United States Government Accountability Office

GAO

Report to Congressional Requesters

October 2010

RECOVERY ACT

Increased Medicaid Funds Aided Enrollment Growth, and Most States Reported Taking Steps to Sustain Their Programs

GAO-11-58

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GAO Highlights

Accountability • Integrity • Reliability

Highlights of GAO-11-58, a report to congressional requesters

Why GAO Did This Study

In February 2009, the American Recovery and Reinvestment Act of 2009 (Recovery Act) initially provided states and the District of Columbia (the District) with an estimated $87 billion in increased Medicaid funds through December 2010, provided they met certain requirements. Funds were made available to states and the District through an increase in the Federal Medical Assistance Percentage (FMAP), the rate at which the federal government matches state expenditures for most Medicaid services. In March 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA), which prohibits states from adopting certain changes to program eligibility in order to receive federal reimbursement, and in August 2010, extended increased FMAP rates through June 2011. GAO was asked to examine issues related to Medicaid funds under the Recovery Act. GAO examined (1) states' and the District's access to and use of increased FMAP funds, and (2) states' and the District's plans to sustain their Medicaid programs once these funds are no longer available.

To do this work, GAO surveyed state Medicaid officials in the 50 states and the District in August 2009 and March 2010 about their program enrollment, uses of funds, program adjustments, and program sustainability. GAO obtained responses from all states and the District. GAO also reviewed CMS data and guidance and interviewed CMS and state officials.

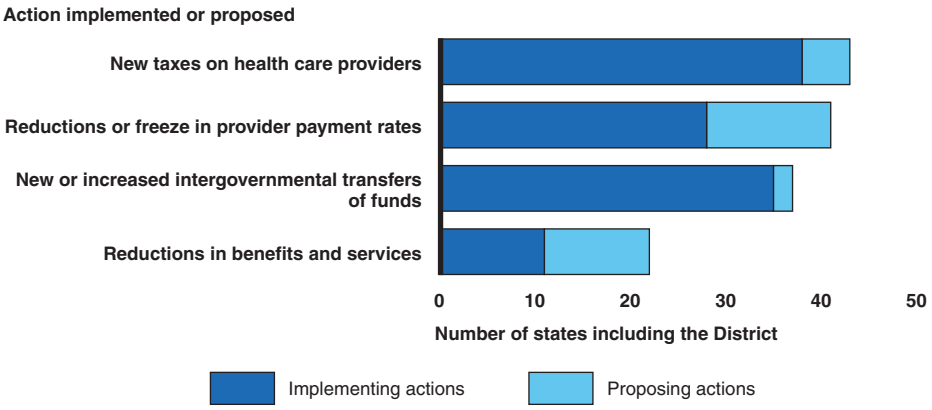
View GAO-11-58 or key components.
For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

States and the District are on pace to draw down about 94 percent—$82 billion of the estimated $87 billion—in increased FMAP funds provided by the Recovery Act. Most states adjusted their Medicaid programs to comply with the act's requirements, and nearly all states and the District reported using the increased FMAP to cover increased enrollment, which grew by 14.2 percent nationally between October 2007 and February 2010. Enrollment growth across the states and the District ranged from about 1 percent to 38 percent, with 22 states and the District experiencing a 10 to less than 20 percent increase. Although most enrollment growth was attributable to children, the highest growth rate was among the nondisabled, nonaged adult population.

Forty-seven states and the District reported concern regarding the sustainability of their Medicaid programs without the increased FMAP, and 46 states took steps to address sustainability, including introducing financing arrangements, such as taxes on health care providers, or reducing provider payments. Most states and the District also reported proposed changes for the future. (See figure.)

Certain Actions Most States and the District of Columbia Reported Implementing or Proposing to Address Medicaid Program Sustainability



Source: GAO analysis of state-reported data.

Congress passed legislation in August 2010 to extend the increased FMAP through June 2011, although at lower rates than provided by the Recovery Act. How the subsequent return to regular FMAP rates will affect states and the District will vary depending on their unique economic circumstances. GAO estimates that regular FMAP rates will be, on average, nearly 11 percentage points lower than increased FMAP rates available in December 2010. For future adjustments, states and the District will need to consider PPACA, which prohibits more restrictive eligibility standards, methods, or procedures until 2014, in order to receive federal Medicaid reimbursement.

HHS provided technical comments to this report, which GAO incorporated as appropriate.

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Abbreviations

CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CNMI	Commonwealth of the Northern Mariana Islands
CPE	certified public expenditure
FFY	federal fiscal year
FMAP	Federal Medical Assistance Percentage
FPL	federal poverty level
HHS	Department of Health and Human Services
IGT	intergovernmental transfer
PPACA	Patient Protection and Affordable Care Act

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

October 8, 2010

The Honorable Tom Harkin
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate

The Honorable Jack Reed
United States Senate

Since the winter of 2007, the nation has faced what is generally reported to be the most serious economic crisis since the Great Depression. From October 2007 to June 2010, the national unemployment rate more than doubled—from 4.7 to 9.5 percent. States' individual experiences varied, with unemployment rates in June 2010 at or above 9 percent in about half the states and as high as 14.2 percent in Nevada.[1] In addition to rising unemployment, the current economic crisis has also led to decreases in state tax revenues and increases in the number of individuals who are eligible for Medicaid, the joint federal-state health financing program for certain low-income populations, which is administered by the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS).

The American Recovery and Reinvestment Act of 2009 (Recovery Act) was enacted in February 2009 to promote economic recovery and investment during this time of economic crisis.[2] Among its stated purposes are to provide fiscal relief to states and to maintain states' Medicaid programs so that Medicaid beneficiaries are assured continuity of services. The Recovery Act initially provided states with an estimated $87 billion in increased federal funds for Medicaid from February 2009 through December 2010, which states could access provided they met certain requirements, including ensuring that their program eligibility requirements are not more restrictive than July 2008 standards.[3] CMS makes Recovery Act funds available to states for state spending on

[1]Throughout this report, the term states refers to the 50 states and the District of Columbia.

[2]Pub. L. No. 111-5, 123 Stat. 115.

[3]See GAO, *Estimated Temporary Medicaid Funding Allocations Related to Section 5001 of the American Recovery and Reinvestment Act*, GAO-09-364R (Washington, D.C.: Feb. 4, 2009).

Medicaid services through an increase in the rate at which the federal government matches state expenditures for these services. The federal government matches states' spending for Medicaid services according to a formula known as the Federal Medical Assistance Percentage (FMAP).[4] Without the fiscal relief provided to state Medicaid programs by the Recovery Act, states reported that they would have faced difficulties maintaining their level of benefits and services to an increasing number of eligible Medicaid beneficiaries.[5]

Moreover, in March 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA), which, among other provisions, prohibits states from adopting more restrictive Medicaid eligibility standards, methodologies, or procedures for adults until 2014 in order for states to receive any federal Medicaid funding.[6] Although some economists have pointed to signs of economic improvement, the budget outlook for states continues to show signs of stress, including a collective $174.1 billion budget gap that states faced for fiscal year 2010, as well as additional projected gaps in 2011 and 2012.[7] To help states address continuing budget gaps, federal legislation amending the Recovery Act was enacted on August 10, 2010, which provides for an extension of increased FMAP funding through June 30, 2011, but at a lower level.[8] In light of lingering

[4]For purposes of this report, the term regular FMAP refers to the FMAP as defined in section 1905(b) of the Social Security Act. The term increased FMAP refers to the temporary FMAP calculated based on provisions of § 5001 of the Recovery Act, as amended by Pub. L. No. 111-226, § 201.

[5]See GAO, *Recovery Act: One Year Later, States' and Localities' Uses of Funds and Opportunities to Strengthen Accountability*, GAO-10-437 (Washington, D.C.: March 2010).

[6]This requirement will continue to apply to children until October 1, 2019. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(b), 124 Stat. 119, 271 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, expands eligibility for Medicaid to include most individuals under age 65 and establishes a national floor for Medicaid eligibility at 133 percent of the federal poverty level ($14,404 for an individual or $29,326 for a family of four in 2009) by January 1, 2014. The act allows states that expand Medicaid coverage to these individuals prior to that date to obtain federal reimbursement based on the regular FMAP.

[7]States are projecting budget gaps of $83.9 billion and $72.1 billion for state fiscal years 2011 and 2012, respectively.

[8]See Pub. L. No. 111-226, § 201, 124 Stat. 2389 (2010). Under the legislation extending the increased FMAP financing, states will receive a general across-the-board increase of 3.2 percentage points in their regular FMAPs for the second quarter of federal fiscal year (FFY) 2011 and a 1.2 percentage point increase in their regular FMAP rates for the third quarter of FFY 2011. States will continue to be eligible for an unemployment adjustment to their regular FMAP rates.

fiscal pressures, it remains to be seen how states will respond to provisions within PPACA and the extension of the increased FMAP funding that will affect the financing of their Medicaid programs.

You expressed interest in states' uses of the increased FMAP funds and concerns they may have once this funding is no longer available. In this report, we examine issues related to the federal Medicaid funds available to states under the Recovery Act, including (1) the extent to which states have accessed and used increased FMAP funds, and (2) how states plan to sustain their Medicaid programs once the increased FMAP funds are no longer available.

To address our objectives, we administered a Web-based survey to the Medicaid directors or their designated contacts in all states in August 2009 and again in March 2010, and obtained response rates of 98 and 100 percent, respectively.[9] We reviewed states' responses to survey questions, which collected information on a variety of topics, including Medicaid enrollment, uses of increased FMAP funds, adjustments made in response to the Recovery Act's requirements, and the longer-term sustainability of their Medicaid programs. We also asked states about potential changes to their eligibility guidelines after Recovery Act funding is no longer available. However, states completed the survey prior to March 23, 2010, the enactment date of PPACA, and prior to enactment of legislation extending Recovery Act funding, and therefore, could not have taken into account provisions of the law when responding. As needed, we followed up with Medicaid officials in selected states to clarify survey responses and to obtain additional information on their compliance with certain Recovery Act requirements. In addition, using a more limited survey, we contacted the five largest U.S. insular areas—American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands—to collect enrollment and other data and obtained responses from four of them.[10] In addition, we reviewed data from CMS on federal Medicaid funds allotted under the Recovery Act for federal fiscal years (FFY) 2009 and 2010; interviewed CMS officials to

[9]As part of GAO's ongoing reports on states' uses of Recovery Act funds, we have collected similar information from a sample of states and the District of Columbia on a more frequent basis. For example, see GAO, *Recovery Act: States' and Localities' Uses of Funds and Actions Needed to Address Implementation Challenges and Bolster Accountability*, GAO-10-604 (Washington, D.C.: May 2010).

[10]We include information reported by the insular areas in appendix III and appendix V.

discuss their oversight of the Medicaid funds provided under the Recovery Act; and reviewed data prepared by Federal Funds Information for States, an organization that tracks and reports on the fiscal impact of federal budget and policy decisions on state budgets and programs. We relied on the survey responses reported by the official identified as the primary contact for the state's Medicaid program and on federal Medicaid data provided by CMS. We did not independently verify these data. However, we reviewed all survey responses and federal Medicaid data for internal consistency and followed up with state officials and CMS for clarification when necessary. Based on these activities, we determined these data were sufficiently reliable for the purpose of our report. (See app. I for additional information on the scope and methodology.)

