



## **American Recovery and Reinvestment Act of 2009 Frequently Asked Questions from States July 7, 2009**

### **Division B, Title I, Section 1001 - Making Work Pay Credit**

**Question 1:** Unlike last year's stimulus payment and regular tax refunds, the Making Work Pay credit is not being sent as a separate check, or just included in a tax refund. People who are working will start getting it in their paychecks as early as April. The tax withheld from their gross pay will go down, resulting in them receiving more take home pay. However, the ARRA says that this amount of credit is not counted as income for determining eligibility for federally funded programs. We are not sure what we are supposed to do. Are we supposed to reduce the amount of the person's gross earned income by the amount of this credit that they will be receiving in each check? Or do we continue to count the person's gross income? Has CMS discussed any method of identifying what the amount would be that we would not count or how we would figure that out?

**Answer:** Section 1001 of the Recovery Act adds a new section to the Internal Revenue Code. Under this new section, a credit against taxes paid is provided to individuals who meet that section's requirements. According to the Internal Revenue Service's Web site (<http://www.irs.gov/newsroom/article/0,,id=204447,00.html>) for people who receive a paycheck and are subject to withholding, the credit will be handled by their employers through automated withholding changes in early spring.

The change in withholding is likely to produce more take home pay for those receiving credit through their paychecks. For others, the credit can be claimed on their 2009 and 2010 tax returns. The credit is the lower of 6.2 percent of the person's earned income, or \$400 (\$800 for a joint return).

To determine the dollar amount of the credit, multiply the individual's earned income (as defined for tax purposes) by 6.2 percent. The result is the dollar amount that should be disregarded. No more than \$400 for an individual, or \$800 for a couple filing a joint return, should be disregarded in any one year.

## **Division B, Title V, Section 5001 – Temporary Increase of Medicaid FMAP**

### **Computation of Increased FMAP**

**Question 2:** CMS indicated there is a Web site that shows States’ projected FMAP increases (percentage and dollars). Please provide the URL for this Web site.

**Answer:** State-specific funding information related to ARRA is accessible through the State funding link on the HHS Recovery Act Web site ([www.hhs.gov/recovery/](http://www.hhs.gov/recovery/)). This information is updated periodically. In order to ensure that States have this information readily available, CMS has shared with each State their preliminary increased FMAP rate as well as the increased Medicaid funding made available.

**Question 3:** Regarding the HHS.gov Web site article titled “Recovery Act (ARRA): Medicaid Grant Award Process” (<http://www.hhs.gov/recovery/fmapprocess.html>), the fourth paragraph states “CMS will use the unadjusted November 2008 Medicaid estimates for each State.” Please define the components of the “unadjusted” calculation.

**Answer:** The unadjusted November 2008 Medicaid estimates is the information as submitted by the States to CMS for the November 2008 budget submission and do not reflect any adjustments made by CMS to the information submitted.

**Question 4:** Will the increased FMAP rates be implemented on a cash basis? Would it be correct to say that the normal rules apply to the determination of FMAP for Medicaid expenditures?

**Answer:** Yes, the normal rules apply. The increased FMAP is available for allowable expenditures incurred by States in the applicable quarters. Under title XIX, medical assistance expenditures are considered to be incurred based on when the State makes a payment to a provider of services; it is not determined by the date of service. The quarter in which the State makes a payment is the quarter in which the expenditure will be considered to be incurred, and the FMAP applicable to that quarter is the appropriate FMAP for that claim. It is important to understand that under ARRA a State’s FMAP can change from quarter to quarter because of the application of the unemployment adjustment. Therefore, prior period expenditures during the period ARRA is in effect must be claimed at the applicable FMAP for the prior quarter. The Medicaid Budget and Expenditure System and Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES) prior period claim forms are being reprogrammed to accept quarterly prior period adjustments.

**Question 5:** We are very curious about the calculation of the FMAP. Since the unemployment numbers released by the Bureau of Labor Statistics (BLS) are preliminary for the first month, we want clarification that the preliminary number can be used in determining the FMAP for that Quarter. We also want to confirm that the three months immediately preceding the quarter will

be the ones used to calculate each quarter's FMAP. (Example: The quarter beginning October 1 will be based on the data available for June, July, and August, since the September unemployment numbers will not be available until the end of October.) Or will there be retroactive FMAP adjustments if the final number for a month changes from the preliminary or to include the immediately preceding month's unemployment?

**Answer:** Section 5001(c) describes the calculation for determining the increase to a State's FMAP related to the levels of unemployment in the State; the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department performs this calculation based on data it obtains from the Bureau of Labor Statistics (BLS) of the Department of Labor. The calculation is based on the average monthly unemployment rate for the State for the most recent previous 3-consecutive-month period for which data are available from BLS prior to the beginning of the quarter for which the FMAP is being determined. Although the most recent data obtained from BLS prior to the beginning of a quarter may be preliminary, because it is the only data prior to the quarter it is used for determining the increased FMAP for the quarter. As such, the increased FMAP is not adjusted later for data that becomes available after the beginning of the quarter; although such later data may be used for subsequent quarter's FMAPs.

**Question 6:** What source is CMS using for the unemployment numbers?

**Answer:** Section 5001(c) describes the calculation and from where the data comes. The source of the unemployment figures is the Bureau of Labor Statistics. Their Web site has the State-specific numbers: <http://www.bls.gov/lau/home.htm>.

### **Scope of Application**

**Question 7a:** In general, for which expenditures is the increased FMAP available?

**Answer:** In general, the increased FMAP is available for allowable Medicaid medical assistance expenditures for which Federal matching is paid ordinarily at the FMAP rate and title IV-E foster care payments. However, refer to the next Q&A for certain specific expenditures for which the increased FMAP is not available.

**Question 7b:** Section 5001(e) of ARRA lists a number of situations where the new *increased* FMAP rates would not apply to certain Medicaid program expenditures. What are those?

