



Center for Medicaid and State Operations

SMD# 09-003

ARRA # 3

June 17, 2009

Dear State Medicaid Director:

This letter is one of a series designed to provide guidance on the implementation of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5. It summarizes most sections of ARRA that impact titles XIX (the Medicaid program) and XXI (the Children's Health Insurance Program, or CHIP) of the Social Security Act (the Act) and provides detail on the sections specific to payments that should not be counted for purposes of eligibility for Federal programs. Future State Medicaid Director letters and other technical guidance will be issued in the coming weeks and months, providing details on the implementation of all other sections, including the Health Information Technology (HIT) provisions and provisions that directly affect American Indian and Alaska Natives enrolled in Medicaid and CHIP.

ARRA is divided into two parts: Division A and Division B. All of the detailed sections in this letter are part of Division B; however, there are many sections in Division A with implications for State Medicaid programs, albeit less direct. We welcome questions from the States on any part of ARRA that impacts titles XIX or XXI and we commit to working with States on any sections of the new law that raise concerns or challenges for States. Please continue to submit questions to CMSOARRAQuestions@cms.hhs.gov. We will post the questions and answers on a continual basis at http://www.cms.hhs.gov/Recovery/09_Medicaid.asp#TopOfPage.

Division B, Title I—Tax, Unemployment, Health, State Fiscal Relief, And Other Provisions, Section 1001 – Making Work Pay Tax Credit

Section 1001 of ARRA provides for a credit against the taxes paid by most working individuals. The credit is the lower of 6.2 percent of the earned income of the taxpayer, or \$400 (\$800 for a joint return), and is available for the 2009 and 2010 tax years. Subsection 1001(c) of ARRA further provides that any credit or refund made under section 1001 will be disregarded for purposes of all Federal and federally-assisted programs, including both the Medicaid and CHIP programs. Enclosure A provides more detailed guidance with regard to implementing this section.

**Title II—Assistance for Unemployed Workers and Struggling Families
Section 2002 – Increase in Unemployment Compensation Benefits**

Section 2002 of ARRA provides for an increase in unemployment compensation benefits for individuals. Subsection 2002(h) of ARRA further provides that the monthly equivalent of any additional compensation paid under section 2002 shall be disregarded when considering the amount of income of an individual for any purpose under the Medicaid and CHIP programs. Enclosure B provides detailed guidance with regard to implementing this section.

Section 2201 – Economic Recovery Payment to Recipients of Social Security, Supplemental Security Income, Railroad Retirement Benefits, and Veterans Disability Compensation or Pension Benefits.

Section 2201 of ARRA provides for a one-time payment of \$250 to individuals who are eligible for benefits under any of the programs listed above, and who meet certain other requirements described in section 2201. Subsection 2201(c) of ARRA further provides that the payments made under section 2201 will be disregarded for purposes of all Federal and federally-assisted programs. This includes both the Medicaid and CHIP programs. Enclosure C provides specific guidance with regard to implementing this section.

Section 2202 - Special Credit for Certain Government Retirees

Section 2202 of ARRA provides for a credit against taxes of \$250 (\$500 in the case of a joint return where both spouses are eligible) for recipients of pensions or annuities for service performed for the Federal Government or any State government. Subsection 2202(d) of ARRA further provides that any credit or refund made as a result of this provision cannot be taken into account as income or resources for two months for purposes of any Federal or federally-assisted programs, including the Medicaid and CHIP programs. Enclosure D provides specific guidance with regard to implementing this section.

Title V—State Fiscal Relief

Section 5001 – Temporary Increase of Medicaid FMAP

As States are aware, Section 5001 of ARRA increased the higher of each State's 2008 or 2009 Federal Medical Assistance Percentage (FMAP) rate by 6.2 percentage points. Similarly, the increase will be applied in the next two fiscal years to the higher of the current or previous year's FMAP (e.g. FY 2010 will be based on the higher of the FY 2009 rate or the FY 2010 rate, FY 2011 will be based on the higher of FY 2010 or FY 2011) for the duration of the recession adjustment period (October 1, 2008 to December 31, 2010). The FMAP rate is further increased for any calendar quarter in which the State experiences a greater than 1.5 percentage point increase in unemployment according to the Bureau of Labor Statistics.

A State is not eligible for these increases if it has restricted its Medicaid eligibility standards, methodologies, or procedures after July 1, 2008, or if the State deposits or credits any amounts attributable (directly or indirectly) to the increased FMAP to any reserve or rainy day fund of the State. States are also ineligible if the State requires political subdivisions within the State to contribute for quarters beginning October 1, 2008, and ending December 2010, a greater percentage of the non-Federal share of Medicaid. Additionally, the increased FMAP is not available for any claims received by the State on days they are out of compliance with the practitioner prompt pay requirements. These prompt pay requirements are then extended to hospital and nursing facility provider claims effective June 1, 2009.

Guidance concerning the eligibility maintenance of effort (MOE) requirements was released on March 25, 2009. That guidance should be viewed as the beginning of the dialogue between CMS and the States on this provision, but it requires further clarification. Please see Enclosure E for two such clarifications.

Section 5002 - Temporary Increase in Disproportionate Share Hospitals (DSH) Allotments During Recession

Section 5002 of ARRA increases the State Medicaid DSH allotments for fiscal year (FY) 2009 by 2.5 percent. Section 5002 further provides that the FY 2010 State Medicaid DSH allotments would then be 102.5 percent of the FY 2009 increased allotment, unless the pre-ARRA calculation of the State's FY 2010 Medicaid DSH allotment would have resulted in a higher allotment.