We conducted a performance audit for this review from December 2009 to August 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Title XIX of the Social Security Act establishes Medicaid as a federal-state partnership that finances health care for certain low-income individuals, including children, families, the aged, and the disabled.[11] Within broad federal requirements, each state operates and administers its Medicaid program in accordance with a CMS-approved state Medicaid plan. These plans detail the populations served, the services covered, and the methods used to calculate payments to providers. All states must provide certain services, such as inpatient and outpatient hospital services, nursing facility services, and physician services, and may provide additional, optional services, such as prescription drugs, dental care, and certain home- and community-based services. The federal government matches most state Medicaid expenditures for covered services according to the FMAP, which is based on a statutory formula drawing on each state's annual per capita income.[12] To obtain federal matching funds for Medicaid, states file

[11]Medicaid programs are administered by the 50 states, the District of Columbia, and the 5 largest U.S. insular areas.

[12]The federal share of a state's Medicaid payments may range from 50 to 83 percent. For the insular areas, the FMAP is set by statute at 50 percent.

quarterly financial reports with CMS and draw down funds through an existing payment management system used by HHS.

The Recovery Act initially provided eligible states with an increased FMAP for 27 months from October 1, 2008, to December 31, 2010.[13] On August 10, 2010 federal legislation was enacted amending the Recovery Act and providing for an extension of increased FMAP funding through June 30, 2011, but at a lower level.[14] Generally, for fiscal year 2009 through the third quarter of fiscal year 2011, the increased FMAP is calculated on a quarterly basis and is comprised of three components: (1) a "hold harmless" provision, which maintains states' regular FMAP rates at the highest rate of any fiscal year from 2008 to 2011; (2) a general across-the-board increase of 6.2 percentage points in states' regular FMAPs through the first quarter of fiscal year 2011, which will be reduced to regular FMAP by July 1, 2011; and (3) a further increase to the regular FMAPs for those states that have a qualifying increase in unemployment rates.[15] Because the unemployment component of the increased FMAP is based on both the level of its regular FMAP and changes in a state's unemployment rate—versus its existing unemployment rate—it does not fully differentiate among states' economic circumstances prior to the downturn. States with comparatively high unemployment rates and higher regular FMAPs did not always receive the largest unemployment adjustment to their FMAPs.[16] For example, Michigan had the highest pre-recession unemployment rate in

[13]Recovery Act, div. B, title V, § 5001, Pub. L. No. 111-5, 123 Stat. at 496. CMS made increased FMAP funds available to states on February 25, 2009, and states could retroactively claim reimbursement for expenditures that occurred as of October 1, 2008.

[14]See Pub. L. No. 111-226, § 201, 124 Stat. 2389 (2010).

[15]Under the Recovery Act, insular areas initially had the option of choosing either an across-the-board increase of 6.2 percentage points to the FMAP rate in conjunction with a 15 percent increase in their federal Medicaid payment limits or a 30 percent increase in their federal Medicaid payment limits. See Recovery Act, Pub. L. No. 111-5, div. B, tit. V, § 5001(b), (d), 123 Stat. 115, 497-498 (2009). CMS officials reported that all five insular areas opted for the 30 percent increase to their federal Medicaid payment limits. After December 31, 2010, insular areas will receive the same FMAP adjustment as states do. See Pub. L. No. 111-226, § 201, 124 Stat. at 2389.

[16]The unemployment adjustment is generally determined using both changes in a state's unemployment rate and its regular FMAP rate. Specifically, the adjustment is calculated, in part, by comparing the unemployment rate during consecutive 3-month periods between December 2009 and January 2011 to the lowest 3-month unemployment rate since January 1, 2006. The unemployment adjustment may vary depending on changes to the underlying regular FMAP rate and hold harmless adjustment in effect for a given quarter. See Pub. L. No. 111-226, § 201, 124 Stat. at 2393.

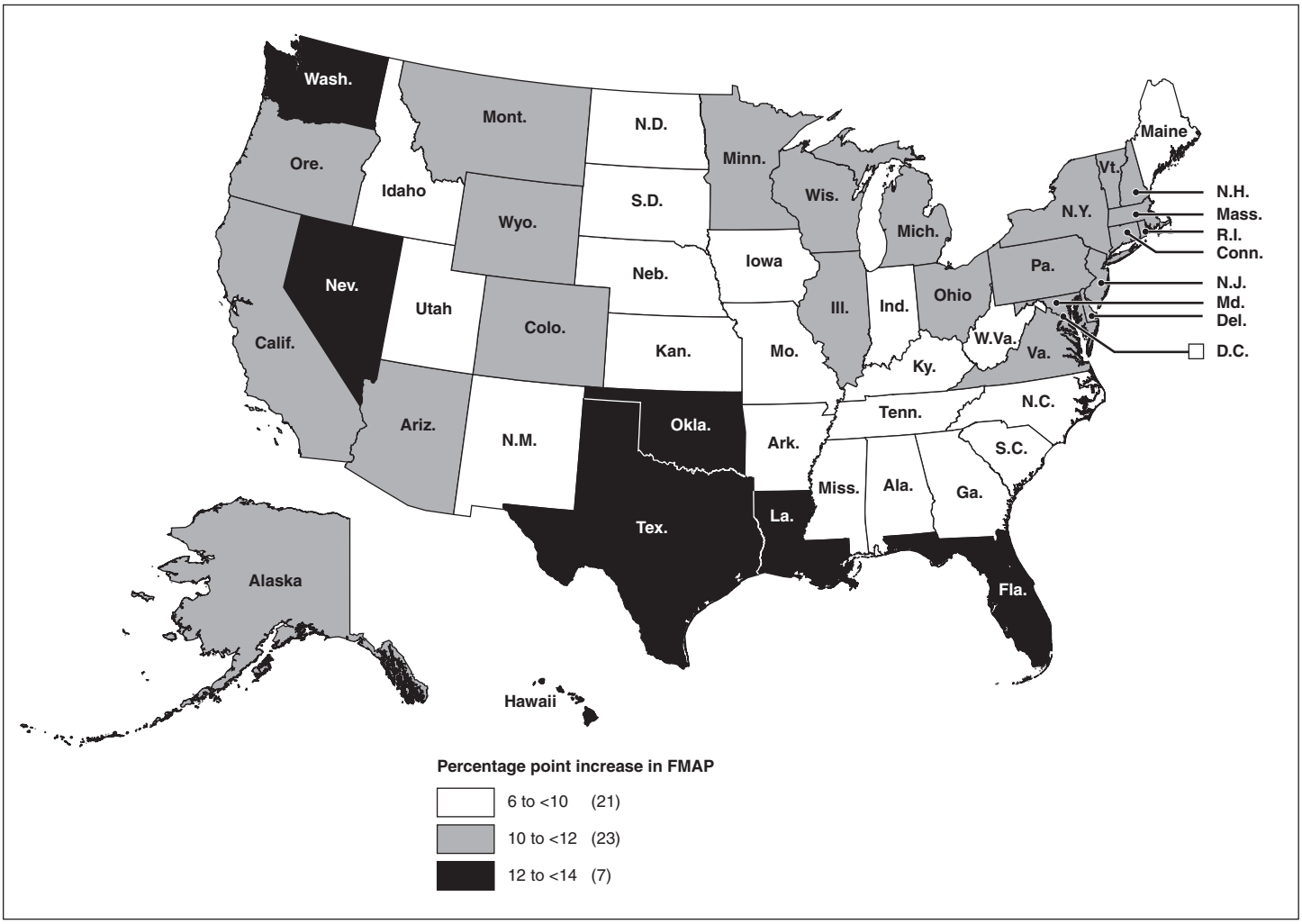
the nation at 7.3 percent in October 2007, and in June 2010, continued to have one of the nation's highest unemployment rates at 13.2 percent. Although the state's unemployment rate increased by 5.9 percentage points over this time, the increased FMAP attributable to the unemployment component in the fourth quarter of FFY 2010 was 3.88 percentage points. In contrast, New Hampshire received an unemployment adjustment of 5.39 percentage points for the same period, although growth in its unemployment rate was significantly lower, and in June 2010, was less than half the unemployment rate in Michigan.[17]

Following enactment of the Recovery Act, FMAP rates substantially increased in all states over the regular 2009 FMAP rates and have continued to increase, albeit at a slower rate, since that time. On average, increased FMAP rates nationally for the first and second quarters of FFY 2009 were 8.58 percentage points higher than regular FFY 2009 FMAP rates. By the fourth quarter of FFY 2010, the increased FMAP rates nationwide had increased by an average of 10.59 percentage points over the regular FFY 2010 FMAPs, with the increase ranging from 6.94 percentage points in North Dakota to 13.87 percentage points in Louisiana.[18] (See fig. 1.)

[17]New Hampshire's unemployment increased 2.5 percentage points during this period—from 3.4 to 5.9 percent.

[18]HHS's Office of Inspector General found that HHS's Office of the Assistant Secretary of Planning and Evaluation and CMS correctly calculated the increased FMAP in accordance with applicable provisions of the Recovery Act. See HHS, Office of the Inspector General, *Review of the Calculations of Temporary Increases in Federal Medical Assistance Percentages Under the American Recovery and Reinvestment Act*, A-09-09-00075 (May 2009); and *Review of the Calculation of Additional Medicaid Funding Awarded Under the American Recovery and Reinvestment Act*, A-09-09-00080 (July 2009).

Figure 1: Percentage Point Increase in States' FMAP for Fourth Quarter Federal Fiscal Year 2010



Sources: GAO analysis of HHS and Federal Funds Information for States data; Map Resources (map).

Note: The increase is based on a comparison between preliminary increased FMAP rates for the fourth quarter fiscal year 2010, which were estimated on May 25, 2010, and the regular FMAP rates for 2010, which were published in the *Federal Register* on November 26, 2008. HHS calculates preliminary FMAP rates using Bureau of Labor Statistics unemployment estimates and adjusts these FMAP rates once the final unemployment numbers become available. Fiscal year refers to the federal fiscal year, which begins October 1 and ends September 30.

For all states, the largest proportion of the increased FMAP was the component attributable to the across-the-board increase of 6.2 percentage points. In addition, the "hold harmless" component contributed to the increase in 17 states, and all states except North Dakota received an increase to their regular FMAP rate based on qualifying increases in unemployment rates.[19] (See app. II for additional information on increased FMAP rates available to states under the Recovery Act.)

For states to qualify for the increased FMAP, they must pay the state's share of Medicaid costs and comply with a number of requirements, including the following:

- States generally may not apply eligibility standards, methodologies, or procedures that are more restrictive than those in effect under their state Medicaid programs on July 1, 2008.[20]
- States must comply with prompt payment requirements.[21]
- States cannot deposit or credit amounts attributable (either directly or indirectly) to certain elements of the increased FMAP in any reserve or rainy day fund of the state.[22]
- States with political subdivisions—such as cities and counties—that contribute to the nonfederal share of Medicaid spending cannot require

[19]Under the Recovery Act, once a state qualifies for an unemployment increase, the increase is maintained through December 31, 2010, regardless of subsequent changes in unemployment rates.

[20]See Recovery Act, div. B, title V, § 5001(f)(1)(A).

