

SHO# 21-004

RE: Temporary increases to FMAP under sections 9811, 9814, 9815, and 9821 of the ARP and administrative claiming for vaccine incentives

August 30, 2021

Dear State Health Official:

This letter provides guidance with respect to temporary increases to the federal medical assistance percentage (FMAP) available to states under sections 9811, 9814, 9815, and 9821 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2), enacted on March 11, 2021.¹ Sections 9811 and 9821 of the ARP provide temporary increased FMAP and Enhanced FMAP (EFMAP) for state Medicaid and Children's Health Insurance Program (CHIP) expenditures on COVID-19 vaccines and COVID-19 vaccine administration. Section 9814 of the ARP provides a temporary increase in FMAP for Medicaid expenditures for states that newly begin to expend amounts for coverage of the entire new adult group described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (Act) under the state plan (or waiver of the plan). Section 9815 of the ARP provides a temporary increase to 100 percent FMAP for Medicaid services received through certain Urban Indian Organizations (UIOs) and certain Native Hawaiian health care entities, including Native Hawaiian health care systems (NHHCSs). Additional detailed background and information on each of these provisions is described within this letter.

This letter informs states of appropriate methods for identifying Medicaid and CHIP expenditures eligible for the relevant ARP-increased FMAP and EFMAP under fee-for-service (FFS) and managed care programs, as well as the process for reporting the associated expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES). In addition, this letter includes information on claiming federal matching funds under sections 1903(a)(7) and 2105(a)(1) (D) of the Act for state administrative costs related to beneficiary COVID-19 and influenza vaccine incentives.

Section 1: Sections 9811 and 9821 of the ARP – Temporary Increased FMAP and EFMAP for Expenditures for COVID-19 Vaccine Administration under Medicaid and CHIP

¹ References in this document to “states” include territories and the District of Columbia.

Background

Section 9811 of the ARP established a new mandatory Medicaid benefit at section 1905(a)(4)(E) of the Act and amended various other sections of the Act, including sections 1902(a)(10), 1916, 1916A, and 1937 of the Act. Under these changes to the statute, nearly all Medicaid beneficiaries must receive coverage of COVID-19 vaccines and their administration, without cost-sharing, including beneficiaries enrolled in most groups with limited benefits. This new coverage requirement applies beginning on the date of enactment of the ARP (March 11, 2021) and (generally) ending on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act (we refer to this period below as the ARP coverage period).² Section 9821 of the ARP added a similar mandatory benefit for CHIP at section 2103(c)(11)(A) of the Act and amended section 2103(e)(2) of the Act. The changes require coverage of COVID-19 vaccines and their administration, without cost-sharing, for all CHIP enrollees, during the same ARP coverage period that applies in Medicaid.

Additionally, section 9811 of the ARP added section 1905(hh) to the Act, which establishes a temporary Medicaid FMAP of 100 percent for amounts expended by a state for medical assistance for a vaccine described in section 1905(a)(4)(E) of the Act (that is, a COVID-19 vaccine) and its administration. The increased FMAP will apply beginning April 1, 2021 and will end on the last day of the first quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act (we refer to this period below as the ARP FMAP period). Section 9821 of the ARP also provides a temporary 100 percent CHIP EFMAP for state expenditures for vaccines described in section 1905(a)(4)(E) of the Act and their administration during the same time period, through the addition of section 2105(c)(12) of the Act. Section 9821 of the ARP also amends section 2104(m) of the Act to make adjustments to CHIP allotments to account for the increase in expenditures due to the temporary increase in EFMAP for COVID-19 vaccines and their administration. CMS interprets sections 1905(hh) and 2105(c)(12) of the Act to mean that the 100 percent FMAP or EFMAP authorized under these sections applies to any services described in section 1905(a)(4)(E), even if they are billed under other Medicaid or CHIP benefits by providers of those benefits. That is, the 100 percent match applies to all state expenditures for COVID-19 vaccines and their administration, even when a COVID-19 vaccination is provided as part of a benefit other than the benefit at section 1905(a)(4)(E), such as when it is provided as part of Medicaid nursing facility or federally qualified health center (FQHC) services.

During the period when the supply of COVID-19 vaccines is federally purchased (as is the case as of the date of this SHO Letter), providers should not be billing for the vaccine doses and states should not make claims to Medicaid or CHIP for federal financial participation (FFP) for COVID-19 vaccine doses. Instead, providers should be billing, and states should be claiming, for COVID-19 vaccine administration. Since states will not claim FFP for COVID-19 vaccine doses

² The optional COVID-19 group at section 1902(a)(10)(A)(ii)(XXIII) of the Act receives this coverage only through the last day of the COVID-19 public health emergency (PHE). No federal financial participation is available for any state expenditures on benefits for this group, including coverage of COVID-19 vaccinations, after the PHE ends.

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at this time, the guidance below is focused only on claiming expenditures for COVID-19 vaccine administration. Should the federal government end purchase of COVID-19 vaccines prior to the end of the ARP coverage and FMAP periods, CMS intends to provide additional guidance on proper claiming for vaccine doses during the ARP FMAP period.

Increases in Medicaid Payment Rates for COVID-19 Vaccine Administration

During the ARP coverage period, states might be interested in increasing payment rates for COVID-19 vaccine administration to reflect temporary and unforeseen costs associated with administering COVID-19 vaccines or to improve access to COVID-19 vaccines for Medicaid beneficiaries. State Medicaid payment rate increases are generally governed by section 1902(a)(30)(A) of the Act, which requires states to assure that Medicaid payments are “consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the [state] plan at least to the extent that such care and services are available to the general population in the geographic area.” CMS has not typically allowed states to pay higher rates to providers based solely on differences in the FMAPs at which CMS matches state expenditures for different Medicaid eligibility groups, so as not to create incentives for providing more extensive coverage or better care to one group versus another, and so as not to encourage states to inflate payment rates solely to maximize FFP. Such temporary inflation, based only on an available increased FMAP and with no defined programmatic objective, would not be consistent with section 1902(a)(30)(A) and may cause program integrity and oversight concerns. However, an increase in COVID-19 vaccine administration payment rates during the ARP coverage period may be consistent with section 1902(a)(30)(A) if the state intends the increases to improve access to COVID-19 vaccine administration or if the state determines that COVID-19 vaccination payment rates are too low to compensate providers based on changes in care or delivery during the ARP coverage period. We note that such payment rate adjustments may be particularly relevant in geographic areas where providers of COVID-19 vaccine administration are not widely available.

