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Medicaid's Continuing Crunch In a Recession: A Mid-Year Update for State FY 2010 and Preview for FY 2011

Executive Summary

All states have greatly benefited from the American Recovery and Reinvestment Act (ARRA) of 2009, primarily through significant increases in federal Medicaid matching rates (FMAP) which will result in an estimated total of $87 billion to states through Medicaid over a nine-quarter period ending in December 2010. However, as the recession continues across the country, Medicaid programs are feeling the strain of increased demand and lower state tax revenues.

From the beginning of state fiscal year 2010, fiscal pressures have escalated and additional program reductions have become a necessity to balance state budgets. At the half-way point in state FY 2010, a total of 44 states and the District of Columbia reported that program enrollment and spending trends are above the levels projected at the beginning of the state fiscal year. Over half of states – a total of 29 – reported that additional mid-year cuts are likely and 15 states indicate they did not yet know or that it is too soon to tell. Many Medicaid programs have been forced to look at mid-fiscal year cuts in provider rates and program benefits. States cannot reduce Medicaid eligibility this year because a condition of receiving the ARRA enhanced federal Medicaid matching funds was that that states had to maintain Medicaid eligibility.

Looking further ahead, the most dominant factor in the preparation of state fiscal year 2011 budgets is the upcoming end of the ARRA enhanced federal Medicaid matching rate. Medicaid directors expect that the end of the ARRA funding will have a dramatic impact on states and in particular on Medicaid. Across the country Medicaid directors described the upcoming abrupt end of these matching funds as a fiscal cliff that would have significant detrimental consequences on overall state budgets and on their programs.

This report provides a mid fiscal-year 2010 update on key state Medicaid issues, including the impacts of the economic downturn. This report augments the most recent annual Medicaid budget survey report which was published in September 2009.[1] That report was based on information provided by all state Medicaid directors in July and August 2009, at the beginning of state fiscal year 2010 for most states.[2] Updating that report, this report is based on discussions with leading Medicaid directors and a brief survey of Medicaid directors in all 50 states and the District of Columbia in November and December 2009 on current Medicaid issues, enrollment trends and the prospect for mid-fiscal year 2010 budget-driven program cuts.

[1] Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz. Caryn Marks and Molly O'Malley, "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," The Kaiser Commission on Medicaid and the Uninsured, September 2009. http://www.kff.org/medicaid/7985.cfm

[2] State fiscal years begin on July 1 in all states except New York (April 1), Texas (September 1), Alabama, Michigan and the District of Columbia (October 1).

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As states approached the mid-point of state fiscal year 2010, Medicaid directors reported that:

- ***The economic downturn is negatively impacting nearly every state budget and Medicaid program, in some cases causing severe distress***. State revenues are down and budget situations are worse than they were only a few months earlier at the beginning of the state fiscal year. The only variation across states is in the severity of the impact. Some states that were spared the early impacts of the economic downturn are now experiencing significant effects on their state and Medicaid budgets.

- ***A total of 44 states and the District of Columbia reported that program enrollment and spending trends are above the levels projected at the beginning of the state fiscal year and a majority of states are facing the prospect of mid-fiscal year 2010 program cutbacks necessitated by state Constitutional requirements for a balanced budget.*** In many states, directors say it is now virtually impossible to identify additional strategies to slow spending growth without looking at benefits, eligibility or provider rates, since they had already undertaken a broad range of aggressive cost containment actions in recent years.

- ***Looking ahead to next fiscal year, severe fiscal challenges are expected to persist and the ARRA enhanced FMAP is scheduled to end December 31, 2010.*** There is no sign of recovery in state revenue that could replace the very large drop in federal funding associated with the end of the ARRA funds. Many governors' proposed budgets for state fiscal year 2011 include drastic cuts to Medicaid as well as other state programs and state employees. With the focus on cutbacks, many directors said that they could not take advantage of the positive new provisions for children's coverage in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), even with the availability of enhanced federal matching funds, because state general funds simply were not available for them to do so. If ARRA is not extended, the requirement that states maintain Medicaid eligibility levels will also end on that date. Medicaid directors see the prospect for widespread program cutbacks in 2011, including eligibility cuts that would affect millions of Medicaid beneficiaries as well as the hospitals, doctors and other providers who depend on Medicaid to pay for health care they provide to Medicaid enrollees.

