Medicaid: The Federal Medical Assistance Percentage (FMAP)

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Summary

Medicaid is a health insurance program jointly funded by the federal government and the states. Historically, eligibility for Medicaid was generally limited to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities; however, recent changes will soon require coverage for childless adults as well. The federal government's share of a state's expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP). The remainder is referred to as the nonfederal share, or state share.

Generally determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). For FY2011, regular FMAPs—that is, excluding the impact of the temporary FMAP increase included in the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5)—range from 50.00% to 74.73%.

The temporary FMAP increase in ARRA is available for nine quarters, subject to certain requirements. The Administration has estimated that the provision will increase federal Medicaid payments to states by more than $90 billion. The ARRA FMAPs end December 31, 2010, but many states assumed that a six-month extension would be provided when they planned their SFY2011 budgets (most of which began on July 1).

Although H.R. 4213 had been the recent vehicle for a six-month extension of ARRA FMAPs, the House and Senate ultimately agreed to a version of the bill that excluded it. In June, two cloture motions that would have cleared the way for another Senate floor vote on a straight extension (S.Amdt. 4369 to H.R. 4213) and a scaled-back extension (S.Amdt. 4386 to H.R. 4213) failed. The scaled-back version would still provide a six-month extension, but it would reduce the across-the-board FMAP increase provided under ARRA from 6.2 percentage points to 3.2 in the second quarter of FY2011 and 1.2 in the third quarter. This scaled-back version is currently slated for another cloture vote as part of S.Amdt. 4567 to H.R. 1586.

The recently enacted Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended by P.L. 111-152) also contains a number of provisions that affect FMAPs. Most notably, it provides FMAPs of up to 100% for certain newly eligible individuals. It also provides—subject to various requirements—increased FMAPs for certain disaster-affected states, primary care payment rate increases, specified preventive services and immunizations, smoking cessation services for pregnant women, specified home and community-based services, and health home services for certain people with chronic conditions.

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Introduction

Medicaid is a health insurance program jointly funded by the federal government and the states. Although states have considerable flexibility to design and administer their Medicaid programs, certain groups of individuals must be covered for certain categories of services. Historically, eligibility was generally limited to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities; however, recent changes will soon require coverage for childless adults as well. The federal government pays a share of each state's Medicaid costs; states must contribute the remaining portion in order to qualify for federal funds.[1]

The Federal Medical Assistance Percentage

The federal government's share of most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which varies by state and is determined by a formula set in statute.[2] Certain Medicaid services receive a higher federal match. For Medicaid administrative costs, the federal share does not vary by state and is generally 50%.[3]

An enhanced FMAP (E-FMAP) 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. When a state expands its Medicaid program using CHIP funds (rather than Medicaid funds), the enhanced FMAP applies and is paid out of the state's federal allotment. The E-FMAP is calculated by reducing the state share under the regular FMAP by 30%.[4]

How FMAPs Are Calculated

The FMAP formula compares each state's per capita income relative to U.S. per capita income, and 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 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 of 55% (i.e., state share of 45%). In addition, the formula's squaring of income provides higher FMAPs to states with below-average incomes than they would otherwise receive (and vice versa, subject to the 50% minimum).[5]

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[1] For a broader overview of financing issues, see CRS Report RS22849, *Medicaid Financing*.

[2] The FMAP is also used in determining the federal share of certain child support enforcement collections, Temporary Assistance for Needy Families (TANF) contingency funds, a portion of the Child Care and Development Fund (CCDF), and foster care and adoption assistance under Title IV-E of the Social Security Act.

[3] See CRS Report RS22101, *State Medicaid Program Administration: A Brief Overview.*

[4] See CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview.*

[5] 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 of 50.39%; if the formula did not include a squaring of per capita income, it would instead produce a higher FMAP of 52.75%. In state B with a *below-average* per capita income of $38,000, the FMAP formula produces an FMAP of 59.39%; if the formula did not include a squaring of per capita (continued...)

The Department of Health and Human Services (HHS) usually publishes FMAPs for an upcoming fiscal year in the *Federal Register* during the preceding November. For example, regular FMAPs for FY2011 (the federal fiscal year that began on October 1, 2010) were calculated and published November 27, 2009.[6] This time lag between announcement and implementation provides an opportunity for states to adjust to FMAP changes, but it also means that the per capita income amounts used to calculate FMAPs for a given fiscal year are several years old by the time the FMAPs take effect.

At the end of this report, **Table A-1** shows regular FY2003-FY2011 FMAPs that are calculated using the formula described above.

Data Used to Calculate State FMAPs

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 FY2011 FMAP calculations, HHS used state per capita personal income data for 2006, 2007, and 2008 that became available from the Department of Commerce's Bureau of Economic Analysis (BEA) in September 2009. The use of a three-year average helps to moderate fluctuations in a state's FMAP 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.[7] 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 (as defined in BEA's national income and product accounts, or NIPA). These components include

- 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).[8]

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 2006 state per capita personal income data published by BEA in September 2008 (used in the calculation of FY2010 FMAPs) differed from the 2006 state per capita personal income data published in September 2009 (used in the calculation of FY2011 FMAPs).

(...continued)

income, it would instead produce a lower FMAP of 57.25%.

[6] 74 *Federal Register* 62315 (November 27, 2009), available at http://aspe.hhs.gov/health/fmap11.pdf.

[7] 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.

[8] 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).

It should be noted that the NIPA definition of personal income used by BEA is not the same as the definition used for personal income tax purposes. Among other differences, NIPA 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 FMAPs

Several factors affect states' FMAPs. 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 changes.

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

Exceptions

Although FMAPs are generally determined by the formula described above, **Table 1** lists exceptions that have been added over the years.

