

## **INCREASED FEDERAL MEDICAL ASSISTANCE PERCENTAGE LEGISLATION**

### **Questions & Answers**

On May 28, 2003, President Bush signed into law (P.L. 108-27) the Jobs and Growth Tax Relief Reconciliation Act of 2003 (TRRA). Subsection 401(a) of TRRA provides temporarily, with respect to certain expenditures by eligible states, increases in the Federal medical assistance percentage (FMAP), that is, the Federal matching rate for states' medical assistance expenditures under their Medicaid programs. Under this provision, the increased FMAP is available only for a period of five calendar quarters, the last two quarters of Federal fiscal year (FFY) 2003 and the first three quarters of FY 2004. Subsection 401(a) of TRRA also increases the limitation on payments to the commonwealths and territories (the territories) as determined under section 1108 of the Social Security Act (the Act).

On June 13, 2003, the Centers for Medicare & Medicaid Services (CMS), Center for Medicaid and State Operations issued State Medicaid Director Letter (SMDL) #03-005 containing initial guidance on section 401(a) of TRRA. The following "Qs & As" provides additional guidance on the TRRA increased FMAP provision:

#### **I. ELIGIBILITY FOR INCREASED FMAP**

##### **Q1. What is the requirement for states to be eligible for the increased FMAP?**

A. Under section 401(a)(6) of TRRA, a state is eligible for an increase in its FMAP for any of the affected quarters of FY 2003 and 2004 only if eligibility under its Medicaid state plan (including any waivers under title XIX or section 1115 of the Act) in effect for such quarter is no more restrictive than the eligibility under such plan or waiver as in effect on September 2, 2003. In making this determination on what is effective on September 2, 2003, CMS will consider only the approved state plan and waivers on September 2, 2003, and subsequently approved state plan amendments and waivers submitted on or prior to September 2, 2003. This is because we do not read the statutory reference to this exact date to include revisions subsequently proposed by the state.

##### **Q2. If a state restricts eligibility under its program after September 2, 2003, causing the increased FMAP to be unavailable, may the state take action to reinstate eligibility for the increased FMAP?**

A. Yes. Section 401(a)(6)(B) of TRRA specifically provides for states, which have restricted eligibility under its program, causing the state to be ineligible for the increased FMAP for the quarters in which the restriction is in effect, to reinstate the less restrictive provisions. Under this section of TRRA, the state will be eligible for the increased FMAP in the first quarter in which it reinstates the less restrictive eligibility.

**Q3. In general, what is the meaning of the term "eligibility," for purposes of determining eligibility in effect under states' Medicaid programs on September 2, 2003, or during one of the calendar quarters for which the increased FMAP is available?**

A. In general, in this context, the term eligibility includes the income and resource methodologies and standards that are used in determining individuals' eligibility for the Medicaid program. It also includes the eligibility groups, such as the categorically needy (both mandatory and optional) and medically needy groups.

**Q4. Are there general principles that are applicable in determining whether the "eligibility" in a state's program is more or less restrictive?**

A. In general, an eligibility condition the application of which would have the result of making an individual ineligible, or less likely to be eligible, would be considered to be more restrictive. An eligibility condition which would have the result of making an individual more likely to be eligible would be considered to be less restrictive.

Examples of an eligibility condition which is "more restrictive":

- A decrease in a state's income and/or resource standard
- A decrease in the amount of an income and/or resource disregard
- A definition of income or resources which includes greater amounts or more types of income and/or resource within the definition of income/resource
- Dropping or reducing an eligibility group, for example, dropping an optional categorically needy, or medically needy group
- Lowering the age limit under which an individual is considered eligible for medical assistance in a state's Medicaid program. For example, section 1905(a)(i) of the Act, defines certain individuals "under the age of 21, or, at the option of the state, under the age of 20, 19, or 18 as the state may choose." In this regard, a lower age limit is more restrictive than a higher one.

