Consolidated Appropriations Act, 2023: FMAP Reduction for Failure to Meet Reporting Requirements under Section 1902(tt)(1) of the Social Security Act

Frequently Asked Questions for State Medicaid and CHIP Agencies

June 30, 2023

Background: The Centers for Medicare & Medicaid Services (CMS) is releasing these answers to frequently asked questions (FAQs) about section 5131(b) of subtitle D of title V of division FF of the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023),[1] which added a new section 1902(tt) to the Social Security Act (the Act). Section 1902(tt)(1) requires that, for each month occurring during the period that begins on April 1, 2023, and ends on June 30, 2024, states submit to CMS (on a timely basis), and CMS makes public, certain monthly data about activities related to eligibility redeterminations conducted during that same period.[2] If a state doesn't satisfy the reporting requirements in section 1902(tt)(1) of the Act during any fiscal quarter that occurs during the period that begins on July 1, 2023, and ends on June 30, 2024, section 1902(tt)(2)(A) requires CMS to reduce the federal medical assistance percentage (FMAP) determined for the state for the quarter under section 1905(b) of the Act by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the state has failed to satisfy such requirements.[3] These FAQs provide additional information for states on how CMS will apply this FMAP reduction. CMS intends to follow this guidance with a rule implementing section 1902(tt) of the Act, but meanwhile, CMS does not expect to take enforcement action against a state that makes good-faith efforts to follow the guidance in this document.

Q1: How does CMS anticipate it will obtain the data necessary for public reporting?

A1: CMS currently believes that all the data states must report under these new reporting requirements are included in existing data sources, including the Transformed Medicaid Statistical Information System (T-MSIS), Unwinding Data Report, and Performance Indicators, and state-based Marketplace (SBM) priority metrics. As such, CMS doesn't anticipate that states will need to submit a separate report (or additional reporting) to CMS to comply with section 1902(tt)(1) of the Act. Rather, CMS anticipates that states will be able to submit the data metrics required under section 1902(tt)(1) through the appropriate existing CMS data reporting tools, as indicated in the "Anticipated Data Source" column in Table 1 below.

However, CMS recognizes that some states might encounter special circumstances—such as an unplanned system outage—that interfere with data submission using the sources listed in Table 1. CMS anticipates that it would consider a state facing such circumstances to be compliant with the section 1902(tt)(1) reporting requirements if the state is making a good-faith effort to submit the required data via another means. If a state believes that it has or will encounter special circumstances that interfere with submission of Medicaid data, the state should contact CMS via an email to CMSUnwindingSupport@cms.hhs.gov as soon as possible to discuss how the state will be able to submit data. If an SBM believes that it has or will

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[1] https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf.

[2] See CMS, RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023, SHO# 23-002.

[3] If a state has been determined by CMS to be out of compliance with the reporting requirements in section 1902(tt)(1), CMS may also require the state to submit and implement a corrective action plan (CAP) and may take other enforcement actions, in accordance with section 1902(tt)(2)(B).

encounter special circumstances when submitting data for purposes of meeting the requirements of section 1902(tt)(1), it should contact SBMEnrollment@cms.hhs.gov.

Q2: What data do states report under section 1902(tt)(1) of the Act, and when is the reporting deadline?

A2: The table below shows the reporting elements under section 1902(tt)(1), the source from which CMS anticipates being able to draw the data (with links to documentation outlining the reporting specifications for each data source), and the reporting deadlines. The information below is generally the same as information presented in Table 2 in SHO# 23-002, except for the column titled "Reporting Deadline for Anticipated Data Source."

Table 1: Reporting Elements Under Section 1902(tt)(1) for the Period from April 1, 2023, through June 30, 2024, Corresponding Anticipated Data Sources, and Reporting Deadlines

