



Center for Medicaid and State Operations

SMD #09-005  
ARRA #5

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Dear State Medicaid Director:

This letter is another in a series of State Medicaid Director correspondence that provides guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Public Law 111-5. This letter provides guidance on the process for accessing the increased Federal Medical Assistance Percentage (FMAP), expenditures for which the increased FMAP is available, and the eligibility “maintenance of effort” (MOE) requirements under section 5001(f) of the Recovery Act.

Section 5001 of the Recovery Act provides eligible States with an increased FMAP for 27 months between October 1, 2008, and December 31, 2010. Under section 5001(f), 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 policies 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. Furthermore, this letter reminds States that, in order to retain Recovery Act funds already drawn, any known MOE violations must have been corrected by June 30, 2009.

**Background**

On February 17, 2009, the Recovery Act was signed into law. The legislation authorizes an estimated \$87 billion in fiscal relief for States in the form of a temporary increase in the funds that the Federal Government contributes toward Medicaid. In an effort to be responsive to public inquiries, on March 25, 2009, the Centers for Medicare & Medicaid Services (CMS) released preliminary information through a Fact Sheet and paper addressing frequently asked questions. This letter provides additional guidance and clarification, and supersedes those prior issuances.

**Increased FMAP Grant Issuance**

States eligible for the increased FMAP will be able to access the additional funds on an ongoing basis. At the beginning of each quarter, the estimated amount of additional funding for that quarter will be determined in accordance with the provisions of section 5001 of the Recovery Act. The estimated additional funds will be determined by calculating the difference between

the increased FMAP under the Recovery Act and the pre-Recovery FMAP, and then multiplying that difference by the estimates of appropriate expenditures submitted by each State.

Initial funding related to the increased FMAPs has been made available to States through separate grant awards issued under the Payment Management System (PMS) in accounts established specifically for the increased FMAP funds. Subsequent grant 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 Recovery Act. The CMS grant letters direct that acceptance of the grant award and withdrawal of such funds from the PMS equates to an attestation by each State that the State 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 Recovery Act.

#### Required Passive Attestations Under the Grant Award

In order to minimize the need for separate review, CMS included five requirements as attestations in each grant award letter to the States. The grant award letter indicates that only after the State has conducted self-assessment and determined that it meets all the requirements under which the increased FMAP and associated funds are available, was it free to draw such funds. This process is referred to as a “passive attestation” whereby each State confirms through its withdrawal of the funds that it meets all requirements. This process obviated the need for a State to submit written confirmation that it met the requirements prior to receiving its funds; rather, the drawing of such funds represents the State’s attestation that it meets all the requirements. The attestations are included as Enclosure A.

#### **Expenditures Eligible for Increased FMAP**

As indicated in the fourth attestation under the grant award, the State must ensure that claims for the increased FMAP include only those expenditures for which it is applicable. Under section 5001(e); the increased FMAP is applicable generally to title XIX, but is not applicable to certain enumerated expenditures. The following list includes those expenditures and certain others to which the increased FMAP is inapplicable for other reasons:

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 Social Security 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 the Recovery Act;
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 Federal poverty level (FPL)) 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.

In general, CMS has interpreted these exclusions narrowly. The increased FMAP is not available for expenditures for eligibility expansion populations added after July 1, 2008; to the extent that the expansion is due to higher income standards for eligibility groups for which the income standard is statutorily based on the FPL, including adding a new FPL-based eligibility group. For example, if the State raised the income standard for an eligible group from 133 to 150 percent of the FPL, expenditures for such individuals with income greater than 133 percent of the FPL would only be eligible for the regular FMAP.

Since medically needy income standards are not statutorily based on the FPL; increases in those standards would be eligible for the increased FMAP. Similarly, changes in the income standards under section 1931 of the Act would be eligible for the increased FMAP, since those standards are based on the prior levels under title IV-A.

If a State can demonstrate that an increase in an income standard was enacted under State law prior to July 1, 2008, and not effective before that date, or that the change had been submitted to CMS as a State plan amendment or waiver request, but had not yet been approved before that date, such an increase would be eligible for increased FMAP.

However, an increase in an income standard enacted under State law after July 1, 2008, or not submitted to CMS for approval until after July 1, 2008, and claims associated with those groups would not be eligible for increased FMAP. For example:

Not Eligible for Increased FMAP	Eligible for Increased FMAP
<ul style="list-style-type: none"> <li>- Increases in an income level statutorily based on the FPL after June 30, 2008; AND/OR,</li> <li>- Addition of a new eligibility group based on the FPL after June 30, 2008.</li> </ul>	<ul style="list-style-type: none"> <li>- Increases in an income level statutorily based on the FPL enacted under State law prior to July 1, 2008, but <u>not effective</u> until after that date; OR,</li> <li>- Increases in an income level statutorily based on the FPL included in a State plan amendment or waiver request under title XIX that was pending approval by CMS on July 1, 2008; OR,</li> <li>- Increase in income standards, or the addition of eligibility groups that are not expressed as a percentage of the poverty line, e.g. the medically needy (irrespective of date).</li> </ul>

The CMS intends to address the issues related to the prompt pay exclusion in separate guidance.