**Q5. Are there particular policy areas which are not considered to be an "eligibility" condition for purposes of determining whether the increased FMAP is available?**

A. The following areas are NOT considered a condition of eligibility for purposes of whether the increased FMAP is available:

- Cost sharing. The imposition of such cost sharing charges which in this context includes premiums, or the increase in such charges is not an eligibility condition for purposes of the availability of the increased FMAP. The non-payment of such charges (such as refusal to pay the cost sharing) and the resulting ineligibility of an individual for such reasons is not considered a condition of eligibility for this purpose.
- Definition of covered "medical assistance" under the State plan Policies which determine the types, or amount, duration, and scope of medical assistance in a state's Medicaid program are NOT considered a condition of eligibility.

- Medical necessity. The criteria for determining medical necessity for a service, including a change in the level of care requirement, as is imposed under certain waivers to qualify for services under the waiver.
- Administrative Requirements. State requirements for individuals to provide documentation such as for verification of income and resources or non-compliance with verification requirements are not considered an eligibility condition for purposes of availability of the increased FMAP. For example, a state may require individuals to complete a form in which they indicate sources of income, resources, or third party liability information. A requirement to submit such information and/or non-compliance with such requirements resulting in ineligibility, are not considered an eligibility condition for this purpose.

**Q6. The availability of certain home and community based services (HCBS) under a states' HCBS waiver program may be contingent on the need for "activities of daily living" (ADL); are ADLs considered a condition of eligibility?**

A. No, we do not consider ADL requirements under a HCBS waiver as an eligibility condition for purposes of the availability of the increased FMAP.

**Q7. How should the redetermination process and the minimum enrollment period in a managed care setting be considered for purposes of the availability of the increased FMAP?**

A. As follows, we distinguish aspects of the administration of the program from programmatic eligibility requirements for purposes of the availability of the increased FMAP:

- Redetermination Process. We do not consider the administrative process under which a state periodically reexamines an individual's Medicaid eligibility, referred to as the redetermination process, to be a condition of eligibility for purposes of the availability of the increased FMAP. Furthermore, the frequency at which a state may perform such periodic redeterminations is not an eligibility condition; therefore changes in this process such as an increase in the frequency of a redetermination does not change an individual's eligibility. For example, a state may change the frequency of periodic redeterminations from 12 months to six months; this change would not be determinative as to whether the increased FMAP is available. The frequency of the redetermination process must be distinguished from the eligibility requirements contained in the state's approved state plan or waiver which are applied in the redetermination process (whether every 12 months, 6 months, or with some other frequency).
- Minimum Enrollment Period in Managed Care. In the managed care setting, states may elect a minimum enrollment period for managed care enrollees during which individuals are deemed to continue to be eligible. This minimum enrollment period is distinguished from the actual eligibility requirements, as contained in the state's approved state plan or waiver; therefore, we do not consider the minimum enrollment

period in managed care and the deemed eligibility status of an individual during such period to be an eligibility condition for purposes of the availability of the increased FMAP.

**Q8. Are eligibility requirements under a states' title XXI-related Medicaid expansion program (referred to as M-SCHIP) considered eligibility conditions for purposes of the availability of the increased FMAP?**

- A. Yes. For purposes of the availability of the increased FMAP, the M-SCHIP option is considered part of the Medicaid program. That is, the M-SCHIP option provides for making certain low-income children eligible under the authority of section 1905(u)(2) and (u)(3) of the Act. That is, the M-SCHIP program is considered part of the Medicaid statute. Therefore, an eligibility conditions that are part of the M-SCHIP program are considered to be part of the Medicaid program, and if eligibility in a state's M-SCHIP program for quarters in which the increase FMAP is available is more restrictive than the eligibility under such plan on September 2, 2003, then the increased FMAP would not be available.

