

medicaid and the uninsured

September 2012

Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)

Key Findings in Brief

The Federal Medical Assistance Percentage (FMAP) determines the federal share of the cost of Medicaid services in each state.

- The FMAP is based on a formula in the federal Medicaid statute that is based on state per capita income. The lower a state's per capita income, the higher the state's FMAP, or federal Medicaid matching rate. FMAPs vary from a floor of 50 percent to a high of 74 percent.
- There are exceptions to the FMAP formula for certain services and certain populations. The Affordable Care Act (ACA) provides an FMAP of 100 percent for the period 2014-2016 and at least 90 percent thereafter for the cost of covering newly eligible low-income adults.
- The costs of administration are generally matched at 50 percent, although some administrative activities receive a higher federal matching rate.
- The federal matching rates for the costs of the Children's Health Insurance Program (CHIP) are enhanced relative to the Medicaid FMAP.

The FMAP has a multiplier effect in state economies.

- Typically states are required to spend some of their own funds to draw down federal Medicaid dollars. For every \$1 in state funds spent on Medicaid, states can draw down at least \$1 additional from the federal government.
- States with higher FMAPs can leverage as much as \$2.85 in federal matching funds for each \$1 they spend.
- States that extend Medicaid coverage under the ACA will receive a favorable FMAP for the expansion population. The federal government will pick up the entire cost of coverage for the first three years, which will be scaled down to a matching rate of 9:1 in 2020 and beyond. So, for every \$1 a state spends on this population, it will leverage \$9 in federal matching funds. This will not vary by per capita income like the basic FMAP.

The FMAP formula has remained basically unchanged throughout the history of the Medicaid program, and temporary adjustments to the formula have resulted in FMAP increases, not decreases.

- On two separate occasions during the last decade, FMAPs were temporarily increased to provide fiscal relief to states during economic downturns.
- Specific-state FMAP adjustments have been made (i.e. for Louisiana following Hurricane Katrina).

Medicaid is the federal-state program for health and long-term care coverage for low-income Americans. Since its enactment in 1965, the Medicaid program has used the Federal Medical Assistance Percentage (FMAP) to determine the share of the cost of covered services that the federal government will pay in each state. On average, the federal share has been 57 percent. Beginning in 2014, the Affordable Care Act (ACA) establishes enhanced FMAPs for the cost of services to low-income adults with incomes up to 138%¹ of the Federal Poverty Level (FPL) who are not currently covered. The expansion FMAPs are 100 percent in 2014 through 2016, and then phase down to 90 percent in 2020 and beyond.² To place these new FMAPs in context, this policy brief provides an overview of the FMAP and temporary changes to the formula over the history of the program.

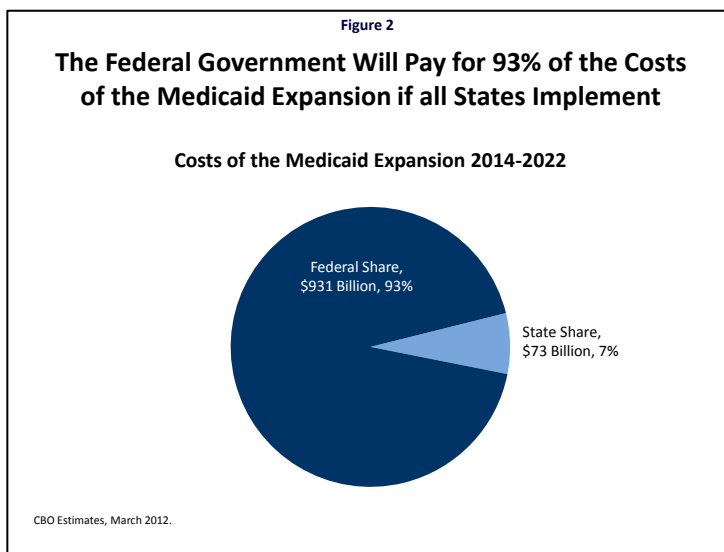
There have, however, been two occasions on which Congress has temporarily increased FMAPs to provide fiscal relief to state Medicaid programs during recessions. The first occurred in response to the 2001 recession. During the 5-quarter period beginning April 2003 through June 2004, every state's FMAP was increased by 2.95 percentage points, and every state was held harmless against any decline in its FMAP that would otherwise have occurred under the normal operation of the formula. The resulting additional federal assistance totaled \$10 billion.⁸

