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# Medicaid's Federal Medical Assistance Percentage (FMAP)

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# Summary

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

The FMAP rate also is used to determine the federal share of other federal programs. For instance, the FMAP rate is used to determine the federal share of spending for foster care maintenance, adoption assistance, and guardianship assistance payments authorized by Title IV-E of the Social Security Act. The FMAP rate also is used to determine the federal share of the "mandatory matching funds" provided by the Child Care Entitlement to States. In addition, it determines the federal share of funding under the Temporary Assistance for Needy Families Contingency Funds and the federal share of collections under the Child Support Services program.

Generally determined annually, the FMAP formula is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita incomes relative to the national average (and vice versa for states with higher per capita incomes). FMAP rates have a statutory minimum of 50% and a statutory maximum of 83%. For FY2025, regular FMAP rates range from 50.00% (10 states) to 76.9% (Mississippi).

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

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

The House of Representatives adopted the House FY2025 budget resolution (H.Con.Res. 14) on February 25, 2025. H.Con.Res. 14 includes reconciliation instructions directing the Committee on Energy and Commerce to reduce the deficit by not less than $880 billion for FY2025 through FY2034. Some press reports suggest that much of the $880 billion in reductions could come from reductions to federal Medicaid expenditures. The media are reporting that some of the policy options being considered for reconciliation would amend the FMAP. These policy options include (1) reducing or removing the statutory floor of 50% for the regular FMAP rates, (2) amending the regular FMAP rate for the District of Columbia, (3) removing the exception to the FMAP rate for the ACA Medicaid expansion, and (4) repealing the incentive for states to implement the ACA Medicaid expansion.

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# Introduction

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

This report describes the FMAP calculation used to reimburse states for most Medicaid expenditures, and it lists the statutory exceptions to the regular FMAP rate. In addition, this report provides a summary of the FY2025 budget reconciliation policy options currently under discussion.

# The Federal Medical Assistance Percentage

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

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

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

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

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

[3] More detail about the exceptions to the regular Federal Medical Assistance Percentage (FMAP) rate is provided under the heading "FMAP Exceptions."

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

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

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

to the availability of funds from a state's federal allotment for CHIP. The E-FMAP rate is calculated by reducing the state share under the regular FMAP rate by 30%.[7]

## How FMAP Rates Are Calculated

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

**FMAP Formula[8]**

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

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

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

## Data Used to Calculate State FMAP Rates

The per capita income amounts used to calculate FMAP rates for a given fiscal year are several years old by the time the FMAP rates take effect because, as specified in Section 1905(b) of the Social Security Act, the per capita income amounts used in the FMAP formula are equal to the average of the three most recent calendar years of data available from the Department of Commerce. In its FY2025 FMAP calculations, HHS used state per capita personal income data for 2020, 2021, and 2022 that became available from the Department of Commerce's Bureau of Economic Analysis (BEA) in September 2023. The use of a three-year average helps to moderate fluctuations in a state's FMAP rate over time.

BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate revised and newly available source data on population and income.[10] It also undertakes a comprehensive data revision—reflecting methodological and other changes—every

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

[8] SSA §1905(b).

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

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

few years that may result in upward and downward revisions to each of the component parts of personal income. These components include the following:

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

As a result of these annual and comprehensive revisions, it is often the case that the value of a state's per capita personal income for a given year will change over time. For example, the 2020 state per capita personal income data published by BEA in September 2021 (used in the calculation of FY2023 FMAP rates) differed from the 2020 state per capita personal income data published in September 2023 (used in the calculation of FY2025 FMAP rates).

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

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

## Factors That Affect FMAP Rates

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

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

In addition to annual revisions of per capita personal income data, comprehensive revisions undertaken every four to five years may also influence regular FMAP rates (e.g., because of

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

changes in the definition of personal income). The impact on FMAP rates will depend on whether the changes are broad (affecting all states) or more selective (affecting only certain states or industries).

## FY2025 Regular FMAP Rates

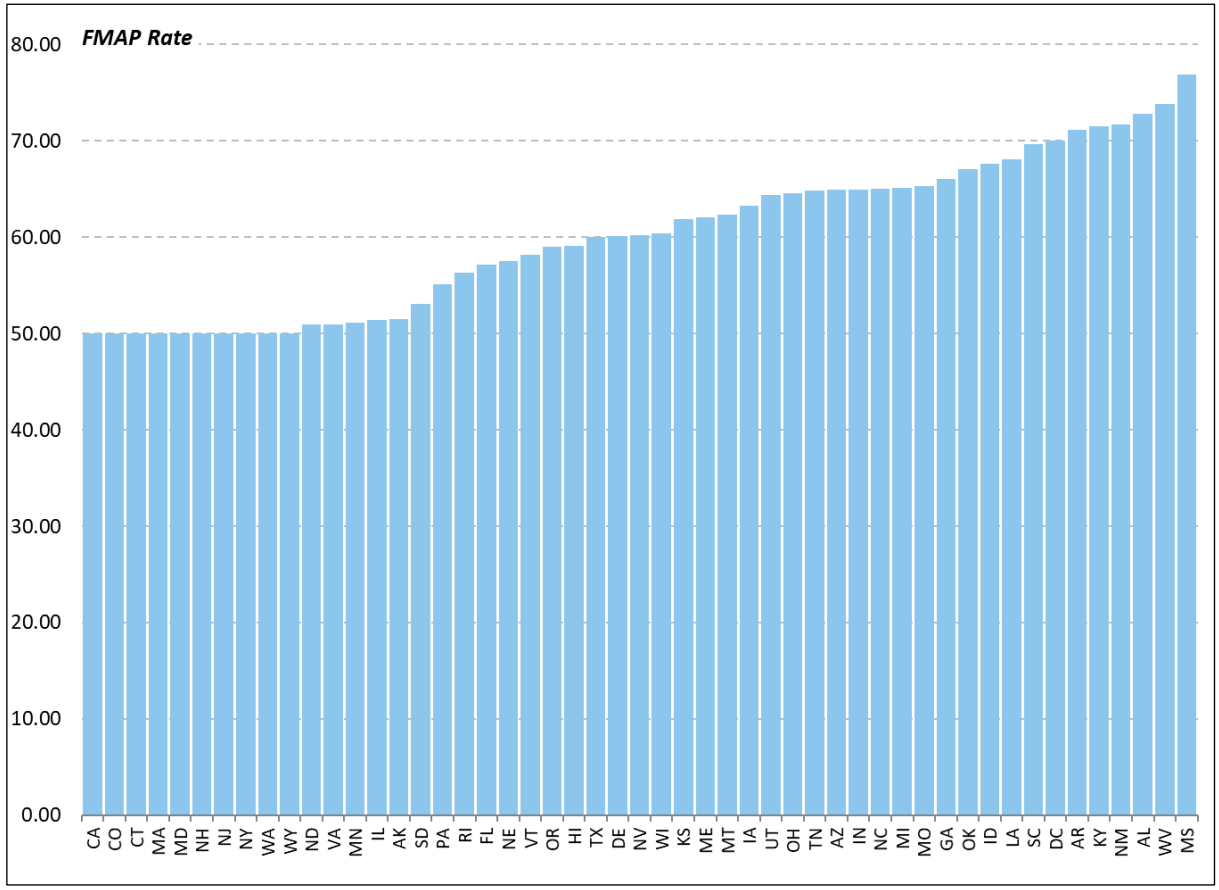
Regular FMAP rates for FY2025 (the federal fiscal year that began on October 1, 2024) were published December 3, 2023, in the *Federal Register*.[12] In the **Appendix A** to this report, **Table A-1** shows regular FMAP rates for each of the 50 states and the District of Columbia for FY2021 through FY2026.