**Q9. Does a reduction in eligibility have to be fully implemented on or before September 2, 2003 in order for a state to qualify for the increased FMAP, or is it merely enough for CMS to have received the request by that date?**

- A. As indicated in the June 13, 2003 state Medicaid director letter, in determining the eligibility under a state's program in effect on September 2, 2003, CMS will consider the approved state plans and waivers that are effective on September 2, 2003. Furthermore, in this regard, CMS will also consider subsequently approved state plan amendments and waivers, but only if they have been submitted by the state and received by CMS on or prior to September 2, 2003. Finally, the ultimately approved effective date for the plan or waiver must include September 2, 2003. That is, although a reduction in eligibility as requested through a plan amendment or waiver does not actually have to be in effect on September 2, 2003, the related plan amendment or waiver request must be submitted by the state and received by CMS by September 2, 2003, and the CMS approval date must include September 2, 2003. This is because, although the plan or waiver request may be submitted and received by CMS by September 2, the ultimate effective date approved by CMS may be after September 2, 2003.

**Q10. What is the issue with respect to the availability of the increased FMAP for the April-June 2003 quarter?**

- A. Under section 401(a)(6) of TRRA, the increased FMAP is not available for expenditures incurred in a quarter in which the eligibility under the state's program effective during the quarter is more restrictive than the eligibility in effect on September 2, 2003. However, this creates a situation in which a state that expands eligibility under its program after the April-June 2003 quarter and which would be in effect on September 2, 2003, would preclude the availability of the increased FMAP for the April – June 2003 quarter. This is because in comparison, the eligibility in effect under the plan in for April – June 2003

quarter would be relatively more restrictive than the expanded eligibility in effect on September 2, 2003. We are aware of this result and are working to achieve a technical correction to the statute to address this issue.

Note: as indicated in the response to the previous question, the date of submittal and receipt of an eligibility change affects the availability of the increased FMAP. In that regard, if a state submitted and CMS received a request for a less restrictive eligibility condition (and which would be effective on September 2) after September 2, 2003, such a change would not be considered to be in effect on September 2, 2003, for purposes of the availability of the increased FMAP. In this example, because the proposal was submitted after September 2, 2003, the fact that the states' program in effect during the April through June 2003 quarter is more restrictive than the program under the state's proposal would not be considered in determining the availability of the increased FMAP.

**Q11. In the special terms and conditions governing states' approved waivers, states may make changes to certain eligibility categories without securing additional approval from CMS; however, under the special terms and conditions, the state needs to notify CMS 60 days prior to such action. In such a case, could the state provide the 60-day notice to CMS of a reduction in eligibility after September 2, 2003, and still be eligible for the increased FMAP?**

A. No. Although the special terms and conditions of the CMS waiver approval does not require the state to obtain further approval by CMS for a change in eligibility, it does require the state to notify CMS of changes in eligibility. In determining whether the (change in) eligibility is in effect on September 2, 2003, for purposes of the availability of the increased FMAP, CMS must be notified by September 2, 2003. In particular, a reduction (more restrictive change) in eligibility would need to be in effect on September 2, 2003, so as to have the comparison of eligibility to be no more restrictive than what is in effect on September 2, 2003. Again, the notification of such a change must be submitted by the state and received by CMS by September 2, 2003.

**Q12. Is the increased FMAP available by quarter, or on an "all or nothing" basis? For example, if the state were to reduce eligibility beginning January 1, 2004, would the increased FMAP still be available for periods prior to January 2004?**

A. The availability of the increased FMAP is on a quarterly basis. Thus, in the example indicated in the question, assuming that eligibility under the state's program for the quarters prior to January 2004 was no more restrictive than the eligibility under the program on September 2, 2003, the increased FMAP would still be available for the period prior to January 2004. Of course, in the example, beginning January 2004, eligibility under the state's program is more restrictive than eligibility on September 2, 2003, and therefore beginning with January 2004, the increased FMAP would no longer be available. Finally, under section 401(a)(6)(B) of TRRA, a state which has restricted eligibility under its program after September 2, 2003 (causing the state to no longer qualify for the increased FMAP beginning with the quarter in which the restriction is in effect), may reinstate the less restrictive provision(s). Under this section

of TRRA, the state will be eligible again for the increased FMAP in the first quarter in which it reinstates the less restrictive eligibility provision in its program.