The second increase occurred in response to the Great Recession of 2007-2009. As in the case of the 2001 recession, states were held harmless against any decline in their FMAP that would otherwise have occurred, and there was an across-the-board increase in FMAPs, although, in this case, the increase was 6.2 percentage points. In addition, there was an increase in FMAP ranging from 1.88 to 5.39 percentage points, based on the increase in a state's unemployment rate. This three-part fiscal relief, including a 6-month phase-down, ran from October 2008 through June 3, 2011, and resulted in additional payments to states totaling \$103 billion.⁹

Congress has also temporarily adjusted FMAPs for individual states that confront unusual circumstances. This happened in the cases of Alaska,¹⁰ Michigan,¹¹ and, most recently, Louisiana, due to extreme fluctuations in state per capita income in the aftermath of Hurricane Katrina.¹² In all of these cases, Congress enacted legislation to increase, not decrease, the FMAP. On one occasion in the early 1980s, legislation was passed to temporarily reduce federal Medicaid matching payments to states over a 3-year period, but this legislation did not alter the FMAP formula.¹³

Enhanced FMAPs in the ACA

Under the ACA, effective January 1, 2014, the federal government will pay 100 percent of the costs incurred by most states to cover newly eligible non-disabled adults under 65 with incomes at or below 138 percent of the FPL (\$15,415 per year for an individual in 2012) through 2016. This federal matching rate will phase down to 90 percent by 2020.¹⁴ States that extend Medicaid coverage to low-income, non-disabled adults will not pay toward the cost of services for this newly eligible population during 2014, 2015, and 2016. This is the same 100 percent FMAP that now applies to the cost of services furnished to Native American Medicaid beneficiaries by the IHS and tribal providers. By 2020, states will have to pay 10 percent of the cost for those newly eligible. The Congressional Budget Office estimates that the federal government will pay for 93 percent of the costs of the Medicaid expansion over the 2014 to 2022 period if all states were to participate (Figure 2).¹⁵



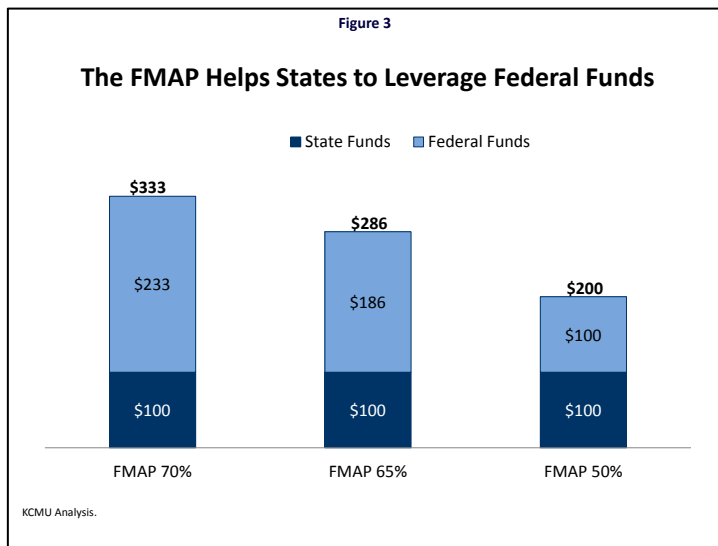
In addition, federal regulations provide for a temporary increase in the federal administrative matching rate to 90 percent for the costs of upgrading eligibility and enrollment systems to prepare for implementation of coverage expansions under health reform.¹⁶