	Reporting Element	Anticipated Data Source	Reporting Deadline for Anticipated Data Source
Apply to All States			
1	Total number of Medicaid and Children's Health Insurance Program (CHIP) beneficiaries for whom a renewal was initiated	Unwinding Data Report, Monthly Metric 4	Due on the 8th of every month for the previous calendar month, as outlined in the Unwinding Data Report Specifications[4]
2	Total number of Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed	Unwinding Data Report, Monthly Metric 5a	
3	Of the Medicaid and CHIP beneficiaries whose Medicaid or CHIP coverage is renewed, those whose coverage is renewed on an *ex-parte* basis	Unwinding Data Report, Monthly Metric 5a(1)	
4	Total number of individuals whose coverage for Medicaid or CHIP was terminated	Unwinding Data Report, Monthly Metric 5b and Unwinding Data Report, Monthly Metric 5c	
5	Total number of individuals whose coverage for Medicaid or CHIP was terminated for procedural reasons	Unwinding Data Report, Monthly Metric 5c	
6	Total number of beneficiaries who were enrolled in a separate CHIP	T-MSIS, CHIP-CODE[5]	CMS anticipates that it will likely need state-reported T-MSIS data to produce these elements. States should maintain current T-MSIS data submissions. To be current, T-MSIS data should be reported monthly

[4] See the Unwinding Data Report Specifications.
[5] See the T-MSIS Data Dictionary.

	Reporting Element	Anticipated Data Source	Reporting Deadline for Anticipated Data Source
			before the last day of the subsequent month.[6]
7	For each state call center, total call center volume	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 1	State reporting on these performance indicators is due on the 8th of every month for the previous calendar month, as outlined in the Overview of the Medicaid and CHIP Eligibility and Enrollment Performance Indicators.[7]
8	For each state call center, average wait times	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 2	
9	For each state call center, average abandonment rate	Medicaid and CHIP Eligibility and Enrollment Performance, Indicator 3	
Apply to states using the federal Marketplace eligibility and enrollment platform (Non-Integrated Eligibility System)			
10	Total number of individuals whose accounts are received at the Marketplace from the state Medicaid/CHIP agency due to a Medicaid/CHIP redetermination	States that use the federal Marketplace eligibility and enrollment platform (federally-facilitated Marketplaces and state-based Marketplaces on the federal platform); CMS anticipates that it will report these data - and that states won't need to report new information	CMS anticipates that it will likely need state-reported T-MSIS data to produce these elements. States should maintain current T-MSIS data submissions. To be current, T-MSIS data should be reported monthly before the last day of the subsequent month.[8]
11	In the accounts received at the Marketplace due to a Medicaid/CHIP redetermination, the number of individuals who apply for and are determined eligible for Marketplace coverage through a Qualified Health Plan (QHP)		
12	In the accounts received at the Marketplace due to a Medicaid/CHIP redetermination and who apply for and are determined eligible for a QHP, the number of individuals who select a Marketplace plan		
Apply to State-based Marketplaces (SBMs) with their own platforms that use a Non-Integrated Eligibility System			
13	Number of individuals whose accounts are received by the SBM or Basic Health Program (BHP)	SBM Priority Metrics, Monthly Metrics 7a and 7b	SBM Priority Metrics should be reported on the 8th of every month for the previous calendar month, as outlined in State-Based Exchanges (SBE) Priority
14	Number of individuals whose accounts are received by the	SBM Priority Metrics, Monthly Metric 9a and 172a	

[6] See CMCS Informational Bulletin, "T-MSIS State Compliance" (March 18, 2019).
[7] See also the Overview of Performance Indicator Project.
[8] See CMCS Informational Bulletin, "T-MSIS State Compliance" (March 18, 2019).

	Reporting Element	Anticipated Data Source	Reporting Deadline for Anticipated Data Source
	SBM or BHP and are determined eligible for a QHP or BHP		Metrics, Overview and Template 1.0 User Guide[9]
15	Number of individuals whose accounts are received by the SBM or BHP and are determined eligible for a QHP or a BHP who make a QHP plan selection or are enrolled in a BHP	SBM Priority Metrics, Monthly Metric 1a and 169a	
Apply to SBMs with Integrated Eligibility System			
16	Number of individuals who are determined eligible for a QHP or a BHP	SBM Priority Metrics, Monthly Metric 9a and 172a	
17	Number of individuals who are determined eligible for a QHP or BHP and make a QHP plan selection or are enrolled in a BHP	SBM Priority Metrics, Monthly Metric 1a and 169a	

Q3: What data reporting issues might result in CMS taking the FMAP reduction?

