

**Statement of
Anne L. Schwartz, PhD, Executive Director**

**Medicaid and CHIP
Payment and Access Commission**

**Before the
Subcommittee on Health
House Committee on Energy and Commerce**

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Summary

At the request of the leadership of this Subcommittee, the Medicaid and CHIP Payment and Access Commission (MACPAC) is engaged in a long-term work plan focused on advising Congress about potential policies and financing reforms to ensure Medicaid's sustainability. To date, we have documented trends in Medicaid expenditures, analyzed spending drivers, and considered incentives under current law. It is in this context that MACPAC is looking at the Federal Medical Assistance Percentage (FMAP).

State Medicaid programs receive federal funds to match the amount they spend on health services and performing administrative tasks. Higher reimbursement is provided to states with lower per capita incomes relative to the national average and vice versa. This formula is intended to reflect states' differing abilities to fund Medicaid from their own revenues. There is a statutory minimum of 50 percent and a maximum of 83 percent although there are several exceptions affecting certain populations, providers, and services. 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. Current E-FMAPs range from 88 to 100 percent. Matching for Medicaid administrative activities does not vary by state and is generally 50 percent.

Over time, congressional and regulatory action have increased the FMAP for specific activities to implement new administrative requirements, create stronger incentives for states to provide certain benefits, and encourage states to extend eligibility for optional groups. An enhanced match has also been used to provide fiscal relief to states during economic downturns or when affected by disasters. In addition, increasing the federal match has allowed Congress to implement federal policy changes without imposing additional costs on states.

Medicaid's current system of financing has been criticized for providing open-ended amounts of federal funds to states, depending upon what states spend, and thus potentially exposing the federal government to unlimited spending. This structure does not incentivize states to be efficient. Moreover, it generally does not encourage states to be innovative or achieve improvements in quality or access. Another concern is that states have an incentive to broaden Medicaid to include other state health functions in order to draw down federal funds.

On the other hand, while these incentives are strong, they are not absolute. States may not claim federal share unless they spend state dollars, raised from legal sources, on activities that are legally matchable. Mindful of their own budget constraints, as well as other political and economic factors that shape their health care markets and the design of their Medicaid programs, states respond differently at different times and in different circumstances.

In its work on administrative capacity, MACPAC has noted that the differential between the federal match for services and administration discourages states' willingness to invest in measuring utilization and quality, collecting and analyzing data, and ensuring program integrity. In the 37 states where health services are matched at greater than 50 percent, states are rewarded by prioritizing spending on services or other activities that have enhanced matching rates over administration.

MACPAC is now focusing intensively on financing and design questions associated with alternatives such as block grants, per capita caps, and capped allotments, including issues such as baselines, growth factors, and state contributions. We look forward to sharing this work with the Subcommittee as part of our June 2016 report.



Statement of Anne L. Schwartz, PhD, Executive Director Medicaid and CHIP Payment and Access Commission

Good morning Chairman Pitts, Vice Chair Guthrie, Ranking Member Green, and Members of the Subcommittee on Health. I am Anne Schwartz, executive director of MACPAC, the Medicaid and CHIP Payment and Access Commission. As you know, MACPAC is a congressional advisory body charged with analyzing and reviewing Medicaid and CHIP policies and making recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services (HHS) and the states on issues affecting these programs. The insights I will share this morning reflect the consensus views of the Commission itself, anchored in a body of analytic work conducted over the past five years. We appreciate the opportunity to share MACPAC's views with the Subcommittee.

At the request of the leadership of this Subcommittee and your colleagues in the Senate, MACPAC is engaged in a long-term work plan focused on advising Congress about potential policies and financing reforms to ensure the sustainability of Medicaid. Our analysis to date has focused on documenting trends in Medicaid expenditures, looking at the drivers of this spending, and considering the incentives created by the design of financing under current law. It is in this context that the Commission is now discussing the role of the Federal Medical Assistance Percentage (FMAP), the statutory formula that determines the federal share of Medicaid costs, which is fundamental to any discussion of federal and state spending.