**Answer:** The increased FMAP does not apply with respect to the following:

- Medicaid disproportionate share hospital (DSH) payments;
- Payments made under title IV of the Social Security Act (the Act), except for payments under part E of title IV;
- Payments made under title XXI at the "enhanced" FMAP rate; in other words, the "enhanced" FMAP rate will not be increased based on the "increased" FMAP. This includes payments made under title XIX made on the basis of the "enhanced

FMAP” specified in section 2105(b) of the Act (including expenditures for individuals eligible on the basis of breast and cervical cancer);

- Expenditures that are not paid based on the FMAP, such as family planning services, which are claimed at a 90 percent rate, and administrative payments;
- 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; and/or
- Any expenditures for individuals made Medicaid-eligible under a State plan or waiver because of income standards (expressed as a percent of the Federal poverty level (FPL)) that are higher than the income standards in effect on July 1, 2008.

**Question 8:** How will CMS expect States to document and differentiate which expenditures they are claiming at the *increased* FMAP rate and which receive regular FMAP falling under the exclusions in section (e)?

**Answer:** The increased FMAP funds must be drawn down separately, tracked separately, and reported to CMS separately for Federal reimbursement, as explained in CMS telephone calls with the States on February 23, 2009, and March 6, 2009, as well as written guidance (e.g., February budget submission letter, issued on March 4, 2009, the ARRA section 5001 factsheet, issued on March 25, 2009). With respect to ongoing expenditures, States must draw down from two Payment Management System (PMS) accounts. The portion of the expenditure related to the regular FMAP is drawn from the regular Medicaid PMS account and the portion of each expenditure associated with the increased FMAP is drawn from the separate ARRA account. The MBES/CBES system is currently being reprogrammed to reflect both the ARRA and the Children’s Health Insurance Program Reauthorization Act of 2007 (CHIPRA) legislative changes.

**Question 9:** Is a State eligible for the increased FMAP rate for certain section 1115 expenditures (Safety Net Care Pool spending) even though a portion of that spending authority is based on its disproportionate share hospital (DSH) allotment?

**Answer:** Yes, such expenditures would be eligible for the increased FMAP rate. Even though the authority to make the payments or cap for the payments is based on the State’s DSH allotment, under the waiver these are not considered DSH expenditures. Similarly, to the extent that States such as Wisconsin, Maine, and the District of Columbia have special terms and conditions under an approved demonstration project that allow them to re-direct a percentage - or up to the full DSH allotment - to provide health care coverage, these payments will be eligible for the increased FMAP rate because for the purposes of the demonstration, these are not considered DSH expenditures. Uncompensated care DSH payments *consistent with an approved Medicaid State Plan methodology* made via the State Plan (including payments under a Section 1115 demonstration) are *not* eligible for increased FMAP. Conversely, any payment made under a Section 1115 demonstration that is *not* pursuant to an approved State Plan DSH methodology for either payments to providers or for the provision of health care to individuals, that is, the payments are not considered to be DSH payments, *are* eligible for the increased FMAP.

### **State Ineligibility for Increased FMAP**

**Question 10:** Section 5001 lists situations which would make a State ineligible to receive increased FMAP. What are those?

**Answer:** States are eligible for the increased FMAP only if 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 become eligible for the period going back to October 1, 2008, if it reinstates the former standards, methodologies, and procedures prior to July 1, 2009 (Section 5001(f)(1) of ARRA). If a State were to reinstate the former standards, methodologies or procedures after July 1, 2009, the eligibility for the increased FMAP would only be effective prospectively, beginning with the first day of the calendar quarter the State reverses the eligibility restriction(s). For reinstatements of eligibility provisions by a State after June 30, 2009, the State would regain eligibility for the increased FMAP back to the beginning of the calendar quarter in which the State reinstates such eligibility provision(s).

States are eligible for the increased FMAP only if 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.)

States are eligible for the increased FMAP only if they do 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 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).

The expenditures for which the State draws funds must be allowable for the increased FMAP under ARRA (see questions 7, 8 and 9). Expenditures for 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 or 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).

The expenditures for which the State draws funds must not include 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).

**Question 11:** Division A, title XVI, section 1606 of the Act states that all laborers or mechanics employed by contractors or subcontractors must be paid no less than the prevailing wage defined

in accordance with the provisions in the U.S. Code. Does failure to meet this requirement at any point during the recession adjustment period jeopardize the State’s ability to draw increased FMAP funds?

**Answer:** Section 5001 of ARRA lays out the requirements for a State to be eligible for the increased FMAP for allowable Medicaid expenditures. As indicated in section 4 of the public law, unless expressly indicated, references to “the Act” in Division A of the public law (such as in the provision cited) are limited in scope to Division A. Therefore, the cited provision is not applicable to the funding under section 5001 in Division B of ARRA.

### **Medicaid Eligibility Maintenance of Effort**

**Question 12:** Eligibility standards and methodologies are fairly clear. How does CMS define “procedures”?

**Answer:** “Procedures” refers to those actions taken by the State in administration of their Medicaid eligibility determination or redetermination process. We recognize that States make many policies and operational process decisions which CMS does not review, approve, or monitor. Any changes in those procedures after July 1, 2008 which might negatively impact a person’s eligibility could put the State at risk for being able to receive the increased FMAP. Before drawing the increased FMAP, States should be diligent about reviewing such procedures to see if they fit within the Maintenance of Effort (MOE) provisions and discussing any questions they might have with CMS. When a State has such questions, they should contact their CMS Regional Office with specific questions so that CMS can discuss the specific situation.

**Question 13:** How will CMS interpret the MOE requirement for waiver eligibility? How does CMS define eligibility standards, methodologies, and procedures for purposes of a home and community-based services (HCBS) waiver?