To change Medicaid provider payment rates, states should propose to amend the Medicaid state plan payment methodology through a state plan amendment (SPA) submission. As with all SPA requests, CMS will review vaccine administration rate requests to ensure consistency with efficiency, economy, and quality of care. States that increase payment rates to account for temporary cost increases or to improve access to COVID-19 vaccine administration may also set an end date within the state plan payment methodology that sunsets the rate increases using a defined time period. For example, a state could temporarily increase Medicaid COVID-19 vaccine administration payment rates through a SPA during the ARP coverage period, and specify that the increase ends on the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period.

Because the ARP coverage period began on March 11, 2021, and will generally extend beyond the end of the COVID-19 Public Health Emergency (PHE), states may need to submit both a Medicaid disaster relief SPA and a regular SPA if they want to increase payment rates for the full ARP coverage period. A state could use the Medicaid disaster relief SPA template to propose increasing COVID-19 vaccine administration payment rates retroactively to March 11, 2021, the beginning of the ARP coverage period, through the end of the COVID-19 PHE. States that use the Medicaid disaster relief SPA template can also submit a request under section 1135 of the Act to waive, or modify, certain Medicaid SPA submission and notice requirements that

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preclude SPAs from taking effect before the state provides public notice under 42 CFR 447.205 or before the first day of the quarter in which the SPA was submitted. See <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/state-plan-flexibilities/index.html> for more details. However, all COVID-19 disaster relief SPAs expire at the end of the COVID-19 PHE, so a state would also need to submit a SPA through the regular (non-disaster relief template) SPA submission process to continue the rate increases through the end of the ARP coverage period.³ States that use the regular SPA submission process would need to issue public notice in accordance with 42 CFR 447.205 and could not receive an effective date for rate increases that is earlier than one day after the notice is issued, or the first day of the quarter in which the SPA is submitted to CMS (whichever is later).

Please note that while states are generally required to cover COVID-19 vaccinations for the entirety of the ARP coverage period (which began March 11, 2021), the ARP FMAP period did not begin until April 1, 2021 regardless of whether a state makes rate increases or develops new rate methodologies prior to April 1, 2021. Prior to the expiration of any temporary rate increases for COVID-19 vaccinations, states should re-visit their state plan payment methodologies for vaccine administration to ensure that rates continue to be sufficient to ensure access to care.

We note the above guidance is specific to Medicaid SPAs and no SPA is needed to increase CHIP payment rates.

Properly Identifying COVID-19 Vaccine Administration Expenditures for Purposes of Claiming FFP at the Increased FMAP and EFMAP during the ARP FMAP Period

In certain circumstances, covered Medicaid and CHIP services, including COVID-19 vaccine administration, are paid by states using bundled payment rates when delivered on a FFS basis or using capitated payments when delivered through managed care. Bundled FFS payments generally reflect all the costs of services and procedures that a beneficiary receives (or is expected to receive) over a defined unit of service on average. When a state pays a health care provider using a FFS bundled payment rate, it makes a single payment to the provider for all services provided per encounter, per day, or per stay, depending on the unit of service a state uses to pay the provider for the bundle of services. For purposes of this discussion, we are using the terms “bundled payment” or “bundled payment rate” to include FFS rates and payments under prospective payment systems (PPS), per diem rates, and other rates that make a single payment per unit of service for multiple Medicaid or CHIP benefits or for the transfer of risk associated with potentially needing to provide those benefits. That is, when we refer to “bundled payment rates,” we describe payment methodologies used to pay providers one payment rate for multiple services or for the transfer of risk associated with potentially providing them, regardless of whether all the services are delivered during every unit of service. While we recognize that there may be inherent differences between prospective payments and other multi-service payments, the guidance within this letter applies to all bundled payment rates that are meant to pay providers for a range of services including COVID-19 vaccine administration, or that are

³ As previously noted, the optional COVID-19 group at section 1902(a)(10)(A)(ii)(XXIII) of the Act receives this coverage only through the last day of the COVID-19 PHE. No federal financial participation is available for any state expenditures on benefits for this group, including coverage of COVID-19 vaccinations, after the PHE ends.

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meant to pay for the transfer of risk for furnishing a range of services that includes COVID-19 vaccine administration.

Capitation payments are payments that states make to a contractor for each beneficiary enrolled under a managed care contract and are based on the actuarially sound capitation rates for the provision of specified services covered under the state plan. States make capitation payments to managed care plans, including managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs), regardless of whether a particular beneficiary receives services during the period covered by the payments. Capitation payments are typically fixed, prospective, monthly payments made by states to their contracted managed care plans.

In both bundled payment rates and capitated payments, the portion of the payment associated with COVID-19 vaccine administration could be co-mingled with payment for other services and it may not be easy to identify which portion of the payment is eligible for the 100 percent FMAP or EFMAP during the ARP FMAP period. When states pay directly for COVID-19 vaccine administration on a FFS basis (e.g., through a fee schedule), the entire state payment may be claimed at the temporary 100 percent FMAP or EFMAP. Although providing 100 percent FMAP or EFMAP may be administratively simple to implement when a state makes a discrete FFS payment for COVID-19 vaccine administration, there are implementation complexities when a state pays for vaccine administration as part of a bundled or capitation payment that is meant to account and pay for other services, or that is meant to account and pay for the transfer of risk for furnishing other services. For bundled FFS payments, states should use one of the two allocation methods described below, or an alternate method that CMS approves, to appropriately identify and report expenditures associated with COVID-19 vaccine administration that are eligible for the increased FMAP or EFMAP.

Identifying State Expenditures for COVID-19 Vaccine Administration under FFS during the ARP FMAP period

In accordance with 42 CFR 431.107(b), 457.236, 457.720, and 457.980, states and enrolled Medicaid providers must maintain records, such as documentation of the services furnished to beneficiaries, to allow the state and the federal government to ensure that applicable federal requirements are met. Additionally, 42 CFR 430.30(c) and 457.630(c) require states to submit the Forms CMS-64 and CMS-21, which are quarterly accounting statements of the state's actual recorded expenditures that serve as the primary basis for Medicaid payments to states under section 1903(a)(1) of the Act, and for CHIP payments to states under section 2105 of the Act. To substantiate claims at the increased FMAP or EFMAP for COVID-19 vaccine administration during the ARP FMAP period on the Forms CMS-64 and/or CMS-21, states must have access to and maintain claims data indicating that a COVID-19 vaccine was administered to an eligible Medicaid or CHIP beneficiary in accordance with 42 CFR 433.32 and 457.226, respectively. CMS recognizes that for certain bundled FFS payments, such as those made through prospective payment systems, health care provider claims may not detail when or whether a COVID-19 vaccine administration is delivered, and states may need to work directly with enrolled providers and update their provider manuals to ensure the state receives adequate documentation of the

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COVID-19 vaccine administration to support a claim for 100 percent FMAP or EFMAP during the ARP FMAP period.