[21]Under the Recovery Act, states are not eligible to receive the increased FMAP for certain claims for days during any period in which that state has failed to meet the prompt payment requirement under the Medicaid statute as applied to those claims. See Recovery Act, div. B, title V, § 5001(f)(2). Prompt payment requires states to pay 90 percent of clean claims from health care practitioners and certain other providers within 30 days of receipt and 99 percent of these claims within 90 days of receipt. See 42 U.S.C. § 1396a(a)(37)(A). A clean claim is a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. See Social Security Act § 1816.

[22]A state is not eligible for certain elements of increased FMAP if any amounts attributable directly or indirectly to them are deposited in or credited to a state reserve or rainy day fund. Recovery Act, div. B, title V, § 5001(f)(3).

the subdivisions to pay a greater percentage of the nonfederal share than would have been required on September 30, 2008.[23]

In addition, states must separately track and report on increased FMAP funds. To help states comply with these requirements, CMS provided the increased FMAP funds to states through a separate account in the payment management system used by HHS, allowing the funds to be tracked separately from regular FMAP funds as required by the act. CMS also provided guidance in the form of state Medicaid director letters and written responses to frequently asked questions, and the agency continues to work with states individually to resolve any compliance issues that may arise.[24]

Despite these restrictions, however, states are able to make certain other adjustments to their Medicaid programs without risking their eligibility for increased FMAP funds. For example, the Recovery Act does not prohibit states from reducing optional services, or reducing provider payment rates. States also continue to have flexibility in how they finance the nonfederal share of Medicaid payments. Specifically, provided they comply with federal limits, states may rely on various financing arrangements, such as provider taxes, certified public expenditures (CPE), or intergovernmental transfers (IGT), to generate the nonfederal share of payments.[25] (See table 1.)

[23]In some states, political subdivisions—such as cities and counties—may be required to help finance the state's share of Medicaid spending. Under the Recovery Act, a state that has such financing arrangements is not eligible for certain elements of the increased FMAP if it requires subdivisions to pay during a quarter of the recession adjustment period a greater percentage of the nonfederal share than the percentage that would have otherwise been required under the state plan on September 30, 2008. See Recovery Act, div. B, title V, § 5001(g)(2). The recession adjustment period is the period beginning October 1, 2008, and ending June 30, 2011.

[24]For example, as of May 3, 2010, CMS's Web site included state Medicaid director letters related to the availability or use of increased FMAP funds. See http://www.cms.hhs.gov/SMDL/SMD/list.asp?sortByDID=1a&submit=Go&filterType=none&filterByDID=-99&sortOrder=ascending&intNumPerPage=10 (accessed May 3, 2010).

[25]GAO, *Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency*, GAO-07-214 (Washington, D.C.: Mar. 30, 2007). In this report, we found that more than half the states ended certain Medicaid financing arrangements, which CMS determined to be inappropriate.

Table 1: Financing Arrangements Used by States to Generate the Nonfederal Share of Medicaid Payments and Limits Imposed on These Arrangements

Financing arrangement	Description	Limits imposed on arrangements
Provider tax	A tax, fee, assessment, or other mandatory payment imposed on health care services or providers. States may use resulting revenue to pay their nonfederal share of Medicaid payments under statutorily specified circumstances.	States may receive federal matching funds for provider taxes only if such taxes are broad-based, uniformly imposed, and do not result in any taxpayers being held harmless (i.e., receiving state funds to reduce the net payment to the state to below the amount of the tax).
Medicaid certified public expenditure (CPE)	A government provider, such as a county hospital, certifies to a state the amount of expenditures for a Medicaid-covered service provided to a Medicaid beneficiary. The state obtains federal Medicaid matching funds based on the amount of the payment.	Medicaid law allows states to finance the nonfederal share of payments with CPEs as long as the funds are (1) derived from state or local tax revenue, and (2) certified by units of local or state government as eligible for federal reimbursement.
Intergovernmental transfer (IGT)	Nonstate public revenue sources, such as local governments or other public entities, which provide the nonfederal share for Medicaid.	CMS requires that (1) IGTs from providers to a state occur before Medicaid supplemental payments are made, and (2) the amount of an IGT not exceed the nonfederal share of the Medicaid payments.

Source: GAO analysis of CMS data.

Note: See GAO, *Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency*, GAO-07-214 (Washington, D.C.: Mar. 30, 2007).

States Have Accessed Most Available Funds and Used Them to Support Medicaid Enrollment Growth

States have accessed most of the increased FMAP funds available to them through the Recovery Act, despite most having to make adjustments to their Medicaid programs to become eligible for the funds. Nearly every state used the funds to cover increased Medicaid enrollment, which grew by over 14 percent nationally between October 2007 and February 2010.

States Have Accessed Most Available Increased FMAP Funds and Made Program Adjustments to Comply with the Act

Through the end of the third quarter of FFY 2010, states had drawn down a total of $60.8 billion in increased FMAP funds—95 percent of the funds available at that point, or 70 percent of the total estimated $87 billion in increased FMAP that was provided through the Recovery Act.[26] If current spending patterns continue, we estimate that the states will draw down $82 billion by December 31, 2010—about 94 percent of the estimated total

[26]CMS officials indicated that states can continue to draw from their increased FMAP grant awards for the last three quarters of FFY 2010 expenditures until CMS finalizes the grant awards for these quarters, a process the agency has not yet completed.

allocation of $87 billion.[27] CMS distributed the increased FMAP funds to states through an existing payment system, thereby providing states with timely access to the funds. Within 3 months of enactment, all but one state had drawn down the increased FMAP funds.[28]

Most states reported making at least one adjustment to their Medicaid programs in order to be eligible for the increased FMAP funds, and 25 states reported making multiple adjustments. Twenty-nine states reported making adjustments to comply with the act's prompt payment requirement, and 26 states reported making adjustments to the act's maintenance of eligibility requirement. For example, several states reported that they were in the process of replacing antiquated claims payment systems or implementing programming changes to existing systems to be able to comply with the prompt payment requirement. Specifically, Hawaii and South Carolina adjusted their claims payment systems to identify claims on a daily basis and developed reporting mechanisms to monitor compliance with the act's prompt payment requirement. In terms of adjustments states made to comply with the maintenance of eligibility requirement, Vermont reported that it eliminated premium increases that it had imposed on certain beneficiaries, and Arizona reported reversing a policy that had increased the frequency at which it determined program eligibility. In addition, 13 states reported making adjustments to the act's requirement on contributions by political subdivisions, and 4 states reported making adjustments to comply with the act's requirement related to rainy day funds.

When asked about the difficulty of complying with the act's requirements in order to access funds, states most frequently reported that meeting the prompt payment requirement posed a high level of difficulty. Nine states reported having not met the prompt payment requirement at some point since the Recovery Act was enacted, with the total number of days reported by a state ranging from 1 day to 48 days. Eight states have either applied for or received a waiver from meeting the prompt payment

[27]We based our estimate on funds drawn by states as of June 30, 2010.

[28]Hawaii first drew down funds on June 15, 2009, the date after which the state reversed recent changes to its income eligibility requirements that state officials believed would make them noncompliant with the act's maintenance of eligibility requirements.

requirement from CMS.[29] (See app. III for additional information on the increased FMAP grant awards and drawdown amounts for each state.)

States Used Increased FMAP Funds to Maintain Their Programs in Light of Enrollment Growth

For FFY 2010 through the first quarter of FFY 2011, nearly all states reported using or planning to use funds freed up by the increased FMAP to cover increased Medicaid caseloads (45 states), maintain Medicaid eligibility (44 states), and to maintain Medicaid benefits and services (44 states). Additionally, the majority of states also reported using or planning to use these funds to help support general state budget needs, maintain institutional provider payment rates, and maintain practitioner payment rates.[30] Despite the variety of purposes for which states used the increased FMAP funds, when asked about the sufficiency of the funds, fewer than half of states (18 states) reported that the 2010 funds were sufficient for the stated purposes of the act—to provide fiscal relief to states and to maintain states' Medicaid programs.

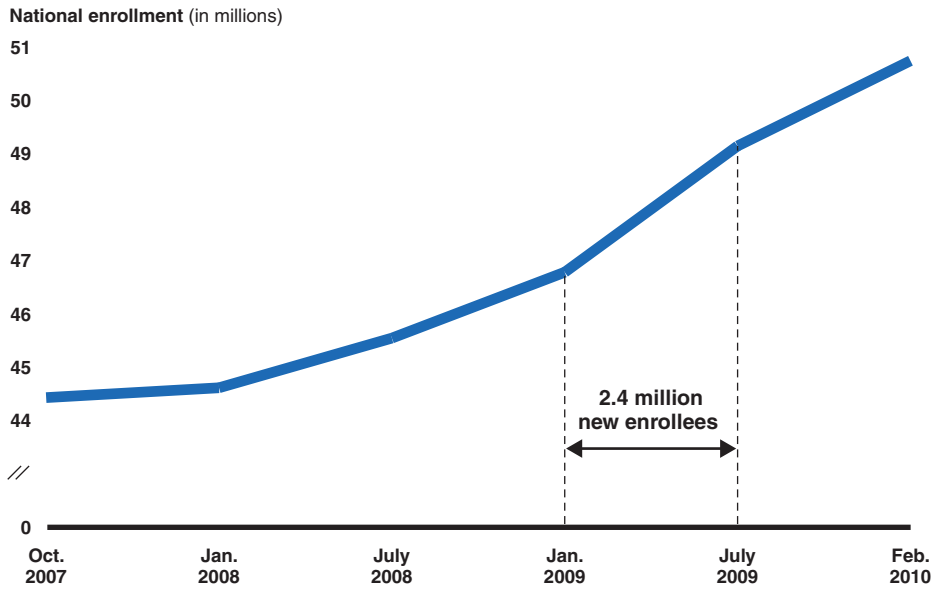
Nonetheless, 46 states reported that the increased FMAP was a major factor in their efforts to support Medicaid enrollment growth which, from October 2007 through February 2010, increased 14.2 percent nationally, which is significantly higher than in previous years.[31] The rate of growth peaked between January 2009 and July 2009, increasing by 5 percent during this 7-month period. (See fig. 2.)

[29]States may obtain a waiver from the act's prompt payment requirements if the Secretary of HHS determines that there are exigent circumstances, including natural disasters, which would prevent a state from the timely processing of claims or compliance with reporting requirements. A CMS official told us that Maine, Maryland, Massachusetts, North Dakota, and Pennsylvania had received approval for a waiver from the act's prompt payment requirement. In addition, CMS reported that three states—Idaho, Michigan, and Wisconsin—have requested waivers that are under review, and Tennessee had withdrawn a request for a waiver.

[30]Fewer than half the states reported using or planning to use these funds to ensure prompt pay requirements were met (21 states); to finance local public health insurance programs or the State Children's Health Insurance Program (CHIP) (10 states); and to increase Medicaid payment rates for certain providers (6 states). In addition, 1 state reported using funds to expand Medicaid eligibility levels and 1 state reported using funds to expand Medicaid benefits and services.

[31]For example, the Henry J. Kaiser Family Foundation estimated that national Medicaid enrollment increased by about 1 percent from December 2004 through June 2007. See the Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment in the 50 States June 2008 Data Update*, Henry J. Kaiser Family Foundation (Washington, D.C., September 2009), http://www.kff.org/medicaid/upload/7606-04.pdf (accessed Jan. 11, 2010).

