

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.

9. Do the requirements to provide continuous coverage during the emergency period apply to individuals who were determined ineligible prior to March 18, 2020, but who continue to receive services pending an appeal?

Yes. Individuals who continue to receive services pending an appeal of a determination of ineligibility would be considered to be enrolled for benefits, if this was their status as of March 18, 2020 and therefore should not be terminated from enrollment until the end of the month when the emergency period ends.

10. Do the requirements to provide continuous coverage apply to CHIP?

No. States do not need to maintain coverage in CHIP in order to receive the temporary increase in the Medicaid federal medical assistance percentage (FMAP) provided under section 6008 of the FFRCA. However, the Maintenance of Effort (MOE) required under section 2105(d)(3) of the Social Security Act continues to apply.

11. Should states continue to conduct redeterminations and act on reported or identified changes in circumstances during the emergency period?

The FFCRA does not prohibit a state from conducting regular Medicaid renewals and redeterminations or acting on reported or identified changes in circumstances. States may also continue to conduct periodic data matching between regular beneficiary renewals, consistent with states' verification plans. However, to receive the increased FMAP, states may not terminate coverage for any beneficiary enrolled in Medicaid on or after March 18, 2020, until the end of the month in which the emergency period ends, unless such individual is no longer a resident of the state or requests voluntary termination. This requirement to maintain continued coverage applies to beneficiaries who might otherwise have coverage terminated after a change in circumstances, including individuals who age out of a Medicaid eligibility group during the emergency period, who lose receipt of benefits that may affect their eligibility (e.g., SSI, foster care assistance payments), and whose whereabouts become unknown.

12. If a state receives information during the emergency period that would make a beneficiary eligible for a different eligibility group, must the state keep the beneficiary enrolled in the group in which he or she is currently enrolled?

To receive the increased FMAP under the FFCRA, states may not terminate coverage for beneficiaries enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, unless the beneficiary voluntarily requests termination from the program or is considered to no longer be a resident of the state. Further, while states may increase the level of assistance provided to a beneficiary who experiences a change in circumstances, such as moving the individual to another eligibility group which provides additional benefits, states may not reduce benefits for any beneficiary enrolled in Medicaid on or after March 18, 2020, through the end of the month in which the emergency period ends, and still qualify for increased FMAP.

13. During the emergency period, should states still terminate Medicaid coverage for deceased individuals?

Yes. Individuals who are determined to be deceased are no longer residents of the state. States may terminate coverage for deceased individuals and remain eligible for receipt of the increased FMAP. States should communicate this clarification to their managed care plans.

C. Flow of Federal Funds and State Reporting

1. Will CMS be releasing funding all at once or through multiple grant awards?

We are prioritizing issuing grant awards to states for additional funding associated with the increased FMAP retroactive to January 1, 2020 first. The first set of grant awards will include increased funding for the period January 1, 2020 through March 31, 2020. We will then provide additional funds based upon state budget estimates for the April 1, 2020 through June 30, 2020. As with all Medicaid grant award funding, these funds will be reconciled against claimed and allowable expenditures when states file their quarterly CMS-64 expenditure reports.

2. When will CMS send the FFP associated with the increased FMAP to states?

We are currently processing grant awards to fund the increase match for the period beginning January 1, 2020 through March 31, 2020. We expect that states will receive the funds in their Payment Management System (PMS) account no later than Wednesday, March 25, 2020. We intend to issue funding for the increased match associated with the quarter beginning April 1, 2020 as close to April 1, 2020 as possible.

3. How did CMS calculate the amount of the grant awards associated with the increased FMAP?

CMS used budget estimates reported and certified by states on the Form CMS-37 in the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) for the quarter ending March 31, 2020 (Q2 FY 2020) to estimate the additional amount of federal funds that would be due States as a result of the 6.2 percentage point FMAP increase. The amount of the additional grant award that each state receives for Q2 FY 2020 will be equal to the difference between the estimated federal share recalculated for Q2 FY 2020 to include the FMAP 6.2 percentage point increase and the federal share previously reported and certified in MBES/CBES for Q2/FFY 2020 by the state for the Q2 FY 2020 budget submission.

