ARRA - Implementing the Medicaid Provisions

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In Brief

- Section 5001 of the American Recovery and Reinvestment Act of 2009 (ARRA) provides eligible states with in increased Federal Medical Assistance Percentage (FMAP) for 27 months between October 1, 2008 and December 31, 2010.

Maintenance of Effort (MOE)

- To access the additional funds associated with the increased FMAP, each state must ensure that the "eligibility standards, methodologies, or procedures" under its Medicaid State Plan, or under its Medicaid waiver or demonstration programs, are not more restrictive during this period than those in effect on July 1, 2008.
- More restrictive eligibility would preclude the state from accessing the increased FMAP funds until the state had restored eligibility standards, methodologies or procedures to those in effect on July 1, 2008.

Increased FMAP Methodology

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

Medicaid Grant Award Process

- With respect to ongoing expenditures, the state must draw federal funds from two PMS subaccounts;
  - the portion of Federal funds related to the regular FMAP must be drawn from the regular Medicaid PMS account; and
  - the portion of Federal funds associated with the increased FMAP must be drawn from the separate ARRA account.
- For the expenditures related to the first two quarters of FY 2009, the State may draw the additional Federal funds available under the increased FMAP provision from the ARRA account only for identified appropriate expenditures under ARRA.

The Five Attestations

- The CMS grant award letters include five attestations relating to the requirements of Section 5001 of the ARRA.
- The CMS grant letters direct that with the acceptance of the grant award and withdrawal of funds from the PMS, **each state attests that it is eligible for such funds**, and that the expenditures for which the funding is claimed are appropriate and consistent with the requirements of Section 5001 of the ARRA.

Attestation #1

- The state is eligible for the increased FMAP because the state is applying **Medicaid eligibility standards, methodologies and procedures that are no more restrictive than those in effect under the state plan (or any waiver or demonstration project) on July 1, 2008**.
- If the state is currently ineligible because it does not meet this condition, the state may be retroactively eligible if it reinstates the former standards, methodologies and procedures prior to July 1, 2009. (Section 5001(f)(1) of ARRA)

Attestation #2

- The state is eligible for the increased FMAP because no amounts attributable (directly or indirectly) to the increased FMAP are deposited or credited to any reserve or rainy day fund of the state. (Section 5001(f)(3) of ARRA)

Attestation #3

- The state is eligible for the increased FMAP because it does not require political subdivisions within the State to contribute for quarters beginning October 1, 2008 and ending December 2010, a greater percentage of the non-federal share of such expenditures (including for expenditures under section 1923 of the Social Security Act) than the respective percentage that would have been required under the state Medicaid plan on September 30, 2008. (Section 5001(g)(2) of ARRA)

Attestation #4 and #5

- The expenditures for which the state draws funds must be **eligible expenditures**.
- The expenditures for which the state draws funds are not payments for health care practitioner claims or certain nursing home and hospital claims that were received by the state during periods in which the state is not in compliance with prompt payment standards. (Section 5001(f)(2) of ARRA)

"Passive Attestation"

- By drawing funds from the increased FMAP ARRA account, the state is attesting it is eligible for the increased FMAP; the expenditures for which it is drawing funds are those for which the increased FMAP are applicable; and that the conditions under which the increased FMAP is available are met.
- In order to minimize the need for separate review, CMS included these five requirements as attestations in each grant award letter to the states.

"Passive Attestation" cont.

- The grant award letter indicated that only after the state had assured itself that it met all of the requirements under which the increased FMAP and associated funds were available, was it free to draw such funds.
- This process is referred to as a “passive attestation” under which each state did not need to send in a written confirmation that it met the requirements prior to receiving its funds; rather, the drawing of such funds represented the state’s attestation that it met all of the requirements.

Implementation Guidance

- Unfortunately, states were not in a good position to determine whether or not they met the requirements included in the five attestations because no formal guidance had been provided by CMS.
- The formal guidance (such as it is) was provided on March 25, 2009 and the funds became available February 25, 2009.

MOE - The Details

No Elimination of Eligibility Groups

- A state/territory must not have eliminated any eligibility groups, or sub-groups under the state plan since July 1, 2008.
- For example, this means that, even if a medically needy group as a whole is still covered under the state plan, the state cannot have eliminated one or more categorical subgroups (e.g., the aged, or the disabled) from the group.
- A state/territory must not have eliminated the coverage for any eligibility group or subgroup authorized in any section 1915(c) Home and Community Based Services Waiver.

Standards, Methodologies and Procedures In General

- A state/territory must not apply other eligibility standards, methodologies, or procedures under its state plan including any 1115 waivers that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, in effect on July 1, 2008.
- This requirement applies to all demonstration-eligible individuals funded through Medicaid including those demonstrations with budget neutrality based on DSH funds.
- Demonstrations using a combination of Medicaid and CHIP funds would also be affected. Only those demonstrations fully funded by CHIP are not subject to the MOE restrictions in section 5001 of the ARRA.