Figure 2: National Medicaid Enrollment Growth, October 2007 through February 2010



Source: GAO analysis of state-reported data.

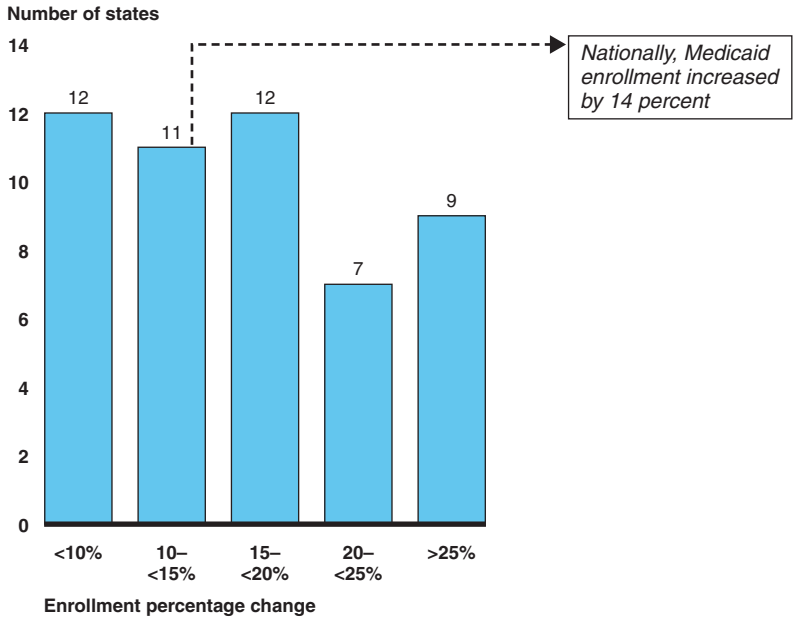
Enrollment growth across the states varied considerably—ranging from about 1 percent in Tennessee and Texas to almost 38 percent in Nevada.[32] Twenty-three states experienced a 10 to less than 20 percent enrollment increase, with 16 states experiencing an enrollment increase of 20 percent or greater.[33] (See fig. 3.) While the magnitude of the enrollment increase across states was largely due to the economic downturn, program expansions and enrollment outreach initiatives implemented in some states prior to the economic downturn also contributed to enrollment growth. Despite states' declining revenues, however, the act's maintenance of eligibility requirement made the increased FMAP contingent on states

[32]The lower enrollment growth in Tennessee and Texas could be due to specific factors. For example, a January 2009 court ruling allowed Tennessee to redetermine eligibility for specific beneficiaries, resulting in a reduction of about 100,000 individuals from their Medicaid program. For Texas, the lower enrollment growth could be due, in part, to the fact that the state provided preliminary enrollment data for September 2009 through February 2010.

[33]Three of the five largest insular areas also provided Medicaid enrollment data for this complete time period. Specifically, during this time, enrollment increased by slightly over 18 percent in Guam and nearly 81 percent in the U.S. Virgin Islands, and was largely unchanged in Puerto Rico.

not adopting more restrictive Medicaid eligibility standards, methodologies, or procedures than those that were in place on July 1, 2008.

Figure 3: Percentage Increase in Medicaid Enrollment for All States, October 2007 through February 2010



Source: GAO analysis of state-reported data.

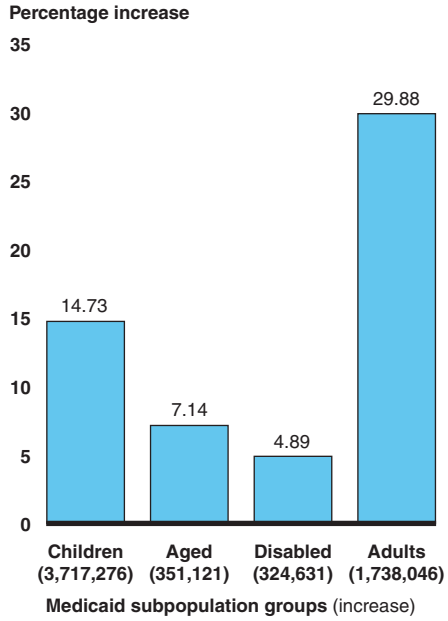
Note: These percentages are based on state-reported Medicaid enrollment data. For some states, the data reported are preliminary and subject to change.

When examining regional variation in enrollment growth, states in the western region of the country most commonly had enrollment increases above the national increase of just over 14 percent (11 of 13 states), while states in the northeast region were least likely to have enrollment increases over the national increase (4 of 9 states). Various factors likely contributed to these regional variations. For example, when compared to national averages, most states in the western region experienced higher than average growth in unemployment (8 of 13 states) and poverty rates (7 of 13 states) during the recession, and higher rates of uninsurance prior to the recession (11 of 13 states). Low enrollment growth in the northeast region may be due, in part, to the fact that many of these states have historically had higher Medicaid income-eligibility levels when compared to states in other regions. For example, in 2009, the majority of states in the northeast extended Medicaid coverage to parents with incomes over

150 percent of the federal poverty level (FPL). In contrast, the majority of states in the southern and western regions generally limited program eligibility to parents under 75 percent of the FPL.

Across the states, most enrollment growth was attributable to children, a population that comprises over half of total Medicaid enrollment, and is sensitive to economic downturns. However, the highest rate of increase during this period occurred among the nondisabled, nonaged adult population. Specifically, from October 2007 through February 2010, enrollment among the nondisabled, nonaged adult population increased by nearly 30 percent, compared to an increase of nearly 15 percent for children.[34] (See fig. 4.)

Figure 4: Enrollment Increases by Medicaid Subpopulation Groups for All States, October 2007 through February 2010



Source: GAO analysis of state-reported data.

Note: These percentages are based on state-reported Medicaid enrollment data. For some states, the data reported are preliminary and subject to change.

[34]During this period, Medicaid enrollment increased by about 7 percent for aged populations and 5 percent for disabled populations.

Of the 29 states with readily available information on the geographic distribution of Medicaid enrollment increases, 21 states reported that the increase was generally distributed evenly across the state, and 8 states reported that the increase was concentrated in certain urban or rural counties. For example, Arizona Medicaid officials reported that the largest enrollment increase occurred in Maricopa County—the state's largest county that includes Phoenix and Scottsdale. Pennsylvania officials reported that the concentration of enrollment growth was mixed between one rural county and two urban counties—Montgomery and Cumberland.

(See app. IV for more information on adjustments made by states to comply with Recovery Act requirements and states' uses of funds freed-up by the increased FMAP. See app. V for additional information on enrollment changes in the states and the largest U.S. insular areas.)

Most States Reported Taking Actions to Sustain Their Medicaid Programs, but Federal Legislation Will Influence Future Program Adjustments

Most states are concerned about their ability to sustain their Medicaid programs once the increased FMAP funds are no longer available, and have taken actions or proposed actions to address program sustainability. However, states' efforts to make future program adjustments will be influenced by recent legislation, including PPACA, and the subsequent extension of the increased FMAP through June 2011.

States' Actions to Address Program Sustainability Include New or Altered Financing Arrangements and Reductions to Provider Payments

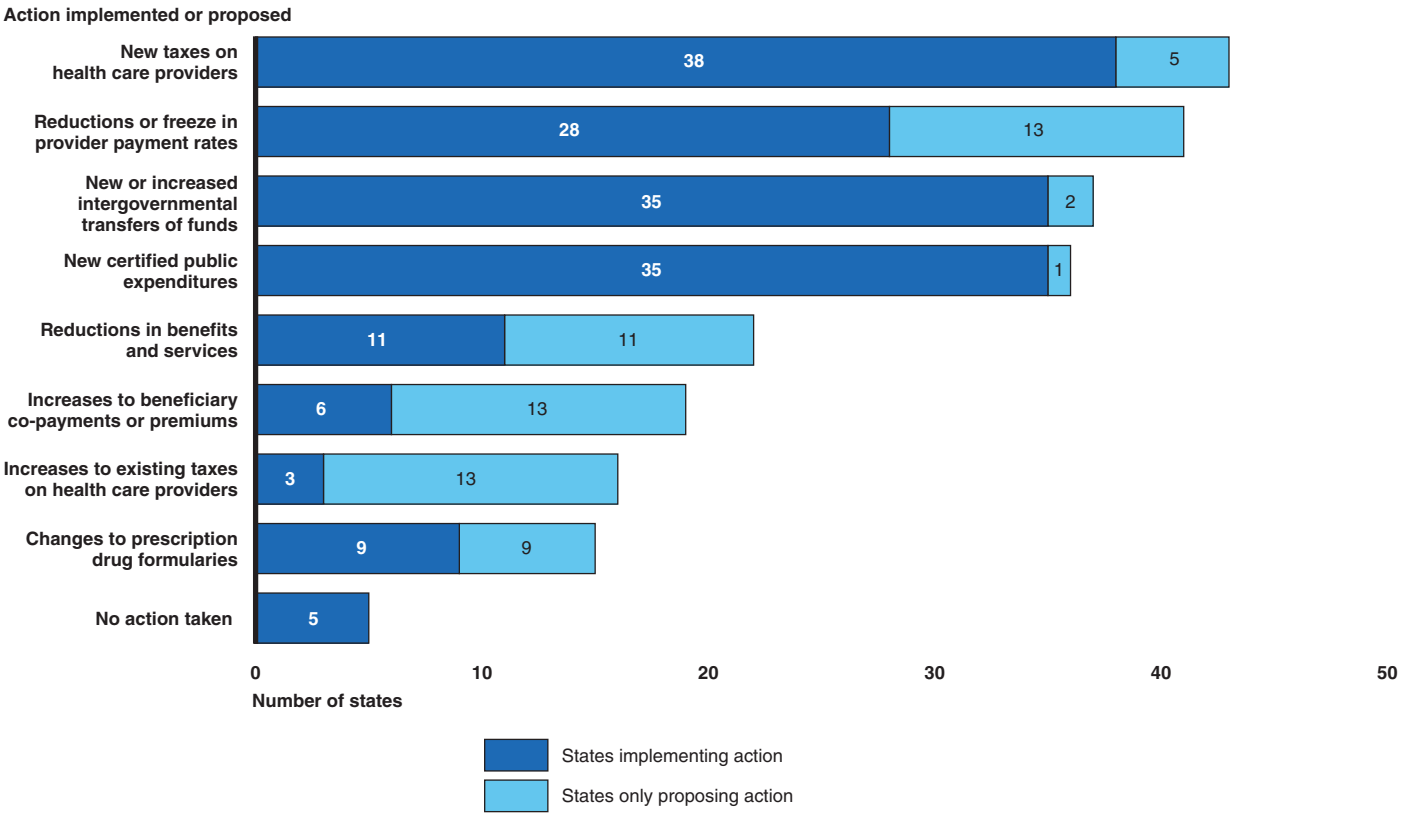
Forty-eight states reported concerns regarding the sustainability of their Medicaid programs after Recovery Act funding is no longer available,[35] with most states reporting that the factors driving their concerns included the increased share of the state's Medicaid payments in 2011, and the projection of the state's economy, tax revenues, and Medicaid enrollment growth for 2011.[36] To address program sustainability, 46 states have taken actions—such as introducing new Medicaid financing arrangements and reducing or freezing practitioner payment rates—and 44 states reported implementing multiple actions. Most commonly, states implemented new financing arrangements or altered existing ones—such as provider taxes, IGTs, and CPEs—to generate additional revenues to help finance the nonfederal share of their Medicaid programs.[37] In addition, most states also reported that they proposed making additional changes to their Medicaid programs for the remainder of fiscal year 2010 or for fiscal year 2011. (See fig. 5.)