CMS will permit states to claim the increased FMAP and EFMAP available during the ARP FMAP period for any bundled FFS payment that the state makes for a unit of service for which the state can document that COVID-19 vaccine administration was the only service provided, for the following reasons. First, in this circumstance, the bundled payment is the state's actual expenditure for COVID-19 vaccine administration. Second, this approach is the most administratively feasible proxy for capturing the vaccination costs built into these types of bundled payments. When a state pays a bundled payment per unit of service that is meant to reflect the provider's costs of providing all covered Medicaid or CHIP services, some portion of the state's bundled payments for units of service that do *not* include a COVID-19 vaccination would likely also be meant to reimburse the provider for its anticipated costs of administering COVID-19 vaccines. However, because the state could not show that an actual COVID-19 vaccination was provided during such units of service, it would have great difficulty substantiating a claim for 100 percent FMAP or EFMAP in the portion of the payment for such units of service that is meant to reimburse the provider for all COVID-19 vaccinations it provides.

However, when COVID-19 vaccine administration is provided with other Medicaid or CHIP services during a unit of service reimbursed with a bundled payment, states should identify the portion of the bundled payment that can be attributed to COVID-19 vaccine administration. In this circumstance, states should claim only the portion of the bundled payment associated with COVID-19 vaccine administration at the 100 percent FMAP or EFMAP for COVID-19 vaccine administration. States should claim the portion of the bundled payment that is not associated with COVID-19 vaccine administration at the FFP rate applicable to those service expenditures at the time of the state's claim for FFP. For example, if a beneficiary is administered a COVID-19 vaccine and also receives a screening and check-up during a unit of service for which the provider is paid a bundled payment, states would claim the portion of the payment associated with the COVID-19 vaccine administration at the 100 percent FMAP or EFMAP, and would claim the portion of the payment attributed to the screening and check-up at the FMAP or EFMAP applicable to those service expenditures.

States may use one of the two methodologies below to properly account for expenditures associated with COVID-19 vaccine administration when paid as part of a bundled FFS payment for a unit of service during which services in addition to a COVID-19 vaccination are provided to a beneficiary:

Allocation Method 1 – A state may use the state plan payment rates for COVID-19 vaccine administration paid to professional providers (e.g., physician services rates) as the amount claimed at 100 percent FMAP or EFMAP for each unit of service paid with a bundled payment that includes COVID-19 vaccine administration and other Medicaid or CHIP services. If a state pays different rates for COVID-19 vaccine administration based on the type of professional provider that administers the vaccine, the state should use the Medicaid state plan rate applicable to the provider type that actually administered the

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vaccine as the allocable amount. The state would subtract the state plan COVID-19 vaccine administration payment rate from the total bundled payment amount, and claim that portion of the payment at the 100 percent FMAP or EFMAP for COVID-19 vaccination expenditures. The state would claim the remainder of the bundled payment at the FFP rate applicable for the other services provided during the unit of service. This approach would reasonably approximate the state's expenditures associated with COVID-19 vaccine administration because the administering provider and associated cost of administering vaccines to beneficiaries would be the same or similar whether those services were reimbursed through a bundled payment or paid discretely.

Allocation Method 2 – A state may use cost report data (this could be Medicare cost report data, or Medicaid or CHIP cost report data that is reported using Medicare cost reporting principles) to identify and allocate the portion of a bundled payment associated with COVID-19 vaccine administration costs when the bundled payment is for a unit of service that includes COVID-19 vaccine administration and other Medicaid or CHIP services. States, with assistance from providers, could use cost report data (e.g., the Medicare 222 Clinic Cost Report) to determine the reasonable cost associated with Medicaid (or CHIP) COVID-19 vaccine administration on a per unit of service basis. States could claim this cost amount at the 100 percent FMAP or EFMAP for COVID-19 vaccine administration expenditures, for units of service that include both a COVID-19 vaccination and other services. For this approach to be feasible, the state would have to be able to obtain the filed cost report data in a reasonable time frame and, using the data, properly identify the amount allocable to Medicaid and/or CHIP COVID-19 vaccine administration for each such unit of service. The state would subtract the allocated Medicaid and/or CHIP COVID-19 vaccine administration cost amount for each such unit of service from the total bundled rate payment amount for that unit of service and claim the allocated amount at the 100 percent FMAP or EFMAP. The remainder of the bundled payment for the unit of service would be claimed at the applicable FFP rate for the other services at the time the state makes its claims for FFP (see above example described in Allocation Method 1). This approach would reasonably approximate the state's expenditures associated with COVID-19 vaccine administration because the cost data would be used to allocate the actual cost of providing COVID-19 vaccine administration to Medicaid and/or CHIP beneficiaries during a unit of service that includes both COVID-19 vaccination and other services.

The state could initially claim the increased FMAP or EFMAP available for COVID-19 vaccine administration expenditures using an approach similar to Allocation Method 1: that is, by claiming an interim amount that is the same as the COVID-19 vaccination payment rate paid to professional providers under the state plan for the portion of the bundled payment associated with COVID-19 vaccine administration. Later, the state's claim for the increased FMAP or EFMAP could be adjusted to reflect actual cost data after cost reports are filed with the state. While claims under both allocation method options are subject to the 2-year claims filing limit in section 1132 of the Act and the implementing regulations at 45 CFR part 95, subpart A, states should take particular care

to ensure adequate time is available to receive and process cost report data when selecting Allocation Method 2.

States are also welcome to propose alternative allocation methodologies for CMS's review and approval. CMS is available to provide technical assistance to help states determine an appropriate methodology for identifying Medicaid and/or CHIP COVID-19 vaccine administration expenditures during the ARP FMAP period.

