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Medicaid's Federal Medical Assistance Percentage (FMAP)

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Summary

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports. Medicaid is jointly funded by the federal government and the states. The federal government's share of most Medicaid expenditures is called the federal medical assistance percentage (FMAP). The remainder is referred to as the state share.

Generally determined annually, the FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%. For FY2021, regular FMAP rates range from 50.00% (13 states) to 77.76% (Mississippi).

The FMAP rate is used to reimburse states for the federal share of most Medicaid expenditures. However, exceptions to the regular FMAP rate have been made for certain states (e.g., the District of Columbia and the territories), situations (e.g., during economic downturns), populations (e.g., individuals covered by the Patient Protection and Affordable Care Act's [P.L. 111-148, as amended] Medicaid expansion and individuals with breast or cervical cancer), providers (e.g., Indian Health Service facilities), and services (e.g., family planning and home health services). In addition, the federal share for most Medicaid administrative costs does not vary by state and is generally 50%.

During the Coronavirus Disease 2019 (COVID-19) public health emergency period, the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) provides a 6.2-percentage-point increase to the regular FMAP rates for all states, the District of Columbia, and the territories. The FFCRA FMAP increase began on January 1, 2020 (the first day of the calendar quarter in which the COVID-19 public health emergency period began), and the FFCRA FMAP increase is set to end on the last day of the calendar quarter in which COVID-19 public health emergency period ends.

To receive the FFCRA FMAP increase, states, the District of Columbia, and the territories are required to meet certain conditions. Such conditions include (1) maintaining Medicaid "eligibility standards, methodologies, and procedures" that are no more restrictive than what was in effect on January 1, 2020; (2) not imposing premiums exceeding the amounts in place as of January 1, 2020; (3) providing continuous coverage of Medicaid enrollees during the public health emergency period; (4) providing coverage for testing services and treatments for COVID–19; and (5) ensuring local governments are not required to contribute a larger percentage of the state's nonfederal Medicaid expenditures or Medicaid DSH payments than otherwise would have been required on March 11, 2020.

The FFCRA FMAP increase does not apply to most FMAP exceptions. However, the FFCRA FMAP increase does apply to a few FMAP exceptions, such as the FMAP exceptions for the Community First Choice option, individuals eligible on the basis of breast and cervical cancer, Certified Community Behavioral Health Clinics, and Money Follows the Person.

The Congressional Budget Office estimates the FFCRA FMAP increase will increase federal expenditures by about $50.0 billion from FY2020 to FY2022. However, the amount of the increase in federal expenditures depends on the length of the COVID-19 public health emergency period and states' actual expenditures.

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Introduction

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports.[1] Medicaid is jointly funded by the federal government and the states. Participation in Medicaid is voluntary for states, though all states, the District of Columbia, and the territories choose to participate. Each state designs and administers its own version of Medicaid under broad federal rules. While states that choose to participate in Medicaid must comply with all federal mandated requirements, state variability is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are reimbursed and delivered. The federal government pays a share of each state's Medicaid expenditures.[2]

This report describes the federal medical assistance percentage (FMAP) calculation used to reimburse states for most Medicaid expenditures, and it lists the statutory exceptions to the regular FMAP rate. In addition, this report provides a summary of the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) FMAP increase that states, the District of Columbia, and the territories are receiving during the Coronavirus Disease 2019 (COVID-19) public health emergency period.

The Federal Medical Assistance Percentage

The federal government's share of most Medicaid service costs is determined by the FMAP rate, which varies by state and is determined by a formula set in statute. The FMAP rate is used to reimburse states for the federal share of most Medicaid expenditures, but exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services.[3]

The FMAP rate also is used to determine the phased-down state contribution ("clawback") for Medicare Part D and the federal share of other federal programs. For instance, the FMAP rate is used to determine the federal share of spending for foster care maintenance, adoption assistance, and guardianship assistance payments authorized by Title IV-E of the Social Security Act.[4] The FMAP rate also is used to determine the federal share of the "mandatory matching funds" provided by the Child Care Entitlement to States.[5] In addition, it determines the federal share of funding under the Temporary Assistance for Needy Families Contingency Funds and the federal share of collections under the Child Support Enforcement program.[6]

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[1] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*.

[2] For a broader overview of financing issues, see CRS Report R42640, *Medicaid Financing and Expenditures*.

[3] More detail about the exceptions to the regular federal medical assistance percentage (FMAP) rate is provided under the heading "FMAP Exceptions."

[4] For more information, see CRS Insight IN11297, *Federal Medical Assistance Percentage (FMAP) Increase Available for Title IV-E Foster Care and Permanency Payments*, and CRS Report R42792, *Child Welfare: A Detailed Overview of Program Eligibility and Funding for Foster Care, Adoption Assistance and Kinship Guardianship Assistance under Title IV-E of the Social Security Act*.

[5] The Child Care Entitlement to States is authorized in §418 of the Social Security Act (SSA). For more information, see CRS In Focus IF10511, *Child Care Entitlement to States*.

[6] For more information about the Temporary Assistance for Needy Families (TANF) Contingency Funds, see CRS Report RL32748, *The Temporary Assistance for Needy Families (TANF) Block Grant: A Primer on TANF Financing and Federal Requirements*.

Separate from the regular FMAP rate, the enhanced FMAP (E-FMAP) rate is provided for both services and administration under the State Children's Health Insurance Program (CHIP), subject to the availability of funds from a state's federal allotment for CHIP. The E-FMAP rate is calculated by reducing the state share under the regular FMAP rate by 30%.[7]

How FMAP Rates Are Calculated

The FMAP formula compares each state's per capita income relative to U.S. per capita income. The formula provides higher reimbursement to states with lower incomes (with a statutory maximum of 83%) and lower reimbursement to states with higher incomes (with a statutory minimum of 50%). The formula[8] for a given state is

$$FMAP_{state} = 1 - ((\text{Per capita income}_{state})^2/(\text{Per capita income}_{U.S.})^2 * 0.45)$$

The use of the 0.45 factor in the formula is designed to ensure that a state with per capita income equal to the U.S. average receives an FMAP rate of 55% (i.e., state share of 45%). In addition, the formula's squaring of income provides higher FMAP rates to states with below-average incomes (and vice versa, subject to the 50% minimum).[9]

The Department of Health & Human Services (HHS) usually publishes FMAP rates for an upcoming fiscal year in the *Federal Register* during the preceding November. This time lag between announcement and implementation provides an opportunity for states to adjust to FMAP rate changes.

Data Used to Calculate State FMAP Rates

The per capita income amounts used to calculate FMAP rates for a given fiscal year are several years old by the time the FMAP rates take effect because, as specified in Section 1905(b) of the Social Security Act, the per capita income amounts used in the FMAP formula are equal to the average of the three most recent calendar years of data available from the Department of Commerce. In its FY2021 FMAP calculations, HHS used state per capita personal income data for 2016, 2017, and 2018 that became available from the Department of Commerce's Bureau of Economic Analysis (BEA) in September 2019. The use of a three-year average helps to moderate fluctuations in a state's FMAP rate over time.

BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate revised and newly available source data on population and income.[10] It also undertakes a comprehensive data revision—reflecting methodological and other changes—every few years that may result in upward and downward revisions to each of the component parts of personal income. These components include the following:

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[7] For more information about CHIP, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*.

[8] SSA §1905(b).

[9] For example, assume that U.S. per capita income is $40,000. In state A with an *above-average* per capita income of $42,000, the FMAP formula produces an FMAP rate of 50.39%; if the formula did not include a squaring of per capita income, it would instead produce a higher FMAP rate of 52.75%. In state B with a *below-average* per capita income of $38,000, the FMAP formula produces an FMAP rate of 59.39%; if the formula did not include a squaring of per capita income, it would instead produce a lower FMAP rate of 57.25%.

[10] Preliminary estimates of state per capita personal income for the latest available calendar year—as well as revised estimates for the two preceding calendar years—are released in April. Revised estimates for all three years are released in September.

- earnings (wages and salaries, employer contributions for employee pension and insurance funds, and proprietors' income);
- dividends, interest, and rent; and
- personal current transfer receipts (e.g., government social benefits such as Social Security, Medicare, Medicaid, state unemployment insurance).[11]

As a result of these annual and comprehensive revisions, it is often the case that the value of a state's per capita personal income for a given year will change over time. For example, the 2016 state per capita personal income data published by BEA in September 2017 (used in the calculation of FY2019 FMAP rates) differed from the 2016 state per capita personal income data published in September 2019 (used in the calculation of FY2021 FMAP rates).

In addition to these revisions, states' per capita incomes are adjusted to reflect the population data from the decennial census, which could affect states' FMAP rates. BEA uses the Census Bureau's population data to calculate states' per capita incomes. The FY2023 FMAP rates are to be calculated using the population data from the 2020 census.

The definition of personal income used by BEA is not the same as the definition used for personal income tax purposes. Among other differences, BEA's personal income excludes capital gains (or losses) and includes transfer receipts (e.g., government social benefits), while income for tax purposes includes capital gains (or losses) and excludes most of these transfers.

Factors That Affect FMAP Rates

Several factors affect states' FMAP rates. The first is the nature of the state economy and, to the extent possible, a state's ability to respond to economic changes (i.e., downturns or upturns). The impact on a particular state of a national economic downturn or upturn will be related to the structure of the state economy and its business sectors. For example, a national decline in automobile sales, while having an impact on all state economies, will have a larger impact in states that manufacture automobiles as production is reduced and workers are laid off.

Second, the FMAP formula relies on per capita personal income *in relation to the U.S. average per capita personal income*. The national economy is basically the sum of all state economies. As a result, the national response to an economic change is the sum of the state responses to economic change. If more states (or larger states) experience an economic decline, the national economy reflects this decline to some extent. However, the national decline will be lower than some states' declines because the total decline has been offset by states with small decreases or even increases (i.e., states with growing economies). The U.S. per capita personal income, because of this balancing of positive and negative, has only a small percentage change each year. Since the FMAP formula compares state changes in per capita personal income (which can have large changes each year) to the U.S. per capita personal income, this comparison can result in significant state FMAP rate changes.

In addition to annual revisions of per capita personal income data, comprehensive revisions undertaken every four to five years may also influence regular FMAP rates (e.g., because of changes in the definition of personal income). The impact on FMAP rates will depend on whether the changes are broad (affecting all states) or more selective (affecting only certain states or industries).

[11] Employer and employee contributions for government social insurance (e.g., Social Security, Medicare, unemployment insurance) are excluded from personal income, and earnings are counted based on residency (i.e., for individuals who live in one state and work in another, their income is counted in the state where they reside).

FY2021 Regular FMAP Rates

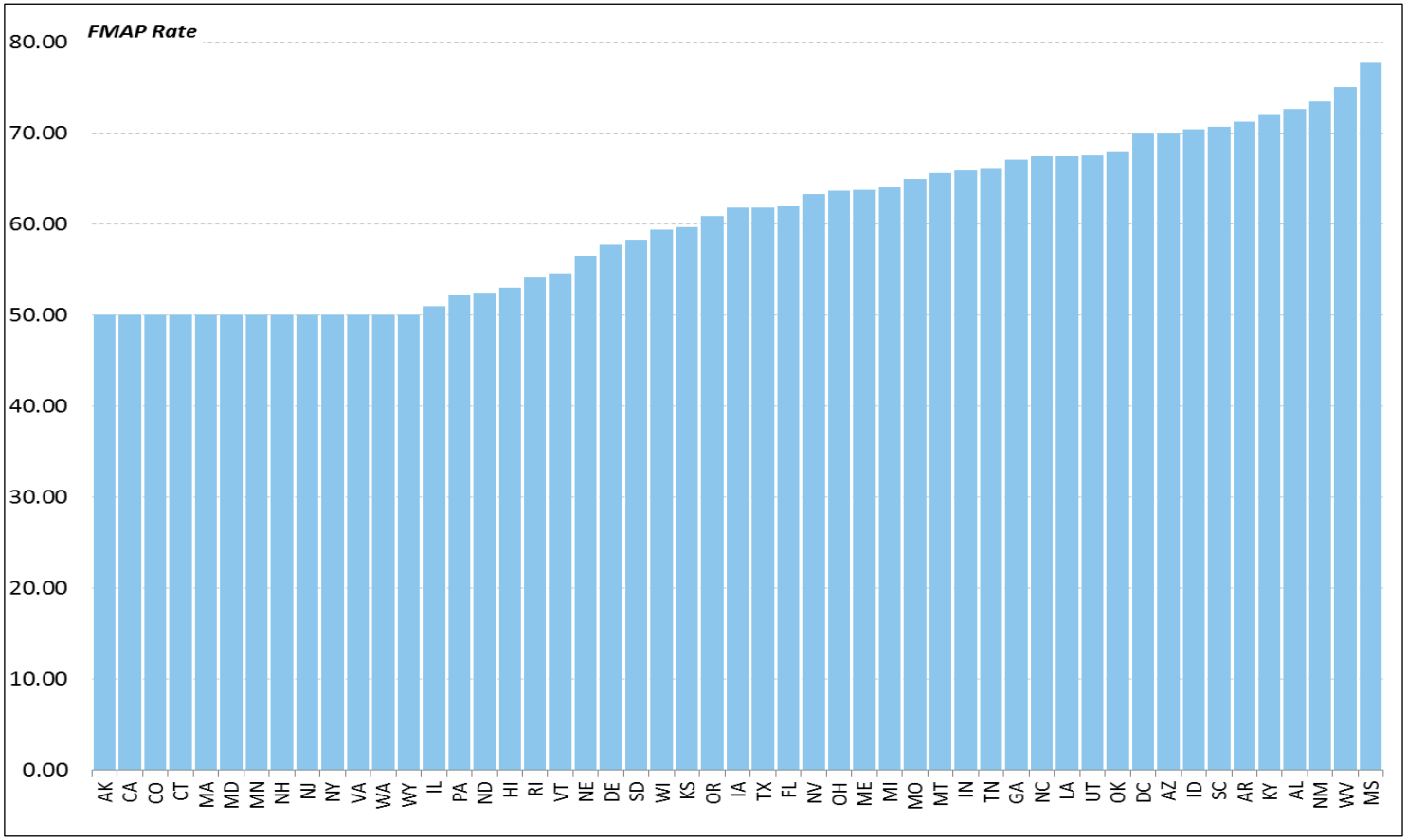
Regular FMAP rates for FY2021 (the federal fiscal year that begins on October 1, 2020) were published December 3, 2019, in the *Federal Register*.[12] In the **Appendix A** to this report, **Table A-1** shows regular FMAP rates for each of the 50 states and the District of Columbia for FY2016 through FY2021.

