DEPARTMENT OF HEALTH & HUMAN SERVICES
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American Recovery and Reinvestment Act of 2009

Section 5001: Increased Federal Medical Assistance Percentage

The Centers for Medicare & Medicaid Services (CMS) is committed to helping to promote economic recovery through our implementation of the American Recovery and Reinvestment Act of 2009 (ARRA) . The legislation authorizes an estimated $87 billion in additional federal funding for States, in the form of a temporary increase in the funds that the Federal government contributes toward Medicaid and Title IV-E programs. This investment will protect people whose eligibility for Medicaid might otherwise be at risk if State budget shortfalls resulted in Medicaid cutbacks. This investment will also generate considerable state economic activity, jobs and wages.

The ARRA provides this money to States through an increase in the Federal Medical Assistance Percentage (FMAP) formula – the formula that generally determines the Federal share of Medicaid expenditures.

On February 23, 2009, the President announced to State Governors the release of more than $15 billion in increased FMAP funding. This $15 billion represents the first two quarters of the increased FMAP funding provided under ARRA. Funds have been deposited in special Treasury accounts so that States, the District of Columbia, and the Territories can start drawing down those funds. States must meet Medicaid eligibility requirements outlined in the law to receive the new funding, and may only claim for appropriate expenditures. CMS is working with the States to ensure that they meet the eligibility requirements in order to access the increased Medicaid funding.

The following documents provide additional details about the implementation of the FMAP increase in ARRA:

1. A fact sheet which presents background information on the new FMAP methodology and grant issuance, clarifications on the eligibility maintenance of effort (MOE) requirements, and procedures for States to regain eligibility for the increased FMAP.
2. Specific questions raised by States regarding the FMAP increase since the enactment of the ARRA.

American Recovery and Reinvestment Act of 2009 (ARRA)
Section 5001: Increased Federal Medical Assistance Percentage (FMAP)
FACTSHEET

Section 5001 of the ARRA provides eligible States with an increased Federal Medical Assistance Percentage (FMAP) for 27 months between October 1, 2008 and December 31, 2010. To access the additional funds associated with the increased FMAP, each State must ensure that the "eligibility standards, methodologies, or procedures" under its Medicaid State Plan, or under its Medicaid waiver or demonstration programs, are not more restrictive during this period than those in effect on July 1, 2008. More restrictive eligibility would preclude the State from accessing the increased FMAP funds until the State had restored eligibility standards, methodologies or procedures to those in effect on July 1, 2008.

Increased FMAP Methodology and Grant Issuance

States that are eligible for the increased FMAP will be able to access the additional funds on an ongoing basis. At the beginning of each quarter, the amount of additional funding for that quarter will be determined in accordance with the provisions of section 5001 of ARRA. The additional funds are determined by calculating the percentage difference between the increased FMAP under ARRA and the pre-ARRA FMAP, and then multiplying that difference by the estimates of appropriate expenditures submitted by each State.

On February 25th, additional funds related to the increased FMAPs for the first two quarters of fiscal year 2009 were made available to States in two separate grant awards issued through the Payment Management System (PMS) into State accounts established specifically for the increased FMAP funds. Subsequent awards will be issued quarterly by the same process. The CMS grant award letters include five attestations relating to the requirements of Section 5001 of the ARRA, as described in the answer to question two in the Frequently Asked Questions document, which is attached. The CMS grant letters direct that with the acceptance of the grant award and withdrawal of such funds from the PMS, each State attests that it is eligible for such funds, and that the expenditures for which the funding is claimed are appropriate and consistent with the requirements of Section 5001 of the ARRA.

