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Medicaid Recession-Related FMAP Increases

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SUMMARY

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Medicaid Recession-Related FMAP Increases

Medicaid is jointly financed by the federal government and the states. States incur Medicaid costs by making payments to service providers (e.g., for doctor visits) and performing administrative activities (e.g., making eligibility determinations), and the federal government reimburses states for a share of these costs. The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP). The FMAP varies by state and is inversely related to each state's per capita income. For FY2020, FMAP rates range from 50% (13 states) to 77% (Mississippi).

Medicaid is a countercyclical program, which means that 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 program, 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. Many states have indicated that past FMAP increases allowed the states to prevent further reductions to their Medicaid programs and other portions of their state budgets.

The federal government provided states with temporary FMAP rate increases to provide states with fiscal relief on two past occasions: in response to the 2001 recession through the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA; P.L. 108-27) and in response to the Great Recession through the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5, as amended by P.L. 111-226). The JGTRRA FMAP increase provided a 2.95 percentage point increase to FMAP rates for the last two quarters of FY2003 and the first three quarters of FY2004. The ARRA FMAP increase provided an across-the-board increase, along with an unemployment-related increase for eligible states. The ARRA across-the-board increase was a 6.2 percentage point FMAP increase, starting in the first quarter of FY2009 and lasting through the first quarter of FY2011; the increase phased down to 3.2 and 1.2 percentage points for the second and third quarters of FY2011, respectively.

Most recently, the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) added a temporary Medicaid FMAP increase of 6.2 percentage points beginning January 1, 2020, and continuing through the Coronavirus Disease 2019 (COVID-19) public health emergency period. Although the country had not officially entered into a recession at the time FFCRA was enacted, a recession with significant increases in the unemployment rate was expected in the near term.

The recession-related FMAP increases have similar components, but there are differences. Similarities of all three of these recession-related FMAP increases include across-the-board FMAP increases; requirements to maintain Medicaid eligibility standards that are no more restrictive than they were prior to the FMAP increases; and requirements to ensure that states do not increase the percentage that local governments contribute to Medicaid expenditures.

However, there are differences in how the recession-related FMAP increases were determined. For instance, the JGTRRA and ARRA FMAP increases included hold-harmless provisions that kept the states' regular FMAP rates from declining, and these increases excluded certain Medicaid expenditures from the FMAP increases. The ARRA FMAP increase had an unemployment-related increase that the JGTRRA and FFCRA increases did not have. Also, the JGTRRA FMAP increase did not have additional requirements for states, but ARRA and FFCRA have differing sets of additional requirements for states to adhere to in order to qualify for the FMAP increases.

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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] Historically, Medicaid eligibility generally has been limited to low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities. Since 2014, however, states have had the option to cover nonelderly adults with income up to 133% of the federal poverty level (FPL)[2] under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) Medicaid expansion.

Medicaid is jointly financed by the federal government and the states.[3] 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.

Medicaid is a countercyclical program, meaning 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, the rate of growth for Medicaid enrollment increases, which also increases the rate of growth for Medicaid expenditures at the same time that state revenues are decreasing.

The federal government provided states with fiscal relief through temporary FMAP rate increases in response to the 2001 recession (March 2001 through November 2001) and the Great Recession (December 2007 through June 2009).[4] The Families First Coronavirus Response Act (FFCRA; P.L. 116-127), enacted on March 18, 2020, recently added a temporary Medicaid FMAP increase, beginning January 1, 2020, and continuing through the Coronavirus Disease 2019 (COVID-19) public health emergency period.[5]

This report begins with an overview of the FMAP rate. Then, it discusses the recession-related impact on the Medicaid program based on the experiences of the 2001 recession and the Great Recession. The final section of this report describes the three recession-related FMAP increases and compares them according to their various aspects, such as time periods for the FMAP increases, the amounts of the increases, and the requirements for states to receive the increases.

The FMAP Rate

The FMAP rate generally is determined annually and varies by state according to each state's per capita income relative to the U.S. per capita income.[6] The formula provides higher FMAP rates,

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

[2] For more information about the federal poverty level (also referred to as the poverty guidelines), see https://aspe.hhs.gov/poverty-guidelines.

[3] For more information about Medicaid financing, see CRS Report R42640, *Medicaid Financing and Expenditures*.

[4] The time periods for the recessions are from National Bureau of Economic Research (NBER), "US Business Cycle Expansions and Contractions," at https://www.nber.org/cycles.html. To determine when the nation is in a recession, NBER examines and compares various measures of broad economic activity, including gross domestic product, economy-wide employment, and income.

[5] The public health emergency period is defined in paragraph (1)(B) of §1135(g) of the Social Security Act (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. The determination was made retroactive to January 27, 2020.

[6] For more information about the Medicaid federal medical assistance percentage (FMAP), see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*.

or federal reimbursement rates, to states with lower per capita incomes, and it provides lower FMAP rates to states with higher per capita incomes.

FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%. For a state with an FMAP of 60%, the state gets 60 cents back from the federal government for every dollar the state spends on its Medicaid program. In FY2020, FMAP rates range from 50.00% (13 states) to 76.98% (Mississippi).[7]

The FMAP formula relies on each state's 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) were to experience an economic decline, the national economy would reflect this decline to some extent. However, the extent of the total decline would be 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, usually has only a small percentage change each year. Because the FMAP formula compares state changes in per capita personal income (which can have large changes each year) with changes in the U.S. per capita personal income, states' FMAP rates often change from year to year. For most of the states experiencing annual FMAP rate changes, the change has been be less than one percentage point—but that can translate to a significant dollar amount.

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 (e.g., the District of Columbia and the territories), situations (e.g., during economic downturns), populations (e.g., ACA Medicaid expansion population and certain women with breast or cervical cancer), providers (e.g., Indian Health Service facilities), and services (e.g., family planning and home health services).

The FMAP is also used to determine the federal share of other federal programs. For instance, it 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.[8] The FMAP rate is also used to determine the relative federal and state shares of the "mandatory matching funds" provided by the Child Care Entitlement to States.[9] In addition, it determines the federal share of funding under the Temporary Assistance for Needy Families (TANF) Contingency Funds and the federal share of collections under the Child Support Enforcement program.[10]

Separate from the regular FMAP rate, the enhanced FMAP (E-FMAP) rate is provided for services and administration under the State Children's Health Insurance Program (CHIP), subject

[7] HHS, "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, 2019 Through September 30, 2020," 83 *Federal Register* 611577, November 28, 2018.

[8] 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*.

[9] The Child Care Entitlement to States is authorized in §418 of the SSA. For more information, see CRS In Focus IF10511, *Child Care Entitlement to States*.

[10] 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*.

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%.[11]

Medicaid and Recessions

Medicaid expenditures are influenced by a number of economic, demographic, and programmatic factors. Economic factors include health care prices, unemployment rates, and individuals' wages. Demographic factors include population growth and the age distribution. Programmatic factors include changes to eligibility and benefits or other program changes. Other factors include the number of eligible individuals who enroll and their utilization of covered services.

Medicaid is a countercyclical program. 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.[12] The effect of recessions on Medicaid enrollment, Medicaid expenditures, and state tax revenues are generally not isolated to the recession period and can continue after the recession has officially ended.[13]

Growth in Medicaid Enrollment

Individuals and their dependents may become eligible for Medicaid because they experience reductions in their incomes due to reduced hours or job loss. During economic downturns, the number of individuals with reduced hours or job losses increases, and the rate of job losses are considerably higher among low-income workers.[14] This increases the number of individuals eligible for Medicaid.

Individuals and their dependents also may lose access to employer-sponsored health insurance. When individuals have reduced hours or experience job loss, they may lose the health insurance coverage they had through their employer for themselves and their dependents. These individuals may be eligible for the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage, which provides temporary access to a former employer's health insurance. However, employers are not required to pay for the cost of COBRA coverage, which may be more expensive than an individual's prior cost of insurance.[15]

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

[12] John Holahan and A. Bowen Garrett, *Rising Unemployment, Medicaid and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured, June 2009, at https://www.kff.org/wp-content/uploads/2013/03/7850.pdf (hereinafter cited as Holahan and Garrett, *Rising Unemployment, Medicaid and the Uninsured*, June 2009).

[13] U.S. Government Accountability Office (GAO), *Medicaid: Improving Responsiveness of Federal Assistance to States during Economic Downturns*, GAO-11-395, March 2011, at https://www.gao.gov/new.items/d11395.pdf (hereinafter cited as GAO-11-395, *Medicaid: Improving Responsiveness*).

[14] GAO-11-395, *Medicaid: Improving Responsiveness*; Laura Snyder and Robin Rudowitz, *Trends in State Medicaid Programs: Looking Back and Looking Ahead*, Kaiser Commission on Medicaid and the Uninsured, June 21, 2016, at https://www.kff.org/report-section/trends-in-state-medicaid-programs-section-1-medicaid-spending-and-enrollment-trends/; Henry S. Farber, "Job Loss in the Great Recession Historical Perspective from the Displaced Workers Survey, 1984-2010," *National Bureau of Economic Research*, May 2011, at https://www.nber.org/papers/w17040; Holahan and Garrett, *Rising Unemployment, Medicaid and the Uninsured*, June 2009.