**Q13. Under certain waivers, such as those approved under section 1915(c) of the Act (relating to home and community based services – HCBS), states can limit the number of individuals that can be eligible under such waivers. Are changes in this limit considered an eligibility condition for purposes of the availability of the increased FMAP?**

**A.** Yes, changes which affect the number of individuals that can be eligible for a waiver, are considered eligibility conditions with respect to the availability of the increased FMAP. For example, if a state decreased the limit on the numbers of individuals that can be eligible under such a waiver, eligibility under the program would be considered more restrictive as compared to the program before the change.

**Q14. A state changes the number of waivers under which it provides HCBS waiver services under its section 1915(c) waiver. Is this an eligibility condition which would affect the availability of the increased FMAP?**

**A.** By itself, changing the number of waivers under which a state covers the waiver population would not be considered an eligibility change, so long as eligibility for individuals under the waivers is the same. For example, a state currently covers the HCBS waiver population under one broad waiver. However, the state intends to revise its program so as to cover the HCBS waiver population under 4 waivers, under which different HCBS waiver services and levels of services are provided under each of the 4 new waivers, based on the characteristics of the population. Nevertheless, the eligibility criteria for the individuals remains the same, and any limits on the total numbers of people covered under either the one waiver previously, or the under the 4 waivers under the proposal, does not change. In that case, the state's proposal would not be considered as revising the eligibility under the plan.

## **II. DETERMINATION OF INCREASED FMAP**

**Q1. How is the increased FMAP determined?**

**A.** Under section 401(a) of TRRA, there are two steps for determining the increased FMAP for each state for the last two quarters of FY 2003, and the first three quarters of FY 2004. First, the increased FMAP for the last two quarters of FY 2003 (as would otherwise be calculated), must be at least equal to the state's FMAP for FY 2002, and second, the FMAP determined under this first step is increased by 2.95 percentage points. Similarly, the increased FMAP for the first three quarters of FY 2004 must be at least equal to the state's FMAP for FY 2003 (as would otherwise be calculated), and second, the FMAP determined under this first step is increased by 2.95 percentage points.

**Q2. How will CMS determine the amount and provide additional funding to the states related to the increased FMAP?**

A. For the third quarter of FY 2003, CMS calculated the states' additional Federal funding needs related to the increased FMAP based on the states' February 2003 quarterly budget estimates submitted to CMS; these amounts were issued to states as a supplemental grant award in mid June 2003. Similarly, for the fourth quarter of FY 2003, CMS calculated the states' additional Federal funding related to the increased FMAP based on the states' May 2003 quarterly budget estimates submitted to CMS; these increased amounts were included in the fourth quarter grant awards issued to states at the beginning of July 2003.

**Q3. Section 401(a) of TRRA refers to “\$10,000,000,000 For A Temporary Increase Of The Medicaid FMAP.” Are states limited to a total of \$10 billion in additional funds related to the increased FMAP provisions?**

A. No. The reference to \$10 billion is only in the title of section 401(a) of TRRA. In the language of the actual provisions of this legislation there is no limit on the amounts of additional Federal matching funds states may claim for the expenditures incurred in the five quarters for which the increased FMAP is applicable.

**Q4. Is there special treatment for “annual grant award” (AGA) states with respect the increased FMAP provisions and in the determination of increased funding?**

A. There are six “annual grant award” (AGA) states (IN, LA, NE, VA, WA, and WI) for which no incremental amounts are shown for the third quarter. The AGA states are not issued an advance grant award for each calendar quarter as is done for most states; rather, at the beginning of the fiscal year CMS issues AGA states grant awards reflecting the states' Federal funding needs for the entire fiscal year. Since the AGA states were issued grant awards at the beginning of FY 2003 in amounts that reflect such states' funding needs for the entire FY 2003, we determined that no incremental grant awards were needed this time for the third quarter of FY 2003. However, as is the case for AGA states at the end of the every fiscal year, at the same time as we look at all states' fourth quarter funding needs, we also review the AGA states' funding needs based on the May 2003 quarterly budget submission. In that regard, and with respect to the increased FMAP provisions, we determined if the AGA states needed additional funds for FY 2003, and issued additional funds as necessary.