**Answer:** There are several standards, methodologies, and procedures germane only to HCBS waivers that potentially impact eligibility. Specifically, CMS has determined that the following would be considered restrictions on eligibility standards, methodologies, and procedures related to HCBS waivers:

1. The State/Territory eliminating the coverage for any eligibility group or subgroup authorized pursuant to 42 CFR 435.217 in any section 1915(c) HCBS waiver
2. 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 HCBS waiver participants under 42 CFR 435.217
3. Adjusting cost neutrality calculations for 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

4. Reducing the number of waiver slots below 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

While these elements have direct relevance to 1915(c) HCBS waivers, other standards, methodologies, and procedures more generally applicable to the Medicaid program also may have direct impact on HCBS or HCBS enrollees (e.g., State adjustments to financial considerations, etc).

**Question 14:** While it's clear that the MOE applies to financial eligibility standards (i.e., poverty levels and asset tests), to the methodologies in place for determining income and assets, and to application/renewal procedures, how will CMS interpret this language to apply to functional eligibility (i.e., need for assistance with a threshold number of Activities of Daily Living (ADL) for home and community-based care section 1915(c) waivers)?

**Answer:** An adjustment as described below would be construed to be contradictory to the MOE provisions of the ARRA:

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 HCBS waiver participants under 42 CFR 435.217.

In this specific example, it is possible that, if a level of care determination takes ADL support needs into consideration, such an adjustment may impact eligibility and therefore may be contradictory to MOE provisions. States may contact their Regional Office for additional clarification.

**Question 15:** If a State began an HCBS waiver waiting list after July 1, 2008, would that be considered a reduction in eligibility?

**Answer:** This will depend on the State's approved waiver capacity as of July 1, 2008. A State will not be out of compliance with the MOE provisions if it does not downwardly adjust its approved and authorized waiver capacity.

**Question 16:** In 2003, when States received a temporary increase in FMAP, CMS instructions specifically excluded from the MOE limits on waiver slots (waiting list) and higher nursing home level of care standards. We assume that CMS' interpretation in 2003 was because waiver services are optional, and restricting States' ability to control access to those services would essentially create an unintended entitlement. Is the CMS interpretation the same for this new MOE?

**Answer:** The maintenance of eligibility (MOE) provision language in the 2003 increased FMAP legislation (section 401(a)(6) of Public Law 108-27) contained different language from the MOE provision in ARRA. In particular, the ARRA MOE provision refers explicitly to "eligibility standards, methodologies, and procedures", where the 2003 MOE provisions referred more

generally to “eligibility under the State plan”. The reference to “procedures” under the current legislation particularly includes aspects of eligibility such as waiver slots and levels of care standards which were not encompassed in the 2003 legislation.

**Question 17:** Does the MOE restrict States from increasing or imposing new verification, documentation, or other requirements in State processes to prevent abuse in transferring assets, for example, in situations involving pooled trusts?

**Answer:** Potentially, yes. Any new requirements since July 1, 2008 that a State may impose on individuals which might negatively impact a person’s eligibility could put the State at risk for being able to receive the increased FMAP. When the State has such questions, they should contact their CMS Regional Office with specific questions so that CMS can discuss the specific situation.

**Question 18:** If actions taken by a State that are procedural in nature, not requiring a State plan amendment or a waiver amendment, result in a reduction in potential Medicaid eligibility, will these affect the States’ ability to receive the increased FMAP?

**Answer:** Potentially, yes. When the State has such questions, they should contact their CMS Regional Office with specific questions so that CMS can discuss the specific situation. See also the answer to Question 12.

**Question 19:** Can States modify or eliminate services, as opposed to eligibility criteria, and still qualify for the increased FMAP?

**Answer:** If the change in the service has no potential impact on an individual’s ability to maintain Medicaid eligibility, such a change would not disqualify a State from the increased FMAP.

**Question 20:** State plan services approved with an effective date of November 1, 2008, changed the Home Health services of the State plan to provide the optional services of Physical Therapy, Occupational Therapy, and Speech Pathology to only pregnant women and individuals who are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. The people who lost those services can receive other mandatory home health services such as skilled nursing. Does this change constitute a reduction in Medicaid eligibility and disqualify the State from receiving the increased FMAP?

**Answer:** No. The FMAP MOE provisions apply only to a reduction in Medicaid eligibility. The beneficiaries described above did not lose eligibility. This scenario would not disqualify a State from receiving increased FMAP.

**Question 21:** Does the MOE requirement apply to provider rates?



**Answer:** There are five attestations that the States must meet in order to be able to draw down the increased FMAP funding under section 5001. None of these attestations requires that the State maintain a certain level of services or benefits, nor is there a requirement concerning reimbursement rates. However, given the significant increases in Federal funding provided to States under the ARRA, we would expect States to carefully consider the impacts on Medicaid beneficiaries and Medicaid providers of any benefit or rate reductions and whether such actions are consistent with the purposes of ARRA.

**Question 22:** After July 1, 2009, what will happen if States revert to more restrictive eligibility standards or institute new ones? Will they lose the increased FMAP retroactively to October 1, 2008, to the beginning of the quarter that the change occurred, or only prospectively?

**Answer:** The availability of increased FMAP funds will be applied on a quarterly basis. Therefore, if a State reduces eligibility prospectively, after July 1, 2009, the increased FMAP will not be available to that State beginning with the current quarter for which the reduction was applicable; the State would not lose eligibility for the increased FMAP for quarters prior to when the current restriction was effective. Furthermore, if the State reinstates the previous eligibility provision, it would become eligible for the increased FMAP beginning with the quarter in which such reinstatement is effective.

The retroactive application of the MOE provision was only pertinent to those eligibility reductions by a State that effected after July 1, 2008, and prior to July 1, 2009. That is, if a State had effected an eligibility reduction after July 1, 2008 and prior to July 1, 2009, it would not be eligible for the increased FMAP retroactive to October 1, 2008, unless it reinstated the July 1, 2008 eligibility provision before July 1, 2009. If the State did effect a reinstatement of the eligibility provision before July 1, 2009, it would be eligible for the increased FMAP retroactive to October 1, 2008.