A3: Although CMS anticipates that all data that states must report will be included in existing data sources, to meet the section 1902(tt)(1) requirements states must report data in a timely manner and the data need to be accessible and usable so that CMS can produce public reports as required under section 1902(tt)(1). CMS intends to provide information on the section 1902(tt)(1) requirements in its forthcoming rule, but meanwhile, if states meet the reporting deadlines listed in table 1, CMS would consider their reporting to be timely for purposes of section 1902(tt)(1) (see additional discussion below in response to Q4 of how CMS intends to interpret "timely" in section 1902(tt)(1)). Additionally, if states submit data according to the existing specifications for the sources listed in table 1, CMS would consider the data to be suitable for the purposes described in section 1902(tt)(1). If a state cannot meet these timelines and specifications, CMS does not expect to take an FMAP reduction or other enforcement action under 1902(tt)(2), as long as the state is making a good-faith effort to report timely, usable data to CMS (including working with CMS to resolve issues, as may be needed).

Q4: Section 1902(tt)(1) requires states to submit the required data "on a timely basis." How does CMS expect to interpret "timely" for purposes of this requirement?

A4: In January 2023, CMS issued SHO# 23-002, in which it indicated that it believed that states could achieve compliance with section 1902(tt)(1) reporting requirements by submitting data through multiple existing data sources.[10] The data collected through these sources are due on different dates, as indicated in

[9] See Overview and Template 1.0 User Guide.

[10] CMS, *RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023*, SHO# 23-002 (PDF), see "Table 2. Reporting Elements Under Section 1902(tt)(1) for the Period from April 1, 2023, through June 30, 2024, and Corresponding Data Sources."

Table 1, above. For example, the total number of Medicaid and CHIP beneficiaries for whom a renewal was initiated will be collected through the Unwinding Data Report, Monthly Metric 4, and the Unwinding Data Report is due on the 8th of the month for the previous calendar month and submitted using the same portal into which states enter their Performance Indicator data.

Although information on how CMS interprets "timely" will likely be included in CMS's upcoming rule on section 1902(tt), meanwhile, CMS would consider states' data reporting to be "timely" for purposes of the section 1902(tt)(1) requirement, and thus would not take an FMAP reduction or other enforcement action under 1902(tt)(2), if states submit data by the reporting deadline specified for each data source in Table 1. CMS further recognizes that some states might encounter special circumstances—such as an unplanned system outage—that interfere with timely data submission. CMS anticipates that it would consider a state facing such circumstances to be compliant with the section 1902(tt)(1) requirements if it is making a good-faith effort to meet the reporting deadline specified for each data source. If a state believes that it has or will encounter special circumstances that interfere with timely submission of Medicaid and CHIP data for purposes of meeting the requirements of section 1902(tt)(1), the state should contact CMS via CMSUnwindingSupport@cms.hhs.gov as soon as possible to discuss how the state will be able to submit data in a timely manner. If an SBM believes that it has encountered or will encounter special circumstances when submitting data for purposes of meeting the requirements of section 1902(tt)(1), it should contact SBMEnrollment@cms.hhs.gov.

As discussed above, CMS also recognizes that some states might encounter special circumstances that interfere with data submission using the sources listed in Table 1. CMS anticipates that it would consider a state facing such circumstances to be compliant with the section 1902(tt)(1) requirements if it is making a good-faith effort to submit the required data timely via another means. States in this situation should contact CMS via the email addresses listed in the previous paragraph.

Q5: How does CMS expect to interpret "timely" with respect to T-MSIS data that might be needed for purposes of section 1902(tt)(1) of the Act?

A5: CMS guidance explains that to remain current on their T-MSIS data submissions, states should submit T-MSIS data on a monthly basis before the last day of the subsequent month (for example, data for June 2023 should be reported by the end of July 2023).[11] While CMS generally does not consider states to be out of compliance with T-MSIS submission timelines until their data submissions are behind by two or more months, this longer time frame would likely create significant issues for section 1902(tt) reporting. If CMS does not receive T-MSIS data by the end of the subsequent month, CMS will likely not be able to timely and accurately calculate separate CHIP enrollment data or certain Marketplace-related data that CMS anticipates reporting under section 1902(tt)(1). Therefore, although information on how CMS interprets "timely" will likely be included in CMS's forthcoming rule on section 1902(tt), meanwhile, CMS would consider states' T-MSIS data reporting to be "timely" for purposes of the section 1902(tt)(1) requirement, and thus would not take an FMAP reduction, or other enforcement action under section 1902(tt)(2), if states submit T-MSIS data by the end of the subsequent month. Additionally, CMS does not expect to take enforcement action under section 1902(tt) against states that make a good-faith effort to meet this timeline, as further explained in the response to Q4. States that are facing difficulties with submitting T-MSIS data according to this guidance should contact CMS as indicated above.