The expenditures and conditions under which the State draws funds must be those for which the increased FMAP is applicable. Under section 5001(e) and (f)(5); the increased FMAP is not applicable to the following expenditures:

1. Expenditures for disproportionate share hospital (DSH) payments;
2. Expenditures for payments made under Title XXI;
3. Expenditures that are claimed based on the enhanced FMAP (described in section 2105(b) of the Act);
4. Expenditures that are not paid based on the FMAP, such as family planning services;
5. Services provided through an Indian Health Service facility which are ineligible because such expenditures receive 100 percent FMAP, which is the FMAP ceiling level under section 5001(f)(5) of ARRA;
6. Expenditures for medical assistance provided to individuals made eligible under a State plan or waiver with income standards (expressed as a percentage of the poverty line) higher than the income standards (as so expressed) for such eligibility as in effect on July 1, 2008; and

7. Expenditures for health care practitioner claims, or certain nursing home and hospital claims, that were received by the State during the periods in which the State is not in compliance with prompt payment standards.

States that have Medicaid program demonstrations in effect as of July 1, 2008 (or authorized under a State law or pending request as of that date) using all or a portion of their disproportionate share hospital (DSH) allotments as part of their budget neutrality limit may claim increased FMAP for expenditures made for individuals made eligible under the demonstration. To the extent that demonstration expenditures are not for DSH "hospital payments," but for expenditures related to demonstration eligibles, those expenditures will be treated as title XIX expenditures eligible for increased FMAP.

There is no availability of increased FMAP for expenditures for eligibility expansion populations added after July 1, 2008 unless the State can demonstrate the eligibility income standard was enacted in State law as of July 1, 2008 or that the State had an amendment or waiver request pending with CMS at that time. Eligibility expansions authorized under State law and submitted to CMS after July 1, 2008 are not eligible for increased FMAP.

Maintenance of Eligibility (MOE) Requirement Provisions

Additional funds available under section 5001 of ARRA will be issued to eligible States on a quarterly basis to separate ARRA-specific PMS accounts for each State. State acceptance and withdrawal of the available ARRA funds from these accounts serves as State assurance that it is in compliance with the requirements in Sections 5001(f)(1) and (g)(2) of the ARRA regarding the "maintenance of effort" for existing Medicaid programs. CMS will continue to actively work with State Medicaid Agencies to ensure adherence to these ARRA MOE provisions. Below is a summary of MOE principles States should actively review when considering formal acceptance and use of the increased FMAP funds.

1. To comply with the eligibility MOE requirements at section 5001(f)(1) of ARRA, the State/Territory must not have eliminated any eligibility groups, or sub-groups under the State plan since July 1, 2008. For example, this means that, even if a medically needy group as a whole is still covered under the State plan, the State cannot have eliminated one or more categorical subgroups (e.g., the aged, or the disabled) from the group.

2. Similarly, the State/Territory must not have eliminated the coverage for any eligibility group or subgroup authorized pursuant to 42 CFR 435.217 in any section 1915(c) Home and Community Based Services Waiver.

3. The State/Territory must not apply other eligibility standards, methodologies, or procedures under its State plan under title XIX of the Social Security Act (including any waiver under such title or under section 1115 of the Act (42 U.S.C. 1315)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) in effect on July 1, 2008. This requirement applies to all demonstration-eligible individuals funded through title XIX including those demonstrations with budget neutrality based on DSH funds. Demonstrations using a combination of title XIX and title XXI funds would also be affected. Only those demonstrations fully funded by title XXI are not subject to the MOE restrictions of this section. Restrictions on eligibility include, but are not limited to, the following:

a. Instituting or increasing premiums that may restrict, limit, or delay eligibility under the Medicaid program for otherwise eligible individuals.
b. Increasing stringency in institutional level of care determination processes that results in individuals losing actual or potential eligibility for Medicaid pursuant to institutional eligibility rules or in the special eligibility group for home and community based service waiver participants under 42 CFR 435.217.
c. Adjusting cost neutrality calculations for section 1915(c) waivers from the aggregate to the individual, resulting in individuals being dropped from waiver coverage or hindered from moving out of an institutional setting.
d. Reducing occupied waiver capacity for section 1915(c) HCBS waivers.
e. Reducing or eliminating section 1915(c) waiver slots that were approved, but unoccupied as of July 1, 2008.
f. Restrictive adjustments to financial eligibility criteria of the Medicaid program or waiver, including the following:
    - Reductions in income or resource standards below those in effect on July 1, 2008;
    - Implementation of income or resource standards that had not been imposed on a group or individuals within a group prior to July 1, 2008;
    - Elimination or reduction of income or resource methodologies favorable to applicants and beneficiaries, including more liberal income or resource methodologies implemented under the authority of section 1902(r)(2) of the Act, in effect prior to July 1, 2008;
    - In 209(b) States, any change in eligibility criteria, standards or methodologies for the aged, blind or disabled, including changes in the definition of blindness or disability, that are more restrictive than the criteria in effect prior to July 1, 2008.
g. Any change in eligibility determination or redetermination processes or procedures that are more stringent or restrictive than those in effect under the State's Medicaid program on July 1, 2008. These include, but are not limited to, the following:
    - Increasing the frequency at which redeterminations are made; for example, increasing the frequency of redeterminations from once every 12 months to once every 6 months.
    - Revoking or otherwise restricting a policy under which an individual's eligibility is determined or redetermined based on an attestation by the individual of the amount and/or type of resources the individual has. This would include, for example, requesting additional evidence concerning resources from individuals when, under previous policy, such additional evidence would not have been requested. However, this would not include implementing a program to verify the assets of aged, blind or disabled Medicaid applicants and recipients in conformance with the requirements of section 1940 of the Social Security Act.
    - Any reduction in the amount of time that the State gives an individual to respond to a request for additional information or documentation needed for an eligibility determination. An example would be if the State previously required a response to such a request within 45 days, but then reduced the time allowed to 30 days.
h. States cannot require political subdivisions within the State to pay a greater percentage of the non-federal share of expenditures than the political subdivisions would have been required to pay prior to application of the increased FMAP (October 1, 2008). If a State requires a political subdivision within the State to contribute the same dollar amount after the application of the increased FMAP, the State would be effectively requiring the political subdivision within the State to pay a greater percentage of the non-federal share

4. No amounts attributable (directly or indirectly) to the increased FMAP may be deposited or credited to any reserve or rainy day fund of the State, except to the extent of any increase based on maintenance of the prior year FMAP levels.

Program modifications not subject to the MOE requirements include:

- Elimination or reduction of eligibility groups whose services are funded wholly under title XXI of the Social Security Act, including those authorized through a section 1115 demonstration.
- Post-eligibility treatment of income determinations.

Reinstatement of Provisions Which Exclude the State from Receiving the Increased FMAP

The increased FMAP is available to eligible States for a 27-month period between October 1, 2008 and December 31, 2010. As such, CMS will continue to work with States to determine initial and on-going eligibility for the increased FMAP. States may regain eligibility for the increased FMAP effective back to October 1, 2008, if they reverse those Medicaid eligibility restrictions which made them ineligible for the increased FMAP on or before June 30, 2009. After June 30, 2009, however, the eligibility for the increased FMAP would only be effective prospectively, beginning with the first calendar quarter the State reverses the eligibility restriction(s). States should send written communication to their CMS Regional Office describing the identified eligibility restriction(s) and the steps the State will take to reverse such restriction(s). States must include an effective date for those reinstatements. If State plan amendments, waiver amendments or other official documents must be prepared and otherwise adjudicated in order to officially reinstate the previous policy, CMS will accept a letter indicating that the eligibility restriction(s) has in fact been reinstated, and the effective date(s) it was reinstated, as sufficient documentation to regain the State's eligibility for the increased FMAP. Conforming State plan(s), waiver(s), or other official documents must be submitted by the State within a reasonable time period.

1. **Question:** Will there be a Federal Register notice instructing States on the process/timing for payments related to the increased FMAP, including any retroactive payments, and, if so, is there an estimated timeline for this?

   Answer: The methodology for determining the increased FMAPs will be published in the Federal Register, and the increased FMAPs determined in accordance with such methodology will be published in the Federal Register on an ongoing basis.