Identifying Eligible Expenditures for COVID-19 Vaccine Administration under Managed Care during the ARP FMAP Period

In order for states to claim the temporary FMAP or EFMAP of 100 percent for amounts expended by a state in a managed care delivery system for COVID-19 vaccine administration, COVID-19 vaccine administration for Medicaid or CHIP beneficiaries enrolled in a managed care delivery system must be a covered benefit under the managed care contract. The portion of the capitation rate that is attributable to COVID-19 vaccine administration and for which the state may claim increased match should be determined based on the data utilized to develop the applicable capitation rates. The portion of the capitation rate claimed at the increased FMAP or EFMAP must be attributable only to COVID-19 vaccine administration. The entire capitation rate cannot be claimed at the increased FMAP or EFMAP even if the administration of a COVID-19 vaccine is the only service received by an enrollee during the period covered by the capitation payment. States may utilize claiming methodologies to identify a reasonable estimate (e.g., proxy) of a portion of the capitation rate attributable only to COVID-19 vaccine administration that is eligible for the increased FMAP or EFMAP. The use of a proxy methodology is solely for FFP claiming purposes and does not negate the requirements that Medicaid and CHIP capitation rates be actuarially sound and developed in compliance with federal requirements under 42 CFR part 438 for Medicaid and 42 CFR part 457, subpart L for CHIP. States have used similar claiming methodologies for FFP for services and populations such as family planning, section 1915(k) benefits, and the adult group described in section 1902(a)(10)(A)(i)(VIII) of the Act, when such services are delivered through managed care and paid as part of a capitation rate.

States could also pay for the COVID-19 vaccine and its administration outside of managed care capitation rates as a non-risk payment arrangement with the managed care plan, subject to the requirements for non-risk contracts specified under 42 CFR § 438.2 and the upper payment limits outlined in 42 CFR § 447.362. Alternatively, states can elect to carve the COVID-19 vaccine and its administration out of the managed care program and contracts and pay for it under their Medicaid FFS programs. Both of these options would simplify claiming increased FMAP or EFMAP, as neither requires a state to determine the portion of the capitation rate that is attributable to COVID-19 vaccines and their administration.

Section 2: Section 9814 of the ARP – Temporary Increase in FMAP for States that Begin to Expend Amounts for Certain Mandatory Individuals

Background

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Section 9814 of the ARP adds section 1905(ii) to the Act. Section 1905(ii) provides an 8-quarter, 5 percentage point increase to a qualifying state or territory's FMAP under section 1905(b) of the Act for a state that newly expands its Medicaid program by adopting under its state plan (or waiver of such plan, including a section 1115 demonstration) the entire eligibility group under section 1902(a)(10)(A)(i)(VIII) of the Act ("Adult group"). A qualifying state is a state that has not expended amounts for all individuals in the Adult group before the March 11, 2021 enactment date of the ARP. Effective beginning with the first calendar quarter during which a qualifying state expends amounts for all individuals in the Adult group, the 5 percentage point FMAP increase is available to a qualifying state for each quarter occurring during the 8-quarter period except for any quarter (and each subsequent quarter) during the 8-quarter period in which a state ceases its Adult group expansion (or limits the expansion to less than the entire Adult group). This increased FMAP applies to certain Medicaid expenditures covered under the state plan or waiver of the plan (including a section 1115 demonstration), as described in the Appendix. CMS encourages states considering newly covering the Adult group to refer to CMS regulations regarding the Adult group and the methodology for determining the federal share of expenditures for the Adult group at 42 CFR 435.119 and 42 CFR part 433, subpart E.

Application Rules

The 5 percentage point FMAP increase is available for services, including those covered under waivers and section 1115 demonstrations, if the state's expenditures for those services are matched at the state-specific FMAP defined in the first sentence of 1905(b) and the state and the expenditures otherwise meet the requirements in section 9814 of the ARP and all ordinarily applicable requirements for federal matching of Medicaid expenditures. As specified in section 1905(ii)(1), for applicable expenditure categories, a state may receive both the 8-quarter, 5 percentage point FMAP increase and the temporary 6.2 percentage point FMAP increase provided under section 6008 of the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127) at the same time, for a state and an expenditure that qualifies for both increases. As a reminder, the temporary 6.2 percentage point FMAP increase under section 6008 of the FFCRA is effective for each qualifying state beginning January 1, 2020 and extending through the last day of the calendar quarter in which the PHE declared by the Secretary of Health and Human Services for COVID-19, including any extensions, terminates.⁴ Please note that while both the 5 percentage point FMAP increase and the 6.2 percentage point FMAP increase apply to many of the same expenditure categories, there are some expenditure categories that may qualify for only one of these two increases. See the Appendix for more information on how the 5- percentage point FMAP increase applies to certain expenditure categories.

Section 3: Section 9815 of the ARP – Extension of 100 percent FMAP to Urban Indian Health Organizations and Native Hawaiian Health Care Systems

⁴ For more information on the criteria states must meet in order to qualify to receive the 6.2 percentage point FMAP increase under section 6008 of the FFCRA, please refer to Section IV, Subsection F, entitled "FFCRA Temporary FMAP Increase," of the COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies (Link: <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>).

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Section 9815 of the ARP amends the third sentence of section 1905(b) of the Act to provide 100 percent FMAP to states for their medical assistance expenditures for services received through an Urban Indian Organization (UIO), as defined at 25 U.S.C. 1603(29), that has a grant or contract with the Indian Health Service (IHS) under title V of the Indian Health Care Improvement Act (IHCIA). It also amends section 1905(b)'s third sentence to provide 100 percent FMAP to states for their medical assistance expenditures for services received through a Native Hawaiian Health Center (NHHHC) as defined at 42 U.S.C. 11711(4) or a qualified entity as defined at 42 U.S.C. 11705(b) that has a grant or contract with the Papa Ola Lokahi under 42 U.S.C. 11707. Under 42 U.S.C. 11705(b), a "qualified entity" means a Native Hawaiian health care system (NHHCS), which must also meet certain criteria as defined in 42 U.S.C. 11711(6).⁵

The 100 percent FMAP for medical assistance expenditures for services received through UIOs, NHHCs, and NHHCSs is available only for the eight fiscal quarters beginning April 1, 2021 and ending March 31, 2023. States will be able to claim 100 percent FMAP for services received through these entities retroactively to April 1, 2021.

Prior to the enactment of section 9815 of the ARP, the third sentence of section 1905(b) provided for 100 percent FMAP for "amounts expended as medical assistance for services which are received through an [IHS] facility whether operated by the [IHS] or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act)." This includes a facility that is operated by a Tribe or Tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA). This statutory language remains in place and was not changed by the ARP. CMS's long-standing interpretation of the pre-ARP language in section 1905(b)'s third sentence is that the 100 percent FMAP for these services is limited to expenditures for services received by American Indian and Alaska Native (AI/AN) Medicaid beneficiaries through IHS facilities (including those operated by Tribes or Tribal organizations). This interpretation of the pre-ARP language is based on the legislative history of that language, which indicates that Congress intended that the 100 percent FMAP would apply only to services received by Medicaid-eligible AI/ANs through IHS facilities (including those operated by Tribes or Tribal organizations).⁶

Unlike the legislative history of the pre-ARP language in the third sentence of section 1905(b), which supports CMS' current interpretation of that language, the legislative history of section 9815 of the ARP contains no indication that Congress intended the 100 percent FMAP for services received through UIOs, NHHCs, and NHHCSs to be limited to services provided to

⁵ Under title V of the IHCIA, the Indian Health Service (IHS) enters into limited, competing contracts and grants with non-profit organizations meeting the statutory definition of Urban Indian Organization to provide health programs for urban Indians residing in urban centers throughout the United States. The Health Resources and Services Administration (HRSA) provides grant funding to the Papa Ola Lokahi to coordinate health care programs and services provided to Native Hawaiians and to five NHHCSs to provide health services to fit the needs of Native Hawaiians located in their respective island communities.

