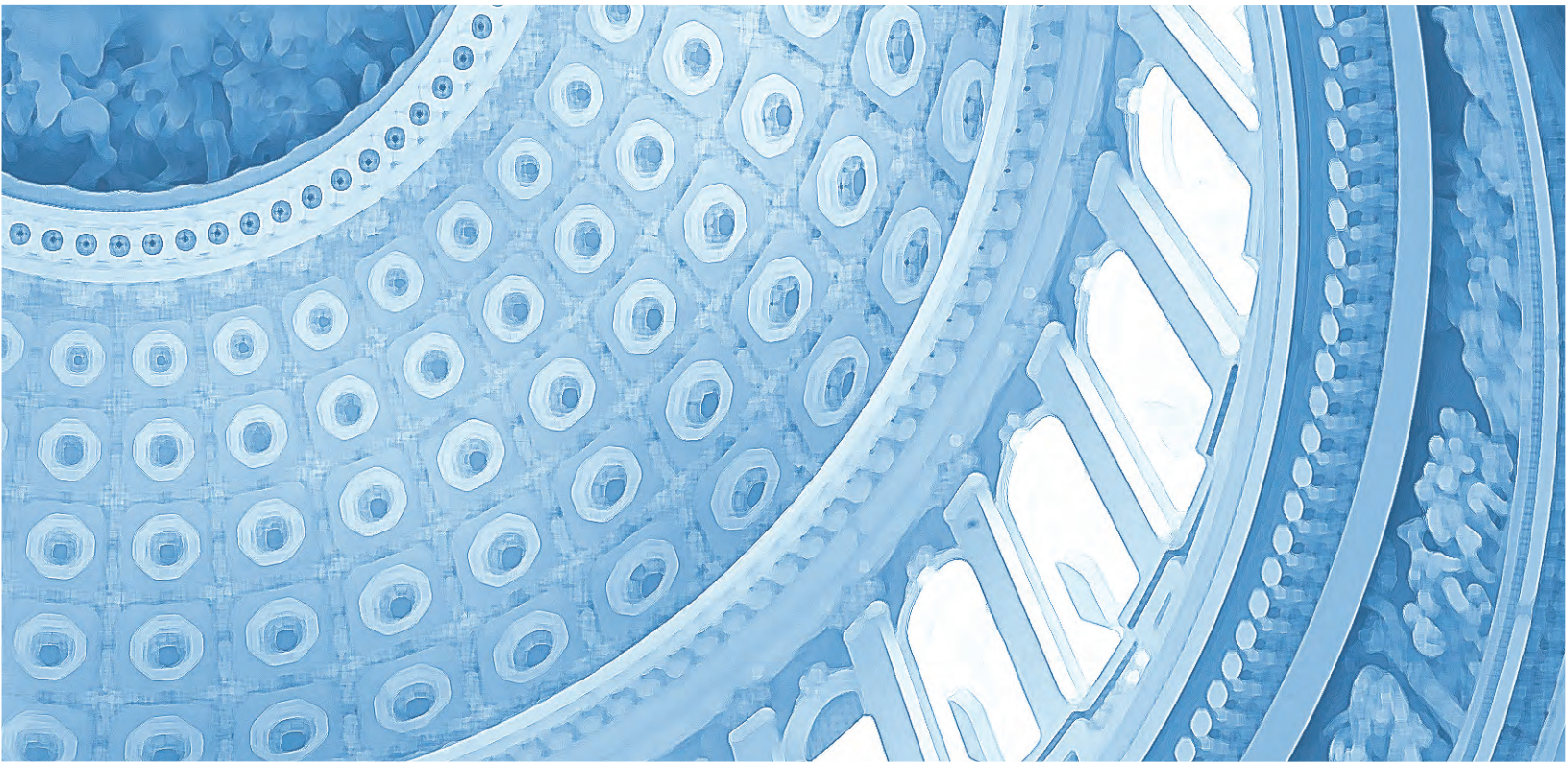
MACPAC

Medicaid and CHIP Payment and Access Commission



Report to the Congress on Medicaid and CHIP

March 2011

MACPAC

Medicaid and CHIP Payment and Access Commission

Overview

The Medicaid and CHIP Payment and Access Commission (MACPAC) was established in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and was later expanded in the Patient Protection and Affordable Care Act of 2010. The U.S. Comptroller General appointed 17 Commissioners in December 2009 who have broad perspectives on Medicaid and CHIP drawn from diverse backgrounds and regions of the United States.

The Commission is a non-partisan, federal, analytic support agency and resource for the Congress on Medicaid and CHIP. MACPAC is the first federal agency charged with providing policy and data analysis to the Congress on Medicaid and CHIP, and making recommendations to the Congress and the Secretary of the Department of Health and Human Services on a wide range of issues affecting these programs. The Commission conducts independent policy analysis and health services research on key Medicaid and CHIP topics, including but not limited to:

- Payment policies;
- Issues related to access to care;
- Eligibility;
- Quality of care;
- Interactions between Medicaid and Medicare; and
- Data development to support policy analysis and program accountability.

As required in its statutory charge, the Commission will submit reports to the Congress on March 15 and June 15 of each year. As applicable, each member of the Commission will vote on recommendations contained in the reports. In addition to making recommendations on Medicaid and CHIP policy to the Congress, the Commission serves as a non-partisan link to coordinate and facilitate Medicaid policy analysis between the Congress, the Department of Health and Human Services, and the states.

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March 15, 2011

The Honorable Joseph R. Biden
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable John A. Boehner
Speaker of the House
U.S. House of Representatives
U.S. Capitol
H-232
Washington, DC 20515

Dear Mr. Vice President and Mr. Speaker:

It is with great pleasure that, on behalf of the Commission, I submit the Medicaid and CHIP Payment and Access Commission's (MACPAC's) inaugural *Report to the Congress on Medicaid and CHIP*. With this Report, we have provided a foundation on which the future work of the Commission will be built.

Established by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, MACPAC is the first Congressional support agency charged with focusing on the Medicaid program and the State Children's Health Insurance Program (CHIP). As specified in our statutory charge, the nonpartisan Commission is dedicated to conducting objective policy and data analysis to assist the Congress in overseeing and improving these programs.

The scope of the Commission's work is broad, as Medicaid and CHIP together cover an estimated 76 million low-income people with diverse and often complex health conditions at a total federal and state cost of more than $400 billion in FY 2010. Of the 68 million persons covered by Medicaid, nearly half are children, but much of the program's spending is for the health services for the more than 16 million seniors and individuals with disabilities and Medicaid coverage, including coverage of long-term care services. CHIP provides health care coverage for an additional 8 million children. In 2009 these two programs accounted for approximately 15 percent of U.S. health care spending. Given the size and scope of the Medicaid and CHIP programs, the Commission's analysis and guidance to the Congress will fill an important analytic gap in the information available to the Congress on payment, access, data, and other related policies.

Although the 17 Commissioners were appointed by the U.S. Comptroller General in December 2009, MACPAC only became operational with appropriations under the Patient Protection and Affordable Care Act (PPACA) in March 2010. The first organizational meeting of the Commission was held in July 2010, and the executive director was appointed in August. In September, the Commission convened its first public meeting and subsequently facilitated four additional public meetings between October 2010 and February 2011. In these public deliberations, the Commission established priorities, reviewed analytic work products, and sought public comment on issues. Through this process, the Commission directed the work that culminated in the completion of this Report.

This March 2011 *Report to the Congress on Medicaid and CHIP* is foundational to the Commission's current analytic agenda and future work. In the first section of the Report, the important roles that Medicaid and CHIP play in the context of the U.S. health care system are outlined and the key elements of both programs are described, along with the analytic issues to be addressed by the Commission in the future. As we begin to address our statutory charge regarding access, payment, and data issues, the last section of the Report establishes the Commission's approach in examining access and payment issues. Data issues are also reviewed and potential improvements in data systems for policy analysis and program accountability are identified.

As part of our analytic framework, the Commission has established the development of key baseline data and information on Medicaid and CHIP as a first priority. Data presented in the Medicaid and CHIP program statistics (MACStats) section are the Commission's first step in providing information on key program features such as eligibility, enrollment, and spending. MACStats will continue to be an important component of all future Commission reports. As we continue to develop our analytic capacity, information in MACStats will provide updates of general program characteristics, as well providing data on the more specific issues in our statutory charge, such as dual eligibles, disabled populations, and managed care.

To meet our charge, consultation with states and key stakeholders will always be a critical component in informing our analytic agenda and our policy development process. As part of the development of this Report to the Congress, we have engaged key stakeholders in the review of our policy agenda, in informing Commission deliberations during our public meetings, and in the review of chapters and data presented in the Report. Moving forward in our analytic work, this will continue to be an important process in Commission deliberations.

As the Commission looks ahead to our future analytic activities and reports, we will continue to build upon the foundation established in this Report. Using the groundwork outlined here, the Commission will strive to provide sound data and nonpartisan analysis to the Congress on how to improve the value of the Medicaid and CHIP programs both in the near term and in the future. We hope the work of the Commission will serve to inform and assist the Congress in its future deliberations.

Sincerely,

Diane Rowland, Sc.D.

Chair

Enclosure

Acknowledgements

The Commission would like to acknowledge the many people who made contributions to this March 2011 *Report to the Congress on Medicaid and CHIP*.

Staff of the Centers for Medicare & Medicaid Services offered valuable insight and technical assistance. In particular, we would like to thank Cindy Mann, Melanie Bella, Carey Appold, Stephanie Bell, Paul Boben, Rebecca Bruno, Aaron Catlin, Sean Cavanaugh, Dianne Heffron, Kirsten Jensen, John Klemm, Yong Li, Anne Martin, Linda Nablo, Elaine Olin, Goldy Rogers, Jennifer Ryan, Jeff Silverman, Richard Strauss, Loan Swisher, Penny Thompson, and Chris Truffer.

This Report benefited from the contributions of many experts with experience in federal and state government and health services research, including Dan Aibel, Andrew Allison, Joseph Antos, Samantha Artiga, Deborah Bachrach, Linda Bilheimer, Andrew Bindman, Pat Casanova, Robin Cohen, Steven Cohen, Christine Coyer, Toby Douglas, Kathleen Dunn, Theresa Eagleson, Charlene Frizzera, Marsha Gold, Darin Gordon, Catherine Hess, Martha Heberlein, Nikki Highsmith, Genevieve Kenney, Richard Kronick, Sharon Long, Stacey Mazer, Stacey McMorrow, Jeffrey Rhoades, Rich Rimkunas, David Rousseau, Matt Salo, Bruce Steinwald, Rob Stewart, Karen Stockley, Lina Walker, Alan Weil, Alice Weiss, Carolyn Yocom, and Stephen Zuckerman.

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Finally, the Commission would like to particularly thank Mark Miller and the staff of the Medicare Payment Advisory Commission for sharing their experience, knowledge, and support during the preparation of this Report in MACPAC's inaugural year.

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Report Summary

Medicaid and the State Children's Health Insurance Program (CHIP) are sources of health care coverage for 76 million people, almost one quarter of the population. Medicaid finances health care and related services for more than 30 million low-income children, more than 10 million low-income persons with disabilities, and 6 million low-income seniors with Medicare. CHIP finances health coverage for 8 million uninsured children in families with moderate incomes above Medicaid eligibility levels.

This is the first report of the Medicaid and CHIP Payment and Access Commission (MACPAC) to the Congress. The purpose of this initial report is to contribute to a better understanding of the Medicaid and CHIP programs, their roles in the U.S. health care system, and the key policy and data issues to be addressed. This first report also sets out an analytic framework that serves as the foundation for the Commission's future work with respect to access and payment. Also included in the Report is a compilation of Medicaid and CHIP program information, including state-specific information about program enrollment, spending, eligibility levels, Medicaid benefits covered, and the federal medical assistance percentage (FMAP). This section of the Report, called MACStats, will be a standing supplement in all Commission reports to the Congress.

The Report is divided into three sections. The first section describes the roles of Medicaid and CHIP in the U.S. health care system and provides overview information for each program. MACStats is the next section, providing Medicaid and CHIP state-specific information and data. The third section of the Report begins a discussion of the Commission's analytic framework for access and payment and identifies key factors the Commission is considering for assessing access, evaluating payment policies, and determining key data needs. This first report to the Congress is foundational and lays the groundwork for recommendations in future reports. The chapters of this report are:

- Chapter 1: Context and Overview of Medicaid and CHIP
- Chapter 2: Overview of Medicaid
- Chapter 3: Overview of the State Children's Health Insurance Program
- Medicaid and CHIP Program Statistics: MACStats
- Chapter 4: Examining Access to Care in Medicaid and CHIP

- Chapter 5: Examining Medicaid Payment Policy
- Chapter 6: Improving Medicaid and CHIP Data for Policy Analysis and Program Accountability

Medicaid and CHIP Today

Medicaid and CHIP's impact is far-reaching, affecting the people they serve, the providers they pay, and the federal and state budgets that fund them. Medicaid is the foundation of the nation's health care safety net, representing a shared federal and state commitment to serving the health needs of low-income families, seniors, and persons with disabilities. Many of the children enrolled in CHIP are from working families who cannot afford insurance coverage or whose employers do not offer health benefits. Like other payers, Medicaid and CHIP operate in a changing health care environment. The joint federal and state programs have undergone significant changes since their enactment, particularly with respect to size, scope, and cost. Today, Medicaid is a $406 billion program that finances health care for 68 million people and CHIP is an $11 billion program that finances health care coverage for 8 million children. The federal government's share of Medicaid program costs is $274 billion and its share of CHIP costs is $8 billion.

Medicaid and CHIP have complex roles in our health system. The populations enrolled in Medicaid and CHIP are diverse, by definition low-income, but also many have chronic and complex health needs resulting in substantial spending. Federal and state officials are challenged to provide Medicaid and CHIP enrollees appropriate access to quality care while simultaneously containing costs, maintaining program integrity, and assuring fiscal accountability. Medicaid, like other payers, is subject to the rising cost of health care. As a result, program spending growth is a concern at both the federal and state level. The fiscal pressure grows during economic downturns when enrollment in these programs increases, as state revenues used to fund the state share of program costs decrease.

In recognition of the programs' significance as sources of health coverage and long-term care assistance for low-income populations, and the complex needs of many Medicaid and CHIP beneficiaries, the Congress established MACPAC as a nonpartisan advisor to provide technical and analytical assistance, and to be a source of current, reliable information to guide policies related to these programs.

Chapter 1: Context and Overview of Medicaid and CHIP

Medicaid and CHIP are major sources of financing for health care services. Those served by these programs include one-third of all children, many low-wage workers and their families, persons with physical and mental disabilities, and low-income seniors with Medicare. Medicaid has evolved from welfare-based coverage to a major source of coverage in our health care system while CHIP provides coverage to children in low-income, mostly working, families.