   We have issued guidance to States through all State calls, individual State calls and through written guidance documents and letters on the funding process. On February 23, 2009 and March 6, 2009 CMS hosted two National All-State calls to discuss the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), ARRA, and the States' February Budget Submission. On March 4, 2009, we issued a letter to States describing these provisions and providing instructions to States about the States' February 2009 budget submissions. During the National calls we discussed all aspects of the increased FMAP made available under section 5001 of the Recovery Act. We also provided information on the HHS.gov website, the February State budget call letter and a fact sheet describing the methodology for determining the grant amounts and process for grant issuance.

2. **Question:** What are the timing and conditions for the issuance and availability of funds to States for the retroactive period beginning October 1, 2008?

   Answer: The additional funds related to the increased FMAP available under ARRA for the period beginning October 1, 2008 have been issued to States in two grant awards for the first two quarters of FY 2009. On February 25, 2009 these funds were provided to States through the Payment Management System (PMS) in a separate account established for this purpose; States could immediately begin drawing such funds from this account at that time as long as they comply with the attestation requirements.

   The grant award letter to each State references five conditions regarding attestation from section 5001 of ARRA. The grant award letter instructs the State that by drawing funds, the State attests that it meets the listed eligibility requirements for the increased FMAP and is claiming for appropriate expenditures. With respect to ongoing expenditures, the State must draw Federal funds from two PMS subaccounts; the portion of Federal funds related to the regular FMAP must be drawn from the regular Medicaid PMS account, and the portion of Federal funds associated with the increased FMAP must be drawn from the separate ARRA account. For the expenditures related to the first two quarters of FY 2009, the State may draw the additional Federal funds available under the increased FMAP provision from the ARRA account only for identified appropriate expenditures under ARRA.

The five attestations that are implicit in the grant award ("passive attestations") are as follows:

1. The State is eligible for the increased FMAP because the State is applying Medicaid eligibility standards, methodologies and procedures that are no more restrictive than those in effect under the State plan (or any waiver or demonstration project) on July 1, 2008. If the State is currently ineligible because it does not meet this condition, the State may be retroactively eligible if it reinstates the former standards, methodologies and procedures prior to July 1, 2009. (Section 5001(f)(1) of ARRA)
2. The State is eligible for the increased FMAP because no amounts attributable (directly or indirectly) to such increased FMAP are deposited or credited to any reserve or rainy day fund of the State. (Section 5001(f)(3) of ARRA)
3. The State is eligible for the increased FMAP because it does not require political subdivisions within the State to contribute for quarters beginning October 1, 2008 and ending December 2010, a greater percentage of the non-Federal share of such expenditures (including for expenditures under section 1923 of the Social Security Act) than the respective percentage that would have been required under the State Medicaid plan on September 30, 2008. (Section 5001(g)(2) of ARRA)
4. The expenditures for which the State draws funds must be eligible expenditures. Expenditures for disproportionate share hospital (DSH) payments are ineligible. Also ineligible are expenditures that are claimed based on the enhanced FMAP (described in section 2105(b) of the Act), or expenditures that are not paid based on the FMAP, such as expenditures for family planning services and administrative expenditures. Expenditures for services provided through an Indian Health Service facility are ineligible because such expenditures receive 100 percent FMAP, which is the ceiling level. Expenditures for medical assistance provided to individuals made eligible because of increased income eligibility standards that are higher than those in effect on July 1, 2008 are also ineligible for the increased FMAP. (Section 5001(e) of ARRA).
5. The expenditures for which the State draws funds are not payments for health care practitioner claims or certain nursing home and hospital claims that were received by the State during periods in which the State is not in compliance with prompt payment standards. (Section 5001(f)(2) of ARRA)

3. **Question:** If a state restores eligibility policies, does it have to send a notification to CMS in order to receive the increased FMAP payment?