Section 5003 - Extension of the Moratoria on Certain Medicaid Final Regulations

The Congressional moratoria that were placed on the interim final regulation relating to optional case management services and the final regulation on allowable provider taxes under the Supplemental Appropriations Act of 2008 (P.L. 110-252) are extended until July 1, 2009 in Section 5003 of ARRA. Similarly, the Congressional moratorium placed on the final regulation concerning school-based administration and transportation services is extended until July 1, 2009. Additionally, CMS is prohibited from taking any action on expenditures made for services between December 8, 2008, and June 30, 2009 implementing the final regulation relating to the Medicaid definition of outpatient hospital facility services published in the *Federal Register* on November 7, 2008.

This section also expressed the "sense of Congress" that the following proposed regulations not be promulgated as final regulations: Medicaid Cost Limit for Certain Providers, Medicaid Payments for Graduate Medical Education, and Rehabilitative Services.

On May 6, 2009, CMS proposed in the *Federal Register* a full rescission of the School-Based Services Final Rule and the Outpatient Services Definition Final Rule, and a partial rescission of the Case Management Services Interim Final Rule (CMS 2287-P2). The provisions of the Case Management Services Interim Final Rule that would be rescinded include the definition of case management services for individuals transitioning from institutional to community services, the single case manager requirement, the requirement for payment methodologies based on 15 minute units of service, and the prohibition of providers authorizing services. Additionally, the rescission removed restrictions on Medicaid Federal Financial Participation for case management services that are a component of another Medicaid covered service, integral to the administration of other non-medical programs, or are Medicaid administrative activities. All other provisions would remain in effect.

Additionally, CMS published a proposed rule to delay enforcement of certain portions of the final rule on allowable provider taxes (CMS 2275-P2). The provisions of the provider tax rule where enforcement would be delayed include only the hold harmless clarifications. The revisions to the threshold levels under the regulatory indirect guarantee hold harmless arrangement test to reflect provisions of the Tax Relief and Health Care Act of 2006 and the amended definition of the class of managed care organization services in accordance with the Deficit Reduction Act of 2005 would remain in effect.

Section 5004 - Extension of Transitional Medical Assistance (TMA)

On April 6, 2009, CMS issued a State Medicaid Director letter that provides guidance on section 5004 of ARRA which extends the Transitional Medical Assistance program for 18 months effective July 1, 2009, through December 31, 2010. The letter also provides guidance on the new option in ARRA for States to modify TMA eligibility requirements. Specifically, ARRA allows States to extend families' Medicaid eligibility under TMA for an initial period of 12 months, rather than an initial period of six months followed by a second 6-month period. ARRA also allows States to revise the requirement for previous receipt of Medicaid. The letter advises States of new ARRA requirements for reporting the average monthly enrollment and participation rates for TMA for adults and children and notes that the format, timing, and frequency of the reports will be specified at a later time. Finally, the letter includes a draft State plan pre-print to assist States in submitting an amendment to revise their State plans to reflect the new TMA requirements.

Section 5005 – Extension of the Qualified Individual (QI) Program

Section 5005 of ARRA extends the Qualified Individual (QI) program through December 2010. Section 5005 also provides for the following allocation amounts:

- For the period from January 1, 2010, through September 30, 2010, the total allocation amount is \$412,500,000.
- For the period from October 1, 2010, through December 31, 2010, the total allocation amount is \$150,000,000.

Section 5006 - Protections for Indians under Medicaid and CHIP

This provision directly affects Indian Tribes and, pursuant to the HHS Tribal Consultation policy, CMS will issue additional guidance after consultation with Tribes. The provision is effective July 1, 2009, so we will be working in the next few months to issue guidance in a timely manner. The following is a brief summary of the section:

Subsection (a) prohibits premiums and cost-sharing for Indians who are provided services by Indian Health providers (including Urban Indian organizations) or through referral by contract health services. Similarly, payments to Indian Health providers cannot be reduced by the amount of any enrollment fee, premium, or cost-sharing in Medicaid or CHIP.

Subsection (b) requires that States must disregard property, including real property and improvements, held in trust or under supervision of the Secretary of the Interior, from resources when determining eligibility for Medicaid or CHIP. Additionally, States must disregard ownership interests and usage rights in federally protected natural resources and items with unique cultural significance or that support maintaining traditional lifestyles according to tribal law or custom.

Subsection (c) codifies sections of the Medicaid Manual instructions regarding protecting Indian property from estate recovery under Medicaid. This section reinforces current policy.

Subsection (d) sets forth several provisions regarding managed care entities. Managed care entities serving Indians that include Indian Health primary care providers are required to allow Indian members to choose the Indian health care provider as their primary care provider. Additionally, contracts with managed care entities must demonstrate that access to Indian health care providers is sufficient for Indian enrollees to receive services, and payment to Indian providers must be at a rate equal to non-Indian health care providers. Managed care entities must make prompt payment to Indian providers consistent with section 1932(f) of the Act.

Section 5006(d) also requires managed care entities to pay Indian federally qualified health centers (FQHCs) that are not participating providers at the same rate as a participating FQHC. Non-FQHC Indian Health care providers under managed care must be paid by the managed care entity or the State, at a rate that is at least equal to what the provider would be paid under the State plan. Lastly, Indian managed care entities may restrict enrollment to include only Indians in the same manner that Indian Health Programs (including the Indian Health Service) restrict enrollment to include only Indians.

Finally, subsection (e) codifies and strengthens existing responsibilities for consultation by CMS and the States with Indian tribes, Indian health programs, and Urban Indian organizations, specifically clarifying the application of these responsibilities under the CHIP program.

We look forward to working with you as you implement these provisions of ARRA.

Sincerely,

/s/

Cindy Mann
Director
Center for Medicaid and State Operations

Enclosures

cc:

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