Federal Medical Assistance Percentage

State Medicaid programs receive federal funds to match the amount of money they spend on health services to Medicaid beneficiaries (in the form of payments to health care providers and managed care plans) and to perform administrative tasks such as making eligibility determinations, enrolling and monitoring providers, and paying claims. This shared federal-state financing arrangement goes back to the program's very beginnings 50 years ago, which built on the Social Security Amendments of 1950 and the Kerr-Mills Act, passed in 1960, both of which provided federal matching funds to states for medical assistance.

Today, the federal share for most health care services is determined by the Federal Medical Assistance Percentage (FMAP). The FMAP is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average and vice versa. This formula is intended to reflect states' differing abilities to fund Medicaid from their own revenues. Although alternative measures have been suggested, the use of per capita income reflects the information available at the time the funding formula was designed.

The FMAP has a statutory minimum of 50 percent and a maximum of 83 percent (Table 1). For example, in fiscal year (FY) 2015, the federal contribution ranged from just over 73.5 percent in Mississippi to 50 percent in New York and 12 other states. There are statutorily set FMAPs for the District of Columbia and the territories.

Historically, the federal share of Medicaid spending has averaged about 57 percent although that share has begun to increase due to the higher matching rate for individuals newly eligible as a result of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).



There are several exceptions to the regular FMAP affecting certain populations, providers, and services (Tables 2 and 3). For example, the federal government pays 100 percent of state Medicaid costs for certain newly eligible non-disabled adults through 2016; after 2016, the rate begins phasing down over several years to 90 percent in 2020 and thereafter. The newly eligible include adults who would not have been eligible for Medicaid in the state as of December 1, 2009, or who were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. Some states that expanded eligibility to low-income parents and adults without children prior to the ACA can also receive a higher matching rate for childless adults.

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. Because of CHIP, eligibility expansions to children since 1997 use CHIP funds from the state's federal allotment, and the E-FMAP applies. E-FMAPs were initially set by reducing the state share under the regular FMAP by 30 percent. Those rates were increased under the ACA, such that current E-FMAPs range from 88 to 100 percent.

The federal matching rate for Medicaid administrative activities does not vary by state and is generally 50 percent, although certain administrative functions have a higher federal match. These exceptions include activities that require medically trained personnel, the operation of information systems for eligibility and claims processing, certain fraud control activities, and administration of services that themselves have higher medical assistance match rates (Table 4). In many cases, higher administrative match rates are provided only for expenditures that meet certain conditions; for example, external quality review activities conducted by an organization that meets specific requirements can be matched at 75 percent, while the same activities conducted by other types of organizations can only be matched at 50 percent.



If a state contracts with managed care plans under a risk contract, amounts paid to the managed care plan to cover administrative functions are matched as a medical assistance cost at the applicable FMAP, not as an administrative cost (42 CFR 438.812). Administrative costs related to CHIP receive federal match at the state's E-FMAP rate for health care services, and therefore this match, unlike the administrative match under Medicaid, varies by state. However, administrative costs for CHIP are limited to 10 percent of the state's annual federal CHIP spending.

Exceptions

At various points in the program's history, congressional and regulatory action have increased the FMAP for specific activities, for example, to:

- help execute certain program functions, such as implementation of modernized eligibility and enrollment systems;
- create stronger incentives for states to provide certain benefits, such as making available to adults, without cost sharing, the full list of preventive services recommended by the U.S. Preventive Services Task Force; and
- encourage states to extend eligibility for optional groups, such as women diagnosed with breast and cervical cancer and children with incomes just above existing Medicaid eligibility levels via CHIP.

An enhanced match has also been used to provide fiscal relief to states during economic downturns or when affected by disasters. In addition, increasing the federal match has allowed Congress to implement federal policy changes without imposing additional costs on states, for example, as was the case with the required increase in payments for primary care services provided by primary care physicians in 2013 and 2014.



Concerns about the FMAP

Medicaid's current system of financing has been criticized for several reasons. It provides open-ended amounts of federal funds to states, depending upon what states spend, and thus potentially exposes the federal government to unlimited spending. This structure does not incentivize states to be efficient, as the more they spend, the more federal dollars they draw down. Moreover, with a few exceptions, it does not encourage states to pursue innovations nor reward them for achieving improvements in quality or access. Another concern is that states have an incentive to broaden Medicaid to include other state health functions where possible in order to draw down federal funds.

