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INSIGHT

Temporary Federal Medical Assistance Percentage (FMAP) Increase for Title IV-E Foster Care and Permanency Payments

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The Families First Coronavirus Response Act (P.L. 116-127) authorizes increased federal funding to states through a 6.2 percentage point increase in the federal medical assistance percentage (FMAP), also known as the Medicaid matching rate. This expanded federal support is available to states that meet specific Medicaid program requirements. It was effective January 1, 2020, the first day of the calendar year quarter in which the Secretary of the U.S. Department of Health and Human Services declared a COVID-19 public health emergency, and is statutorily set to remain in place until the last day of the calendar year quarter in which the public health emergency period ends. (Currently, that date is December 31, 2022.)

The FMAP is used to determine the federal share of costs in Medicaid and other programs, including the Foster Care, Prevention, and Permanency program, authorized in Title IV-E of the Social Security Act (SSA) and commonly called the *IV-E program*. According to the HHS's Administration for Children and Families (ACF), the FMAP increase applies to states, territories, and tribes operating a IV-E program (hereinafter, "states and tribes").

What is the Foster Care, Prevention, and Permanency (Title IV-E) program?

Foster care is a temporary living arrangement for children that a state determines are not able to safely continue to live in their own homes. Most children placed in foster care live in the foster family home of a nonrelative or relative. Typically, the first goal of the state child welfare agency is to provide services to enable a child to safely reunite with his or her parents. If this is determined not possible or appropriate, the agency works to find a new permanent home for the child through adoption or legal guardianship.

What IV-E program costs receive federal support at the FMAP?

States and tribes operating a IV-E program provide payments for foster care maintenance and adoption assistance to eligible children, and the federal government is obligated to reimburse them for a part of the

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cost of those payments. Further, they may opt to use the IV-E program to provide kinship guardianship assistance payments to eligible children.

The FMAP is used to determine the federal share of IV-E foster care maintenance, adoption assistance, and guardianship assistance payments. These payments are provided by states and tribes on an ongoing basis to an eligible child's foster care provider, adoptive parent, or legal guardian. During FY2021, on an average monthly basis, IV-E payments were made on behalf of 715,100 children, including 142,100 children in foster care and 573,000 children in adoptive or guardianship homes.

The federal share of all other IV-E costs is provided at fixed rates that are the same in every state or tribe. These rates are not changed by the FMAP increase and apply to costs of program administration (50%) and training (75%). Additionally, federal support for the optional provision of IV-E prevention services and selected kinship navigator programs is regularly set at 50%. However, the Supporting Foster Youth and Families Through the Pandemic Act (Division X of P.L. 116-260) temporarily set federal support for both at 100% (April 1, 2020-September 30, 2021). Beginning with FY2027, the federal share of IV-E prevention services (not including related administration and training) is set at the FMAP.

What is the FMAP in each jurisdiction?

The FMAP for each of the 50 states is annually computed by HHS using a formula provided in the Medicaid program (§1905(b) of the SSA). The formula provides that states with higher per capita income (relative to the per capita income nationally) receive lower federal reimbursement rates, while states with lower per capita income receive higher federal reimbursement rates. State regular FY2023 FMAPs are shown in the *Federal Register*. P.L. 116-127 temporarily increases each state's FMAP by 6.2 percentage points. For example, if a state's regular FMAP is 50.00%, during the COVID-19 public health emergency it is increased to 56.20%. The highest regular state FMAP for FY2021 is 78.31%, and during the COVID-19 emergency this FMAP has increased to roughly 84.82%.

For the IV-E program, tribal FMAPs are determined by HHS-ACF based on the description given in Title IV-E of the SSA (§479B(d)).

The FMAP for the District of Columbia is fixed in Title IV-E (§474(a)(1) and (2) of the SSA) at 70% in every year. P.L. 116-260 (Division X, §11) amended P.L. 116-127 to ensure that in any quarter when the District of Columbia's Medicaid program is (or was) eligible for the FMAP increase, the 6.2 percentage point increase also applies to the District of Columbia's IV-E program.

The FMAP for territories, including Puerto Rico and the U.S. Virgin Islands, which operate IV-E programs, is fixed in Medicaid law at 55% each year. However, each territory's overall federal IV-E spending is subject to a social services spending cap (§1108(a) of the SSA), so the temporary FMAP enhancement is not expected to increase their federal IV-E support.

How is the money distributed?

States and tribes operating a IV-E program submit quarterly claims to HHS-ACF. These claims represent program spending. If a state submits claims showing that it spent $100,000 for IV-E maintenance or assistance payments while its FMAP is temporarily raised from 50.0% to 56.2%, the federal government is obligated to send the state $56,200 (rather than the $50,000 required under the state's regular FMAP of 50.0%).

How much money has the FMAP increase provided?

For the first seven quarters of the enhanced FMAP (January 1, 2020-September 30, 2021), HHS-ACF estimates $846 million in federal IV-E funding attributable to the 6.2 percentage point bump in the FMAP, or roughly $121 million for each fiscal year quarter.

What requirements must a state meet to receive the FMAP increase?

Under P.L. 116-127, to receive the FMAP increase states must meet the following Medicaid requirements: maintain eligibility policies for the program; continue coverage for enrolled beneficiaries; not increase individual premiums; cover COVID-19 testing, services, and treatment without cost sharing; and not increase local funding requirements.

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