[35]States completed our survey in March 2010, at which time the Recovery Act provided that the increased FMAP rates would no longer be available to states beginning on January 1, 2011, and approximately 4 months before legislation to extend the increased FMAP through June 2011 was enacted.

[36]As an indicator of the fiscal duress states have experienced over the past several years, 43 states cut their state fiscal year 2009 enacted budgets and 40 states cut their state fiscal year 2010 budgets after enactment. By comparison, only 12 states cut their enacted budgets in state fiscal year 2008. In addition, only 4 states—Delaware, Florida, Ohio, and Virginia—reported meeting their 2010 revenues estimates. See Federal Funds Information for States, *State Policy Reports 2010*, Volume 28, Issue 10 (Washington D.C., July 2010.)

[37]States reported implementing new taxes on private hospitals, intermediate care facilities for persons with mental retardation, and nursing facilities.

Figure 5: Actions States Reported Implementing or Proposing to Address Medicaid Program Sustainability



Source: GAO analysis of state-reported data.

Twenty-eight states reported that they reduced or froze Medicaid payment rates to certain Medicaid providers in response to concerns about program sustainability.[38] For example, in December 2009, Iowa implemented across-the-board rate reductions for most providers ranging from 2.5 to 5 percent, which will remain in effect until June 30, 2011. Similarly, Maryland reduced or froze payments for physicians and hospitals, and for long-term care services and home- and community-based services. States also reported reducing benefits and services, changing prescription drug formularies, or increasing beneficiary copayments or premiums. Four states—Florida, Illinois, Mississippi, and Texas—and the District of Columbia reported that they did not implement any changes in response to

[38]Fourteen states that reported reducing or freezing Medicaid practitioner or institutional provider payment rates also implemented new provider taxes.

their concerns about program sustainability; however, Medicaid officials in most of those states and the District told us that they were considering future changes.

In addition to these program changes, over half the states reported making administrative changes that could affect Medicaid application processing time, such as decreasing the number of staff or staff hours available for processing Medicaid applications, increasing furlough days, and decreasing the number of Medicaid intake facilities. Despite these actions, most states kept pace with the increasing number of applications they received. Specifically, of the 33 states reporting data, 25 processed on average at least 95 percent of applications they received each month.

(See app. IV for additional information on state actions to address program sustainability. App. VI provides more information on changes to states' share of Medicaid payments when increased FMAP is no longer available.)

States' Efforts to Make Future Program Adjustments Will Be Influenced by Federal Legislation

States indicated that legislation to extend the increased FMAP funding would help address their concerns about program sustainability. At the time of our survey, legislation extending the increased FMAP had been proposed, but not enacted. Despite uncertainties about the availability of the increased FMAP beyond December 2010, however, 30 states had assumed a 6-month extension of the increased FMAP in their fiscal year 2011 budgets without any changes to the way it is calculated as provided for under the Recovery Act, and only 9 of these states had contingency plans in place if such legislation was not enacted.[39]

On August 10, 2010, Congress passed legislation amending § 5001 of the Recovery Act to extend the increased FMAP through June 30, 2011, but at a lower level.[40] Specifically, under the amendments to the Recovery Act, states' increased FMAP rates will decrease by at least 3 percentage points beginning on January 1, 2011, and continue to be phased down to their regular FMAP rates by July 1, 2011. For states that had assumed an unmodified extension of the increased FMAP, the available federal funds

[39]See National Conference of State Legislature's May 6, 2010 letter to Congress: *FMAP Extension and the Impact on States, Table 1. Six-Month FMAP Extension*, http://www.ncsl.org/default.aspx?TabId=20284 (accessed July 29, 2010).

[40]See Pub. L. No. 111-226, § 201, 124 Stat. 2389.

will be less than anticipated. However, without the extension, we estimate that states, on average, would have faced a nearly 11 percentage point decrease in their FMAP rates on January 1, 2011.[41] The additional 6 months of increased FMAP funding will allow states more time to adjust as they return to their regular FMAP rates. How states will fare as they return to their regular FMAP rates will vary depending on each state's unique economic circumstances and the size of their Medicaid population.[42] Officials from several states indicated that the loss of increased FMAP funds would distress their state's budget, requiring the state to make additional program reductions, as the following examples illustrate.

- Wisconsin Medicaid officials reported that the state would need to reduce Medicaid expenses by $1 billion annually, or about 20 percent of the state's Medicaid budget, and are considering several options, including eliminating the state's prescription drug program for seniors and several rate reform initiatives.[43]

- Colorado Medicaid officials reported that the state would need to reduce Medicaid expenditures by an estimated $250 million, in addition to approximately $320 million the state has already cut. The state reported that the additional expenditure reduction would require drastic cuts to optional programs, benefits, and provider rates.

In addition, the recently enacted PPACA includes several provisions that affect states' Medicaid programs, and states will need to take into account these provisions when considering additional adjustments to their programs. Specifically, the maintenance of eligibility requirement under PPACA precludes states from receiving federal Medicaid funding if they apply eligibility standards, methods, or procedures, under their plan or a waiver, that are more restrictive for adults than those in effect on the date of PPACA's enactment until the date the Secretary of HHS determines that

[41]We based our estimates on the most recently available increased FMAP rates and the 2011 regular FMAP rates, and assumed no change in states' unemployment adjustment.

[42]When increased FMAP funds are no longer available, states' share of Medicaid payments will increase.

[43]In terms of reform initiatives, Wisconsin reported adjusting provider payments based on outcomes and error rates, continuing a Medicaid quality improvement effort that included a managed care pay-for-performance initiative, and implementing care management and coordination strategies.

a health insurance exchange established by the state is fully operational, which must be no later than January 1, 2014.[44,45]

PPACA also provides states with an opportunity to obtain additional Medicaid funds, either immediately or in the future. For example, PPACA requires states to cover all persons under 65 who are not already eligible under mandatory eligibility groups up to 133 percent of the FPL by 2014, but states have the option to expand eligibility immediately and to receive federal funds for these individuals.[46] As of August 12, 2010, Connecticut and the District have obtained CMS approval to shift eligible low-income adults from existing state health care programs into Medicaid.[47] The act also includes provisions to facilitate states' use of home- and community-based long-term care services.[48]

Agency Comments

In commenting on a draft of this report, HHS provided technical comments, which we incorporated as appropriate. HHS did not comment on our findings.

We are sending copies of this report to the Secretary of HHS, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

[44]Pub. L. No. 111-148, § 2001(b)(2), 124 Stat. 118, 275. This requirement will continue to apply to children until October 1, 2019. Beginning on January 1, 2011, this provision may have limited applicability if a state certifies to the Secretary that it has a budget deficit or projects to have a budget deficit in the following fiscal year. Pub. L. No. 111-148, § 2001(b)(2). According to CMS officials, the agency is currently developing guidance on various PPACA provisions.

[45]Prior to the enactment of PPACA, 10 states reported they were considering reducing eligibility once increased FMAP funds were no longer available.

[46]See CMS, State Medicaid Director Letter #10-005, *New Option for Coverage of Individuals under Medicaid* (Apr. 9, 2010).

[47]Five states provided coverage to working parents and seven states provided coverage to childless adults through state-funded programs in 2009.

[48]See, e.g., Pub. L. No. 111-148, § 2402, 10202.

If you or your staff members have any questions, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix VII.

Carolyn L. Yocom
Acting Director, Health Care

Appendix I: Scope and Methodology

To examine the extent to which states have accessed increased Federal Medical Assistance Percentage (FMAP) funds, we reviewed data provided by two divisions within the Department of Health and Human Services (HHS)—the Centers for Medicare & Medicaid Services (CMS) and the Office of the Assistant Secretary for Planning and Evaluation—on increased FMAP rates and Medicaid grant awards under the Recovery Act for federal fiscal years (FFY) 2009 and 2010. We analyzed data on increased FMAP rates to determine the proportion of each state's increase attributable to the three components prescribed in the act: the across-the-board component, the hold harmless component, and the unemployment component. We compared preliminary fourth quarter FFY 2010 increased FMAP rates to the 2011 regular FMAP rates to estimate the percentage increase in states' share of Medicaid payments once the increased FMAP is no longer available.

We also analyzed CMS data on increased FMAP funds to determine each state's total available grant award for FFYs 2009 and 2010 and the percentage each state had drawn from their available grants as of June 30, 2010. Based on these drawdown rates, we projected the total amount of increased FMAP funds that states would draw down by December 31, 2010. We interviewed CMS officials to understand how they compiled data on increased FMAP funds and to clarify anomalies we identified in the data. We also discussed CMS officials' oversight of the Medicaid funds provided under the Recovery Act and specifically addressed their oversight of states' actions to comply with the act's eligibility requirements for increased FMAP. We also reviewed relevant CMS guidance, including a sample of increased FMAP grant award letters, a fact sheet, frequently asked questions documents, and state Medicaid director letters related to the act.

To examine how states used the increased FMAP funds and how states planned to sustain their Medicaid program once the increased FMAP funds are no longer available, we administered a Web-based survey to the Medicaid directors or their designated contacts in all states in August 2009 and in March 2010, and obtained a response rate of 98 and 100 percent, respectively.[1] The surveys asked states to provide information on a variety

[1]In addition, using a more limited survey, we contacted the five largest U.S. insular areas—American Samoa, Guam, the Commonwealth of the Northern Mariana Islands (CNMI), Puerto Rico, and the U.S. Virgin Islands—to collect enrollment and other data and obtained responses from CNMI, Guam, Puerto Rico, and U.S. Virgin Islands. Information reported by the insular areas is included in appendix III and appendix V.

of topics, including their uses of increased FMAP funds, monthly Medicaid enrollment from October 2007 through February 2010, adjustments made in response to the act's requirements, and any concerns they had about the longer-term sustainability of their Medicaid programs. We pretested the surveys with Medicaid officials from four states. We reviewed all survey responses, and where appropriate, included these responses in the report. As needed, we followed up with Medicaid officials in selected states to clarify responses, to request corrected enrollment data, or to obtain additional information on their compliance with certain Recovery Act requirements.

We analyzed the Medicaid enrollment data obtained from the surveys to determine total enrollment growth and percentage change in enrollment for each state between October 2007 and February 2010. We also analyzed the enrollment data to determine the extent to which each Medicaid subpopulation—children, aged individuals, disabled individuals, and adults (nonaged, nondisabled)—contributed to overall enrollment growth during this period. We analyzed the survey data on Medicaid applications to determine any changes in states' processing volumes and rates over this period. We did not independently verify these data; however, we reviewed all survey responses and federal Medicaid data for internal consistency, validity, and reliability.[2] Based on these activities, we determined these data were sufficiently reliable for the purpose of our report.