On the other hand, while these incentives are strong, they are not absolute. States may not claim federal share unless they spend state dollars, raised from legal sources, on activities that are legally matchable. Mindful of their own budget constraints, as well as other political and economic factors that shape their health care markets and the design of their Medicaid programs, states respond differently at different times and in different circumstances.

Let me provide a few examples. First, states make informed choices about the design of their programs, and thus do not always take up the opportunity to draw enhanced match. For example, Section 2703 of the ACA provided authority for state Medicaid programs to create health homes, integrating acute and behavioral health care for persons with chronic conditions or serious mental illness. In addition to giving states significant flexibility in the design of these programs, the law also provided an enhanced 90 percent federal match for two years.

Representatives from the states of Missouri and Maine both testified at a public Commission meeting as to the importance of these additional funds in allowing their states to pursue this new model of care. And yet, as of



December 2015, fewer than half of states have done so with only 20 states and the District of Columbia adopting the model.

Second, because states must raise state share, they do not always take advantage of all the federal dollars that are potentially available to them. For example, in the case of CHIP, of the \$21.1 billion in federal funds appropriated for FY 2015 and thus available to states to match spending on services provided to children covered by CHIP, only \$11.3 billion was provided to states in allotments based on their prior year spending.

In addition, the current FMAP has been criticized for being unresponsive to changing economic conditions, and whether it should be based on per capita income or other measures. To these, I would add several other concerns that MACPAC has identified.

In its work on the challenges states face in administering the Medicaid program, the Commission has noted that the differential between the federal match for services and administration exerts downward pressure on states' willingness to invest in activities measuring utilization and quality, collecting and analyzing data, and ensuring program integrity. As noted in the Commission's June 2014 report to Congress, in the 37 states where health services are matched at greater than 50 percent, states can increase the total budget available for Medicaid by prioritizing spending on services over administration.

The federal government does provide enhanced matching funds for some administrative activities, including operation of an approved Medicaid Management Information System and updated eligibility systems. While these activities are important to the effective administration of high-performing Medicaid programs, enhanced match is not available for other activities that states undertake to improve efficiency and promote value.



This differential between the two match rates also creates a disincentive for states to focus on prevention of fraud and abuse. Such functions are matched at 50 percent, while the activities of a state's Medicaid fraud control unit, aimed at detecting fraud and abuse after they have occurred, are matched at 75 percent.

Conclusion

Over the next several months, MACPAC will be focusing intensively on program financing and design questions associated with other financing alternatives such as block grants, per capita caps, capped allotments, and shared savings. These include issues such as baselines, growth factors, and state contributions. We look forward to sharing this work with the Subcommittee as part of the Commission's June report to Congress.

Again, thank you for this opportunity to share the Commission's work with this Subcommittee.



Table 1. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, FYs 2012-2016

Section 1: Overview—Key Statistics



Section 1

EXHIBIT 6. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, FYs 2012–2016

State	FMAPs for Medicaid					E-FMAPs for CHIP				
	FY 2012	FY 2013	FY 2014 ¹	FY 2015 ¹	FY 2016 ²	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016 ²
Alabama	68.62%	68.53%	68.12%	68.99%	69.87%	78.03%	77.97%	77.68%	78.29%	100.00%
Alaska	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Arizona	67.30	65.68	67.23	68.46	68.92	77.11	75.98	77.06	77.92	100.00
Arkansas	70.71	70.17	70.10	70.88	70.00	79.50	79.12	79.07	79.62	100.00
California	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Colorado	50.00	50.00	50.00	51.01	50.72	65.00	65.00	65.00	65.71	88.50
Connecticut	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Delaware	54.17	55.67	55.31	53.63	54.83	67.92	68.97	68.72	67.54	91.38
District of Columbia	70.00	70.00	70.00	70.00	70.00	79.00	79.00	79.00	79.00	100.00
Florida	56.04	58.08	58.79	59.72	60.67	69.23	70.66	71.15	71.80	95.47
Georgia	66.16	65.56	65.93	66.94	67.55	76.31	75.89	76.15	76.86	100.00
Hawaii	50.48	51.86	51.85	52.23	53.98	65.34	66.30	66.30	66.56	90.79
Idaho	70.23	71.00	71.64	71.75	71.24	79.16	79.70	80.15	80.23	100.00
Illinois	50.00	50.00	50.00	50.76	50.89	65.00	65.00	65.00	65.53	88.62
Indiana	66.96	67.16	66.92	66.52	66.60	76.87	77.01	76.84	76.56	99.62
Iowa	60.71	59.59	57.93	55.54	54.91	72.50	71.71	70.55	68.88	91.44
Kansas	56.91	56.51	56.91	56.63	55.96	69.84	69.56	69.84	69.64	92.17
Kentucky	71.18	70.55	69.83	69.94	70.32	79.83	79.39	78.88	78.96	100.00
Louisiana ³	69.78	65.51	62.11	62.05	62.21	72.76	72.87	72.69	73.44	96.55
Maine	63.27	62.57	61.55	61.88	62.67	74.29	73.80	73.09	73.32	96.87
Maryland	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Massachusetts	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Michigan	66.14	66.39	66.32	65.54	65.60	76.30	76.47	76.42	75.88	98.92
Minnesota	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Mississippi	74.18	73.43	73.05	73.58	74.17	81.93	81.40	81.14	81.51	100.00
Missouri	63.45	61.37	62.03	63.45	63.28	74.42	72.96	73.42	74.42	97.30
Montana	66.11	66.00	66.33	65.90	65.24	76.28	76.20	76.43	76.13	98.67
Nebraska	56.64	55.76	54.74	53.27	51.16	69.65	69.03	68.32	67.29	88.81