**Question 23:** In the all-State conference call on February 23, 2009, CMS said that before drawing the increased FMAP funds, States would attest that they are in compliance with the requirements in sections 5001(f)(1) and (g)(2) of the ARRA regarding the “maintenance of effort.” CMS further explained that this was a passive attestation. What is passive attestation? How will States attest? What should States send in and to whom? Will CMS approve the attestation? May the States draw funds before the attestation is approved? Must States attest before each draw down?

**Answer:** By drawing funds from the increased FMAP ARRA account, the State is agreeing, that is, “attesting” that: it is eligible for the increased FMAP; the expenditures for which it is drawing funds are those for which the increased FMAP is 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, and avoid delays in providing State the ARRA funds, 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, by simply drawing down the funds the State was attesting that it had carefully considered all five attestations and that it met those requirements. In addition, the March 4, 2009, February budget submission letter to all States reiterates these attestations.

**Question 24:** Regarding the worksheets attached to ‘Request to Share Information with States on FMAP Increase Provision in ARRA and to Obtain Related Information from States—ACTION’ sent on February 25, 2009: Please explain the use of the ‘Adjusted State Share’ column in the worksheet.

**Answer:** This column, for purposes of the calculation of the increased FMAP, should be disregarded as it has no bearing on the final increased FMAP for each quarter. The pertinent columns are columns D (hold harmless FY 2009), E (FY 2009 FMAP with 6.2 percent increase), and J (unemployment adjustment) the sum of which is then reflected in columns K and L for the 1<sup>st</sup> quarter and 2<sup>nd</sup> quarter FY 2009 FMAP adjustment for each State.

### **Reversal of Actions Which Exclude the State from Receiving the Increased FMAP**

**Question 25a:** When a State chooses to restore eligibility to pre-reduction levels, does it have to send a notification to CMS in order to receive the increased FMAP payment? Does it have to wait for the official reversal documents, such as State plan amendments or waiver amendments, to be processed?

**Answer:** 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). In this regard, the reversal of the eligibility restriction must actually be effected; following that, the State would be eligible for the increased FMAP effective with the beginning of the quarter in which the eligibility restriction was reversed. 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.

**Question 25b:** If a State has more restrictive eligibility standards, methodologies, or procedures than those that were in effect on July 1, 2008, and the State suspends those during the time they are receiving increased FMAP (i.e., through December 31, 2010), can the more restrictive standards kick back in automatically on January 1, 2011?

**Answer:** After the period for increased FMAP ends on December 31, 2010, barring any new or extending legislation to the contrary, States would be free to initiate more restrictive eligibility standards, methodologies, and procedures. Those elections that are subject to CMS review and approval, such as State plan or waiver amendments, would need to transverse the normal approval process. They could not be set up to happen automatically.

### **Prompt Pay Requirements**

**Question 26:** What are the quarterly reporting requirements for States to demonstrate they are in compliance with the requirements for timely payment of claims for nursing facilities and hospitals?

**Answer:** CMS is working with States to better understand current reporting mechanisms in place for timely payment and tracking of claims. CMS will be issuing further guidance on this provision shortly. However, it should be noted that ARRA requires each State to demonstrate that it is in compliance with the prompt pay requirements and compliance is measured on a daily basis; the guidance we are developing will indicate what States need to have in place in order to be able to demonstrate compliance.

**Question 27:** Can providers get waivers of the prompt payment requirements?

**Answer:** Under section 5001(f)(2)(A)(iii) of ARRA, the Secretary may grant a waiver of the prompt pay requirements to a State during any period in which there are exigent circumstances (such as natural disasters) which prevent compliance by the State with the requirements. Each waiver request will be evaluated on a State specific basis and we will provide more detailed guidance on the waiver process as part of our overall guidance on prompt pay requirements. Waivers of the prompt payment requirements are granted to States, not providers; however, depending on the circumstances of the State we could consider waivers of the prompt payment requirements with respect to claims from certain categories of providers.

**Question 28:** Regarding the prompt pay requirement, Section 42 U.S.C. 1396a(a)(37)(A) refers specifically to fee-for-service payments, as indicated in the language above referring to “claims received by a State from a practitioner.” My State is primarily a managed care State, so the State does not receive claims from practitioners, except in the small fee-for-service program for Native Americans and Federal Emergency Services. Managed care prompt pay requirements are found at 42 U.S.C. 1396u-2(f). Since this statute is not specifically cited in ARRA’s prompt pay requirement and because of the wording of the requirement above, please confirm that this requirement applies only to fee-for-service payments and not payments made by managed care organizations.

**Answer:** The prompt pay provisions are not applicable to the payments that the Medicaid managed care plans make to their contracted providers. Further guidance on the prompt pay provisions will be available shortly.

### **Prohibition on Depositing Funds into Rainy Day Accounts**

**Question 29:** There are limitations regarding using the new FMAP to fill State rainy day funds. What counts as a rainy day fund or reserve fund? How are rainy day funds being defined? If a State plans to end the year with a balance in the bank, would that be considered a rainy day fund? Our State Legislature and Governor’s Office has requested an explanation to the “rainy day” component of the ARRA. How does this provision relate to currently budgeted State general 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 into any reserve or rainy day fund of the State. The expectation is that any State funds that would have been used to fund the non-Federal share of Medicaid payments that are now “freed up” (because of increased Federal matching funds available for Medicaid expenditures), are used within the State and are not held in a reserve account to be used sometime in the future. We understand that the freed up State funds may be used for purposes other than Medicaid, but we will need to understand how they have actually been used. We would also expect that if a State’s rainy day or reserve fund increases that this information is communicated to CMS. If so, the State must clearly document that it has expended an amount equal to the amount of the increased FMAP it has received during the year, either in the Medicaid program or other program(s) within the State.

**Question 30:** Some States are set up so that any extra funds automatically go into their rainy day reserve fund. What happens if this occurs with the *increased* FMAP funds?

**Answer:** If there is an increase to such a fund, the State would have to be prepared to show detailed accounting of how the increase is unrelated to the increased FMAP funds received. This would include, but not necessarily be limited to, other factors within the State that caused the increase in the rainy day/reserve fund and a detailed accounting and reporting of how all of the increased FMAP funds were spent within the State (including how “freed-up” State funds were used for Medicaid and/or other purposes). The burden of proof will be the responsibility of the State.