Medicaid's role in our health care delivery system is unique: the program covers the diverse health needs of enrollees; directly supports safety-net providers; covers long-term services and supports

for low-income Medicare beneficiaries, and reduces uncompensated care. Incremental additions and changes have been layered on top of Medicaid's original foundation, expanding the scope of whom the program serves, what it provides, and its costs.

Federal and state Medicaid officials share responsibility for administering Medicaid and CHIP, including providing enrollees appropriate access to care; maintaining coverage of people and benefits during economic downturns; ensuring adequate provider participation; coordinating care with Medicare for low-income elderly and disabled; and containing costs while meeting diverse, complex, and costly health care needs. At the same time, program managers must maintain program integrity and fiscal accountability.

Chapter 1 briefly describes Medicaid and CHIP, highlights the history of the programs, and places them in the context of the U.S. health care system.

Chapter 2: Overview of Medicaid

Medicaid is a means-tested entitlement program that is jointly administered and financed by the federal government and states. It has a national framework but varies by state in terms of eligibility, benefits, and payment. Total program expenditures were over $400 billion in FY 2010 to finance health services for 68 million people, about half of whom were children. People eligible for Medicaid coverage have historically included low-income children and their parents, pregnant women, individuals with disabilities, and individuals age 65 and older. Low-income adults who do not fall into one of these groups will also be eligible for Medicaid beginning in 2014, or earlier at state option.

Medicaid coverage of services is more than health insurance typically provides. Medicaid covers routine standard health care services that are also covered by Medicare and employer-sponsored insurance. Medicaid also covers services not covered under Medicare or traditional health insurance; most notably long-term services and supports and certain therapy services important for the coverage of low-income seniors and persons with physical or mental disabilities, and children with special health care needs.

Medicaid coverage varies by state since benefits are a combination of federal mandatory and state optional benefits. Although the majority of Medicaid benefit spending still occurs in fee for service, most states use managed care arrangements to administer services and pay providers for their low-income families. States have applied waiver authorities to test changes in service delivery approaches and have expanded their use of managed care over the years, particularly for low-income children and their families. Today, almost 50 percent of Medicaid enrollees are enrolled in risk-based arrangements.

Medicaid spending has grown in recent decades. Economic downturns compound the fiscal challenge since loss of jobs and income result in more people eligible for Medicaid. Today, many states face budget shortfalls elevating Medicaid policy issues.

Chapter 2 highlights eligibility, coverage, payment, financing, and administration of the Medicaid program. Current Medicaid enrollment and

spending is addressed and future program issues regarding upcoming eligibility and service expansions, and financing are identified.

Chapter 3: Overview of the State Children's Health Insurance Program

CHIP is a much smaller program than Medicaid both in terms of covered individuals and total costs. Like Medicaid, states administer their CHIP programs within federal rules and receive federal matching funds for program expenditures. However, CHIP differs from Medicaid in a variety of ways, most notably in its focus on children.

Under CHIP, federal funding is at a higher matching rate and is capped, and there is no mandatory level of coverage. States have flexibility to use a Medicaid expansion approach to administer CHIP, create a separate CHIP program, or use a combination of the two. In separate CHIP programs, states have additional flexibility to cap enrollment, implement waiting periods, tailor benefit packages, and charge premiums, deductibles, coinsurance and other cost-sharing.

In 1997, just before CHIP's implementation, 10 million children lacked health insurance. In 2010, 6 million children were uninsured, with the largest decrease among low-income, mostly working, families. This contrasts to the increase in uninsurance among adults during the same period.

Chapter 3 highlights CHIP eligibility, benefits and cost-sharing, state program flexibility, and the federal-state financing structure. In addition, the impact of recent legislative changes on the current CHIP program is explained and future program issues are identified.

Medicaid and CHIP Program Statistics: MACStats

MACStats is a Medicaid and CHIP program statistics supplement in the gray-banded center of the Report that provides key data and information about Medicaid and CHIP in one section. MACStats was created because data and information about the Medicaid and CHIP programs can often be difficult to find and are spread out across a variety of sources.

MACStats provides state-level and national information about the Medicaid and CHIP programs. This section also provides information that places these programs in a broader context, such as Medicaid and CHIP as a part of state budgets and national health expenditures. MACStats will be included in all MACPAC reports to the Congress.

In this report, MACStats includes state-specific information about program enrollment, spending, eligibility levels, optional Medicaid benefits covered, and the federal medical assistance percentage (FMAP), as well as an overview of cost-sharing permitted under Medicaid and the dollar amount of common federal poverty levels (FPLs) used to enroll people in these programs.

Chapter 4: Examining Access to Care in Medicaid and CHIP

MACPAC has developed an evolving framework for measuring access that takes into account the characteristics and complex health needs of Medicaid and CHIP populations as well as program variability across states. The Commission's approach aims to help shape our future work on monitoring and evaluating access to services for Medicaid and CHIP enrollees. This initial framework will also serve as the basis for our work to develop an early-warning system (EWS) to identify areas with provider shortages and other factors that adversely affect, or that could potentially adversely affect, access to care for, or the health status of, Medicaid and CHIP enrollees.

The Commission's framework, which focuses on primary and specialty care providers and services, has three main elements: enrollees and their unique characteristics, availability, and utilization. Enrollee factors such as geographic location, cultural diversity, and discontinuous eligibility must be accounted for along with income levels and health care needs. Availability of providers is also significant to access, and is influenced by overall supply and provider participation. Utilization encompasses whether and how services are used, the affordability of services, and how easily enrollees can navigate the health system. In addition, the Commission will evaluate overall access in terms of the appropriateness of services and settings for care; efficiency, economy, and quality of care; and overall health outcomes.

Using this framework, a set of measures will be identified and monitored to provide both an understanding of where access levels exist today and to track trends moving forward. We expect our access framework to continually evolve to address new health care practice patterns, changing program needs, and new Commission priorities.

Chapter 4 presents the Commission's access framework, which focuses on primary and specialty care providers and services.

Chapter 5: Examining Medicaid Payment Policy

Medicaid is an important payer of health care services in the U.S. and, like other payers, Medicaid seeks payment policies that promote delivery of efficient, high-quality care. The program's unique characteristics, such as its diverse population with wide-ranging health care needs, joint federal and state financing, and cost-sharing limitations for enrollees, raise a number of considerations for developing effective payment policies.

The statute provides states substantial flexibility in determining provider payment rates and, as a result, states have taken a variety of different approaches to Medicaid payment. This variation raises questions regarding the relationship of payment policies to access and quality, and the potential role for payment innovations that best address efficiency and economy while assuring access to appropriate and high-quality services.

Currently no sources exist that systematically and comprehensively explain how states determine Medicaid payments or evaluate whether or not payments meet statutory requirements and promote value-based purchasing—ensuring access to appropriate, efficient, high-quality care at the appropriate time and in the appropriate setting.

MACPAC's goal is to identify payment policies that account for the complexity of Medicaid enrollees and the Medicaid marketplace, and encourage appropriate access and quality while controlling the rate of Medicaid spending.

Chapter 5 begins the Commission's initial assessment of Medicaid payment policy and outlines our approach for future work. The chapter focuses on fee-for-service (FFS) payment for hospital and physician services and highlights federal statutory and regulatory changes that have shaped FFS payment.

Chapter 6: Improving Medicaid and CHIP Data for Policy Analysis and Program Accountability

Medicaid and CHIP data provide the information needed to answer policy questions that affect enrollees, providers, states, the federal government, and others. It also is the means by which policymakers ensure fiscal accountability for taxpayer dollars. There is no single Medicaid and CHIP data source. As a result, comprehensive analyses of the programs require data from states, CMS, surveys, and other sources.

Federal Medicaid and CHIP administrative data can help to answer key policy and accountability questions such as: What services are beneficiaries receiving? Do enrollees receive appropriate care? Which policy choices most affect that care and its costs? Do federal legislators and administrators have a clear picture of how Medicaid and CHIP dollars are spent?

Federal administrative data are derived from state-reported program and enrollee information, and they are the basis for most national and cross-state analyses of program enrollment, expenditures, and service use. For example, administrative data are used to project future enrollment and spending trends, analyze spending growth, analyze service use, and analyze billing and utilization patterns to identify potential program fraud and abuse.

Longstanding challenges regarding state-reported data variability, comparability, consistency, and timeliness date back to the enactment of the programs. Different Medicaid and CHIP information is collected from states at different times for different purposes, resulting in multiple federal administrative data sets. There currently is overlapping content across federal data sets with states reporting the same information about their Medicaid and CHIP programs more than once. In addition to redundancies, gaps in the data sources also exist which ultimately limit their usefulness.

Chapter 6 describes the major federal sources of administrative data for the Medicaid and CHIP program, and how these data are used to address policy and program accountability issues. MACPAC will provide informative and timely data to the Congress to address the role and impact of Medicaid and CHIP in the near and long term.

CHAPTER 1

Context and Overview of Medicaid and CHIP

Section 1900(b)(1)(D) of the Social Security Act - [MACPAC shall] submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

Chapter Summary

Medicaid and the State Children's Health Insurance Program (CHIP) are sources of health coverage for 76 million people, almost one quarter of the population. Those served by these programs include one-third of all children, many low-wage workers and their families, persons who have physical and mental disabilities, and seniors with Medicare. Medicaid has evolved from welfare-based coverage to a central component of our health care system while CHIP provides coverage to children in low-income, mostly working families. Together, these joint federal-state programs account for 15 percent of total U.S. health care spending.

Medicaid's role in our health care delivery system is unique: the program covers the diverse health needs of enrollees; directly supports safety-net providers; complements Medicare for low-income beneficiaries; and reduces the burden of uncompensated care. Incremental additions and changes have been layered on top of Medicaid's original foundation, expanding the scope of whom the program serves, what it provides, and how much it costs. Today, Medicaid is a source of coverage for millions of low-income Americans.

CHIP is structured differently from Medicaid and at the time of its creation it was uncertain whether states would respond to the new federal funding opportunity to extend health care coverage to more uninsured children. Within three years of enactment, though, all states and territories had children enrolled in CHIP-financed coverage.

Federal and state Medicaid officials are responsible for administering Medicaid and CHIP, including providing enrollees appropriate access to care, maintaining coverage of people and benefits during economic downturns, ensuring adequate provider participation, coordinating care with Medicare for low-income seniors and persons with disabilities, and containing costs while meeting diverse, complex and costly health care needs. At the same time, program managers must maintain program integrity and fiscal accountability.

In recognition of the programs' significance as sources of health coverage and long-term care assistance for low-income populations, and the complex needs of many Medicaid and CHIP beneficiaries, the Congress established the Medicaid and CHIP Payment and Access Commission (MACPAC) as a nonpartisan advisor to provide technical and analytical assistance and to be a source of current, reliable information to guide policies related to these programs. In our first report to the Congress, the Commission provides baseline information about Medicaid and CHIP, including key policy and data questions that need to be addressed. We also establish an analytic framework that serves as the foundation for our future work.

This chapter briefly describes Medicaid and CHIP, the history of health care coverage and these programs, and situates them in the context of the U.S. health care system.

CHAPTER 1

Context and Overview of Medicaid and CHIP

Medicaid and the State Children's Health Insurance Program (CHIP) are joint federal-state programs that provide health care coverage to millions of Americans—more than one-third of all children and 16 percent of Medicare beneficiaries, among many others (Table 1-1, MedPAC 2010a). As major payers in our health care system, they account for over 15 percent of total U.S. health care spending (Figure 1-1).

Medicaid and CHIP provide coverage for medical and medically related services for the most economically disadvantaged populations: low-income children and their families, low-income seniors, and low-income persons with disabilities. These populations are unique in terms of the breadth and intensity of their health needs, the impact of poverty and unemployment on their ability to obtain health care services, and the degree to which they require assistance in paying for care.

Medicaid's Unique Role

Medicaid was enacted as part of the same legislation that created Medicare—the Social Security Amendments of 1965 (P.L. 89-97). Like Medicare and employer-sponsored insurance (ESI), Medicaid is a major source of coverage for health care. Medicaid accounts for 15 percent of U.S. health spending while Medicare and private insurance (including ESI) account for 20 percent and 32 percent, respectively (Figure 1-1).

Medicaid provides coverage for a range of medical services and supports that goes beyond the benefits provided under Medicare or ESI. Medicaid benefits include acute care services that are typical of Medicare and ESI; however, Medicaid benefits also include services not covered by Medicare or ESI such as long-term services and supports, rehabilitative services and therapies, assistive technology (e.g., communication

BOX 1-1. Key Medicaid and CHIP Facts

People

Medicaid provided health care coverage for 68 million low-income people during FY 2010 including (OACT 2011a):

- 33 million children;
- 11 million persons with disabilities;
- 17 million non-disabled adults (e.g., pregnant women, parents of Medicaid enrolled children);
- 6 million seniors; and
- 1 million people in the U.S. territories.

CHIP covered 8 million children in FY 2010 (Table 3 in MACStats).

90 percent of CHIP children have family incomes below 200 percent of the federal poverty level ($37,060 for a family of 3) (Table 4 in MACStats).

Expenditures

Medicaid federal and state expenditures were over $400 billion in FY 2010 (Table 6 in MACStats) and account for:

- 8.1 percent of total federal outlays (OMB 2011);
- 33 percent of all nursing home expenditures (Figure 1-2);
- 36 percent of all home health care expenditures (Figure 1-2); and
- 25 percent of all mental health and substance abuse treatment spending (Mark et al. 2007).

CHIP federal and state expenditures in FY 2010 were $11 billion (Table 8 in MACStats).

devices), and non-emergency transportation services. Medicaid also pays for Medicare premiums and cost sharing for over 9 million seniors and persons with disabilities who are eligible for both Medicare and Medicaid (Table 2 in MACStats). Medicaid serves many people who have high levels of need for services and high health care costs, including the frail elderly, young persons with physical disabilities, and developmentally or intellectually challenged persons residing in long-term care facilities or living in the community. Many of the people who rely on Medicaid to pay for health care services are unable to work at all or are low-wage workers who are not offered ESI or cannot afford ESI. The gap in the availability of insurance coverage for low-income families would be larger if Medicaid were not present. In addition, many Medicaid enrollees would be uninsurable in the individual private health insurance market.