[15] Holahan and Garrett, *Rising Unemployment, Medicaid and the Uninsured*, June 2009.

Some individuals, or their dependents, might already be Medicaid eligible and have employer-sponsored health insurance. During economic downturns, employers may lower the amount they contribute to the cost of health benefits or decide to no longer provide health insurance coverage to these employees. This increase in the cost of or loss of employer-sponsored health insurance may result in these individuals enrolling for Medicaid coverage.

As discussed below, there is a relationship between the unemployment rate and Medicaid enrollment. The ACA Medicaid expansion, which was implemented after the last recession, is expected to increase the effects of a recession on Medicaid enrollment.

Medicaid Enrollment Growth During Recent Recessions

Medicaid enrollment follows economic cycles, with enrollment growth increasing at a faster rate during economic downturns and Medicaid enrollment growth increasing at a slower rate when economic conditions improve.[16]

The U.S. Government Accountability Office (GAO) analyzed federal Medicaid enrollment data during the 2001 recession and the Great Recession. GAO found that during the 2001 recession, the national unemployment rate increased from 4.3% to 5.5%, and total Medicaid enrollment increased by approximately 2 million (or 5.6%). GAO also found that during the Great Recession, the national unemployment rate grew from 5.0% to 9.5%, and Medicaid enrollment rose by nearly 4.3 million (or 9.7%).[17]

Potential Impact of Medicaid Expansion on Enrollment Growth

The ACA Medicaid expansion that went into effect in 2014 is expected to increase the effects of a recession on Medicaid enrollment.[18] As there has not been a recession since states have had the option to implement the Medicaid expansion, there is no experience available to quantify the impact.[19]

During the Great Recession, Medicaid eligibility in most states was not available to many of the individuals who lost their jobs. This is because nonelderly adults without dependent children were not eligible for Medicaid. Prior to the Medicaid expansion, Medicaid eligibility for nonelderly adults, in most states, was limited to individuals with disabilities, pregnant women, and parents of poor children. Also, states' Medicaid income eligibility thresholds for parents were significantly lower than the income eligibility level for the Medicaid expansion of up to 133% of FPL.[20]

As a result of the Medicaid expansion, the percentage of adults eligible for Medicaid during future periods of high unemployment is expected to be larger than in the past.[21] An increase in the rate of enrollment growth for the Medicaid expansion in response to an increase in the unemployment rate would have less of an impact on state budgets than an increase in the rate of

[16] Holahan and Garrett, *Rising Unemployment, Medicaid and the Uninsured*, June 2009.

[17] GAO-11-395, *Medicaid: Improving Responsiveness*.

[18] Paul D. Jacobs, Steven C. Hill, and Salam Abdus, "Adults Are More Likely To Become Eligible For Medicaid During Future Recessions If Their State Expanded Medicaid," *Health Affairs*, vol. 36, no. 1 (January 2017) (hereinafter cited as Jacobs, Hill, and Abdus, "Adults Are More Likely To Become Eligible For Medicaid During Future Recessions").

[19] For more information about the Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*; and CRS Report R43564, *The ACA Medicaid Expansion*.

[20] Jacobs, Hill, and Abdus, "Adults Are More Likely To Become Eligible For Medicaid During Future Recessions."

[21] Jacobs, Hill, and Abdus, "Adults Are More Likely To Become Eligible For Medicaid During Future Recessions."

enrollment growth for the traditional Medicaid populations because the federal matching rate for the Medicaid expansion is 90%, which is higher than the regular FMAP rate.[22] Although the state share of the Medicaid expansion is 10% of the expenditures, the increase in the enrollment for the Medicaid expansion during economic downturns could contribute to states' budget pressures.

Medicaid Expenditures and State Revenues

Increases in Medicaid enrollment growth during economic downturns generally result in an increased rate of growth for total Medicaid expenditures.[23] As with Medicaid enrollment, when the economic conditions improve, Medicaid expenditure growth tends to slow.

At the same time that unemployment rate increases during economic downturns cause Medicaid enrollment and expenditures to increase at a faster rate, states general revenues are negatively affected.[24] During the 2001 recession, states experienced a 4.2% decline in state tax revenue from state FY2001 to state FY2002.[25]

In the study described in the "Medicaid Enrollment Growth During Recent Recessions" section, GAO also looked at the impact of the Great Recession on total state tax revenues. Nationally, GAO found that the Great Recession led to a 10.2% decline in state tax revenues from the fourth quarter of 2007 to the fourth quarter of 2009.[26] The impact of the Great Recession on state tax revenue varied significantly from state to state.[27] Although state tax revenue for most states (44 states and the District of Columbia) decreased, these revenue decreases ranged from 1% in Iowa to 23% in Arizona.[28]

Medicaid accounts for almost 20% of state general fund expenditures, and it is the second largest category of general fund expenditures for states.[29] The reduction in state tax revenue during economic downturns can make it difficult for states to finance the state share of Medicaid, especially while Medicaid enrollment and expenditures are increasing.[30] Since most states are required to balance their budgets, the reduced state tax revenues and increased Medicaid expenditures, among other budget pressures, may lead states to increase taxes, reduce expenditures—including for the Medicaid program—or both.[31]

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[22] For more information about the Medicaid matching rate for the Medicaid expansion, see CRS In Focus IF10399, *Overview of the ACA Medicaid Expansion*.

[23] Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, *2016 Actuarial Report on the Financial Outlook for Medicaid*, 2017.

[24] GAO-11-395, *Medicaid: Improving Responsiveness*.

[25] This is based on data that state legislative fiscal officers provided to the National Conference for State Legislatures (NCSL). Todd Haggerty, *"Weakcovery": State General Fund Revenues, Economic Downturns & Recoveries*, NCSL, January 2013, at https://www.ncsl.org/research/fiscal-policy/state-revenues-downturns-and-recoveries.aspx.

[26] GAO-11-395, *Medicaid: Improving Responsiveness*.

[27] GAO-11-395, *Medicaid: Improving Responsiveness*.

[28] GAO-11-395, *Medicaid: Improving Responsiveness*.

[29] Elementary and secondary education is the largest category of general fund expenditures for states. National Association of State Budget Officers, *2019 State Expenditure Report: Fiscal Years 2017-2019*, November 2019, at https://www.nasbo.org/reports-data/state-expenditure-report.

[30] GAO-11-395, *Medicaid: Improving Responsiveness*.

[31] Kaiser Commission on Medicaid and the Uninsured, *Rising Unemployment Medicaid and the Uninsured: A Multi-Year Snapshot of State Financing Effects*, January 2009, at https://www.kff.org/wp-content/uploads/2013/03/7850_fs.pdf; Holahan and Garrett, *Rising Unemployment, Medicaid and the Uninsured*, June 2009.

In response to the 2001 recession, 34 states reduced Medicaid expenditures by freezing or reducing provider payments, eliminating coverage for optional services, increasing premiums, and increasing copayments for prescription drugs.[32] As a result of the Great Recession, 31 states froze or reduced Medicaid provider rates or increased Medicaid provider taxes,[33] and other states reduced prescription drug costs and limited or eliminated coverage for optional services, such as mental health or dental care.[34]

After Recessions

The impacts of recessions on Medicaid enrollment, Medicaid expenditures, and state tax revenues have continued even after the recessions have officially ended. For example, the 2001 recession officially ended in November 2001, but state tax revenue continued to decline through the second quarter of 2002, and the national unemployment rate remained above prerecession levels through June 2003. Medicaid enrollment increased at higher than average rates of growth through 2003.

Although the Great Recession officially ended in June 2009, 25 states continued to experience unemployment rates above 9%, until at least December 2010.[35] Some states were still feeling the effects of the recession in 2011 and 2012.[36] The timing and duration of the continued impact of national recessions on states have varied according to the economic conditions and revenue structures of each state, along with the mix of each state's industries and resources.[37]

Recession-Related FMAP Increases

In the past, two laws have provided states with fiscal relief through temporary FMAP rate increases due to recessions: the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA; P.L. 108-27) and the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5, as amended by P.L. 111-226). In addition, the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) recently provided a temporary FMAP increase during the COVID-19 public health emergency period.

As noted by GAO, "the FMAP is a readily available mechanism for providing temporary assistance to states because assistance can be distributed quickly, with states obtaining funds on a quarterly basis through Medicaid's existing payment system."[38] The increased FMAP rates help states maintain their Medicaid programs during economic downturns. Also, the increased FMAP rates effectively reduce the state share of Medicaid expenditures for states, allowing states to use the state funding that would have been used for the state share of Medicaid—if there were not a recession-related FMAP rate—for non-Medicaid state budget needs.[39]

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[32] GAO-11-395, *Medicaid: Improving Responsiveness*.

[33] For more information about Medicaid provider taxes, see CRS Report RS22843, *Medicaid Provider Taxes*.

[34] GAO-11-395, *Medicaid: Improving Responsiveness*.

[35] GAO-11-395, *Medicaid: Improving Responsiveness*.

[36] CMS, Office of the Actuary, *2012 Actuarial Report on the Financial Outlook for Medicaid*, 2013; GAO-11-395, *Medicaid: Improving Responsiveness*.