**Question 31:** Under the guidance set forth by CMS and Federal statute, can States use the stimulus Medicaid allotment for anything other than providing Medicaid services?

**Answer:** The increased FMAP can only be used to match allowable Medicaid expenditures. However, the availability of increased FMAP funding will free-up State funds, which may be spent on activities that may or may not be related to the Medicaid program. Eligibility in Medicaid, however, must be maintained at pre-July 1, 2008 levels pursuant to the MOE requirement. States may use this freed up State money to fund other programs within the State,

such as education, or to maintain aspects of their Medicaid program that may have been previously cut due to budgetary constraints. The important factor is that the States spend the entirety of their increased FMAP funds and report on specific uses of these funds to CMS on an ongoing basis. Instructions for reporting on the use of these funds will be issued to States shortly.

### **Local Government Share in the State's Medicaid Match**

**Question 32:** ARRA makes States ineligible for increased FMAP if they increase the local government's share of the State Medicaid match to a percentage greater than was in place under the State plan on September 30, 2008. Our State policy makers have posed the following scenario (the numbers in the example are made up for simplicity) and asked if it would constitute a violation of the proposed restriction language:

Under current law, a formula is used to calculate the amount of funding counties are required to pay for a certain program with the State's generally paying about 50% of the growth and the counties paying about 50% of the growth. If that formula is changed, requiring the counties to pay 100% of the growth in FY 2010, however, the overall county percentage is still below what they contributed in FY 2008 (due to higher growth in the overall State match), would that make the State ineligible for the increased FMAP?

Will CMS score this restriction based entirely on the percentages paid at the end of the recession period, or will a change to the methodology used to calculate county contribution (resulting in a greater contribution) be considered a violation?

**Answer:** Under section 5001(g)(2), during the recession adjustment period (October 1, 2008 – December 31, 2010), States may not require the **percentage** of a State's non-Federal share of expenditures contributed by political subdivisions within a State to be greater than the percentage required under the State's plan on September 30, 2008. This test is applied on a percentage basis and **not** on a dollar basis. For example, if on September 30, 2008, a State required its political subdivision to contribute 10 percent of the non-Federal share of its Medicaid expenditures, then, during the recession adjustment period, the political subdivisions must continue to contribute no more than 10 percent of the non-Federal share in order for the State to continue to be in compliance with the ARRA requirements.

**Question 33:** Our State's legislature has cut funding for Graduate Medical Education and other Medicaid programs. The counties have approached the State with the possibility of voluntarily providing the non-Federal share for some of these expenditures that have been cut by the State legislature. Section 5001(g)(2) of ARRA prohibits States from *requiring* political subdivisions to contribute a greater percentage toward the non-Federal share of expenditures than otherwise would have been required on September 30, 2008. If this is done on a voluntary basis and at the request of the State's political subdivisions, would that violate provisions on maintaining the ratio of local share?

**Answer:** As noted above, if the percentage of the political subdivisions' non-Federal share increases during the recession period, even on a "voluntary" basis, the State would be in violation of the ARRA requirement.

**Question 34a:** There are some facilities that have been and currently are using Certified Public Expenditures (CPEs) as the funding mechanism. These facilities include a local public hospital and the State's university hospital. Another group includes the State-owned Institutes for Mental Disease (IMD). The State has been exploring the possibility of converting to the use of Intergovernmental Transfers (IGTs) as the funding mechanism instead of CPEs. The question is, would converting from CPE to IGT be considered a violation of attestation #3, in which the State attests that they do not require political subdivisions to contribute a greater percentage of the non-Federal share of expenditures beginning October 1, 2008?

**Answer:** Not necessarily. Under a CPE financing mechanism the applicable percentage of the non-Federal share for claiming purposes is no less than 100 percent (but could be more if the State does not share with the subdivision the Federal payment). By moving to an IGT financing mechanism, the non-Federal share contribution could not be any more than 100 percent of the non-Federal share, or such higher level as is represented by the CPEs. That is, under a CPE funding mechanism, the political subdivision is contributing at least 100 percent of the non-Federal share of its expenditures. Therefore, if a State moved to an IGT funding mechanism during the recession adjustment period the political subdivision making the IGT could not contribute more than the percentage of the non-Federal share that it would have through CPEs. In doing so, the State must credit the political subdivision with the reduction in the non-Federal share resulting from the increased FMAP under ARRA.

**Question 34b:** How are transfers from departments within a State treated for purposes of this provision? If the State's Department of Mental Health normally transfers funds it was appropriated from the State to the Medicaid Department for Medicaid payments, do these transfers have to be in the same percentage or can they remain at the same dollar amount?

**Answer:** These are considered transfers between Departments within the State itself and not contributions or transfers from political subdivisions. Therefore, such transfers between Departments within the State government are not bound by the requirements at section 5001(g)(2) of ARRA.

**Question 34c:** Is section 5001(g)(2) applicable to the following: IGTs, CPEs, and health care related taxes?

**Answer:** IGTs from a political subdivision to the State would have to comply with this provision. Therefore, the amount of the IGTs from a political subdivision may not increase on a percentage basis from what was transferred as of September 30, 2008. States should carefully review requirements with their political subdivisions to ensure that any agreements where specific dollar amounts are transferred are adjusted so that the overall percentage of the non-Federal share contribution is not increased due to the increase in the FMAP rate and the reduction in the non-Federal share.

Under a CPE financing mechanism the applicable percentage of the non-Federal share for claiming purposes is no less than 100 percent (but could be more if the State does not share with the subdivision the Federal payment). The State should ensure that, as the Federal share increases, the reduction in the non-Federal share is credited proportionately to the contributing public agency certifying public expenditures.