Medicaid is an important payer of care delivered by providers such as hospitals and nursing homes. Along with CHIP, the program accounted for approximately 18 percent of total hospital expenditures and 33 percent of total nursing home expenditures in 2009 (Figure 1-2). In addition, Medicaid directly supports safety net providers such as hospitals receiving disproportionate share payments,[1] community health centers, school-based

[1] Disproportionate share hospital (DSH) adjustment payments provide additional help to those hospitals that serve a significantly disproportionate number of low-income patients; eligible hospitals are referred to as DSH hospitals.

health centers, and mental health clinics. These are the providers who consistently see and treat uninsured patients as well as Medicaid enrollees. Medicaid is a substantial payer for these providers.

For low-income Medicare beneficiaries Medicaid's benefit package "wraps around" Medicare coverage, filling in benefit limitations and gaps (e.g., long-term nursing home care) and paying premiums and cost-sharing. Medicaid also covers people who might otherwise be uninsured, thus reducing the burden of uncompensated care. Although Medicaid was designed to play a supporting role for Medicare from the beginning, its importance to federal and state efforts to address social and economic challenges has evolved as the program has changed over time.

Medicaid has faced a variety of issues since its inception. Just as for Medicare and ESI, ensuring program efficiency and quality of services is a perennial issue for Medicaid. Federal and state Medicaid officials are responsible for providing enrollees appropriate access to care, maintaining coverage of people and benefits during economic downturns, ensuring adequate provider participation, coordinating care with Medicare for low-income seniors and persons with disabilities, and containing costs while meeting diverse, complex and costly health care needs. At the same time, program managers must maintain program integrity as well as fiscal accountability for federal and state tax dollars.

Brief History of Medicaid, CHIP, and Other Health Coverage

Early Employer-Sponsored Insurance

The modern approach to health care coverage came about in the 1920s as health care became more sophisticated and expensive. The first Blue Cross plan began in 1929 in Texas when the Baylor University Hospital agreed to provide 1,500 school teachers with up to 21 days of hospital care a year for $6.00 per person. The first Blue Shield plan designed for coverage of physician services began in 1939. The success of "the Blues" persuaded commercial insurers to enter the field and private insurers accelerated these efforts in the 1940s when businesses, seeking ways to bypass wartime wage controls, began to compete for labor by offering health insurance (Starr 1982). About 12 million people were covered by private health insurance in 1940—less than 10 percent of the population. In 1950, 75 million people, about 49 percent of the population, were covered by private health insurance (Fronstin 1998). Today over 194 million people, about 64 percent of the population, are covered by private health insurance (Table 1-1).

Public Funds for Health Care

Around the time the Blue Cross and Blue Shield programs started, health care services for indigent persons were provided primarily through a patchwork of programs sponsored by state and local governments, charities, and community hospitals. Federal financial assistance to states for

the costs of these services was provided through grant programs. The Social Security Act of 1935 included Title V, now the Maternal and Child Health (MCH) Block Grant, which was designed to support state efforts to extend health and welfare services for mothers and children, in particular children with special health care needs. This resulted in the establishment of state departments of health or public welfare in some states, and facilitated the efforts of existing agencies in others.

The Social Security Amendments of 1950 provided federal matching funds for state payments to medical providers on behalf of individuals receiving public assistance payments (i.e., welfare). In 1960, the Kerr-Mills Act created a new program, Medical Assistance for the Aged. This means-tested grant program provided federal funds to states that chose to provide health care services to seniors with incomes above levels needed to qualify for public assistance but nonetheless in need of assistance for medical expenses. These individuals were referred to as the "medically needy aged."

In 1965 the Congress legislated a combination of approaches to improve access to health care for seniors and other populations. The Social Security Amendments of 1965 created a national hospital insurance program to cover nearly all of the elderly (Medicare Part A), a national voluntary supplementary medical insurance program (Medicare Part B), and an expansion of the Kerr-Mills federal grant program to help elderly individuals with out-of-pocket expenses, such as premiums, copayments, deductibles, and costs for uncovered services. At the same time, the Congress decided to extend the Kerr-Mills program to cover additional populations including families with children, the blind, and the disabled. This new program, called Medicaid, retained the Kerr-Mills structure of a federal and state partnership for administration and funding for health care services for the indigent. Thus Medicaid became the partner legislation to Medicare.

Medicaid's Evolution and the Introduction of CHIP

Since its inception in 1965, the Medicaid program has evolved substantially from welfare-based coverage to a major payer in our health care system. The federal government has made significant changes in eligibility criteria, covered services, and financing of the program over the years. In addition, states have made a variety of changes to their programs, such as covering optional populations and incorporating home and community-based services in their systems of long-term services and supports. One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery model. States have explored various managed care approaches over the years, pursuing such arrangements mostly for children and non-disabled adults. Today almost 50 percent of Medicaid enrollees are enrolled in risk-based arrangements (Box 2-2).

Many of the changes to the Medicaid program have been in response to the growing number of low-income individuals in need of medical assistance, the need to improve access to care, and the need to contain the rising costs of providing medical assistance. Some changes have been made to enhance state flexibility for program administration, such as the establishment of managed care program waivers. Other changes, like the disproportionate share hospital

(DSH) spending controls and the addition of the prescription drug rebate program, were implemented by the Congress for fiscal integrity reasons: to limit what funds states can use to draw their federal share so an appropriate federal and state financial partnership is maintained and to help lower total Medicaid spending on prescription drugs, respectively. CHIP was enacted in 1997 in response to the then 10 million uninsured children (Martinez and Cohen 2010). Many of these children resided in families who could not afford to purchase employer-sponsored or private insurance coverage, and had incomes too high to qualify for Medicaid. CHIP has undergone several changes since its inception, particularly with respect to coverage for adults and financing.

Box 1-2 highlights selected federal legislative milestones of the Medicaid and CHIP programs since their enactment. Subsequent chapters in this Report discuss some of these changes in more detail.

Program Basics

Medicaid

Medicaid is inherently a complex program. Like Medicare, Medicaid is an entitlement program. Eligible individuals have federal rights, protected by federal courts, to payment for medically necessary health care services defined in statute and the federal government is obligated to funding a share of the outlays for those services. Medicaid is a means-tested program and federally financed with general revenues; there is no federal trust fund or dedicated tax revenues to finance federal Medicaid expenditures. Medicaid spending is driven by enrollment growth, inflation, and policy changes. Generally, it is more variable from year to year than Medicare (Holahan 2009). A key factor driving federal Medicaid expenditures is state coverage and payment decisions. Typically, the federal share of total Medicaid expenditures nationally is 57 percent and the state share is 43 percent.[2]

Medicaid is a program where variability is the rule rather than the exception. As a federal-state program, states establish their own Medicaid eligibility standards, benefits packages, payment rates, and administration policies under broad federal guidelines, effectively establishing 56 different Medicaid programs—one for each state, territory, and the District of Columbia.

Although there is a basic core of Medicaid coverage, populations and benefits included in one state may not be covered or have limited coverage in others. Provider payment methods, standards, and rates vary from state to state as well. Individual state use of managed care, home and community-based services, and other options also vary. This variability is driven by the program's inherent flexibility with state options regarding whom is covered, what is covered, and how services are paid. Medicaid has never been a "one size fits all" program. Another driver of program variability is federal matching fund rates for states. States receive federal matching funds for at least half of their Medicaid spending; most states, however, receive more. Federal matching rates, called federal medical assistance percentages (FMAPs), range from

[2] In response to the recent recession, the Congress provided states with a temporary increase in Medicaid federal medical assistance percentages (FMAPs) that has increased the federal share of total Medicaid expenditures. The increase will end in June 2011, at which point the federal and state shares of expenditures nationally are anticipated to return to 57 percent and 43 percent, respectively.

BOX 1-2. Selected Federal Legislative Milestones

1965	The Medicaid program is established to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind and individuals with disabilities.
1967	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for all Medicaid children under 21 is established.
1971	States are allowed to cover services in intermediate care facilities (ICFs) and in facilities for the mentally retarded (ICFs/MR).
1972	States are allowed to link Medicaid eligibility for elderly, blind and disabled residents to eligibility for cash assistance under the newly enacted federal Supplemental Security Income program (SSI) or keep Medicaid eligibility criteria separate.
1981	Medicaid freedom of choice waivers (1915(b)) and home and community-based care waivers (1915(c)) are established; states are required to provide additional payments to hospitals treating a disproportionate share of low-income patients (DSH) but allowed to set their own payments for hospitals separate from Medicare.
1988	Medicaid coverage for pregnant women and infants (up to age one) to 100 percent of the federal poverty level (FPL) is mandated; special eligibility rules are established for institutionalized persons whose spouse remains in the community to prevent "spousal impoverishment;" Qualified Medicare Beneficiary (QMB) group is established.
1990	Phased-in Medicaid coverage of children ages 6 –18 in families with incomes up to 100 percent of FPL is mandated with states required to cover a new age cohort each year until 18 year olds are covered in 2002. Prescription Drug Rebate Program is established; Specified Low-Income Medicare Beneficiary (SLMB) eligibility group is established.
1991	Disproportionate Share Hospital (DSH) spending controls are established in Medicaid; provider donations are banned and provider taxes are capped.
1996	Medicaid's link to welfare benefits is severed; enrollment/termination of Medicaid is no longer automatic with receipt/loss of welfare cash assistance.
1997	State Children's Health Insurance Program (CHIP) is created; new managed care options and requirements for states are established.
1999	States are permitted to provide Medicaid coverage to working disabled individuals with incomes above 250 percent FPL and impose income-related premiums on such individuals.
2000	Health Insurance Flexibility and Accountability (HIFA) waivers are established to increase health insurance coverage for non-traditional groups of Medicaid beneficiaries via premium assistance.
2001	Health Insurance Flexibility and Accountability (HIFA) waivers are established to increase health insurance coverage for non-traditional groups of Medicaid beneficiaries via premium assistance.

BOX 1-2, Continued

2005	States are permitted to use "benchmark" coverage in lieu of Medicaid benefits package for adult enrollees and to increase copayments for non-emergency services; increased penalties are imposed for assets transferred at less than fair market value to qualify for nursing home care; prescription drug payment policies are changed. CHIP coverage for childless adults is eliminated effective in 2009.
2009	CHIP is reauthorized through FY 2013; coverage for parents is phased out by 2014; MACPAC is established.
2010	Beginning in 2014, Medicaid eligibility is expanded to include all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133 percent FPL based on modified adjusted gross income; increase in primary care services payments rates to 100 percent of the Medicare payment rates for 2013 and 2014.

50 to 75 percent in FY 2011; states are currently receiving a temporary increase through June 2011 (Table 14 in MACStats).

Medicaid's complexity has increased over the years with the addition of new eligibility groups, benefits, and payment policies as federal and state governments balance social, economic, and political considerations affecting public assistance. Growing numbers of people without health insurance, public health crises, natural disasters, and economic downturns have all led to temporary or permanent changes to Medicaid. Incremental additions and changes to the program have been layered on top of Medicaid's original foundation, expanding the scope of whom the program serves, what it provides, and how much it costs. As a result, Medicaid is a very large program in terms of enrollment, expenditures, and as a share of federal and state budgets.

State Children's Health Insurance Program (CHIP[3])

Like Medicaid, CHIP is a federal and state partnership in which states opt to participate in order to receive federal funds for health care coverage. Unlike Medicaid, CHIP is not an entitlement. Compared to Medicaid, which is a $406 billion program that covers 68 million people, including 33 million children, CHIP is an $11 billion program that covers approximately 8 million children (Box 1-1). Together, the programs provide health care insurance to over one-third of all children. Because of its size and interactions with Medicaid in many states, it is often difficult to separate CHIP statistics from Medicaid.

Enacted in 1997, CHIP is designed to provide health insurance coverage for children in families who have too much income to qualify for Medicaid. Federal funding for CHIP is divided

[3] Initially referred to as SCHIP, the acronym was changed to CHIP when the program was reauthorized in 2009.

among the states in the form of capped federal allotments which are provided to the states on a matching basis. The federal CHIP match is an enhanced FMAP and like Medicaid, the federal CHIP matching rate varies by state, with states being responsible for 30 percent of national CHIP expenditures, and the federal government financing the remaining 70 percent. CHIP is currently federally funded through FY 2015.

States have three options for designing their CHIP programs: (1) expand their existing Medicaid program, (2) create a separate child health insurance program, or (3) use a combination of the two approaches. In separate CHIP programs, benefits, premiums, and cost-sharing requirements differ from Medicaid; however, states choosing to use the Medicaid expansion approach for CHIP must provide full Medicaid benefits and adhere to Medicaid cost-sharing rules. Most states began by expanding their existing Medicaid programs but over time more states have elected to design separate programs that operate in combination with the Medicaid program.

The CHIP program allows states to experiment with providing health insurance coverage that more closely resembles what might be available in the commercial health insurance market. This flexibility was eventually applied to Medicaid as well, with the allowance of benchmark benefit packages (as discussed in Chapter 2).[4]

Picture of Coverage Today

According to the most recent survey estimates of the non-institutionalized population (e.g., excluding individuals in nursing homes) 34.4 percent of children were enrolled in Medicaid or CHIP and 8.8 percent were uninsured; among adults aged 19-64, 8.5 percent were enrolled in Medicaid or CHIP and 22.4 percent were uninsured. (See Table 1-1.)

Nearly all seniors—94.4 percent of those age 65 and older—have Medicare; only 1 percent are uninsured (Table 1-1). The standard Medicare benefits package is not as extensive as Medicaid's and its cost-sharing requirements are greater than most other health insurance (Peterson 2009). For example, the Medicare deductible for a hospitalization in 2011 is more than $1,100. Sixteen percent of all Medicare beneficiaries, including those in nursing facilities and other institutions, are "dual eligibles." These people are eligible and enrolled in both Medicare, which is their primary source of coverage, and Medicaid. Medicaid pays Medicare premiums, deductibles and cost-sharing for dual eligibles and covers long-term services and supports, as well as other services not covered or limited by Medicare. While most dual eligible are seniors, 41 percent are persons with disabilities under age 65 (MedPAC 2010b).

[4] As first authorized by the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), states may amend their Medicaid state plans to provide benefit packages other than the minimum standard benefits identified in the definition of "medical assistance" in 1905(a). These benchmark benefit packages or benchmark-equivalent packages are allowed for certain populations. The benchmark benefit packages for states to choose from are the Blue Cross and Blue Shield standard option available to federal employees, a plan available to state employees, and coverage offered by the HMO plan in the state with the largest commercial, non-Medicaid enrollment. In addition, states may design their own benefit package and obtain approval from the Secretary of the U.S. Department of Health and Human Services (HHS), if the Secretary determines the coverage is appropriate for the population.