Figure 1 shows the state distribution of regular FMAP rates for FY2021. Thirteen states are to have the statutory minimum FMAP rate of 50.00%, and Mississippi is to have the highest FMAP rate of 77.76%.

[12] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2020 Through September 30, 2021," 84 *Federal Register* 66204, December 3, 2019.

Figure 1. State Distribution of Regular FMAP Rates

(FY2021)

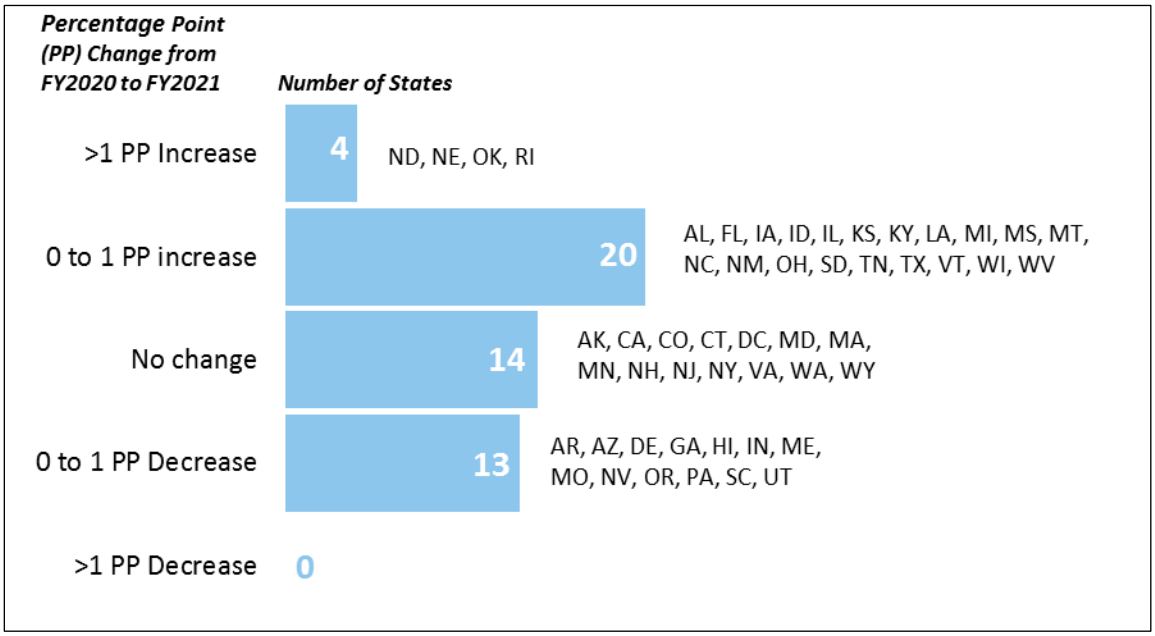


Sources: Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2020 Through September 30, 2021," 84 *Federal Register* 66204, December 3, 2019.

Note: State-by-state FY2021 regular FMAP rates are listed in **Table A-1**.

As shown in **Figure 2**, from FY2020 to FY2021, the regular FMAP rates for 37 states are to change, whereas the regular FMAP rates for the remaining 14 states (including the District of Columbia) are to remain the same.[13]

Figure 2. FMAP Rate Changes for States from FY2020 to FY2021



Source: Prepared by the Congressional Research Service (CRS) using FY2020 and FY2021 regular FMAP rates.
Note: Specific FMAP rate changes for each state are listed in **Table A-1**.

For most of the states experiencing an FMAP rate change from FY2020 to FY2021, the change is to be less than one percentage point. The regular FMAP rate for 20 states is to increase by as much as one percentage point, and the FMAP rate for 13 states is to decrease by as much as one percentage point.

For states with an FMAP rate change from FY2020 to FY2021, four states are to have an FMAP rate increase of greater than one percentage point. North Dakota is to have the largest FMAP rate increase of 2.35 percentage points, with the FMAP rate increasing from 50.05% to 52.40%. No states are to experience an FMAP rate decrease of greater than one percentage point.

The District of Columbia's FY2021 FMAP rate was not calculated according to the regular FMAP formula because the FMAP rate for the District of Columbia has been set in statute at 70% since 1998 for the purposes of Title XIX and XXI of the Social Security Act. However, for other purposes, the FMAP rate for the District of Columbia is 50%, unless otherwise specified by law.

FMAP Exceptions

Although FMAP rates are generally determined by the formula described above, exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. Some of these exceptions were included in the Social Security Amendments of 1965 (P.L. 89-97), which is the law that enacted the Medicaid program. Other exceptions have been

[13] Thirteen of the states with no change to their regular FMAP rates from FY2020 to FY2021 receive the statutory minimum FMAP rate of 50%, and the regular FMAP rate for the District of Columbia is statutorily set at 70%.

added over the years. **Table 1** lists examples of current exceptions to the FMAP in Medicaid statute and regulations; past FMAP exceptions are listed in **Table B-1**. Many of the exceptions to the FMAP rate are used as a means to incentivize states to cover certain services or populations or conduct administrative activities. However, general administrative expenditures receive the lowest federal matching rate for Medicaid of 50%.