**Figure 1** shows the state distribution of regular FMAP rates for FY2025. Ten states have the statutory minimum FMAP rate of 50.00%, and Mississippi has the highest FMAP rate of 76.9%.

[12] Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2024, Through September 30, 2025," 88 *Federal Register* 81090, November 21, 2023.

**Figure 1. State Distribution of Regular FMAP Rates**

(FY2025)

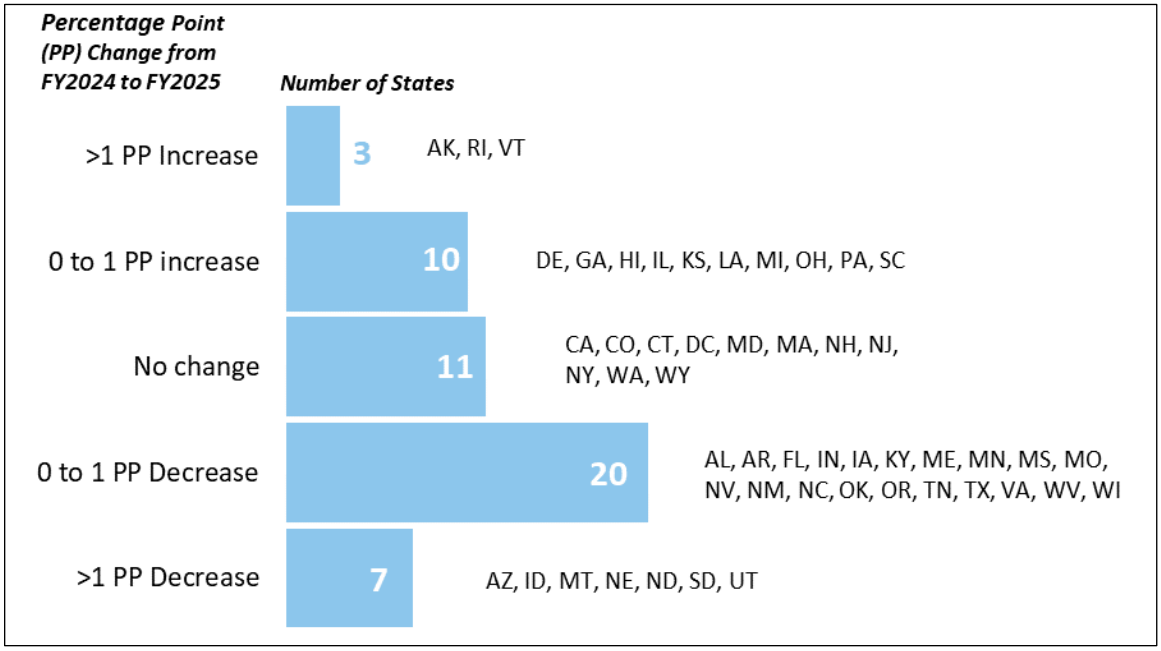



**Sources:** Department of Health and Human Services, "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2024, Through September 30, 2025," 88 *Federal Register* 81090, November 21, 2023.

**Note:** State-by-state FY2025 regular FMAP rates are listed in **Table A-1**. FMAP = Federal medical assistance percentage.

As shown in **Figure 2**, from FY2024 to FY2025, the regular FMAP rates for 40 states changed, whereas the regular FMAP rates for the remaining 11 states (including the District of Columbia) remained the same.[13]

**Figure 2. FMAP Rate Changes for States from FY2024 to FY2025**




**Source:** Prepared by the Congressional Research Service (CRS) using FY2024 and FY2025 regular FMAP rates.

**Note:** Specific FMAP rate changes for each state are listed in **Table A-1**.

For most of the states experiencing an FMAP rate change from FY2024 to FY2025, the change was less than one percentage point. The regular FMAP rate for 10 states increased by as much as one percentage point, and the FMAP rate for 20 states decreased by as much as one percentage point.

For states with an FMAP rate change from FY2024 to FY2025, ten states had an FMAP rate change of greater than one percentage point. Alaska had the largest FMAP rate increase of 1.53 percentage points, and North Dakota had the largest FMAP decrease of 2.85 percentage points.

The District of Columbia's FY2025 FMAP rate was not calculated according to the regular FMAP formula, because the FMAP rate for the District of Columbia has been set in statute at 70% since 1998 for the purposes of Title XIX and XXI of the Social Security Act. However, for other purposes, the FMAP rate for the District of Columbia is 50%, unless otherwise specified by law.

## FMAP Exceptions

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

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

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

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

| Exception | Description | Citations |
|---|---|---|
| **Territories and Certain States** | | |
| Temporary Increase for Implementing Expansion | A five-percentage-point increase to the regular FMAP rate for eight quarters to qualifying states that implement the ACA Medicaid expansion after March 11, 2021. | P.L. 117-2; SSA §1905(ii) |
| Territories Since December 21, 2019 | Since December 21, 2019, the FMAP rate for American Samoa, CNMI, Guam, and the U.S. Virgin Islands has been 83%, and this FMAP rate is permanent. For Puerto Rico, the FMAP rate is 76% for the period beginning December 21, 2019, and ending December 3, 2021, and for the period beginning January 1, 2022, and ending September 30, 2027. (For more information about the FMAP rate for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*). | Most recently P.L. 117-328; SSA §1905(ff) |
| Territories Since July 1, 2011 | As of July 1, 2011, FMAP rates for the territories (Puerto Rico, American Samoa, CNMI, Guam, and the U.S. Virgin Islands) were increased from 50% to 55%. Subsequently, the regular FMAP rates for American Samoa, CNMI, Guam, and the U.S. Virgin Islands were permanently increased to 83%. However, Puerto Rico's FMAP rate is temporarily increased to 76% until September 30, 2027, when, under current law, Puerto Rico's regular FMAP rate is to revert to 55%. (For more information about the FMAP rate for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*.) | Most recently P.L. 111-148, as amended by P.L. 111-152; SSA §1905(b), 1108(f) and (g) |
| District of Columbia | As of FY1998, the District of Columbia's FMAP rate is set at 70% (without this exception, it would be at the statutory minimum of 50%). The 70% also applies for purposes of computing the E-FMAP rate for CHIP. | P.L. 105-33; SSA §1905(b) |