[37] GAO-11-395, *Medicaid: Improving Responsiveness*.

[38] GAO-11-395, *Medicaid: Improving Responsiveness*.

[39] GAO-11-395, *Medicaid: Improving Responsiveness*; Gabriel Chodorow-Reich, et al., "Does State Fiscal Relief During Recessions Increase Employment? Evidence from the American Recovery and Reinvestment Act," *American Economic Journal: Economic Policy*, vol. 4, no. 3 (August 2012) (hereinafter cited as Chodorow-Reich, et al., "Does State Fiscal Relief Increase Employment? Evidence from ARRA," August 2012).

As shown in **Table 1**, the recession-related FMAP increases have similar components, but there are differences. All three recession-related FMAP increases had across-the-board increases to the regular FMAP rates as their main component. The JGTRRA across-the-board increase of 2.95 percentage points was lower than the 6.2 percentage point across-the-board increases for ARRA and FFCRA. The ARRA across-the-board increase phased out at the end of the time period for the FMAP increase, but the other two increases do not phase down. In addition, the JGTRRA and ARRA FMAP increases included hold-harmless provisions that kept states' regular FMAP rates from declining, and these increases did not apply to certain Medicaid expenditures that use the regular FMAP rate. The FFCRA FMAP increase, however, does not exclude Medicaid expenditures that use the regular FMAP rate. Also, the ARRA FMAP increase included an unemployment-related additional increase to the FMAP, but the JGTRRA and FFCRA FMAP increases do not. JGTRRA and FFCRA applied the FMAP increases to the territories and provided the territories additional federal Medicaid funding, but ARRA gave the territories a choice of the across-the-board FMAP increase, along with increased funding or a larger increase in funding without an FMAP increase.

All three of the recession-related FMAP increases have requirements for states in order to qualify for the FMAP increase. For example, all three FMAP increases require states to maintain Medicaid eligibility standards that are no more restrictive than those that were in effect on a certain date. All three also prohibit states from increasing the percentage local governments are required to contribute to the state share of Medicaid.[40] The JGTRRA FMAP increase did not have additional requirements for states, but the ARRA and FFCRA FMAP increases include differing sets of additional requirements for states, which are listed in **Table 1**.

Table 1. Comparison of Medicaid Recession-Related FMAP Increase Provisions

	JGTRRA FMAP Increase	ARRA FMAP Increase	FFCRA FMAP Increase
Time Period for Increase	Last two quarters of FY2003 and the first three quarters of FY2004.	First quarter of FY2009 through the third quarter of FY2011.	Starting January 1, 2020, through the last day of the calendar quarter in which the Coronavirus Disease 2019 (COVID-19) public health emergency period ends.[a]
Funding Limit	Limited to $10 billion.	None.	None.
States	50 states, the District of Columbia, and the territories.	50 states and the District of Columbia.	50 states, the District of Columbia, and the territories.[b]
Hold-Harmless Provision	Yes.	Yes.	No.
Across-the-Board FMAP Increase	2.95 percentage points.	6.2 percentage points phased down to 3.2 and then 1.2 for the last two quarters, respectively.	6.2 percentage points.
Unemployment-Related Increase	None.	Three-tier unemployment-related increase.	None.

[40] Some states require local governments to finance part of the nonfederal (i.e., state) share of Medicaid costs. Because a temporary FMAP rate increase would reduce a state's nonfederal share, a local government required to contribute a specified dollar amount (or some other amount that is not a fixed percentage of the nonfederal share) could pay a larger percentage of the nonfederal share than it otherwise would have without the FMAP rate increase.

	JGTRRA FMAP Increase	ARRA FMAP Increase	FFCRA FMAP Increase
Medicaid Payments Excluded	Did not apply to Medicaid DSH payments and Medicaid payments matched using the E-FMAP.	Did not apply to the following Medicaid expenditures: (1) DSH payments, (2) Medicaid payments matched using the E-FMAP, and (3) most expenditures for individuals who were eligible for Medicaid because of a state expansion of eligibility implemented after July 1, 2008.	None.
Application to FMAP Exceptions[c]	None.	None.	Community First Choice services.[d] FMAP exceptions calculated based on the regular FMAP are indirectly increased.[e]
Maintenance of Effort for Eligibility	Medicaid eligibility is no more restrictive than what was in effect on September 2, 2003.	Medicaid "eligibility standards, methodologies, and procedures" are no more restrictive than what was in effect on July 1, 2008.	Medicaid "eligibility standards, methodologies, and procedures" are no more restrictive than what was in effect on January 1, 2020.
Restriction of Requirement for Local Funding	Ensure that local governments were not required to pay a larger percentage of the state's nonfederal Medicaid expenditures than otherwise would have been required on April 1, 2003.	Ensure that local governments were 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 September 30, 2008.	Ensure that 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.
Other Requirements	None.	States were also required to do the following: (1) comply with requirements for prompt payment of health care providers under Medicaid; (2) not deposit or credit the additional federal funds paid as a result of the increase to any reserve or rainy day fund; and (3) submit a report to the HHS Secretary regarding how the additional federal funds paid as a result of the temporary FMAP increase were expended.	States are also required to (1) not impose premiums exceeding the amount in place as of January 1, 2020[f]; (2) provide continuous coverage of Medicaid enrollees during the public health emergency period; and (3) provide coverage (without the imposition of cost sharing) for testing services and treatments for COVID–19 (including vaccines, specialized equipment, and therapies).

	JGTRRA FMAP Increase	ARRA FMAP Increase	FFCRA FMAP Increase
Territories Specific Provisions[g]	Increase of 5.9% in the federal Medicaid annual capped funding.	Choice of 6.2 percentage points FMAP increase along with a 15% increase in annual capped funding or regular FMAP rate along with a 30% increase in its cap.	Increases the additional federal Medicaid funding available for each territory in FY2020 and FY2021.[h]

Sources: American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5, as amended by P.L. 111-226); Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA; P.L. 108-27); Families First Coronavirus Response Act (FFCRA; P.L. 116-127); and Centers for Medicare & Medicaid Services (CMS), *Families First Coronavirus Response Act – Increased FMAP FAQs*, March 24, 2020 (updated April 13 2020), at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf; CMS, *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.

Notes: FMAP = federal medical assistance percentage; E-FMAP = enhanced federal medical assistance percentage; DSH = disproportionate share hospital; HHS = Department of Health and Human Services.

a. The public health emergency period is defined as paragraph (1)(B) of Section 1135(g) of the Social Security Act, which is a public health emergency declared by the HHS Secretary pursuant to Section 319 of the Public Health Service Act. This is referring to the public health emergency declared with respect to the COVID-19 outbreak by the HHS Secretary on January 31, 2020. The determination was made retroactive to January 27, 2020.

b. The regular FMAP rates for the territories are statutorily set at 55%. However, for the remainder of FY2020 and FY2021, the FMAP rates for the territories are increased to 83% for American Samoa, Commonwealth of the Northern Mariana Islands, Guam, and the U.S. Virgin Islands and to 76% for Puerto Rico. The FFCRA FMAP increase is added to the FMAPs for FY2020 and FY2021 (i.e., 83% and 76%, respectively).

c. 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.

d. Expenditures for the Community First Choice services receive both the six percentage point FMAP increase under section 1915(k) of the Social Security Act and the FFCRA FMAP increase, if the expenditures otherwise qualify.

e. FMAP exceptions calculated based on the regular FMAP use the regular FMAP plus the FFCRA FMAP increase for the calculation. These FMAP exceptions are for individuals eligible on the basis of breast and cervical cancer, Certified Community Behavioral Health Clinics, and Money Follows the Person.

f. Section 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).

g. Federal Medicaid funding to the states and the District of Columbia is open-ended, but the Medicaid programs in the territories are subject to annual federal capped funding. The permanent source of federal Medicaid funding for the territories is the annual federal capped funding, and this funding has been supplemented since July 1, 2011, with additional Medicaid funding. For more information about Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

h. Section 6009 of FFCRA.

The following sections provide summaries of the recession-related FMAP rate increases from JGTRRA, ARRA, and FFCRA, as well as the time period for the FMAP increases, the amount of the increases, and the requirements for states to receive them.

JGTRRA FMAP Increase

As part of the state fiscal relief for FY2003 and FY2004 included in JGTRRA, FMAP rates for the 50 states, the District of Columbia, and the territories were held harmless and increased in the

last two quarters of FY2003 and the first three quarters of FY2004.[41] This provision was statutorily limited to $10 billion.[42] **Table A-1** shows JGTRRA FMAP increases for the 50 states, the District of Columbia, and the territories.

The FMAP rates were increased by an across-the-board 2.95 percentage points for each state (i.e., the 50 states, the District of Columbia, and the territories). The FMAP increase did not apply to Medicaid disproportionate share hospital (DSH) payments and Medicaid payments that were matched using the E-FMAP (e.g., breast and cervical cancer treatment).

The hold-harmless provision kept the FMAP rates from declining during that period. Specifically, for FY2003, if a state's FY2002 FMAP rate was higher than the FY2003 rate (without the 2.95 percentage point increase), then the FY2002 rate was substituted for the FY2003 rate for the last two quarters of FY2003. Similarly in FY2004, if a state's FY2003 FMAP rate was higher than the FY2004 rate (without the 2.95 percentage point increase), then the FY2003 rate was substituted for the FY2004 rate for the first three quarters of FY2004.