Table 1. Exceptions to the Regular FMAP for Medicaid

Exception	Description	Citations
Territories and Certain States		
Territories	FMAPs for the territories (Puerto Rico, American Samoa, the Northern Mariana Islands, Guam, and the Virgin Islands) are currently set at 50% and, unlike the 50 states and the District of Columbia, the territories are subject to federal spending caps. As of 7/1/2011, their FMAPs will increase to 55%. The 55% also applies for purposes of computing the enhanced FMAP for CHIP.	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's FMAP 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 enhanced FMAP for CHIP.	P.L. 105-33; SSA § 1905(b)
Alaska	Alaska's FMAP 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 FMAPs); and was held at its FY2005 level for FY2006-FY2007. These provisions also applied for purposes of computing the enhanced FMAP 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, FY2003-FY2004	FMAPs 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 approximately $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, 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).	P.L. 108-27 § 401(a)
State fiscal relief, FY2009-FY2011	FMAPs are increased from the first quarter of FY2009 through the first quarter of FY2011, providing states an estimated $90 billion in additional funds. All states receive a hold harmless to prevent any decline in regular FMAPs and an across-the-board increase of 6.2 percentage points; qualifying states receive 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 along with a 30% increase in its cap; all chose the latter. States must meet certain requirements in order to receive the increase (see text for details).	P.L. 111-5 § 5001
Adjustment for Hurricane Katrina	In computing FMAPs 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. Due to lags in the availability of data used to calculate FMAPs, FY2008 was the first year to which the provision applied. HHS proposed and finalized a methodology that prevented the lowering of any FY2008 FMAPs and increased the FY2008 FMAP 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 FMAPs 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 FMAPs after FY2008. The provision also applied for purposes of computing the enhanced FMAP for CHIP.	P.L. 109-171 § 6053(b); 72 *Federal Register* 3391 (January 25, 2007) and 44146 (August 7, 2007)

Exception	Description	Citations
Adjustment for disaster recovery	As of 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 FMAP declines by a specified amount. To trigger the adjustment, a state's regular FMAP must be at least three percentage points less than last year's regular FMAP plus (if applicable) any hold harmless increase under P.L. 111-5; the adjustment is an FMAP increase equal to 50% of the difference between the two. To continue receiving the adjustment, the state's regular FMAP must be at least three percentage points less than last year's adjusted FMAP; the adjustment is an FMAP increase equal to 25% of the difference between the two. It appears that Louisiana is the only state that will qualify in CY2011. It meets the Stafford Act criteria and its regular FY2011 FMAP (63.61%) is at least three percentage points less than its regular FY2010 FMAP plus hold harmless (72.47%); its adjustment will be 4.43 percentage points, for a total FMAP of 68.04%.	P.L. 111-148, as amended by P.L. 111-152; SSA § 1905(aa)
Adjustment for certain employer contributions	As of FY2006, significantly disproportionate employer pension and insurance fund contributions will be excluded from the calculation of Medicaid FMAPs. 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 FMAPs. HHS recently proposed a methodology for making the adjustments in a notice with comment period.	P.L. 111-3 § 614; 75 *Federal Register* 32182 (June 7, 2010)
Certain Populations		
Newly eligible individuals enrolled in new eligibility group through 133% FPL	Historically, Medicaid eligibility has generally been limited to low-income individuals who fall into specified categories (typically children, parents, pregnant women, disabled, and elderly). As of CY2014, states will be required to cover individuals under a new eligibility group for nonelderly, nonpregnant adults at or below 133% FPL. An increased FMAP will be provided for "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 12/1/2009 or were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. Newly eligible FMAPs will 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	Although Medicaid eligibility has generally been limited to certain categories of individuals, some states provide health coverage for all low-income individuals using Medicaid waivers and/or state-only funds. As a result, they have few or no individuals who will qualify for the "newly eligible" FMAP beginning in CY2014. To address this issue, as of CY2014, an increased FMAP will be provided for individuals in "expansion states" who are enrolled in the new eligibility group for nonelderly, nonpregnant adults at or below 133% FPL. Expansion states are defined as those that, as of 3/23/2010 (P.L. 111-148's enactment date), 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 FMAPs [regular FMAP + (newly eligible FMAP – 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+] will lead the expansion state FMAPs to vary based on a state's regular FMAP until CY2019, at which point they will equal newly eligible FMAPs: 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)
Other expansion state individuals	During CY2014 and CY2015, an FMAP increase of 2.2 percentage points is available for expansion states that (1) the Secretary of HHS determines will not receive any FMAP increase for newly eligible individuals and (2) have 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 increase applies to those who are *not* newly eligible individuals as described in relation to the new eligibility group for nonelderly, nonpregnant adults at or below 133% FPL. It appears that Vermont meets the criteria for this increase.	P.L. 111-148, as amended by P.L. 111-152; SSA § 1905(z)(1)

Exception	Description	Citations
Certain women with breast and 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 enhanced FMAP 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. This provision has been extended numerous times and is currently funded through December 2010.	P.L. 105-33, most recently extended via P.L. 111-5; SSA § 1933(d)
Certain Providers		
Indian Health Service facility	States receive 100% federal reimbursement for services provided through an Indian Health Service facility.	P.L. 94-437; SSA § 1905(b)
Primary care payment rates	During CY2013 and CY2014, states are required to provide Medicaid payments that are at or above 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 will receive 100% federal reimbursement for expenditures attributable to the amount by which Medicare exceeds their Medicaid payment rates in effect on 7/1/2009.	P.L. 111-148, as amended by P.L. 111-152; SSA § 1902(a)(13)(C)
Certain Services		
Family planning	States receive 90% federal reimbursement for family planning services and supplies.	P.L. 92-603; SSA § 1903(a)(5)
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 (USPSTF) and adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) will receive a one percentage point increase in their FMAP for those services. It is unclear whether the increase will apply to preventive services that may already be coverable under the mandatory Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for individuals under age 21.	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 will also receive a one percentage point increase in their FMAP for smoking cessation services that are mandatory for pregnant women.	P.L. 111-148, as amended by P.L. 111-152; SSA § 1905(b)
Health homes	As of CY2011, states have a new option for providing a "health home" and associated services to certain individuals with chronic conditions. They will 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)
Home and community-based attendant services and supports	As of FY2011, states have a new 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 will receive a six percentage point increase in their FMAP for these services.	P.L. 111-148, as amended by P.L. 111-152; SSA § 1915(k)(2)
State balancing incentive payments	During FY2011-FY2015, state balancing incentive payments are available under certain conditions for states in which less than 50% of Medicaid expenditures for long-term services and supports (LTSS) are non-institutional. Qualifying states with less than 25% non-institutional LTSS must plan to achieve a 25% target and can receive a five percentage point increase in their FMAP for non-institutional LTSS; those with less than 50% must plan to achieve a 50% target and can receive a two percentage point increase. Federal spending on these increased FMAPs is 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 the table.