⁶ See H. Rep. No. 94-1026 (1976) ("Since the 100 percent Federal matching funds are available under Medicaid only for services for Medicaid-eligible Indians in Indian Health Service facilities (where care is already provided without cost to these Indians), the Committee notes that this represents primarily a shift in Federal expenditures from the Indian Health Service budget to the Medicaid (title XIX) budget.").

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AI/ANs or Native Hawaiians.⁷ Therefore, CMS is interpreting the amendments made by section 9815 of the ARP to authorize 100 percent FMAP for expenditures for services received by *all* Medicaid beneficiaries through UIOs, NHHCs, and NHHCSs. CMS's longstanding interpretation limiting the application of 100 percent FMAP to services received by AI/AN beneficiaries through IHS facilities (whether operated by IHS or by Tribes or Tribal organizations) remains unchanged; states must claim services received by non-AI/AN beneficiaries through these facilities at their regular, state-specific FMAP under section 1905(b), or the otherwise applicable FMAP if that state-specific FMAP does not apply.

The third sentence of section 1905(b) of the Act is about the federal matching percentage that CMS pays to states for certain Medicaid expenditures, and it is silent about the payment rates states opt to pay to the health care providers named in that sentence. States have the discretion to set and adjust Medicaid provider payment rates, consistent with section 1902(a)(30)(A) of the Act, as long as the state payment rates are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the state plan at least to the extent that such care and services are available to the general population in the geographic area. CMS is available to provide technical assistance to states that believe adjusting their reimbursement rates for UIOs, NHHCs, and NHHCSs is appropriate.

Section 4: Claiming FFP at the Increased FMAP under Sections 9811, 9814, 9815, and 9821 of the ARP through the MBES/CBES

FFP associated with the temporarily increased FMAP and EFMAP under sections 1905(hh), 1905(ii), and 2105(c)(12) of the Act, and the third sentence of section 1905(b) of the Act, is made available to states based on amounts reported by states on quarterly budget and expenditures reports in MBES/CBES. As discussed above, under sections 1905(hh) and 2105(c)(12) of the Act, a temporary FMAP and EFMAP of 100 percent is available for qualifying state expenditures on COVID-19 vaccines and their administration beginning April 1, 2021 (third quarter of the federal fiscal year (FFY) 2021) and ending on the last day of the first quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act. As discussed above, under the third sentence of section 1905(b) of the Act, a temporary FMAP of 100 percent is available for qualifying state medical assistance expenditures for services received through certain UIOs, NHHCs and NHHCSs from April 1, 2021 through March 31, 2023. And, as discussed above, under section 1905(ii) of the Act, effective beginning with the first calendar quarter during which a qualifying state expends amounts for all individuals in the Adult group, a 5 percentage point FMAP increase is available to a qualifying state for each quarter occurring during an 8-quarter period except for any quarter (and each subsequent quarter) during the 8-quarter period during which a state ceases its Adult group expansion (or limits the expansion to less than the entire Adult group).

⁷ H. Rep. No. 117-7 (2021), at 173 (“Section 3106 would, for eight calendar quarters, provide a 100 percent federal matching rate for services to Medicaid enrollees who access care in the Urban Indian Health Programs (UIHPs) or the Native Hawaiian Health Care System(NHHCS).”), <https://www.congress.gov/117/crpt/hrpt/7/CRPT-117hrpt7.pdf>.

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- **Obtaining FFP associated with the increased FMAP for Medicaid under sections 1905(hh) and 1905(ii) of the Act and the third sentence of section 1905(b)**
 - **Form CMS-37** - CMS will provide advance FFP associated with the temporary increased FMAP under sections 1905(hh) and 1905(ii) of the Act and the third sentence of section 1905(b) to states based on budget estimates submitted on the quarterly Form CMS-37 (Medicaid Program Budget Report; Quarterly Distribution of Funding Requirements) as described in 42 CFR 430.30(b).
 - **Form CMS 64** - CMS will reconcile the advance FFP amounts that include temporary increased FMAP under sections 1905(hh) and 1905(ii) of the Act and the third sentence of section 1905(b) to states' actual recorded expenditures submitted through the quarterly Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program) as described in 42 CFR 430.30(c).

- **Obtaining FFP associated with increased EFMAP for Medicaid-CHIP (MCHIP)/CHIP under section 2105(c)(12) of the Act**
 - **Form CMS 37/21B** – CMS will provide an advance adjustment amount to a state's applicable fiscal year CHIP Allotment based on budget estimates submitted by the state on the applicable quarterly Form CMS 37.1/37.3 for its Medicaid-CHIP (MCHIP) Expansion and Form CMS-21B for a separate CHIP as described in 42 CFR 457.630(b), as applicable.
 - **Form CMS 64.21U/CMS 21** - CMS will reconcile such fiscal year's advance CHIP allotment adjustment based on actual recorded expenditures submitted through the quarterly Form CMS 64.21U for Medicaid-CHIP (MCHIP) Expansion and Form CMS-21 as required by 42 CFR 457.630(c) for CHIP, as applicable.
 - **Please note:** Section 9821(c) of the ARP adds section 2104(m)(12) to the Act, which provides for an adjustment to a state's fiscal year CHIP allotment, beginning with FY 2021, related to the increased expenditures associated with the 100 percent EFMAP for vaccine and vaccine administration under section 2105(c)(12) of the Act for such fiscal year. CMS provided additional information regarding this provision in the budget instructions emailed to states on August 5, 2021.

- **MBES Modifications** - CMS is working to modify the MBES to reflect the temporary increased FMAP and EFMAP under sections 1905(hh), 1905(ii), 2105(c)(12), and the third sentence of section 1905(b) of the Act. Once the MBES/CBES is modified, the system will enable state entry of expenditures at these temporary matching rates, and will apply the increases to actual claimed expenditures. Expenditure reporting associated with the temporary increased matching rates for the third quarter of FFY 2021 may be delayed. In those cases, states may need to report expenditures associated with these rates through prior period adjustments in subsequent quarters.

