under the State plan under Title XIX of the Act that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for an individual described in section 1902(a)(10)(A)(i) of the Act.

(3) For purposes of establishing under paragraphs (a)(1) and (2) of this section whether an individual would not have been eligible for full benefits, benchmark coverage, or benchmark equivalent coverage under a waiver or demonstration program in effect on December 1, 2009, the State must provide CMS with its analysis, in accordance with guidance issued by CMS, about whether the benefits available under such waiver or demonstration constituted full benefits, benchmark coverage, or benchmark equivalent coverage. CMS will review such analysis and confirm the applicable FMAP. Individuals for whom such benefits or coverage would have been available under such waiver or demonstration are not newly eligible individuals.

(b)(1) *Expansion State* means a State that, as of March 23, 2010, offered health benefits coverage statewide to parents and nonpregnant, childless adults whose income is at least 100 percent of the Federal Poverty Level. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence will not be considered to be an expansion State. Such health benefits coverage must:

(i) Have included inpatient hospital services;

(ii) Not have been dependent on access to employer coverage, employer contribution, or employment; and

(iii) Not have been limited to premium assistance, hospital-only benefits, a high deductible health plan, or benefits under a demonstration program authorized under section 1938 of the Act.

(2) For purposes of paragraph (b)(1) of this section and for §433.10(c)(8), a nonpregnant childless adult means an individual who is not eligible based on pregnancy and does not meet the definition of a caretaker relative in §435.4 of this chapter.

§ 433.206 Threshold methodology.

(a) *Overview.* Effective January 1, 2014, States must apply the threshold methodology described in this paragraph for purposes of determining the appropriate claiming for the Federal share of expenditures at the applicable FMAP rates described in §433.10(b) and (c) for medical assistance provided with respect to individuals who have been determined eligible for the Medicaid program under §435.119 of this chapter. Subject to the provisions of this paragraph, States must apply the CMS-approved State specific threshold methodology to determine and distinguish such individuals as newly or not newly eligible individuals in accordance with the definition in §433.204(a)(1), and in accordance with States' Medicaid eligibility criteria as in effect on December 1, 2009 and to attribute their associated medical expenditures with the appropriate FMAP. The threshold methodology must not be applied by States for the purpose of determining the applicable FMAP for individuals under any other eligibility category other than §435.119 of this chapter.

(b) *General principles.* The threshold methodology should:

(1) Not impact the timing or approval of an individual's eligibility for Medicaid.

(2) 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.

(3) Provide a valid and accurate accounting of individuals who would have been eligible in accordance with the December 1, 2009 eligibility standards and applicable eligibility categories for the benefits described in §433.204(a)(1), and subject to paragraphs (d), (e), and (g) of this section, by incorporating simplified assessments of resources, enrollment cap requirements in place at that time, and other special circumstances as approved by CMS, respectively.

(4) Operate efficiently, without further review once an individual has been determined not to be newly eligible based on the December 1, 2009 standards for any eligibility category.

(c) *Components of the threshold methodology*. Subject to the submission of a threshold methodology State plan amendment as specified in paragraph (h) of this section, the provisions of the threshold methodology consist of two components, the individual income-based determination and population-based non-income adjustments to reflect resource criteria, enrollment caps in effect on December 1, 2009, and other factors in accordance with paragraph (g) of this section.

(1) *Scope*. The threshold methodology shall apply with respect to the population, and the associated expenditures for such population, which has been determined eligible for Medicaid under section 1902(a)(10)(A)(i)(VIII) of the Act and in accordance with § 435.119 of this chapter. This population and associated expenditures must not include individuals who have been determined eligible for Medicaid under any other mandatory or optional eligibility category.

(2) *Benefit criteria for newly eligible*. An individual eligible for and enrolled under § 435.119 of this chapter is considered newly eligible if, with respect to the applicable eligibility category in effect on December 1, 2009, the benefits did not meet the criteria described in the newly eligible definition at § 433.204(a)(1).

(3) *Individual income-based determination*. The individual income-based determination shall be a comparison of the individual's MAGI-based income to the income standard in effect on December 1, 2009, as converted to an equivalent MAGI-based income standard for each applicable eligibility category as in effect on that date, as follows.

(i) The amount of an individual's income under the threshold methodology is the MAGI-based income determined in accordance with § 435.603 of this chapter.

(ii) For each individual, the equivalent MAGI-based income eligibility standard is the applicable income eligibility standard for the applicable category of eligibility as in effect on December 1, 2009 that is converted to an equivalent MAGI-based income standard. For example, as applicable, a separate MAGI-based income standard will be applied for individuals determined to be disabled who would have been eligible under an optional eligibility category in effect on December 1, 2009 that was based on disability. For these purposes, the applicable equivalent MAGI-based standard is the standard as submitted by the State and approved by CMS in accordance with CMS guidance.