- ***The prospect of national health care reform including a major expansion of Medicaid left many Medicaid Directors with concerns about financing and administrative capacity.*** Health reform bills passed by both the House and Senate would use Medicaid as a primary vehicle to expand health coverage for low-income, uninsured individuals, specifically including adults without children. In a time of extreme fiscal constraint, when states have insufficient revenue to finance current operations, Medicaid directors were concerned about the fiscal impacts of national health reform on their states. They also were concerned about state administrative capacity and the availability of qualified people to do the required work at a time when many states have been experiencing staff cut-backs, furlough days and across-the-board program cuts.

Leading Medicaid directors believe the highest priority for federal action should be to avoid an abrupt and major reduction in federal funding to their program by extending the ARRA temporary FMAP enhancement for a significant time, followed by a phase-down period. Directors point out that states simply are not in a position at this time to replace the ARRA funds with state funding and without additional federal help states will be forced to look at significant program cuts to balance their budgets.

Introduction and Background

The purpose of this report is to provide a mid fiscal-year 2010 update on key Medicaid issues. This report augments the most recent Medicaid budget survey report, which was based on a comprehensive survey and interviews with all state Medicaid directors conducted at the beginning of the fiscal year. The annual survey report was published in September 2009.[3] This report is based on a brief survey of Medicaid directors in all 50 states and the District of Columbia and a structured discussion with leading Medicaid directors who serve on the Executive Committee of the National Association of State Medicaid Directors. The discussion and the brief survey focused on current Medicaid issues at the state and federal levels, current Medicaid enrollment and spending trends and the prospect for mid-fiscal year 2010 budget-driven program cuts.

Medicaid is a federal entitlement program that provides health and long-term care coverage for low-income Americans. Medicaid is administered by the states under rules established in federal law that allow each state the flexibility to shape its own program in terms of eligibility, benefits, provider payment rates and delivery systems. During federal fiscal year 2009, Medicaid provided coverage for over 60 million persons and total Medicaid expenditures were estimated to exceed $386 billion.[4]

Medicaid is financed jointly by the states and federal government, with the federal government providing matching funds based on actual total program expenditures. The federal Medicaid matching rate (known as the Federal Medical Assistance Percentage or FMAP) is calculated each year for each state, and it varies depending on the average personal income in the state. Prior to FY 2009, the FMAP has averaged about 57 percent, with the FMAP for wealthier states at the statutory floor of 50 percent and FMAPs for poorer states ranging up to a high of 76 percent. The ARRA established a formula that temporarily raised FMAPs for all states for nine quarters, with additional increases based on each state's unemployment rates. During fiscal years 2009 and 2010, the ARRA-enhanced state FMAPs range from a minimum of about 61 percent to a high of over 84 percent, with quarterly adjustments depending on changes in the unemployment rate in each state.

When state legislatures finalized state budgets for FY 2010, the economic downturn was already having an impact on Medicaid spending. During fiscal year 2009, Medicaid spending increased on average by 7.9 percent. The number of persons enrolled in the program increased in every state in FY 2009, with increases averaging 5.4 percent, the highest level of enrollment growth since 2003, making enrollment growth the primary driver of increased Medicaid spending in FY 2009. When legislatures adopted budgets for FY 2010, the projections for annual Medicaid enrollment growth were that the pace of growth would accelerate on average to 6.6 percent. On the basis of expected enrollment growth, it might have been expected that legislatures would have appropriated funding for a comparable increase in Medicaid spending in FY 2010, but instead legislatures authorized spending growth of only 6.3 percent (i.e., a drop from the actual growth of 7.9 percent the prior year.) The reason for the decrease was that state revenues were dropping below projections, and states did not have the general fund dollars to authorize a higher

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[3] Ibid, "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," The Kaiser Commission on Medicaid and the Uninsured, September 2009.

[4] Andrea Sisko, Christopher Truffer, Sheila Smith, Sean Keehan, Jonathan Cylus, John A. Poisal, M. Kent Clemens, and Joseph Lizonitz, "Health Spending Projections Through 2018: Recession Effects Add Uncertainty To The Outlook," *Health Affairs*, published online 24 February 2009.

rate of Medicaid spending growth, even with the ARRA-enhanced FMAP levels. Indeed, the decreases in state revenues in calendar 2009 were of historic size, with the three largest quarterly drops in state revenues ever recorded occurring in each of the first three quarters of the year.[5]

Not surprisingly then, Medicaid officials identified the recession as the dominate driver of Medicaid policy for FY 2010, as Medicaid caseloads increased, Medicaid spending grew, state revenues dropped sharply and pressure to reduce all state spending intensified in the face of large and growing budget shortfalls. Without question, the ARRA funding through the enhanced FMAP provided critical help to states in balancing their budgets. However, in many cases this funding was not sufficient as caseloads and expenditures were increasing beyond budgeted levels. In many states it was becoming clear that the budget enacted by the legislature would not be fully sufficient to finance the program for the fiscal year, making it necessary for many states to consider mid-fiscal year program reductions in provider rates and benefits provided to Medicaid enrollees.