Notes: Unless noted, exceptions do not apply for purposes of computing the enhanced FMAP for CHIP. SSA = Social Security Act; FPL = federal poverty line.

Recent Issues and Legislation

Temporary FMAP Increase in ARRA

In the 111th Congress, a temporary FMAP increase was included in the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5).[9] States are receiving the increase for nine quarters, subject to certain requirements. Although House-passed and Senate-passed versions were broadly similar, one difference was the degree to which funds would be targeted at states experiencing unemployment rate increases. The enacted version reflected a middle ground on this issue.[10] The Administration has estimated that the provision will increase federal payments to states by more than $90 billion.[11]

Details of the ARRA provision are as follows:

- For a "recession adjustment period" that begins with the first quarter of FY2009 and runs through the first quarter of FY2011 (i.e., October 1, 2008, through December 31, 2010), the provision holds all states harmless from any decline in their regular FMAPs, provides all states with an across-the-board increase of 6.2 percentage points, and provides qualifying states with an unemployment-related increase.[12] It allowed each territory to make a one-time choice between an FMAP

[9] In the 110th Congress, a temporary FMAP increase was debated but not adopted at the end of 2008.

[10] According to statements made during a Senate Finance Committee markup on January 27, 2009, it was estimated that the House-passed version would provide about half of its spending via hold harmless and across-the-board increases, and about half via an unemployment-related increase. In contrast, the Senate-passed version was estimated to provide an 80%/20% split. The enacted version reflects a 65%/35% split.

[11] Guidance from the Centers for Medicare and Medicaid Services (CMS) indicated that federal payments would increase by $87 billion, as did cost estimates from the Congressional Budget Office; see Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Director letter #09-005 (ARRA #5), August 19, 2009, http://www.cms.hhs.gov/SMDL/downloads/SMD081909.pdf. Since then, CMS has altered its interpretation of certain ARRA FMAP provisions so that states will receive an additional $4.3 billion; see "Obama Administration Grants Relief to States on Payments to Medicare for Part D Costs," HHS News Release, February 18, 2010, http://www.hhs.gov/news/press/2010pres/02/20100218c.html. In particular, the amount of "clawback" money states are required to pay the federal government for expenditures in Part D (the Medicare prescription drug program) by individuals enrolled in both Medicare and Medicaid ("dual eligibles") is now reduced based on the increased ARRA FMAPs, in spite of prior guidance to the contrary; see Question 10 of "Frequently Asked Questions American Recovery & Reinvestment Tax Act of 2009 (ARRA)," CMS, http://www.cms.hhs.gov/recovery/downloads/arrafmapfactsheet.pdf. The February 18, 2009, news release explained, "States make clawback payments monthly and CMS is currently reprogramming its billing system to calculate the new, reduced payments owed by states. The savings, which are retroactive to October 2008, will be deducted from what they otherwise would have owed going forward."

[12] States are evaluated on a quarterly basis for the unemployment-related FMAP increase, which equals a percentage reduction in the state share. A state is evaluated based on its unemployment rate in the most recent three-month period for which data are available (except for the first two and last two quarters of the temporary FMAP increase, for which the three-month period is specified) compared to its lowest unemployment rate in any three-month period beginning on or after January 1, 2006. The criteria are 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. A state's percentage reduction could increase over time as its unemployment rate increases, but it would not be allowed to decrease until the fourth quarter of FY2010 (for most states, this corresponds with the first quarter of SFY2011). The percentage reduction is applied to the state share after the hold harmless increase and after one-half of the 6.2 percentage point increase (i.e., 3.1 percentage points). For example, after applying the across-the-board increase, a state with a regular FMAP of 50% would have an (continued...)

increase of 6.2 percentage points along with a 15% increase in its spending cap, or its regular FMAP along with a 30% increase in its cap; all chose the latter.

- The full amount of the temporary ARRA FMAP increase applies only to Medicaid, excluding disproportionate share hospital payments and expenditures for individuals who are eligible for Medicaid because of an increase in a state's income eligibility standards above what was in effect on July 1, 2008. A portion of the temporary FMAP increase (hold harmless plus across-the-board) applies to Title IV-E foster care and adoption assistance.
- To receive ARRA FMAPs, states are required to do the following: maintain their Medicaid "eligibility standards, methodologies, and procedures" as in effect on July 1, 2008;[13,14] comply with requirements for prompt payment of health care providers under Medicaid (and report to the HHS Secretary on their compliance);[15] not deposit or credit the additional federal funds paid as a result of the increase to any reserve or rainy day fund; ensure that local governments do not pay a larger percentage of the state's nonfederal Medicaid expenditures than otherwise would have been required on September 30, 2008;[16] and submit a

(...continued)

FMAP of 56.20%. If the state share (after the hold harmless and one-half of the across-the-board increase) were further reduced by 5.5%, the state would receive an additional FMAP increase of 2.58 percentage points (46.9 state share * 0.055 reduction in state share = 2.58). The state's total FMAP increase would be 8.78 points (6.2 + 2.58 = 8.78), providing an FMAP of 58.78%.