(iii) With respect to income eligibility criteria, if the individual's MAGI-based income is at or below the applicable converted MAGI-based income standard for the relevant eligibility category or group, then the individual is included in the population that is not newly eligible;

(iv) With respect to income eligibility criteria, if the individual's MAGI-based income is greater than the applicable converted MAGI-based income standard for the relevant eligibility category or group, then the individual is included in the population that is newly eligible;

(v) *Treatment of spend-down programs*. Treatment of medically needy or spend-down programs under the threshold methodology is described in paragraph (f) of this section.

(vi) For purposes of comparing the individual's MAGI-based income to the applicable converted MAGI-based income standard in effect on December 1, 2009, an individual will not be considered disabled absent an actual disability determination for the individual that is in accordance with the disability definition applicable for the State under Title XIX of the Act.

(4) *Treatment of disability*. For purposes of applying the appropriate FMAP under § 433.10(b) or (c) for the medical assistance expenditures of an individual in applying the definition of newly eligible under § 433.204(a)(1), for eligibility categories or groups as in effect on December 1, 2009 for which disability was an eligibility criteria:

(i) *During the period of a disability determination*. During the period for which a disability determination is pending, including during the period of any appeal process, and absent an actual disability determination for the individual that is in accordance with the disability definition applicable for the State under Title XIX of the Act,

the individual is not considered to be disabled.

(ii) *Following a disability determination.* With respect to an individual for which a disability determination was pending, following the actual determination of disability, the individual will be considered disabled effective with the date of the disability determination, or, if later, the disability onset date, as determined.

(5) *Population-based adjustments to the populations of newly eligible and not newly eligible.*

(i) The State may elect a resource criteria proxy adjustment described in paragraph (d) of this section.

(ii) States that had a waiver or demonstration program with an enrollment cap in effect as of December 1, 2009 must apply an adjustment based on enrollment caps, subject to the definition of newly eligible individual in § 433.204(a)(1) and paragraph (e) of this section.

(iii) States that have special circumstances may need to submit associated proxy methodologies to CMS for approval by CMS as described in paragraph (g) of this section.

(6) *Application of FMAP rates to adult group expenditures.* Subject to population adjustments under paragraphs (d), (e), or (g) of this section, federal funding for a State's expenditures for medical assistance provided to individuals determined eligible under § 435.119 of this chapter, including individuals determined eligible under that eligibility group during the evaluation for another eligibility category, must be claimed using the applicable FMAP as follows:

(i) The newly eligible FMAP under § 433.10(c)(6) is applicable for the medical assistance expenditures for individuals determined to be newly eligible, as defined in § 433.204(a)(1).

(ii) The applicable FMAP under § 433.10(b) or § 433.10(c)(7) or (8) is applicable for the medical assistance expenditures for individuals determined not to be newly eligible.

(7) *Status as newly or not newly eligible.* Under the threshold methodology States must provide that once individuals are determined under the threshold methodology to be either newly or not newly eligible individuals in accordance with the applicable December 1, 2009 eligibility criteria, the State would apply that determination until a new determination of MAGI-based income has been made in accordance with § 435.916 of this chapter, or the individual has been otherwise determined not to be covered under the adult group set forth at § 435.119 of this chapter.

(d) *Optional resource criteria proxy adjustment.* (1) *General.* Under an election under this paragraph (d), the State may use a resource proxy methodology for purposes of adjusting the claims for the expenditures of the population enrolled under § 435.119 of this chapter to account for individuals who would not have been eligible for Medicaid because of the application of resource criteria as in effect for such population as of December 1, 2009, and therefore would meet the newly eligible individual definition at § 433.204(a)(1). Under this paragraph (d), a State may elect to apply a resource proxy methodology with respect to the resource criteria as in effect on December 1, 2009 and applied to the expenditures for a specific eligibility category or categories of individuals as in effect on December 1, 2009, or applied to the expenditures of the entire population enrolled under § 435.119 of this chapter. As provided in paragraph (d)(4) of this section, the State must indicate any resource proxy election in the threshold methodology State plan amendment submitted under paragraph (h) of this section. The use of a resource proxy methodology must not delay or interfere with the eligibility determination for an individual.

(2) A State's resource proxy methodology must:

(i) Describe each eligibility group or groups for which an individual eligible under § 435.119 would have been eligible on December 1, 2009, subject to resource criteria, and a methodology to apply those resource criteria as an adjustment to the total expenditures to adjust determinations of the newly eligible population under paragraph (c) of this section.

(ii) Be auditable.