[11] See CMCS Informational Bulletin, "T-MSIS State Compliance" (March 18, 2019).

Q6: How does CMS expect to assess the completeness of states' data submissions?

A6: Although information on how CMS interprets section 1902(tt)(1) will likely be included in CMS's upcoming rule, meanwhile, CMS would consider data submitted by states for each reporting element to be complete for purposes of 1902(tt)(1) if the data are sufficient to ensure CMS can obtain and publicly report on the information described in section 1902(tt)(1). States should be able to meet this standard if they follow the specifications for each reporting element for each data source listed in Table 1, and they should contact CMS if they have questions about their ability to report each data element according to the specifications. If a state has questions about meeting the specifications of Medicaid data elements, states should contact CMSUnwindingSupport@cms.hhs.gov. If an SBM has questions about meeting the specifications of SBM data elements, states should contact SBMEnrollment@cms.hhs.gov.

Q7: Does CMS interpret the requirement in section 1902(tt)(1) of the Act to submit a report "[f]or each month occurring during the period that begins on April 1, 2023, and ends on June 30, 2024" to apply to reporting on the activities that occurred during each such month, the submission of the report to CMS in each such month, or both?

A7: CMS interprets this statutory language to require state reporting on activities that occurred *during* each month in the period from April 1, 2023 through June 30, 2024, even if the report itself is not submitted to CMS until *after* the month in question. For example, states must report on activities occurring in June 2024, even though those reports will likely be submitted after June 30, 2024 if states follow the guidance above regarding deadlines for reporting specific data. Further information on this interpretation may be included in CMS's upcoming rule on section 1902(tt); meanwhile, CMS does not expect to take enforcement action under section 1902(tt) against states that follow this guidance.

Q8: For which quarters could the FMAP reduction apply?

A8: CMS will apply the FMAP reduction to each quarter during the period that begins on July 1, 2023, and ends on June 30, 2024, if the state doesn't satisfy reporting requirements for one or more months within that quarter. In other words, CMS will evaluate state-reported data reflecting activities during the months that fall between July 1, 2023, through June 30, 2024, for purposes of the FMAP reduction. CMS recognizes states will submit data reflecting activities during the last month of a quarter after the quarter ends. Any FMAP reduction would apply to the quarter that includes the month that the data reflect, not the quarter in which the data are due. The FMAP reduction won't apply to the quarter April 1, 2023, to June 30, 2023; CMS will not evaluate state-reported data reflecting activities during these months for purposes of the FMAP reduction.

Q9: Which months of data will CMS review for purposes of the FMAP reduction?

A9: CMS will review state-reported data reflecting activities during the months that fall between July 1, 2023 and June 30, 2024 for purposes of the possible FMAP reduction for failure to comply with reporting requirements. As noted in the response to Q7 above, data reflecting activities during those months might be submitted after June 30, 2024. For example, if a state failed to submit compliant data reflecting activities in June 2024, CMS expects that it would apply the FMAP reduction to quarter three of federal fiscal year 2024, even though states might submit the data reflecting activities in June 2024 in the next quarter.

Q10: To which FMAPs would the reduction be applied?

A10: Section 1902(tt)(2)(A) refers to a reduction in "the [FMAP] determined for the state for the quarter under section 1905(b)." As it has done with respect to similar statutory language,[12] CMS interprets this language to refer to the state-specific FMAP defined in the first sentence of section 1905(b) of the Act. Thus, in general, the FMAP reduction will be applied to medical assistance expenditures for which federal matching is paid ordinarily at that state-specific FMAP. Accordingly, the FMAP reduction wouldn't apply with respect to Medicaid expenditures that are not matched at the state-specific FMAP defined in the first sentence of section 1905(b) of the Act, such as Medicaid administrative expenditures matched at the 50% rate described in section 1903(a)(7) and expenditures for family planning services and supplies that are matched at 90% under section 1903(a)(5). Additionally, the definition of the state-specific FMAP in section 1905(b) is modified by language referencing other statutory provisions. For example, the first sentence of section 1905(b) says that the state-specific FMAP defined in that section is "subject to" certain other provisions of section 1905. However, some of those other provisions of section 1905 also include language indicating that the FMAP described in the provision replaces the FMAP in the first sentence of section 1905(b) entirely, in which case the FMAP reduction in section 1902(tt)(2)(A) does not apply.