TABLE 1-1. Sources of Health Insurance by Age, 2010

	Total (millions)	Private	Medicaid/ CHIP	Medicare	Uninsured	
					Percent	Millions
All ages	303.4	60.8%	15.1%	14.0%	16.2%	49.1
0-18	78.8	54.4%	34.4%	0.2%	8.8%	7.0
19-64	186.1	64.9%	8.5%	3.1%	22.4%	41.8
65+	38.5	54.1%	7.8%	94.4%	1.0%	0.4

Note: Coverage status and type is measured at the time of the survey among civilian, non-institutionalized population. Percentages within each age group may sum to more than 100 percent because people can have multiple sources of health insurance.
Source: Analysis of National Health Interview Survey, by the National Center for Health Statistics, Centers for Disease Control and Prevention for MACPAC.

Medicaid and CHIP in the Context of U.S. Health Care Spending

Combined federal and state expenditures for Medicaid and CHIP accounted for over 15 percent of U.S. health care spending in 2009, the most recent year for which historical data are available (Figure 1-1). In comparison, Medicare and private insurance accounted for about 20 percent and 32 percent, respectively.

For certain types of care, Medicaid and CHIP account for a substantially larger portion of the U.S. total than other payers.[5] In 2009, Medicaid financed 36 percent of home health care, 33 percent of nursing home care, and 53 percent of other health, residential, and personal health care (Figure 1-2). For other services, Medicaid and CHIP account for a smaller share than might be expected based on enrollment. Lower payment rates, differing coverage policies (e.g., Medicaid provides dental for children but generally not adults), and different groups' proportionate use of services (e.g., people over age 65 use more services than younger enrollees) offer a partial explanation.[6]

As Figure 1-3 indicates, Medicaid is the dominant source of payment for long-term services and supports (LTSS), followed by out-of-pocket payments by individuals and families. Medicaid accounted for 48 percent of all long-term care spending in 2009, $127 billion out of a total $264 billion.[7] The program also financed one-quarter of mental health and substance abuse spending in 2003, the most recent year for which data are readily available (Mark et al. 2007).

Unlike Medicare, for which a substantial portion of federal spending is financed by dedicated revenue sources that include payroll taxes and enrollee premiums, federal spending for

[5] Although amounts cited here include CHIP, it accounts for no more than 3 percent of total Medicaid and CHIP spending.

[6] As described in more detail in Chapters 2 and 3, states are required to cover certain benefits while others are optional.

[7] MACPAC analysis of unpublished NHE detail from the Office of the Actuary, Centers for Medicare and Medicaid Services.

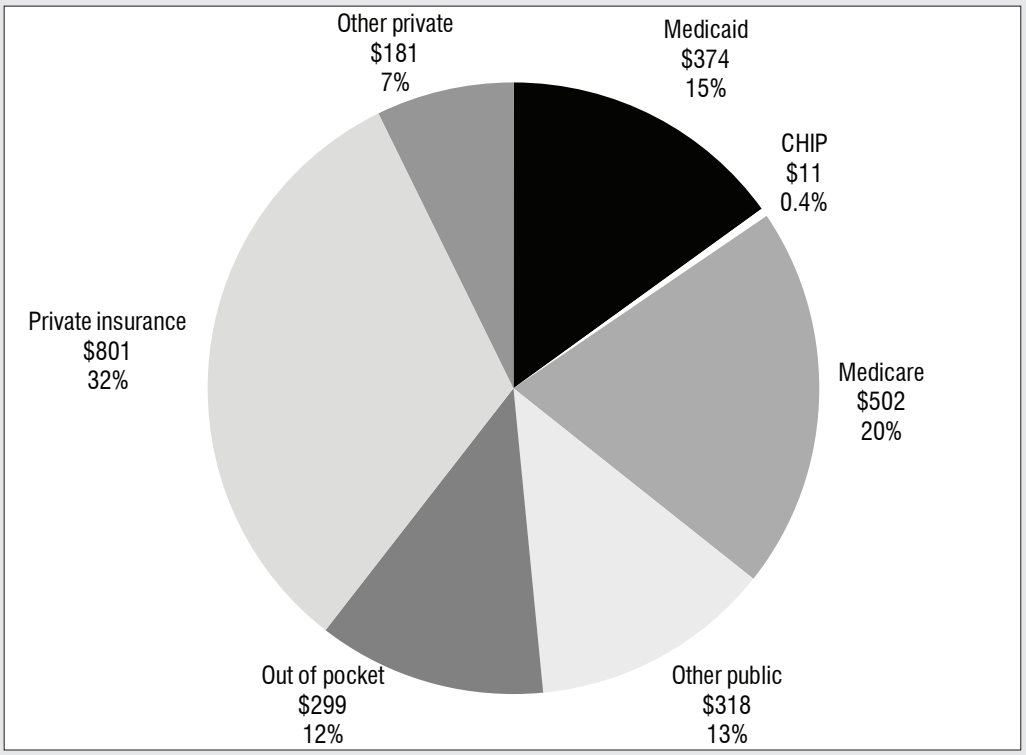
Medicaid and CHIP is financed by general revenues (OACT 2010). The programs represent a growing portion of the federal budget, having increased from 1.4 percent of federal outlays in FY 1970 to 8.1 percent in FY 2010; in comparison, Medicare increased from 3.0 percent of federal outlays to 12.3 percent (OMB 2011).

Medicaid and CHIP have increased as a share of U.S. health care spending over time, along with Medicare and private insurance; in contrast, out-of-pocket and other public spending shares have decreased (Figure 1-4).[8] In addition, as health care has consumed a growing share of the nation's economy, so have Medicaid and CHIP. Between FY 1970 and FY 2009, total U.S. health care spending increased from 7.2 percent of gross domestic product (GDP) to 17.6 percent. Over the same period, Medicaid and CHIP spending increased from 0.5 percent of GDP to 2.7 percent (OACT 2011b).

Balancing Federal and State Interests

Part of the challenge in setting policies for Medicaid and CHIP is balancing federal and state interests. Both the federal and state governments have a financial stake in the programs and

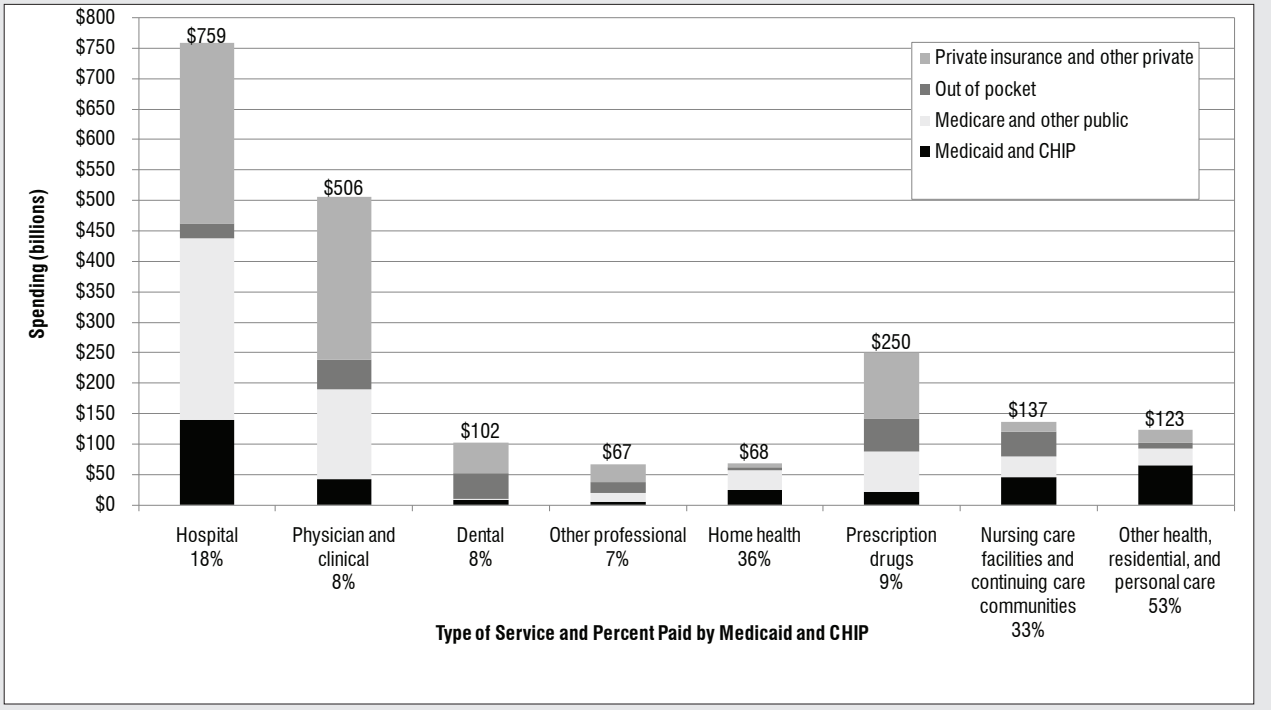
FIGURE 1-1. U.S. Health Care Spending by Source, 2009 (billions)



Note: Total spending is $2.486 trillion.
Source: See Table 16 in MACStats

[8] Although amounts cited here include CHIP, it accounts for no more than 3 percent of total Medicaid and CHIP spending.

FIGURE 1-2. U.S. Health Care Spending on Selected Services by Source, 2009



Note: Services not shown are non-prescription drugs and non-durable medical products ($43 billion, nearly all of which is out of pocket) and durable medical equipment ($35 billion, primarily out of pocket and Medicare). Nursing/continuing care and other care categories reflect new data and methods as of 2011. In prior releases, Medicaid accounted for about 40% of nursing home expenditures and about three-quarters of other personal health care expenditures.

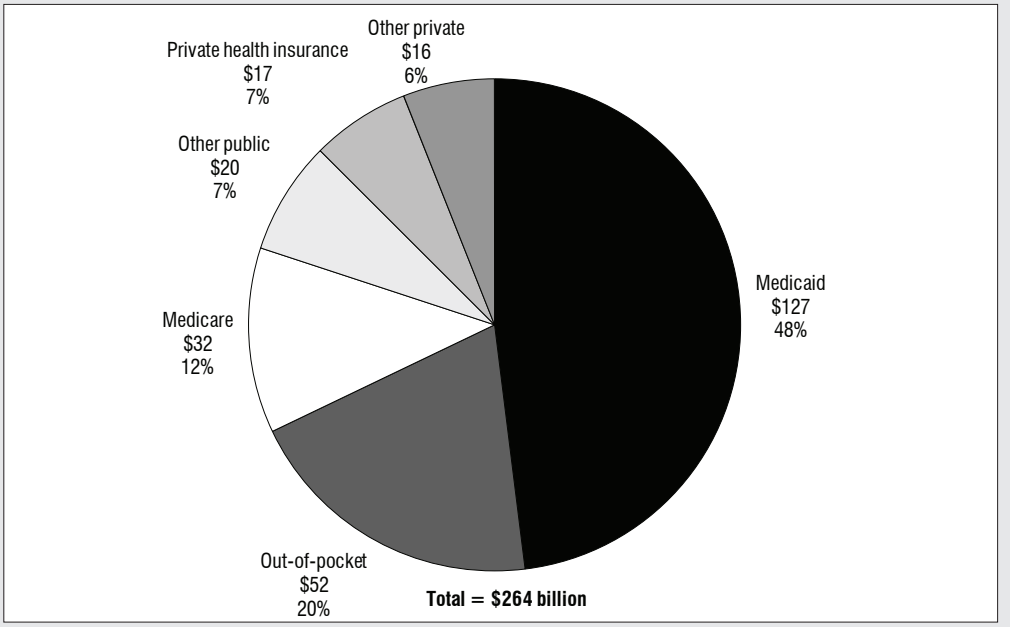
Source: See Table 16 in MACStats

reconciling their often different, sometimes conflicting priorities can be difficult, particularly under stressful fiscal circumstances such as during a national and/or state recession.

Medicaid and CHIP provide an important source of revenue for the health care industry that affects economic activity throughout the nation. They are major sources of federal financing for costs that might otherwise be borne by state and local governments, and by individuals and providers. Enrollment in the program has grown steadily, particularly in times of economic downturns, which exacerbate the pressure on federal and state budgets. States are subject to the same underlying medical cost drivers that other payers struggle to control, such as changing medical practice patterns and high-cost technological innovations. These cost drivers, along with state needs to balance budgets, and federal interests for fiscal accountability, are a few of the factors that contribute to tension between the federal and state partners in administering Medicaid and CHIP.

The individual entitlement of Medicaid, coupled with the longstanding FMAP formula determining the level of federal support for each state program, creates incentives for states to maximize or

FIGURE 1-3. Spending for Long-term Services and Supports by Source, 2009 (billions)



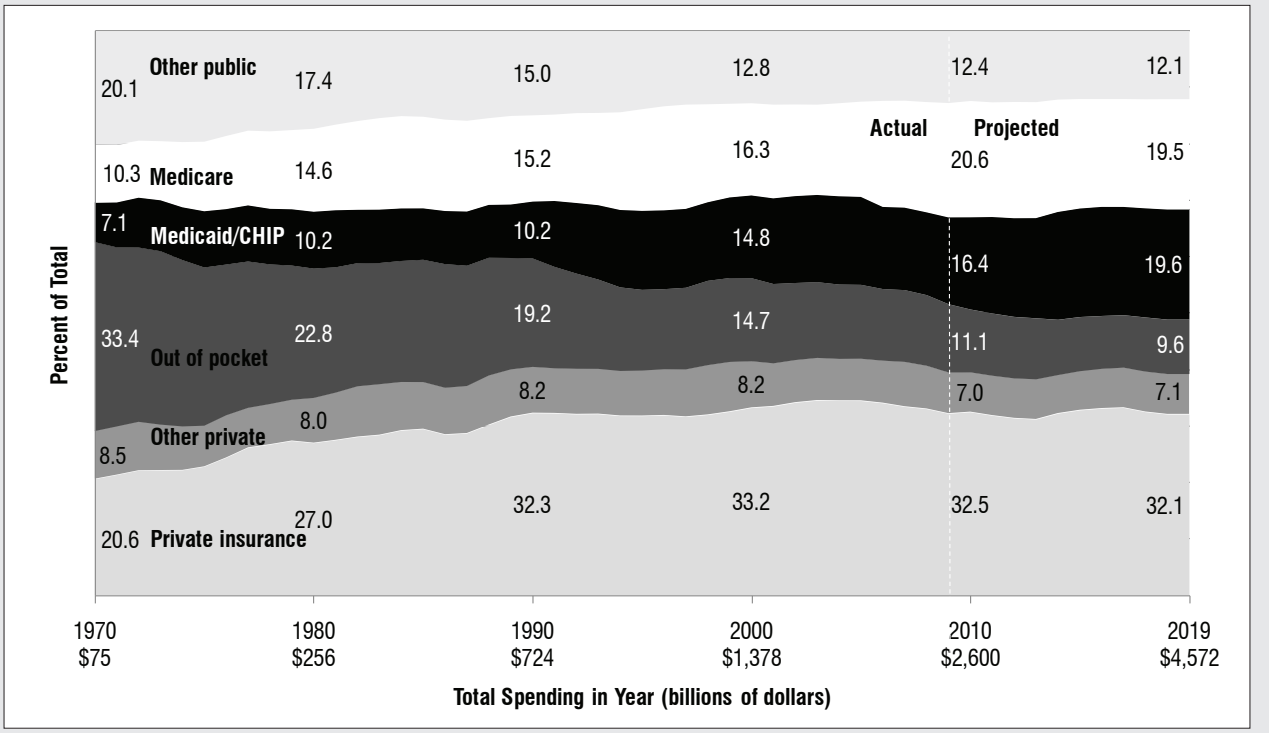
Note: Includes nursing care facility and continuing care retirement community (with the exception of Medicare, which only pays for these services on a short-term basis), home health (all payers), residential care for individuals with intellectual disabilities and for mental health and substance abuse (all payers), and home and community-based waiver (for which Medicaid is the only payer) expenditures. Includes Medicaid hospital-based nursing/continuing care and Medicaid and Medicare home health expenditures that are categorized as hospital expenditures in published national health expenditure (NHE) estimates. Estimates may differ from those published elsewhere due to variation in the treatment of Medicare, residential care, and hospital-based expenditures, as well as from those published earlier due to a comprehensive revision of NHE estimates released in 2011.