MACStats

EXHIBIT 6. (continued)



State	FMAPs for Medicaid					E-FMAPs for CHIP				
	FY 2012	FY 2013	FY 2014 ¹	FY 2015 ¹	FY 2016 ²	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016 ²
Nevada	56.20%	59.74%	63.10%	64.36%	64.93%	69.34%	71.82%	74.17%	75.05%	98.45%
New Hampshire	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
New Jersey	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
New Mexico	69.36	69.07	69.20	69.65	70.37	78.55	78.35	78.44	78.76	100.00
New York	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
North Carolina	65.28	65.51	65.78	65.88	66.24	75.70	75.86	76.05	76.12	99.37
North Dakota	55.40	52.27	50.00	50.00	50.00	68.78	66.59	65.00	65.00	88.00
Ohio	64.15	63.58	63.02	62.64	62.47	74.91	74.51	74.11	73.85	96.73
Oklahoma	63.88	64.00	64.02	62.30	60.99	74.72	74.80	74.81	73.61	95.69
Oregon	62.91	62.44	63.14	64.06	64.38	74.04	73.71	74.20	74.84	98.07
Pennsylvania	55.07	54.28	53.52	51.82	52.01	68.55	68.00	67.46	66.27	89.41
Rhode Island	52.12	51.26	50.11	50.00	50.42	66.48	65.88	65.08	65.00	88.29
South Carolina	70.24	70.43	70.57	70.64	71.08	79.17	79.30	79.40	79.45	100.00
South Dakota	59.13	56.19	53.54	51.64	51.61	71.39	69.33	67.48	66.15	89.13
Tennessee	66.36	66.13	65.29	64.99	65.05	76.45	76.29	75.70	75.49	98.54
Texas	58.22	59.30	58.69	58.05	57.13	70.75	71.51	71.08	70.64	92.99
Utah	70.99	69.61	70.34	70.56	70.24	79.69	78.73	79.24	79.39	100.00
Vermont	57.58	56.04	55.11	54.01	53.90	70.31	69.23	68.58	67.81	90.73
Virginia	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
Washington	50.00	50.00	50.00	50.03	50.00	65.00	65.00	65.00	65.02	88.00
West Virginia	72.62	72.04	71.09	71.35	71.42	80.83	80.43	79.76	79.95	100.00
Wisconsin	60.53	59.74	59.06	58.27	58.23	72.37	71.82	71.34	70.79	93.76
Wyoming	50.00	50.00	50.00	50.00	50.00	65.00	65.00	65.00	65.00	88.00
American Samoa	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Guam	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
N. Mariana Islands	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Puerto Rico	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50
Virgin Islands	55.00	55.00	55.00	55.00	55.00	68.50	68.50	68.50	68.50	91.50

EXHIBIT 6. (continued)

Notes: FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. ACA is Patient Protection and Affordable Care Act (P.L. 111-148, as amended). The federal government's share of most Medicaid service costs is determined by the FMAP, with some exceptions. For Medicaid administrative costs, the federal share does not vary by state and is generally 50 percent. The E-FMAP determines the federal share of both service and administrative costs for CHIP, subject to the availability of funds from a state's federal allotments for CHIP.