Furthermore, the FMAP reduction would indirectly apply to CHIP expenditures and expenditures for individuals eligible for medical assistance on the basis of needing treatment for breast or cervical cancer that are matched at the "enhanced" FMAP (EFMAP) described in section 2105(b) of the Act. 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 or decreases for a state, the EFMAP also increases or decreases, though not in the exact same amount.

See the Appendix below for further details on the application of the FMAP reduction to other FMAPs.

Q11: If a state doesn't comply with section 1902(tt)(1) for one month during a quarter, would the FMAP reduction apply to the entire quarter?

A11: Section 1902(tt)(2)(A) specifies that the FMAP reduction applies to "each fiscal quarter." The statute doesn't give CMS the authority to limit the reduction to a single month. If a state doesn't meet the reporting requirements in one, two, or three of the three months within a quarter, the reduction will apply to the FMAP for the entire quarter.

Q12: How would the FMAP reduction be applied to states that fail to meet the reporting requirements for more than one quarter?

A12: Section 1902(tt)(2)(A) requires that "the [FMAP] determined for the state for the quarter under section 1905(b) shall be reduced by the number of percentage points (not to exceed 1 percentage point) equal to the product of 0.25 percentage points and the number of fiscal quarters during such period for which the state has failed to satisfy such requirements." CMS interprets this language as follows. When states are noncompliant in multiple quarters, the FMAP reduction will increase by 0.25 percentage points for each quarter of noncompliance. For example, if a state were out of compliance for three quarters, the reduction would be: a 0.25 percentage point FMAP reduction in the first quarter of noncompliance, a 0.50

[12] See, for example, SHO# 21-004, "Temporary increases to FMAP under sections 9811, 9814, 9815, and 9821 of the ARP and administrative claiming for vaccine incentives," issued Aug. 30, 2021.

percentage point FMAP reduction in the second quarter of noncompliance, and a 0.75 percentage point FMAP reduction in the third quarter of noncompliance (see following examples).

Table 2: Example of a state out of compliance in three consecutive quarters

	Compliant?	Assess FMAP reduction?	Percentage point reduction assessed on that quarter's FMAP
July 2023	No	Yes	0.25
August	No		
September	No		
October	No	Yes	0.50
November	No		
December	No		
January 2024	No	Yes	0.75
February	Yes		
March	Yes		
April	Yes	No	0
May	Yes		
June	Yes		

Table 3: Example of a state out of compliance in two non-consecutive quarters

	Compliant?	Assess FMAP reduction?	Percentage point reduction assessed on that quarter's FMAP
July 2023	No	Yes	0.25
August	No		
September	No		
October	Yes	No	0
November	Yes		
December	Yes		
January 2024	No	Yes	0.50
February	Yes		
March	Yes		
April	Yes	No	0
May	Yes		
June	Yes		

Q13: If CMS takes an FMAP reduction, and the state submits the required data only after CMS takes the FMAP reduction, would CMS restore the lost federal financial participation (FFP) associated with the FMAP reduction?

A13: If CMS takes an FMAP reduction because the state did not timely report data, or because the state did not report complete or usable data, and the state later submits compliant data, CMS does not anticipate that it would restore the FFP associated with the FMAP reduction (although the state would be able to appeal the reduction, as discussed below). That is because CMS would not consider a state's delayed submission of complete or usable data to be timely, if the data are not submitted until after CMS has already determined the state is not making good-faith efforts to timely submit it. CMS needs to use these data to publicly report on time-sensitive state activities, as it is required to do under section 1902(tt)(1) of the Act. As discussed in the responses above to Q1, Q3, Q4 and Q5, CMS will consider states' special

circumstances and does not expect to apply an FMAP reduction if a state is making a good-faith effort to comply with the section 1902(tt)(1) requirements. As further explained in the response to Q15, if necessary, CMS will follow the process for issuing a disallowance when taking an FMAP reduction under section 1902(tt)(2)(A) of the Act, and states will be able to appeal, as set forth in 42 C.F.R. 430.42.