To qualify for the JGTRRA FMAP increase, a state could not have had a Medicaid plan with more restrictive eligibility rules than the plan in effect on September 2, 2003. If a state restored program eligibility to the levels in effect on September 2, 2003, then the state would have qualified for the increased FMAP rate for the entire quarter in which eligibility was reinstated.

States also needed to ensure that local governments were not required to contribute a larger percentage of the state's nonfederal Medicaid expenditures than otherwise would have been required on April 1, 2003, for the last two quarters of FY2003 and the first three quarters of FY2004.

In addition to the JGTRRA FMAP increase, JGTRRA increased the federal Medicaid funding available for each of the territories by 5.9%.[43]

The JGTRRA FMAP increase was provided to states in FY2003 and FY2004, well after the recession ended in November 2001. All states received the same FMAP increase, and the increase was not based on need using measures such as unemployment rates or state tax revenues.[44]

States indicated that the JGTRRA FMAP increase prevented states from making additional cuts to the Medicaid program and other portions of state budgets. Specifically, 36 states said the JGTRRA FMAP increase helped to fund increased Medicaid expenditures, and 31 states said the increase allowed states to minimize or postpone Medicaid cuts or freezes.[45]

ARRA FMAP Increase

ARRA provided an FMAP rate increase to states, which was later extended by P.L. 111-226.[46] The ARRA FMAP rate increase lasted for nine quarters, starting October 2008 and continuing

[41] §401(a) of the Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA; P.L. 108-27).

[42] In addition to the $10 billion for the FMAP rate increases, JGTRRA provided $10 billion in general assistance divided among the states to be used for essential government services.

[43] Federal Medicaid funding to the states and the District of Columbia is open-ended, but the Medicaid programs in the territories are subject to annual federal capped funding. For more information about Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

[44] GAO-11-395, *Medicaid: Improving Responsiveness*.

[45] Kaiser Commission on Medicaid and the Uninsured, *State Fiscal Conditions and Medicaid*, November 2004, at https://www.kff.org/medicaid/fact-sheet/state-fiscal-conditions-and-medicaid-update/.

[46] §5001 of the American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) and amended by §201 of P.L.

through December 2010, and totaled an estimated $89 billion.[47] This temporary FMAP rate increase was extended by six months as part of P.L. 111-226—the extension totaled an estimated $16.1 billion.[48] With the extension, the ARRA FMAP rate increase ran for a total of 11 quarters, from the first quarter of FY2009 through the third quarter of FY2011 (i.e., October 2008 through June 2011), subject to certain requirements. **Table B-1** shows the ARRA FMAP increase for the 50 states and the District of Columbia.

For a "recession adjustment period" that began with the first quarter of FY2009 and ran through the third quarter of FY2011 (i.e., October 2008 through June 2011), ARRA held all states harmless from any decline in their regular FMAP rates throughout the period.[49] All states (i.e., the 50 states and the District of Columbia) received an across-the-board increase of 6.2 percentage points to their regular FMAP rates 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 percentage points.[50]

Throughout the period, states with unemployment rates that had increased by certain amounts in a quarter received an additional unemployment-related increase. There were three tiers of this unemployment-related increase. See "ARRA Unemployment-Related FMAP Increase" for details about the unemployment related increase, including how it was calculated.

ARRA Unemployment-Related FMAP Increase

The unemployment-related FMAP rate increase, which equaled a percentage reduction in the state share, was determined for each state on a quarterly basis. A state was evaluated based on its average unemployment rate in the most recent three-month period for which data were available (except for the first two and last two quarters of the temporary FMAP rate increase, for which the applicable three-month period differs) compared with its lowest average unemployment rate in any three-month period beginning on or after January 1, 2006.

The criteria were as follows: unemployment rate increase of at least 1.5 but less than 2.5 percentage points = 5.5% reduction in state share; increase of at least 2.5 but less than 3.5 percentage points = 8.5% reduction; increase of at least 3.5 percentage points = 11.5% reduction.

The percentage reduction was applied to the state share after the hold-harmless increase and after one-half of the across-the-board increase. For example, after applying the across-the-board increase of 6.2 percentage points that applied for most of the recession adjustment period, a state with a regular FMAP rate of 50% would have an FMAP rate of 56.20%. If the state share after the hold-harmless and one-half of the across-the-board increase to the federal share (i.e., 46.9%) were further reduced by 5.5% (the lowest unemployment rate increase tier), the state would have receive an additional FMAP rate increase of 2.58 percentage points (46.9 state share * 0.055 reduction in state share = 2.58). The state's total FMAP rate increase would have been 8.78 points (6.2 + 2.58 = 8.78), and the state's FMAP rate would have been 58.78%. **Table B-2** shows how the FMAPs under ARRA were calculated for the second quarter of FY2010, including the 6.2 percentage point across-the-board increase and the unemployment-related increases.

A state's percentage reduction could increase over time as its unemployment rate increased, but the percentage reduction was not allowed to decrease until the second quarter of FY2011.

The ARRA FMAP increase was not available to the territories, but each territory was allowed to make a one-time choice between (1) an FMAP rate increase of 6.2 percentage points along with a

111-226.

[47] GAO-11-395, *Medicaid: Improving Responsiveness*.

[48] GAO-11-395, *Medicaid: Improving Responsiveness*.

[49] The hold-harmless provision was determined by using as the FMAP rate for the current year, the greater of any prior fiscal year FMAP rates between FY2008-FY2010, or the rate calculated for the current fiscal year. HHS, "Adjusted Federal Medical Assistance Percentage (FMAP) Rates for the Second and Third Quarters of Fiscal Year 2011 (FY11)," 76 *Federal Register* 32204, June 3, 2011.

[50] The phased down, across-the-board increase for the last six months was part of the six-month extension included in P.L. 111-226.

15% increase in its annual capped funding or (2) the regular FMAP rate along with a 30% increase in its capped funding. All territories chose the latter.[51]

The full amount of the temporary ARRA FMAP rate increase applied to most Medicaid expenditures, but not to the following Medicaid expenditures: (1) DSH payments,[52] (2) Medicaid payments that were matched using the E-FMAP (e.g., breast and cervical cancer treatment), and (3) most expenditures for individuals who were eligible for Medicaid because of a state expansion of eligibility implemented after July 1, 2008.[53]

To receive ARRA FMAP rate increases, states were required to do the following: (1) ensure their Medicaid "eligibility standards, methodologies, and procedures" were no more restrictive than those that were in effect on July 1, 2008; (2) comply with requirements for prompt payment of health care providers under Medicaid; (3) not deposit or credit the additional federal funds paid as a result of the increase to any reserve or rainy day fund; (4) ensure that local governments did not pay a larger percentage of the state's nonfederal Medicaid expenditures (or a greater percentage of the nonfederal share of Medicaid DSH payments) than otherwise would have been required on September 30, 2008;[54] and (5) submit a report to the Secretary of the Department of Health and Human Services regarding how the additional federal funds paid as a result of the temporary FMAP increase were expended.[55] P.L. 111-226 added a requirement for the last six months (i.e., January 1, 2011, through June 30, 2011) that states certify that they would request and use the funds.

FMAP rate increases reduced the amount of state funding required to maintain a given level of Medicaid services. For states that contemplated cuts in order to slow the growth of or reduce Medicaid spending (e.g., by eliminating coverage of certain benefits, freezing or reducing provider reimbursement rates, or increasing cost-sharing or premiums for beneficiaries), increased federal funding enabled them to avoid those cuts.[56]

For others, the state savings that resulted from an FMAP rate increase were used for various purposes that were not limited to Medicaid. For example, 36 states reported that they used funds

[51] HHS, "Adjusted Federal Medical Assistance Percentage (FMAP) Rates for the Second and Third Quarters of Fiscal Year 2011 (FY11)," 76 *Federal Register* 32204, June 3, 2011.

[52] §5002 of ARRA temporarily increased states' disproportionate share hospital (DSH) allotments for FY2009 and FY2010 to 102.5% of what the DSH allotment would have been without ARRA for each year. For more about Medicaid DSH allotments, see CRS Report R42865, *Medicaid Disproportionate Share Hospital Payments*.

[53] The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) included an exception to the July 1, 2008, rule for certain childless adults that states were required to transfer from CHIP to a Medicaid waiver by December 31, 2009. Under P.L. 111-226, states were able to receive ARRA FMAP rates after January 1, 2010, for nonpregnant childless adults in Medicaid who would have been eligible for CHIP based on standards in effect on December 31, 2009.

[54] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) clarified that *voluntary* local contributions would not lead a state to run afoul of this requirement. See HHS, CMS, State Medicaid Director letter #10-010 (ARRA #7), June 21, 2010.

[55] For the requirements related to rainy day funds and local governments' share of nonfederal expenditures, the law was written such that states would be denied the across-the-board and unemployment-related FMAP rate increases (and territories would be denied cap increases) if they were out of compliance; however, they would not be denied the hold-harmless FMAP rate increase. In contrast, for the requirements related to maintenance of eligibility and prompt payment, states would be denied all of the temporary FMAP rate increase (including hold harmless) if they were out of compliance.