| Exception | Description | Citations |
|---|---|---|
| **Special Situations** | | |
| Adjustment for Disaster Recovery | Beginning in CY2011, a disaster-recovery FMAP adjustment is available for states in which (1) during one of the preceding seven years, the President declared a major disaster under the Stafford Act and every county in the state warranted at least public assistance under that act and (2) the regular FMAP rate declines by a specified amount. To trigger the adjustment, a state's regular FMAP rate must be at least three percentage points less than such state's last year's regular FMAP rate plus (if applicable) any hold harmless increase under P.L. 111-5; the adjustment is an FMAP rate increase equal to 50% of the difference between the two. To continue receiving the adjustment, the state's regular FMAP rate must be at least three percentage points less than last year's adjusted FMAP rate; the adjustment is an FMAP rate increase equal to 25% of the difference between the two. Louisiana is the only state that was eligible for the disaster-recovery adjusted FMAP from the fourth quarter of FY2011 (when the adjustment was first available) through FY2014. No state has met the requirements since FY2014. | P.L. 111-148, as amended by P.L. 111-152, P.L. 112-96 P.L, and P.L. 112-141; SSA §1905(aa); 75 *Federal Register* 80501 (December 22, 2010) |
| Adjustment for Certain Employer Contributions | As of FY2006, significantly disproportionate employer pension and insurance fund contributions will be excluded from the calculation of Medicaid FMAP rates. This will have the effect of reducing certain states' per capita personal income relative to the national average, which in turn could increase their Medicaid FMAP rates. Any identifiable employer contributions toward pensions or other employee insurance funds are considered to be significantly disproportionate if the increase in the amount of employer contributions accrued to residents of a state exceeds 25% of the total increase in personal income in that state for the year involved. To date, no state has qualified for this adjustment. | P.L. 111-3; 75 *Federal Register* 63482 (October 15, 2010) |
| **Certain Populations** | | |
| Children with Medically Complex Conditions | Beginning October 1, 2022, states have the option to provide coordinated care through a health home for children with medically complex conditions. During the first two fiscal year quarters that the option is in effect, the FMAP rate is increased by 15 percentage points for expenditures on the applicable health home services, but in no case may the FMAP rate exceed 90%. | P.L. 116-16; SSA §1945A |
| "Newly Eligible" Individuals Enrolled in New Eligibility Group Through 133% FPL | Since January 1, 2014, states have had the option to expand Medicaid coverage to non-elderly, nonpregnant adults at or below 133% FPL (i.e., the ACA Medicaid expansion). An increased federal matching rate is provided for services rendered to "newly eligible" individuals in this group. The "newly eligible" are defined as those who would not have been eligible for Medicaid in the state as of December 1, 2009 or were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. The federal matching rates for "newly eligible" individuals equal:<br>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) |

| Exception | Description | Citations |
|---|---|---|
| "Expansion State" Individuals Enrolled in New Eligibility Group Through 133% FPL | Prior to the ACA Medicaid expansion, some states provided health coverage for all low-income individuals using Medicaid waivers. As a result, these states have few or no individuals who qualify for the "newly eligible" federal matching rate. To address this issue, as of CY2014, an increased federal matching rate is available for individuals in "expansion states" who were eligible for Medicaid as of March 23, 2010 (P.L. 111-148's enactment date) in the new eligibility group for non-elderly, nonpregnant adults at or below 133% FPL. "Expansion states" are defined as those that, as of March 23, 2010, offered health benefits coverage meeting certain criteria statewide to parents and nonpregnant childless adults at least through 100% FPL. The formula used to calculate "expansion state" federal matching rates is [regular FMAP + (newly eligible federal matching rate – regular FMAP) * transition percentage equal to 50% in CY2014, 60% in CY2015, 70% in CY2016, 80% in CY2017, 90% in CY2018, and 100% in CY2019+]. Since the formula for the "expansion state" federal matching rate is based on the regular FMAP rate, the "expansion state" federal matching rates vary based on a states' regular FMAP rates until CY2019, at which point they are to equal the "newly eligible" federal matching rates:<br>CY2014 = at least 75%; CY2015 = at least 80%; CY2016 = at least 85%; CY2017 = at least 86%; CY2018 = at least 90%; CY2019 = 93%; CY2020+ = 90%. | P.L. 111-148, as amended by P.L. 111-152; SSA §1905(z)(2) |
| Certain Women with Breast or Cervical Cancer | For states that opt to cover certain women with breast or cervical cancer who do not qualify for Medicaid under a mandatory eligibility pathway and are otherwise uninsured, expenditures for these women are reimbursed using the E-FMAP rate that applies to CHIP. | P.L. 106-354, as amended by P.L. 107-121; SSA §1905(b) |
| Qualifying Individuals Program | States are required to pay Medicare Part B premiums for Medicare beneficiaries with income between 120% and 135% FPL and limited assets (referred to as "qualifying individuals"), up to a specified dollar allotment. They receive 100% federal reimbursement for these costs, which are financed at the federal level by a transfer of funds from Medicare to Medicaid. | P.L. 105-33, permanently extended via P.L. 114-10; SSA §1933(d) |
| **Certain Providers** | | |
| Indian Health Service Facility | States receive 100% federal reimbursement for Medicaid services provided through an Indian Health Service facility. | P.L. 94-437; SSA §1905(b) |
| **Certain Services** | | |
| Certified Community Behavioral Health Clinic Services | States receive the E-FMAP rate for services provided to Medicaid enrollees who are not newly eligible under the ACA Medicaid expansion provided in a Certified Community Behavioral Health Clinic. | P.L. 113-93; 42 U.S.C. §1396a note. |