Table 1. Current Exceptions to the Regular FMAP Rates for Medicaid

Exception	Description	Citations
Territories and Certain States		
Temporary Increase for Territories	For part of FY2020 (i.e., December 21, 2019, through September 30, 2020) and FY2021, the FMAP rates for the territories are increased from 55% to 83% for American Samoa, CNMI, Guam, and the U.S. Virgin Islands and from 55% to 76% for Puerto Rico. (For more information about the FMAP rate for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*).	P.L. 116-94; SSA §1905(ff)
Territories Since July 1, 2011	As of July 1, 2011, FMAP rates for the territories (Puerto Rico, American Samoa, CNMI, Guam, and the U.S. Virgin Islands) were increased from 50% to 55%. Unlike the 50 states and the District of Columbia, the territories are subject to federal spending caps. The 55% also applies for purposes of computing the E-FMAP rate for CHIP. However, for part of FY2019, FY2020, and FY2021, the regular FMAP rates for the territories have been increased temporarily, as discussed above in "Temporary Increase for Territories" and in **Table B-1**. (For more information about the FMAP rate for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*).	Most recently P.L. 111-148, as amended by P.L. 111-152; SSA §1905(b), 1108(f) and (g)
District of Columbia	As of FY1998, the District of Columbia's FMAP rate is set at 70% (without this exception, it would be at the statutory minimum of 50%). The 70% also applies for purposes of computing the E-FMAP rate for CHIP.	P.L. 105-33; SSA §1905(b)
Special Situations		
State Fiscal Relief	A 6.2-percentage-point increase to the FMAP rates for all states, the District of Columbia, and the territories for each calendar quarter occurring during the COVID-19 public health emergency period, beginning the first day of calendar quarter in which the emergency period began (i.e., January 1, 2020) and ending on the last day of the calendar quarter in which the public health emergency period ends.[a] States are required to meet certain requirements to receive the increase. (For more information about the FMAP increase, see "FMAP Increase During the COVID-19 Public Health Emergency" or CRS Report R46346, *Medicaid Recession-Related FMAP Increases*).	P.L. 116-127, as amended by P.L. 116-136 §3720

Exception	Description	Citations
Adjustment for Disaster Recovery	Beginning in CY2011, a disaster-recovery FMAP adjustment is available for states in which (1) during one of the preceding seven years, the President declared a major disaster under the Stafford Act and every county in the state warranted at least public assistance under that act and (2) the regular FMAP rate declines by a specified amount. To trigger the adjustment, a state's regular FMAP rate must be at least three percentage points less than such state's last year's regular FMAP rate plus (if applicable) any hold harmless increase under P.L. 111-5; the adjustment is an FMAP rate increase equal to 50% of the difference between the two. To continue receiving the adjustment, the state's regular FMAP rate must be at least three percentage points less than last year's adjusted FMAP rate; the adjustment is an FMAP rate increase equal to 25% of the difference between the two. Louisiana is the only state that was eligible for the disaster-recovery adjusted FMAP from the fourth quarter of FY2011 (when the adjustment was first available) through FY2014. No state has met the requirements since FY2014.	P.L. 111-148, as amended by P.L. 111-152, P.L. 112-96 P.L, and P.L. 112-141; SSA §1905(aa); 75 *Federal Register* 80501 (December 22, 2010)
Adjustment for Certain Employer Contributions	As of FY2006, significantly disproportionate employer pension and insurance fund contributions will be excluded from the calculation of Medicaid FMAP rates. This will have the effect of reducing certain states' per capita personal income relative to the national average, which in turn could increase their Medicaid FMAP rates. Any identifiable employer contributions towards pensions or other employee insurance funds are considered to be significantly disproportionate if the increase in the amount of employer contributions accrued to residents of a state exceeds 25% of the total increase in personal income in that state for the year involved. To date, no state has qualified for this adjustment.	P.L. 111-3; 75 *Federal Register* 63482 (October 15, 2010)
Certain Populations		
COVID-19 Testing for the Uninsured	During the COVID-19 public health emergency period,[a] states have the option to extend COVID-19 testing, testing-related state plan services, testing-related visits, and the administration of the testing without cost sharing to uninsured individuals under the Medicaid program. For medical assistance and administrative costs associated with uninsured individuals who are eligible for Medicaid under this state option, states receive 100% federal reimbursement (i.e., fully federally funded).	P.L. 116-127, as amended by P.L. 116-136; SSA §1902(a)(10)(XXIII) and (ss).
Children with Medically Complex Conditions	Beginning October 1, 2022, states have the option to provide coordinated care through a health home for children with medically complex conditions. During the first two fiscal year quarters that the option is in effect, the FMAP rate is increased by 15 percentage points for expenditures on the applicable health home services, but in no case may the FMAP rate exceed 90%.	P.L. 116-16; SSA §1945A

Exception	Description	Citations
"Newly Eligible" Individuals Enrolled in New Eligibility Group Through 133% FPL	Since January 1, 2014, states have had the option to expand Medicaid coverage to non-elderly, nonpregnant adults at or below 133% FPL (i.e., the ACA Medicaid expansion). An increased federal matching rate is provided for services rendered to "newly eligible" individuals in this group. The "newly eligible" are defined as those who would not have been eligible for Medicaid in the state as of December 1, 2009 or were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. The federal matching rates for "newly eligible" individuals equal: CY2014-CY2016 = 100%; CY2017 = 95%; CY2018 = 94%; CY2019 = 93%; CY2020+ = 90%.	P.L. 111-148, as amended by P.L. 111-152; SSA §1905(y)
"Expansion State" Individuals Enrolled in New Eligibility Group Through 133% FPL	Prior to the ACA Medicaid expansion, some states provided health coverage for all low-income individuals using Medicaid waivers. As a result, these states have few or no individuals who qualify for the "newly eligible" federal matching rate. To address this issue, as of CY2014, an increased federal matching rate is available for individuals in "expansion states" who were eligible for Medicaid as of March 23, 2010 (P.L. 111-148's enactment date) in the new eligibility group for non-elderly, nonpregnant adults at or below 133% FPL. "Expansion states" are defined as those that, as of March 23, 2010, offered health benefits coverage meeting certain criteria statewide to parents and nonpregnant childless adults at least through 100% FPL. The formula used to calculate "expansion state" federal matching rates is [regular FMAP + (newly eligible federal matching rate – regular FMAP) * transition percentage equal to 50% in CY2014, 60% in CY2015, 70% in CY2016, 80% in CY2017, 90% in CY2018, and 100% in CY2019+]. Since the formula for the "expansion state" federal matching rate is based on the regular FMAP rate, the "expansion state" federal matching rates vary based on a states' regular FMAP rates until CY2019, at which point they are to equal the "newly eligible" federal matching rates: CY2014 = at least 75%; CY2015 = at least 80%; CY2016 = at least 85%; CY2017 = at least 86%; CY2018 = at least 90%; CY2019 = 93%; CY2020+ = 90%.	P.L. 111-148, as amended by P.L. 111-152; SSA §1905(z)(2)
Certain Women with Breast or Cervical Cancer	For states that opt to cover certain women with breast or cervical cancer who do not qualify for Medicaid under a mandatory eligibility pathway and are otherwise uninsured, expenditures for these women are reimbursed using the E-FMAP rate that applies to CHIP.	P.L. 106-354, as amended by P.L. 107-121; SSA §1905(b)
Qualifying Individuals Program	States are required to pay Medicare Part B premiums for Medicare beneficiaries with income between 120% and 135% FPL and limited assets (referred to as "qualifying individuals"), up to a specified dollar allotment. They receive 100% federal reimbursement for these costs, which are financed at the federal level by a transfer of funds from Medicare to Medicaid.	P.L. 105-33, permanently extended via P.L. 114-10 ; SSA §1933(d)
Certain Providers		
Indian Health Service Facility	States receive 100% federal reimbursement for Medicaid services provided through an Indian Health Service facility.	P.L. 94-437; SSA §1905(b)