**Q5. Will CMS provide additional funds if the supplemental grant awards for the third quarter, or the advance grant awards are not sufficient for the states funding needs?**

A. Regardless of the supplemental grant awards we are issuing for the third quarter related to the FMAP increase, or the amount of the advance grant awards for the fourth quarter, 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.

### **III. EXPENDITURES**

#### **Q1. In general, for which expenditures is the increased FMAP available?**

A. In general, the increased FMAP is available for allowable medical assistance expenditures. However, refer to the next Q&A for expenditures that the increased FMAP is not available.

#### **Q2. In general, for which expenditures is the increased FMAP not available?**

A. Subsection 401(a)(5) of TRRA provides that the increased FMAP does **not** apply with respect to the following:

- Medicaid disproportionate share hospital payments
- Payments under title IV and title XXI of the Act (the Federal matching percentage under these programs is a function of the Medicaid FMAP rate). This provision indicates that the Medicaid FMAP applied for the purposes of these programs will be the Medicaid FMAP otherwise determined without application of the provisions of TRRA.
- Payments under Medicaid that are based on the “enhanced FMAP” described in section 2105(b) of the Act. The Federal matching rate for certain Medicaid expenditures is tied to the “enhanced FMAP” referenced in section 2105(b) of the Act. In turn, the enhanced FMAP is calculated based on the Medicaid FMAP. This provision of TRRA indicates that the enhanced FMAP under section 2105(b) of the Act will be based on the Medicaid FMAP otherwise determined without application of the provisions of TRRA.

#### **Q3. Does the new increased FMAP apply to administrative costs?**

A. No. The (increased) FMAP represents the matching rate at which a state's expenditures for medical assistance are matched by the Federal Government; it is not available for matching state's administrative costs.

#### **Q4. What is the operating definition of incurred expenditures for purposes of determining whether the increased FMAP is available?**

A. The increased FMAP is available for expenditures incurred by states in the applicable quarters. The TRRA did not change the definition of incurred expenditures under the Medicaid program. In particular, 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 incurred quarter is that which must be applied. In this context, the increased FMAP will be available for expenditures incurred during one of the five quarters for which the increased FMAP is available.



**Q5. Is the increased FMAP available for all claims reported on quarterly expenditure reports (i.e. Form CMS-64) submitted on and after April 1, 2003, or is it available with respect to claims paid by the states on and after April 1, 2003?**

A. The definition of expenditures for which the increased FMAP is available is not based on the quarterly expenditure report in which the expenditure is reported. As indicated in the all state letter, dated June 13, 2003, the definition of expenditures for which the increased FMAP is available is contingent on when such expenditures are incurred by the state; and in this regard, "incurred" means the period in which the state makes such payment to a medical provider.

**Q6. For which calendar quarters is the increased FMAP available?**

A. Under section 401(a)(1)-(3) of TRRA, the increased FMAP is available for the last two quarters of Federal FY 2003 (April 1, 2003 through September 30, 2003), and the first three quarters of FY 2004 (October 1, 2003 through June 30, 2004).

**Q7. How should drug rebate collections be treated with respect to availability of the increased FMAP for a state?**

A. For 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 second quarter of FY 2003, the regular FMAP applicable for FY 2003 would be used. However, if the state received the drug rebate from the manufacturer in the 3<sup>rd</sup> quarter of FY 2003, the increased FMAP associated with the 3<sup>rd</sup> quarter of FY 2003 should be used.

With respect to reporting the drug rebate receipts, the state should report such collections as a current quarter collection or a prior period collection based on the quarter it received the rebate and the quarter of the expenditure report submission. This would apply, for example, when a state received a drug rebate in the second quarter of FY 2003, and the state is reporting such receipt on the 3<sup>rd</sup> quarter expenditure report. In this example, the FMAP associated with the 2<sup>nd</sup> quarter of FY 2003 is the applicable FMAP; that is, it is the regular FMAP, not the increased FMAP that should be associated with the claim. Since the state is reporting this 2<sup>nd</sup> quarter drug rebate receipt on the 3<sup>rd</sup> quarter expenditure report, the amount of the drug rebate should be reported as a prior period adjustment, indicating the 2<sup>nd</sup> quarter as the prior quarter. This is because the expenditure was incurred by the state in the second quarter, and the state delayed reporting it until the 3<sup>rd</sup> quarter submission; that is, any expenditures from quarters prior to the 3<sup>rd</sup> quarter should be reported as a prior period claim.