In addition, we analyzed other state economic and fiscal data—such as poverty rates, unemployment rates, and Medicaid eligibility levels—to examine their relationship to overall Medicaid enrollment growth within states and regions.[3] We also reviewed data prepared by Federal Funds Information for States, an organization that tracks and reports on the fiscal impact of federal budget and policy decisions on state budgets and programs. Finally, we reviewed relevant provisions of the Patient Protection and Affordable Care Act, and other legislation that affect states' Medicaid programs.[4]

[2]For example, some state-reported Medicaid enrollment data obtained through our survey were preliminary and subject to update.

[3]We obtained poverty rates from the U.S. Census Bureau, unemployment rates from the Bureau of Labor Statistics, and Medicaid eligibility levels from the Henry J. Kaiser Family Foundation.

[4]The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

We conducted a performance audit for this review from December 2009 to August 2010 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Regular and Preliminary Increased Fourth Quarter 2010 FMAP Rates and Components of the Increase

State	Regular FMAP, fiscal year 2010[a]	Preliminary increased FMAP, fiscal year 2010, fourth quarter[a]	Percentage point FMAP increase	Component and its percentage contribution to the FMAP increase[b]		
				Across the board	Unemployment increase[c]	Hold-harmless
Alabama	68.01	77.53	9.52	65	35	0
Alaska	51.53	62.46	10.93	57	35	9
Arizona	65.75	75.93	10.18	61	35	4
Arkansas	72.78	81.18	8.40	74	24	2
California	50.00	61.59	11.59	53	47	0
Colorado	50.00	61.59	11.59	53	47	0
Connecticut	50.00	61.59	11.59	53	47	0
Delaware	50.21	61.78	11.57	54	46	0
District of Columbia	70.00	79.29	9.29	67	33	0
Florida	54.98	67.64	12.66	49	36	15
Georgia	65.10	74.96	9.86	63	37	0
Hawaii	54.24	67.35	13.11	47	35	17
Idaho	69.40	79.18	9.78	63	32	5
Illinois	50.17	61.88	11.71	53	46	1
Indiana	65.93	75.69	9.76	64	36	0
Iowa	63.51	72.55	9.04	69	31	0
Kansas	60.38	69.68	9.30	67	33	0
Kentucky	70.96	80.14	9.18	68	32	0
Louisiana	67.61	81.48	13.87	45	20	35
Maine	64.99	74.86	9.87	63	37	0
Maryland	50.00	61.59	11.59	53	47	0
Massachusetts	50.00	61.59	11.59	53	47	0
Michigan	63.19	73.27	10.08	62	38	0
Minnesota	50.00	61.59	11.59	53	47	0
Mississippi	75.67	84.86	9.19	67	26	7
Missouri	64.51	74.43	9.92	63	38	0
Montana	67.42	77.99	10.57	59	31	11
Nebraska	60.56	68.76	8.20	76	24	0
Nevada	50.16	63.93	13.77	45	37	18
New Hampshire	50.00	61.59	11.59	53	47	0
New Jersey	50.00	61.59	11.59	53	47	0
New Mexico	71.35	80.49	9.14	68	32	0

State	Regular FMAP, fiscal year 2010[a]	Preliminary increased FMAP, fiscal year 2010, fourth quarter[a]	Percentage point FMAP increase	Component and its percentage contribution to the FMAP increase[b]		
				Across the board	Unemployment increase[c]	Hold-harmless
New York	50.00	61.59	11.59	53	47	0
North Carolina	65.13	74.98	9.85	63	37	0
North Dakota[d]	63.01	69.95	6.94	89	0	11
Ohio	63.42	73.47	10.05	62	38	0
Oklahoma	64.43	76.73	12.30	50	28	22
Oregon	62.74	72.87	10.13	61	39	0
Pennsylvania	54.81	65.85	11.04	56	44	0
Rhode Island	52.63	63.92	11.29	55	45	0
South Carolina	70.32	79.58	9.26	67	33	0
South Dakota	62.72	70.80	8.08	77	23	0
Tennessee	65.57	75.37	9.80	63	37	0
Texas	58.73	70.94	12.21	51	34	15
Utah	71.68	80.78	9.10	68	32	0
Vermont	58.73	69.96	11.23	55	38	6
Virginia	50.00	61.59	11.59	53	47	0
Washington	50.12	62.94	12.82	48	41	11
West Virginia	74.04	83.05	9.01	69	29	2
Wisconsin	60.21	70.63	10.42	60	40	0
Wyoming	50.00	61.59	11.59	53	47	0
National (average)	**60.13**	**70.72**	**10.59**	**60**	**37**	**4**
Midwest (average)	60.63	70.23	9.59	66	33	1
Northeast (average)	53.46	64.73	11.26	55	44	1
South (average)	64.33	74.86	10.54	60	34	6
West (average)	58.80	69.90	11.10	57	37	6

Source: GAO analysis of HHS and Federal Funds Information for States data.

Note: Fiscal year refers to the federal fiscal year (FFY), which begins October 1 and ends September 30. HHS calculates preliminary FMAP rates using Bureau of Labor Statistics unemployment estimates and adjusts these FMAP rates once the final unemployment numbers become available.

[a]The regular FFY 2010 FMAP rates were published in the *Federal Register* on November 26, 2008. The fourth quarter FFY 2010 increased FMAP rates are preliminary and were published by Federal Funds Information for States on May 25, 2010.

[b]Average percentage does not add to 100 percent due to rounding.

[c]Under the Recovery Act, once a state qualifies for an unemployment increase, the increase is maintained through December 31, 2010.

[d]North Dakota is the only state that did not receive an increase to its preliminary FMAP rate due to qualifying increases in the state's unemployment rate during the period.

Appendix III: Increased FMAP Grant Awards and Funds Drawn Down

(Dollars in thousands)

State	Increased FMAP grant award for FFY 2009 and first three quarters of FFY 2010	Funds drawn down as of June 30, 2010	Percentage of funds drawn down as of June 30, 2010
Alabama	$638,953	$631,364	99
Alaska	157,609	154,985	98
Arizona	1,447,964	1,396,738	96
Arkansas	469,834	469,834	100
California	8,161,837	7,351,033	90
Colorado	672,250	619,292	92
Connecticut	941,177	939,428	100
Delaware	239,691	239,053	100
District of Columbia	256,088	239,930	94
Florida	3,365,155	3,365,155	100
Georgia[a]	1,190,337	1,193,457	100
Hawaii	269,586	257,846	96
Idaho	214,118	205,630	96
Illinois	2,358,447	2,223,231	94
Indiana	1,167,154	958,449	82
Iowa	403,129	396,591	98
Kansas	344,657	338,804	98
Kentucky	814,502	777,703	95
Louisiana	1,054,562	1,042,376	99
Maine	411,781	397,339	96
Maryland	1,257,917	1,225,053	97
Massachusetts	2,317,095	2,175,125	94
Michigan	1,837,917	1,814,387	99
Minnesota	1,378,171	1,340,052	97
Mississippi	608,627	566,203	93
Missouri	1,164,170	1,134,237	97
Montana	143,761	140,898	98
Nebraska	215,324	196,639	91
Nevada	335,985	322,158	96
New Hampshire	190,083	182,005	96
New Jersey	1,613,002	1,568,194	97
New Mexico	459,972	446,452	97

(Dollars in thousands)

State	Increased FMAP grant award for FFY 2009 and first three quarters of FFY 2010	Funds drawn down as of June 30, 2010	Percentage of funds drawn down as of June 30, 2010
New York	8,659,348	7,725,736	89
North Carolina	1,710,739	1,710,739	100
North Dakota	73,305	54,735	75
Ohio	2,279,147	2,164,154	95
Oklahoma	720,511	633,511	88
Oregon	654,847	623,060	95
Pennsylvania[a]	2,927,271	2,927,763	100
Rhode Island	349,968	348,336	100
South Carolina	679,978	658,052	97
South Dakota	91,604	91,163	100
Tennessee	1,142,763	1,120,362	98
Texas	4,189,789	4,164,967	99
Utah	249,728	201,441	81
Vermont	207,888	207,453	100
Virginia	1,111,452	1,103,904	99
Washington	1,435,402	1,228,353	86
West Virginia	342,068	340,742	100
Wisconsin	1,098,529	1,073,922	98
Wyoming	80,556	72,658	90
Total for states and the District	**$64,105,746**	**$60,760,690**	**95**
Insular area[b]			
American Samoa	5,625	3,646	65
CNMI	3,089	1,517	49
Guam	8,550	1,400	16
Puerto Rico	190,433	93,799	49
U.S. Virgin Islands	8,857	0	0
Grand total	**$64,322,299**	**$60,861,053**	**95**

Source: GAO analysis of HHS data, as of June 30, 2010.

Note: All percentages are rounded.

[a]These states have drawn down slightly more than is available through their increased FMAP grant and we rounded the percentage down to 100. CMS officials indicated that they recognize that these states have drawn down more than is available through the increased FMAP grant and that CMS is working with these states to resolve this issue.

[b]Under the Recovery Act, insular areas initially had the option of choosing either an across-the-board increase of 6.2 percentage points to the FMAP rate in conjunction with a 15 percent increase in their federal Medicaid payment limits or a 30 percent increase in their federal Medicaid payment limits through December 31, 2010. See Recovery Act, div. B, title V, § 5001(b)(2),(d). All five insular areas opted for the 30 percent increase to the cap in their federal Medicaid allotment. After December 31, 2010, insular areas will receive the same FMAP adjustment as states do. See Pub. L. No. 111-226, § 201, 124 Stat. at 2389.

Appendix IV: State-Reported Adjustments to Medicaid Programs and Uses of Funds Freed Up by the Increased FMAP

Table 2: State-Reported Adjustments to Medicaid Programs to Meet Recovery Act Requirements

	Recovery Act requirement			
State	Maintenance of eligibility[a]	Prompt payment[b]	Rainy day funds[c]	Political subdivisions[d]
Alabama		●		
Alaska				
Arizona	●	●		●
Arkansas				●
California	●	●		
Colorado				
Connecticut		●		
Delaware	●			
District of Columbia				
Florida	●	●		
Georgia				
Hawaii	●	●		
Idaho		●		●
Illinois	●	●		●
Indiana	●	●		
Iowa	●			
Kansas		●		●
Kentucky		●		
Louisiana		●		
Maine	●			
Maryland	●			
Massachusetts	●			
Michigan		●		
Minnesota	●	●	●	●
Mississippi		●		
Missouri		●		●
Montana			●	●
Nebraska	●			
Nevada	●	●		
New Hampshire	●			
New Jersey	●	●		
New Mexico		●	●	●
New York				●

State	Recovery Act requirement			
	Maintenance of eligibility[a]	Prompt payment[b]	Rainy day funds[c]	Political subdivisions[d]
North Carolina				
North Dakota				
Ohio	●	●		
Oklahoma				
Oregon	●	●		●
Pennsylvania	●	●		
Rhode Island	●	●		
South Carolina	●	●		
South Dakota	N/A	N/A	N/A	N/A
Tennessee	●	●		
Texas	●	●		
Utah	●		●	●
Vermont	●	●		
Virginia	●	●		
Washington				
West Virginia		●		●
Wisconsin	N/A	N/A	N/A	N/A
Wyoming				
Total	**26**	**29**	**4**	**13**

Source: GAO analysis of state-reported data.

Note: We asked states about adjustments to comply with the requirements specified in the Recovery Act in both surveys. South Dakota and Wisconsin did not provide responses to the August 2009 survey.