Exception	Description	Citations
Certain Services		
Certified Community Behavioral Health Clinic Services	States receive the E-FMAP rate for services provided to Medicaid enrollees who are not newly eligible under the ACA Medicaid expansion provided in a Certified Community Behavioral Health Clinic.	P.L. 113-93; 42 U.S.C. §1396a note.
Certain Preventive Services and Immunizations	As of CY2013, states that opt to cover—with no cost sharing—clinical preventive services recommended with a grade of A or B by the United States Preventive Services Task Force and adult immunizations recommended by the Advisory Committee on Immunization Practices receive a one percentage point increase in their FMAP rate for those services.	P.L. 111-148, as amended by P.L. 111-152; SSA §1905(b)
Smoking Cessation for Pregnant Women	As of CY2013, states that opt to cover USPSTF preventive services and ACIP adult immunizations as noted above also receive a one percentage point increase in their FMAP rate for smoking cessation services that are mandatory for pregnant women.	P.L. 111-148, as amended by P.L. 111-152; SSA §1905(b)
Money Follows the Person Rebalancing Demonstration	States participating in the Money Follows the Person Demonstration receive an enhanced federal matching rate for home- and community-based services provided to support Medicaid enrollees during their first year in the community, after residing in an institution for 90 consecutive days or more. Specifically, states receive a federal matching rate ranging from 75% to 90%, which is determined by increasing the regular FMAP rate by half the state share (i.e., subtract regular FMAP rate from 100% and divide by two). This federal match is limited to 90%.	P.L. 109-171; 42 U.S.C. §1396a note.
Family Planning	States receive 90% federal reimbursement for family planning services and supplies.	P.L. 92-603; SSA §1903(a)(5)
Health Homes	As of CY2011, states have an option for providing "health home" and associated services to certain individuals with chronic conditions. They receive 90% federal reimbursement for these services for the first eight quarters that the health home option is in effect in the state.	P.L. 111-148, as amended by P.L. 111-152; SSA §1945(c)(1)
Community First Choice Option	As of FY2011, states have an option for providing home and community-based attendant services and supports for certain individuals at or below 150% FPL, or a higher income level applicable to those who require an institutional level of care. They receive a six percentage point increase in their regular FMAP rate for these services.	P.L. 111-148, as amended by P.L. 111-152; SSA §1915(k)(2)
Administrative Activities		
Electronic Visit Verification System	States receive 90% federal matching rate for the design, development, or installation of electronic visit verification systems for personal care and home health care services. States receive 75% federal matching rate for the operation and maintenance of these systems.	P.L. 114-255; SSA §1903(l)(6)(A)

Exception	Description	Citations
Prescription Drug Monitoring Programs	For FY2019 and FY2020, states receive 100% federal matching rate (i.e., fully federally funded) for the design, development, or implementation of prescription drug monitoring programs. To receive this increased federal matching rate, states must have prescription drug monitoring programs information-sharing agreements with contiguous states.	P.L. 115-271; SSA §1944(f)
Health Information Technology	States receive 100% federal matching rate (i.e., fully federally funded) for incentive payments to eligible Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology through 2021, and states receive 90% federal matching rate for administrative expenses related to the program.	P.L. 111-5; SSA §1903(a)(3)(F)
Training of Medical Personnel	States receive 75% federal matching rate for costs attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel.	P.L. 89-97; SSA §1903(a)(2)(A)&(B)
Citizenship Verification System	States receive 90% federal matching rate for the design, development, or installation of citizenship verification systems. States receive 75% federal matching rate for the operation of these systems.	P.L. 111-3; SSA §1903(a)(3)(H)
Immigration Verification System	States receive 100% federal reimbursement for the cost of implementation and operation of an immigration status verification system.	P.L. 99-603; SSA §1903(a)(4)
Fraud Control Unit	States receive 75% federal matching rate for state expenditures related to the operation of a state Medicaid fraud control unit.	P.L. 95-142; SSA §1903(a)(6)
Preadmission Screening	State expenditures attributable to preadmission screening and resident review for individuals with mental illness or mental retardation who are admitted to a nursing facility receive 75% federal matching rate.	P.L. 100-203; SSA §1903(a)(2)(C)
Survey and Certification	States receive 75% federal matching rate for state expenditures related to survey and certification of nursing facilities.	P.L. 100-203; SSA §1903(a)(2)(D)
Managed Care Review Activities	States receive 75% federal matching rate for state expenditures related to performance of medical and utilization review activities or external independent review of managed care activities.	P.L. 97-35; SSA §1903(a)(3)(C)

Exception	Description	Citations
Claims and Eligibility Systems	States receive 90% federal matching rate for the design, development, or installation of mechanized claims systems and 75% federal matching rate for operating mechanized claims systems. Both federal reimbursement percentages are subject to certain criteria set by the Secretary of HHS, which includes whether the activity is likely to provide more efficient, economical, and effective administration of claims processing. CMS published a final rule to permanently amend the definition of Mechanized Claims Processing and Information Retrieval systems to include systems used for eligibility determination, enrollment, and eligibility reporting activities thereby making the 90% federal matching rate available for the design, development and installation or enhancement of eligibility determination systems, and 75% federal matching rate for maintenance and operations available for such systems.	P.L. 92-603; SSA §1903(a)(3)(A) and (B); 80 *Federal Register* 75819 (December 4, 2015)
Translation or Interpretation Services	Administrative expenditures for translation or interpretation services in connection with the "enrollment of, retention of, and use of services" under Medicaid receive 75% federal matching rate. For CHIP, the increased match is 75%, or the state's E-FMAP rate plus 5 percentage points, whichever is higher, and the CHIP increased match is subject to the 10% cap on administrative expenditures. The increased federal matching rate for translation or interpretation services is only available for eligible expenditures claimed as administrative and not expenditures claimed as medical assistance-related (which receive each state's regular FMAP rate).	P.L. 111-3; SSA §1903(a)(2)(E); State Medicaid Director Letter, State Health Official 10-007, CHIPRA 18, July 1, 2010.
General Administration	Remaining state expenditures found necessary for proper and efficient administration of the state plan receive a 50% federal matching rate.	P.L. 89-97; SSA §1903(a)(7)

Source: CRS, based on sources noted in the table.

Notes: Unless noted, exceptions do not apply for purposes of computing the E-FMAP rate for CHIP. ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); CHIP = Children's Health Insurance Program; CHIPRA = Children's Health Insurance Program Reauthorization Act (); CNMI = Commonwealth of the Northern Mariana Islands; COVID-19 = Coronavirus Disease 2019; E-FMAP = enhanced federal medical assistance percentage; EHR = electronic health record; FMAP = federal medical assistance percentage; FPL = federal poverty level; SPA = state plan amendment; SSA = Social Security Act.

a. The public health emergency period is defined in paragraph (1)(B) of §1135(g) of the SSA as a public health emergency declared by the Secretary of the Department of Health and Human Services (HHS) pursuant to §319 of the Public Health Service Act. This refers to the public health emergency declared by the HHS Secretary on January 31, 2020, with respect to the COVID-19 outbreak. An emergency determination under §319 of the Public Health Service Act terminates after 90 days, unless terminated earlier by the HHS Secretary, and is renewable for additional 90-day periods.