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- **Other Expenditure Reporting Information** - States should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter. The applicable FMAP is based on date of payment, not date of service for current quarter original expenditures. The FMAP applicable to expenditures for prior period adjustments should be the FMAP at which the original expenditure was claimed, for both private and governmental providers. All states are responsible for reporting Medicaid and CHIP collections and overpayments on the Form CMS-64 and CMS 21, as required by our regulations. States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including the temporary increased FMAP or EFMAP under 1905(hh), 1905(ii), or 2105(c)(12) of the Act or the third sentence of section 1905(b) of the Act. Recoveries of FFP must be returned at the same match rate at which they were originally claimed. Therefore, if a Medicaid or CHIP expenditure was claimed using the temporary increased FMAP or EFMAP under section 1905(hh), 1905(ii), or 2105(c)(12) of the Act, or the third sentence of section 1905(b) of the Act, the federal share of any recoveries associated with that expenditure should be returned using the same temporary increased FMAP or EFMAP. Consistent with existing requirements, states must document expenditures to ensure a clear audit trail, including isolating expenditures that are matched at increased FMAP or EFMAP rates. CMS will conduct oversight to ensure that expenditures are allowable, accurate, and are claimed at the correct FMAP rate.

Section 5: Administrative Claiming for State-Funded Beneficiary Incentives for COVID-19 and Influenza Vaccinations

Recently, the Federal government and states have taken numerous steps to address COVID-19 vaccine hesitancy and to increase COVID-19 vaccination rates, because of the significant burden COVID-19 has had on the healthcare system. In addition to the strain on the healthcare system from COVID-19, influenza can place a substantial burden on Medicaid and CHIP providers and beneficiaries each year. Thus, in addition to supporting state efforts to encourage uptake of COVID-19 vaccinations among Medicaid and CHIP beneficiaries, CMS supports state efforts to encourage uptake of influenza vaccinations among Medicaid and CHIP beneficiaries. Improved influenza vaccination rates may help to reduce strain on the healthcare system and better enable providers to focus on treating COVID-19 and other conditions. While all vaccinations help to address the burden of disease, both COVID-19 and influenza have proven to be especially detrimental to beneficiaries in facility settings. In addition, as the country enters into the influenza season during an increase of COVID-19 cases and the return of many individuals to in-person academic and work settings, it is of paramount importance that beneficiaries access all resources necessary to avoid infections and subsequent medical visits.

CMS has received questions from multiple states about whether administrative FFP is available for state-funded monetary incentives to Medicaid and CHIP beneficiaries to encourage them to get a COVID-19 or influenza vaccination. We have determined that FFP is available, subject to applicable federal requirements, for state administrative costs on monetary incentives funded by states and paid to Medicaid and CHIP beneficiaries in an effort to increase vaccination uptake for COVID-19 or influenza. These costs will further the efficient administration of the Medicaid and

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CHIP programs by encouraging COVID-19 and influenza vaccination uptake among Medicaid and CHIP beneficiaries, thereby reducing the incidence of these diseases and reducing burden on the health care system. We are available to provide technical assistance to states that are interested in developing beneficiary vaccine incentive programs and will adjudicate state proposals on a case-by-case basis, consistent with the existing process for administrative claiming proposals. Below, we discuss the application of this policy to help states better understand which costs they may propose to claim as administrative costs under Medicaid and CHIP.

Section 1903(a)(7) of the Act and implementing regulations at 42 CFR 433.15(b)(7) specify payment of FFP at 50 percent for state expenditures found necessary by the Secretary for the proper and efficient administration of the Medicaid state plan. Similarly, states may claim for reasonable costs incurred by the state to administer the CHIP state plan at state-specific rates for CHIP under section 2105(a)(1)(D)(v) of the Act.⁸ CMS determines which activities fall under the definition of administrative expenditures eligible for FFP under these authorities. CMS has consistently stated that allowable claims under section 1903(a)(7) must be directly related to the administration of the Medicaid program, and therefore must be directly related to Medicaid state plan or waiver services.⁹ Similarly, 42 CFR 457.622(e) provides that CHIP administrative expenditures should support the operation of the State child health assistance plan, and that, in general, FFP for administration under title XXI is not available for costs of activities related to the operation of other programs.

CMS has determined that paying beneficiaries a monetary incentive, out of state funds, to receive COVID-19 and influenza vaccinations, could be necessary for the proper and efficient operation of the Medicaid state plan and a reasonable cost of administering the CHIP state plan in certain circumstances. States might be able to establish that administrative expenditures on state-funded beneficiary vaccine incentives for these vaccines would increase uptake of these vaccines, and thus would lead to more efficient operation of the state plan by significantly reducing the likelihood of severe COVID-19 and/or influenza disease burden among vaccinated beneficiaries, thereby reducing utilization of health care resources, improving access to health care providers for all beneficiaries, and lowering costs for the Medicaid and/or CHIP programs. Moreover, encouraging beneficiaries to get vaccinated for COVID-19 and influenza would benefit even beneficiaries who remain unvaccinated, because it would make it less likely that unvaccinated beneficiaries would become ill with those diseases, by promoting increased population immunity.

States that are interested in claiming their expenditures on state-funded COVID-19 or influenza vaccine administration incentives as an administrative cost in Medicaid or CHIP should submit an amendment to their Public Assistance Cost Allocation Plan (PACAP), which is approved by

⁸ Administrative costs related to CHIP receive federal match at the state's EFMAP rate for health care services, and therefore the matching rate for these costs varies by state. However, administrative costs for CHIP are limited to 10 percent of the state's annual federal CHIP spending. See Section 2105(c)(2)(A) of the Act.

⁹ See State Medicaid Director Letter (Dec. 20, 1994) (1994 SMDL), <https://www.hhs.gov/guidance/document/allowable-administrative-costs>.

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HHS's Division of Cost Allocation Services (CAS), with CMS concurrence. As is always the case, CMS recommends that states submit the proposed administrative claiming methodology to CMS in advance of, or concurrently with, submission to CAS for review and approval to expedite the process. CMS will review the proposal using our existing administrative claiming criteria, as outlined in the 2003 *Medicaid School-Based Administrative Claiming Guide*,¹⁰ as well as cost allocation principles at 2 CFR part 200. Reported expenditures must be reasonable, allowable, and allocable. As stated in the 1994 SMDL, Medicaid state administrative costs matched by CMS may not include funding for general public health initiatives that are made available to all persons, such as statewide vaccine initiatives, unless the campaign is explicitly directed at assisting Medicaid-eligible individuals to access the Medicaid program.¹¹ Other general principles from the 1994 SMDL also apply (e.g., an allowable administrative cost must be supported by a system that has the capability to isolate the costs directly related to the support of the Medicaid program from all other costs incurred by the agency).

