

## CMS Guidance on Increased Medicaid Funding Provides Important Protections for Medicaid Consumers

On February 17, 2009, President Obama signed economic stimulus legislation, the American Recovery and Reinvestment Act of 2009 (ARRA), into law. Section 5001 of ARRA provides an additional \$87 billion in federal funding for Medicaid for the period from October 1, 2008, through December 31, 2010. The law provides that the federal matching rate for every state's Medicaid program—the share of Medicaid costs paid by the federal government, or the FMAP—will be increased by at least 6.2 percentage points. States with higher unemployment rates will get an even greater bump in federal assistance.

On March 25, 2009, the Centers for Medicare and Medicaid Services (CMS) released a fact sheet and Frequently Asked Questions providing guidance on the implementation of the FMAP increase under ARRA. The guidance describes how CMS is interpreting the law and indicates where the agency has made decisions about details that may not have been fleshed out in the statute. As expected, the guidance reiterates certain provisions of the statute (such as which expenditures are, and which are not, eligible for the enhanced Medicaid match), but it also provides new information on the following two items, both of which are important for consumers and advocates:<sup>1</sup>

1. What is required of states to meet the Maintenance of Effort (MOE) requirement, and
2. How will the enhanced FMAP be applied to states that have expanded Medicaid eligibility after July 1, 2008?

### 1. What is included in the Maintenance of Effort requirement (MOE)?

The economic recovery act allows states to get the increased Medicaid funds only if they have not acted since July 1, 2008, to reduce the income limits for Medicaid or otherwise make it more difficult for people to get or keep Medicaid. (The law gives states until July 1, 2009, to reverse any eligibility cuts that they enacted or implemented after July 1, 2008, and thus to qualify for the additional funds.) CMS's guidance defines what constitutes a reduction in eligibility for the purposes of qualifying for the increased federal Medicaid funding, and it does so in a way that protects many vulnerable people in Medicaid.

CMS's interpretation of the MOE requirement protects Medicaid consumers from a wide range of recently enacted or proposed policies that would have reduced the number of people enrolled in Medicaid. The list includes direct eligibility cuts, such as eliminating coverage for an entire group of people, as well as other policy changes that would have resulted in people losing coverage, such as charging more for Medicaid coverage. Of particular note, several states have made or proposed changes to programs that help seniors and people with disabilities live independently; the

CMS guidance clarifies that any changes to such waiver programs that would result in fewer people being enrolled would violate the MOE requirement for the increased federal Medicaid funding. As a result of this guidance, states will have to reverse these cuts or rescind these proposals, at least until December 31, 2010.

To be in compliance with the MOE, a state cannot have done the following after July 1, 2008:

- Eliminated eligibility for any groups or sub-groups. For example, a state cannot have reduced the income eligibility limit for parents or eliminated its medically needy program for people with disabilities.
- Charged new or higher monthly premiums that would make it harder for someone to afford Medicaid.<sup>2</sup>
- Imposed new, or reduced existing, income or resource standards, including asset tests, that would cause individuals to lose coverage or prevent them from becoming eligible.
- Changed the eligibility criteria or procedures for aged, blind, or disabled individuals, for example, by decreasing income limits or instituting a stricter definition of disability or blindness.<sup>3</sup>
- Made it more difficult for people to apply for or renew their coverage by, for example, increasing the number of times per year that a person or family has to reapply for Medicaid, requiring more paperwork or documentation, or reducing the time allowed to respond to a request for additional information.
- Made it harder for an individual to qualify for nursing home care or home- and community-based waiver services.
- Eliminated coverage for home- and community-based waiver care that costs more than institutional care, which could make it harder for some individuals to qualify for waiver coverage.
- Removed individuals currently receiving services through a home- and community-based waiver program or reduced or eliminated home- and community-based waiver slots that were approved but not filled as of July 1, 2008.

## **2. Are all Medicaid expansions implemented after July 1, 2008, excluded from receiving the enhanced FMAP?**

Under the economic recovery act, a state cannot get the enhanced FMAP for expenses related to a Medicaid expansion that was enacted after July 1, 2008. Congress included this restriction in an effort to keep ARRA funding focused on filling severe budget shortfalls. The restriction left some states with newly implemented expansions, or enacted-but-not-yet-implemented expansions, wondering if their expansions would be eligible for the additional federal funding. The CMS guidance clarifies that states with expansions enacted into law before July 1, 2008, can get the enhanced federal matching funds for expenses related to those expansions, even if they were implemented after that date. This includes expansions that are scheduled for implementation this year or in 2010.

Note that while a state may not receive the enhanced federal funding for expenses related to a state Medicaid expansion that is enacted this year or in 2010, ARRA does not prohibit states from expanding coverage while they are receiving the enhanced match. That is, states are permitted to enact and implement new expansions in 2009 and 2010. They will receive their regular Medicaid match rate for any expenses related to such expansions, and the enhanced match for services provided to people who are, or would have been, eligible as of July 1, 2008.

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<sup>1</sup> For more on what's in the statute, see Families USA's *Frequently Asked Questions about the Temporary Extra Medicaid Funding in the Economic Recovery Package*, available online at <http://www.familiesusa.org/issues/medicaid/fmap-faqs.html>.

<sup>2</sup> States can charge premiums in Medicaid only under limited circumstances. Most states that charge premiums do so in a Medicaid demonstration waiver that covers people with higher incomes relative to "traditional" Medicaid enrollees. The MOE requirement would also apply to any state decision to charge a premium under the Deficit Reduction Act of 2005 (DRA) option.

<sup>3</sup> This applies to a state that has stricter eligibility criteria for aged, blind, or disabled individuals than those used by the Social Security Administration for SSI eligibility; such states are known as 209(b) states. The eleven 209(b) states are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.



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