Source: MACPAC analysis of unpublished NHE detail from the Office of the Actuary, Centers for Medicare & Medicaid Services

augment the federal share of Medicaid costs. In addition, virtually all states have requirements to balance their budgets; measures they take to meet that requirement often include cuts in Medicaid that affect providers and beneficiaries. Finally, fiscal stresses are compounded by the rising cost of health care and the fact that Medicaid is designed to be countercyclical. Medicaid enrollment and spending increase when there is a downturn in the economic cycle and there is growth in the low-income population as unemployment, and loss of employer-sponsored insurance increase. Without Medicaid and CHIP, uninsurance would be more prevalent during economic downturns. Because of the underlying dynamics of this enrollment growth, however, Medicaid often struggles to meet its multiple federal and state responsibilities and interests under difficult fiscal conditions. During robust economic times, on the other hand, management of federal and state interests can be easier.

As federal and state Medicaid officials move forward and continue to shape Medicaid, understanding the scope and role of the program in context of the health care system as a whole, the people it serves, and the providers and programs it supports, is essential. The following two chapters describe Medicaid and CHIP, their roles in delivering and financing health care services, and their impact on people and providers. Current data on program enrollment, expenditures, and financing are also provided.

FIGURE 1-4. Distribution of U.S. Health Care Spending by Source, 1970–2019 (billions)



Source: See Table 17 in MACStats

MACPAC

In recognition of the programs' significance as sources of health coverage and long-term care assistance for low-income populations, and the complex needs of many Medicaid and CHIP beneficiaries, the Congress established the Medicaid and CHIP Payment and Access Commission (MACPAC) as a nonpartisan advisor to provide technical and analytical assistance and to be a source of current, reliable information to guide policies related to these programs.

MACPAC was authorized in the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3), and was later expanded in the Patient Protection and Affordable Care Act (P.L. 111-148) in 2010. MACPAC's responsibilities are to advise the Congress on Medicaid and CHIP program policies including access, payment, eligibility, enrollment and retention, coverage, and quality. MACPAC also is responsible for advising the Congress on interactions of Medicaid and CHIP payment policies with health care delivery and Medicare. Furthermore, the Commission is to develop an early-warning system to identify provider shortage areas and other factors that adversely affect access to care by Medicaid and CHIP beneficiaries.

MACPAC's objective is to create an independent analytic base of information integrating both data and policy analysis to support nonpartisan recommendations to the Congress and also to the Secretary of the Department of Health and

Human Services (HHS) and the states. In order to fulfill our mandate to develop an independent capacity to serve the information and analytic needs of policymakers, the Commission must work with its partners—the Congress, the Secretary of HHS, the Centers for Medicare & Medicaid Services (CMS), and the states to improve the quality, depth, and transparency of data, information, and dialogue about Medicaid and CHIP.

The purpose of this first report to the Congress is to contribute to a better understanding of the Medicaid and CHIP programs, their roles in the U.S. health care system, and key policy and data issues that need to be addressed. In addition, this Report outlines MACPAC's approach to developing its independent analytic base necessary to meet its mandate advising the Congress. Future Commission work, including technical assistance and mandated reports to the Congress, will rely on this base of research, data, and policy analysis.

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CHAPTER 2

Overview of Medicaid

Section 1900(b) of the Social Security Act directs the Commission to review policies of the Medicaid program and the State Children's Health Insurance Program (CHIP) affecting access to covered items and services, including payment policies, eligibility policies, enrollment and retention processes, coverage policies, quality of care, the interaction of Medicaid and CHIP payment policies with health care delivery generally, interactions with Medicare and Medicaid, and other access policies.

Chapter Summary

The Medicaid program was enacted to allow states, at their option with federal financial support, to provide medical assistance to certain low-income families and individuals who could not afford the costs of necessary health care. Today, the program finances health coverage for an estimated 68 million people, about half of whom are children.

Medicaid pays for routine health care services, as well as benefits that are limited or not typically covered under Medicare or traditional health insurance, such as long-term services and supports. Low-income seniors, people with physical or mental disabilities, and children with special health care needs may rely the most on these Medicaid services. The breadth of Medicaid coverage varies by state because benefits are a combination of federal mandatory and state optional benefits. While the majority of Medicaid benefit spending occurs under fee-for-service (FFS) arrangements, many states contract with managed care plans to administer benefits and pay providers. In addition, states have been granted waivers to test changes in eligibility and care delivery.

Medicaid spending has grown in recent decades. Economic downturns compound the fiscal challenge since loss of jobs and income result in more people eligible for Medicaid. Today, many states face budget shortfalls, elevating Medicaid policy issues. This chapter highlights Medicaid eligibility, benefits and cost-sharing, state program flexibility, and the federal-state financing structure. In addition, the impacts of recent legislative changes on the current program are explained and future program issues are identified.

CHAPTER 2

Overview of Medicaid

Medicaid was established in 1965 under Title XIX of the Social Security Act (the Act). Its statutory purpose is to enable states, at their option, to furnish medical assistance, as well as rehabilitative and other services, for certain families and individuals whose income and resources (assets) are insufficient to meet the costs of necessary medical services (Section 1901 of the Act). It has evolved from a program that primarily served welfare recipients to one that finances health coverage for a substantial number of low-income people—an estimated 68 million in FY 2010, about half of whom are children under age 19. Each state operates its Medicaid program in accordance with a state plan submitted to and approved by the Centers for Medicare & Medicaid Services (CMS) that describes the nature and scope of the program (e.g., administrative structure and operations, eligibility, covered benefits, payment methods). Most of the discussion in this chapter reflects policies and operational approaches within Medicaid's federal framework for state plans. Major sections separately address eligibility, benefits, and financing and administration. The chapter also describes several authorities in the Act that provide states additional flexibility in operating their Medicaid programs under waivers of certain federal requirements.

Eligibility for Medicaid

People eligible for Medicaid coverage have historically included low-income children and their parents, pregnant women, individuals with disabilities, and individuals age 65 and older. Under the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended), low-income adults who do not fall into one of these groups will also be eligible for Medicaid beginning in 2014, or earlier at state option. However, as described in this section, additional eligibility criteria apply and not all low-income people are covered. Minimum income and other eligibility criteria are set by the federal government; states may opt to cover additional people beyond these federal minimums. All individuals

who meet these federal and state criteria are entitled to enroll in the program and receive Medicaid benefits.

For many people eligible for Medicaid, other coverage may be unavailable or unaffordable. In 2008, for example, among people working full time, less than one-third of those with family incomes at or below the federal poverty level (FPL, currently $18,530 for a family of three) and less than half of those at or below 200 percent FPL ($37,060 for that same family) were offered health insurance through their job.[1] In comparison, more than three-quarters of full-time workers with family incomes above 200 percent FPL received an offer.[2]

Some individuals who are eligible for Medicaid as a result of their low incomes—and in some cases, high medical expenses—may have other coverage, such as Medicare (among individuals age 65 and older and certain persons with disabilities) or private insurance (e.g., from a child's non-custodial parent). In these cases, Medicaid is generally the payer of last resort—that is, the other insurance pays for the expenses it covers and Medicaid then "wraps around" to provide additional services that are covered by Medicaid but not the primary insurance. Medicaid also pays for certain cost-sharing amounts charged to enrollees by their primary insurance (as noted later, state Medicaid programs may charge their own cost-sharing amounts). This is particularly important for "dual eligibles," the one of every six Medicare beneficiaries who are also enrolled in Medicaid, which helps to pay for their Medicare premiums and, in most cases, deductible and coinsurance amounts. For most dual eligibles, Medicaid also provides benefits not covered by Medicare (MedPAC 2010).

History

At the time of enactment, states that chose to participate in Medicaid were required to provide coverage to all "categorically needy" individuals who received cash payments under federal assistance programs for aged, blind, and disabled individuals, as well as families with dependent children.[3] Each federal assistance program was administered by the states, which often set their income eligibility thresholds below the FPL. In addition to covering these mandatory categorically needy individuals under Medicaid, states could choose to cover optional "medically needy" individuals who fell within one of the federal assistance categories (aged, blind, disabled, families with dependent children)—but whose higher incomes made them ineligible for cash payments and whose medical expenses (if any) would be deducted when determining countable income for eligibility purposes.

Until the mid-1980s, eligibility for Medicaid continued to be closely tied to the receipt of cash payments under states' Aid to Families with

[1] See Table 19 in MACStats for dollar amounts that reflect various FPL percentages for different family sizes, as well as for Alaska and Hawaii, whose FPLs differ.

[2] Agency for Healthcare Research and Quality (AHRQ) analysis for MACPAC of 2008 Medical Expenditure Panel Survey, Household Component (MEPS-HC), 2011.

[3] For an overview of Medicaid enrollment and spending growth as the program evolved from enactment through 1999, see Klemm 2000.

Dependent Children (AFDC) programs and the federal Supplemental Security Income (SSI) program.[4]

For SSI recipients, a federal income eligibility standard with annual cost-of-living increases meant that Medicaid eligibility generally kept pace with inflation. For AFDC recipients, however, the income eligibility standards set by states varied significantly and had been declining in real (inflation-adjusted) terms since the 1970s (Burwell and Rymer 1987).

Between 1984 and 1990, the Congress made significant changes to Medicaid for pregnant women and children. It created new mandatory and optional eligibility groups for them that were based on income relative to the FPL rather than to receipt of cash payments under AFDC. This shift was significant; not only did the FPL represent a national amount that was much higher than most states' income eligibility standards for AFDC, it also is increased annually to account for inflation. Mandatory and optional eligibility was also extended to, among others, additional individuals ages 65 and older and persons with disabilities, as well as families transitioning from welfare to work.[5]

The program also saw changes under the welfare reform law of 1996, which severed the link between Medicaid and cash assistance for families with children. As a result, Medicaid eligibility for these families is now based on specified income and asset standards and methodologies—generally those that were in effect for AFDC as of July 16, 1996, with state options to be more or less restrictive—rather than receipt of benefits under the Temporary Assistance for Needy Families (TANF) program that replaced AFDC. Other major changes in Medicaid eligibility to date include the creation of CHIP (which has been implemented as a Medicaid expansion in many states; see Chapter 3) in 1997 and the expansion of Medicaid eligibility for non-elderly adults under PPACA.

The Medicaid Program Today

Although a detailed discussion of all eligibility pathways contained in the Medicaid statute is not provided here, Medicaid eligibility groups are typically defined by the populations they cover and the financial (i.e., income and asset) criteria that apply. Some eligibility groups are mandated by federal law and some may be covered at state option. Figure 2-1 provides summary information on Medicaid and CHIP income eligibility by major populations covered. For state-level detail on income thresholds for major eligibility groups, see Tables 9 through 11 in MACStats.

As noted earlier, populations covered under Medicaid have historically included low-income children and their parents, pregnant women, persons with disabilities, and individuals over the age of 65. As a result of PPACA, however, adults under age 65 with incomes at or below 133 percent FPL (currently $14,484 for a single person) who are not pregnant and do not have Medicare coverage may be covered at state option through 2013 and must be covered starting in 2014.

Some people, including most individuals age 65 and older and persons with disabilities who receive

[4] SSI was enacted in 1972 to replace federal assistance programs for aged, blind, and disabled individuals that had previously been administered by the states.

[5] For a legislative history through this period, see U.S. House of Representatives 1993.

SSI cash assistance payments and children who are in foster care, qualify for Medicaid automatically by virtue of their participation in those programs.[6] Others must meet financial (i.e., income and asset) criteria that vary both by group and among states (Figure 2-1). For example, pregnant women with incomes at or below 133 percent FPL ($24,645 for a family of three)—or higher in some states—are a mandatory eligibility group.[7] However, many states opt to cover additional pregnant women with incomes above mandatory levels. Most states have eliminated asset tests for children and pregnant women and about half have done so for parents (Heberlein et al. 2011). The treatment of both income and assets can be complex for individuals in need of long-term services and supports (LTSS) (Walker and Accius 2010).

Along with falling into a specified eligibility group, individuals must meet other criteria in order to qualify for Medicaid. For example, they must be citizens or nationals of the United States or qualified aliens in order to receive the full range of benefits offered under the program.[8] Non-qualified aliens (as well as qualified aliens subject to a five-year bar on full benefits) who meet income and all other eligibility criteria for the program can only receive limited emergency Medicaid coverage.[9] In addition, individuals in need of LTSS may be required to meet functional eligibility criteria that demonstrate difficulty performing activities necessary for self care and independent living.

For FY 2009, Figure 2-2 shows the estimated distribution of Medicaid enrollment and benefit spending by enrollees' basis of eligibility. (See Table 2 in MACStats for state-level enrollment for FY 2008 and national estimates for FY 2009-FY 2012). Although individuals age 65 and older and persons with disabilities account for less than one-third of enrollees, they account for about two-thirds of Medicaid spending on benefits.

These two groups account for a disproportionate share of Medicaid spending because they have substantially higher per-enrollee costs than others. For example, estimated average spending on a non-disabled child enrolled in Medicaid for the entire year was about $2,900 in FY 2009 (including federal and state dollars); the figure for a non-disabled adult under age 65 was about $4,100.[10] In comparison, estimated average spending on a person eligible on the basis of a disability who was enrolled for the entire year was about $16,600; for a person age 65 or older, it was about $15,700

[6] Eleven "209(b)" states (referring to a section of the Social Security Act) may use criteria that differ from SSI when determining Medicaid eligibility.