FMAP Multiplier

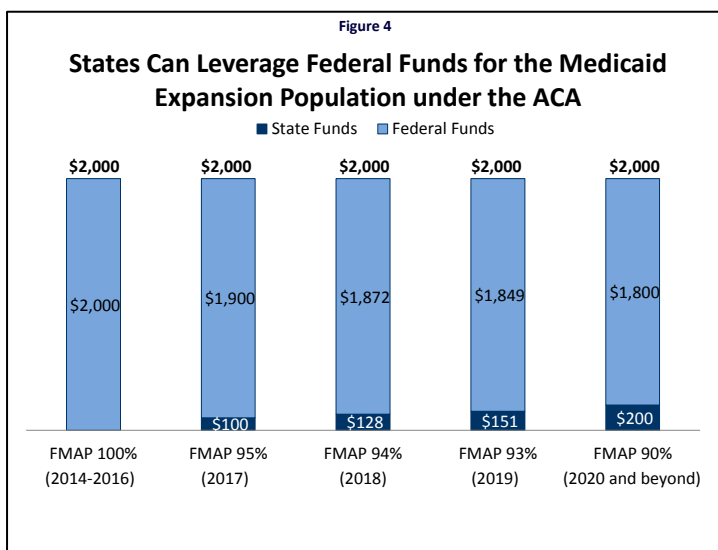
FMAPs determine the federal government’s share of financing for Medicaid, which provides health and long-term care services to low-income citizens.¹⁷ Viewed through a financing lens, however, FMAPs are also a measure of the leverage of a state dollar. For example, in a state with a 50 percent FMAP, \$100 in state spending can leverage \$100 in federal funds, adding \$200 in spending to the state’s economy – a multiplier of 1:1. In a state with a 70 percent FMAP, \$100 of state spending brings in \$233 in federal funds, adding \$333 in spending to the state’s economy – a multiplier of 1:2.33 (Figure 3).

A high FMAP is intended to assist a low per capita income state in purchasing covered services for its Medicaid beneficiaries. It can pay providers and plans the same amount as a low FMAP state, but with less fiscal effort. To spend \$1000 on a child, a state with a 50

percent FMAP must spend \$500 in state funds, while a state with a 70 percent FMAP must pay \$300 in state funds. However, when the high FMAP state wants to reduce its state general fund spending, it requires deeper cuts in payments to providers and plans than the low FMAP state. Using the above example, a \$100 cut in state spending would reduce total spending on the child from \$1000 to \$800 in a state with a 50 percent match rate and from \$1000 to \$667 in a state with a 70 percent match rate.



The multipliers associated with the Medicaid expansion are highly favorable to the states. Assume that a state pays \$2,000 for a covered service for an adult eligible under the expansion. During the first three years, there is no state contribution. In 2017, when the FMAP phases down to 95 percent, the state contribution to pay for a \$2000 service would be \$100 and the state share would only increase to \$200 in 2020 and beyond. The \$200 state share in 2020 still leverages \$1800 in federal funds (Figure 4).



Conclusion

The FMAP formula governs the relative share of the cost of Medicaid services that the federal government pays. This formula has been basically unchanged since the enactment of the program in 1965. There are some exceptions to the formula for particular services and populations—i.e., 100% for services furnished through IHS and tribal facilities and 90% for family planning services and supplies. Those exceptions are higher than any state’s regular FMAP, apply uniformly to all states, and have been unchanged since their enactment in the 1970s. In recent years, Congress has twice increased FMAPs across the board to provide temporary fiscal relief to states during recessions. The historical record, which shows stability in availability of federal funds over time, can help inform states as they consider whether to move forward with the Medicaid expansion.

