CMS Issues Guidance on Maintenance of Effort Requirements for Enhanced FMAP

Prepared by Jane Perkins
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The Centers for Medicare & Medicaid Services (CMS) recently issued a guidance document, entitled *American Recovery and Reinvestment Act of 2009 Section 5001: Increased Federal Medical Assistance Percentage*.[1]

Section 5001 offers states temporary increases in their federal medical assistance percentage (FMAP) between October 1, 2008 and December 31, 2010. The CMS guidance addresses increased FMAP methodology and grant issuance; reinstatement processes when states reverse disqualifying policies; frequently asked questions from states; and Section 5001's maintenance of effort (MOE) provision.

Increased FMAP is specifically conditioned on states maintaining "eligibility standards, methodologies, and procedures" in effect on July 1, 2008. *See* ARRA, § 5001(f)(1)(A). This memorandum summarizes the CMS guidance regarding MOE.[2]

According to CMS, states/territories must actively review a number of factors when considering acceptance and use of increased FMAP, including:

1. The state/territory must not have eliminated any eligibility groups or sub-groups under the state plan. For example, states with medically needy programs cannot eliminate one or more categorical subgroups (e.g. the aged or the disabled) from coverage;

2. The state/territory must not have eliminated coverage of any eligibility group or subgroup in any Home and Community Based Services (HCBS) waiver under 42 U.S.C. § 1396n (Social Security Act, § 1915(c)); and

3. Improper restrictions on eligibility include, but are not limited to:
    - Instituting or increasing premiums that may restrict, limit or delay eligibility;
    - Increasing the stringency of the level of care determination process that results in individuals losing actual or potential eligibility for institutional care or the HCBS waiver under 42 U.S.C. § 1396n;
    - Adjusting the cost neutrality calculation under an HCBS waiver from aggregate to individual caps, such that individuals lose waiver coverage or are hindered in moving out of an institutional setting;

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[1]. Source: Georgetown University Health Policy Institute Center for Children and Families.

[2] For additional background, see Randy Boyle and Jane Perkins, National Health Law Program, *State Maintenance of Effort Requirements for Enhanced FMAP* (Mar. 10, 2009), available at www.healthlaw.org.

- Reducing the "occupied waiver capacity" of an HCBS waiver;
- Reducing or eliminating HCBS waiver slots approved but not filled as of July 1, 2008;
- Introducing restrictive adjustments in financial criteria, including: reducing income or resource standards; implementing income or resource standards that had not been imposed on a group or individual within a group; eliminating or reducing income or resource methodologies favorable to applicants or beneficiaries (including more liberal methodologies under section 1902(r)(2) of the Social Security Act); and, in 209(b) states, restricting criteria for the aged, blind or disabled, including changing in the definition of blindness or disability; and
- Changing eligibility determination or redetermination processes or procedures including: increasing the frequency of redeterminations (e.g. from annually to every six months); reducing the amount of time an individual has to respond to requests for information; revoking or otherwise restricting a policy under which eligibility is decided based on an attestation by the individual of the amount and/or type of their resources. However, this does *not* include a program to verify assets of aged, blind or disabled individuals required by 42 U.S.C. § 1396w (effective June 30, 2008).

CMS gives a couple of examples of modifications that are not subject to MOE:

- Eliminating or reducing eligibility groups whose services are funded entirely through CHIP funding (including through a Section 1115 demonstration); and
- Post-eligibility treatment of income determinations.

The MOE requirement applies to eligibility standards, methodologies or procedures under a state plan under Title XIX of the Social Security Act, including any waiver under Title XIX or under Section 1115 of the Social Security Act (42 U.S.C. § 1315). The requirement applies to all demonstration-eligible individuals funded through Title XIX, including those demonstrations with budget neutrality based on DSH funds. Demonstrations using a combination of Title XIX and Title XXI (CHIP) funds are also affected. The only demonstrations not subject to the MOE requirements are those funded entirely through Title XXI (CHIP) funding.

The guidance clarifies that a state cannot require a political subdivision to pay a greater percentage of the non-federal share of expenditures than the political subdivision would have been required to pay prior to the increased FMAP (October 1, 2008). Thus, this provison would be violated if the state required a political subdivision to contribute the same dollar amount after the application of the increased FMAP because the state would, in effect, be requiring the subdivision to pay an increased percentage of the non-federal share of expenditures.

ARRA prohibits a state from depositing or crediting increased FMAP directly or indirectly to any reserve or rainy-day fund of the state. According to CMS, this applies "except to the extent of any increase based on maintenance of the prior year FMAP levels."