[13] States that have restricted their "eligibility standards, procedures, or methodologies" can reinstate them in any quarter to begin receiving the temporary FMAP increase. In addition, those that reinstate them prior to July 1, 2009, can receive the increase for the first three quarters of FY2009. States were required by HHS to attest that they meet the eligibility requirements; see http://www.hhs.gov/recovery/fmapprocess.html. HHS indicated that four states (MS, NC, SC, VA) were ineligible when funding estimates were first released on February 23, 2009, but those states have since been cleared to receive the increase. A more recent study found that the ARRA requirements resulted in 14 states reversing and 5 states abandoning planned restrictions to eligibility; see Kaiser Commission on Medicaid and the Uninsured, *State Fiscal Conditions and Medicaid*, September 2009, at http://www.kff.org/medicaid/upload/7580-05.pdf. For guidance on the maintenance of effort requirements, see Department of Health and Human Services, Centers for Medicare and Medicaid Services, State Medicaid Director letter #09-005 (ARRA #5), August 19, 2009, http://www.cms.hhs.gov/SMDL/downloads/SMD081909.pdf. For the temporary FMAP increase enacted in 2003, the law referred only to "eligibility" and the HHS interpretation did not include procedural changes (e.g., increasing the frequency of eligibility redeterminations was not considered an eligibility restriction); see http://www.cms.hhs.gov/smdl/downloads/smd061303.pdf. The ARRA language is more stringent.

[14] Prior to the enactment of P.L. 111-148 (the Patient Protection and Affordable Care Act, PPACA), as amended by P.L. 111-152, Arizona was slated to "eliminate the KidsCare [CHIP] program effective June 15, 2010"; Letter from Arizona Health Care Cost Containment System (AHCCCS) Assistant Director Monica Coury to Moe Gagnon, CMS, March 18, 2010, http://www.azahcccs.gov/shared/Downloads/News/Cover_Letter_KC_Elim.pdf. Because Arizona's CHIP program is entirely separate from Medicaid, this action would not have been relevant to the ARRA maintenance of effort (MOE). Arizona had also planned to "scale back eligibility" for parents and childless adults in Medicaid; Letter from Maria Coury to Steven Rubio, CMS, March 18, http://www.azahcccs.gov/shared/Downloads/News/WaiverNotice_Final.pdf. However, as discussed later in this report, the state may not be taking these actions because of MOE provisions in the recently enacted Patient Protection and Affordable Care Act.

[15] More specifically, the temporary FMAP increase is not be available for any claim received by the state from a health care practitioner subject to prompt pay requirements for such days during any period in which the state has failed to pay claims in accordance with those requirements.

[16] Some states require local governments to finance part of the nonfederal (i.e., state) share of Medicaid costs. Since a temporary FMAP increase would reduce a state's nonfederal share, a local government whose required contribution is 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 increase. The recently enacted Patient Protection and Affordable Care Act clarified that *voluntary* local contributions would not lead a state to run (continued...)

report to the Secretary regarding how the additional federal funds paid as a result of the temporary FMAP increase were expended.[17]

At the end of this report, **Table A-2** and **Table A-3** show the increased FMAPs for FY2009 and the first two quarters of FY2010 provided under ARRA. ARRA FMAPs for the last two quarters of FY2010 and the first quarter of FY2011 have not yet been published. **Table A-2** also shows the additional federal Medicaid funding provided to states as a result of their increased FY2009 FMAPs. For the second quarter of FY2010, 41 states and the District of Columbia are in the highest tier for the unemployment adjustment. Two additional states had previously been in the highest tier and are benefiting from a hold harmless provision that prevents their unemployment adjustment from declining through the third quarter of FY2010.

FMAP increases reduce the amount of state funding that is required to maintain a given level of Medicaid services. For states that are contemplating 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, increasing cost-sharing or premiums for beneficiaries), increased federal funding could enable them to avoid those cuts. For others, the state savings that result from an FMAP increase could be used for a variety of purposes that are not limited to Medicaid.[18]

In addition to avoiding cuts to Medicaid, CBO has indicated that providing additional federal aid to states that are facing fiscal pressures will probably stimulate the economy. However, the estimated effects vary.[19] Federal aid to states whose budgets are relatively healthy might provide little stimulus if it is used to build up rainy day funds (a prohibited use of the ARRA FMAP increase), rather than increase spending or reduce taxes.[20]

Six-Month Extension of ARRA FMAPs

The President's FY2011 budget called for extending ARRA's temporary FMAP increase by six months, through June 30, 2011.[21] CBO has estimated the federal cost of a straight six-month

(...continued)

afoul of this requirement.

[17] 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 increases (and territories would be denied cap increases) if they are out of compliance; however, they would not be denied the hold harmless FMAP increase. In contrast, for the requirements related to maintenance of eligibility and prompt payment, states would be denied all of the temporary FMAP increases (including hold harmless) if they are out of compliance.

[18] For example, 36 states reported that they used funds from the ARRA FMAP increase to close or reduce their Medicaid budget shortfall; however, 44 states used the funds to close or reduce state general fund shortfalls. See Kaiser Commission on Medicaid and the Uninsured, *State Fiscal Conditions and Medicaid*, September 2009, at http://www.kff.org/medicaid/upload/7580-05.pdf. Additional information on state fiscal conditions is available from a number of sources, including the Center on Budget and Policy Priorities (for example, see *An Update on State Budget Cuts*, May 25, 2010, http://www.cbpp.org/files/3-13-08sfp.pdf.); the National Association of State Budget Officers and the National Governors Association, which jointly publish a variety of publications (http://www.nasbo.org/); and the National Conference of State Legislatures (http://www.ncsl.org/Default.aspx?TabID=756&tabs=951,61,161#951).

[19] Congressional Budget Office, letter to the Honorable Charles E. Grassley, March 2, 2009, http://www.cbo.gov/ftpdocs/100xx/doc10008/03-02-Macro_Effects_of_ARRA.pdf.