We do not believe that health care-related taxes are impacted by this provision. Health care-related taxes are not requirements imposed upon political subdivisions for purposes of financing the non-Federal share of Medicaid payments. The health care-related tax is assessed against health care providers for the provision of certain health care items or services. In order to be considered a permissible source of non-Federal share financing, a healthcare-related tax must meet other statutory requirements at section 1903(w) of the Act.

**Question 34d:** What is the definition of a “political subdivision” and what relationship does this have to any of the regulations CMS published regarding the definition of a unit of government?

**Answer:** States have considerable discretion to create and define “political subdivisions” but must apply the same definitions under Medicaid as they do for other purposes under State law. There are no CMS regulations in effect at this time that would establish another definition of political subdivision so we would accept the State’s designation of its political subdivisions.

**Question 34e:** What if a State has a program established where local governments pay a fixed percentage of a total allotted amount (e.g., the State’s DSH allotment or available room under their UPL)? Is it CMS’ interpretation of this section that the State cannot require the political subdivision of the State, to continue to pay a fixed percentage of the total amount for the State to be eligible for increased FMAP funds under ARRA? To be eligible for increased FMAP funds is the State required to revise this agreement to provide that during the recession adjustment period the political subdivision must pay the regular State Medical Assistance Percentage (S-MAP)? To be eligible for increased FMAP funds, is the State required to revise this agreement to provide that, during the recession adjustment period, the political subdivision must pay some other percentage of the total amount? If so, what percentage must it pay?

**Answer:** The State must evaluate the percentage of the non-Federal share the political subdivision was previously providing (as of September 30, 2008). The State must then determine if this percentage has effectively increased with any of the changes authorized under ARRA. The State must ensure that the percentage of the non-Federal share contribution from the political subdivision is no more than what it was required to contribute as of September 30, 2008. If, as a result of the ARRA changes, the political subdivision’s percentage contribution of the non-Federal share has increased then the State would be in violation of ARRA.

### **Drawing Down Funds and Reporting**

**Question 35:** When CMS says “able to access” does that mean States are being sent money for two quarters based on estimated need and then a reconciliation will occur, or are the funds going

to be released as the standard reimbursement forms and reports are sent to CMS? An earlier White House release described the funding as “grant awards” under ARRA. The fact that governors and their staffs have been told to expect less money in the second two quarters lends support to the notion that these funds are being “advanced” to States.

**Answer:** An estimate of the first and second quarter FY 2009 increased FMAP funds was made available for draw down by States through separate grant awards issued through the PMS on February 25, 2009. The grant awards were set up in a separate account designed just for the increased funding amounts under ARRA and this account is called “09-INC-FMAP”. The grant award letter to each State included five attestations from section 5001 of ARRA that each State passively would attest to by drawing any of the funds. Only if the State had assured itself that it had met all of these attestations, would it be prudent for that State to draw down the appropriate amount of funds for the retroactive period. With respect to ongoing Medicaid program expenditures for which the increased FMAP is available, States must draw down from two PMS accounts; the portion of each expenditure related to the regular FMAP is drawn from the regular Medicaid PMS account (the “MP” account), and the portion of each expenditure associated with the increased FMAP is drawn from the separate ARRA account (the “09-INC-FMAP” account). States must draw funds for any expenditure that are excluded from the increased FMAP (e.g., DSH) only from their regular FMAP account in PMS (the “MP” account). The increased FMAP for the first and second quarters of fiscal year 2009 was published in the *Federal Register* on April 21, 2009.

CMS issued two sets of grant awards that provided funds to States, reflecting an estimate of the amount 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. As discussed below, there is a possibility that the grant awards will be adjusted to the extent necessary to conform to the methodology set forth in any formal rulemaking document.

**Question 36:** How will CMS instruct States on the process/timing for increased payments, including any retroactive payments, and, if so, is there an estimated timeline for this? At what point can States expect first retroactive payments to be made to them?

**Answer:** In order to implement the increased FMAP as rapidly as possible, immediate guidance was given to States through All-State calls, individual State calls, the [www.hhs.gov/recovery/](http://www.hhs.gov/recovery/) Web site, and through written guidance documents and letters. CMS hosted All-State calls discussing the CHIPRA and ARRA February Budget Submission on February 23 and March 6. During those calls we discussed all aspects of the increased FMAP made available under section 5001 of ARRA. CMS issued written guidance to States through the ARRA section 5001 fact sheet, distributed to States on March 25, 2009.

**Question 37:** 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 States simply deposit the funds in their general funds without a need to report further on where the increased 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 issued 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 of HHS no later than September 30, 2011, regarding how the additional increased FMAP funds were expended. CMS is working with the States and HHS to develop an ongoing quarterly reporting process which will allow States to explain their overall use of the increased FMAP funds during the quarter and such reports will be able to be used by the States to produce the final report due in September 2011. Further guidance will be developed for such reporting. This reporting is in addition to the quarterly Medicaid expenditure reporting that States submit through the MBES/CBES.

**Question 38:** We are confused about the distribution of the first two quarters of increased funding. Will CMS issue some clarifying guidance? If so, will this be distributed through your State listserv e-mails?

**Answer:** CMS has 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 funds for the retroactive period back to October 1, 2008, can be drawn down immediately by the States, assuming they comply with the attestation requirements.

For the first 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 the quarter, or we used the November 2008 estimates for those States which had yet to submit an expenditure report for the 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 second quarter of FY 2009 we used the unadjusted November estimates for each State. Using these numbers, we calculated the difference between what the States have submitted on these estimates using the pre-ARRA FY 2009 FMAPs and the increased ARRA FY 2009 FMAPs.

- In accordance with the guidelines established by the Office of Management and Budget, the grant awards were issued in a separate account in Payment Management System (PMS) (09-INC-FMAP) 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 allowability of such expenditures and any necessary reconciling grant awards have yet to be reviewed 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 ARRA.