We are working to modify MBES/CBES as soon as possible to reflect each state's increased FMAPs; however, in the meantime, we are providing additional funds to states in estimated amounts described above. Once MBES/CBES is reprogrammed to utilize the increased FMAPs, the system will automatically determine the correct amount of federal funds related to the increased FMAPs, and apply such FMAPs for the actual claimed expenditures that were incurred on or after January 1, 2020, and before the end of the emergency period. Per our standard Medicaid grant award reconciliation process, CMS will reconcile all amounts advanced to the state, including estimated amounts based on the increased FMAP, to actual

Medicaid expenditures reported by the state for the relevant quarter and recover any unexpended amounts or pay any additional amounts due to the state.

4. The increased FMAP is available for expenditures incurred as early as January 1, 2020. Can states draw all funding associated with the increased FMAP as soon as they receive it?

If the state meets all applicable requirements and conditions established within section 6008 and other applicable existing federal requirements, it can draw funds associated with allowable Medicaid expenditures that have already been incurred and are eligible for the increased match. A state may not draw funds for expenditures it has not yet incurred, expenditures incurred prior to January 1, 2020, or expenditures that are not otherwise eligible for the increased FMAP.

5. Will grant awards issued relating to the increased FMAP be subject to adjustment or are they set amounts?

In calculating grant awards for the increased FMAP associated with the quarter ending March 31, 2020, we used estimated expenditures submitted and certified by states on the Form CMS-37. The final determination of allowability of expenditures eligible for the increased FMAP and any necessary reconciling grant awards will be determined after all the actual expenditures for the quarter have been submitted by the states and reviewed by CMS. At that time, final reconciling grant awards will be issued to reflect the amounts that the states are finally due based on federal requirements, including those specified in the Families First Coronavirus Response Act. Consistent with our existing practice and federal requirements, any overpayment or underpayment will factor into (be offset against or added to) the grant award for the following quarter.

6. What happens if a state determines that its spending will exceed its budget estimate? Will additional funding be available?

Consistent with existing practice, states have an opportunity at any time throughout each quarter to request additional funding from CMS as necessary to cover allowable Medicaid administrative and service costs, including those eligible for the 6.2 percentage point increased FMAP. Should any state need additional funds before the end of a quarter, they may request them through a supplemental request to the extent that the state and its expenditures qualify for the increased FMAP and have a permissible source of non-Federal share. CMS will evaluate such requests and issue any appropriate additional supplemental grant awards.

7. How will CMS expect states to document and differentiate which expenditures they are claiming at the increased FMAP rate and expenditures matched at other rates?

Consistent with existing requirements, states must document expenditures to ensure a clear audit trail, including by isolating expenditures that are matched at increased FFP rates. We will be performing oversight to ensure that the state expenditures are allowable and accurate, including with respect to the matching rate claimed. We are currently working to modify the Form CMS-64 and Form CMS-37 in the MBES/CBES system to accommodate the changes from the Families First Coronavirus Response Act, including reporting of budget estimates and expenditures eligible for the increase FMAP. We intend to issue further guidance and

offer training to states as soon as possible on reporting budget estimates on the CMS-37 and quarterly expenditures on the Form CMS-64.

8. Are there special reporting requirements for the Form CMS-64 or Form CMS-37 (i.e., separate lines or a separate report for the increased FMAP)?

We are currently working to modify the Form CMS-64 and Form CMS-37 in the MBES/CBES system to accommodate the changes from the Families First Coronavirus Response Act, including reporting of budget estimates and expenditures eligible for the increased FMAP. We intend to issue further guidance and offer training to states as soon as possible.

9. Will CMS expect states to document and differentiate which draws from its Payment Management System (PMS) account are applicable to the increased FMAP rate and which expenditures are matched at other rates? If so, how?

Consistent with existing requirements, states must document expenditures and draws to ensure a clear audit trail for use of federal funds. We expect states, on a quarterly basis, to provide CMS with a breakout of the total amount of PMS draws by quarter that are related to expenditure eligible for the increase FMAP and the total amount of PMS draws that were *not* for expenditures related to the increased FMAP. CMS expects states to provide this information as soon as possible at the end of every quarter. In line with our current processes, we will continue to reconcile states' PMS subaccounts with actual expenditures once states report them in MBES/CBES and CMS reviews the expenditures for accuracy and allowability. States' total draws in PMS are expected to equal the actual total expenditures reported for such quarter/fiscal year in MBES/CBES.