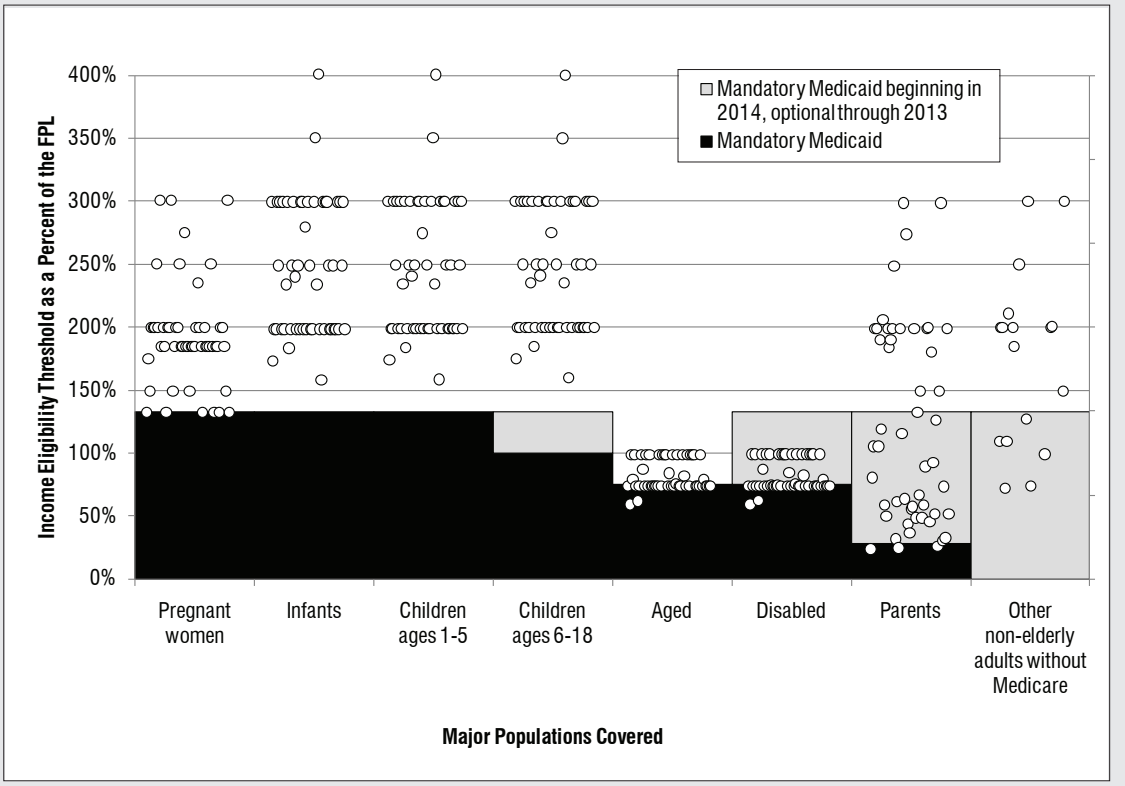
[7] The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) set a generally applicable mandatory income eligibility level of 133 percent FPL for pregnant women and infants. However, at the time of enactment, 15 states had already opted to cover them at higher levels—which ranged from 150 percent FPL to 185 percent FPL (Hill 1992)—and their mandatory levels were set at these higher amounts.

[8] The term qualified alien was created by the welfare reform law of 1996 (P.L. 104-193). Examples include legal permanent residents (LPRs), refugees, and asylees. LPRs entering after August 22, 1996, are generally barred from receiving full Medicaid benefits for five years, after which coverage becomes a state option. However, children and pregnant women who are lawfully present may be covered during the five-year bar at state option.

[9] Examples of non-qualified aliens include those who are unauthorized or illegally present, as well as students and other nonimmigrants who are admitted for a temporary purpose.

[10] Not all enrollees are covered by Medicaid for a full year. As a result, spending per person enrolled for a full year shown here (annual spending divided by average monthly enrollment) will be higher than spending per person ever enrolled in Medicaid during the year (annual spending divided by the number of people who had at least one month of enrollment during the year).

FIGURE 2-1. Medicaid and CHIP Income Eligibility by Major Populations Covered



Note: Dots on the chart generally represent state Medicaid or CHIP upper income eligibility thresholds for each population and may include employer-sponsored premium assistance and limited benefit packages; however, individuals with high medical expenses or long-term care needs may be eligible at higher income levels than those shown. Excludes eligibility for aged and disabled dual eligibles who only receive assistance with Medicare premiums and cost-sharing. In addition to meeting income criteria, individuals may be subject to an asset test and must meet additional eligibility criteria as noted in the text of Chapters 2 and 3.

Bars on the chart do not reflect Medicaid mandatory thresholds in all states. Exceptions include parents (varies by state, bar reflects U.S. median); pregnant women and infants (higher in 15 states than the generally applicable 133 percent FPL shown here); and aged and disabled individuals (11 states may use a threshold that differs from the SSI level shown here).

The mandatory thresholds for parents and disabled individuals will not change as of 2014; however, individuals above the current thresholds will gain mandatory status up to 133 percent FPL under the new eligibility group for other non-elderly adults who are not pregnant and do not have Medicare coverage.

Source: Social Security Act and Tables 9 through 11 in MACStats.

(OACT 2010). These differences in Medicaid costs across groups are even more striking in light of the fact that most enrollees over age 65 and about a third of enrollees with disabilities also have Medicare coverage,[11] which is the primary payer for their hospital, physician, and other acute care services.

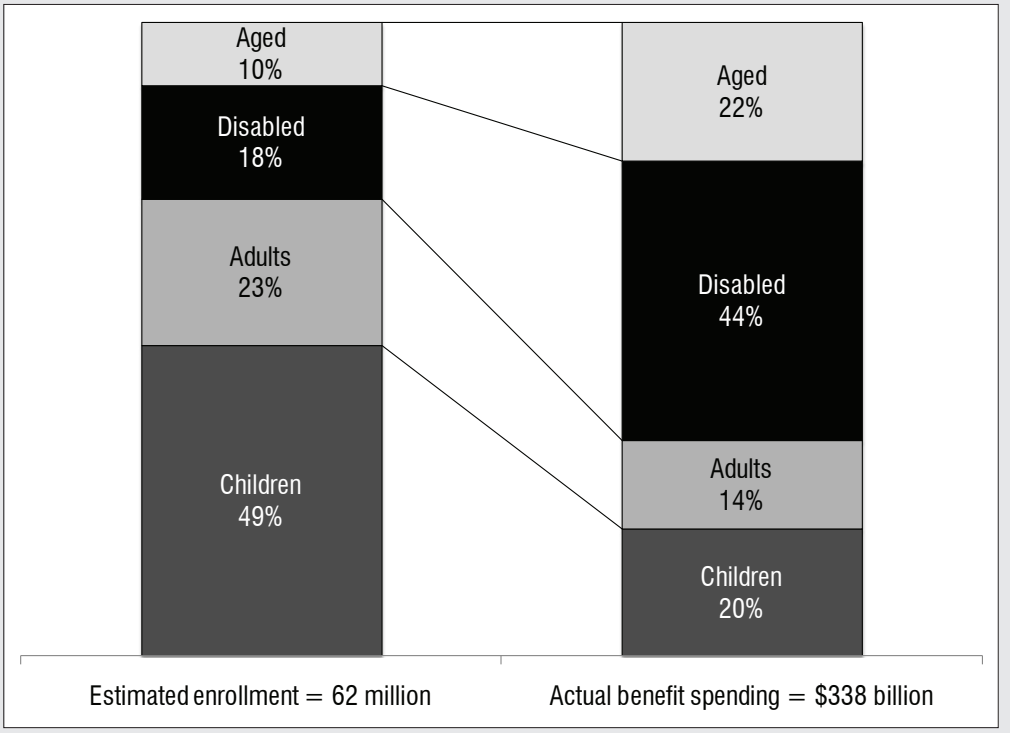
Eligibility: Future Issues

PPACA includes a maintenance of effort (MOE) provision that requires states to maintain the eligibility policies they had in place on the date of its enactment—until 2014 for adults and through FY 2019 for children—regardless of mandatory or optional status.[12] In addition, to coordinate determinations of eligibility with the subsidies for

[11] MACPAC analysis of FY 2008 Medicaid Statistical Information System (MSIS) data.

[12] For 2011-2013, there is an exception to the MOE for nonpregnant, nondisabled adults above 133 percent FPL if the state has a budget deficit. States are also subject to an MOE requirement through June 2011 as a condition of receiving a temporary increase in federal funds noted later in this chapter.

FIGURE 2-2. Distribution of Medicaid Enrollment and Benefit Spending by Basis of Eligibility, Estimated FY 2009



Note: Adults and children are non-disabled enrollees under age 65 and 19, respectively. Reflects people ever enrolled during the year and includes federal and state dollars. Excludes the territories, disproportionate share hospital (DSH) payments, and adjustments.

Source: OACT 2010

health insurance coverage that PPACA authorizes, starting in 2014 the way in which income and assets are counted for purposes of Medicaid and CHIP eligibility will change. Countable income for most Medicaid and CHIP enrollees, primarily those who are under age 65 and not disabled, will be based on modified adjusted gross income (MAGI) rules.[13] In addition, no asset test will apply to these individuals. In order to accommodate these changes and others made by PPACA, including the expansion of coverage for non-elderly adults, most states will need to make substantial modifications to their eligibility determination systems and processes.

Medicaid Benefits

In addition to covering routine services, Medicaid provides certain benefits that are limited or not typically covered under traditional health insurance. For example, it provides LTSS for individuals with physical and mental disabilities, including those

[13] Despite the fact that Medicaid eligibility has shifted away from the receipt of cash assistance payments, states are generally required to apply state-specific AFDC or federal SSI rules regarding exclusions and disregards (e.g., a portion of earned income, certain child care expenses) that reduce the amount of income and assets that are counted for Medicaid eligibility purposes. MAGI has its own rules for counting income (e.g., it excludes some or all Social Security benefits). For individuals whose eligibility is determined using MAGI starting in 2014, the only income disregard that will apply is a dollar amount equal to five percent of the FPL. This means, for example, that an individual whose total income equals 138 percent FPL will only have 133 percent FPL counted when his or her Medicaid eligibility is determined. In the transition to MAGI, states will be required to ensure that individuals do not lose eligibility based on the new method for counting income.

TABLE 2-1. Mandatory and Optional Medicaid Benefits

Mandatory

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for individuals under age 21 (screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state)
- Family planning services and supplies
- Federally qualified health center services
- Freestanding birth center services
- Home health services
- Laboratory and X-ray services
- Nursing facility services (for ages 21 and over)
- Nurse midwife services (to the extent authorized to practice under state law or regulation)
- Nurse practitioner services (to the extent authorized to practice under state law or regulation)
- Rural heath clinic services
- Tobacco cessation counseling and pharmacotherapy for pregnant women
- Non-emergency transportation[14]

Optional (number of states covering benefit)

- Medical or remedial care provided by licensed practitioners under state law. (Specific provider types, as well as all optional benefits states cover, are listed in Table 12 in MACStats.)
- Intermediate care facility services for individuals with mental retardation (51)
- Clinic services (50)
- Skilled nursing facility services for individuals under age 21 (50)
- Occupational therapy services (50)
- Optometry services (50)
- Physical therapy services (50)
- Prescribed drugs (50)
- Targeted case management services (50)
- Prosthetic devices (49)
- Hospice services (48)
- Inpatient psychiatric services for individuals under age 21 (48)
- Dental services (46)
- Eyeglasses (45)
- Services for individuals with speech, hearing, and language disorders (45)
- Audiology services (43)
- Inpatient hospital services, nursing facility services, and intermediate care services for individuals age 65 or older in institutions for mental diseases (42)
- Emergency hospital services[15] (40)
- Dentures (37)
- Preventive services (37)
- Personal care services (35)
- Private duty nursing services (33)
- Rehabilitative services (33)
- Diagnostic services (32)
- Program for All-Inclusive Care for the Elderly (PACE) services (31)
- Screening services (30)
- Chiropractic services (29)
- Critical hospital services (22)
- Respiratory care for ventilator-dependent individuals (22)
- Primary care case management services (14)
- Services furnished in a religious nonmedical health care institution (13)
- Tuberculosis-related services (13)
- Home and community-based services (HCBS)[16](4)
- Sickle cell disease-related services (2)
- Health homes for enrollees with chronic conditions (new benefit as of January 1, 2011)

Note: This table provides a list of mandatory and optional state plan benefits for the 50 states and the District of Columbia. It does not include services provided under a Medicaid waiver; for example, while four states provide HCBS under the state plan option, all states offer home and community-based services through waivers.

Source: See Table 12 in MACStats

[14] Federal regulations require states to provide transportation services; they may do so as an administrative function or as part of the Medicaid benefit package.

[15] Federal regulations define these services as being those that are necessary to prevent the death or serious impairment of the health of the recipient and, because of the threat to life, necessitates the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet Medicare's participation requirements or the definition of inpatient or outpatient hospital services under Medicaid rules.

[16] While only four states provide HCBS under the state plan option, all states offer HCBS through waivers.

BOX 2-1. Medicaid's Role in Long-term Services and Supports

People who have a chronic illness or a physical or mental disability may use long-term services and supports (LTSS) to assist them with basic daily activities (such as bathing, dressing, and moving in and out of a bed or chair). Their need for assistance can change over time. With many of these services not covered by Medicare or private insurance, Medicaid is the de facto payer of LTSS for many people, paying about half of these costs nationally (Figure 1-3). The people who use these services span all ages and often have significant acute care needs as well. For example, services such as inpatient hospital, physician, and prescription drugs accounted for about a quarter of Medicaid spending among enrollees receiving LTSS in FY 2002 (Sommers et al. 2006).[17]

The Supreme Court, in *Olmstead v. L.C.,* 119 S. Ct. 2176 (June 22, 1999), ruled that people with disabilities who are capable of living in the community should have the option to reside in the most integrated setting appropriate to their needs, and that to deny these services constitutes discrimination under the Americans with Disabilities Act (ADA). As communicated by CMS in a letter to state Medicaid directors, states are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional care if: the state's treatment professionals reasonably determine that care in the community is appropriate; the enrollee does not decline such treatment; and the community placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state-supported disability services (CMS 2000).

enrolled in Medicare, which does not cover these services (Wenzlow et al. 2008). Under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements, it provides a broad range of therapies and services for children, including those with special health care needs (Peters 2006). It also provides translation, interpretation, and non-emergency transportation services that may not be covered under private plans.