#### **IV. COMMONWEALTHS AND TERRITORIES**

##### **Q1. Is the increased FMAP available for expenditures incurred by the Commonwealths and Territories?**

- A. Yes. Under section 401(a)(8)(B) of TRRA, the term “state” has the same meaning given for such term for purposes of title XIX of the Act, the Medicaid statute. Under section 1101(a) of the Act, the commonwealths and territories are considered to be states for purposes of title XIX of the Act. Therefore, the commonwealths and territories will receive the same FMAP increase as the 50 states and District of Columbia will receive under this new law. Since the usual FMAP for the commonwealths and territories is 50 percent, the increased FMAP for them would be 52.95 percent.

##### **Q2. Under TRRA, the limit on Federal funding for the jurisdictions under section 1108 of the Act has been increased; how is the amount of the increase determined?**

- A. Section 401(a)(4) of TRRA provides that the limitation for the territories section under 1108 of the Act, shall be increased by 5.90 percent for the last two quarters of FY 2003 and the first three quarters of FY 2004. CMS is implementing this provision by prorating the territorial cap, as otherwise determined for the fiscal year under section 1108 of the Act, among the four quarters of the fiscal year. For FY 2003, these third and fourth quarter prorated amounts will be increased by 5.9 percent. In effect, operationally, for FY 2003 the dollar increase in the section cap will be equal to two-fourths of the section 1108 cap multiplied by 5.9 percent. For FY 2004, the dollar increase in the section 1108 cap will be equal to three-fourths of the section 1108 cap multiplied by 5.9 percent. The revised section 1108 caps were provided to the commonwealths and territories as an attachment to the June 13, 2003, State Medicaid Directors letter.

##### **Q3. How does the increase in the section 1108 cap apply for expenditures incurred by the Territories?**

- A. The entire FY 2003 increase in the section 1108 cap is available for expenditures incurred by the commonwealths and territories beginning with the third quarter of FY 2003. The entire FY 2004 increase in the section 1108 cap is available for expenditures incurred by commonwealths and territories beginning with the first quarter of FY 2004. The increased FMAPs applicable to FY 2003 and FY 2004 is available to the commonwealths and territories for the third and fourth quarter of FY 2003, and the first, second and third quarter of FY 2004, respectively.

#### **V. REPORTING OF EXPENDITURES**

##### **Q1. How will states report expenditures for which the increased FMAP is available?**

- A. The first quarter for which the increased FMAP is available is the third quarter of

FY 2003; states are required to submit the quarterly expenditure report (Form CMS-64) for this quarter beginning July 30, 2003. CMS is currently in the process of working with its contractors to revise the quarterly expenditure report to automatically reflect the availability of the increased FMAP for the expenditures to which it is applicable.

**Q2. Is the increased FMAP available for prior period claims?**

- A. Yes. The increased FMAP is available for expenditures incurred by states in the five calendar quarters to which it is applicable. Current quarter expenditures would be claimed on the quarterly expenditure reports for the applicable quarters; however, states do typically make claims for expenditures incurred in prior quarters. So long as the prior period claims are for one of the five quarters for which the increased FMAP is available, states may make claims at the increased FMAP for prior period claims, subject to any applicable requirements, such as the two-year timely filing provisions.

**Q3. How should states report prior period claims for which the increased FMAP is available?**

- A. States typically make prior period claims on the prior period claim forms of the Form CMS-64. However, in the past, states only needed to identify the fiscal year for which the prior period claims was associated. We recognize that the increased FMAP is associated with specific quarter. In that regard, CMS is revising the quarterly expenditure report to allow for states to appropriately identify the quarters for which the prior period claims would be associated with the increased FMAPs.