Table 1: Current FMAPs for Medicaid and CHIP

State	Medicaid				CHIP			
	FY 2012		FY 2013		FY 2012		FY 2013	
	FMAP	Multiplier	FMAP	Multiplier	FMAP	Multiplier	FMAP	Multiplier
United States	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Alabama	68.62%	2.19	68.53%	2.18	78.03%	3.55	77.97%	3.54
Alaska	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Arizona	67.30%	2.06	65.68%	1.91	77.11%	3.37	75.98%	3.16
Arkansas	70.71%	2.41	70.17%	2.35	79.50%	3.88	79.12%	3.79
California	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Colorado	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Connecticut	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Delaware	54.17%	1.18	55.67%	1.26	67.92%	2.12	68.97%	2.22
District of Columbia	70.00%	2.33	70.00%	2.33	79.00%	3.76	79.00%	3.76
Florida	56.04%	1.27	58.08%	1.39	69.23%	2.25	70.66%	2.41
Georgia	66.16%	1.96	65.56%	1.90	76.31%	3.22	75.89%	3.15
Hawaii	50.48%	1.02	51.86%	1.08	65.34%	1.89	66.30%	1.97
Idaho	70.23%	2.36	71.00%	2.45	79.16%	3.80	79.70%	3.93
Illinois	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Indiana	66.96%	2.03	67.16%	2.05	76.87%	3.32	77.01%	3.35
Iowa	60.71%	1.55	59.59%	1.47	72.50%	2.64	71.71%	2.53
Kansas	56.91%	1.32	56.51%	1.30	69.84%	2.32	69.56%	2.29
Kentucky	71.18%	2.47	70.55%	2.40	79.83%	3.96	79.39%	3.85
Louisiana	61.09%	1.57	61.24%	1.58	72.76%	2.67	72.87%	2.69
Maine	63.27%	1.72	62.57%	1.67	74.29%	2.89	73.80%	2.82
Maryland	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Massachusetts	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Michigan	66.14%	1.95	66.39%	1.98	76.30%	3.22	76.47%	3.25
Minnesota	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Mississippi	74.18%	2.87	73.43%	2.76	81.93%	4.53	81.40%	4.38
Missouri	63.45%	1.74	61.37%	1.59	74.42%	2.91	72.96%	2.70
Montana	66.11%	1.95	66.00%	1.94	76.28%	3.22	76.20%	3.20
Nebraska	56.64%	1.31	55.76%	1.26	69.65%	2.29	69.03%	2.23
Nevada	56.20%	1.28	59.74%	1.48	69.34%	2.26	71.82%	2.55
New Hampshire	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
New Jersey	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
New Mexico	69.36%	2.26	69.07%	2.23	78.55%	3.66	78.35%	3.62
New York	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
North Carolina	65.28%	1.88	65.51%	1.90	75.70%	3.12	75.86%	3.14
North Dakota	55.40%	1.24	52.27%	1.10	68.78%	2.20	66.59%	1.99
Ohio	64.15%	1.79	63.58%	1.75	74.91%	2.99	74.51%	2.92
Oklahoma	63.88%	1.77	64.00%	1.78	74.72%	2.96	74.80%	2.97
Oregon	62.91%	1.70	62.44%	1.66	74.04%	2.85	73.71%	2.80
Pennsylvania	55.07%	1.23	54.28%	1.19	68.55%	2.18	68.00%	2.13
Rhode Island	52.12%	1.09	51.26%	1.05	66.48%	1.98	65.88%	1.93
South Carolina	70.24%	2.36	70.43%	2.38	79.17%	3.80	79.30%	3.83
South Dakota	59.13%	1.45	56.19%	1.28	71.39%	2.50	69.33%	2.26
Tennessee	66.36%	1.97	66.13%	1.95	76.45%	3.25	76.29%	3.22
Texas	58.22%	1.39	59.30%	1.46	70.75%	2.42	71.51%	2.51
Utah	70.99%	2.45	69.61%	2.29	79.69%	3.92	78.73%	3.70
Vermont	57.58%	1.36	56.04%	1.27	70.31%	2.37	69.23%	2.25
Virginia	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Washington	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
West Virginia	72.62%	2.65	72.04%	2.58	80.83%	4.22	80.43%	4.11
Wisconsin	60.53%	1.53	59.74%	1.48	72.37%	2.62	71.82%	2.55
Wyoming	50.00%	1.00	50.00%	1.00	65.00%	1.86	65.00%	1.86
Puerto Rico and US Territories	50.00%	1.00	55.00%	1.22	65.00%	1.86	68.50%	2.17