To be considered for approval, any state proposal for vaccine incentives would need to include safeguards to ensure that the incentive is received only by the beneficiaries or the guardians of beneficiaries who receive a vaccine. In addition, any claims for FFP must meet documentation requirements and are subject to audit. Documentation for administrative activities must clearly demonstrate that the activities directly support the administration of the Medicaid or CHIP program.¹² See 42 CFR 433.32(a) and 457.226(a) (requiring that states maintain an accounting system and supporting fiscal records to assure that claims for federal funds are in accord with applicable federal requirements), and 42 CFR 433.32(b) and (c) and 457.226(b) and (c) (establishing retention periods for records that support claims for federal funds). Also, 42 CFR 457.622(e) provides that allowable administrative expenditures under CHIP "should support the operation of the State child health assistance plan" and that generally, "FFP for administration under title XXI is not available for costs of activities related to the operation of other programs." CMS may also ask that a state agree to provide an evaluation of the impact of the federally matched incentives on vaccine uptake. Finally, any state proposal to disseminate state-funded vaccine beneficiary incentives through health care providers or managed care plans should include appropriate safeguards to prevent abuse and to ensure compliance with all existing federal requirements regarding payments to Medicaid and CHIP beneficiaries.

For managed care enrollees, CMS would permit states to contract with their managed care plans to disseminate state-funded beneficiary vaccine incentives for COVID-19 and influenza to beneficiaries as an administrative activity. Any administrative costs or payments to the plans associated with performing the activities associated with beneficiary vaccine incentives must be paid separately on an administrative cost basis and not included in the risk-based managed care capitation rates under separate contracts or amendment to an existing contract. States could pay the managed care plans for performing the activities associated with administering these incentive programs on a cost basis and then claim FFP for those expenditures under the administrative cost claiming authorities described above for incentive payments made to beneficiaries to incentivize beneficiaries to become vaccinated. States should ensure that they

¹⁰ <https://www.hhs.gov/guidance/document/2003-school-based-administrative-claiming-guidance>.

¹¹ <https://www.hhs.gov/guidance/document/allowable-administrative-costs>.

¹² Id.

receive the managed care plan data that is necessary for any requested evaluation of the impact of the federally-matched incentives on vaccine uptake.

Closing

CMS is committed to supporting states in their efforts to provide access to COVID-19 vaccinations. CMS will consider state requests for federal matching funds for their administrative expenditures to pay beneficiaries monetary incentives to increase uptake of COVID-19 and influenza vaccinations. As discussed above, sections 9811 and 9821 of the ARP provide for coverage of COVID-19 vaccine administration and for a temporary increase in FMAP and EFMAP for state expenditures on that coverage. CMS is also committed to working with states on issues related to expanding their Medicaid programs to cover certain low-income adults and to helping states access the temporary 100 percent FMAP for services received through certain UIOs, NHHCs and NHHCSs. CMS is available to provide technical assistance in all these areas.

If you have specific questions regarding coverage SPAs, please contact Kirsten Jensen at 410-786-8146.

If you have specific questions about submitting a Medicaid expansion SPA, please contact Sarah Spector at 410-786-3031.

If you have specific questions about submitting reimbursement SPAs, please contact Todd McMillion at 312-353-9860.

Sincerely,

A black rectangular redaction box covering the signature of Daniel Tsai.

Daniel Tsai
Deputy Administrator and Director

Appendix – Application of the Increased FMAP under Section 1905(ii) of the Act

In general, states' expenditures for medical assistance are matched at the state-specific FMAP defined in the first sentence of section 1905(b) of the Act unless otherwise specified in statute. For a "qualifying state" defined under section 1905(ii)(3) of the Act, the FMAP determined under section 1905(b) of the Act "for such [s]tate" is increased by 5 percentage points for an 8-quarter period under section 1905(ii)(1) of the Act. The increased FMAP under section 1905(ii) also applies to qualifying territories' FMAPs, which are defined under section 1905(ff) of the Act for the period between December 21, 2019 and September 30, 2021, so the references in this section to "states" also include the territories.¹³

Because the language of section 1905(ii) refers to an increase in the FMAP determined under section 1905(b) "for such [s]tate," CMS will apply the temporary 5 percentage point FMAP increase under section 1905(ii) of the Act to expenditures matched at the state-specific FMAP defined in the first sentence of section 1905(b) of the Act, with certain exceptions as described below. The definition of the state-specific FMAP in section 1905(b) is modified by language referencing other statutory provisions. For example, the first sentence of section 1905(b) says that the state-specific FMAP defined in that section is "subject to" certain other provisions of section 1905, including 1905(ii). However, some of those other provisions of section 1905 also include language indicating that the FMAP described in the provision replaces the FMAP in the first sentence of section 1905(b) entirely, in which case the section 1905(ii) increase does not apply.

Certain other statutory provisions increase the state-specific FMAP in the first sentence of 1905(b) of the Act. The temporary 5 percentage point FMAP increase under section 1905(ii) of the Act is available in addition to certain other FMAP increases, including:

- The 10 percentage point increase under section 9817 of the ARP, which temporarily increases the FMAP by 10 percentage points, up to 95 percent, for allowable medical assistance expenditures for certain home and community-based services under the Medicaid program beginning April 1, 2021, and ending March 31, 2022. (Section 9817(a) of the ARP provides that this 10 percentage point increase is in addition to any increase applicable under section 1905(ii) of the Act but in no case can the FMAP for these expenditures exceed 95 percent).
- The 1 percentage point increase under clause (5) of the first sentence of section 1905(b) of the Act for certain preventive services and vaccinations when that increase is applied to the state's FMAP as defined in section 1905(b)'s first sentence (because this increase is defined in the first sentence of section 1905(b)).

¹³ Section 1905(ii)(2)(D) provides that the temporary FMAP increase for territories' expenditures under section 1905(ii) is not taken into account for the purposes of applying the caps on federal matching funds under section 1108(f) and (g) of the Act.