| Exception | Description | Citations |
|---|---|---|
| Certain Preventive Services and Immunizations | As of CY2013, states that opt to cover—with no cost sharing—clinical preventive services recommended with a grade of A or B by the United States Preventive Services Task Force and adult immunizations recommended by the Advisory Committee on Immunization Practices receive a one percentage point increase in their FMAP rate for those services. | P.L. 111-148, as amended by P.L. 111-152; SSA §1905(b) |
| Smoking Cessation for Pregnant Women | As of CY2013, states that opt to cover USPSTF preventive services and ACIP adult immunizations as noted above also receive a one percentage point increase in their FMAP rate for smoking cessation services that are mandatory for pregnant women. | P.L. 111-148, as amended by P.L. 111-152; SSA §1905(b) |
| Money Follows the Person Rebalancing Demonstration | States participating in the Money Follows the Person Demonstration receive an enhanced federal matching rate for home- and community-based services provided to support Medicaid enrollees during their first year in the community, after residing in an institution for 60 consecutive days or more. Specifically, states receive a federal matching rate ranging from 75% to 90%, which is determined by increasing the regular FMAP rate by half the state share (i.e., subtract regular FMAP rate from 100% and divide by two). This federal match is limited to 90%. | P.L. 109-171; 42 U.S.C. §1396a note. |
| Family Planning | States receive 90% federal reimbursement for family planning services and supplies. | P.L. 92-603; SSA §1903(a)(5) |
| Health Homes | As of CY2011, states have an option for providing "health home" and associated services to certain individuals with chronic conditions. They receive 90% federal reimbursement for these services for the first eight quarters that the health home option is in effect in the state. | P.L. 111-148, as amended by P.L. 111-152; SSA §1945(c)(1) |
| Community First Choice Option | As of FY2011, states have an option for providing home and community-based attendant services and supports for certain individuals at or below 150% FPL, or a higher income level applicable to those who require an institutional level of care. They receive a six percentage point increase in their regular FMAP rate for these services. | P.L. 111-148, as amended by P.L. 111-152; SSA §1915(k)(2) |
| **Administrative Activities** | | |
| Electronic Visit Verification System | States receive 90% federal matching rate for the design, development, or installation of electronic visit verification systems for personal care and home health care services. States receive 75% federal matching rate for the operation and maintenance of these systems. | P.L. 114-255; SSA §1903(l)(6)(A) |
| Health Information Technology | States receive 100% federal matching rate (i.e., fully federally funded) for incentive payments to eligible Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology through 2021, and states receive 90% federal matching rate for administrative expenses related to the program. | P.L. 111-5; SSA §1903(a)(3)(F) |

| Exception | Description | Citations |
|---|---|---|
| Training of Medical Personnel | States receive 75% federal matching rate for costs attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel. | P.L. 89-97; SSA §1903(a)(2)(A)&(B) |
| Citizenship Verification System | States receive 90% federal matching rate for the design, development, or installation of citizenship verification systems. States receive 75% federal matching rate for the operation of these systems. | P.L. 111-3; SSA §1903(a)(3)(H) |
| Immigration Verification System | States receive 100% federal reimbursement for the cost of implementation and operation of an immigration status verification system. | P.L. 99-603; SSA §1903(a)(4) |
| Fraud Control Unit | States receive 75% federal matching rate for state expenditures related to the operation of a state Medicaid fraud control unit. | P.L. 95-142; SSA §1903(a)(6) |
| Preadmission Screening | State expenditures attributable to preadmission screening and resident review for individuals with mental illness or mental retardation who are admitted to a nursing facility receive 75% federal matching rate. | P.L. 100-203; SSA §1903(a)(2)(C) |
| Survey and Certification | States receive 75% federal matching rate for state expenditures related to survey and certification of nursing facilities. | P.L. 100-203; SSA §1903(a)(2)(D) |
| Managed Care Review Activities | States receive 75% federal matching rate for state expenditures related to performance of medical and utilization review activities or external independent review of managed care activities. | P.L. 97-35; SSA §1903(a)(3)(C) |
| Claims and Eligibility Systems | States receive 90% federal matching rate for the design, development, or installation of mechanized claims systems and 75% federal matching rate for operating mechanized claims systems. Both federal reimbursement percentages are subject to certain criteria set by the Secretary of HHS, which includes whether the activity is likely to provide more efficient, economical, and effective administration of claims processing. CMS published a final rule to permanently amend the definition of Mechanized Claims Processing and Information Retrieval systems to include systems used for eligibility determination, enrollment, and eligibility reporting activities thereby making the 90% federal matching rate available for the design, development and installation or enhancement of eligibility determination systems, and 75% federal matching rate for maintenance and operations available for such systems. | P.L. 92-603; SSA §1903(a)(3)(A) and (B); 80 *Federal Register* 75819 (December 4, 2015) |
| Translation or Interpretation Services | Administrative expenditures for translation or interpretation services in connection with the "enrollment of, retention of, and use of services" under Medicaid receive 75% federal matching rate. For CHIP, the increased match is 75%, or the state's E-FMAP rate plus 5 percentage points, whichever is higher, and the CHIP increased match is subject to the 10% cap on administrative expenditures. The increased federal matching rate for translation or interpretation services is only available for eligible expenditures claimed as administrative and not expenditures claimed as medical assistance-related (which receive each state's regular FMAP rate). | P.L. 111-3; SSA §1903(a)(2)(E); State Medicaid Director Letter, State Health Official 10-007, CHIPRA 18, July 1, 2010. |

| Exception | Description | Citations |
|---|---|---|
| General Administration | Remaining state expenditures found necessary for proper and efficient administration of the state plan receive a 50% federal matching rate. | P.L. 89-97; SSA §1903(a)(7) |

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

**Notes:** Unless noted, exceptions do not apply for purposes of computing the E-FMAP rate for CHIP. ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); ACIP = Advisory Committee on Immunization Practices; CHIP = Children's Health Insurance Program; CHIPRA = Children's Health Insurance Program Reauthorization Act (P.L. 111-3); CMS = Centers for Medicare & Medicaid Services; CNMI = Commonwealth of the Northern Mariana Islands; E-FMAP = enhanced federal medical assistance percentage; EHR = electronic health record; FMAP = federal medical assistance percentage; FPL = federal poverty level; SPA = state plan amendment; SSA = Social Security Act; USPSTF = United States Preventive Services Task Force.

## Reduction to Regular FMAP Rates

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

### Electronic Visit Verification Systems

For personal care services or home health care services requiring an in-home visit by a provider, states' FMAP rates are reduced for those services if the states do not have an electronic visit verification system. For personal care services, the FMAP reductions could start in CY2020; for home health care services, the FMAP reductions could start in CY2023. The FMAP reductions could be 0.25 percentage points in the first year the reductions are in effect, 0.5 percentage points for the second year, 0.75 percentage points for the third year, and 1 percentage point for subsequent years.[14]

### Asset Verification Programs

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

- 0.12 percentage points for calendar quarters in 2021 and 2022;
- 0.25 percentage points for calendar quarters in 2023;
- 0.35 percentage points for calendar quarters in 2024; and
- 0.50 percentage points for calendar quarters in 2025 and each year thereafter.[15]

The asset verification program requirements apply to Puerto Rico beginning January 1, 2026. If Puerto Rico does not have an asset verification program, starting January 1, 2026, the regular FMAP rate for Puerto Rico would be reduced by

- 0.12 percentage points for calendar quarters in FY2026 starting on or after January 1, 2026;
- 0.25 percentage points for calendar quarters in FY2027;

[14] P.L. 114-255 §12006; SSA §1903(l)(1)(A).