Q14: Would the FMAP reduction be applied if a State-based Marketplace (SBM) that has its own platform and that is separate from the Medicaid or CHIP agency doesn't report required data timely?

A14: States are responsible for timely reporting of both Medicaid and SBM data, and the requirement to report these data is in section 1902(tt) of the Act, which is part of the Medicaid statute and imposes requirements on state Medicaid agencies. In states in which an SBM fails to timely report the required data, CMS would apply the FMAP reduction.

Q15: How does CMS plan to implement the FMAP reduction?

A15: Using the Medicaid and CHIP Budget and Expenditure System (MBES/CBES), CMS will track states' reported expenditures for any noncompliant quarters and will apply any FMAP reductions to applicable Medicaid medical assistance expenditures. For states identified as noncompliant, CMS will calculate the amount of the FMAP reduction and request that states make a voluntary adjustment to the Form CMS-64 to return the funds to CMS. If the state does not voluntarily return the funds, CMS will initiate disallowance proceedings; CMS will treat the extra federal financial participation claimed due to the state's failure to voluntarily return the funds as an unallowable "portion of claim" per 42 C.F.R. 430.42.

Appendix – Application of the FMAP Reduction under Section 1902(tt)(2)(A) of the Act

CMS interprets section 1902(tt)(2)(A) to require CMS to apply the FMAP reduction to expenditures that are matched at the state-specific FMAP defined in the first sentence of section 1905(b) of the Act. Several state expenditures are not matched at this FMAP, and thus, the section 1902(tt)(2)(A) reduction does not apply to those expenditures. This includes any expenditure for which the FMAP is defined under other provisions of the Act. For example, while the first sentence of section 1905(b) is "subject to" the FMAP in section 1933(d) relating to the Qualifying Individuals program, the FMAP in section 1933(d) is not a state-specific FMAP defined under section 1905(b), so it is not reduced under section 1902(tt)(2)(A). Additionally, as discussed above, other expenditures are matched at FMAPs defined in provisions that the first sentence of section 1905(b) is "subject to," but the language defining those FMAPs indicates that they are meant to supersede or replace the state-specific FMAP entirely. Accordingly, the federal matching rates for the following categories of expenditures would not be reduced under section 1902(tt)(2)(A) of the Act:

- Expenditures matched at the various FFP rates provided in sections 1903(a)(2) through (a)(7) of the Act (such as administrative expenditures and expenditures for family planning services and supplies).
- Expenditures matched at the "disaster-recovery" FMAP specified in section 1905(aa) of the Act.
- 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).
- Expenditures for medical assistance services "received through" an Indian Health Service (IHS) facility (including facilities operated by an Indian tribe or tribal organization under the Indian Self-Determination and Education Assistance Act), which are matched at 100 percent FMAP under the third sentence of section 1905(b) of the Act (i.e., not the first sentence of that section).
- Expenditures matched at 100 percent for individuals in Qualifying Individuals programs under section 1933(d) (see discussion above).
- Expenditures for health home services under section 1945 of the Act when matched at the 90 percent FMAP as specified in section 1945(c)(1). After the initial increased FMAP period for these services that is described in section 1945(c)(1) ends, the FMAP for expenditures on section 1945 health home services might be reduced under section 1902(tt)(2)(A) of the Act.
- Expenditures for medical assistance for COVID–19 vaccines and the administration of these vaccines, which are matched at 100 percent FMAP "[n]otwithstanding any other provision of this title" under section 1905(hh) of the Act, as added by section 9811 of the ARP.
- Expenditures for qualifying community-based mobile crisis intervention services under section 1947 of the Act as added by section 9813 of the ARP, for the applicable 12-quarter period that they are matched at 85 percent FMAP.[13]

CMS is available for technical assistance if states have questions about whether the FMAP reduction would apply to a particular expenditure category.

[13] See section 1947(c) of the Act.