It was in this context that leading Medicaid directors gathered in November 2009 to discuss the impact of the economic downturn on FY 2010 on Medicaid enrollment and spending trends, the implications for Medicaid policies for the balance of the current fiscal year and the potential implications for FY 2010, the implementation of CHIPRA in their states, and their perspectives on national health care reform.

Methodology

Medicaid directors who serve on the Executive Committee of the National Association of State Medicaid Directors (NASMD) were invited by the Kaiser Commission on Medicaid and the Uninsured to participate in a special discussion on the impact of the current economic downturn on their state Medicaid program. The structured discussion focused on how the economy was affecting Medicaid, what changes were expected in Medicaid in the next year, issues for Medicaid relating to health reform as it is being considered in the Congress, and assuming adoption of health reform, issues and concerns relating to state administration and implementation, and the impacts of health care reform on their states. The discussion took place during the annual meeting of the National Association of State Medicaid Directors, which was held November 9 – 11, 2009 in Crystal City, Virginia.

Participating in the roundtable discussion were Medicaid directors from 8 states: Alabama, New Mexico, Nevada, Oklahoma, Pennsylvania, Tennessee, Washington, and Maine. Also participating were the Executive Director and staff of NASMD. Following the discussion, Medicaid directors from all other states were interviewed in person, by email or phone. Altogether, this report is based on input from Medicaid directors in all 50 states and the District of Columbia.

[5] Source: *Lucy Dadayan and Donald J. Boyd*, "Recession or No Recession, State Tax Revenues Remain Negative," Rockefeller Institute of Government, January 2010. www.rockinst.org

Key Findings

The economic downturn is affecting every state budget and Medicaid program, with the impact varying only in the degree of impact, with some states experiencing severe distress and others a milder impact.

In state after state, Medicaid directors described a state budget situation in which state revenues were coming in far below projections and states were experiencing unprecedented budget shortfalls. Shortfalls were occurring now in states that heretofore had not experienced major budget problems during the current recession. States reported that the ARRA enhanced federal matching funds had provided critical funding and had protected programs from reductions in eligibility. However, even with this additional funding, states were reporting that they had been forced to cut provider payment rates and program benefits due to current budget shortfalls. Further, states reported that they were beginning the process of planning for cuts next fiscal year to replace the loss of the enhanced FMAP funding. The clear message from Medicaid directors in most states was that the economy had a profound impact of state budgets in the early months of FY 2010 and that across the states their Medicaid and Child Health Insurance Programs (CHIP) would be expected to bear a share of the burden of addressing overall state budget problems.

Already in FY 2010, most states had implemented across-the-board spending restrictions such as hiring freezes or travel bans as a first step to address budget shortfalls. Some states are now implementing furloughs of state employees and employee layoffs. In many cases these changes have constrained the state's administrative capability to manage their program and program budget. In addition, most states also have had to implement Medicaid program cuts including reductions in provider payment rates and restrictions or eliminations of covered benefits.

However, these restrictions and program cuts did not and could not come close to addressing the more serious budget gaps. Among the most dire state economic crises are those in California, Nevada and Arizona.

- California, after making significant budget reductions and temporary tax increases, is dealing with an 18 month budget gap through FY 2011 of over $20 billion (or 17 percent of its total budget). With federal ARRA money ending and the expiration of temporary tax increases the deficit is expected to grow to an annual deficit of $21 billion in fiscal year 2012-13.

- Nevada has seen state revenues plummet as a result of the dramatic downturns in gaming, housing and overall economic activity. Nevada reached 13.5 percent unemployment in December 2009 with no expectation of a recovery happening in the near future.

- Arizona has a $2 billion deficit in its $10 billion 2010 budget, with the deficit expected to grow to $3 billion in the 2011 budget.

- Other states including Michigan, Pennsylvania, Tennessee, Washington and New Mexico also reported major state budget shortfalls.

