

Families First Coronavirus Response Act – Increased FMAP FAQs

On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state and territory's ¹ Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act (the Act) effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services for COVID-19², including any extensions, terminates.

A. General Questions

1. Which states are eligible for the 6.2 percentage point FMAP increase?

All states and territories are eligible for the increased FMAP, provided they meet the requirements of section 6008(b) and (c) of the Families First Coronavirus Response Act. While CMS has not conducted reviews for state compliance, we believe that all states can take steps to be compliant and earn the enhanced funding, and CMS will provide technical assistance to states on this issue. The specific criteria that states and territories must meet in order to qualify for the increased FMAP is described in section C of this FAQ document (below).

2. Does the 6.2 percentage point FMAP increase apply to all match rates used in determining how much Federal Financial Participation (FFP) states receive for Medicaid expenditures?

In general, the increased FMAP is available for allowable Medicaid medical assistance expenditures for which federal matching is paid ordinarily at the state-specific FMAP rate defined in the first sentence of section 1905(b) of the Act. The increase does not apply with respect to the following Medicaid expenditures:

- Medicaid administrative expenditures, for which the matching rate is not defined in section 1905(b).
- Adult group expenditures matched at the “newly eligible” FMAP specified in section 1905(y) of the Act.
- Adult group expenditures matched at the “expansion state” FMAP specified in section 1905(z) of the Act.
- Expenditures for family planning services eligible for 90% match as specified in section 1903(a)(5).

¹ Unless specifically noted, each reference to a state or states in these FAQs includes a reference to the District of Columbia and the territories.

² The emergency period is defined in paragraph (1)(B) of section 1135(g) of the Act, as amended by H.R. 6074—The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123). The Secretary's determination that a public health emergency exists was issued on January 31, 2020 with an effective date of January 27, 2020. The declaration is available at <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>.

- Expenditures for services “received through” an IHS facility (including an IHS facility operated by an Indian tribe or tribal organization), as the 100% match rate for these services is not the same as the state-specific FMAP defined in the first sentence of section 1905(b) to which the 6.2 percentage point FMAP increase applies.
- Expenditures matched at 100% for individuals in Qualifying Individuals programs.
- Health home services under section 1945 of the Act when these are matched at 90% as specified in section 1945(c)(1). After the initial enhanced FMAP period for these services that is described in section 1945(c)(1), they will be matched at the state’s regular FMAP, which might be subject to the 6.2 percentage point increase under section 6008(a).
- Community First Choice (CFC) 1915(k) service expenditures already eligible for a 6 percentage point in Federal match rate increase.
- Any other expenditures not matched at the FMAP determined for each state that is defined in the first sentence of section 1905(b).

3. Is the increased FMAP available for Medicaid DSH expenditures?

Yes, if the expenditures are matched at the 1905(b) FMAP and the state and the expenditures otherwise meet the qualifying requirements (the expenditures were incurred during the applicable time period, the state meets the requirements in section 6008(b) and (c) of the FFCRA).

4. Does the 6.2 percentage point FMAP increase apply to Children’s Health Insurance Program expenditures and expenditures for individuals eligible on the basis of breast and cervical cancer that are matched at the “enhanced” FMAP (EFMAP) under section 2105(b) of the Act?

Not directly. The EFMAP in section 2105(b) of the Act is calculated using the FMAP as defined in the first sentence of section 1905(b) of the Act as a “base.” Therefore, generally, as the 1905(b) FMAP increases for a state, the EFMAP also increases for the state, though not in the exact same amount. Therefore, the EFMAP will increase for states coinciding with the duration of the 6.2 percentage point increase to the FMAP.

Please note that under section 2105(b) of the Act, the EFMAP for CHIP expenditures only is increased by 11.5 percentage points for the Federal Fiscal Year (FY) 2020 (October 1, 2019 through September 30, 2020) with a cap of 100% for this same period. The 100% cap will still apply as the maximum match rate for CHIP expenditures. For FY 2021 and after, the EFMAP under section 2105(b) of the Act is capped at 85%. Optional Breast and Cervical Cancer expenditures are matched at the uninincreased EFMAP (that is, the EFMAP without the 11.5 percentage point increase described above).

Optional Breast and Cervical Cancer expenditures under section 2105(b) of the Act are matched at the uninincreased EFMAP (that is, the EFMAP without the 11.5 percentage point increase for CHIP expenditures described above).

Example of the Impact of the 6.2 percentage point FMAP Increase on the Section 2105(b) EFMAP Calculation

	Without 6.2 percentage point FMAP Increase	With 6.2 percentage point FMAP Increase
1905(b) FMAP	50%	56.2%
EFMAP Calculation	$(50\% \times 0.7) + 0.3$	$(56.2\% \times 0.7) + 0.3$
EFMAP (non-CHIP)	65%	69.34%
EFMAP for CHIP (FY 2020)	76.5% (65% + 11.5%)	80.84% (69.34% + 11.5%)

5. For which period is the FMAP increase available?

Section 6008(a) of the FFCRA states that the increased FMAP is available for each calendar quarter occurring during the public health emergency. As the public health emergency for COVID-19 was declared by the Secretary of Health and Human Services on January 31, 2020, the increased FMAP is available for qualifying expenditures that were incurred on or after January 1, 2020 and through the end of the quarter in which the public health emergency including any extensions, ends. At the time the public health emergency period for COVID-19 ends, CMS will inform states.