**VI. NON-FEDERAL SHARE FUNDING REQUIREMENTS**

**Q1. What is the non-Federal share (NFS) funding requirement under the TRRA provisions?**

- A. Under section 401(a)(7) of TRRA, states may not require that the percentage of a state's NFS of expenditures contributed by political subdivisions within a state to be greater than the percentage required under the state's plan on April 1, 2003. Under existing Medicaid provisions at section 1902(a)(2) of the Act, and 42 CFR 433.53 of the regulations, a state plan must require that the NFS of total Medicaid spending statewide be comprised of at least 40 percent of state (as distinguished from local) funds. In order to implement section 401(a)(7) of TRRA, CMS will need to identify each state that has a requirement for political subdivisions within the state to contribute toward the non-Federal share of expenditures, and with respect to such states to determine the applicable percentage as of April 1, 2003. On a subsequent basis, with respect to the five-quarter period for which the increased FMAP is available, the state must maintain this NFS funding percentage. We note that since this is a state plan requirement, if this condition is not met, the state would be considered to be out of compliance resulting in the applicable compliance process and any appropriate sanctions.

**Q2. Is a state in compliance with the requirements of section 401(a)(7) of TRRA if, with respect to an expenditure of the same total amount, it requires a political subdivision within the state to contribute the same dollar amount to meet the state's NFS of the expenditure as was required prior to the application of the increased FMAP? This would result in an effective increase in the percentage of the required political subdivision's contribution to the federally required NFS of the expenditure compared to the percentage that would have been contributed if the increased FMAP was not available?**

**A.** Under section 401(a)(7) of TRRA, states cannot require political subdivisions within the state to pay a greater percentage of the NFS of expenditures than the political subdivisions would have been required to pay prior to application of the increased FMAP. If a state requires a political subdivision within the state to contribute the same dollar amount, after the application of the increased FMAP the state would be effectively requiring political subdivisions within the state to pay a greater percentage of the NFS of expenditures. Therefore, the state would not be in compliance with the requirements of section 401(a)(7) of TRRA. The following example illustrates this:

Example. Prior to the FMAP increase under section 401(a)(7) of TRRA, a state's FMAP is 60 percent; after the FMAP increase, the state's FMAP is 62.95 percent. With respect to a \$10,000 total computable expenditure, prior to the FMAP increase the Federal share (FS) amount would be \$6,000, and the NFS amount would be \$4,000. Furthermore, prior to the application of the FMAP increase under TRRA, the state required the local political subdivision to pay 100 percent of the federally required NFS of expenditures. Therefore, in this example, prior to the application of the FMAP increase, the local subdivision paid \$4,000 (40 percent) of the \$10,000 expenditure. After the application of the FMAP increase, with respect to the \$10,000 expenditure, the state intends to require the local subdivision to continue to contribute \$4,000 of this expenditure.

With the application of the 62.95 percent increased FMAP, the FS of the \$10,000 total expenditure would be \$6,295 and the federally required NFS of this expenditure would be \$3,705. However, after the application of the increased FMAP, the state requires the local subdivision to continue to contribute the same \$4,000 amount as it previously required with respect to the total \$10,000 expenditure. The effect of this is that the percentage of the federally required NFS amount of the expenditure that the local political subdivision would be contributing would be effectively increased. That is, prior to the application the percentage of the federally required NFS that the local political subdivision contributed is 100 percent, calculated as \$4,000 (the contribution) divided by the required NFS of \$4,000 (40 percent of \$10,000). After the FMAP increase, based on the \$4,000 the state is requiring the local subdivision to contribute on the \$10,000 expenditure, the percentage local subdivision is contributing is 107.96 percent of the required NFS, calculated as \$4,000 (the state continued required contribution) divided by \$3,705 (37.05 percent of \$10,000, representing the federally required NFS amount). Since the percentage of the NFS amount required under Federal Medicaid statute that the local subdivision is being required to contribute has increased from 100 percent

(\$4,000/\$4,000) to 107.96 percent (\$4,000/\$3,705), the state would not be in compliance with section 401(a)(7) of TRRA.