No state reported that it was immune from the effects of the economic downturn. Every state indicated that the state was experiencing growth in its Medicaid enrollment or spending or was considering actions to curtail spending in their Medicaid budget. Even energy-rich states such as Oklahoma and Texas, where state revenues had been affected less in the early stages of the recession, reported that they were facing overall state budget issues including issues relating to Medicaid.

Halfway into state FY 2010, in the vast majority of states, Medicaid enrollment and spending trends are above the levels projected at the beginning of the state fiscal year.

The same forces that have caused state revenues to slow also caused increases in Medicaid enrollment and spending. Across the states, Medicaid directors reported growth in the numbers of persons enrolling in Medicaid, and growth in Medicaid spending. Based on updated enrollment information provided by state Medicaid officials for this report, growth in enrollment was above the levels projected at the beginning of the fiscal year in nearly every state (44 states and the District of Columbia). Among these states, it was not uncommon for Medicaid directors to indicate that they had begun the fiscal year with an expectation that they would experience a high rate of growth in enrollment this year, but that actual enrollment growth was even higher than the projections. In six states, Medicaid directors indicated that enrollment was tracking with projections. Among these six states, a common theme was expressed by one director, who said that "It is growing fast, but not faster" than originally projected. In no state was current enrollment growth lower than originally projected.

When fiscal year 2010 began, Medicaid budgets were based on projected growth in the numbers of persons enrolled in Medicaid that averaged 6.6 percent across all states. The experience in the first half of FY 2010 suggests that initial projections will prove to be low, in some cases by a substantial margin, with the largest growth often in states with the most significant budget shortfalls. In this brief survey, states were asked to indicate whether enrollment growth so far in FY 2010 was greater than, the same or less than what was projected at the beginning of the fiscal year. States were not asked to provide specific percentages, although some did. State responses illustrate the current state experience with Medicaid enrollment growth:

- Oregon enrollment is "growing fast" as was projected. South Dakota reported "Enrollment is growing incredibly fast". New Hampshire and Pennsylvania said recent rapid enrollment growth has been primarily among children, although a few states such as Iowa said the proportion of growth among adults was higher than expected.

- New Hampshire said that those coming on to Medicaid over the past year were primarily children whose parents had insurance and lost it, or had high deductibles and that "…as a result there is incredible pent up demand for preventive services and elective procedures on the medical and dental side."

- Idaho reported enrollment growth had unexpectedly accelerated in recent months, from growth of about four percent over the past year, to growth in the last two months at an annual rate of over 8 percent.

- A few states reported double digit rates of growth in enrollment. Utah budgeted enrollment growth at 12 percent, reflecting planned eligibility expansions, but in the first months of FY 2010 annualized enrollment growth was 16 percent. Hawaii's enrollment growth was also above 10 percent.

Enrollment growth is a primary determinant of Medicaid spending growth, but it is not the only factor. States are also experiencing spending increases due to higher utilization and health care inflation. Some states said that in addition to other cost control approaches, they also were focusing on strategies to control utilization.

Most states are facing the prospect of mid-year 2010 program reductions

Medicaid directors indicated that as of November or December 2009, mid-year budget-driven Medicaid cutbacks were very likely or a possibility in 44 states in FY 2010, including a total of 29 states that indicated mid-year cuts were likely or had already occurred, and 15 additional states where they were a possibility. The ARRA prohibits states from reducing or restricting eligibility for the program, however reductions in provider rates and program benefits are still allowed. Since Medicaid is such a large program within state budgets and state revenues have fallen so sharply, and states are required to balance their budgets annually, it is difficult for a state to address a statewide budget shortfall without cutting Medicaid spending along with other programs.

Several states indicated that every possible cost containment option that was not prohibited by the ARRA was now on the table. Across the states where mid-fiscal year cuts are likely, the most likely cuts are further reductions in provider rates (listed by 21 states) and reductions or restrictions of program benefits (listed by 8 states). In addition, states also listed the following as likely budget-cutting targets: cuts in various specially funded programs such as disproportionate share hospital and graduate medical education funding, changes to pharmacy programs, increased program integrity, utilization review and third party liability work.