APPENDIX

The FMAP Formula. The FMAP formula is:

$$1 - \left[\left(\frac{(\text{State Per Capita Income})^2}{(\text{National Per Capita Income})^2} \right) * 0.45 \right]$$

Under this formula, a state's FMAP is based on the ratio of its per capita income, squared, to the U.S. per capita income, squared. States with per capita incomes above the national level receive a lower federal matching rate; states with per capita incomes below the national level receive a higher matching rate. A state with average per capita income will have an FMAP of 55 percent. The effect of the square is to increase the range of the matching percentages.

The operation of the formula is bound by statute. No state can have an FMAP lower than 50 percent or higher than 83 percent. As shown in Table 1 (prior page), FMAPs in FY 2012 ranged from 50 percent to a high of 74.18 percent, well below the 83 percent upper bound. In FY 2013, the highest FMAP will be 73.43 percent. This reflects a historical trend in which FMAPs at the upper end are slowly declining.¹⁸

FMAPs are recalculated for each federal fiscal year and published in October or November of the prior calendar year, so that states have notice of any changes. The recalculation is based on state and national income data from the most recently available three-year period. For example, the FMAPs for FY 2013, which begins October 1, 2012, were published on November 30, 2011 and are based on per capita income data for 2008, 2009, and 2010.¹⁹

It is not unusual for any given state's FMAP to change by a percentage point or two from year-to-year due to changes in personal income. For example, Florida's FMAP will increase from 56.04 percent in FY 2012 to 58.08 percent in FY 2013. North Dakota's FMAP, on the other hand, will fall from 55.40 percent in FY 2012 to 52.27 percent in FY 2013. Because of the amount and size of most state Medicaid programs, even these small percentage point changes can have significant year-to-year fiscal consequences for state budgets.

Table 1 shows each state's FMAP for FY 2012 and FY 2013. Fourteen states have federal matching rates of 50 percent in both years: Alaska, California, Colorado, Connecticut, Illinois, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Virginia, Washington, and Wyoming. At the other end of the spectrum, six states and the District of Columbia have matching rates of 70 percent or higher in both years: Arkansas, Idaho, Kentucky, Mississippi, South Carolina, and West Virginia.

Enhanced FMAP for CHIP. The enhanced FMAP, or eFMAP, is used to determine the federal share of the cost of the Children's Health Insurance Program (CHIP). It is also set by statute²⁰ and is equal to a state's FMAP, increased by 30 percent of 100 minus the state's FMAP (expressed in percentage points). For example, the eFMAP for a state with an FMAP of 50 percent is 65 percent (50 percent plus 15 percentage points (0.3 times 100 percent minus 50 percent)). By statute, the eFMAP cannot exceed 85 percent. Federal matching rates for the CHIP program are shown in Table 1. Each state's CHIP matching rate is scheduled to increase by 23 percentage points beginning October 1, 2015.²¹

Exceptions to FMAP. A state's FMAP determines the federal government's share of the state's cost for most Medicaid services and most groups of Medicaid beneficiaries. There are some exceptions, uniform across all states (see Table 2, next page). Some of these exceptions apply to mandatory populations or services. The federal government pays 100 percent of the cost of Medicaid services furnished to Native Americans and Alaska Natives who are Medicaid beneficiaries by the IHS or by tribes or tribal organizations contracting with the IHS. The federal government pays 90 percent of the costs of family planning services and supplies.