States can require enrollees to share in the costs of their Medicaid coverage (such as through copayments for services and premiums to enroll), but certain exemptions and limits apply. Although the majority of Medicaid spending occurs under fee-for-service arrangements whereby states pay providers directly for care received by enrollees, many states also contract with managed care plans to administer benefits and pay providers.

Covered Services

Under Medicaid, states are required to cover "mandatory" benefits and may choose to cover "optional" benefits. These benefits are defined in federal statute and regulations and cover specific items, provider types, and service types; however, the breadth of coverage (i.e., amount, duration,

[17] A more current estimate might differ somewhat due to the transfer of most prescription drug costs for dual eligibles from Medicaid to Medicare Part D beginning in 2006.

and scope) varies by state. For example, one state may elect to cap the number of inpatient hospital days an enrollee might receive each year, while another state may allow an unlimited number of inpatient hospital days.

Within a state, each service provided must be adequate in amount, duration, and scope to reasonably achieve its purpose, although the state may limit coverage of a service based on criteria such as medical necessity or through utilization control measures. In addition, benefits for most enrollees must be equivalent in amount, duration, and scope (known as the comparability rule); benefits must be the same throughout the state (the statewideness rule); and enrollees must have freedom of choice among health care providers and practitioners or managed care plans participating in Medicaid.

As an alternative to traditional Medicaid benefits, states may enroll state-specified groups (excluding individuals with special medical needs and certain others) in benchmark and benchmark-equivalent benefit packages.[18] States that elect to use this benefit design can provide coverage that is equal to the Blue Cross and Blue Shield standard provider plan under the Federal Employees Health Benefits Program; a plan offered to state employees; the largest commercial health maintenance organization (HMO) in the state; or other coverage approved by the Secretary of HHS appropriate for the targeted population. A benchmark-equivalent benefit package must be actuarially equivalent to the benchmark to which it is being compared and must include certain benefits.[19]

Benchmark and benchmark-equivalent packages allow states to bypass requirements that have traditionally applied to Medicaid, such as statewideness, comparability, and freedom of choice. States must assure access to EPSDT services for children under age 21 either through these packages or as additional benefits provided by the state.

States also have the option to use premium assistance programs to help eligible individuals purchase private insurance through their employer and 39 do so with Medicaid funds (GAO 2010). However, less than one percent of enrollees are enrolled in these programs (Shirk 2010).

Enrollee Cost-Sharing

States can require that certain groups of Medicaid enrollees pay enrollment fees, premiums, deductibles, coinsurance, copayments, or similar cost-sharing amounts. There are, however, specific guidelines regarding who may be charged these fees, the services for which they may be charged, and the amount allowed (Table 13 in MACStats).

Enrollees exempt from cost-sharing include: children under age 18, enrollees receiving hospice care, those in nursing facilities and intermediate care facilities for the mentally retarded (ICFs-MR),

[18] Groups that are exempt from mandatory enrollment in these benefit packages include pregnant women, dual eligibles, those who qualify for Medicaid on the basis of blindness or disability, enrollees receiving hospice care, and those who are medically frail or have special medical needs.

[19] A benchmark-equivalent benefit package must include inpatient and outpatient hospital services, physician services, laboratory and X-ray services, emergency care, well-baby and well-child care, family planning services and supplies, and other appropriate preventive care. It must also include at least 75 percent of the actuarial value of coverage under the benchmark package for prescription drugs, mental health services, vision care, and hearing services, if these services are included in the comparison package.

and certain enrollees in hospitals and other medical institutions. Pregnancy-related services, emergency services, family planning services and supplies, and items and services provided to an Indian are also excluded from cost-sharing.

Adults with family incomes at or below 100 percent FPL (currently $18,530 for a family of three) may only be charged nominal amounts for certain services and premiums may not be imposed at or below 150 percent FPL ($27,795 for a family of three). For adults with family incomes above 100 percent FPL, states may impose nominal or higher cost-sharing for some services; in addition, those with incomes above 150 percent FPL may be charged premiums. Regardless of income level, states must ensure that the aggregate amount paid by individuals subject to cost-sharing above nominal amounts does not exceed five percent of a family's monthly or quarterly income.

Service Delivery and Payment Mechanisms

The majority of Medicaid spending occurs under FFS arrangements whereby states pay providers directly for care provided to enrollees. Many states, however, also contract with managed care plans to administer benefits and pay providers (Box 2-2). Section 1902(a)(30)(A) of the Social Security Act is the foundational statutory provision that governs payment for all Medicaid-covered services, requiring that they are consistent with efficiency, economy, and quality of care and are sufficient to provide access equivalent to the general population. In Chapter 5 we discuss payment policies and issues in greater depth.

In addition to or in lieu of standard payments, some providers with special roles in delivering care receive enhanced support from Medicaid. For example, federally qualified health centers (FQHCs), which are located in high-need areas and provide care to more than 7 million Medicaid and CHIP enrollees, receive cost-based payments for these patients.[20] Hospitals that serve large numbers of low-income and uninsured individuals may receive disproportionate share hospital (DSH) payments. In addition, states may make non-DSH supplemental payments to increase reimbursement above standard rates for certain providers, including hospitals and nursing homes. In general, DSH and non-DSH supplemental payments are made in aggregate amounts that are not tied to individual Medicaid enrollees and the services they receive.

As noted earlier, Medicaid is a dominant payer of LTSS. In recent decades there has been a significant shift in the delivery of care for people with mental and physical disabilities away from nursing homes, ICFs-MR, and other institutional settings to community-based alternatives (Vladeck 2003). For both institutional and community providers of LTSS, Medicaid accounts for a significant share of revenues (Quinn and Kitchener 2007).

Benefits: Future Issues

PPACA brings a variety of mandatory and optional changes to Medicaid benefits in the years to come. These changes include the coverage of services provided in free-standing birthing centers, expansion of preventive care for adults,

[20] These 7 million Medicaid and CHIP enrollees accounted for nearly 40 percent of FQHC patient volume in 2009; figures exclude FQHC "look-alikes" that also receive cost-based payments (HRSA 2009).

BOX 2-2. Fee for Service and Managed Care Arrangements

States may offer Medicaid benefits on a fee-for-service (FFS) basis, through managed care plans, or both. Under a FFS model, the state pays providers directly for each covered service received by a Medicaid enrollee. Under managed care, the state pays a fee to a managed care plan for each person enrolled in the plan; in turn, the plan pays providers for all of the Medicaid services an enrollee may require that are included in the plan's contract. Under primary care case management (PCCM) programs, providers are typically paid a small monthly case management fee for coordinating and monitoring care that is in addition to FFS reimbursement for providing primary care services.

Statistics from CMS often include managed care plans that provide comprehensive and limited benefits, as well as PCCMs, in the definition of Medicaid managed care. "Limited-benefit plans" are a diverse assortment of plans that typically manage a subset of benefits such as mental health and non-emergency transportation. Under a broad definition of managed care that includes comprehensive plans, limited-benefit plans, and PCCM programs, CMS reports that more than 70 percent of Medicaid enrollees nationally are in managed care (CMS 2010b). If the definition of managed care is restricted only to plans that provide comprehensive benefits, 47 percent of Medicaid enrollees were in managed care in FY 2008 (Table 2 in MACStats). In FY 2010, comprehensive managed care plans accounted for nearly 21 percent of Medicaid spending on benefits; limited-benefit plans and PCCM programs accounted for less than 3 percent (Table 7 in MACStats).

smoking cessation services for pregnant women, changes in the scope of coverage for children receiving hospice care, new statutory authority for consumer-directed personal care attendant services, "health homes" for people with chronic conditions, and new options for home and community-based services. In addition, beginning in 2014, benchmark and benchmark-equivalent packages must cover "essential health benefits" so that they align with plans offered through the individual and small group insurance markets.[21]

Under PPACA's 2014 eligibility expansion, most adults under age 65 who are new to Medicaid will be required to enroll in either benchmark or benchmark-equivalent benefit packages. However, as under existing rules for these packages, individuals with special medical needs are exempt and states have flexibility under a Secretary-approved benchmark or a benchmark-equivalent package to include additional Medicaid benefits. Since enrollees may experience shifts in their basis of eligibility (e.g., to a pregnancy category) as their income and health status changes, states must have systems for tracking changes in status to ensure that individuals are able to receive the services to which they are entitled.

Financing and Administration of Medicaid

Medicaid is a major source of federal financing for costs that might otherwise be borne by states and

[21] "Essential benefits" are defined as ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. For benchmark-equivalent benefit packages, prescription drugs and mental health services must be added to the basic services covered by the package.

local governments solely from their own revenues, individuals paying out of pocket, and providers supplying care for free or at reduced rates. Enrollment in Medicaid has grown steadily and particularly rapidly during economic downturns, a situation that places extra pressure on public budgets as tax revenues decline. With regard to spending growth in Medicaid, states are subject to the same underlying drivers of health care costs that other payers contend with, such as medical practice patterns and new, high-cost technologies.

Financing Medicaid

Financing for the Medicaid program is a shared responsibility of the federal government and the states. States that operate their Medicaid programs within federal guidelines are entitled to federal reimbursement for a share of their total program costs. States incur these costs by making payments to health care providers and managed care plans and by performing administrative tasks such as making eligibility determinations, enrolling and monitoring providers, and paying claims. They then submit quarterly expense reports in order to receive federal matching dollars. As shown in Table 6 in MACStats, FY 2010 Medicaid spending totaled $406 billion, with a federal share of $274 billion and a state share of $132 billion.

The federal share for Medicaid administrative costs is generally 50 percent. The federal share for most Medicaid service costs is determined by the federal medical assistance percentage (FMAP), which is based on a formula that provides higher reimbursement to states with lower per capita incomes—a measure of states' ability to fund Medicaid that was available at the time the formula was designed (GAO 2003)—relative to the national average (and vice versa). FMAPs have a statutory minimum of 50 percent and maximum of 83 percent. Certain exceptions apply, however, for the territories and the District of Columbia (whose FMAPs are set in statute); special situations (e.g., temporary state fiscal relief); and certain populations, providers, and services (e.g., services provided through Indian Health Service facilities). See Table 14 in MACStats for state-level information on FMAPs.

Unlike Medicare, an exclusively federal program for which a substantial portion of spending is financed by dedicated revenue sources that include payroll taxes and enrollee premiums, federal spending for Medicaid and CHIP is financed by general revenues (OACT 2010). Medicaid and CHIP represent a growing portion of the federal budget, having increased from 1.4 percent of federal outlays in FY 1970 to 8.1 percent in FY 2010; in comparison, Medicare increased from 3.0 percent of federal outlays to 12.3 percent over the same period (OMB 2011).

Funding for the nonfederal, or state, share of Medicaid comes from a variety of sources; at least 40 percent must be financed by the state and up to 60 percent may come from local governments. In state fiscal year (SFY) 2009, states reported that about 80 percent of the nonfederal share of their Medicaid costs was financed by state general funds, most of which are raised from personal income, sales, and corporate income taxes. The remaining 20 percent was financed by other state funds, including local funds and provider taxes, fees, donations, and assessments (NASBO 2010).

Medicaid is typically the largest or second-largest share of state budgets when they are viewed

BOX 2-3. Reductions in State Medicaid Spending Require Much Larger Reductions in Total Medicaid Spending

In most years, the federal share of Medicaid spending nationally is 57 percent. However, the FMAPs that determine the federal share of most Medicaid costs vary by state, with a statutory minimum of 50 percent and maximum of 83 percent. Thus, the non-federal, or state, share of Medicaid spending typically ranges from 20 percent to 50 percent. As result of this shared federal-state financing, obtaining a set level of savings in the *state* share of Medicaid spending requires much larger *overall* Medicaid spending reductions.

For example: A state with an FMAP of 70 percent expects total Medicaid spending of $60 million in the upcoming year; thus, the federal share of Medicaid spending is projected to be $42 million and the state's share $18 million. If the state wants to spend $6 million less in state dollars, it would have to reduce total Medicaid spending by $20 million. If the state's FMAP were lower, say 50 percent, obtaining state-share savings of $6 million would require that total Medicaid spending be reduced by just $12 million.

nationally; however, there is substantial variation both across states (when budgets are viewed individually) and within states (when distinctions are made between total and state-funded budgets). The program also accounts for more than two-thirds of state government health expenditures and more than 40 percent of state spending from federal funds (Milbank 2005, NASBO 2010).[22] Looking at *total* state budgets for SFY 2009 (including funds from all state and federal sources), Medicaid accounted for 21.1 percent of those budgets nationally. However, looking at the *state-funded portion* of state budgets for SFY 2009 (i.e., the portion that states must finance on their own through taxes and other means), Medicaid accounted for only 12.2 percent. For information on the variation across states under both of these measures, see Table 15 in MACStats.

When states seek to reduce the amount spent on Medicaid out of their own funds, they must reduce *total* Medicaid expenditures by substantially more than the reduction in state dollars that they seek. This is because the federal government matches at least half of states' Medicaid spending. (See Box 2-3.) The policy levers specific to Medicaid and CHIP over which states have some discretion include eligibility (as noted earlier, however, states are currently subject to an MOE requirement that applies to most populations); covered benefits; enrollee cost-sharing and premiums; and provider payments (discussed further in Chapter 5). Taking steps to address fraud, waste, and abuse also have potential for savings, but may require up-front spending to obtain longer-term results.

Medicaid spending has grown in recent decades, partly because of rising enrollment and partly because of rising costs per enrollee. Overall spending for Medicaid benefits grew at an annual average rate of 11.2 percent (7.1 percent after adjusting for inflation) between FY 1975

[22] In SFY 2003, the most recent year for which data are readily available, health expenditures accounted for 31.5 percent of state budgets; Medicaid accounted for more than two-thirds of that amount.

and FY 2002; about 40 percent of the growth during that period was due to a growing number of recipients and about 60 percent was due to increases in real (inflation-adjusted) treatment costs per recipient (CBO 2006). A more recent analysis indicates that, between FY 2000 and FY 2007, overall spending for Medicaid benefits has largely been driven by enrollment and—as with other payers—underlying health care inflation, meaning that increases in real treatment costs have played a smaller role (Holahan and Yemane 2009).

In addition to affecting state and federal budgets, the Medicaid and CHIP programs affect the U.S. economy through spending that generates health sector jobs, income, and tax receipts—as well as through labor market and other incentive effects.[23] At the state level, spending on Medicaid and CHIP draws down federal matching funds that might not otherwise flow into a state's economy; spending on programs funded solely with state dollars is not multiplied in this manner. At the federal level, the economic effects of Medicaid and CHIP spending may depend on the extent to which that spending contributes to deficits.