[a]States generally may not apply eligibility standards, methodologies, or procedures that are more restrictive than those in effect under their state Medicaid programs on July 1, 2008. See Recovery Act, div. B, title V, § 5001(f)(1)(A).

[b]Under the Recovery Act, states are not eligible to receive the increased FMAP for certain claims for days during any period in which that state has failed to meet the prompt payment requirement under the Medicaid statute as applied to those claims. See Recovery Act, div. B, title V, § 5001(f)(2). Prompt payment requires states to pay 90 percent of clean claims from health care practitioners and certain other providers within 30 days of receipt and 99 percent of these claims within 90 days of receipt. See 42 U.S.C. § 1396a(a)(37)(A). A clean claim is a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. See Social Security Act § 1816.

[c]A state is not eligible for certain elements of increased FMAP if any amounts attributable directly or indirectly to them are deposited in or credited to a state reserve or rainy day fund. Recovery Act, div. B, title V, § 5001(f)(3).

[d]States with political subdivisions—such as cities and counties—that contribute to the nonfederal share of Medicaid spending cannot require the subdivisions to pay a greater percentage of the nonfederal share than would have been required on September 30, 2008. See Recovery Act, div. B, title V, § 5001(g)(2).

Table 3: State-Reported Uses of Freed-Up Funds for State Fiscal Year 2009

State	Cover increased Medicaid caseload	Maintain Medicaid eligibility levels	Maintain Medicaid benefits and services[a]	Maintain Medicaid payment rates for institutional providers	Maintain Medicaid payment rates for practitioners	Ensure prompt payment requirements are met	Finance State Children's Health Insurance Program (CHIP)	Finance general budget needs
Alabama	●	●	●	●	●	●		●
Alaska								●
Arizona	●	●	●					●
Arkansas	●	●	●	●	●			
California	●	●	●			●		●
Colorado[d]	●	●	●	●	●			●
Connecticut								●
Delaware								
District of Columbia[d]								●
Florida	●	●	●	●	●			●
Georgia	●	●	●	●	●			●
Hawaii	●		●					●
Idaho	●	●	●	●	●	●		●
Illinois	●	●	●	●	●[c]	●		●
Indiana	●	●	●	●	●			●
Iowa	●	●	●	●	●			
Kansas	●	●	●	●	●			●
Kentucky	●	●	●	●	●	●	●	●
Louisiana	●	●	●	●	●			
Maine	●	●	●	●	●			●
Maryland	●	●[b]	●	●[f]	●[c]	●	●	●
Massachusetts	●	●	●	●	●			
Michigan	●	●	●	●	●	●		●
Minnesota	●	●[b]	●	●	●	●	●	●
Mississippi	●	●	●					●
Missouri	●	●	●	●	●			●
Montana								●
Nebraska	●	●	●	●[f]	●[c]			
Nevada	●	●	●				●	●
New Hampshire	●	●	●	●	●			●
New Jersey	●	●	●	●	●	●	●	●

State	Cover increased Medicaid caseload	Maintain Medicaid eligibility levels	Maintain Medicaid benefits and services[a]	Maintain Medicaid payment rates for institutional providers	Maintain Medicaid payment rates for practitioners	Ensure prompt payment requirements are met	Finance State Children's Health Insurance Program (CHIP)	Finance general budget needs
New Mexico	●	●	●	●	●	●		
New York[d]	●			●[f]				●
North Carolina								●
North Dakota[g,h]								
Ohio								●
Oklahoma								●
Oregon	●	●	●	●	●	●		
Pennsylvania	●	●	●	●	●	●		●
Rhode Island	●	●	●	●	●	●		●
South Carolina	●	●	●	●[f]	●	●		
South Dakota[e]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tennessee[d]		●	●		●			●
Texas	●	●	●	●[f]	●			
Utah	●	●	●	●	●			●
Vermont	●	●	●	●[f]	●[c]			
Virginia	●	●	●	●	●		●	●
Washington	●	●	●	●	●		●	
West Virginia	●	●	●	●	●	●		
Wisconsin[e]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Wyoming	●	●	●					
Total	**39**	**38**	**39**	**33**	**33**	**15**	**7**	**34**

Source: GAO analysis of state-reported data.

Note: While the increased FMAP funds available under the Recovery Act are for Medicaid services only, the receipt of these funds may reduce the funds that states would otherwise have to use for their Medicaid programs, and states have reported using these freed-up funds for a variety of purposes. We provided a list of uses from which states could select. We asked states to report uses or planned uses for increased FMAP funds for state fiscal year 2009.

[a]We also asked states if they used funds to expand Medicaid benefits and services. No state reported using funds for this purpose.

[b]State also reported using funds to expand Medicaid eligibility levels.

[c]State also reported using funds to increase Medicaid payment rates for practitioners.

[d]State reported using funds to finance local or state public health insurance programs other than Medicaid or CHIP.

[e]State did not provide responses to this survey.

[f]State also reported using funds to increase Medicaid payment rates for institutional providers.

[g]State reported using funds to increase Medicaid payment rates for practitioners.

[h]State reported using funds to increase Medicaid payment rates for institutional providers.

Table 4: State-Reported Uses or Planned Uses of Freed-Up Funds for Federal Fiscal Year 2010 through First Quarter of Federal Fiscal Year 2011

State	Cover increased Medicaid caseload	Maintain Medicaid eligibility levels	Maintain Medicaid benefits and services	Maintain Medicaid payment rates for institutional providers	Maintain Medicaid payment rates for practitioners	Ensure prompt payment requirements are met	Finance local public health programs or CHIP (programs other than Medicaid)	Finance general budget needs
Alabama	●	●	●	●	●	●		
Alaska	●	●	●					
Arizona	●	●	●	●	●			●
Arkansas	●	●	●	●	●			●
California	●	●						●
Colorado	●	●	●					●
Connecticut	●	●	●	●	●		●	●
Delaware								
District of Columbia	●	●	●	●	●		●	●
Florida	●	●	●		●			●
Georgia	●	●	●	●	●		●	●
Hawaii	●	●	●	●	●			●
Idaho	●	●	●	●	●	●		
Illinois	●	●	●	●	●	●		
Indiana	●	●	●					●
Iowa	●	●	●	●	●			
Kansas	●	●	●	●				●
Kentucky	●	●	●	●	●	●		●
Louisiana	●	●	●	●	●	●		
Maine	●	●	●	●	●	●		●
Maryland[d]	●	●	●[a]			●		●
Massachusetts	●	●	●	●	●	●	●	●
Michigan	●	●	●	●	●	●		●
Minnesota	●	●	●	●	●	●	●	●
Mississippi	●							●
Missouri	●	●	●	●	●			●
Montana	●	●	●	●[d]	●[b]	●		●
Nebraska	●	●	●	●[d]	●[b]	●		●
Nevada	●	●	●	●				
New Hampshire	●	●[f]	●	●	●	●		●
New Jersey	●	●	●	●	●	●		●

State	Cover increased Medicaid caseload	Maintain Medicaid eligibility levels	Maintain Medicaid benefits and services	Maintain Medicaid payment rates for institutional providers	Maintain Medicaid payment rates for practitioners	Ensure prompt payment requirements are met	Finance local public health programs or CHIP (programs other than Medicaid)	Finance general budget needs
New Mexico	●	●	●	●		●	●	●
New York	●	●	●	●	●			●
North Carolina								●
North Dakota[c,e]								
Ohio								●
Oklahoma	●	●	●	●		●		●
Oregon	●	●	●	●	●[b]	●	●	
Pennsylvania	●	●	●	●	●	●		●
Rhode Island			●	●	●			●
South Carolina	●	●	●	●[d]	●[b]		●	●
South Dakota	●	●	●	●	●		●	●
Tennessee	●	●	●	●	●	●		●
Texas								
Utah	●	●	●					
Vermont	●	●	●	●	●			
Virginia	●	●	●	●	●		●	●
Washington	●	●	●	●	●	●		●
West Virginia	●	●	●	●	●	●		●
Wisconsin	●	●	●					
Wyoming	●	●	●					
Total	**45**	**44**	**44**	**36**	**33**	**21**	**10**	**36**

Source: GAO analysis of state-reported data.

Notes: While the increased FMAP funds available under the Recovery Act are for Medicaid services only, the receipt of these funds may reduce the funds that states would otherwise have to use for their Medicaid programs, and states have reported using these freed-up funds for a variety of purposes. We provided a list of uses from which states could select. We asked states to report uses or planned uses for increased FMAP funds for FFY 2010 and the first quarter of FFY 2011, and all states and the District of Columbia provided responses.

[a]State also reported using or planning to use funds to expand Medicaid benefits and services.

[b]State also reported using or planning to use funds to increase Medicaid payment rates for practitioners.

[c]State reported using or planning to use funds to increase Medicaid payment rates for practitioners.

[d]State also reported using or planning to use funds to increase Medicaid payment rates for institutional providers.

[e]State also reported using or planning to use funds to increase Medicaid payment rates for institutional providers.

[f]State also reported using funds to expand Medicaid eligibility levels.

Table 5: Actions States Reported Implementing between October 2009 and February 2010 to Address Concerns about Medicaid Program Sustainability

State	New provider Tax	New or increased IGT[a]	New CPE[b]	Reduction or freeze in practitioner payment rates	Reduction or freeze in institutional payment rates	Reductions in benefits and services	Increase to co-pays or premiums	Change to drug formulary	No action taken
Alabama	●	●	●						
Alaska	●	●	●						
Arizona				●	●	●			
Arkansas	●	●	●						
California	●	●	●		●	●			
Colorado				●	●	●	●	●	
Connecticut	●	●	●					●	
Delaware	●	●	●	●	●				
District of Columbia									●
Florida									●
Georgia				●	●				
Hawaii	●	●	●						
Idaho	●	●	●	●	●	●	●		
Illinois									●
Indiana	●	●	●	●	●				
Iowa	●			●	●				
Kansas	●	●	●	●		●			
Kentucky	●	●	●					●	
Louisiana	●	●	●	●	●				
Maine	●	●	●						
Maryland	●	●	●	●				●	
Massachusetts				●	●				
Michigan				●					
Minnesota	●	●	●						
Mississippi									●
Missouri	●	●	●	●					
Montana	●	●	●						
Nebraska	●	●	●					●	
Nevada	●	●	●	●				●	
New Hampshire	●	●	●	●	●	●	●		
New Jersey						●		●	
New Mexico	●	●	●	●					

State	New provider Tax	New or increased IGT[a]	New CPE[b]	Reduction or freeze in practitioner payment rates	Reduction or freeze in institutional payment rates	Reductions in benefits and services	Increase to co-pays or premiums	Change to drug formulary	No action taken
New York					●				
North Carolina				●		●	●	●	
North Dakota	●	●	●						
Ohio	●			●					
Oklahoma	●	●	●	●	●	●	●		
Oregon	●	●	●	●		●		●	
Pennsylvania	●								
Rhode Island	●	●	●						
South Carolina	●	●	●						
South Dakota	●	●	●	●	●				
Tennessee	●	●	●						
Texas									●
Utah	●	●	●	●	●				
Vermont	●	●	●	●	●	●	●		
Virginia	●	●	●		●				
Washington	●	●	●						
West Virginia	●	●	●						
Wisconsin	●	●	●	●	●				
Wyoming	●	●	●	●	●				
Total	**38**	**35**	**35**	**25**	**19**	**11**	**6**	**9**	**5**

Source: GAO analysis of state-reported data.