- For future quarters, the funds will be made available for the increased FMAP amounts based upon the State budget estimates submitted by the States for each quarter. So, all States' estimates during the period of the increased FMAP will contain the amounts the States are requesting at the regular FMAP rate and the amounts the States are requesting for the increased FMAP. The advanced grant awards for the quarter will be based upon the CMS review of the State budget submissions just as they are under the pre-ARRA process. During the quarter, States will also be allowed to request supplemental funding if their estimates change. After the end of the quarter, reconciling grant awards will be processed based upon approved allowable expenditures.
- Any overpayment or underpayment will factor into (be offset against or added to) the grant award for the following quarter.

CMS discussed the process for accessing the funds during the February 23 and March 6 All-State calls. CMS also is working with States individually to provide technical assistance.

**Question 39:** How far out do you want our projected PMS draw amounts and times? Will States be held exactly to our PMS draw estimates?

**Answer:** Because the initial grant awards provided to the States for the first and second quarters of FY 2009 contained up to five months of retroactive increased FMAP funds that could potentially be drawn immediately by the State, the Department of the Treasury had requested that States provide us with some sense of their plan for the draw down of the retroactive funding so that the Treasury could adjust their cash availability accordingly for this potentially large outflow of Federal funds. This estimate was only needed for the first month of this process.

**Question 40:** As of April 1, will States be getting a regular grant award and another grant award for the increased money? If States get two awards, do they draw from the regular rate pot of money and then the difference comes from the increased pot?

**Answer:** Yes, during the entire period that the increased FMAP funding is available, States will be getting two separate grant awards. As described earlier, the increased FMAP funds must be drawn down separately, tracked separately, and reported to CMS separately for Federal reimbursement, as explained in CMS telephone calls with the States and written guidance. States must draw down from two separate PMS accounts. The portion of the expenditure related to the regular FMAP is drawn from the regular Medicaid PMS account, and the portion of each expenditure associated with the increased FMAP is drawn from the separate ARRA "09-INC-FMAP" account.

**Question 41:** We are still unclear regarding the process to be followed to draw down the increased FMAP for the October to current period which has already passed. Is there additional information available regarding how that is to be accomplished? Are there special requirements for drawing this money, other than it is in a separate grant?

**Answer:** See response to question 40 above.

**Question 42:** Can all of the funds be drawn now?

**Answer:** If the State meets all applicable requirements and conditions established within section 5001 of ARRA, a State could draw funds associated with allowable Medicaid expenditures that have been incurred. A State may not draw funds for expenditures it has not incurred.

**Question 43:** What type of documentation will be needed for these funds? For instance, will CMS require manual worksheets based on the prior expenditures showing the calculation of the new increased FMAP amount?

**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 issued 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. CMS is currently working with the States to develop an ongoing quarterly reporting process which will allow States to explain their overall use of the increased FMAP funds during the quarter and such reports will be able to be used by the States to produce the final report due in September 2011. Further guidance will be developed for such reporting. This reporting is in addition to the quarterly Medicaid expenditure reporting that States submit through the MBES/CBES.

**Question 44:** Are there special reporting requirements for the CMS-64 Report (i.e., separate lines or a separate report for the increased FMAP)?

**Answer:** The MBES/CBES system currently is being reprogrammed to reflect both the ARRA and CHIPRA legislative changes. Once those changes are completed there will be instructions provided for the new reporting changes and there will be appropriate training conducted. At the time the reprogramming is completed, any final budget and/or expenditure data that has been submitted by the States under the old reporting requirements will automatically be converted to the revised reporting formats and the States will not have to resubmit their data.

**Question 45:** Are these funds subject to the Cash Management Improvement Act (CMIA)? If so, for the retrospective amounts, what dates would be used in the calculation?

**Answer:** Yes, the CMIA establishes requirements for Federal agencies and grant recipients (in this case, State Medicaid Agencies) for cash management and the drawdown of Federal funds. The funds associated with the increased FMAP are governed by the same CMIA requirements as have always been in place and applicable to regular FMAP funds. Dates used for any calculation of penalties imposed under CMIA would be determined on a case-by-case basis and in conjunction with the Department of the Treasury.

**Question 46:** Will the amounts for the first and second quarter be adjusted and, if so, will the adjustment be made for the next quarter, or will it go back to the first and second quarter and then require another adjustment for the previously adjusted expenditures? It appears that the calculation for the first quarter is based on a much smaller number than the actual expenditures on the CMS-64 Report.

**Answer:** It should be noted that the States' estimated expenditures were used in determining the grant awards for the retroactive period. The final determination of allowability of such expenditures and any necessary reconciling grant awards have yet to be reviewed 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 ARRA. Any overpayment or underpayment will factor into (be offset against or added to) the grant award for the following quarter.

**Question 47:** Do the increased FMAP funds only pertain to expenditures or do they also pertain to cash receipts, drug rebates, etc?

**Answer:** For the purposes of determining the appropriate and applicable FMAP rate, drug rebate collections are considered incurred in the quarter in which the State actually receives the rebate from the drug manufacturer. Therefore, the FMAP associated with that quarter would be the applicable FMAP rate. For example, if a State received a drug rebate from the manufacturer in the third quarter of FY 2009, the increased FMAP associated with the third quarter of FY 2009 should be used.

With respect to reporting cash receipts, the State should report such collections as a current quarter collection or a prior period collection based on the quarter it received the collection and the quarter of the expenditure report submission. It should be reported with respect to the quarter in which the collection was received by the State.

**Question 48:** If our calculations for the prior expenditures come to a higher amount than the amount CMS allocates to us, will there be additional or supplemental awards for the increased FMAP grant?

**Answer:** Regardless of the supplemental grant awards we have already issued or the amount of the advance grant awards for future quarters, should any State need additional funds before the end of a quarter, they may request them through a supplemental request. CMS will evaluate such requests and issue any appropriate additional supplemental grant awards.

**Question 49:** Do we base the increased FMAP on date of payment, date of service, or base it on the claims that were submitted on the quarterly CMS-64 Report?

**Answer:** Under Medicaid, medical assistance expenditures are considered to be incurred based on when the State makes a payment to a provider of services; it is not determined by the date of service. The quarter in which the State makes a payment is the quarter in which the expenditure

will be considered to be incurred, and the FMAP applicable to that incurred quarter is that which must be applied.