Reduction to Regular FMAP Rates

While many FMAP exceptions are used to incentivize states, the FMAP rate also can be used as a means to penalize states through a reduction to the FMAP rate. There are FMAP reductions for the territories, electronic visit verification systems, and asset verification programs.

Territories

The FMAP rates for the territories could be reduced if the territories do not comply with certain program integrity requirements. Puerto Rico's FMAP reduction is different than the FMAP reduction for American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands.

American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the U.S. Virgin Islands are required to designate a program integrity lead by October 1, 2020. Starting in FY2021, the FMAP rate for these four territories could be reduced if a program integrity lead has not been designated. Specifically, for each fiscal quarter in FY2021, the FMAP rate for a territory without a program integrity lead could be reduced by 0.25 percentage points multiplied by the total number of consecutive fiscal quarters the territory has not designated a program integrity lead, not to exceed 5 percentage points.[14]

Puerto Rico also is required to designate a program integrity lead, but by June 20, 2020, instead of by October 1, 2020. Puerto Rico has the following additional program integrity requirements: (1) publish a plan to develop measures to satisfy the payment error rate measurement requirements by June 20, 2021; (2) publish a contracting reform plan to combat fraudulent, wasteful, or abusive Medicaid contracts by December 20, 2020; and (3) publish a plan to comply with the Medicaid eligibility quality control requirements by June 20, 2021.

Starting January 1, 2020, through September 30, 2021, for each of the four program integrity requirements (including requirements imposed under the terms of each plan) that Puerto Rico is out of compliance, Puerto Rico's FMAP rate is reduced by 0.25 percentage points multiplied by the total number of consecutive fiscal quarters Puerto Rico has not been in compliance with the requirement, not to exceed 2.5 percentage points.[15] For Puerto Rico, there is an exception to the FMAP reduction for extenuating circumstances that prevent Puerto Rico from satisfying the requirements or if Puerto Rico has made reasonable progress toward satisfying the requirements.

Electronic Visit Verification Systems

For personal care services or home health care services requiring an in-home visit by a provider, states' FMAP rates are reduced for those services if the states do not have an electronic visit verification system. For personal care services, the FMAP reductions could start in CY2020; for home health care services, the FMAP reductions could start in CY2023. The FMAP reductions could be 0.25 percentage points in the first year the reductions are in effect, 0.5 percentage points for the second year, 0.75 percentage points for the third year, and 1 percentage point for subsequent years.[16]

Asset Verification Programs

Section 1940 of the Social Security Act requires that states verify assets of individuals applying for the aged, blind, or disabled Medicaid eligibility pathways using the states' asset verification programs. For states without an asset verification program, starting January 1, 2021, the regular FMAP rate for the state could be reduced by

[14] P.L. 116-94 §201; SSA §1108(g)(8)(B).

[15] P.L. 116-94 §201; SSA §1108(g)(7)(B).

[16] P.L. 114-255 §12006; SSA §1903(l)(6)(A).

- 0.12 percentage points for calendar quarters in 2021 and 2022;
- 0.25 percentage points for calendar quarters in 2023;
- 0.35 percentage points for calendar quarters in 2024; and
- 0.50 percentage points for calendar quarters in 2025 and each year thereafter.[17]

FMAP Increase During the COVID-19 Public Health Emergency

Since March 2020, various states' stay-at-home orders due to COVID-19 have affected the economy and led to massive layoffs, furloughs, and surges in unemployment claims. The job losses have affected the Medicaid program because Medicaid is a countercyclical program, which means the rate of growth for Medicaid enrollment tends to accelerate when the economy weakens and tends to slow when the economy gains strength.

During recessions, growth in the unemployment rate results in an increase in the rate of growth for Medicaid enrollment, which increases the rate of growth for Medicaid expenditures at the same time that state revenues decline. Reduced state revenues can make it difficult for states to continue financing their Medicaid programs, especially with the recession-related growth in Medicaid enrollment.

Federal fiscal relief to states is provided during recessions through adjustments to the FMAP rate, because this process for getting federal Medicaid funding to states is already in place. In the past, two temporary FMAP increases provided states with fiscal relief due to recessions through the Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27) and the American Recovery and Reinvestment Act of 2009 (P.L. 111-5). To be eligible for these temporary FMAP increases, states had to meet certain conditions.[18]

In response to the economic impact of the COVID-19 public health emergency, the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) provides a 6.2-percentage-point increase to the FMAP rates for all states, the District of Columbia, and the territories, beginning on the first day of the calendar quarter in which the COVID-19 public health emergency period began (i.e., January 1, 2020) and ending on the last day of the calendar quarter in which the COVID-19 public health emergency period ends.[19]

To receive this increased FMAP rate, states, the District of Columbia, and the territories are required to (1) ensure their Medicaid "eligibility standards, methodologies, and procedures" are no more restrictive than those that were in effect on January 1, 2020;[20] (2) not impose premiums

[17] P.L. 116-3 §4; SSA §1940(k)

[18] For more information about these FMAP increases, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*.

[19] The public health emergency period is defined in paragraph (1)(B) of §1135(g) of the SSA as a public health emergency declared by the Secretary of the Department of Health and Human Services (HHS) pursuant to §319 of the Public Health Service Act. This refers to the public health emergency declared by the HHS Secretary on January 31, 2020, with respect to the Coronavirus Disease 2019 (COVID-19) outbreak. An emergency determination under §319 of the Public Health Service Act terminates after 90 days, unless terminated earlier by the HHS Secretary, and is renewable for additional 90-day periods.

[20] A similar provision was in place prior to the Family First Coronavirus Response Act (FFCRA; P.L. 116-127) for Medicaid and CHIP children. Under SSA §1902(gg)(2) and SSA §2105(d)(3), states are required to maintain the Medicaid and CHIP eligibility standards, methodologies, and procedures for children in place on the date of enactment

exceeding the amounts in place as of January 1, 2020;[21] (3) provide continuous coverage of Medicaid enrollees during the COVID-19 public health emergency period;[22] and (4) provide coverage (without the imposition of cost sharing) for testing services and treatments for COVID–19 (including vaccines, specialized equipment, and therapies).

Another condition to receive the FFCRA FMAP increase is that states, the District of Columbia, and the territories cannot require local governments to fund a larger percentage of the state's nonfederal Medicaid expenditures for the Medicaid state plan or Medicaid DSH payments than what was required on March 11, 2020.[23]

The FFCRA FMAP increase does not apply to most FMAP exceptions, including the FMAP exceptions for the ACA Medicaid expansion, family planning, and home health services. However, the FFCRA FMAP increase does apply to a few FMAP exceptions, such as the FMAP exceptions for the Community First Choice option, individuals eligible on the basis of breast and cervical cancer, Certified Community Behavioral Health Clinics, and Money Follows the Person.[24]

Conclusion

The FMAP rate is used to reimburse states for the federal share of most Medicaid expenditures. In FY2021, 13 states are to have the statutory minimum FMAP rate of 50% and Mississippi is to have the highest FMAP rate of 77.76%. From FY2020 to FY2021, the regular FMAP rates for 37 states are to change, whereas the regular FMAP rates for the remaining 14 states (including the District of Columbia) are to remain the same.