Other exceptions apply to optional populations or services. In states that elect to cover uninsured women who need treatment for breast or cervical cancer, the costs of treatment services are matched at the state's CHIP eFMAP rate. The federal government will match at a 90 percent rate, for eight calendar quarters, the cost of

providing health home services to beneficiaries with chronic conditions.²² Beginning on January 1, 2013, the costs of approved clinical preventive services for adults covered without cost-sharing requirements will be matched at the state’s regular FMAP plus one percentage point.²³

A number of the special FMAs relate to long-term care services and supports. Under the Community First Choice option, the costs of home and community-based attendant services and supports a state elects to provide to individuals with disabilities are matched at the state’s regular FMAP plus 6 percentage points.²⁴ Under the “Money Follows the Person” (MFP) Rebalancing Demonstration Program, the costs of transitioning individuals out of institutions into the community are matched at an “MFP-enhanced” FMAP—the state’s regular FMAP plus half of the percentage point difference between the FMAP and 100 percent.²⁵ And, under the State Balancing Incentive Payments Program, the costs of furnishing non-institutionally based long-term care services and supports are matched at a participating state’s FMAP plus 5 percentage points or plus 2 percentage points, depending upon the percentage of long-term care spending that a state applies to home- and community-based services.²⁶

Finally, under ACA, effective January 1, 2014, the federal government will pay 100 percent of the costs incurred by most states that cover non-disabled adults under 65 with incomes at or below 138 percent of the federal poverty level (\$15,415 per year for an individual in 2012) through 2016. This federal matching rate will phase down to 90 percent by 2020.²⁷

Service/Population	FMAP
Breast and Cervical Cancer Treatment	State's CHIP eFMAP rate
Clinical Preventive Services for Adults (effective January 1, 2013)	State's FMAP + 1 percentage point
Family Planning Services	90%
Health Home Services for Beneficiaries with Chronic Conditions	90%*
Home and Community-Based Attendant Services and Supports for People with Disabilities	State's FMAP + 6 percentage points
Money Follows the Person (MFP) Rebalancing Demonstration	MFP-enhanced FMAP**
State Balancing Incentive Payments Program	State’s FMAP + 5 or 2 percentage points***
Services provided through Indian Health Service and Tribal Facilities	100%
Newly eligible, non-disabled adults under age 65 up to 138% FPL (effective January 1, 2014)	100%****
* These services are matched at the enhanced rate for eight calendar quarters. ** Authorized through 2016. *** Authorized through 2015. **** In most states the FMAP is 100% from 2014-2016, 95% for 2017, 94% for 2018, 93% for 2019, and 90% for 2020 and beyond.	

Administrative Matching Rates. In general, costs incurred by states in administering the Medicaid program are matched by the federal government at a 50 percent rate. There are, however, several types of administrative functions which are matched at higher rates, ranging from 75 to 100 percent. These rates, each of which is specified in statute,²⁸ are shown in Table 3. In addition, federal regulations provide for a temporary increase in the federal matching rate to 90 percent for the costs of upgrading eligibility and enrollment systems to prepare for the implementation of coverage expansions under health reform.²⁹ Because administrative costs, on average, account for only about 4 percent of total federal program spending, these matching rates are of less fiscal consequence to a state than its FMAP.

Table 3: Administrative Matching Rates*	
Administrative Activity or Function	Matching Rate
Adoption and use of electronic health record (EHR) technology	100%
Citizenship verification	90%
Design, development, and installation of information systems for citizenship verification	90%
Management and operation of information systems for citizenship verification	75%
Design, development, and installation of MMIS	90%
Management and operation of MMIS	75%
Identification and education of individuals with sickle cell gene	50%
Immigration status verification	100%
Independent external reviews of managed care plans	75%
Medical and utilization review	75%
Preadmission screening and resident review	75%
Skilled professional medical personnel	75%
State fraud and abuse control unit activities	75%
State survey and certification	75%
Translation and interpretation services for children	75%
Other program administration activities	50%**
* By regulation, the matching rate for the costs of upgrading eligibility and enrollment systems incurred before December 31, 2015 is 90%.	
** Includes identification and education of individuals with Sickle Cell Disease.	

¹ The income standard for the newly eligible low-income adult group is at or below 133% of FPL (\$14,856 for an individual, \$30,656 for a family of four in 2012). However, in calculating income, the Medicaid statute requires that states disregard an amount of income equal to 5 percent of the FPL, which takes into account family size. As a result, the effective income eligibility level is at or below 138% of FPL (\$15,415 for an individual, \$31,809 for a family of four in 2012).