10. Does the increased FMAP only pertain to state expenditures or does it also pertain to collections and overpayments?

All states are responsible for reporting Medicaid collections and overpayments on the CMS-64. States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including when the original rate incorporated the 6.2 percentage point FMAP increase.

11. If a state recovers a provider payment that was originally claimed by the state with the 6.2 percentage point increased FMAP, should it return the FFP associated with the recovery at the increased FMAP?

Yes, recoveries of FFP must be returned at the same match rate at which they were originally claimed. Therefore, if a Medicaid expenditure was claimed using the increased FMAP, the federal share of any recoveries associated with that expenditure would have to be returned using the same increased FMAP.

D. Requesting Increased FMAP

1. To be eligible for the 6.2 percentage point FMAP increase, section 6008(c) of the Families First Coronavirus Response Act provides that states must not require political subdivisions of the state to pay a greater portion of the non-federal share of expenditures required under section 1902(a)(2) of the Act or payments under 1923 of

the Act than was required on March 11, 2020. Will CMS require states and territories to demonstrate compliance with this provision prior to receiving the increased FMAP?

While states are required to ensure compliance with this section, CMS will not require that states submit a demonstration of compliance prior to drawing FFP associated with the increased FMAP. Instead, CMS will require states to attest to compliance. If this attestation is determined to be incorrect such that the state does not satisfy the conditions under section 6008(c) of the Families First Coronavirus Response Act, then the state will be required to return the increased FFP for which it did not qualify to CMS.

2. Will CMS require that states attest to meeting the requirements of section 6008 of the Families First Coronavirus Response Act when drawing the FFP associated with the increased FMAP?

Yes. States must attest that they will assure compliance with the requirements in sections 6008(b) and (c) of the Families First Coronavirus Response Act. If this attestation is determined to be incorrect such that the state does not satisfy all applicable conditions under section 6008 of the Families First Coronavirus Response Act, then the state will be required to return the increased FFP for which it did not qualify to CMS.

3. How will states attest? What should states send in and to whom? Will CMS approve the attestation? May states draw funds before the attestation is approved? Must states attest before each draw down?

By drawing funds from the increased FMAP account in the Payment Management System (PMS), each state is “attesting” that: it is eligible for the increased FMAP; the expenditures for which it is drawing funds are those for which the increased FMAP is applicable; and that the conditions under which the increased FMAP is available are met. The attestation includes specific agreement with enumerated requirements of sections 6008(b) and (c) of the Families First Coronavirus Response Act. To minimize the need for separate review, avoid state burden, and expedite providing funding to states, CMS has included these requirements as attestations in each grant award letter to the states. The grant award letter indicates that only after the state has assured itself that it meets all of the requirements under which the increased FMAP and associated funds were available, is 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, by simply drawing down the funds the state was attesting that it had carefully considered all attestations and that it met those requirements. If this is determined to be incorrect such that the state does not satisfy all applicable conditions under section 6008 of the Families First Coronavirus Response Act, then the state will be required to return the increased FFP for which it did not qualify to CMS.

4. Does CMS intend to issue more specific guidance on the requirements relating to political subdivisions in section 6008(c)?

Section 6008(c) modifies section 1905(cc) of Act by providing that, to be eligible for the increased FMAP under section 6008(a) of the Families First Coronavirus Response Act, states must not require political subdivisions of the state to pay a greater portion of the non-federal share of expenditures required under section 1902(a)(2) of the Act or payments under

1923 of the Act than was required on March 11, 2020. CMS has already issued guidance about section 1905(cc) of the Act, including most recently through State Medicaid Director Letter #10-023 on November 9, 2010. States should refer to this guidance regarding requirements of section 1905(cc). Of note, for increased FMAP available under section 6008 of the Families First Coronavirus Response Act, the reference to “December 31, 2009” in section 1905(cc) of the Act shall be deemed to be a reference to “March 11, 2020.”