Answer: Yes. Section 5001(f) of the ARRA sets forth maintenance of eligibility (MOE) requirement that States must meet to qualify for the increased FMAP. It also provides States which fail to initially satisfy the MOE requirements an opportunity to reinstate their eligibility standards, methodologies, and procedures by July 1, 2009 and become eligible for the increased FMAP retroactive to October 1, 2008. To document eligibility for the increased FMAP, such States should notify CMS in writing of the date of the implementation of the reinstated eligibility policies. However, it is not necessary to have a State Plan amendment or waiver amendment submitted and approved prior to drawing funds based on the increased FMAP. States will still need to submit timely amendments to their State plan(s) or waiver(s) needed to effect the reinstatement, as appropriate, to ensure that expenditures based on the reinstated eligibility policies are not considered to be erroneous, and are eligible for the increased FMAP.

4. **Question:** Is HHS/CMS providing guidance on the requirement that States request funding as it pertains to the increased FMAP?

   Answer: As noted in Question 2 above, the States already have amounts in their PMS increased FMAP ARRA accounts which reflect their actual expenditures (if available) or estimates for the first and second quarters of FY 2009. On an ongoing basis, the States will request the additional increased FMAP funding as part of the established quarterly Medicaid budget submission to CMS, and those funds will be provided on a quarterly basis through a separate increased FMAP grant award issued to each State. States will continue to receive a separate grant award reflecting the amounts of the funding at the regular FMAP.

5. **Question:** What is passive attestation?

   Answer: By drawing funds from the increased FMAP ARRA account, the State is attesting it is eligible for the increased FMAP; the expenditures for which it is drawing funds are those for which the increased FMAP are applicable; and that the conditions under which the increased FMAP is available are met. The attestation includes specific agreement with five enumerated requirements of section 5001 of ARRA. In order to minimize the need for separate review, CMS included these five requirements as attestations in each grant award letter to the States. The grant award letter indicated that only after the State had assured itself that it met all of the requirements under which the increased FMAP and associated funds were available, was it free to draw such funds. This process is referred to as a "passive attestation" under which each State did not need to send in a written confirmation that it met the requirements prior to receiving its funds; rather, the drawing of such funds represented the State's attestation that it met all of the requirements.

6. **Question:** Is there more specific information beyond the press release on what States need to do to access the new funds?

   Answer: Yes. In general, the funds are accessed through the PMS through subaccounts that are separate from the regular FMAP accounts. As discussed in the factsheet, funds available for States to draw from those accounts are set forth in grant awards, based on estimated or actual expenditures, as discussed above. The process for accessing the funds was discussed during the national all-State calls conducted on February 23 and March 6. Also, the February Budget call letter CMS issued to States on Wednesday, March 4, 2009 provides further information about the funding process. CMS central office is available to provide technical assistance should there be further questions from States about accessing funds.

7. **Question:** It's clear that ARRA Section 5001 applies to financial eligibility standards, i.e. poverty levels and asset tests, as well as to the methodologies in place for determining income and assets, and to application/renewal procedures. Has there been any indication of how States should interpret this language to apply to functional eligibility, i.e. need for assistance with a threshold number of activities of daily living (ADLs) for home and community-based care section 1915(c) waivers?

- Will States have the ability to modify or eliminate services, as opposed to eligibility criteria, and still qualify for the increased FMAP.
- Also, is there any indication of how States should interpret this as it applies to eligibility criteria for services?

Answer: Section 3c of the ARRA Factsheet addresses changes in HCBS waiver programs that may impact States' eligibility for increased ARRA FMAP funds. Changes in waiver program procedures (including medical necessity and level of care determinations) that restrict or limit eligibility for waiver services will put at risk the State's eligibility for increased FMAP. States must analyze program changes and are advised to consult with CMS staff regarding impacts on eligibility for increased FMAP.

8. **Question:** Can States get waivers of the prompt payment requirements?

   Answer: Yes, under section 5001(f)(2)(A)(iii) of ARRA, the Secretary may waive the prompt pay requirements during any period in which there are exigent circumstances such as natural disasters which prevent compliance with the requirements. Each waiver request will be evaluated on a case-by-case basis, and we will be developing more detailed guidance. In the meantime, States should review the waiver requirements contained in existing regulations at 42 CFR 447.45(e) for further details on waivers of timely processing requirements.

