poverty lines that have been specified in the approved state plan.

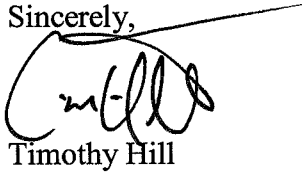
Under section 1905(z)(1)(B) of the Act, if a state, including territories, will not receive any payments on the basis of the increased newly eligible FMAP, meets the definition of an expansion state, and has not been approved to divert a portion of their Medicaid disproportionate share hospital (DSH) allotment to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009, the state will also qualify for a temporary 2.2 percentage point increase in its regular FMAP rate. This increased 2.2 percentage point increase is available, for a two year period, to match the expenditures for all Medicaid beneficiaries, not just those who are enrolled in the new adult group. Since none of the territories are authorized by the statute to receive the newly eligible FMAP, and since none of the territories have DSH allotments under the statute, any territory that meets the criteria for an expansion state will necessarily qualify for the 2.2 percentage point increase.

To confirm that Guam qualifies for the increased expansion state FMAP as well as the temporary 2.2 percentage point increase in the regular FMAP, please respond in writing as described in the attachment to this letter. The benefit analysis described in Attachment A is necessary to establish the territory's status as an expansion state. Completion of the guide is not required as it is merely a form to use at your option; however, the type of information contained in it is needed for CMS to confirm your applicable FMAPs. Upon reviewing your benefit analyses, we may seek additional information and/or clarification.

Finally, submission of your analysis will not obligate Guam to any requirements related to any decisions made about whether and/or when to adopt the new adult coverage category. Rather, providing this information will enable CMS to provide you with information about the FMAP(s) that might apply depending on the territory's decision and whether it meets the associated conditions.

We are committed to reviewing your information and working with you and your staff to confirm the applicable FMAPs in a timely manner. It would facilitate the CMS analysis if you can submit this information to Kristin Fan at Kristin.Fan@cms.hhs.gov by March 15, 2014. Your CMS Regional Office staff, along with your State Operations and Technical Assistance (SOTA) team will work with you on this issue; please contact them or Kristin Fan if you have any questions.

Sincerely,



Timothy Hill
Director
Financial Management Group

Attachment

cc:

Gloria Nagle, Associate Regional Administrator, Division of Medicaid and Children's Health Operations

Barbara Edwards, Director, Disabled and Elderly Health Programs Group

Eliot Fishman, Director, Children and Adults Health Programs Group

Jennifer Ryan, Director, Intergovernmental and External Affairs Group

Attachment - Guide to Demonstration Benefit Analysis

This Attachment provides a guide to information needed for CMS to determine which FMAPs may apply for adult populations provided coverage through section 1115 demonstrations prior to enactment of the Affordable Care Act. Use of this guide is not required; however, the information referenced below will help CMS to confirm the applicable FMAPs. A separate analysis should be undertaken for each demonstration or territory-specific coverage group, if different populations received different benefits. CMS may request additional information to address specific questions; the below questions represent a uniform starting point for analysis.

In answering the questions below, please cite the applicable demonstration special terms and conditions or state-based policy.

1. Did the territory provide coverage to parents and childless adults up to at least 100 percent of applicable poverty line, as of March 23, 2010?

2. If the territory provided coverage, please answer questions (a) through (d) below:

    a. What was the upper income level of coverage for parents as of March 23, 2010?

    b. What was the upper income level for coverage of childless adults as of March 23, 2010?

    c. If coverage was provided through a section 1115 demonstration, please provide the demonstration's name and project number; if through a state-only program, please identify the state-only program.

    d. Was this coverage based on the federal poverty line or on a local poverty line specified in the approved state plan?

3. Was this coverage offered on a territory-wide basis?

4. What was the scope of coverage provided to these populations?

    a. Did the coverage include inpatient hospital services?

    b. Was the coverage dependent on access to employer coverage, employer contribution, or employment?

    c. Was the coverage limited to:

        i. premium assistance?
        ii. hospital-only benefits?
        iii. a high deductible health plan?
        iv. a health opportunity account?