**Q3. Does the provision under section 401(a)(7) of TRRA apply with respect to the NFS of expenditures associated with the Medicaid expansion eligibility groups?**

A. Yes. The Medicaid expansion population, as referenced in section 1905(u) of the Act, is under title XIX, the Medicaid statute. Therefore, expenditures related to this group are considered “expenditures under the State Medicaid plan” for purposes of the provision in section 401(a)(7) of TRRA.

**Q4. What expenditures must be considered in determining whether a state is in compliance with the provisions of section 401(a)(7) of TRRA?**

A. Section 401(a)(7) of TRRA refers to “the non-Federal share expenditures under the state Medicaid plan required under section 1902(a)(2) of the Social Security Act” and including any title XIX and Section 1115 waivers. Section 1902(a)(2) of the Act, in turn refers to “the non-Federal share of the expenditures under the plan with respect to which payment under section 1903 are authorized by this title.” Finally, section 1903 of the Act refers to all Medicaid expenditures that a state may incur in its program, including both medical assistance and administrative expenditures for which a state may claim Federal matching payments.

**Q5. Under section 1902(a)(2) of the Act and Medicaid regulations at 42 CFR 433. 53(b), state (as distinguished from local) funds must be used to pay at least 40 percent of the NFS of total expenditures under the Medicaid plan; that is, the local subdivisions cannot contribute more than 60 percent of the NFS of expenditures. If the state currently requires local political subdivisions to contribute less than the 60 percent maximum amount permitted under the statute and regulations, can the state require the local subdivisions to increase their percentage contribution up to 60 percent and still be in compliance with the NFS requirement under section 401(a)(7) of TRRA?**

A. No. As required by section 401(a)(7) of TRRA, states cannot increase the percentage of the NFS that local subdivisions are required to pay to a percentage that is greater than that required under the plan on April 1, 2003. Therefore, although increasing the NFS contribution for local subdivisions to 60 percent may be permissible under the NFS requirements under section 1902(a)(2) of the Act, if the local subdivisions’ percentage of NFS requirement is greater than the percentage required under the state plan on April 1, 2003, the state would not be in compliance with the TRRA requirements.

## **VII. TREASURY DEPARTMENT PROVISIONS**

**Q1. Under section 401(b) of TRRA, \$10 billion was allocated to states under a new title VI of the Social Security Act to assist in government services; can states use these Federal funds for purposes of providing the non-Federal share of Medicaid and/or SCHIP expenditures?**

A. No. Medicaid regulations at 42 CFR 433.51(c), and SCHIP regulations at 42 CFR 457.628(a), indicate that unless the Federal funds (in this case, the states' allocations under section 401(b) of TRRA) are specifically authorized by Federal law to be used to match other Federal funds, that is, Federal matching funds under the Medicaid program and/or the SCHIP, they (the funds under section 401(b) of TRRA) cannot be used as the non-Federal share in the Medicaid program and/or the SCHIP. The CMS position is that these TRRA funds are not specifically authorized to be used to match Medicaid and/or SCHIP funds.

**Q2. The \$10 billion fund under the new title VI of the Social Security Act is being administered by the Treasury Department; what has the Treasury Department released with respect to this provision?**

A. On June 4, 2003, Treasury Secretary Snow released a letter to the Governors announcing the availability of funds under the new title VI of the Social Security Act - Temporary State Fiscal Relief. The following Treasury Department websites describe this provision:

Treasury Department, June 4, 2003, Press Release:

<http://www.treas.gov/press/releases/js453.htm>

Treasury Department, June 4, 2003, letter from Treasury Department Secretary Snow to Governors:

<http://www.treas.gov/press/releases/reports/stateletter.pdf>

Table indicating each state's allocation of the \$10 billion under Title VI of the Social Security Act:

<http://www.treas.gov/press/releases/reports/paymenttable.pdf>

Certification Form to be submitted by states to Treasury Department:

<http://www.treas.gov/press/releases/reports/certificationformmsword.doc>