(iii) Be based on statistically valid data, which is either:

(A) Existing State data from and for periods before January 1, 2014 on the

resources of individuals who had applied and received a determination with respect to Medicaid eligibility, including resource eligibility under the State's applicable December 1, 2009 eligibility criteria. The existing State data must be specifically related to resource eligibility determinations, indicate the number and types of individuals for whom resource determinations were made, and establish the denial rates specifically identified as due to excess resources; or

(B) Post-eligibility State data on the resources of individuals described in paragraph (d)(2)(iii)(B)(*1*) and (*2*) of this section, based on and obtained through a post-eligibility statistically valid sample of such individuals with respect to the applicable Medicaid eligibility categories and resource eligibility criteria under the State's applicable December 1, 2009 eligibility criteria:

(*1*) State data from and for periods before January 1, 2014 must be for individuals in eligibility categories relevant to § 435.119 of this chapter who apply and receive a determination with respect to Medicaid eligibility, including both approvals and denials, to establish denial rates specifically due to excess resources and identify numbers and types of individuals.

(*2*) State data from and for periods on or after January 1, 2014 must only be for individuals determined eligible and enrolled under § 435.119 of this chapter, must compare individuals' resources to the applicable December 1, 2009 resource criteria to establish denial rates specifically due to excess resources, and identify numbers and types of individuals.

(iv) Describe the State data on individuals' resources used and the application of such data. Whether such State data is based on data described in paragraph (d)(2)(iii)(A) or (B) of this section, such State data must represent sampling results for a period of sufficient length to be statistically valid.

(v) Provide that the resource proxy methodology will account for the treatment of resources in a statistically valid manner when there is a lack of sufficient information to make a resource determination for a particular individual in a sampled population.

(vi) Describe the application of the resource proxy methodology in establishing the amount and submission of claims for Federal funding by the State for the medical assistance expenditures of the applicable eligibility group(s). Such claims submitted under the resource proxy methodology must reflect the appropriate FMAP for the medical assistance expenditures of the affected eligibility group(s).

(vii) As appropriate, describe and demonstrate the statistical validity of the resource proxy methodology and the use of data under such methodology.

(3) *Effective date for application of resource proxy*. The resource proxy shall not be effective prior to the beginning of the quarter in which such resource proxy is submitted to CMS under the threshold methodology State plan in paragraph (h) of this section.

(4) *One time election for resource proxy*. The election, application, and description of a resource proxy methodology under this paragraph for individuals determined eligible under § 435.119 must be included in a one-time submission of a State plan amendment submitted under paragraph (h) of this section no later than one year from the first day of the quarter in which eligibility for individuals under § 435.119 of this chapter is initially effective for the State.

(e) *Enrollment caps adjustment*. (1) *Scope*. Certain States may have applied enrollment caps, limits, or waiting lists in their Medicaid programs as in effect on December 1, 2009. Under the definition of newly eligible individual in § 433.204(a)(1), such States must consider as newly eligible those individuals eligible under § 435.119 of this chapter who would otherwise be eligible for full benefits, benchmark coverage, or benchmark equivalent coverage provided through a demonstration under the State plan effective December 1, 2009, but would not have been enrolled (or would have been on a waiting list) based on the application of an enrollment cap or limit determined in accordance with the approved demonstration as in effect on that date. Such

States must only apply such enrollment cap, limit or waiting list provisions with respect to eligibility category or categories for which such provisions were applicable (for example, nonpregnant childless adults or parents/caretaker relatives) and in effect under the State's Medicaid program on December 1, 2009. For this purpose, individuals who would have been on a waiting list are considered as not enrolled under the demonstration.

(2) A State for which multiple enrollment caps or limits were in effect under its December 1, 2009 Medicaid program may elect to combine such enrollment caps or limits, unless such treatment would preclude claiming of Federal funding at the applicable FMAP rate required under § 433.10(b) or (c) (for example, to distinguish claims for childless adults and parents in an expansion State) for the medical assistance expenditures of individuals determined eligible and enrolled under § 435.119 of this chapter; a State with enrollment cap or limit provisions that would preclude combining enrollment caps or limit provisions must use separate caps; or, the State, at its option, may elect to use separate caps.

(3) For purposes of claiming Federal funding, with respect to each claiming period for which the State claims Federal funding for an eligibility category for which an enrollment cap or limit is applicable and in effect on December 1, 2009, the State must account for:

(i) The total unduplicated number of individuals eligible and enrolled under § 435.119 of this chapter for the applicable claiming period.

(ii) The total State medical assistance expenditures for individuals eligible and enrolled under § 435.119 of this chapter 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 1, 2009.

(A) For States that elect under paragraph (e)(2) of this section to combine the enrollment caps, the enrollment cap is the sum of the enrollment caps for each eligibility group which is being combined.

(B) For States that elect to treat the enrollment caps separately under paragraph (e)(2) of this section, each enrollment cap will be accounted for separately.