[56] GAO-11-395, *Medicaid: Improving Responsiveness*.

from the ARRA FMAP rate increase to close or reduce their Medicaid budget shortfall, and 44 states used the funds to close or reduce state general fund shortfalls.[57]

In addition to avoiding cuts to Medicaid, the Congressional Budget Office (CBO) indicated in 2009 that providing additional federal aid to states that were facing fiscal pressures would probably stimulate the economy.[58] However, CBO noted that the effects would vary. Federal aid to states with relatively healthy budgets would have provided little stimulus if the aid were used to build up rainy day funds (a prohibited use of the ARRA FMAP rate increase), rather than to increase spending or reduce taxes.[59] One study found the ARRA FMAP increase "had an economically large and statistically robust positive effect on employment."[60]

GAO determined that the ARRA FMAP increase was better timed than the JGTRRA FMAP increase because the ARRA FMAP increase began during the recession, when all states were experiencing Medicaid enrollment increases and state tax revenue decreases.[61] GAO also found that the ARRA FMAP increase was better targeted than the JGTRRA FMAP increase because the ARRA increase included unemployment-related adjustments for certain states.[62]

FFCRA FMAP Increase

FFCRA provides an increase to the FMAP rate for all states, the District of Columbia, and the territories of 6.2 percentage points, beginning on the first day of the calendar quarter in which the COVID-19 public health emergency period began[63] (i.e., January 1, 2020) and ending on the last day of the calendar quarter in which the last day of the COVID-19 public health emergency period ends.[64] **Table C-1** shows the FY2020 FMAP rates for the states, the District of Columbia, and the territories and those FMAP rates plus 6.2 percentage points.

To receive this increased FMAP rate, states, the District of Columbia, and the territories are required to (1) ensure that their Medicaid "eligibility standards, methodologies, and procedures" are no more restrictive than those that were in effect on January 1, 2020;[65] (2) not impose premiums exceeding the amounts in place as of January 1, 2020;[66] (3) provide continuous

[57] Kaiser Commission on Medicaid and the Uninsured, *State Fiscal Conditions and Medicaid*, September 2009.

[58] U.S. Congressional Budget Office (CBO), *Letter to the Honorable Charles E. Grassley*, March 2, 2009.

[59] Statement of Peter R. Orszag, Director, CBO, in U.S. Congress, Senate Committee on Finance, *Options for Responding to Short-Term Economic Weakness*, 110th Cong., 2nd sess., January 22, 2008.

[60] Chodorow-Reich, et al., "Does State Fiscal Relief Increase Employment? Evidence from ARRA," August 2012.

[61] GAO-11-395, *Medicaid: Improving Responsiveness*.

[62] GAO-11-395, *Medicaid: Improving Responsiveness*.

[63] The public health emergency period is defined as paragraph (1)(B) of §1135(g) of the SSA, which is a public health emergency declared by the HHS Secretary pursuant to §319 of the Public Health Service Act. This is referring to the public health emergency declared with respect to the COVID-19 outbreak by the HHS Secretary on January 31, 2020. The determination was made retroactive to January 27, 2020.

[64] §6008 of the Families First Coronavirus Response Act (FFCRA; P.L. 116-127); CMS, *Families First Coronavirus Response Act – Increased FMAP FAQs*, March 24, 2020 (updated April 13 2020), at https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-faqs.pdf.

[65] A similar provision was in place prior to FFCRA 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 of the ACA (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.

[66] §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).

coverage of Medicaid enrollees during the COVID-19 public health emergency period;[67] 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.

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. For Community First Choice services, the FFCRA FMAP increase is added to the six percentage point FMAP increase under Section 1915(k) of the Social Security Act, if the expenditures otherwise qualify.[68] Also, FMAP exceptions calculated based on the regular FMAP use the regular FMAP plus the FFCRA FMAP increase for the calculation. These FMAP exceptions are for individuals eligible on the basis of breast and cervical cancer, Certified Community Behavioral Health Clinics, and Money Follows the Person.[69]

In addition to the territories receiving the FFCRA FMAP increase, FFCRA increases the federal Medicaid funding available for each territory in FY2020 and FY2021.[70] The aggregate additional funding for the territories increases from $3.0 billion to $3.1 billion in FY2020 and from $3.1 billion to $3.2 billion in FY2021.[71]

In the past, GAO developed a prototype formula for temporary FMAP increases. One of the key components of the GAO prototype was making the temporary FMAP increase automatic so the FMAP increase could begin closer to the onset of a national recession.[72] Although the FFCRA does not provide an automatic increase, the FFCRA FMAP increase is starting prior to an expected economic downturn.[73]

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[67] 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).

[68] CMS, 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 (hereinafter cited as CMS, FFCRA, CARES Act FAQs, April, 13, 2020).

[69] CMS, *FFCRA, CARES Act FAQs*, April, 13, 2020.

[70] The regular FMAP rates for the territories are statutorily set at 55%. However, for the remainder of FY2020 and FY2021, the FMAP rates for the territories are increased to 83% for American Samoa, Commonwealth of the Northern Mariana Islands, Guam, and U.S. Virgin Islands and to 76% for Puerto Rico. The FFCRA FMAP increase is added to the FMAPs for FY2020 and FY2021 (i.e., 83% and 76%, respectively). CMS, *FFCRA, CARES Act FAQs*, April, 13, 2020.

[71] For more information about Medicaid funding for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.

[72] GAO-11-395, *Medicaid: Improving Responsiveness*.

[73] Phillip Swagel, *Updating CBO's Economic Forecast to Account for the Pandemic*, CBO, April 2, 2020, at https://www.cbo.gov/publication/56314.

Conclusion

The FMAP rate has been used as a means to provide fiscal relief to states in response to the 2001 recession, the Great Recession, and current economic conditions due to the COVID-19 public health emergency. These recession-related FMAP increases have been provided at times when states have experienced growth in unemployment rates that results in increases in the rate of growth for Medicaid enrollment, which in turn increases the rate of growth for Medicaid expenditures at the same time that state revenues decline.

These recession-related FMAP increases are similar but have some significant differences. All three of these recession-related FMAP increases have across-the-board FMAP increases; requirements to maintain Medicaid eligibility standards that are no more restrictive than they were prior to the FMAP increases; and requirements to ensure that states do not increase the percentage that local governments contribute to Medicaid expenditures.

However, the JGTRRA and ARRA FMAP increases included hold-harmless provisions that kept the states' regular FMAP rates from declining, and these increases excluded certain Medicaid expenditures from the FMAP increases. The ARRA FMAP increase had an unemployment-related increase that the JGTRRA and FFCRA increases did not have. Also, the JGTRRA FMAP increase did not have additional requirements for states, but ARRA and FFCRA have differing sets of additional requirements for states to adhere to in order to qualify for the FMAP increases.

In addition, many states indicated that the JGTRRA and ARRA FMAP increases provided fiscal relief that allowed the states to prevent further reductions to the Medicaid programs and other portions of their state budgets.

Appendix A. Jobs and Growth Tax Relief Reconciliation Act of 2003 FMAP Increase

The Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA; P.L. 108-27) included a provision that increased federal medical assistance percentage (FMAP) rates for the 50 states, the District of Columbia, and the territories during the last two quarters of FY2003 and the first three quarters of FY2004. The FMAP rates were held harmless and increased by an across-the-board 2.95 percentage points for each state (i.e., the 50 states, the District of Columbia, and the territories). The JGTRRA FMAP increases were subject to certain requirements for states. For more detail about the JGTRRA FMAP increase, see "JGTRRA FMAP Increase." **Table A-1** shows states' regular FMAP rates and JGTRRA FMAP rates for FY2003 and FY2004.