Reductions in funding for their Children Health Insurance Programs were also being considered since CHIP is not included in the ARRA eligibility maintenance of effort requirements. For example, California has proposed to reduce eligibility for CHIP from 250 percent to 200 percent of the federal poverty level, increase premiums by $14 per child ($42 maximum per family) and eliminate vision coverage as a benefit. Tennessee suspended new enrollments for CHIP effective December 1, 2009, but that freeze was lifted in February 2010. Arizona has also imposed a freeze on enrollment for CHIP and South Carolina has proposed a cap on CHIP enrollment.

In addition to program reductions, several Medicaid Directors indicated that their states are considering expanded use of provider taxes as a means to maintain provider rates and program benefits. One example is California, which is proposing a hospital tax that would generate up to $2 billion in federal funds that would be used to help finance Medi-Cal.

States have fewer and fewer options to reduce program expenditures

Medicaid directors indicated that they now face particular difficulty identifying new budget reduction strategies. Many states made major budget reductions in fiscal year 2009 and at the beginning of the current fiscal year. These reductions were in addition to major budget reductions made only a few years ago during the last recession, many of which have not yet been restored. Further, in some states, litigation has limited the states' ability to make reductions, especially in the area of provider rates. In the past year, two federal circuit courts of appeal have found against state provider rate reductions, significantly limiting the ability of states in those circuits from reducing provider rates. Litigation in California has

prevented the implementation of provider rate reductions that were proposed in the prior fiscal year budget further contributing to the deficit in the current year. With the ARRA limits on eligibility and these court actions on provider rates, many Medicaid officials believe that the ability of states to control their expenditures is now extremely limited.

Medicaid directors were highly supportive of efforts to improve the program and save money, including options such as improving quality and assuring medical homes for all beneficiaries. However, one director indicated that the spending reductions needed to address current budget shortfalls could not be met by the savings achieved by improvements in the program such as medical homes. Rather larger scale reductions would be needed as the possible savings levels were insufficient to meet the need.

Looking ahead, Medicaid directors fear an upcoming fiscal cliff in FY 2011

Medicaid directors strongly voiced their view that there is no chance that their state economy and state revenues would return to a level where they could absorb the impending loss of the ARRA-increased federal matching funds. State officials fear that it will be several years before state revenues will rebound to actual 2007 levels, and when revenues do rebound, there will be significant pent-up demand for funding in many program areas, including the need to replace ARRA funding that was used in other parts of the budget. Medicaid officials indicated that without an extended continuation of the ARRA funding that Medicaid programs will face a dramatic drop in federal matching funds. It will be such a steep fiscal cliff that the only possible option will be large eligibility reductions. Several Medicaid directors said they were at a loss on how they possibly could make the cuts necessary to offset the loss of ARRA funding for their program. Several governors assume that the ARRA FMAP increase will be extended in their budgets including Alabama, California, Georgia, Maine, Maryland, Massachusetts, Missouri and New Mexico.

California's FY 2011 budget includes $750 million in proposed savings through cost containment strategies including limits on services, utilization controls, providing for increased beneficiary cost sharing and other programmatic changes. In addition, the California budget proposes $292 million in savings in reductions by eliminating full scope benefits for certain immigrants, eliminating the optional Adult Day Health Care benefit, deferring payments to institutional providers and rescinding a statutory rate increase for Family Planning services. The Governor's budget would also reduce eligibility for Healthy Families (CHIP) from 250 percent of poverty to 200 percent of poverty. Without significant federal aid (including the continuation of the ARRA FMAP) the Governor's budget calls for a trigger that would eliminate additional optional benefits in Medicaid, reduce eligibility to minimum levels and eliminate the CHIP program.

Medicaid directors supported the CHIPRA improvements to the Child Health Insurance Program but most said their states do not have the funds to improve their programs

The Medicaid directors were asked whether their states would be proceeding with adopting changes to implement the improvements in CHIPRA. Due to the budget shortfalls, very few states believed they were in a position to adopt the improvements in eligibility procedures, even though there was consensus that they were positive actions that would be attractive to most states in better economic times. Most directors agreed that their states simply did not have funding to pay for the cost of increased caseload in the CHIP programs. As an indicator of the severity of state budget shortfalls, at least two states

(California and Washington) are facing large reductions in the CHIP programs. As indicted above, California has proposed both a reduction in eligibility and increased premiums for CHIP.

Medicaid directors are watching to see the outcome of national health care reform given the prospect for an expanded role for states in implementing and financing coverage for the uninsured.