(C) The level of the enrollment cap will be as authorized under the demonstration in effect on December 1, 2009; or, if the State had affirmatively set the cap at a lower level consistent with flexibility provided by the demonstration terms and conditions, the State may elect to apply the lower cap as in effect in the State on December 1, 2009. If a State elects to use such an alternate State-specified enrollment cap, the State will provide CMS with evidence, in its State plan amendment submitted to CMS under paragraph (h) of this section, that it had affirmatively implemented such a cap. Whether the State uses the authorized cap or a lower, verifiable cap as in effect in the State consistent with the demonstration special terms and conditions, the amount of expenditures up to the proportion of the 2009 enrollment cap to the total number of currently enrolled people in the group would not be claimed at the newly eligible FMAP.

(4) States for which an enrollment cap, limit, or waiting list was applicable under their Medicaid programs as in effect on December 1, 2009, must describe the treatment of such provision or provisions in the submission to CMS for approval by CMS in accordance with the State plan requirements outlined in § 433.206(h).

(f) *Application of spend-down income eligibility criteria.* (1) *General.* Certain States' Medicaid programs as in effect on December 1, 2009 may have included eligibility categories for which deduction of incurred medical expenses from income (referred to as spend-down) under the provisions of sections 1902(a)(10)(C) or 1902(f) of the Act was applied in determining individuals' Medicaid eligibility. Paragraphs (f)(2) and (3) of this section apply, for purposes of determining whether an individual enrolled under § 435.119 of this chapter meets the definition of newly eligible under § 433.204(a)(1), and for purposes of applying the appropriate FMAP under § 433.10(b) or (c) for the medical assistance expenditures of the

individual for which a spend-down eligibility category of a State effective on December 1, 2009 is applicable.

(2) *Not newly eligible individual.* For purposes of a State's spend-down provision, an individual enrolled under § 435.119 of this chapter whose income before the deduction of incurred medical expenses is less than or equal to the applicable December 1, 2009 State spend-down eligibility income level that would have resulted in full benefits is considered not newly eligible. The FMAP applicable for the medical assistance expenditures of such an individual is the appropriate FMAP under § 433.10(b) and (c) as applicable for an individual who is not newly eligible.

(3) *Newly eligible individual.* For purposes of a State's spend-down provision, an individual enrolled under § 435.119 of this chapter whose income before the deduction of incurred medical expenses is greater than the applicable State spend-down eligibility income level is considered newly eligible. The FMAP applicable for the medical assistance expenditures of such an individual is the appropriate FMAP under § 433.10(b) and (c) as applicable for an individual who is newly eligible.

(g) *Special circumstances.* States may submit additional proxy methodologies to CMS for approval by CMS in accordance with the State plan requirements outlined in § 433.206(h).

(h) *Threshold methodology State plan requirements.* To claim expenditures at the increased FMAPs described in § 433.210(c)(6) or (c)(8), the State must amend its State plan under the provisions of subpart B of part 430 to reflect the threshold methodology the State implements in accordance with the provisions of this section. The threshold methodology will be included as an attachment to the State plan and, explicitly and by reference, must:

(1) Specify that the threshold methodology the State implements is in accordance with this section;

(2) Specify that the threshold methodology the State implements accounts for the individuals determined eligible under the adult group in § 435.119 of this chapter as a newly eligible individual or not newly eligible individual; and, on that basis, the State implements appropriate tracking for purpose of claiming Federal Medicaid funding for the associated medical assistance expenditures.

(3) Reference the converted MAGI-based December 1, 2009 income eligibility standards and the associated eligibility groups, describe how the State will apply such standards and methodologies, and include other relevant criteria in the assignment of FMAP.

(4) Indicate any required provisions, or options and alternatives the State elects, with respect to:

(i) Treatment of resources, in accordance with paragraph (d) of this section;

(ii) Treatment of enrollment caps or waiting lists, in accordance with paragraph (e) of this section; and

(iii) Special circumstances as approved by CMS in accordance with paragraph (g) of this section.

[78 FR 19942, April 2, 2013, as amended at 78 FR 32991, June 3, 2013]

Subpart F—Refunding of Federal Share of Medicaid Overpayments to Providers

SOURCE: 54 FR 5460, Feb. 3, 1989, unless otherwise noted.

§ 433.300 Basis.

This subpart implements—

(a) Section 1903(d)(2)(A) of the Act, which directs that quarterly Federal payments to the States under title XIX (Medicaid) of the Act are to be reduced or increased to make adjustment for prior overpayments or underpayments that the Secretary determines have been made.

(b) Section 1903(d)(2)(C) and (D) of the Act, which provides that a State has 1 year from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 1-year period, whether or not recovery is made, unless the State is unable to recover from a provider because the overpayment is a debt that has been discharged in bankruptcy or is otherwise uncollectable.

(c) Section 1903(d)(3) of the Act, which provides that the Secretary will