[20] Statement of Peter R. Orszag, Director, Congressional Budget Office, before the Committee on Finance, U.S. Senate, *Options for Responding to Short-Term Economic Weakness*, January 22, 2008, at http://cbo.gov/ftpdocs/89xx/doc8932/01-22-TestimonyEconStimulus.pdf.

[21] See Department of Health and Human Services, *Budget in Brief: FY2011*, p. 60, available at http://www.hhs.gov/asrt/(continued...)

extension of the existing ARRA provision at about $24 billion; it has also estimated a scaled-back six-month extension at a cost of about $16 billion. Thirty states assumed that a six-month extension would be provided when they planned their SFY2011 budgets (most of which began on July 1),[22] and as of early July, about half of those did not yet have contingency plans.[23]

Although H.R. 4213 had been the recent vehicle for a six-month extension of ARRA FMAPs, the House and Senate ultimately agreed to a version of the bill that excluded it.[24] On March 10, 2010, the Senate passed a version of H.R. 4213 that included a straight six-month extension of the existing ARRA provision; on May 28, the House passed a version that excluded the extension. In June, two cloture motions that would have cleared the way for another Senate floor vote on a straight extension (S.Amdt. 4369 to H.R. 4213) and a scaled-back extension (S.Amdt. 4386 to H.R. 4213) failed. The scaled-back version would still provide a six-month extension, but it would reduce the across-the-board FMAP increase provided under ARRA from 6.2 percentage points to 3.2 in the second quarter of FY2011 and 1.2 in the third quarter.

In contrast to ARRA, the March 10 Senate-passed H.R. 4213 and the Senate amendments noted above would provide increased FMAPs to a state only if its chief executive officer certifies that the state will request and use such additional federal funds. The Senate amendments would also address a limitation of the increased FMAPs under ARRA. If a state expands Medicaid income eligibility to those who would not have been eligible on July 1, 2008, it cannot receive the ARRA FMAP increase for those individuals. Under the Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3), a number of states were required to move their childless adult populations out of CHIP by December 31, 2009, and could apply to have them enrolled under a Medicaid waiver. However, ARRA FMAPs are not currently available for these childless adults because they had not been eligible for Medicaid on July 1, 2008. The Senate amendments would permit states to receive ARRA FMAPs for nonpregnant childless adults in Medicaid who would have been eligible for CHIP based on standards in effect on December 31, 2009. It appears that Idaho, Michigan, and New Mexico would be affected by this provision.

The scaled-back version previously defeated in a cloture vote (S.Amdt. 4369) is currently slated for another cloture vote as part of S.Amdt. 4567 to H.R. 1586.

FMAP Changes in the New Health Reform Law

The recently enacted Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended by P.L. 111-152) contains a number of provisions that affect FMAPs, some of which are discussed below. For more information, see **Table 1**.

(...continued)

ob/docbudget/2011budgetinbrief.pdf. The Administration did not provide state-level projections of the impact of the extension. Families USA provided projections of the additional federal Medicaid money states would receive from the six-month extension at "States in Need: Congress Should Extend Temporary Increase in Medicaid Funding," February 2010, p. 8, available at http://www.familiesusa.org/assets/pdfs/states-in-need.pdf.

[22] See information available at National Conference of State Legislatures, *Legislative Update: Extention of ARRA Enhanced Medicaid Match* , http://www.ncsl.org/?tabid=19710.

[23] Jane Norman, "States Face an Uphill Battle to Nail Down Medicaid Funds," *CQ HealthBeat*, July 12, 2010.

[24] Prior to the action on H.R. 4213, there were two House floor votes on a six-month extension (H.R. 3962 on November 7, 2009, and H.R. 2847 on December 16, 2009) and no Senate floor votes.

As a condition of receiving *any* Medicaid funds, PPACA requires states to comply with maintenance of effort (MOE) provisions that prevent them from restricting eligibility. Prior to CY2014, states cannot make their Medicaid or child CHIP eligibility standards, methodologies, or procedures more restrictive than they were as of March 23, 2010 (PPACA's enactment date).[25] After that date, states can scale back on eligibility for adults but must continue the MOE for children under age 19 through FY2019.

Newly Eligible FMAPs. Historically, Medicaid eligibility has generally been limited to low-income individuals who fall into specified categories (typically children, parents, pregnant women, disabled, and elderly). As of CY2014, states will be required to cover individuals under a new eligibility group for nonelderly, nonpregnant adults at or below 133% of the federal poverty line (FPL).[26] An increased FMAP will be provided for "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. Newly eligible FMAPs will equal:

- CY2014-CY2016 = 100%;
- CY2017 = 95%;
- CY2018 = 94%;
- CY2019 = 93%;
- CY2020+ = 90%.

Expansion State FMAPs. Although Medicaid eligibility has generally been limited to certain categories of individuals, some states provide health coverage for all low-income individuals using Medicaid waivers and/or state-only funds. As a result, they have few or no individuals who will qualify for the "newly eligible" FMAP. As of CY2014, an increased FMAP will be provided for individuals in "expansion states" who are enrolled in the new eligibility group for nonelderly, nonpregnant adults at or below 133% FPL. Expansion states are defined as those that, as of March 23, 2010 (PPACA's enactment date), offered health benefits coverage meeting certain criteria[27] statewide to parents and nonpregnant childless adults at least through 100% FPL. The formula used to calculate expansion state FMAPs will lead them to vary based on a state's regular FMAP until CY2019, at which point they will equal newly eligible FMAPs:[28]

[25] In CY2011-CY2013, there is an exception to the MOE for nonpregnant, nondisabled adults above 133% FPL if the state has a deficit. As discussed in an earlier footnote, Arizona had planned to restrict Medicaid and CHIP eligibility. However, it concluded that the changes would violate the MOE requirements in PPACA. See letter from Arizona Health Care Cost Containment System (AHCCCS) Director Thomas J. Betlach to Governor Janice K. Brewer, March 25, 2010, http://www.azahcccs.gov/reporting/Downloads/HealthCareReform/GovernorBrewerLetter_03-25-10.pdf.