National health reform bills adopted by both the House and the Senate envision an expanded role for Medicaid in coverage for the uninsured. Of particular note, the bills would add coverage for adults without children, based solely on income. Depending on the details of the final bill, the expansions could add 15 to 18 million individuals to Medicaid coverage. This would be the most significant expansion of Medicaid since its original enactment in 1965.

An expansion of this magnitude has obvious implications for the funding and administration of the program. Not surprisingly, given the financial conditions across the states, the concern most commonly mentioned by state Medicaid officials related to the inability of states to afford the cost of the Medicaid expansion in their state. The concern was expressed in several parts. The first part would be the direct cost of the expansion of eligibility, with millions of individuals newly enrolled in Medicaid. In addition, even though the bills provide for full federal funding for the first few years of an expansion, state officials were concerned that there would be many new enrollees who were not in the expansion groups for which the enhanced FMAP would not be available. This would cause state spending to increase, especially if eligibility rules relating to assets are changed, as is proposed in the bills.

Medicaid officials were also concerned that providers, already reluctant to serve Medicaid patients at current payment rates, might not be willing to serve additional Medicaid patients. With so many new enrollees, payment rates to providers would have to be increased in many states to assure access for both existing enrollees and those newly enrolled. Some directors believed that it would be necessary to increase provider rates for both primary and specialty care to ensure that their programs had provider networks and to assure that care was available for all program enrollees. These directors believed strongly that their states must be adequately funded for the new Medicaid cost including the expansion and the cost of increasing rates for primary and specialty care providers.

In addition, officials were concerned about the administrative capacity of states to handle new responsibilities related to eligibility expansions and possible responsibilities with a new health insurance exchange. There was no reluctance to take on the tasks and the challenges, but at a time when Medicaid agencies are already facing staff shortages, furlough days and across-the-board administrative and program cuts, directors expressed concern about whether they would have the staff resources to do the required work, including the eligibility determination and enrollment of large numbers of newly-eligible individuals.

Medicaid directors were particularly supportive of the proposed eligibility simplifications that would be provided in health care reform. The only concern related again to how to finance the administrative costs to implement them. The proposed financing methodology would allow states to claim enhanced federal matching funds only for new enrollees in the expansion group. This would require states to do a complex eligibility determination, including the existing asset test, and then record who qualified for the enhanced federal funds and who did not. Directors believed that to meet the objective of simplified eligibility determination and documentation that there had to be a provision that would allow states to claim the enhanced funding in a simplified manner.

Conclusion

At the halfway point in state fiscal year 2010, state Medicaid directors faced a dramatically challenging economic environment with significant impacts on Medicaid in their state. The situation they described in November and December 2009 reflected the economic stress that states are suffering due to the effects of the national economic recession. For almost all states, FY 2010 is yet another year of significant budget problems. Even those states that had avoided deep fiscal problems in FY 2009 were now seeing major budget issues. The ARRA funding provided vital relief to Medicaid programs and ensured that current enrollees would remain eligible for the program, but the ARRA funding was not enough to allow states to avoid major program reductions in Medicaid rates and benefits. Now, state officials in almost all states are focused on how to deal with significant budget shortfalls for FY 2010 and beyond.

Medicaid officials have few reasonable options left to restrain Medicaid spending growth in this economic downturn, and most states are considering further program cuts in the balance of FY 2010. Even with the enhanced match rate and the influx of federal funds with Medicaid spending, state officials indicated that they must still cut general fund spending for Medicaid which results in reductions in federal revenue. States also indicated that they are not able to take advantage of new options included in CHIPRA.

The biggest fear Medicaid directors is the loss of the ARRA-enhanced federal Medicaid matching rates that are scheduled to end in December 2010, the mid-point of fiscal year 2011 for most states, and the impact this fiscal cliff will have, particularly on program eligibility. Medicaid officials believe major program cuts (including eligibility cuts) are almost a certainty in most states if the enhanced federal funding is not extended. States are carefully watching discussions in Congress to extend the ARRA FMAP. A six month extension of these funds was included in the jobs bill passed by the House and was also included in President Obama's FY 2011 proposed budget released on February 1, 2010.

In addition, Medicaid directors are carefully watching the outcome of Congressional action on national health care reform, with particular attention on how states will be expected to implement and finance proposed Medicaid eligibility expansions.

This policy brief was prepared by Vernon Smith and Stan Rosenstein from Health Management Associates and Robin Rudowitz from the Kaiser Commission on Medicaid and the Uninsured. The authors express thanks to Vivian Auble of HMA for her skilled assistance with finalization of the brief.

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.