**Question 50:** When will CMS send the grant letters to the States?

**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 PMS in a separate account established for this purpose. States could immediately begin drawing such funds from this account at that time. The grant award letters were also mailed that week.

**Question 51:** Will the grants be issued as States' regular Medicaid assistance grants and not a separate grant, like the State Children's Health Insurance Program?

**Answer:** States will receive two quarterly grant awards; one will be for the regular FMAP rate and the second will be for the additional funds available from the increased FMAP rate as authorized by ARRA. As mentioned earlier, separate reporting and accounting of the increased FMAP funds is required.

**Question 52:** How will ARRA be applied to FY 2010 and the first quarter of FY 2011 grant awards?

**Answer:** The same quarterly grant award process will be applied for future quarters. This will involve States receiving two separate grants for each quarter; one for the regular FMAP and the second for the increased FMAP.

### **Miscellaneous Questions:**

**Question 53:** CMS hosted an All-State conference call to give an overview of section 5001 on February 23, 2009, which was very helpful. Was the call recorded and, if so, is it available for States to hear again?

**Answer:** We are glad the call was helpful. The February 23, 2009 conference call was not recorded, but there will be further calls held with States, as appropriate, to ensure proper implementation of the ARRA provisions as additional guidance is released.

**Question 54:** Is CMS planning to release official guidance on the implementation of the Temporary Increased Medicaid FMAP? If so, when?

**Answer:** CMS released a Fact Sheet and Questions and Answers on March 25, 2009, which address the temporary increased Medicaid FMAP. CMS has also provided extensive guidance to States through the National All-State calls and through individual State calls as specific questions arise in each State. Additional guidance will be released soon.

**Question 55:** CMS held an MMIS Regional Conference last year that was very helpful. Could you possibly hold Regional Conferences on all the ARRA provisions that impact Medicaid?

**Answer:** As we develop outreach and education materials, we will be considering all communication venues. It is helpful to know what types of communications are useful; please continue to provide that feedback.

**Question 56:** Is HHS/CMS providing guidance on the requirement that governors request funding as it pertains to the increased FMAP?

**Answer:** There is no requirement that governors request funding for the increased FMAP (this appears to be a reference to a requirement applicable only to Division A of ARRA; the increased FMAP is in Division B of ARRA). As noted in earlier responses to questions, the States already received the increased FMAP estimates for the first and second quarters of FY 2009 in their PMS accounts (09-INC-FMAP) and the funds are available to be drawn down as the States assure themselves they have satisfied the attestation requirements. On an ongoing basis the States will simply request the additional increased FMAP funding as part of their normal Medicaid budget submission to CMS, and those funds will be provided on a quarterly basis through an 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 along with this increased FMAP grant award. As States make draws from their PMS accounts to make Medicaid expenditures that are subject to the increased FMAP they must draw the applicable portion from their regular FMAP grant award (“MP” account) and the increased FMAP portion from that grant award (“09-INC-FMAP” account). Expenditures which are excluded from the increased FMAP are always drawn from the regular FMAP account (“MP” account).

**Question 57:** During the February 23, 2009, conference call, CMS indicated that States would need to identify the regular FMAP budget projection and also the increased FMAP budget projection. Does the State need to provide the same level of detail for the increased FMAP budget projection as we do the regular?

**Answer:** The budget projection information should be the same for both the regular FMAP and the increased FMAP. These are not different expenditures, rather the same expenditure with an increased amount of Federal funding available.

**Question 58:** States report recoveries made at their current FMAP. If States pay providers at the increased rate, can we continue to recover at the current FMAP or must we use the increased FMAP?

**Answer:** First, States do not report recoveries at the current FMAP rate; they report recoveries at the FMAP rate that was in effect at the point the expenditure was made. Recoveries of Federal funds must be returned in the same manner in which they were claimed. Therefore, if a Medicaid expenditure was claimed using the increased FMAP, any recoveries associated with that expenditure would have to be returned using the same increased FMAP. It is important to understand that, under ARRA, a State’s FMAP can change from quarter to quarter because of the

application of the unemployment adjustment. Therefore, prior period expenditures during the period ARRA is in effect must be claimed at the applicable FMAP for the prior quarter. The MBES/CBES prior period claim forms are being reprogrammed to accept quarterly prior period adjustments.

**Division B, Title V, Section 5002**  
**Temporary Increase in DSH Allotments During Recession**

**Question 59:** Please explain the timing and State amounts for distributions for the DSH payments under ARRA. Were the DSH payments included in the Medicaid disbursements made to the States already or will they occur separately? Do you have any estimates you can share on what States would receive under the additional DSH payments under ARRA?

**Answer:** CMS has determined and informed States of the increase to their DSH allotments under section 5002 of ARRA. States will be able to access the increased amounts of their DSH allotments once they have exhausted their original FY 2009 DSH allotments. Through the quarterly budget process, and on an ongoing basis, CMS monitors States' expenditures and funding requirements in each quarter. Should any States need access to the additional funds represented by the increased DSH allotment, CMS will issue grant awards to them for such purpose. Historically, not every State expends its full DSH allotment for a fiscal; at this time it is unclear the extent to which States will utilize the additional DSH allotments under ARRA.

**Question 60:** Is there a single increase of 2.5 percent in DSH pools in FFY 2009 that then extends into FFY 2010, or, if there is a second and additional increase of 2.5 percent in FFY 2010 as well, for a cumulative increase of 5 percent?

**Answer:** The FY 2009 DSH allotment under ARRA is equal to 102.5 percent of the pre-ARRA DSH allotment for FY 2009. The FY 2010 DSH allotment under the ARRA provision is equal to the higher of 102.5 percent of the FY 2009 DSH allotment as determined under ARRA, or the FY 2010 DSH allotment as would otherwise have been determined under the pre-ARRA Medicaid statute. Therefore, the FY 2010 DSH allotment would be at least about 5 percent more than the pre-ARRA FY 2009 allotment.

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