[26] When determining Medicaid eligibility for this group (and others) beginning in CY2014, states will be required to disregard a dollar amount of income equal to 5% FPL. The disregard will allow individuals at or below 138% FPL to enroll in the new eligibility group by reducing their countable income to 133% FPL or less.

[27] The coverage must include inpatient hospital services and cannot consist only of the following: premium assistance (or Medicaid coverage otherwise dependent on employer coverage or contribution), hospital-only plans, high-deductible health plans, or Health Opportunity Accounts under Section 1938 of the Social Security Act.

[28] Expansion FMAP formula = [regular FMAP + (newly eligible FMAP – 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+].

- CY2014 = at least 75%;
- CY2015 = at least 80%;
- CY2016 = at least 85%;
- CY2017 = at least 86%;
- CY2018 = at least 90%;
- CY2019 = 93%;
- CY2020+ = 90%.

Although HHS will make the official determination, one source suggests that 11 states (Arizona, Delaware, Hawaii, Maine, Massachusetts, Minnesota, New York, Pennsylvania, Vermont, Washington, Wisconsin) and the District of Columbia might meet the definition of an expansion state.[29]

During CY2014 and CY2015, an FMAP increase of 2.2 percentage points is available for expansion states that (1) the Secretary of HHS determines will not receive any FMAP increase for newly eligible individuals and (2) have 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 increase applies to those who are *not* newly eligible individuals as described in relation to the new eligibility group for nonelderly, nonpregnant adults at or below 133% FPL. It appears that Vermont meets the criteria for this increase.

Additional Medicaid Changes. As noted in **Table 1**, PPACA also provides—subject to various requirements—an increased FMAP for certain disaster-affected states, primary care payment rate increases, specified preventive services and immunizations, smoking cessation services for pregnant women, specified home and community-based services, and health home services for certain people with chronic conditions.

CHIP. Prior to PPACA, federal CHIP allotments were provided through FY2013 and states received reimbursement for CHIP expenditures based on the E-FMAP described at the beginning of this report. Under PPACA, the E-FMAP for CHIP expenditures in FY2016-FY2019 will be increased by 23 percentage points, up to 100%.[30] PPACA also provides new federal CHIP allotments for FY2014 and FY2015. However, no federal CHIP allotments are provided during the period in which the 23-point increase in the E-FMAP is slated to be in effect.

Exclusion of Certain Employer Contributions from FMAP Calculations

CHIPRA requires that significantly disproportionate employer pension and insurance fund contributions be excluded from the calculation of Medicaid FMAPs beginning with FY2006. This

[29] However, by December 2009, the source notes that some (e.g., Maine, Pennsylvania, Washington) had closed enrollment in these programs. See Table 2 in Kaiser Commission on Medicaid and the Uninsured, *Where are States Today?*, December 2009, http://www.kff.org/medicaid/upload/7993.pdf.

[30] Currently, E-FMAPs can range from 65% to a maximum of 85%. If the PPACA increase applied in FY2011, nine states (Alabama, Arkansas, Idaho, Kentucky, Mississippi, New Mexico, South Carolina, Utah, West Virginia) and the District of Columbia would have a CHIP matching rate of 100%.

will have the effect of reducing certain states' per capita personal income relative to the national average, which in turn could increase their Medicaid FMAPs. HHS recently proposed a methodology for making the adjustments in a notice with comment period.[31]

[31] 75 *Federal Register* 32182, June 7, 2010.

Appendix. Regular and ARRA FMAPs for Medicaid

Table A-1. Regular FMAPs, FY2003-FY2011

State	FY03 first 2 quarters	FY03 last 2 quarters[a]	FY04 first 3 quarters[a]	FY04 last quarter	FY05	FY06[b]	FY07[b]	FY08[b]	FY09[b]	FY10[b]	FY11[b]
Alabama	70.60	73.55	73.70	70.75	70.83	69.51	68.85	67.62	67.98	68.01	68.54
Alaska[c]	58.27	61.22	61.34	58.39	57.58	57.58	57.58	52.48	50.53	51.43	50.00
Arizona	67.25	70.20	70.21	67.26	67.45	66.98	66.47	66.20	65.77	65.75	65.85
Arkansas	74.28	77.23	77.62	74.67	74.75	73.77	73.37	72.94	72.81	72.78	71.37
California	50.00	54.35	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Colorado	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Connecticut	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Delaware	50.00	52.95	52.95	50.00	50.38	50.09	50.00	50.00	50.00	50.21	53.15
District of Columbia	70.00	72.95	72.95	70.00	70.00	70.00	70.00	70.00	70.00	70.00	70.00
Florida	58.83	61.78	61.88	58.93	58.90	58.89	58.76	56.83	55.40	54.98	55.45
Georgia	59.60	62.55	62.55	59.58	60.44	60.60	61.97	63.10	64.49	65.10	65.33
Hawaii	58.77	61.72	61.85	58.90	58.47	58.81	57.55	56.50	55.11	54.24	51.79
Idaho	70.96	73.97	73.91	70.46	70.62	69.91	70.36	69.87	69.77	69.40	68.85
Illinois	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.32	50.17	50.20
Indiana	61.97	64.99	65.27	62.32	62.78	62.98	62.61	62.69	64.26	65.93	66.52
Iowa	63.50	66.45	66.88	63.93	63.55	63.61	61.98	61.73	62.62	63.51	62.63
Kansas	60.15	63.15	63.77	60.82	61.01	60.41	60.25	59.43	60.08	60.38	59.05
Kentucky	69.89	72.89	73.04	70.09	69.60	69.26	69.58	69.78	70.13	70.96	71.49
Louisiana	71.28	74.23	74.58	71.63	71.04	69.79	69.69	72.47	71.31	67.61	63.61
Maine	66.22	69.53	69.17	66.01	64.89	62.90	63.27	63.31	64.41	64.99	63.80
Maryland	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Massachusetts	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Michigan	55.42	59.31	58.84	55.89	56.71	56.59	56.38	58.10	60.27	63.19	65.79
Minnesota	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Mississippi	76.62	79.57	80.03	77.08	77.08	76.00	75.89	76.29	75.84	75.67	74.73
Missouri	61.23	64.18	64.42	61.47	61.15	61.93	61.60	62.42	63.19	64.51	63.29
Montana	72.96	75.91	75.91	72.85	71.90	70.54	69.11	68.53	68.04	67.42	66.81
Nebraska	59.52	62.50	62.84	59.89	59.64	59.68	57.93	58.02	59.54	60.56	58.44
Nevada	52.39	55.34	57.88	54.93	55.90	54.76	53.93	52.64	50.00	50.16	51.61
New Hampshire	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Jersey	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
New Mexico	74.56	77.51	77.80	74.85	74.30	71.15	71.93	71.04	70.88	71.35	69.78
New York	50.00	52.95	52.95	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
North Carolina	62.56	65.51	65.80	62.85	63.63	63.49	64.52	64.05	64.60	65.13	64.71
North Dakota	68.36	72.82	71.31	68.31	67.49	65.85	64.72	63.75	63.15	63.01	60.35
Ohio	58.83	61.78	62.18	59.23	59.68	59.88	59.66	60.79	62.14	63.42	63.69
Oklahoma	70.56	73.51	73.51	70.24	70.18	67.91	68.14	67.10	65.90	64.43	64.94