² Kaiser Commission on Medicaid and the Uninsured, *How will the Medicaid Expansion for Adults Impact Eligibility and Coverage?*, July 2012, available at <http://www.kff.org/medicaid/8338.cfm>.

³ Sections 1905(b) and 1101(a)(8)(B) of the Social Security Act. The formula does not determine the FMAPs for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; for these jurisdictions, the FMAPs are fixed in statute. The FMAP for the District of Columbia is set at 70 percent per section 4725(b) of the Balanced Budget Act of 1997, P.L. 105-33. The FMAPs for Puerto Rico and the territories are set at 55% per section 2005(c) of the Patient Protection and Affordable Care Act, P.L. 111-148.

⁴ Section 299E(a) of the Social Security Amendments of 1972. P.L. 92-603.

⁵ Section 402(e) of the Indian Health Care Improvement Act of 1976, P.L. 94-437.

⁶ The Government Accountability Office (GAO) has proposed revising the formula by substituting total taxable resources and people in poverty for per capita income as the factors driving the formula. Government Accountability Office, *Medicaid: Matching Formula's Performance and Potential Modifications* (GAO/T-HEHS-95-226), July 27, 1995. Differences in Funding Ability Among States Often are Widened, (GAO-03-620), July 10, 2003.

⁷ Government Accountability Office, *Medicaid: Improving Responsiveness of Federal Assistance to States During Economic Downturns* (GAO 11-395), March 31, 2011; *Medicaid: Prototype Formula would Provide Automatic, Targeted Assistance to States During Economic Downturns* (GAO 12-38), November 2011.

⁸ V. Wachino, M. O'Malley, R. Rudowitz, *Financing Health Coverage: the Fiscal Relief Experience*, Kaiser Commission on Medicaid and the Uninsured, November 2005, available at <http://www.kff.org/medicaid/7434.cfm>.

⁹ Kaiser Commission on Medicaid and Uninsured, *Impact of the Medicaid Fiscal Relief Provisions in the American Recovery and Reinvestment Act (ARRA)*, October 2011, available at <http://www.kff.org/medicaid/8252.cfm>.

¹⁰ Section 4725(a) of the Balanced Budget Act of 1997, P.L. 105-33, set the FMAP for Alaska at 59.8 percent for fiscal years 1998, 1999, and 2000.

¹¹ Section 614 of the Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3, requires that, in calculating per capita income for a state, the Secretary disregard employer pension and insurance fund contributions made beginning in calendar year 2003 if they exceed 25 percent of the total increase in personal income in the state for the year. The purpose was to adjust for the impact of the one-time auto manufacturer pension distribution on Michigan's FMAP beginning in FY 2006.

¹² Section 2006 of the Patient Protection and Affordable Care Act, P.L. 111-148. This provision was subsequently modified to adjust for an unintentional overpayment by section 3204(b) of the Middle Class Tax Relief and Job Creation Act of 2012, P.L. 112-96, and by section 100123 of the Moving Ahead for Progress in the 21st Century Act (MAP-21), P.L. 112-141.

¹³ Section 2161(a) of the Omnibus Budget Reconciliation Act of 1981, P. L. 97-35, temporarily reduced federal Medicaid matching payments to states over a 3-year period but it did so without altering the FMAP formula. Instead, it reduced the amount of federal Medicaid matching funds a state would otherwise receive after applying its regular FMAP to its spending on services. The amount of the reduction was determined by a percentage: 3 percent in FY 1982, 4 percent in FY 1983, and 4.5 percent in FY 1984. This percentage was adjusted downward in the case of states with high unemployment, states that adopted specified policies to control hospital costs, states that had high fraud and abuse recoveries, and states that met low spending growth targets.

¹⁴ For states that were covering childless adults at their existing federal matching rates prior to March 23, 2010, the ACA phases in an increase in the federal matching rate so that by 2019, federal matching rates for this population will equal the rate for the newly eligible Medicaid expansion population at 93% in 2019 and 90% in 2020 and prospectively. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, May 2010, available at <http://www.kff.org/healthreform/8076.cfm>.