9. **Question:** Does the MOE requirement apply to provider rates?

   Answer: No. The MOE requirement explicitly applies to "eligibility standards, methodologies, or procedures;" this does not include provider reimbursement rates.

10. **Question:** How does the increase in FMAP impact the Medicare Part D phased-down State contribution (the "clawback")?

    Answer: The increase in FMAP does <u>not</u> apply to the clawback provision.

11. **Question:** Some States are set up so that any extra funds go into their rainy day reserve fund; what happens if this occurs with FMAP funds?

    Answer: Section 5001(f)(3) prohibits a State from receiving the increased FMAP if it deposits or credits any of the funds from the increased FMAP (other than amounts related to the "hold-harmless" component of the increased FMAP), directly or indirectly, into any reserve or rainy day fund of the State. Therefore, if any of the indicated increased FMAP funds were deposited in such reserve or rainy day funds, the State would be ineligible for the increased FMAP (other than for the "hold-harmless" amounts) and, if the State incorrectly claimed the additional funding, the State would be subject to audit and disallowance of that funding. The statute does not prohibit States from using these funds for either the Medicaid program or any other State purpose EXCEPT a reserve or rainy day fund

12. **Question:** With respect to the process for drawing down funds, does "able to access" mean States are being sent money for two quarters based on estimated need and then a

Answer: CMS issued two sets of grant awards that provided funds to States reflecting an estimate of the amounts of increased funding that they are potentially due for the first and second quarters of FY 2009 as a result of the temporary increases to the Medicaid FMAPs provided under section 5001 of ARRA. The funding for the retroactive period back to October 1, 2008 can be drawn down immediately by the States, assuming they comply with the attestation requirements (see questions 2 and 5 above).

For the 1st quarter of FY 2009, to the extent available, the grant awards were based on the expenditures for those States which had submitted an actual expenditure report for this quarter, or we used the November 2008 estimates for those States which had yet to submit an expenditure report for this quarter. Using these numbers we calculated the difference between the Federal funds the States would be eligible for using the pre-ARRA 2009 FMAPs and the amounts that they would be eligible for using the increased ARRA 2009 FMAPs. For the 2nd quarter of FY 2009, we used the unadjusted November 2008 estimates from each State.

- In accordance with the guidelines established by Office of Management and Budget, the grant awards were issued in a separate account in PMS specifically designated by the Treasury for the ARRA funds, and the States will have to draw these funds from that account.
- It should be noted that the States' estimated expenditures were used in determining the grant awards for the retroactive period. The final determination of allowable expenditures and reconciliation of grant awards have yet to be determined by CMS. When all the actual expenditures for the quarter have been submitted by the States, and reviewed by CMS, final reconciling grant awards will be issued to reflect the amounts that the States are finally due under the ARRA.
- Any overpayment or underpayment will factor into the calculation of the grant award for the following quarter.

13. **Question:** Will these funds be tracked separately and will States have any obligation to report further on the use of these funds once they have submitted reimbursement information, or do they simply deposit them in their general funds without a need to report further on where the enhanced match is directed?

Answer: These funds must be drawn down separately, tracked separately, and reported to CMS separately for Federal reimbursement; this information was explained in the National All-State calls on February 23 and March 6, and in the February 2009 budget letter CMS issued to States on March 4, 2009. In addition, section 5001(g)(1) of ARRA provides that each State which receives increased FMAP funding will be required to submit a report to the Secretary no later than September 30, 2011 regarding how the additional increased FMAP funds were expended. Further guidance will be developed for such reporting, but each State must track and account for the expenditure of the increased FMAP funds.

14. **Question:** There seems to be some confusion about the distribution of the first two quarters of funding. Do you know if CMS will be issuing some clarifying guidance? If so, will this be distributed through your State listserv emails?

    Answer: See answers to questions 1-3 above.