These regular FMAP rates for states, the District of Columbia, and the territories are temporarily increased by 6.2 percentage points to provide some fiscal relief to states during the COVID-19 public health emergency period. The Congressional Budget Office estimates the FFCRA FMAP increase will increase federal expenditures by about $50.0 billion from FY2020 to FY2022.[25] However, the amount of the increase in federal expenditures depends on the length of the COVID-19 public health emergency period and states' actual expenditures.

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of the Patient Protection and Affordable Care Act (P.L. 111-148) through FY2027. The penalty for states' noncompliance with either the Medicaid or the CHIP maintenance of effort requirements for children would be the loss of all federal Medicaid funds.

[21] §3720 of the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) delays the application of the premium requirement until 30 days after March 18, 2020 (i.e., the date of enactment for FFCRA).

[22] Specifically, the continuous coverage requirement means that to receive the increased FMAP rate, states need to maintain Medicaid eligibility for individuals enrolled in Medicaid on the date of enactment (i.e., March 18, 2020) or for individuals who enroll during the public health emergency period through the end of the month in which the public health emergency period ends (unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the state).

[23] See CRS In Focus IF10422, *Medicaid Disproportionate Share Hospital (DSH) Reductions*.

[24] Center for Medicare & Medicaid Services, "Families First Coronavirus Response Act (FFCRA), P.L. 116-127 Coronavirus Aid, Relief, and Economic Security (CARES) Act, P.L. 116-136 Frequently Asked Questions (FAQs)," April 13, 2020, at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf.

[25] Congressional Budget Office, *H.R. 6201, Families First Coronavirus Response Act*, April 2, 2020, at https://www.cbo.gov/system/files/2020-04/HR6201.pdf.

Appendix A. FMAP Rates for Medicaid, by State

Table A-1 shows regular FY2016-FY2021 FMAP rates calculated according to the formula described in the text of the report (see "How FMAP Rates Are Calculated"). In FY2021, FMAP rates range from 50% (13 states) to 77.76% (Mississippi). From FY2020 to FY2021, regular FMAP rates are to decrease for 13 states, increase for 24 states, and remain the same for 14 states (including the District of Columbia). Most of the states (13 states) for which the FMAP rates do not change have the statutory minimum FMAP rate of 50%, and the FMAP rate for the District of Columbia is statutorily set at 70%.

Table A-1. Regular FMAP Rates, by State, FY2016-FY2021

State	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	Change FY2020 to FY2021
Alabama	69.87	70.16	71.44	71.88	71.97	72.58	0.61
Alaska	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Arizona	68.92	69.24	69.89	69.81	70.02	70.01	-0.01
Arkansas	70.00	69.69	70.87	70.51	71.42	71.23	-0.19
California	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Colorado	50.72	50.02	50.00	50.00	50.00	50.00	0.00
Connecticut	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Delaware	54.83	54.20	56.43	57.55	57.86	57.74	-0.12
District of Columbia[a]	70.00	70.00	70.00	70.00	70.00	70.00	0.00
Florida	60.67	61.10	61.79	60.87	61.47	61.96	0.49
Georgia	67.55	67.89	68.50	67.62	67.30	67.03	-0.27
Hawaii	53.98	54.93	54.78	53.92	53.47	53.02	-0.45
Idaho	71.24	71.51	71.17	71.13	70.34	70.41	0.07
Illinois	50.89	51.30	50.74	50.31	50.14	50.96	0.82
Indiana	66.60	66.74	65.59	65.96	65.84	65.83	-0.01
Iowa	54.91	56.74	58.48	59.93	61.20	61.75	0.55
Kansas	55.96	56.21	54.74	57.10	59.16	59.68	0.52
Kentucky	70.32	70.46	71.17	71.67	71.82	72.05	0.23
Louisiana	62.21	62.28	63.69	65.00	66.86	67.42	0.56
Maine	62.67	64.38	64.34	64.52	63.80	63.69	-0.11
Maryland	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Michigan	65.60	65.15	64.78	64.45	64.06	64.08	0.02
Minnesota	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Mississippi	74.17	74.63	75.65	76.39	76.98	77.76	0.78
Missouri	63.28	63.21	64.61	65.40	65.65	64.96	-0.69
Montana	65.24	65.56	65.38	65.54	64.78	65.60	0.82

State	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	Change FY2020 to FY2021
Nebraska	51.16	51.85	52.55	52.58	54.72	56.47	1.75
Nevada	64.93	64.67	65.75	64.87	63.93	63.30	-0.63
New Hampshire	50.00	50.00	50.00	50.00	50.00	50.00	0.00
New Jersey	50.00	50.00	50.00	50.00	50.00	50.00	0.00
New Mexico	70.37	71.13	72.16	72.26	72.71	73.46	0.75
New York	50.00	50.00	50.00	50.00	50.00	50.00	0.00
North Carolina	66.24	66.88	67.61	67.16	67.03	67.40	0.37
North Dakota	50.00	50.00	50.00	50.00	50.05	52.40	2.35
Ohio	62.47	62.32	62.78	63.09	63.02	63.63	0.61
Oklahoma	60.99	59.94	58.57	62.38	66.02	67.99	1.97
Oregon	64.38	64.47	63.62	62.56	61.23	60.84	-0.39
Pennsylvania	52.01	51.78	51.82	52.25	52.25	52.20	-0.05
Rhode Island	50.42	51.02	51.45	52.57	52.95	54.09	1.14
South Carolina	71.08	71.30	71.58	71.22	70.70	70.63	-0.07
South Dakota	51.61	54.94	55.34	56.71	57.62	58.28	0.66
Tennessee	65.05	64.96	65.82	65.87	65.21	66.10	0.89
Texas	57.13	56.18	56.88	58.19	60.89	61.81	0.92
Utah	70.24	69.90	70.26	69.71	68.19	67.52	-0.67
Vermont	53.90	54.46	53.47	53.89	53.86	54.57	0.71
Virginia	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Washington	50.00	50.00	50.00	50.00	50.00	50.00	0.00
West Virginia	71.42	71.80	73.24	74.34	74.94	74.99	0.05
Wisconsin	58.23	58.51	58.77	59.37	59.36	59.37	0.01
Wyoming	50.00	50.00	50.00	50.00	50.00	50.00	0.00
Number with increase from previous year	22	25	25	23	19	24	
Number stayed the same from previous year	12	13	13	14	15	14	
Number with decrease from previous year	16	12	12	13	17	13	

Source: Department of Health and Human Services, Annual *Federal Register* Notices.