The Specifics

- The March 25, 2009 guidance provides specifics, but notes that the restrictions on eligibility include, but are not limited to those delineated in the guidance.

Restrictions Include:

- Instituting or increasing premiums that may restrict, limit, or delay eligibility under the Medicaid program for otherwise eligible individuals.
- Increasing stringency in institutional level of care determination processes that results in individuals losing actual or potential eligibility for Medicaid pursuant to institutional eligibility rules or in the special eligibility group for home and community based service waiver participants.
- Adjusting cost neutrality calculations for section 1915(c) waivers from the aggregate to the individual, resulting in individuals being dropped from waiver coverage or hindered from moving out of an institutional setting.

Restrictions Include: cont.

- Reducing occupied waiver capacity for section 1915(c) HCBS waivers.
- Reducing or eliminating section 1915(c) waiver slots that were approved, but unoccupied as of July 1, 2008.

Restrictions Include: cont.

- Restrictive adjustments to financial eligibility criteria of the Medicaid program or waiver, including the following: •
  - Reductions in income or resource standards below those in effect on July 1, 2008;
  - Implementation of income or resource standards that had not been imposed on a group or individuals within a group prior to July 1, 2008;
  - Elimination or reduction of income or resource methodologies favorable to applicants and beneficiaries, including more liberal income or resource methodologies implemented under the authority of section 1902(r)(2) of the Act, in effect prior to July 1, 2008;
  - In 209(b) States, any change in eligibility criteria, standards or methodologies for the aged, blind or disabled, including changes in the definition of blindness or disability, that are more restrictive than the criteria in effect prior to July 1, 2008.

Restrictions Include: cont.

- Any change in eligibility determination or redetermination processes or procedures that are more stringent or restrictive than those in effect under the State's Medicaid program on July 1, 2008, including but not limited to:
  - Increasing the frequency at which redeterminations are made; for example, increasing the frequency of redeterminations from once every 12 months to once every 6 months.
- Any reduction in the amount of time that the State gives an individual to respond to a request for additional information or documentation needed for an eligibility determination. An example would be if the State previously required a response to such a request within 45 days, but then reduced the time allowed to 30 days.

Restrictions Include: cont.

- Revoking or otherwise restricting a policy under which an individual's eligibility is determined or redetermined based on an attestation by the individual of the amount and/or type of resources the individual has. This would include, for example, requesting additional evidence concerning resources from individuals when, under previous policy, the additional evidence would not have been requested.
  - This would not include implementing a program to verify the assets of aged, blind or disabled Medicaid applicants and recipients in conformance with the requirements of new asset verification program established in P.L. 110-252.

Reinstatement of Provisions to Become Eligible for FMAP Increase

Before June 30, 2009

- 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.**

Reinstatement of Provisions to Become Eligible for FMAP Increase

After June 30, 2009

- Eligibility for the increased FMAP would only be effective prospectively, beginning with the first calendar quarter the state reverses the eligibility restriction.

Reinstatement Procedures

- States should send a written communication to the CMS Regional Office delineating actions taken to come into compliance and the effective date of the changes.
- If state plan amendments and similar changes are required, CMS will accept a letter indicating that the eligibility requirements have been reinstated, but documentation must be submitted by the state "within a reasonable time period".

Prompt Pay

- The guidance is relatively silent on the prompt pay provisions.
- CMS staff could not identify a state that they were certain could meet the standards set in the statute.
- The National Association of State Medicaid Directors (NASMD) indicated in a letter to the Acting HHS Secretary that costly systems changes would be needed to comply.
- There is a waiver provision for the provisions related to practitioners, but not for those related to hospitals and nursing facilities.

What is the Cash Management Improvement Act of 1990 (CMIA)

- The CMIA was enacted to ensure greater efficiency, effectiveness and equity in the exchange of funds between the federal government and state and local governments.
- It was written to prevent:
  - States from drawing federal funds in advance of need; and
  - The federal government from providing late grant awards to states

What is the CMIA cont.

- It was believed that both the federal government and state and local governments were jockeying for the interest earned on the funds.
- Under the provisions of the CMIA, a state owes interest if it draws down federal funds before making program expenditures.

ARRA/CMIA

- States must be careful. To avoid interest penalties associated with the CMIA, states must:
  - Carefully draw down the Medicaid funds, using the two separate pots of funds; and
  - Make certain they are in compliance with the provisions of ARRA so that the expenditures are covered by the ARRA enhanced funding.

Reporting Requirements

- States must account for any state spending that is related to state funds being freed up as a result of the enhanced federal Medicaid match.
- States will be required to submit a report to the HHS Secretary regarding ARRA-related expenditures.

States with an MOE Issue

- According to a memo sent out on March 16, 2009, by the HHS Administration for Children and Families (ACF), the following states have a MOE issue: Arizona, California, Maine, Massachusetts, Minnesota, South Carolina, and Vermont.
- This has not been independently verified by state contacts.