[15] P.L. 116-3 §4; SSA §1940(k)(1)(A).

- 0.35 percentage points for calendar quarters in FY2028; and
- 0.50 percentage points for calendar quarters in FY2029 and each year thereafter.[16]

# Budget Reconciliation and FMAP Reform

The House of Representatives adopted the House FY2025 budget resolution (H.Con.Res. 14) on February 25, 2025.[17] H.Con.Res. 14 includes reconciliation instructions directing the Committee on Energy and Commerce to reduce the deficit by not less than $880 billion for FY2025 through FY2034. Some press reports suggest that much of the $880 billion in reductions could come from reductions to federal Medicaid expenditures.[18] The media have reported that some of the policy options that have been considered for reconciliation would amend the FMAP. These policy options include (1) reducing or removing the statutory floor of 50% for the regular FMAP rates, (2) amending the regular FMAP rate for the District of Columbia, (3) removing the exception to the FMAP rate for the ACA Medicaid expansion, and (4) repealing the incentive for states to implement the ACA Medicaid expansion.[19]

## Statutory Floor for FMAP

As mentioned above, the regular FMAP for states can range from 50% to 83% based on each states' per capita income. One of the policy options under consideration to be included in the reconciliation package would remove the FMAP floor of 50%. The statutory floor of 50% for the regular FMAP rate has been in place since the Medicaid program was enacted in 1965.[20] The structure for the federal share of Medicaid expenditures was based on Medicaid's predecessor program (i.e., Kerr-Mills).

In FY2025, 10 states have a regular FMAP rate of 50%: California, Colorado, Connecticut, Massachusetts, Maryland, New Hampshire, New Jersey, New York, Washington, and Wyoming. While the FMAP rate for states could change annually, many of the states receiving the 50% FMAP in FY2025 consistently have a regular FMAP rate of 50%. If the FMAP rate statutory floor of 50% is reduced or removed, the impacted states would pay a higher share of most Medicaid expenditures. As calculated by the Federal Funds Information for States, if the FMAP

[16] P.L. 117-328; SSA §1940(k)(1)(B).

[17] The Senate has adopted a FY2025 Budget Resolution (S.Con.Res. 7) on February 21, 2025 that differs from the FY2025 House Budget Resolution. For more information about FY2025 budget resolutions, see CRS Report R48474, *Reconciliation Instructions in the House and Senate FY2025 Budget Resolutions: In Brief*.

[18] Margot Sanger-Katz and Alicia Parlapiano, "What Can House Republicans Cut Instead of Medicaid? Not Much.," *New York Times*, February 25, 2025, https://www.nytimes.com/2025/02/25/upshot/republicans-medicaid-house-budget.html; Joe Light, "Medicaid Cuts Appear Inevitable. States May Pick Up the Bill," *Barron's*, February 26, 2025, https://www.barrons.com/articles/medicaid-cuts-taxes-states-312ebfd5.

[19] Ben Leonard, Meredith Lee Hill, and Kelsey Tamborrino, "House GOP Puts Medicaid, ACA, Climate Measures on Chopping Block," *Politico*, January 10, 2025, https://www.politico.com/news/2025/01/10/spending-cuts-house-gop-reconciliation-medicaid-00197541. The article links to "an early list of potential spending offsets obtained by POLITICO," https://www.politico.com/f/?id=00000194-5115-d639-a395-7db5d6b70000. Benjamin Guggenheim, "GOP Budget Menu Outlines Sweeping Spending Cuts," *Politico Pro*, January 17, 2025, https://subscriber.politicopro.com/article/2025/01/reconciliation-menu-reveals-wide-ranging-gop-policy-priorities-00198940. The article links to a "detailed menu of options for blockbuster legislation including tax cuts and other GOP priorities, obtained by POLITICO," https://www.politico.com/f/?id=00000194-74a8-d40a-ab9e-7fbc70940000.

[20] Social Security Amendments of 1965 (P.L. 89-97).

floor of 50% were removed, Massachusetts would have the lowest regular FMAP rate at 24.17%.[21]

The Congressional Budget Office (CBO) estimates removing the statutory floor of the FMAP would reduce federal Medicaid outlays by $530 billion from FY2025 through FY2034.[22]

## Amend FMAP Rate for the District of Columbia

The FMAP rate for the District of Columbia is not determined using the formula used by the 50 states. Instead, the FMAP rate for the District of Columbia is set at 70%. Another policy option being considered for reconciliation is having the FMAP for the District of Columbia be determined according to the FMAP formula.

This exception to the FMAP rate for the District of Columbia has been in place since FY1998. If the FMAP for the District of Columbia were calculated according to the formula used for the 50 states under current law, the District of Columbia would have an FMAP rate of 50%.[23] If the FMAP rate for the District of Columbia is reduced, the District of Columbia would have to pay a higher share of their Medicaid expenditures.

## FMAP Rate for ACA Medicaid Expansion

The ACA Medicaid expansion was implemented January 1, 2014.[24] At the beginning, there were two exceptions for the ACA Medicaid expansion: (1) the *newly eligible* matching rate for individuals newly eligible for Medicaid through the expansion and (2) the *expansion state* matching rate for individuals in the expansion population who were eligible for Medicaid at the time the ACA was enacted.

Initially, these matching rates varied, and the newly eligible matching rate was higher than the expansion state matching rate. Since 2019, the two matching rates have been the same (i.e., 93% in 2019 and 90% in 2020 and subsequent years). Under these matching rates, the federal government's share of Medicaid expenditures is higher than under states' regular FMAP rates.

One of the policy options being considered for reconciliation is to eliminate the FMAP exception for the ACA Medicaid expansion. If the FMAP exception for the ACA Medicaid expansion were eliminated, the states would have to pay a higher share of the expenditures for the ACA Medicaid expansion enrollees. There are 12 states with different "trigger laws" that would either eliminate the ACA Medicaid expansion or direct additional actions by state if the FMAP rate for the expansion is reduced from 90%.[25]

CBO estimates eliminating the FMAP exception for the ACA Medicaid expansion would the net effect of reducing the federal deficit by $561 billion from FY2025 through FY2034.[26] In addition to savings due to the federal government paying a lower share of the ACA Medicaid expansion

[21] Trinity Tomsic, "Final FY 2025 FMAPs," *Federal Funds Information for States*, Issue Brief 23-12, October 3, 2023.