### **Eligibility Maintenance of Effort (MOE) Requirements**

Under section 5001(f)(1) of the Recovery Act, a State is not eligible for the increased FMAP if it adopts “eligibility standards, methodologies, or procedures,” (referred to below as “eligibility policies”) under its State plan or any waiver, that are more restrictive than those in effect on July 1, 2008. The first required passive attestation incorporated into the grant award concerns this eligibility MOE requirement. A State should first determine whether it has changed its eligibility policies from those in effect on July 1, 2008. In general, the statutory term “in effect” means the actual standards, methodologies, or procedures that States were utilizing on July 1, 2008, to determine or redetermine eligibility for Medicaid under the State plan or through a waiver program, and which are consistent with Federal statute and regulations. To the extent that a State has not changed its actual eligibility policies since July 1, 2008, there would be no eligibility MOE issue. CMS will not consider a State to have changed its eligibility policies when the State amends outdated provisions in State guidance or even in the State plan when such amendments merely codify policies that were actually in effect on July 1, 2008, and are consistent with Federal law.

If a State has changed its eligibility policies, the next question is whether those changed policies are more restrictive than those in effect on July 1, 2008. In reviewing this issue, CMS will not consider as more restrictive changes in eligibility policies that were required to comply with Federal statutes, regulations, or provisions of a State plan, demonstration, or waiver program approved as of July 1, 2008. The Recovery Act contains no language indicating that Congress intended to limit ongoing actions required to ensure compliance with program requirements. Furthermore, it is not plausible to require States to choose between the increased FMAP and potential disallowances for expenditures that were inconsistent with applicable Medicaid authorities.

Apart from compliance-related changes, CMS would consider changes in State eligibility policies to be more restrictive if the changes result in determinations of ineligibility for individuals who would have been considered eligible as of July 1, 2008. This includes changes that impose burdens on eligible beneficiaries that cause them to be determined ineligible. For example, changes in the frequency of eligibility re-determinations (for example, from 12 months to 6 months) cause eligible individuals to lose coverage and would be considered more restrictive. Similarly, increases in premiums or enrollment fees that are a condition for eligibility would be considered more restrictive. Changes in section 1915(c) waiver eligibility to replace aggregate cost neutrality with individual cost neutrality or to eliminate occupied or funded waiver capacity would also be more restrictive. More stringent institutional level of care assessments, which impact eligibility for individuals in institutional and section 1915(c) home and community based settings, are additional examples of changes resulting in more restrictive eligibility policies.

More restrictive eligibility policies would also include more restrictive income or resource standards, disability criteria, or the elimination or reduction of liberal income and/or resource methodologies under section 1902(r)(2) of the Act that had been in effect as of July 1, 2008. In addition, elimination of any eligibility group or subgroup that was included under the approved State plan or under an approved waiver as of July 1, 2008, would be viewed as more restrictive.

For example, even if a medically needy group as a whole is still covered under the State plan, elimination of one or more categorical subgroups (e.g., the aged, or the disabled) from the group is a more restrictive eligibility policy.

Similarly, elimination of any eligibility group or subgroup authorized pursuant to 42 CFR 435.217 under a section 1915(c) waiver would be a more restrictive eligibility policy. The same would be true for elimination of a group or subgroup of individuals eligible under a title XIX demonstration project pursuant to section 1115 of the Act, including combination title XIX and title XXI demonstrations, except to the extent that the demonstration involved a separate title XXI program demonstration, to which title XXI rules apply.

Importantly, reductions in waiver slots under section 1915(c) waivers may be considered MOE issues because of the direct relationship between enrollment in a 1915(c) waiver and Medicaid eligibility for the individuals described in 42 CFR 435.217. In particular, reductions in the maximum number of waiver slots in an approved waiver would only be consistent with the Recovery Act MOE requirements if the State can demonstrate that the number of waiver slots available is the higher of the number of waiver slots that were occupied as of July 1, 2008, or the number the State legislature actually funded as of that date. Any such changes must be expressly identifiable in State law. Funding may not be reduced to a level below that which was available on July 1, 2008.

More restrictive eligibility policies would also include changes in eligibility procedures that are not reflected in an approved State plan or approved waiver document. Therefore, CMS may not be aware of an MOE issue in a State unless either the State or other concerned parties alert CMS to the issue. For this reason, each State must review its own eligibility policies to determine if there is a change, and if it is more restrictive. CMS will continue to work with States to provide technical assistance to determine the necessary action to assure compliance with approved State plans, waiver programs and the Recovery Act requirements throughout the period ending on December 31, 2010.

Program modifications that do not directly affect eligibility are not subject to the eligibility MOE requirements. These modifications include changes to the post-eligibility application of patient income to the cost of institutional or other long-term care, modifications to provider payment rates, modifications to the benefit package that would eliminate optional benefits, or imposition or increase of co-payments or co-insurance with respect to a covered service.

### **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 reversed 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 is only effective prospectively, 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.

Included with this letter is also an enclosure which provides some examples of what would constitute a restriction to eligibility standards, methodologies, or procedures.

If you have questions regarding this guidance, please contact Mr. Bill Lasowski, Deputy Director, Center for Medicaid and State Operations who may be reached at (410) 786-2003.

Sincerely,

/s/

Cindy Mann  
Director

Enclosures

cc:

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