Table A-1. FY2003 and FY2004 Regular FMAP Rates and JGTRRA FMAP Rates

	FY2003		FY2004	
State	First Two Quarters—Regular FMAP Rate	Last Two Quarters—JGTRRA FMAP Rate	First Three Quarters—JGTRRA FMAP Rate	Last Quarter—Regular FMAP Rate
Alabama	70.60	73.55	73.70	70.75
Alaska[a]	58.27	61.22	61.34	58.39
American Samoa[b]	50.00	52.95	52.95	50.00
Arizona	67.25	70.20	70.21	67.26
Arkansas	74.28	77.23	77.62	74.67
California	50.00	54.35	52.95	50.00
Colorado	50.00	52.95	52.95	50.00
Connecticut	50.00	52.95	52.95	50.00
Delaware	50.00	52.95	52.95	50.00
District of Columbia[c]	70.00	72.95	72.95	70.00
Florida	58.83	61.78	61.88	58.93
Georgia	59.60	62.55	62.55	59.58
Guam[b]	50.00	52.95	52.95	50.00
Hawaii	58.77	61.72	61.85	58.90
Idaho	70.96	73.97	73.91	70.46
Illinois	50.00	52.95	52.95	50.00
Indiana	61.97	64.99	65.27	62.32
Iowa	63.50	66.45	66.88	63.93
Kansas	60.15	63.15	63.77	60.82
Kentucky	69.89	72.89	73.04	70.09
Louisiana	71.28	74.23	74.58	71.63
Maine	66.22	69.53	69.17	66.01
Maryland	50.00	52.95	52.95	50.00
Massachusetts	50.00	52.95	52.95	50.00
Michigan	55.42	59.31	58.84	55.89
Minnesota	50.00	52.95	52.95	50.00

State	FY2003		FY2004	
	First Two Quarters—Regular FMAP Rate	Last Two Quarters—JGTRRA FMAP Rate	First Three Quarters—JGTRRA FMAP Rate	Last Quarter—Regular FMAP Rate
Mississippi	76.62	79.57	80.03	77.08
Missouri	61.23	64.18	64.42	61.47
Montana	72.96	75.91	75.91	72.85
Nebraska	59.52	62.50	62.84	59.89
Nevada	52.39	55.34	57.88	54.93
New Hampshire	50.00	52.95	52.95	50.00
New Jersey	50.00	52.95	52.95	50.00
New Mexico	74.56	77.51	77.80	74.85
New York	50.00	52.95	52.95	50.00
North Carolina	62.56	65.51	65.80	62.85
North Dakota	68.36	72.82	71.31	68.31
Commonwealth of the Northern Mariana Islands[b]	50.00	52.95	52.95	50.00
Ohio	58.83	61.78	62.18	59.23
Oklahoma	70.56	73.51	73.51	70.24
Oregon	60.16	63.11	63.76	60.81
Pennsylvania	54.69	57.64	57.71	54.76
Puerto Rico[b]	50.00	52.95	52.95	50.00
Rhode Island	55.40	58.35	58.98	56.03
South Carolina	69.81	72.76	72.81	69.86
South Dakota	65.29	68.88	68.62	65.67
Tennessee	64.59	67.54	67.54	64.40
Texas	59.99	63.12	63.17	60.22
Utah	71.24	74.19	74.67	71.72
Vermont	62.41	66.01	65.36	61.34
U.S. Virgin Islands[b]	50.00	52.95	52.95	50.00
Virginia	50.53	54.40	53.48	50.00
Washington	50.00	53.32	52.95	50.00
West Virginia	75.04	78.22	78.14	75.19
Wisconsin	58.43	61.52	61.38	58.41
Wyoming	61.32	64.92	64.27	59.77

Sources: Department of Health and Human Services (HHS), "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy, Aged, Blind, or Disabled Persons for October 1, 2002 Through September 30, 2003," 66 *Federal Register* 59790, November 30, 2001; HHS, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2003 Through September 30, 2004," 67 *Federal Register* 69223, November 15, 2002; HHS, "Federal Financial Participation in State Assistance Expenditures; Temporary Increase of Federal Matching Shares for Medicaid for the Last 2 Calendar Quarters of Fiscal Year 2003 and the First 3 Quarters of Fiscal Year 2004," 68 *Federal Register* 35889, June 17, 2003.

Notes: FMAP = federal medical assistance percentage; JGTRRA = Jobs and Growth Tax Relief Reconciliation Act of 2003 (JGTRRA; P.L. 108-27).

a. An alternative formula was used to determine Alaska's regular FMAP rate for FY2001-FY2005, which reduced the state's per capita income by 5% (thereby increasing its FMAP rate).

b. The regular FMAP rate for the territories (American Samoa, Guam, Commonwealth of the Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands) was set at 50%. In addition to the JGTRRA FMAP increase, JGTRRA increased the federal Medicaid funding available for each of the territories by 5.9%.

c. The District of Columbia's regular FMAP rate has been set at 70% since FY1998 (without this exception, it would be at the statutory minimum of 50%).

Appendix B. American Recovery and Reinvestment Act of 2009 FMAP Increase

The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) provided a temporary FMAP rate increase to the 50 states and the District of Columbia that was later extended by P.L. 111-226. With the extension, the ARRA FMAP increase lasted from the first quarter of FY2009 through the third quarter of FY2011 (i.e., October 2008 through June 2011).[74]

ARRA held all states harmless from any decline in their regular FMAP rates throughout the period. Under the ARRA FMAP increases, all states (i.e., the 50 states and the District of Columbia) received an across-the-board increase of 6.2 percentage points to their regular FMAP through the first quarter of FY2011, at which point the across-the-board percentage point increase phased down to 3.2 and then 1.2 percentage points for the second and third quarters of FY2011, respectively.

Throughout the period, states with unemployment rates that had increased by certain amounts for a quarter received an additional unemployment-related increase. There were three tiers of the unemployment-related increase. See "ARRA Unemployment-Related Increase" for details about the unemployment-related increase, including how it was calculated.

The ARRA FMAP increases were subject to certain requirements for states. For more information about the ARRA FMAP increases and these requirements, see "ARRA FMAP Increase."

Table B-1 shows the FMAP rate increases under ARRA and extended by P.L. 111-226 for each quarter, from the first quarter of FY2009 through the third quarter of FY2011. **Table B-2** provides an example of how the FMAPs under ARRA with the hold-harmless and the unemployment-related increases were calculated for the second quarter of FY2010.

[74] The American Recovery and Reinvestment Act of 2009 (ARRA; P.L. 111-5) FMAP increase was not available to the territories, but each territory was allowed to make a one-time choice between an FMAP rate increase of 6.2 percentage points along with a 15% increase in its annual capped funding, or its regular FMAP rate along with a 30% increase in its capped funding. All territories chose the latter.

Table B-1. FMAP Rate Increase Under ARRA and Extended by P.L. 111-226

FY2009 1st Quarter to FY2011 3rd Quarter

State	FY2009 1st quarter	FY2009 2nd quarter	FY2009 3rd quarter	FY2009 4th quarter	FY2010 1st quarter	FY2010 2nd quarter	FY2010 3rd quarter	FY2010 4th quarter	FY2011 1st quarter	FY2011 2nd quarter	FY2011 3rd quarter
Alabama	76.64	76.64	77.51	77.51	77.53	77.53	77.53	77.53	78.00	75.17	73.29
Alaska	58.68	58.68	61.12	61.12	61.12	62.46	62.46	62.46	62.46	59.58	57.67
Arizona	75.01	75.01	75.93	75.93	75.93	75.93	75.93	75.93	75.93	73.10	71.22
Arkansas	79.14	79.14	80.46	80.46	80.46	81.18	81.18	81.18	81.18	78.30	76.39
California	61.59	61.59	61.59	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88
Colorado	58.78	58.78	61.59	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88
Connecticut	60.19	60.19	60.19	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88
Delaware	60.19	60.19	61.59	61.59	61.78	61.78	61.78	61.78	64.38	61.55	59.67
District of Columbia[a]	77.68	77.68	79.29	79.29	79.29	79.29	79.29	79.29	79.29	76.47	74.58
Florida	67.64	67.64	67.64	67.64	67.64	67.64	67.64	67.64	67.64	64.81	62.93
Georgia	73.44	73.44	74.42	74.42	74.96	74.96	74.96	74.96	75.16	72.33	70.45
Hawaii	66.13	66.13	67.35	67.35	67.35	67.35	67.35	67.35	67.35	64.52	62.63
Idaho	78.37	78.37	79.18	79.18	79.18	79.18	79.18	79.18	79.18	76.35	74.47
Illinois	60.48	60.48	61.88	61.88	61.88	61.88	61.88	61.88	61.88	59.05	57.16
Indiana	73.23	73.23	74.21	74.21	75.69	75.69	75.69	75.69	76.21	73.39	71.50
Iowa	68.82	68.82	68.82	70.71	72.55	72.55	72.55	72.55	72.55	69.68	67.76
Kansas	66.28	66.28	68.31	69.41	69.68	69.68	69.68	69.68	69.68	66.81	64.90
Kentucky	77.80	77.80	79.41	79.41	80.14	80.14	80.14	80.14	80.61	77.78	75.90
Louisiana	80.01	80.01	80.01	80.75	81.48	81.48	81.48	81.48	81.48	78.65	76.77
Maine	72.40	72.40	74.35	74.35	74.86	74.86	74.86	74.86	74.86	72.03	70.15
Maryland	58.78	58.78	60.19	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88