State	FY03 first 2 quarters	FY03 last 2 quarters[a]	FY04 first 3 quarters[a]	FY04 last quarter	FY05	FY06[b]	FY07[b]	FY08[b]	FY09[b]	FY10[b]	FY11[b]
Oregon	60.16	63.11	63.76	60.81	61.12	61.57	61.07	60.86	62.45	62.74	62.85
Pennsylvania	54.69	57.64	57.71	54.76	53.84	55.05	54.39	54.08	54.52	54.81	55.64
Rhode Island	55.40	58.35	58.98	56.03	55.38	54.45	52.35	52.51	52.59	52.63	52.97
South Carolina	69.81	72.76	72.81	69.86	69.89	69.32	69.54	69.79	70.07	70.32	70.04
South Dakota	65.29	68.88	68.62	65.67	66.03	65.07	62.92	60.03	62.55	62.72	61.25
Tennessee	64.59	67.54	67.54	64.40	64.81	63.99	63.65	63.71	64.28	65.57	65.85
Texas	59.99	63.12	63.17	60.22	60.87	60.66	60.78	60.56[d]	59.44	58.73	60.56
Utah	71.24	74.19	74.67	71.72	72.14	70.76	70.14	71.63	70.71	71.68	71.13
Vermont	62.41	66.01	65.36	61.34	60.11	58.49	58.93	59.03	59.45	58.73	58.71
Virginia	50.53	54.40	53.48	50.00	50.00	50.00	50.00	50.00	50.00	50.00	50.00
Washington	50.00	53.32	52.95	50.00	50.00	50.00	50.12	51.52	50.94	50.12	50.00
West Virginia	75.04	78.22	78.14	75.19	74.65	72.99	72.82	74.25	73.73	74.04	73.24
Wisconsin	58.43	61.52	61.38	58.41	58.32	57.65	57.47	57.62	59.38	60.21	60.16
Wyoming	61.32	64.92	64.27	59.77	57.90	54.23	52.91	50.00	50.00	50.00	50.00
Number with decrease from previous year	17	—	—	11[e]	19[f]	28	27	20	17	14	22

Source: Department of Health and Human Services (HHS).

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

a. The Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27) temporarily increased Medicaid FMAPs to provide states with approximately $10 billion in additional funds (they also received $10 billion in direct grants).

b. FY2006 and later years do not reflect increases that may result from excluding certain employer contributions from the calculation of Medicaid FMAPs, as required by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). FY2009-FY2011 FMAPs do not reflect temporary increases provided under the American Recovery and Reinvestment Act of 2009 (P.L. 111-5). FY2011 does not reflect increases (e.g., for disaster recovery) that may be available as a result of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended by P.L. 111-152). See text for details.

c. Alaska's Medicaid FMAP used an alternative formula for FY2001-FY2005 (P.L. 106-554) and did not decrease in FY2006-FY2007 because of a provision in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). Prior to DRA, Alaska had reverted to using the same FMAP calculation as other states, providing an FY2006 FMAP of 50.16% and FY2007 FMAP of 51.07%.

d. This FY2008 value of 60.56% was provided by HHS implementation of a DRA provision related to Hurricane Katrina. Using the regular FMAP formula, the state's FY2008 value would have been 60.53%.

e. Compared to regular FMAPs that applied in the first two quarters of FY2003.

f. Compared to regular FMAPs that applied in the last quarter of FY2004.