FMAPs for Medicaid are generally calculated based on a formula that compares each state's per capita income relative to U.S. per capita income and provides a higher federal match for states with lower per capita incomes, subject to a statutory minimum (50 percent) and maximum (83 percent). The general formula for a given state is:

$$\text{FMAP} = 1 - \frac{[(\text{state per capita income})^2 / (\text{U.S. per capita income})^2 \times 0.45]}{1}$$

Medicaid exceptions to this formula include the District of Columbia (set in statute at 70 percent) and the territories (set in statute at 55 percent). Other Medicaid exceptions apply to certain services, providers, or situations (e.g., services provided through an Indian Health Service facility receive an FMAP of 100 percent). Enhanced FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent and adding 23 percentage points (see note 2).

¹ For certain newly eligible individuals under the Medicaid expansion beginning in 2014, there is an increased FMAP (100 percent in 2014 through 2016, phasing down to 90 percent in 2020 and subsequent years). An increased FMAP is also available for certain states that previously expanded eligibility to low-income parents and non-pregnant adults without children prior to enactment of the ACA.

² Under the ACA, beginning on October 1, 2015, and ending on September 30, 2019, the enhanced FMAP is increased by 23 percentage points, not to exceed 100 percent, for all states.

³ Louisiana received a disaster-recovery state FMAP adjustment for the fourth quarter of FY 2011 and FYs 2012–2014.

Sources: U.S. Department of Health and Human Services, *Federal Register* notices for various years.

Table 2. Current Exceptions to Standard Federal Match Rates

Statutory exception	Federal match rate	Social Security Act and other citations	Notes
Territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands)	55 percent	1905(b); 1108(f), (g)	Subject to federal spending caps. Also applies for purposes of computing the CHIP E-FMAP.
District of Columbia	70 percent	1905(b)	Without this exception, would be at statutory minimum of 50 percent. Also applies for purposes of computing the CHIP E-FMAP.
Adjustment for disaster recovery	Varies	1905(aa)	As of CY 2011, a disaster recovery FMAP adjustment is available for states that have experienced a federally-declared disaster and where the FMAP has declined by a specified amount.
Adjustment for certain employer contributions	Varies	P.L. 111-3 § 614; <i>Federal Register</i> 75, no. 199 (October 15): 63480	As of FY 2006, significantly disproportionate employer pension and insurance fund contributions are excluded from calculation of Medicaid FMAPs. ¹
Newly eligible individuals enrolled in new eligibility group through 138 percent FPL	CY 2014–CY 2016 = 100 percent CY 2017 = 95 percent CY 2018 = 94 percent CY 2019 = 93 percent CY 2020+ = 90 percent	1905(y)	As of CY 2014, applies to expenditures for the new eligibility group for non-elderly, non-pregnant adults with incomes at or below 133 percent FPL, 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 due to limits or caps on waiver enrollment.
Expansion state individuals enrolled in the new eligibility group through 133 percent FPL	CY 2014 = at least 75 percent CY 2015 = at least 80 percent CY 2016 = at least 85 percent CY 2017 = at least 86 percent CY 2018 = at least 90 percent CY 2019 = 93 percent CY 2020+ = 90 percent	1905(z)(2)	As of CY 2014, applies to expenditures for individuals who are enrolled in the new eligibility group for non-elderly, non-pregnant adults with incomes at or below 133 percent FPL in states that had already expanded eligibility to parents and non-pregnant childless adults at least through 100 percent FPL as of March 23, 2010 (when the ACA was enacted).
Certain women with breast or cervical cancer	Applicable state E-FMAP	1905(b)	Applies to expenditures for an optional group of certain women with breast or cervical cancer who do not qualify for Medicaid under a mandatory eligibility pathway and are otherwise uninsured.