[22] Congressional Budget Office, "Reduce Federal Medicaid Matching Rates," Options for Reducing the Deficit: 2025 to 2034, December 12, 2024, https://www.cbo.gov/budget-options/60898.

[23] If the policy option to remove the FMAP floor of 50% is enacted in addition to removing the FMAP exception for the District of Columbia, the FMAP rate for the District of Columbia would be less than 50%.

[24] For more information about the ACA Medicaid expansion, see CRS Report R43564, *The ACA Medicaid Expansion*.

[25] CRS analysis found the following 12 states had trigger laws: Arizona, Arkansas, Idaho, Indiana, Illinois, Iowa, Montana, New Hampshire, New Mexico, North Carolina, Utah, and Virginia.

[26] Congressional Budget Office, "Reduce Federal Medicaid Matching Rates," Options for Reducing the Deficit: 2025 to 2034, December 12, 2024, https://www.cbo.gov/budget-options/60898.

expenditures, CBO assumes that if the FMAP exception for the expansion is eliminated, some states would no longer cover the ACA Medicaid expansion population.[27]

## Incentive for ACA Medicaid Expansion

Section 9814 of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) added a financial incentive for states that have not implemented the ACA Medicaid expansion (i.e., *non-expansion states*) to implement the expansion. The ARPA incentive provides a five-percentage-point increase to the regular FMAP rate for eight quarters to a non-expansion state that implements the ACA Medicaid expansion after the date of enactment (i.e., March 11, 2021). To date, two states (Missouri and Oklahoma) received the full eight fiscal quarters of the ARPA incentive for states to implement the ACA Medicaid expansion, and two states (South Dakota and North Carolina) are currently receiving the ARPA incentive for states to implement the ACA Medicaid expansion.

One of the policy options being considered for reconciliation is to eliminate this incentive for states to implement the ACA Medicaid expansion. If this policy option were enacted, it might make it less likely for the 10 states without the ACA Medicaid expansion to implement the ACA Medicaid expansion.

# Conclusion

The FMAP rate is used to reimburse states for the federal share of most Medicaid expenditures. In FY2025, 10 states are to have the statutory minimum FMAP rate of 50% and Mississippi is to have the highest FMAP rate of 76.9%. From FY2024 to FY2025, the regular FMAP rates for 40 states are to change, whereas the regular FMAP rates for the remaining 11 states (including the District of Columbia) are to remain the same.

The House of Representatives adopted the House FY2025 budget resolution (H.Con.Res. 14) on February 25, 2025. H.Con.Res. 14 includes reconciliation instructions directing the Committee on Energy and Commerce to reduce the deficit by not less than $880 billion for FY2025 through FY2034. Some press reports suggest that much of the $880 billion in reductions could come from reductions to federal Medicaid expenditures.[28] The media have reported that some of the policy options that have been considered for reconciliation would amend the FMAP. These policy options include (1) reducing or removing the statutory floor of 50% for the regular FMAP rates, (2) amending the regular FMAP rate for the District of Columbia, (3) reducing or removing the exception to the FMAP rate for the ACA Medicaid expansion, and (4) repealing the incentive for states to implement the ACA Medicaid expansion.[29]

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[27] Some of the expansion population in states that eliminate the ACA Medicaid expansion would be eligible for subsidized exchange coverage or employer-sponsored health insurance.

[28] Margot Sanger-Katz and Alicia Parlapiano, "What Can House Republicans Cut Instead of Medicaid? Not Much.," *New York Times*, February 25, 2025, https://www.nytimes.com/2025/02/25/upshot/republicans-medicaid-house-budget.html; Joe Light, "Medicaid Cuts Appear Inevitable. States May Pick Up the Bill," *Barron's*, February 26, 2025, https://www.barrons.com/articles/medicaid-cuts-taxes-states-312ebfd5.

[29] Ben Leonard, Meredith Lee Hill, and Kelsey Tamborrino, "House GOP Puts Medicaid, ACA, Climate Measures on Chopping Block," *Politico*, January 10, 2025, https://www.politico.com/news/2025/01/10/spending-cuts-house-gop-reconciliation-medicaid-00197541. The article links to "an early list of potential spending offsets obtained by POLITICO," https://www.politico.com/f/?id=00000194-5115-d639-a395-7db5d6b70000. Benjamin Guggenheim, "GOP Budget Menu Outlines Sweeping Spending Cuts," *Politico Pro*, January 17, 2025, https://subscriber.politicopro.com/article/2025/01/reconciliation-menu-reveals-wide-ranging-gop-policy-priorities-00198940. The article links to a "detailed menu of options for blockbuster legislation including tax cuts and other GOP priorities, obtained by POLITICO," https://www.politico.com/f/?id=00000194-74a8-d40a-ab9e-7fbc70940000.

# Appendix A. FMAP Rates for Medicaid, by State

**Table A-1** shows regular FY2021-FY2026 FMAP rates calculated according to the formula described in the text of the report (see "How FMAP Rates Are Calculated"). In FY2025, FMAP rates range from 50% (10 states) to 76.9% (Mississippi), and in FY2026, 10 states will have a 50% FMAP rate and the highest FMAP rate will be 76.9 (Mississippi). From FY2025 to FY2026, regular FMAP rates are to decrease for 26 states, increase for 13 states, and remain the same for 12 states (including the District of Columbia). Most of the states (10 states) for which the FMAP rates do not change have the statutory minimum FMAP rate of 50%, and the FMAP rate for the District of Columbia is statutorily set at 70%. Also, the FMAP rate for Mississippi is the same in FY2025 and FY2026.