6. How do states know whether an otherwise qualifying expenditure falls within the period for which the increased FMAP is available?

States should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter. For purposes of determining which FMAP applies, expenditures are considered to be incurred based on when the state makes a payment to a provider, not based on 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.

7. Is the increased FMAP available for services provided under waivers and section 1115 demonstrations?

Yes, if the expenditures are matched at the FMAP defined in the first sentence of 1905(b) and the state and the expenditures otherwise meet the qualifying requirements in section 6008 of the FFCRA.

8. Are states required to submit a State Plan Amendment (SPA) to be eligible for the 6.2 percentage point FMAP increase?

No, states are not required to submit a SPA to be eligible for the FMAP increase. However, only expenditures matched at the FMAP defined in the first sentence of 1905(b) that are incurred by states that meet the qualifying requirements in section 6008 of the Families First Coronavirus Response Act are eligible for the increased FMAP.

B. Requirements for States to Receive Increased FMAP

1. What must a state do to receive a 6.2 percentage point temporary increase to the federal medical assistance percentage (FMAP)?

To qualify for the temporary FMAP increase, states must, through the end of the month when the public health emergency ends:

- a. Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (maintenance of effort requirement).
- b. Not charge premiums that exceed those that were in place as of January 1, 2020
- c. Cover, without impositions of any cost sharing, testing, services and treatments—including vaccines, specialized equipment, and therapies—related to COVID-19.
- d. Not terminate individuals from Medicaid if such individuals were enrolled in the program as of the date of the beginning of the emergency period, or becomes enrolled during the emergency period, unless the individual voluntarily terminates eligibility or is no longer a resident of the state (continuous coverage requirement).

These requirements became effective on March 18, 2020. More information on these conditions is provided below.

2. What is the maintenance of effort (MOE) requirement in the FFCRA? What types of eligibility and enrollment changes can states make to respond to the current emergency and still receive temporary increased FMAP?

States may not impose eligibility standards, methodologies, or procedures that are more restrictive than those that were in place on January 1, 2020, in order to receive increased FMAP during the emergency period. States may continue to make temporary or permanent eligibility and enrollment changes that are less restrictive during the emergency period, such as lowering premiums, easing burden associated with verification requirements, and streamlining the application process, as permitted by law, including under any applicable federal waiver or modification authorities. CMS is available to provide technical assistance to any state that implemented any such more restrictive standards, methodologies, or procedures between January 1, 2020 and enactment of the FFCRA.

3. Can states increase premiums under the state plan (or waiver) after January 1, 2020 and still receive temporary increased FMAP?

No. A state that increases premiums for any beneficiaries above the amounts in effect on January 1, 2020 is not eligible for the temporary increased FMAP.

4. Are states required to cover any COVID-related services as a condition of receiving the temporary increased FMAP?

Yes. States must cover, under the state plan (or waiver), testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies, for any quarter in which the temporary increased FMAP is claimed.

5. Which items and services must states exempt from cost sharing in order to be eligible for the temporary increased FMAP?

States may not impose deductibles, copayments, coinsurance or other cost sharing charges for any services described in question C.4., above – i.e., testing services and treatments for COVID-19, including vaccines, specialized equipment, and therapies – in the quarter in which the temporary increased FMAP is claimed.

6. Are states required to provide continuous coverage for all Medicaid beneficiaries through the end of the month in which the emergency period ends?

Yes. In order to receive the temporary FMAP increase provided under section 6008 of the FFCRA, states must provide continuous coverage, through the end of the month in which the emergency period ends, to all Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who are no longer considered to be residents of the state.

7. If a state has already terminated coverage for individuals enrolled as of March 18, 2020, what actions should the state take? Must those individuals have their coverage reinstated?

To receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid during the emergency period effective March 18, 2020, unless the beneficiary voluntarily requested to be disenrolled, or is no longer a resident of the state. States that want to qualify for the increased FMAP should make a good faith effort to identify and reinstate individuals whose coverage was terminated on or after the date of enactment for reasons other than a voluntary request for termination or ineligibility due to residency. At a minimum, states are expected to inform individuals whose coverage was terminated after March 18, 2020 of their continued eligibility and encourage them to contact the state to reenroll. Where feasible, states should automatically reinstate coverage for individuals terminated after March 18, 2020 and should suspend any terminations already scheduled to occur during the emergency period. Coverage should be reinstated back to the date of termination.

8. Does continuous coverage for the emergency period apply to individuals who are receiving benefits during a period of presumptive eligibility?

Individuals who have been determined presumptively eligible for Medicaid have not received a determination of eligibility under the state plan, and are therefore not “enrolled” and subject to the requirements for continuous coverage described under section 6008 of the FFCRA.