Statutory exception	Federal match rate	Social Security Act and other citations	Notes
Individuals in the Qualifying Individuals program	100 percent	1933(d)	Applies to expenditures for Medicare Part B premiums for Medicare beneficiaries with incomes between 120 percent and 135 percent FPL and limited assets, up to a specified dollar allotment.
Indian Health Service facility services	100 percent	1905(b)	Applies to expenditures for services provided through an Indian Health Service facility.
Family planning services	90 percent	1903(a)(5)	Applies to expenditures for family planning services and supplies.
Certain preventive services and immunizations	FMAP plus 1 percentage point	1905(b)	Applies to expenditures for certain clinical preventive services and certain adult immunizations in states that cover these services, beginning in CY 2013.
Smoking cessation services for pregnant women	FMAP plus 1 percentage point	1905(b)	Applies to expenditures for smoking cessation services that are mandatory for pregnant women in states that cover certain clinical preventive services and certain adult immunizations, beginning in CY 2013.
Health homes	90 percent	1945(c)(1)	Applies to expenditures for optional health home and associated services for certain individuals with chronic conditions; available beginning in CY 2011 for the first eight quarters the health home option is in effect in the state.
Home and community-based attendant services and supports	FMAP plus 6 percentage points	1915(k)(2)	Applies to expenditures for new optional home and community-based attendant services and supports for certain individuals with incomes at or below 150 percent FPL, or a higher income level applicable to those who require an institutional level of care.

Notes: FY is fiscal year. CY is calendar year. FMAP is Federal Medical Assistance Percentage. E-FMAP is Enhanced Federal Medical Assistance Percentage. FPL is federal poverty level. ACA is Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

¹Employer contributions to insurance and pension funds are among the components of state per capita personal income that HHS uses to calculate the FMAP. Other components of state per capita personal income include wages and salaries; dividends, interest, and rent; and government social benefits such as Social Security, Medicare, Medicaid, and state unemployment insurance.



Table 3. Expired Exceptions to Standard Federal Medical Assistance Percentages (FMAPs)

Congress created temporary exceptions for special situations, such as state fiscal relief, that have now expired. For example, the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) provided a temporary increase in each state's FMAP from October 2008 through December 2010, that was later extended at lower levels through June 2011. Expired exceptions are described in the table below.

Expired Statutory Exception	FMAP	Citations	Notes
Alaska	Varies	P.L. 105-33 § 4725(a); P.L. 106-554 Appendix F § 706; P.L. 109-171 § 6053(a)	From FY 1998–FY 2000 Alaska's FMAP was set in statute at 59.80%, alternative formula used to calculate Alaska's FMAP from FY 2001–FY 2005, and was held at the FY 2005 level for FY 2006–FY 2007. Also applied for purposes of computing the CHIP E-FMAP.
State fiscal relief, FY 2003–FY 2004	FMAP plus 2.95 percentage points	P.L. 108-27 § 401(a)	FMAPs for the last two quarters of FY 2003 and the first three quarters of FY 2004 were not allowed to decline and were increased by 2.95 percentage points (did not apply to certain expenditures).
State fiscal relief, FY 2009–FY 2011	FMAP plus 6.2, 3.2, or 1.2 percentage points	P.L. 111-5 § 5001, as amended by P.L. 111-226 § 201	FMAPs were increased from the first quarter of FY 2009 through the third quarter of FY 2011. FMAPs were not allowed to decline and were increased by 6.2 percentage points until the last two quarters of the period, at which point they were increased by 3.2 percentage points and then 1.2 percentage points. Certain qualifying states received an additional unemployment-related increase. Territories received 30% increases in their spending caps in lieu of a percentage point increase in the FMAP and small increase in the spending cap.
Adjustment for Hurricane Katrina	Varies	P.L. 109-171 § 6053(b); 72 <i>Federal Register</i> 3391 (January 25, 2007) and 72 <i>Federal Register</i> 44146 (August 7, 2007)	Has not technically expired but the methodology does not allow for adjusting FMAPs after FY 2008.
Other expansion state individuals	FMAP plus 2.2 percentage points	1905(z)(1)	During CY 2014 and CY 2015 expansion states that meet certain criteria could receive an FMAP increase of 2.2 percentage points for those who are not newly eligible individuals.