**Table A-1. Regular FMAP Rates, by State, FY2021-FY2026**

| State | FY2021 | FY2022 | FY2023 | FY2024 | FY2025 | FY2026 | Change FY2025 to FY2026 |
|---|---|---|---|---|---|---|---|
| Alabama | 72.58 | 72.37 | 72.43 | 73.12 | 72.84 | 72.63 | -0.21 |
| Alaska | 50.00 | 50.00 | 50.00 | 50.01 | 51.54 | 52.42 | 0.88 |
| Arizona | 70.01 | 70.01 | 69.56 | 66.29 | 64.89 | 64.34 | -0.55 |
| Arkansas | 71.23 | 71.62 | 71.31 | 72.00 | 71.14 | 69.23 | -1.91 |
| California | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| Colorado | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| Connecticut | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| Delaware | 57.74 | 57.72 | 58.49 | 59.71 | 60.15 | 59.41 | -0.74 |
| District of Columbia[a] | 70.00 | 70.00 | 70.00 | 70.00 | 70.00 | 70.00 | 0.00 |
| Florida | 61.96 | 61.03 | 60.05 | 57.96 | 57.17 | 57.22 | 0.05 |
| Georgia | 67.03 | 66.85 | 66.02 | 65.89 | 66.04 | 66.40 | 0.36 |
| Hawaii | 53.02 | 53.64 | 56.06 | 58.56 | 59.08 | 59.68 | 0.60 |
| Idaho | 70.41 | 70.21 | 70.11 | 69.72 | 67.59 | 66.91 | -0.68 |
| Illinois | 50.96 | 51.09 | 50.00 | 51.09 | 51.38 | 51.82 | 0.44 |
| Indiana | 65.83 | 66.30 | 65.66 | 65.62 | 64.90 | 64.74 | -0.16 |
| Iowa | 61.75 | 62.14 | 63.13 | 64.13 | 63.25 | 62.70 | -0.55 |
| Kansas | 59.68 | 60.16 | 59.76 | 60.97 | 61.87 | 60.67 | -1.20 |
| Kentucky | 72.05 | 72.75 | 72.17 | 71.78 | 71.48 | 71.41 | -0.07 |
| Louisiana | 67.42 | 68.02 | 67.28 | 67.67 | 68.06 | 67.83 | -0.23 |
| Maine | 63.69 | 64.00 | 63.29 | 62.65 | 62.06 | 61.29 | -0.77 |
| Maryland | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| Massachusetts | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| Michigan | 64.08 | 65.48 | 64.71 | 64.94 | 65.13 | 65.30 | 0.17 |
| Minnesota | 50.00 | 50.51 | 50.79 | 51.49 | 51.16 | 50.68 | -0.48 |
| Mississippi | 77.76 | 78.31 | 77.86 | 77.27 | 76.90 | 76.90 | 0.00 |
| Missouri | 64.96 | 66.36 | 65.81 | 66.07 | 65.31 | 64.44 | -0.87 |

| State | FY2021 | FY2022 | FY2023 | FY2024 | FY2025 | FY2026 | Change FY2025 to FY2026 |
|---|---|---|---|---|---|---|---|
| Montana | 65.60 | 64.90 | 64.12 | 63.91 | 62.37 | 61.47 | -0.90 |
| Nebraska | 56.47 | 57.80 | 57.87 | 58.60 | 57.52 | 55.94 | -1.58 |
| Nevada | 63.30 | 62.59 | 62.65 | 60.77 | 60.22 | 59.80 | -0.42 |
| New Hampshire | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| New Jersey | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| New Mexico | 73.46 | 73.71 | 73.26 | 72.59 | 71.68 | 71.66 | -0.02 |
| New York | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| North Carolina | 67.40 | 67.65 | 67.71 | 65.91 | 65.06 | 64.62 | -0.44 |
| North Dakota | 52.40 | 53.59 | 51.55 | 53.82 | 50.97 | 50.99 | 0.02 |
| Ohio | 63.63 | 64.10 | 63.58 | 64.30 | 64.60 | 64.85 | 0.25 |
| Oklahoma | 67.99 | 68.31 | 67.36 | 67.53 | 67.08 | 66.47 | -0.61 |
| Oregon | 60.84 | 60.22 | 60.32 | 59.31 | 59.00 | 57.75 | -1.25 |
| Pennsylvania | 52.20 | 52.68 | 52.00 | 54.12 | 55.09 | 56.06 | 0.97 |
| Rhode Island | 54.09 | 54.88 | 53.96 | 55.01 | 56.31 | 57.50 | 1.19 |
| South Carolina | 70.63 | 70.75 | 70.58 | 69.53 | 69.67 | 69.53 | -0.14 |
| South Dakota | 58.28 | 58.69 | 56.74 | 54.98 | 53.07 | 51.01 | -2.06 |
| Tennessee | 66.10 | 66.36 | 66.10 | 65.28 | 64.81 | 64.16 | -0.65 |
| Texas | 61.81 | 60.80 | 59.87 | 60.15 | 60.00 | 59.83 | -0.17 |
| Utah | 67.52 | 66.83 | 65.90 | 65.90 | 64.36 | 62.46 | -1.90 |
| Vermont | 54.57 | 56.47 | 55.82 | 56.75 | 58.19 | 59.01 | 0.82 |
| Virginia | 50.00 | 50.00 | 50.65 | 51.22 | 50.99 | 50.39 | -0.60 |
| Washington | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| West Virginia | 74.99 | 74.68 | 74.02 | 74.10 | 73.84 | 74.22 | 0.38 |
| Wisconsin | 59.37 | 59.88 | 60.10 | 60.66 | 60.43 | 60.68 | 0.25 |
| Wyoming | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 50.00 | 0.00 |
| Number with increase from previous year | 24 | 26 | 11 | 23 | 13 | 13 | |
| Number stayed the same from previous year | 13 | 13 | 11 | 11 | 10 | 12 | |
| Number with decrease from previous year | 13 | 11 | 28 | 16 | 27 | 26 | |

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

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

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

# Appendix B. Past FMAP Rate Exceptions

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

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

| Exception | Description | Citations |
|---|---|---|
| **Territories and Certain States** | | |
| Territories | For November 22, 2019, through December 20, 2019, the FMAP rate for the territories was increased from 55% to 100% (i.e., fully federally funded) for all territories. (For more information about the FMAP rate for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*). | P.L. 116-69 §1302; SSA §1905(ff) |
| Territories | For October 1, 2019, through November 21, 2019, the FMAP rate for the territories was increased from 55% to 100% (i.e., fully federally funded) for all territories. (For more information about the FMAP rate for the territories, see CRS In Focus IF11012, *Medicaid Financing for the Territories*). | P.L. 116-59 §1302; SSA §1905(ff) |
| Territories | For the period of January 1, 2019, through September 30, 2019, CNMI received an additional $36 million in federal Medicaid funding; for this additional funding, the FMAP rate was increased from 55% to 100%.<br>Increased the FMAP rate from 55% to 100% for American Samoa and Guam for the territories' share of additional Medicaid federal funding provided in the ACA that was available through September 30, 2019. | P.L. 116-20 §802; SSA §1108(g)(5) |
| Territories | For the period of January 1, 2018, through September 30, 2019, Puerto Rico and the U.S. Virgin Islands received additional federal Medicaid funding. The FMAP rate was increased from 55% to 100% for this additional federal Medicaid funding. | P.L. 115-123 §20301; SSA §1108(g)(5) |
| Alaska | Alaska's FMAP rate was set in statute for FY1998-FY2000 at 59.80%; used an alternative formula for FY2001-FY2005 that reduced the state's per capita income by 5% (thereby increasing its FMAP rate); and was held at its FY2005 level for FY2006-FY2007. These provisions also applied for purposes of computing the E-FMAP rate for CHIP. | P.L. 105-33 §4725(a); P.L. 106-554 Appendix F §706; P.L. 109-171 §6053(a) |
| **Special Situations** | | |
| State Fiscal Relief | A 6.2-percentage-point increase to the FMAP rates for all states, the District of Columbia, and the territories for each calendar quarter occurring during January 1, 2020, through December 31, 2023. States were required to meet certain requirements to receive the increase. (For more information about the FMAP increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*). | Most recently P.L. 117-328; P.L. 116-127 §6008, as amended by P.L. 116-136 §3720 |