Table A-2. Increased FMAPs Under ARRA, FY2009

State	Regular FMAP FY09 (excluding ARRA)	ARRA FMAP 1st quarter FY09	ARRA FMAP 2nd quarter FY09	ARRA FMAP 3rd quarter FY09	ARRA FMAP 4th quarter FY09	Additional federal Medicaid funding to states, FY09 (millions)
Alabama	67.98	76.64	76.64	77.51	77.51	$354
Alaska	50.53	58.68	58.68	61.12	61.12	$80
Arizona	65.77	75.01	75.01	75.93	75.93	$760
Arkansas	72.81	79.14	79.14	80.46	80.46	$232
California	50.00	61.59	61.59	61.59	61.59	$3,831
Colorado	50.00	58.78	58.78	61.59	61.59	$309
Connecticut	50.00	60.19	60.19	60.19	61.59	$503
Delaware	50.00	60.19	60.19	61.59	61.59	$130
District of Columbia	70.00	77.68	77.68	79.29	79.29	$127
Florida	55.40	67.64	67.64	67.64	67.64	$1,792
Georgia	64.49	73.44	73.44	74.42	74.42	$669
Hawaii	55.11	66.13	66.13	67.35	67.35	$151
Idaho	69.77	78.37	78.37	79.18	79.18	$114
Illinois	50.32	60.48	60.48	61.88	61.88	$1,214
Indiana	64.26	73.23	73.23	74.21	74.21	$558
Iowa	62.62	68.82	68.82	68.82	70.71	$193
Kansas	60.08	66.28	66.28	68.31	69.41	$175
Kentucky	70.13	77.80	77.80	79.41	79.41	$427
Louisiana	71.31	80.01	80.01	80.01	80.75	$467
Maine	64.41	72.40	72.40	74.35	74.35	$222
Maryland	50.00	58.78	58.78	60.19	61.59	$615
Massachusetts	50.00	58.78	58.78	60.19	61.59	$1,206
Michigan	60.27	69.58	69.58	70.68	70.68	$990
Minnesota	50.00	60.19	60.19	61.59	61.59	$787
Mississippi	75.84	83.62	83.62	84.24	84.24	$292
Missouri	63.19	71.24	71.24	73.27	73.27	$620
Montana	68.04	76.29	76.29	77.14	77.14	$69
Nebraska	59.54	65.74	65.74	67.79	67.79	$111
Nevada	50.00	63.93	63.93	63.93	63.93	$180
New Hampshire	50.00	56.20	56.20	58.78	60.19	$84
New Jersey	50.00	58.78	58.78	61.59	61.59	$853
New Mexico	70.88	77.24	77.24	78.66	79.44	$229
New York	50.00	58.78	58.78	60.19	61.59	$4,318
North Carolina	64.60	73.55	73.55	74.51	74.51	$947
North Dakota	63.15	69.95	69.95	69.95	69.95	$39
Ohio	62.14	70.25	70.25	72.34	72.34	$1,184
Oklahoma	65.90	74.94	74.94	74.94	75.83	$337

State	Regular FMAP FY09 (excluding ARRA)	ARRA FMAP 1st quarter FY09	ARRA FMAP 2nd quarter FY09	ARRA FMAP 3rd quarter FY09	ARRA FMAP 4th quarter FY09	Additional federal Medicaid funding to states, FY09 (millions)
Oregon	62.45	71.58	71.58	72.61	72.61	$339
Pennsylvania	54.52	63.05	63.05	64.32	65.59	$1,537
Rhode Island	52.59	63.89	63.89	63.89	63.89	$195
South Carolina	70.07	78.55	78.55	79.36	79.36	$369
South Dakota	62.55	68.75	68.75	70.64	70.64	$48
Tennessee	64.28	73.25	73.25	74.23	74.23	$623
Texas	59.44	68.76	68.76	68.76	69.85	$1,992
Utah	70.71	77.83	77.83	79.98	79.98	$125
Vermont	59.45	67.71	67.71	69.96	69.96	$106
Virginia	50.00	58.78	58.78	61.59	61.59	$573
Washington	50.94	60.22	60.22	62.94	62.94	$643
West Virginia	73.73	80.45	80.45	81.70	83.05	$172
Wisconsin	59.38	65.58	65.58	68.77	69.89	$614
Wyoming	50.00	56.20	56.20	56.20	58.78	$34
Total						**$32,540**

Source: Department of Health and Human Services (HHS).

Notes: The 2009 funding numbers above do not reflect the impact of the Administration's altered interpretation of an ARRA FMAP provision yielding $4.3 billion more for states over the entire recession adjustment period ("Obama Administration Grants Relief to States on Payments to Medicare for Part D Costs," HHS News Release, February 18, 2010, http://www.hhs.gov/news/press/2010pres/02/20100218c.html). The news release explained, "The savings, which are retroactive to October 2008, will be deducted from what [states] otherwise would have owed going forward [for clawback payments]."

The territories are not shown. Each territory could chose between an FMAP increase of 6.2 percentage points along with a 15% increase in its spending cap, or its regular FMAP along with a 30% increase in its spending cap; all chose the latter. The increased spending caps resulted in nearly $100 million more federal Medicaid funding to the territories in FY2009, mostly to Puerto Rico ($93.8 million).

Table A-3. Increased FMAPs Under ARRA, First and Second Quarters of FY2010

State	Regular FMAP FY10	ARRA FMAP 1st quarter FY10	Calculation of ARRA FMAP 2nd quarter FY10: Hold harmless: highest of FY08-FY10 regular FMAPs	Hold harmless plus 6.2 percentage points	3-month average unemployment ending Dec. 2009	Lowest 3-month average unemployment since Jan. 2006	Unemployment difference	Unemployment tier	Unemployment adjustment	ARRA FMAP 2nd quarter FY10
			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	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
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[a]	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

State	Regular FMAP FY10	ARRA FMAP 1st quarter FY10	Calculation of ARRA FMAP 2nd quarter FY10: Hold harmless: highest of FY08-FY10 regular FMAPs	Hold harmless plus 6.2 percentage points	3-month average unemployment ending Dec. 2009	Lowest 3-month average unemployment since Jan. 2006	Unemployment difference	Unemployment tier	Unemployment adjustment	ARRA FMAP 2nd quarter FY10
			A	B=A+6.2	C	D	E=C-D	F	G=(100-A-3.1)*F%	H=B+G
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
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[b]	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[a]	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
Wyoming	50.00	61.59	50.00	56.20	7.5	2.8	4.7	11.5	5.39	61.59

Source: 75 *Federal Register* 5325 (February 2, 2010) and 22807 (April 30, 2010).

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

b. North Dakota does not receive an unemployment adjustment because its current unemployment rate has not exceeded its lowest unemployment rate by at least 1.5 percentage points. In comparison, 13 states failed to qualify for an unemployment adjustment when ARRA FMAPs were provided for the first two quarters of FY2009.

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