Note: We asked states to consider actions implemented to address concerns over the sustainability of their Medicaid programs after increased FMAP funds were no longer available.

[a]IGT = Intergovernmental transfer

[b]CPE = Certified public expenditure

Appendix V: Medicaid Enrollment and Enrollment Changes by Subpopulation Group from October 2007 through February 2010

State	Total enrollment, February 2010	Percentage change, October 2007 to February 2010				
		All populations	Children	Aged	Disabled	Adults
Alabama	835,136	11.89	19.53	-14.23	4.81	-0.68[a]
Alaska	97,354	21.56	27.04	0.61	9.45	25.18
Arizona	1,422,444	28.92	25.85	13.76	5.51	46.47
Arkansas	582,246	5.51	7.14	-6.45	8.29	0.86
California	7,231,029	9.60	11.67	6.33	4.64	-7.97
Colorado	501,596	29.09	36.44	6.45	7.58	42.68
Connecticut	485,993	19.35	10.73	115.88	-4.46	26.05
Delaware	173,987	15.39	11.02	1.99	9.43	26.09
District of Columbia	151,331	11.88	10.68	0.44	12.02	11.83
Florida	2,730,912	29.04	35.77	14.43	N/A	N/A
Georgia	1,433,830	15.18	22.50	8.22	3.04	7.37
Hawaii	252,820	22.30	17.57	4.22	7.15	41.81
Idaho	185,916	23.67	20.57	30.66	15.47	89.81
Illinois	2,392,106	25.06	15.11	7.45	5.70	79.92
Indiana	973,084	20.70	18.40	8.16	11.74	9.83
Iowa	436,373	22.32	27.53	0.96	9.26	35.36
Kansas	280,406	6.79	6.55	-4.06	8.96	-5.05
Kentucky	730,433	9.12	13.82	-8.88	4.38	6.31
Louisiana	1,023,728	16.60	14.74	0.23	11.51	16.66
Maine	278,936	6.49	11.44	-1.13	4.00	10.97
Maryland	740,101	28.57	24.43	-0.45	7.30	64.40
Massachusetts	1,416,297	12.72	8.38	2.54	7.85	23.23
Michigan	1,797,960	16.13	14.70	36.73	0.55	28.27
Minnesota	645,905	11.48	10.61	-2.96	4.50	25.95
Mississippi	618,147	9.88	15.97	-4.27	8.38	78.80
Missouri	881,177	14.30	9.56	9.18	23.03	30.14
Montana	97,816	15.08	23.62	3.52	-10.49	24.42
Nebraska	200,867	13.64	16.09	-2.23	8.94	21.61
Nevada	251,062	37.76	52.92	9.57	7.98	34.00
New Hampshire	118,060	15.62	21.06	-0.35	34.62	-19.67
New Jersey	827,928	10.68	16.44	1.27	6.59	-3.83
New Mexico	467,763	15.15	20.16	-7.20	-18.28	5.27
New York	4,631,913	12.38	13.59	6.92	N/A	65.40

State	Total enrollment, February 2010	Percentage change, October 2007 to February 2010				
		All populations	Children	Aged	Disabled	Adults
North Carolina	1,426,024	16.15	19.68	-3.64	7.15	43.73
North Dakota	61,456	21.79	36.37	3.20	5.79	8.31
Ohio	1,899,388	16.46	17.26	3.14	8.54	27.81
Oklahoma	616,018	13.01	16.01	6.96	N/A	11.27
Oregon	539,228	28.50	32.37	15.14	19.67	31.51
Pennsylvania	2,073,245	8.60	6.86	8.87	11.14	17.45
Rhode Island	186,317	15.03	-2.11	-0.05	1.21	31.96
South Carolina	735,947	6.34	11.53	-3.85	2.99	0.55
South Dakota	99,248	9.28	11.57	-3.75	7.99	9.72
Tennessee	1,322,976	1.13	11.06	13.93	-33.80	10.64
Texas	3,162,057	0.64	-2.09	8.70	12.06	-10.61
Utah	249,545	25.72	39.83	9.30	15.94	13.62
Vermont	157,659	21.68	7.39	-3.47	7.31	47.99
Virginia	775,046	18.42	26.65	-1.07	9.54	17.62
Washington	1,068,572	13.54	18.31	3.98	8.91	6.31
West Virginia	328,307	8.28	9.58	-1.58	7.59	12.18
Wisconsin	1,081,743	30.96	17.80	5.09	-2.66	98.65
Wyoming	66,505	14.84	18.04	3.37	8.68	14.71
Total for states	**50,743,937**	**14.21**	**14.73**	**7.14**	**4.89**	**29.88**
Insular area[b]						
Guam	27,882	18.03	16.85	3.15	19.89	20.01
Puerto Rico	1,565,746	-0.31	-4.92	4.16	11.85	-7.91
U.S. Virgin Islands	8,274	80.97	-	-	-	-
U.S. geographic region						
Midwest	10,749,713	19.29	15.44	8.23	6.88	43.70
Northeast	10,176,348	11.85	11.22	8.13	8.12	39.89
South	17,386,226	12.14	14.85	5.64	2.14	14.52
West	12,431,650	14.92	16.39	7.19	5.36	25.51

Source: GAO analysis of state-reported and insular-area reported data.

Note: For some states, the data reported are preliminary and subject to change.

[a]Alabama indicated that it experienced a decrease in its adult enrollment due to terminations and denials resulting from the citizenship and identity documentation requirement, which the state began enforcing in April 2007.

[b]Due to limitations in enrollment data reported by certain insular areas, we were unable to conduct complete analyses.

Appendix VI: Estimated Changes in States' FMAP Rates and Share of Medicaid Payments

State	Estimated increased FMAP for FFY 2011[a]			Regular FMAP for FFY 2011[b]	Change between first and fourth quarters FFY 2011	
	First quarter	Second quarter	Third quarter	Fourth quarter	Percentage point decrease in FMAP rate[c]	Percentage increase in state share of Medicaid payments[d]
Alabama	77.53	74.53	72.53	68.54	8.99	40
Alaska	62.46	59.46	57.46	50.00	12.46	33
Arizona	75.93	72.93	70.93	65.85	10.08	42
Arkansas	81.18	78.18	76.18	71.37	9.81	52
California	61.59	58.59	56.59	50.00	11.59	30
Colorado	61.59	58.59	56.59	50.00	11.59	30
Connecticut	61.59	58.59	56.59	50.00	11.59	30
Delaware	61.78	58.78	56.78	53.15	8.63	23
District of Columbia	79.29	76.29	74.29	70.00	9.29	45
Florida	67.64	64.64	62.64	55.45	12.19	38
Georgia	74.96	71.96	69.96	65.33	9.63	38
Hawaii	67.35	64.35	62.35	51.79	15.56	48
Idaho	79.18	76.18	74.18	68.85	10.33	50
Illinois	61.88	58.88	56.88	50.20	11.68	31
Indiana	75.69	72.69	70.69	66.52	9.17	38
Iowa	72.55	69.55	67.55	62.63	9.92	36
Kansas	69.68	66.68	64.68	59.05	10.63	35
Kentucky	80.14	77.14	75.14	71.49	8.65	44
Louisiana[e]	81.48	78.48	76.48	63.61	17.87	96
Maine	74.86	71.86	69.86	63.80	11.06	44
Maryland	61.59	58.59	56.59	50.00	11.59	30
Massachusetts	61.59	58.59	56.59	50.00	11.59	30
Michigan	73.27	70.27	68.27	65.79	7.48	28
Minnesota	61.59	58.59	56.59	50.00	11.59	30
Mississippi	84.86	81.86	79.86	74.73	10.13	67
Missouri	74.43	71.43	69.43	63.29	11.14	44
Montana	77.99	74.99	72.99	66.81	11.18	51
Nebraska	68.76	65.76	63.76	58.44	10.32	33
Nevada	63.93	60.93	58.93	51.61	12.32	34
New Hampshire	61.59	58.59	56.59	50.00	11.59	30
New Jersey	61.59	58.59	56.59	50.00	11.59	30

State	Estimated increased FMAP for FFY 2011[a]			Regular FMAP for FFY 2011[b]	Change between first and fourth quarters FFY 2011	
	First quarter	Second quarter	Third quarter	Fourth quarter	Percentage point decrease in FMAP rate[c]	Percentage increase in state share of Medicaid payments[d]
New Mexico	80.49	77.49	75.49	69.78	10.71	55
New York	61.59	58.59	56.59	50.00	11.59	30
North Carolina	74.98	71.98	69.98	64.71	10.27	41
North Dakota	69.95	66.95	64.95	60.35	9.60	32
Ohio	73.47	70.47	68.47	63.69	9.78	37
Oklahoma	76.73	73.73	71.73	64.94	11.79	51
Oregon	72.87	69.87	67.87	62.85	10.02	37
Pennsylvania	65.85	62.85	60.85	55.64	10.21	30
Rhode Island	63.92	60.92	58.92	52.97	10.95	30
South Carolina	79.58	76.58	74.58	70.04	9.54	47
South Dakota	70.80	67.80	65.80	61.25	9.55	33
Tennessee	75.37	72.37	70.37	65.85	9.52	39
Texas	70.94	67.94	65.94	60.56	10.38	36
Utah	80.78	77.78	75.78	71.13	9.65	50
Vermont	69.96	66.96	64.96	58.71	11.25	37
Virginia	61.59	58.59	56.59	50.00	11.59	30
Washington	62.94	59.94	57.94	50.00	12.94	35
West Virginia	83.05	80.05	78.05	73.24	9.81	58
Wisconsin	70.63	67.63	65.63	60.16	10.47	36
Wyoming	61.59	58.59	56.59	50.00	11.59	30
US (average)	**70.72**	**67.72**	**65.72**	**59.89**	**10.83**	**39.26**

Source: GAO analysis of HHS and Federal Funds Information for States data.

Note: Increased FMAP will no longer be available to states beginning on July 1, 2011.

[a]We used preliminary fourth quarter FFY 2010 FMAP rates to estimate FMAP rates for the first three quarters of FFY 2011. The preliminary fourth quarter FFY 2010 FMAP rates were published by Federal Funds Information for States on May 25, 2010.

[b]The fiscal year 2011 regular FMAP rates were published by HHS in the *Federal Register* on November 27, 2009.

[c]Estimated FMAP percentage point decrease for each state between the first quarter FFY 2011 increased FMAP rate and the 2011 regular FMAP rate.

[d]Estimated percentage increase in state share of Medicaid payments between the first quarter FFY 2011 increased FMAP rate and the 2011 regular FMAP rate.

[e]For the portion of federal fiscal year 2011 not in the Recovery Act recession adjustment period (i.e., after December 31, 2010), the Patient Protection and Affordable Care Act (PPACA) will provide Louisiana with an FMAP of 68.04 (rather than the current FMAP of 63.61).

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

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In addition to the contact name above, the following team members made key contributions to this report: Susan Anthony, Assistant Director; Emily Beller; Laura Brogan; Ted Burik; Julianne Flowers; Zachary Levinson; Drew Long; and Kevin Milne.

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