State	FY2009 1st quarter	FY2009 2nd quarter	FY2009 3rd quarter	FY2009 4th quarter	FY2010 1st quarter	FY2010 2nd quarter	FY2010 3rd quarter	FY2010 4th quarter	FY2011 1st quarter	FY2011 2nd quarter	FY2011 3rd quarter
Massachusetts	58.78	58.78	60.19	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88
Michigan	69.58	69.58	70.68	70.68	73.27	73.27	73.27	73.27	75.57	72.74	70.86
Minnesota	60.19	60.19	61.59	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88
Mississippi	83.62	83.62	84.24	84.24	84.86	84.86	84.86	84.86	84.86	82.03	80.15
Missouri	71.24	71.24	73.27	73.27	74.43	74.43	74.43	74.43	74.43	71.61	69.72
Montana	76.29	76.29	77.14	77.14	77.99	77.99	77.99	77.99	77.99	75.17	73.28
Nebraska	65.74	65.74	67.79	67.79	68.76	68.76	68.76	68.76	68.76	65.84	63.90
Nevada	63.93	63.93	63.93	63.93	63.93	63.93	63.93	63.93	63.93	61.10	59.22
New Hampshire	56.20	56.20	58.78	60.19	61.59	61.59	61.59	61.59	61.59	58.77	56.88
New Jersey	58.78	58.78	61.59	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88
New Mexico	77.24	77.24	78.66	79.44	80.49	80.49	80.49	80.49	80.49	77.66	75.78
New York	58.78	58.78	60.19	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88
North Carolina	73.55	73.55	74.51	74.51	74.98	74.98	74.98	74.98	74.98	72.16	70.27
North Dakota	69.95	69.95	69.95	69.95	69.95	69.95	69.95	69.95	69.95	66.95	64.95
Ohio	70.25	70.25	72.34	72.34	73.47	73.47	73.47	73.47	73.71	70.88	69.00
Oklahoma	74.94	74.94	74.94	75.83	75.83	76.73	76.73	76.73	76.73	73.90	72.01
Oregon	71.58	71.58	72.61	72.61	72.87	72.87	72.87	72.87	72.97	70.14	68.25
Pennsylvania	63.05	63.05	64.32	65.59	65.85	65.85	65.85	65.85	66.58	63.76	61.87
Rhode Island	63.89	63.89	63.89	63.89	63.92	63.92	63.92	63.92	64.22	61.39	59.51
South Carolina	78.55	78.55	79.36	79.36	79.58	79.58	79.58	79.58	79.58	76.75	74.86
South Dakota	68.75	68.75	70.64	70.64	70.80	70.80	70.80	70.80	70.80	68.95	67.04
Tennessee	73.25	73.25	74.23	74.23	75.37	75.37	75.37	75.37	75.62	72.79	70.91
Texas	68.76	68.76	68.76	69.85	70.94	70.94	70.94	70.94	70.94	68.11	66.23

State	FY2009 1st quarter	FY2009 2nd quarter	FY2009 3rd quarter	FY2009 4th quarter	FY2010 1st quarter	FY2010 2nd quarter	FY2010 3rd quarter	FY2010 4th quarter	FY2011 1st quarter	FY2011 2nd quarter	FY2011 3rd quarter
Utah	77.83	77.83	79.98	79.98	80.78	80.78	80.78	80.78	80.78	77.95	76.07
Vermont	67.71	67.71	69.96	69.96	69.96	69.96	69.96	69.96	69.96	67.13	65.24
Virginia	58.78	58.78	61.59	61.59	61.59	61.59	61.59	61.59	61.59	58.77	56.88
Washington	60.22	60.22	62.94	62.94	62.94	62.94	62.94	62.94	62.94	60.11	58.23
West Virginia	80.45	80.45	81.70	83.05	83.05	83.05	83.05	83.05	83.05	80.23	78.34
Wisconsin	65.58	65.58	68.77	69.89	70.63	70.63	70.63	70.63	70.63	67.80	65.92
Wyoming	56.20	56.20	56.20	58.78	61.59	61.59	61.59	61.59	61.59	58.77	56.88

Sources: Department of Health and Human Services (HHS), "Notice of Availability of Federal Matching Shares for Medicaid and Foster Care and Adoption Assistance," 74 *Federal Register* 18235, April 21, 2009; HHS, "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 for Adjustments to the Third and Fourth Quarters of Fiscal Year 2009 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," 74 *Federal Register* 64697, December 8, 2009; HHS, "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) for Adjustments to the First Quarter of Fiscal Year 2010 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," 75 *Federal Register* 5325, February 2, 2010; HHS, "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) for Adjustments to the Second Quarter of Fiscal Year 2010 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," 75 *Federal Register* 22807, April 30, 2010; HHS, "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) for Adjustments to the Third Quarter of Fiscal Year 2010 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," 75 *Federal Register* 52530, August 26, 2010; HHS, "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) for Adjustments to the Fourth Quarter of Fiscal Year 2010 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," 75 *Federal Register* 66763, October 29, 2010; HHS, "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) for Adjustments to the Fourth Quarter of Fiscal Year 2010 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," 75 FR 66763, October 29, 2010; HHS, "Adjusted Federal Medical Assistance Percentage (FMAP) Rate for the First Quarter of Fiscal Year 2011," 76 *Federal Register* 5811, February 2, 2011; HHS, "Adjusted Federal Medical Assistance Percentage (FMAP) Rates for the Second and Third Quarters of Fiscal Year 2011 (FY11)," 76 FR 32204, June 3, 2011.

Notes: FMAP = federal medical assistance percentage; ARRA = American Recovery and Reinvestment Act of 2009 (P.L. 111-5).

a. The District of Columbia's regular FMAP rate has been set at 70% since FY1998 (without this exception, it would be at the statutory minimum of 50%).

Table B-2. Calculation of Increased FMAPs Under ARRA for the Second Quarter of FY2010

			Calculation of ARRA FMAP 2nd quarter FY2010							
State	Regular FMAP FY2010	ARRA FMAP 1st quarter FY2010	Hold harmless: highest of FY2008-FY2010 regular FMAPs	Hold harmless plus 6.2 percentage points	Three-month average unemploy-ment ending Dec. 2009	Lowest three-month average unemploy-ment since Jan. 2006	Unemploy-ment difference	Unemploy-ment tier	Unemploy-ment adjustment	ARRA FMAP 2nd quarter FY2010
			A	B=A+6.2	C	D	E=C-D	F	G=(100-A-3.1)*F%	H=B+G
Alabama	68.01	77.53	68.01	74.21	10.9	3.3	7.6	11.5	3.32	77.53
Alaska	51.43	61.12	52.48	58.68	8.5	6.0	2.5	8.5	3.78	62.46
Arizona	65.75	75.93	66.20	72.40	9.2	3.6	5.6	11.5	3.53	75.93
Arkansas	72.78	80.46	72.94	79.14	7.6	4.8	2.8	8.5	2.04	81.18
California	50.00	61.59	50.00	56.20	12.3	4.8	7.5	11.5	5.39	61.59
Colorado	50.00	61.59	50.00	56.20	7.4	3.6	3.8	11.5	5.39	61.59
Connecticut	50.00	61.59	50.00	56.20	8.7	4.3	4.4	11.5	5.39	61.59
Delaware	50.21	61.78	50.21	56.41	8.6	3.3	5.3	11.5	5.37	61.78
District of Columbia[a]	70.00	79.29	70.00	76.20	11.6	5.4	6.2	11.5	3.09	79.29
Florida	54.98	67.64	56.83	63.03	11.6	3.3	8.3	11.5	4.61	67.64
Georgia	65.10	74.96	65.10	71.30	10.2	4.3	5.9	11.5	3.66	74.96
Hawaii	54.24	67.35	56.50	62.70	6.9	2.2	4.7	11.5	4.65	67.35
Idaho	69.40	79.18	69.87	76.07	9.0	2.8	6.2	11.5	3.11	79.18
Illinois	50.17	61.88	50.32	56.52	10.9	4.4	6.5	11.5	5.36	61.88
Indiana	65.93	75.69	65.93	72.13	9.8	4.4	5.4	11.5	3.56	75.69
Iowa	63.51	72.55	63.51	69.71	6.5	3.7	2.8	8.5	2.84	72.55

State	Regular FMAP FY2010	ARRA FMAP 1st quarter FY2010	Calculation of ARRA FMAP 2nd quarter FY2010							
			Hold harmless: highest of FY2008-FY2010 regular FMAPs	Hold harmless plus 6.2 percentage points	Three-month average unemploy-ment ending Dec. 2009	Lowest three-month average unemploy-ment since Jan. 2006	Unemploy-ment difference	Unemploy-ment tier	Unemploy-ment adjustment	ARRA FMAP 2nd quarter FY2010
			A	B=A+6.2	C	D	E=C-D	F	G=(100-A-3.1)*F%	H=B+G
Kansas	60.38	69.68	60.38	66.58	6.7	4.0	2.7	8.5	3.10	69.68
Kentucky	70.96	80.14	70.96	77.16	10.7	5.4	5.3	11.5	2.98	80.14
Louisiana	67.61	81.48	72.47	78.67	7.3	3.5	3.8	11.5	2.81	81.48
Maine	64.99	74.86	64.99	71.19	8.1	4.4	3.7	11.5	3.67	74.86
Maryland	50.00	61.59	50.00	56.20	7.3	3.4	3.9	11.5	5.39	61.59
Massachusetts	50.00	61.59	50.00	56.20	9.2	4.4	4.8	11.5	5.39	61.59
Michigan	63.19	73.27	63.19	69.39	14.4	6.7	7.7	11.5	3.88	73.27
Minnesota	50.00	61.59	50.00	56.20	7.6	3.9	3.7	11.5	5.39	61.59
Mississippi	75.67	84.86	76.29	82.49	10.4	6.0	4.4	11.5	2.37	84.86
Missouri	64.51	74.43	64.51	70.71	9.6	4.7	4.9	11.5	3.72	74.43
Montana	67.42	77.99	68.53	74.73	6.6	3.2	3.4	8.5	3.26[b]	77.99
Nebraska	60.56	68.76	60.56	66.76	4.6	2.8	1.8	5.5	2.00	68.76
Nevada	50.16	63.93	52.64	58.84	12.9	4.2	8.7	11.5	5.09	63.93
New Hampshire	50.00	61.59	50.00	56.20	6.9	3.4	3.5	11.5	5.39	61.59
New Jersey	50.00	61.59	50.00	56.20	9.9	4.2	5.7	11.5	5.39	61.59
New Mexico	71.35	80.49	71.35	77.55	8.1	3.5	4.6	11.5	2.94	80.49
New York	50.00	61.59	50.00	56.20	8.9	4.3	4.6	11.5	5.39	61.59