Notes: Reflects FMAP rates calculated using the regular FMAP formula, with exceptions noted below.

a. Section 4725(b) of the Balanced Budget Act of 1997 amended Section 1905(b) to provide that the FMAP rate for the District of Columbia shall be set at 70% for purposes of titles XIX and XXI and for capitation payments and DSH allotments under those titles. For other purposes, the percentage for the District of Columbia is 50%, unless otherwise specified by law.

Appendix B. Past FMAP Rate Exceptions

Although FMAP rates are generally determined by the statutory formula described above, **Table 1** lists current exceptions that have been added to the Medicaid statute and regulations over the years, and **Table B-1** lists past FMAP exceptions.

Table B-1. Past Exceptions to the Regular FMAP Rates for Medicaid

Exception	Description	Citations
Territories and Certain States		
Territories	For November 22, 2019, through December 20, 2019, the FMAP rate for the territories was increased from 55% to 100% (i.e., fully federally funded) for all territories. (For more information about the FMAP rate for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*).	P.L. 116-69 §1302; SSA §1905(ff)
Territories	For October 1, 2019, through November 21, 2019, the FMAP rate for the territories was increased from 55% to 100% (i.e., fully federally funded) for all territories. (For more information about the FMAP rate for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*).	P.L. 116-59 §1302; SSA §1905(ff)
Territories	For the period of January 1, 2019, through September 30, 2019, CNMI received an additional $36 million in federal Medicaid funding; for this additional funding, the FMAP rate was increased from 55% to 100%. Increased the FMAP rate from 55% to 100% for American Samoa and Guam for the territories' share of additional Medicaid federal funding provided in the ACA that was available through September 30, 2019.	P.L. 116-20 §802; SSA §1108(g)(5)
Territories	For the period of January 1, 2018, through September 30, 2019, Puerto Rico and the U.S. Virgin Islands received additional federal Medicaid funding. The FMAP rate was increased from 55% to 100% for this additional federal Medicaid funding.	P.L. 115-123 §20301; SSA §1108(g)(5)
Alaska	Alaska's FMAP rate was set in statute for FY1998-FY2000 at 59.80%; used an alternative formula for FY2001-FY2005 that reduced the state's per capita income by 5% (thereby increasing its FMAP rate); and was held at its FY2005 level for FY2006-FY2007. These provisions also applied for purposes of computing the E-FMAP rate for CHIP.	P.L. 105-33 §4725(a); P.L. 106-554 Appendix F §706; P.L. 109-171 §6053(a)
Special Situations		
State Fiscal Relief, FY2009-FY2011	FMAP rates were increased from the first quarter of FY2009 through the third quarter of FY2011, providing states with more than $100 billion (about $84 billion for the original provision and $16 billion for a six-month extension) in additional funds. All states received a hold harmless to prevent any decline in regular FMAP rates and an across-the-board increase of 6.2 percentage points until the last two quarters of the period, at which point the across-the-board percentage point increase phased down to 3.2 and then 1.2; qualifying states received an additional unemployment-related increase. Each territory could choose between an FMAP increase of 6.2 percentage points along with a 15% increase in its spending cap, or its regular FMAP rate along with a 30% increase in its cap; all chose the latter. States were required to meet certain requirements in order to receive the increase. (For more information about the FMAP increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*).	P.L. 111-5 §5001, as amended by P.L. 111-226 §201

Exception	Description	Citations
Adjustment for Hurricane Katrina	In computing FMAP rates for any year after 2006 for a state that the Secretary of HHS determines has a significant number of Hurricane Katrina evacuees as of October 1, 2005, the Secretary must disregard such evacuees and their incomes. Although it was labeled as a "hold harmless for Katrina impact," the provision language required evacuees to be disregarded even if their inclusion would increase a state's FMAP rate. Due to lags in the availability of data used to calculate FMAP rates, FY2008 was the first year to which the provision applied. HHS proposed and finalized a methodology that prevented the lowering of any FY2008 FMAP rates and increased the FY2008 FMAP rate for one state (Texas). The methodology took advantage of a data timing issue that does not apply after FY2008. HHS had initially expressed concern that some states could see lower FMAP rates in later years as a result of the provision, but the final methodology indicated that there is no reliable way to track the number and income of evacuees on an ongoing basis and therefore no basis for adjusting FMAP rates after FY2008. The provision also applied for purposes of computing the enhanced FMAP rate for CHIP.	P.L. 109-171; 72 Federal Register 3391 (January 25, 2007) and 44146 (August 7, 2007)
State Fiscal Relief, FY2003-FY2004	FMAP rates for the last two quarters of FY2003 and the first three quarters of FY2004 were not allowed to decline (i.e., were held harmless) and were increased by an additional 2.95 percentage points, providing states with about $10 billion in additional funds (they also received $10 billion in direct grants). Although Medicaid disproportionate share hospital (DSH) payments are reimbursed using the FMAP rate, the increase did not apply to DSH. States had to meet certain requirements in order to receive an increase (e.g., they could not restrict eligibility after a specified date). (For more information about the FMAP increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*).	P.L. 108-27 §401(a)
Certain Populations		
Certain "Expansion States"	During CY2014 and CY2015, an FMAP rate increase of 2.2 percentage points was available for "expansion states" that (1) the Secretary of HHS determines did not receive any federal matching rate increase for "newly eligible" individuals and (2) had not been approved to divert Medicaid disproportionate share hospital funds to pay for the cost of health coverage under a waiver in effect as of July 2009. The FMAP rate increase applied to those who are *not* "newly eligible" individuals as described in relation to the new eligibility group for non-elderly, nonpregnant adults at or below 133% FPL.	P.L. 111-148, as amended by P.L. 111-152; SSA §1905(z)(1)
Certain Providers		
Primary Care Payment Rates	During CY2013 and CY2014, states were required to provide Medicaid payments at or above the Medicare rates for primary care services (defined as evaluation and management and certain administration of immunizations) furnished by a physician with a primary specialty designation of family, general internal, or pediatric medicine. States received 100% federal reimbursement for expenditures attributable to the amount by which Medicare exceeded their Medicaid payment rates in effect on July 1, 2009.	P.L. 111-148, as amended by P.L. 111-152; SSA §1902(a)(13)(C); 77 *Federal Register* 66670.

Certain Services		
State Balancing Incentive Payments	During FY2011-FY2015, state balancing incentive payments were available under certain conditions for states in which less than 50% of Medicaid expenditures for long-term services and supports (LTSS) were noninstitutional. Qualifying states with less than 25% noninstitutional LTSS had to plan to achieve a 25% target to receive a five percentage point increase in their FMAP rate for noninstitutional LTSS; those with less than 50% had to plan to achieve a 50% target to receive a two percentage point increase. Federal spending on these increased FMAP rates was limited to $3 billion during the period.	P.L. 111-148, as amended by P.L. 111-152, §10202

Source: Congressional Research Service, based on sources noted in table.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148 as amended); CNMI = Commonwealth of the Northern Mariana Islands; DSH = disproportionate share hospital; FMAP = federal medical assistance percentage; FPL = federal poverty level.

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