- The 6 percentage point increase for Community First Choice (CFC) expenditures under section 1915(k) of the Act (which is an increase to the FMAP “applicable to the State (as determined under section 1905(b)),”¹⁴ and thus increases the FMAP in section 1905(b)’s first sentence).
- The increased FMAP for expenditures related to the Money Follows the Person demonstration program defined in the Deficit Reduction Act of 2005 (Pub. L. 109-171), section 6071(e)(5) (because that law expressly states that this FMAP increase is to the FMAP defined in section 1905(b)’s first sentence).
- The 6.2 percentage point FMAP increase to the state-specific FMAP defined in the first sentence of 1905(b) of the Act as provided under section 6008 of the FFCRA for states and expenditures that qualify for that temporary FMAP increase (because this is authorized by the language of section 1905(ii), but note that not all expenditures can qualify for both increases).

Section 1905(ii)(2) of the Act explicitly precludes the application of the temporary 5 percentage point FMAP increase to certain types of expenditures. Specifically, section 1905(ii)(2) provides that this increase:

- Does not apply with respect to Medicaid disproportionate share hospital (DSH) payments under section 1923 of the Act (note that because the federal match rate for DSH payments can be increased by the FFCRA section 6008 increase, this is an example of when the two FMAP increases under section 1905(ii) and FFCRA section 6008 do not both apply to the same expenditure category).
- Is not taken into account when calculating the enhanced FMAP determined under section 2105(b) of the Act, which is the federal match rate for:
 - Child health assistance expenditures for targeted low income children as defined in section 2110 of the Act (separate CHIP); expenditures for optional targeted low income children as provided under section 1905(u) of the Act (Medicaid-CHIP expansion) as applicable; qualifying state expenditures described under section 2105(g) of the Act, and most expenditures identified under section 2105(a)(1)(D) of the Act including payments for other child health assistance for targeted low-income children, health services initiatives (HSIs), outreach activities, and other reasonable costs incurred by the State to administer the plan;
 - Expenditures for individuals eligible for medical assistance on the basis of needing treatment for breast or cervical cancer (see clause 4 of section 1905(b)’s first sentence); and
 - Expenditures for services provided to certain enrollees under the Certified Community Behavioral Health Clinics program (see section 223(d)(5)(B) of the Protecting Access to Medicare Act of 2014, Pub. L. 113-93).
- Is not taken into account for the purposes of block grants for TANF, supporting enforcement of child support obligations, or foster care and transitional independent living programs under Titles IV-A, IV-D, or IV-E of the Act.

¹⁴ Section 1915(k)(2) of the Act.

Additionally, because the 5 percentage point FMAP increase under section 1905(ii) does not apply to expenditures that are not matched at the state-specific FMAP defined in the first sentence of section 1905(b) of the Act, there are several other state expenditures to which the section 1905(ii) increase does not apply. This includes any expenditure for which the FMAP is defined under other provisions of the Act. For example, while the first sentence of section 1905(b) is “subject to” the FMAP in section 1933(d) relating to the Qualifying Individuals program, the FMAP in section 1933(d) is not a state-specific FMAP defined under section 1905(b), so it is not increased under section 1905(ii). Additionally, as discussed above, other expenditures are matched at FMAPs defined in provisions that the first sentence of section 1905(b) is “subject to,” but the language defining those FMAPs indicates that they are meant to supersede or replace the state-specific FMAP entirely. Accordingly, the following categories of expenditures, in addition to those listed in section 1905(ii)(2), are *not eligible* to receive the 5 percentage point FMAP increase under section 1905(ii) of the Act:

- Expenditures matched at the various federal financial participation (FFP) rates provided in sections 1903(a)(2) through (a)(7) of the Act (such as administrative expenditures and expenditures for family planning services and supplies).
- Expenditures matched at the “disaster-recovery” FMAP specified in section 1905(aa) of the Act.
- Adult group expenditures matched at the “newly eligible” FMAP specified in section 1905(y) of the Act.
- Adult group expenditures matched at the “expansion state” FMAP specified in section 1905(z).
- Expenditures for medical assistance services “received through” the following types of facilities, which are matched at 100 percent FMAP under the third sentence of section 1905(b) of the Act (i.e., not the first sentence of that section):
 - An IHS facility (including facilities operated by an Indian tribe or tribal organization under the ISDEAA);¹⁵
 - A UIO (as defined at 25 U.S.C. 1603(29)) that has a grant or contract with the IHS under title V of the IHCA, from April 1, 2021 through March 31, 2023;¹⁶ or
 - An NHHCS or NHHCS (as described above), from April 1, 2021 through March 31, 2023.
- Expenditures matched at 100 percent for individuals in Qualifying Individuals programs under section 1933(d) (see discussion above).
- Expenditures for health home services under section 1945 of the Act when matched at the 90 percent FMAP as specified in section 1945(c)(1). After the initial increased FMAP period for these services that is described in section 1945(c)(1) ends, expenditures on section 1945 health home services may be eligible for the 5 percentage point increase under section 1905(ii) of the Act.
- Expenditures for health home services for children with medically complex conditions under section 1945A of the Act, when qualifying expenditures receive a temporary 15

¹⁵ As discussed above, 100 percent FMAP will be limited to expenditures for services received by American Indian and Alaska Native (AI/AN) Medicaid beneficiaries through IHS facilities (including those operated by Tribes or Tribal organizations under the ISDEAA).

¹⁶ As discussed above, 100 percent FMAP will apply to expenditures for services received by all Medicaid beneficiaries through UIOs, NHHCSs, and NHHCSs.

percentage point FMAP increase as described in section 1945A(c)(1) of the Act. After the increased FMAP period for these services that is described in section 1945A(c)(1) ends, expenditures on section 1945A health home services may be eligible for the 5 percentage point increase under section 1905(ii) of the Act.

- Expenditures for medical assistance for COVID–19 vaccines and the administration of these vaccines, which are matched at 100 percent FMAP “[n]otwithstanding any other provision of this title” under section 1905(hh) of the Act, as added by section 9811 of the ARP.
- Expenditures for qualifying community-based mobile crisis intervention services under section 1947 of the Act as added by section 9813 of the ARP, for the applicable 12-quarter period that they are matched at 85 percent FMAP, unless application of the 5 percentage point increase under section 1905(ii) to the state’s regular FMAP defined in the first sentence of section 1905(b) would result in an FMAP higher than 85 percent (in which case that higher FMAP applies to those expenditures).¹⁷
- Expenditures eligible for 100 percent FMAP for services furnished to beneficiaries eligible under the optional COVID-19 group defined in section 1902(a)(10)(A)(ii)(XXIII) of the Act, as added by section 6004 of the FFCRA. The federal matching rate for these expenditures is defined in the last sentence of section 1905(b) of the Act, not the first.

¹⁷ See section 1947(c) of the Act.