State	Regular FMAP FY2010	ARRA FMAP 1st quarter FY2010	Calculation of ARRA FMAP 2nd quarter FY2010							
			Hold harmless: highest of FY2008-FY2010 regular FMAPs	Hold harmless plus 6.2 percentage points	Three-month average unemploy-ment ending Dec. 2009	Lowest three-month average unemploy-ment since Jan. 2006	Unemploy-ment difference	Unemploy-ment tier	Unemploy-ment adjustment	ARRA FMAP 2nd quarter FY2010
			A	B=A+6.2	C	D	E=C-D	F	G=(100-A-3.1)*F%	H=B+G
North Carolina	65.13	74.98	65.13	71.33	10.9	4.5	6.4	11.5	3.65	74.98
North Dakota	63.01	69.95	63.75	69.95	4.3	3.0	1.3	0.0	0.00[c]	69.95
Ohio	63.42	73.47	63.42	69.62	10.8	5.3	5.5	11.5	3.85	73.47
Oklahoma	64.43	75.83	67.10	73.30	6.9	3.3	3.6	11.5	3.43	76.73
Oregon	62.74	72.87	62.74	68.94	10.7	5.0	5.7	11.5	3.93	72.87
Pennsylvania	54.81	65.85	54.81	61.01	8.7	4.3	4.4	11.5	4.84	65.85
Rhode Island	52.63	63.92	52.63	58.83	12.5	4.8	7.7	11.5	5.09	63.92
South Carolina	70.32	79.58	70.32	76.52	12.3	5.5	6.8	11.5	3.06	79.58
South Dakota	62.72	70.80	62.72	68.92	4.7	2.7	2.0	5.5	1.88	70.80
Tennessee	65.57	75.37	65.57	71.77	10.7	4.5	6.2	11.5	3.60	75.37
Texas	58.73	70.94	60.56	66.76	8.2	4.4	3.8	11.5	4.18	70.94
Utah	71.68	80.78	71.68	77.88	6.6	2.5	4.1	11.5	2.90	80.78
Vermont	58.73	69.96	59.45	65.65	6.7	3.5	3.2	8.5	4.31[b]	69.96
Virginia	50.00	61.59	50.00	56.20	6.8	2.8	4.0	11.5	5.39	61.59
Washington	50.12	62.94	51.52	57.72	9.2	4.4	4.8	11.5	5.22	62.94
West Virginia	74.04	83.05	74.25	80.45	8.9	4.2	4.7	11.5	2.60	83.05
Wisconsin	60.21	70.63	60.21	66.41	8.6	4.4	4.2	11.5	4.22	70.63

State	Regular FMAP FY2010	ARRA FMAP 1st quarter FY2010	Calculation of ARRA FMAP 2nd quarter FY2010							
			Hold harmless: highest of FY2008-FY2010 regular FMAPs	Hold harmless plus 6.2 percentage points	Three-month average unemploy-ment ending Dec. 2009	Lowest three-month average unemploy-ment since Jan. 2006	Unemploy-ment difference	Unemploy-ment tier	Unemploy-ment adjustment	ARRA FMAP 2nd quarter FY2010
			A	B=A+6.2	C	D	E=C-D	F	G=(100-A-3.1)*F%	H=B+G
Wyoming	50.00	61.59	50.00	56.20	7.5	2.8	4.7	11.5	5.39	61.59

Sources: Department of Health and Human Services (HHS), "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) for Adjustments to the First Quarter of Fiscal Year 2010 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," 75 *Federal Register* 5325, February 2, 2010; HHS, "Implementation of Section 5001 of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) for Adjustments to the Second Quarter of Fiscal Year 2010 Federal Medical Assistance Percentage Rates for Federal Matching Shares for Medicaid and Title IV-E Foster Care, Adoption Assistance and Guardianship Assistance Programs," 75 *Federal Register* 22807, April 30, 2010.

Notes: FMAP = federal medical assistance percentage; ARRA = American Recovery and Reinvestment Act of 2009 (P.L. 111-5).

a. The District of Columbia's regular FMAP rate has been set at 70% since FY1998 (without this exception, it would be at the statutory minimum of 50%).

b. Unemployment adjustments were held harmless (through the first quarter of FY2011) from reductions. Although Montana and Vermont were in the middle unemployment tier for the second quarter of FY2010, they were previously in the highest tier. As a result, their unemployment adjustments for the second quarter of FY2010 were calculated as if they were still in the highest tier.

c. North Dakota did not receive an unemployment adjustment because its unemployment rate did not exceed its lowest unemployment rate by at least 1.5 percentage points.

Appendix C. Families First Coronavirus Response Act FMAP Increase

The Families First Coronavirus Response Act (FFCRA; P.L. 116-127) provides an increase to the FMAP rate for the 50 states, the District of Columbia, and the territories of 6.2 percentage points, beginning on the first day of calendar quarter in which the public health emergency period began (i.e., January 1, 2020) and ending on the last day of the calendar quarter in which the last day of the public health emergency period ends. See the "FFCRA FMAP Increase" section for information about the state requirements for receiving the FFCRA FMAP increase. **Table C-1** shows states' FY2020 FMAP rates and those FMAP rates plus the 6.2 percentage points added by FFCRA.

Table C-1. FY2020 Regular FMAP Rates and Regular Rates Plus 6.2 Percentage Points for the FFCRA FMAP Increase

State	First Quarter, Regular FY2020 FMAP Rates	Last Three Quarters, Regular FMAP Rates Plus 6.2 Percentage Points
Alabama	71.97	78.17
Alaska	50.00	56.20
American Samoa[a]	83.00	89.20
Arizona	70.02	76.22
Arkansas	71.42	77.62
California	50.00	56.20
Colorado	50.00	56.20
Connecticut	50.00	56.20
Delaware	57.86	64.06
District of Columbia[b]	70.00	76.20
Florida	61.47	67.67
Georgia	67.30	73.50
Guam[a]	83.00	89.20
Hawaii	53.47	59.67
Idaho	70.34	76.54
Illinois	50.14	56.34
Indiana	65.84	72.04
Iowa	61.20	67.40
Kansas	59.16	65.36
Kentucky	71.82	78.02
Louisiana	66.86	73.06
Maine	63.80	70.00
Maryland	50.00	56.20

State	First Quarter, Regular FY2020 FMAP Rates	Last Three Quarters, Regular FMAP Rates Plus 6.2 Percentage Points
Massachusetts	50.00	56.20
Michigan	64.06	70.26
Minnesota	50.00	56.20
Mississippi	76.98	83.18
Missouri	65.65	71.85
Montana	64.78	70.98
Nebraska	54.72	60.92
Nevada	63.93	70.13
New Hampshire	50.00	56.20
New Jersey	50.00	56.20
New Mexico	72.71	78.91
New York	50.00	56.20
North Carolina	67.03	73.23
North Dakota	50.05	56.25
Commonwealth of the Northern Mariana Islands[a]	83.00	89.20
Ohio	63.02	69.22
Oklahoma	66.02	72.22
Oregon	61.23	67.43
Pennsylvania	52.25	58.45
Puerto Rico[a]	76.00	88.20
Rhode Island	52.95	59.15
South Carolina	70.70	76.90
South Dakota	57.62	63.82
Tennessee	65.21	71.41
Texas	60.89	67.09
Utah	68.19	74.39
Vermont	53.86	60.06
U.S. Virgin Islands[a]	83.00	89.20
Virginia	50.00	56.20
Washington	50.00	56.20
West Virginia	74.94	81.14
Wisconsin	59.36	65.56
Wyoming	50.00	56.20

Sources: The regular FY2020 FMAP rates are from 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, 2019 Through September 30, 2020," 83 *Federal Register* 61157, November 28, 2018. Congressional Research Service added the 6.2 percentage points for the last column.

Notes: FMAP = federal medical assistance percentage; FFCRA = Families First Coronavirus Response Act (P.L. 116-127).

a. The regular FMAP rates for the territories are statutorily set at 55%. However, for the remainder of FY2020 and FY2021, the FMAP rates for the territories are increased to 83% for American Samoa, Commonwealth of the Northern Mariana Islands, Guam, and U.S. Virgin Islands and to 76% for Puerto Rico. The FFCRA FMAP increase is added to the FMAPs for FY2020 and FY2021 (i.e., 83% and 76%). Centers 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, https://www.medicaid.gov/state-resource-center/downloads/covid-19-section-6008-CARES-faqs.pdf.

b. The District of Columbia's regular FMAP rate has been set at 70% since FY1998 (without this exception, it would be at the statutory minimum of 50%).

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