| Exception | Description | Citations |
|---|---|---|
| State Fiscal Relief, FY2009-FY2011 | FMAP rates were increased from the first quarter of FY2009 through the third quarter of FY2011, providing states with more than $100 billion (about $84 billion for the original provision and $16 billion for a six-month extension) in additional funds. All states received a hold harmless to prevent any decline in regular FMAP rates and an across-the-board increase of 6.2 percentage points until the last two quarters of the period, at which point the across-the-board percentage point increase phased down to 3.2 and then 1.2; qualifying states received an additional unemployment-related increase. Each territory could choose between an FMAP increase of 6.2 percentage points along with a 15% increase in its spending cap, or its regular FMAP rate along with a 30% increase in its cap; all chose the latter. States were required to meet certain requirements in order to receive the increase. (For more information about the FMAP increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*). | P.L. 111-5 §5001, as amended by P.L. 111-226 §201 |
| Adjustment for Hurricane Katrina | In computing FMAP rates for any year after 2006 for a state that the Secretary of HHS determines has a significant number of Hurricane Katrina evacuees as of October 1, 2005, the Secretary must disregard such evacuees and their incomes. Although it was labeled as a "hold harmless for Katrina impact," the provision language required evacuees to be disregarded even if their inclusion would increase a state's FMAP rate. Due to lags in the availability of data used to calculate FMAP rates, FY2008 was the first year to which the provision applied. HHS proposed and finalized a methodology that prevented the lowering of any FY2008 FMAP rates and increased the FY2008 FMAP rate for one state (Texas). The methodology took advantage of a data timing issue that does not apply after FY2008. HHS had initially expressed concern that some states could see lower FMAP rates in later years as a result of the provision, but the final methodology indicated that there is no reliable way to track the number and income of evacuees on an ongoing basis and therefore no basis for adjusting FMAP rates after FY2008. The provision also applied for purposes of computing the enhanced FMAP rate for CHIP. | P.L. 109-171; 72 *Federal Register* 3391 (January 25, 2007) and 44146 (August 7, 2007) |
| State Fiscal Relief, FY2003-FY2004 | FMAP rates for the last two quarters of FY2003 and the first three quarters of FY2004 were not allowed to decline (i.e., were held harmless) and were increased by an additional 2.95 percentage points, providing states with about $10 billion in additional funds (they also received $10 billion in direct grants). Although Medicaid DSH payments are reimbursed using the FMAP rate, the increase did not apply to DSH. States had to meet certain requirements in order to receive an increase (e.g., they could not restrict eligibility after a specified date). (For more information about the FMAP increase, see CRS Report R46346, *Medicaid Recession-Related FMAP Increases*). | P.L. 108-27 §401(a) |
| **Certain Populations** | | |
| COVID-19 Testing for the Uninsured | During the COVID-19 public health emergency period, states had the option to extend COVID-19 testing, testing-related state plan services, testing-related visits, and the administration of the testing without cost sharing to uninsured individuals under the Medicaid program. For medical assistance and administrative costs associated with uninsured individuals who were eligible for Medicaid under this state option, states received 100% federal reimbursement (i.e., fully federally funded). | P.L. 116-27, as amended by P.L. 116-136; SSA §1902(a)(10)(XXIII) and (ss). |

| Exception | Description | Citations |
|---|---|---|
| Certain "Expansion States" | During CY2014 and CY2015, an FMAP rate increase of 2.2 percentage points was available for "expansion states" that (1) the Secretary of HHS determines did not receive any federal matching rate increase for "newly eligible" individuals and (2) had not been approved to divert Medicaid disproportionate share hospital funds to pay for the cost of health coverage under a waiver in effect as of July 2009. The FMAP rate increase applied to those who are *not* "newly eligible" individuals as described in relation to the new eligibility group for non-elderly, nonpregnant adults at or below 133% FPL. | P.L. 111-148, as amended by P.L. 111-152; SSA §1905(z)(1) |
| **Certain Providers** | | |
| Extension of 100% FMAP to UIOs and Native Hawaiian Health Care Systems | Provided eight fiscal quarters of 100% federal reimbursement (i.e., fully federally funded) for Medicaid services received through (1) UIOs and (2) Native Hawaiian Health Centers for the period April 1, 2021, through March 31, 2023. | P.L. 117-2; SSA §1905(b) |
| Primary Care Payment Rates | During CY2013 and CY2014, states were required to provide Medicaid payments at or above the Medicare rates for primary care services (defined as evaluation and management and certain administration of immunizations) furnished by a physician with a primary specialty designation of family, general internal, or pediatric medicine. States received 100% federal reimbursement for expenditures attributable to the amount by which Medicare exceeded their Medicaid payment rates in effect on July 1, 2009. | P.L. 111-148, as amended by P.L. 111-152; SSA §1902(a)(13)(C); 77 *Federal Register* 66670. |
| **Certain Services** | | |
| State Balancing Incentive Payments | During FY2011-FY2015, state balancing incentive payments were available under certain conditions for states in which less than 50% of Medicaid expenditures for LTSS were noninstitutional. Qualifying states with less than 25% noninstitutional LTSS had to plan to achieve a 25% target to receive a five percentage point increase in their FMAP rate for noninstitutional LTSS; those with less than 50% had to plan to achieve a 50% target to receive a two percentage point increase. Federal spending on these increased FMAP rates was limited to $3 billion during the period. | P.L. 111-148, as amended by P.L. 111-152, §10202 |
| **Administrative Activities** | | |
| Prescription Drug Monitoring Programs | For FY2019 and FY2020, states receive 100% federal matching rate (i.e., fully federally funded) for the design, development, or implementation of prescription drug monitoring programs. To receive this increased federal matching rate, states must have prescription drug monitoring programs information-sharing agreements with contiguous states. | P.L. 115-271; SSA §1944(f) |

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

**Notes:** ACA = Patient Protection and Affordable Care Act (P.L. 111-148 as amended); CHIP = State Children's Health Insurance Program; CNMI = Commonwealth of the Northern Mariana Islands; COVID-19 = Coronavirus Disease 2019; DSH = disproportionate share hospital; FMAP = federal medical assistance percentage; FPL = federal poverty level; HHS = Department of Health and Human Services; LTSS = long-term services and supports; UIO = Urban Indian Organization.

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## Disclaimer