¹⁵ The CBO revised its estimates for federal and state Medicaid spending in light of the Supreme Court decision in the National Federation of Independent Business (NFIB) case. The revised estimate projects federal Medicaid spending of \$642 billion and state Medicaid spending of \$41 billion over the 2014 through 2022 period. Table 4 available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

¹⁶ 76 Fed. Reg. 21949 (April 19, 2012). Enhanced funding at the 90% rate is available for costs of goods and services incurred by December 31, 2015 for design, development and implementation (DDI) that comply with certain defined standards and conditions. Enhanced funding at the 75% rate is available for maintenance and operations (M&O) of systems that were built using enhanced funding during the DDI phase. Available at <https://www.federalregister.gov/articles/2011/04/19/2011-9340/medicaid-program-federal-funding-for-medicaid-eligibility-determination-and-enrollment-activities>.

¹⁷ At least nominally. The effective federal matching rate is also a function of the nature of the state share. D. Rousseau and A. Schneider, *Current Issues in Medicaid Financing—An Overview of IGTs, UPLs, and DSH*, Kaiser Commission on Medicaid and the Uninsured, April 2004, available at <http://www.kff.org/medicaid/7071.cfm>.

¹⁸ Kaiser Commission on Medicaid and the Uninsured, *An Overview of Changes in the Federal Medical Assistance Percentages (FMAPs) for Medicaid*, July 2011, available at <http://www.kff.org/medicaid/8210.cfm>.

¹⁹ 76 Fed. Reg. 74061 (November 30, 2011), available at <http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf>.

²⁰ Section 2105(b) of the Social Security Act.

²¹ Section 2101(a) of the Patient Protection and Affordable Care Act, P.L. 111-148. This enhanced eFMAP cannot exceed 100 percent and expires on September 30, 2019. Federal allotments for CHIP are fully authorized through FY 2015 only, section 10203 of P.L. 111-148.

²² Section 1945(c)(1) of the Social Security Act, as added by section 2703 of the Patient Protection and Affordable Care Act, P.L. 111-148.

²³ Section 1905(b)(5) of the Social Security Act, as added by section 4106 of the Patient Protection and Affordable Care Act, P.L. 111-148.

²⁴ Section 1915(k)(2) of the Social Security Act, as added by Section 2401 of the Patient Protection and Affordable Care Act, P.L. 111-148.

²⁵ The MFP Rebalancing Demonstration program was authorized through 2011 by section 6071 of the Deficit Reduction Act of 2005, P.L. 109-171, and reauthorized through 2016 by section 2403 of the Patient Protection and Accountable Care Act, P.L. 111-148. The “MFP-enhanced” FMAP cannot exceed 90 percent. The total amount of federal matching funds for this demonstration is capped at \$450 million per year.

²⁶ The State Balancing Incentive Payments Program is authorized through 2015 by section 10202 of the Patient Protection and Affordable Care Act, P.L. 111-148. The enhanced FMAP is applied to the cost of non-institutional long-term care services and supports, not across-the-board, in states that elect to participate. States in which less than 25 percent of Medicaid long-term care spending was used to pay for home and community-based services (HCBS) in 2009 qualify for a 5 percentage point increase in their FMAP. States in which less than 50 percent of Medicaid long-term care spending was used to pay for HCBS services receive a 2 percentage point increase. Total federal matching funds available through 2015 are capped at \$3 billion.

²⁷ Kaiser Family Foundation, *A Guide to the Supreme Court’s Affordable Care Act Decision*, July 2012, available at <http://www.kff.org/healthreform/8332.cfm>. For states that were covering childless adults prior to March 23, 2010, the ACA phases in an increase in the federal matching rate so that by 2019, federal matching rates for this population will equal the rate for the newly eligible Medicaid expansion population at 93% in 2019 and 90% in 2020 and beyond. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, May 2010, available at <http://www.kff.org/healthreform/8076.cfm>.

²⁸ Section 1903(a)(2)–(7) of the Social Security Act.

²⁹ See footnote 16.

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