Expired Statutory Exception	FMAP	Citations	Notes
Primary care payment rates	100 percent	P.L. 111-148, as amended by P.L. 111-152; SSA § 1902(a)(13)(C)	During CY 2013 and CY 2014 states were required to provide Medicaid payments at or above Medicare rates for primary care services furnished by certain types of primary care providers; 100% FMAP applied to any difference between the Medicaid payment rate in effect on 7/1/2009 and the Medicare payment rates for CY 2013 and CY 2014.
State balancing incentive payments	FMAP plus 5.0 percentage points	P.L. 111-148, as amended by P.L. 111-152, § 10202	During FY 2011–FY 2015 qualifying states could receive a two to five percentage point increase in their FMAP for non-institutional long term services and supports for increasing the proportion of payments made for non-institutional long term services and supports to a specified target level.



Table 4. Federal Match Rates for Medicaid Administrative Activities

Medicaid administrative activity	Federal match rate	Social Security Act citation	Regulation (all citations are to 42 CFR)
General Medicaid administration	50 percent	1903(a)(7)	432.50, 433.15
General Medicaid eligibility determination and redetermination processes	50 percent	1903(a)(7)	435.1001
Determining presumptive eligibility for children and providing services to presumptively eligible children	50 percent	1903(a)(7)	435.1001
Costs incident to an eye examination or medical examination to determine whether an individual is blind or disabled for eligibility purposes	50 percent	1903(a)(7)	435.1001
Activities conducted by skilled professional medical personnel (and their direct support staff), including training	75 percent	1903(a)(2)	432.50(b)(1);432.50(d); 433.15(b)(5)
Preadmission screening and resident review (PASRR) for individuals with mental illness or mental retardation who are admitted to a nursing facility	75 percent	1903(a)(2)(C), 1919(e)(7)	Part 483, subparts C and E; 433.15(b)(9)
Survey and certification of nursing facilities	75 percent	1903(a)(2)(D)	No corresponding regulation
Translation and interpretation services for children in families for whom English is not the primary language	75 percent	1903(a)(2)(E)	No corresponding regulation
Operation of an approved Medicaid management information system (MMIS) for claims and information processing	75 percent	1903(a)(3)(B)	433, subpart C; 432.50(b)(2); 433.15(b)(3), (4); 433.116; 433.117(c)
Medical and utilization review activities performed by an external quality review organization (EQRO) or quality improvement organization (QIO)	75 percent	1903(a)(3)(C)	433.15(b)(6)
Quality review of Medicaid managed care organizations performed by a EQRO	75 percent	1903(a)(3)(C)(ii)	438.358, 438.320
Operation of a state Medicaid fraud control unit (MFCU)	75 percent	1903(a)(6)(B); 1903(b)(3)	1007.19
Implementation of a state MFCU	90 percent	1903(a)(6)(A); 1903(b)(3)	1007.19
Implementation of an MMIS	90 percent	1903(a)(3)(A)(i)	433 subpart C, 432.50 (b)(3)
Administration of family planning services	90 percent	1903(a)(5)	432.50(b)(5); 433.15(b)(2)
Operation of an approved updated system for eligibility determinations	90 percent	1903(a)(3)(A)(i)	433.112(c)
Administration of incentive payment programs for the adoption of electronic health records (EHR)	90 percent	1903(t)	495 subpart D
Implementation and operation of immigration status verification systems	100 percent	1903(a)(4)	No corresponding regulation



Medicaid administrative activity	Federal match rate	Social Security Act citation	Regulation (all citations are to 42 CFR)
Incentive payments to eligible providers for the adoption of EHR	100 percent	1903(a)(3)(F)	495.320-495.322, 495.326-495.362
MMIS modifications necessary for collection and reporting on child health measures	Equivalent to state FMAP rate	1903(a)(3)(A)(iii)	

Notes: SSA is Social Security Act. CFR is Code of Federal Regulations. FMAP is Federal Medical Assistance Percentage (the standard federal Medicaid match rate).

If the SSA or CFR describes an administrative activity for which the match rate is 50 percent, it is not included in the table (even though the match rate may be specifically mentioned in statute or regulation). If the SSA or CFR describes a match rate that is no longer applicable or applies to a service or activity that is no longer applicable, it is not included in the table (e.g., 1903(a)(3)(D), which describes a 75 percent match for costs incurred between 1991 and 1993 to adopt a drug use review program).