Administration

Although CMS is responsible for Medicaid program administration at the federal level, individual state Medicaid agencies establish many policies and manage their own programs on a day-to-day basis. Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency will often contract with other public or private entities to perform various program functions. For example, most states contract with the private sector to operate their Medicaid Management Information Systems (MMISs) (CMS 2011), which are used to process claims for payment from providers and perform a variety of other tasks (e.g., monitor service utilization and provide data to meet federal reporting requirements). In addition, state—and often local—agencies that are responsible for eligibility determinations may be separate from those that deal with provider and payment issues.

CMS oversees the approval of state plan amendments, waivers, and demonstrations and provides guidance to states through State Medicaid Director (SMD) and State Health Official (SHO) letters. As a condition of receiving federal Medicaid funds, Section 1902 of the Social Security Act requires states to have a state plan on file with CMS that demonstrates an understanding of all federal Medicaid requirements. States are required to submit state plan amendments (SPAs) to CMS for review and approval prior to making program modifications. In addition to SPAs, CMS works with state Medicaid agencies to review and approve waivers (discussed later in this chapter).

Once states opt to participate in Medicaid, as all currently do, they are obligated to administer their programs within federal guidelines and requirements. The federal share for Medicaid administrative costs is generally 50 percent, but certain administrative functions receive a higher federal share. For example, upgrades to computer and data systems may be eligible for a 75 percent or

[23] For a discussion of the potential multiplier effects of federal transfers to states for Medicaid and other purposes in the context of stimulus funding, see CBO 2009. For a discussion of the potential labor market and other incentive effects of Medicaid, see Box 2-1 in CBO 2010.

90 percent federal match if certain criteria are met, a key issue for states as they implement eligibility and other changes related to PPACA.[24] In recent years, state Medicaid program administration costs have grown at about the same rate as service costs and thus have remained a relatively constant share of total Medicaid spending, about five percent.[25] Funding for Medicaid-related administrative activities at CMS generally comes from annual appropriations.

Compliance with federal and state Medicaid program policies is monitored in a number of ways. For example, under the Payment Error Rate Measurement (PERM) program for Medicaid and CHIP, a sample of claims and eligibility determinations are reviewed in a rotating subset of states each year (GAO 2011a). States also undertake their own efforts to address program integrity issues. Although discussions of such issues are often limited to fraud and abuse by Medicaid providers, as well as enrollees, a broader view encompasses program management issues. These issues include policy development and execution, which affect the ability of states and the federal government to ensure that enrollees receive quality care and that taxpayer dollars are spent appropriately (Wachino 2007). Partly in response to concerns about Medicaid's vulnerability to significant financial losses and previously low levels of resources devoted to program integrity, the Congress has provided new requirements and funding for these activities in recent years (GAO 2011b, Brice-Smith 2010).

Financing and Administration: Future Issues

In an economic downturn, state Medicaid and CHIP programs face dual pressures. First, enrollment increases at a faster rate than would otherwise be expected, because job and income losses lead more people to become eligible (Holahan and Garrett 2009). Second, it can be more difficult to finance the state share of Medicaid and CHIP costs, because state revenues fall below expected levels (Brinner et al. 2008). States are currently facing severe budget pressures as a result of the recent recession (NGA 2010) and are receiving a temporary increase in the share of their Medicaid costs paid by the federal government (GAO 2010b). The increase began in FY 2009 and will run through the third quarter of FY 2011, which corresponds with the end of SFY 2011 for most states. As a result, many are facing difficult budget choices as they plan for SFY 2012.

For individuals who meet the definition of "newly eligible" under the Medicaid expansion for non-elderly adults beginning in 2014, PPACA provides an increased FMAP (100 percent in 2014 and 2015, phasing down to 90 percent in 2020 and subsequent years). The newly eligible include those who would not have been eligible for Medicaid in the state as of December 1, 2009, or who were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. An increased FMAP is also available for states that had expanded eligibility prior to PPACA and thus would have few or no individuals who qualify as newly eligible.

[24] A recent proposed rule from CMS describes the availability of federal reimbursement for Medicaid data systems under current law. See CMS 2010c.

[25] Excludes administrative activities that are exclusively federal (e.g., program oversight by CMS staff).

Waivers

The overview provided in this chapter generally reflects the operation of Medicaid programs under "state plan" rules. However, as discussed in this section, the Social Security Act (the Act) contains multiple waiver authorities that provide states flexibility in certain areas by allowing them to operate their programs without regard to federal requirements that would otherwise apply. For example, the Act provides the authority to waive certain provisions of the Medicaid and CHIP statutes such as eligibility and benefits in order to explore new approaches to the delivery of and payment for health care and long-term services and supports. This flexibility has enabled states to make fundamental changes to their programs. All states operate one or more Medicaid waivers, which are generally referred to by the section of the Act granting the waiver authority. Those waivers are categorized as program waivers or research and demonstration projects. Regardless of the type of waiver, estimated federal spending over the period for which the waiver is in effect cannot be greater than they would have been without the waiver. Approval of states' waiver applications is at the discretion of the Secretary of HHS.

Medicaid Program Waivers

Enacted by the Congress in the Omnibus Reconciliation Act (OBRA) of 1981, Medicaid program waivers offer states additional targeted flexibility to test new approaches in service delivery. These waivers are specific to the Medicaid program and must not lead federal Medicaid expenditures over the waiver approval period to be higher than they would have been without the waiver.

- **Freedom of Choice: Section 1915(b) waivers.** The Medicaid statute generally guarantees beneficiaries freedom of choice of providers, but Section 1915(b) waivers permit states to implement service delivery models (e.g., those involving primary care case management programs or managed care plans) that restrict beneficiaries' choice of providers other than in emergency circumstances. States can also use Section 1915(b) to waive statewideness requirements (e.g., to provide managed care in a limited geographic area) and comparability requirements (e.g., to provide enhanced benefits to managed care enrollees).[26] Section 1915(b) waivers must be "cost effective" and show federal expenditures are not greater under the waiver. Section 1915(b) waivers are approved for two years with two-year renewal periods. There is no limit to how often a state can apply for or the Secretary can approve renewal of a 1915(b) waiver.[27]
- **Home and Community-Based Services (HCBS): Section 1915(c) waivers.** Section 1915(c) of the Medicaid statute authorizes states to provide home and community-based services as an alternative to institutional care in nursing homes, ICFs-MR, and hospitals. States use this authority to "rebalance" long term services and supports in their Medicaid

[26] The Secretary is precluded from restricting freedom of choice for Medicaid family planning services, waiving provisions that establish payments to rural health clinics and federally qualified health centers, and payments to disproportionate share hospitals for infants and young children.

[27] In addition to these waivers, a provision included in the Balanced Budget Act of 1997 (P.L. 105-33) allows states to require mandatory managed care enrollment for most groups under regular statutory rules through a state plan option.

programs from institutional settings to community settings. The statute identifies services that may be considered home and community-based services, including case management, homemaker/home health aide services, personal care services, adult day health, habilitation services, and respite care. The Secretary may also approve other services needed to avoid institutionalization. Under HCBS waivers, states can provide targeted sets of services to specific populations including, for example, seniors, people with physical disabilities or HIV/AIDS, individuals with developmental disabilities, and people with traumatic brain injuries.

HCBS waiver programs must be "cost neutral," meaning expenditures on behalf of enrollees in the waiver should be no greater than they would have been if the individual had resided in an institution. States are permitted to impose caps on waiver program enrollment and on the average costs per person to ensure that they do not exceed the cost-neutrality limit. HCBS waivers are approved for three years with an unlimited number of five-year renewals.[28]

Section 1115 Research and Demonstration Projects

Section 1115 of the Social Security Act gives broad authority to the Secretary to authorize "any experimental, pilot or demonstration project likely to assist in promoting the objectives of the programs" specified in that section of the Act. Under Section 1115 research and demonstration authority, states may waive certain provisions of the Medicaid and CHIP statutes related to state program design.[29] Section 1115 research and demonstration projects are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state; however, authority has also been used to focus on specific services or populations, such as family planning and people with HIV/AIDS. Provisions that may be waived under Section 1115 include Medicaid eligibility criteria, covered services, and service delivery and payment methods used by the state to administer the program.

Section 1115 demonstrations are required to be "budget neutral" (or "allotment neutral" for CHIP), meaning estimated federal spending over the waiver approval period must be no greater than they would have been without the waiver. To maintain budget neutrality, states identify savings in their proposed 1115 demonstrations that will offset the cost of any program expansion. The savings can include managed care savings, redirecting Medicaid DSH payments, and benefit and cost-sharing savings. Budget neutrality is a federal

[28] A provision included in the Deficit Reduction Act of 2005 (P.L. 109-171) allows states to convert their HCBS waivers into state plan options. PPACA also made changes to waiver and state plan options for HCBS.

[29] The Secretary does not have the authority to waive certain program elements such as the federal matching payment system for states. Waiver authority for CHIP is by reference in Sections 2107(e)(2)(A) and (f) of the Act.

TABLE 2-2. Medicaid Waivers and Research Demonstrations

Authority	Waiver Period	Renewal Period	Number Active	Number of States with waiver/demonstration
1915(b)	2	2	44 (as of 2009)	25
1915(c)	3	5	287 (as of 2008)	all
1115	5	3	66 (as of 2011)	41

Note: Section 1115 numbers include comprehensive statewide health care reform demonstrations, as well as those that are more limited in scope such as family planning.
Sources: CMS 2010a, 2010d.

regulatory policy, not a statutory requirement like cost effectiveness under 1915(b) waivers and cost neutrality under 1915(c) waivers. Section 1115 demonstrations include a research or evaluation component and usually are approved for a five-year period, with a possible three-year renewal period after the first five years.[30]

The ability to waive certain aspects of the Medicaid statute gives states flexibility to experiment with different approaches to program operation, service delivery, and financing in terms of both program expansion and contraction. Section 1115 authority has been used in a variety of ways and for an array of purposes. Such authority is not needed to expand or contract (within federal requirements) Medicaid coverage for low-income children, parents of dependent children, pregnant women, and elderly or disabled populations because states can do so under regular program options. However, Section 1115 authority is currently needed to:

- cap enrollment in Medicaid;
- reduce benefits below federal standards;
- increase premiums or cost-sharing beyond federal standards;
- cover adults not eligible under the new PPACA option; and
- implement different benefits and cost-sharing for different enrollee groups.

States have used 1115 research and demonstration authority for broad, structural changes to their Medicaid programs that affect both coverage and costs. Section 1115 research and demonstration projects for Medicaid and CHIP have included fundamental program alterations including:

- expanding coverage to uninsured populations such as adults not otherwise eligible under Medicaid and parents and pregnant women under CHIP;
- mandating managed care enrollment;
- using managed long-term care programs for service coordination and cost containment;
- providing tiered benefit packages and cost-sharing for different groups of enrollees across a state;

[30] In the early to mid 1990s there were several large federally funded, multi-state evaluations. As the volume of research and demonstration projects increased and federal research budgets diminished, efforts shifted toward state-specific, state-funded evaluations.

- implementing premium assistance programs for enrollees that are not subject to federal benefit or cost-sharing rules;
- creating defined contribution programs establishing a specific level of funding for each enrollee;
- capping federal Medicaid funding; and
- capping Medicaid enrollment for optional population groups.

Looking Forward

Medicaid serves a substantial number of low-income people—an estimated 68 million in FY 2010. In addition to covering routine services, it provides a range of benefits that are limited or not typically covered under traditional health insurance. Despite its unique role, however, the program is still subject to the same underlying medical cost drivers that other payers struggle to control, such as medical practice patterns and new, high-cost technologies. Although Medicaid is a major source of federal financing for states and the coverage they provide to low-income people, difficult choices are being made in the current budget environment. Future Commission reports will continue to support the work of the Congress, the executive branch, and the states in their consideration of specific policy issues and the broader role of Medicaid in the U.S. health care system.

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CHAPTER 3

Overview of the State Children's Health Insurance Program

Section 1900(b) of the Social Security Act directs the Commission to review policies of the Medicaid program and the State Children's Health Insurance Program (CHIP) affecting access to covered items and services, including payment policies, eligibility policies, enrollment and retention processes, coverage policies, quality of care, the interaction of Medicaid and CHIP payment policies with health care delivery generally, interactions with Medicare and Medicaid, and other access policies.

Chapter Summary

CHIP is a joint federal-state program established to provide coverage to uninsured children in mostly working families whose incomes are too high to qualify for Medicaid. Enacted in 1997, CHIP has allowed states to provide health insurance benefits more similar to those offered in the commercial health insurance market.

CHIP is smaller than Medicaid both in terms of covered individuals (8 million vs. 68 million) and total spending ($11 billion vs. $400 billion). Like Medicaid, states administer their programs within federal rules and receive federal matching funds for program expenditures. CHIP, however, differs from Medicaid in a variety of ways. Under CHIP, federal funding is capped and there is no mandatory level of coverage. States can operate their CHIP programs as an expansion of Medicaid, a CHIP program separate from Medicaid, or a combination of both. In separate CHIP programs, there is no individual entitlement; states have additional flexibility to cap enrollment and implement waiting periods. In separate CHIP programs, states can also tailor benefit packages; charge premiums, deductibles, coinsurance and other cost-sharing; and generally exert greater control over their state spending and federal funds (allotments) than under Medicaid.

In its short existence, CHIP has undergone substantial legislative changes. For example, the formula for allotting federal CHIP funds to states was overhauled, due to misalignments between states' CHIP spending and their allotments of federal CHIP funds. Today, CHIP has a complex financing structure that includes rebasing state allotments every two years, redistributing unused federal allotment funds to states, a contingency fund for states that exhaust their federal CHIP funds, and bonus payments for state performance. Federal appropriations for CHIP allotments end after FY 2015. Although states have wide flexibility to expand children's CHIP eligibility, the federal CHIP statute was altered so that if a state covers children above 300 percent of the federal poverty level (FPL), the federal funding for those children will generally be at the regular Medicaid matching rate, rather than CHIP's enhanced rate. In FY 2010, 98 percent of children enrolled in CHIP had family income at or below 250 percent FPL, which is $46,325 for a family of three.

This chapter highlights CHIP eligibility, benefits and cost-sharing, state program flexibility, and the federal-state financing structure. In addition, the impacts of recent legislative changes on the current CHIP program are explained and future program issues are identified.

CHAPTER 3

Overview of the State Children's Health Insurance Program

In 1997, 10 million children were without health insurance (Martinez and Cohen 2010). Many of these children were in working families whose income was just above states' Medicaid eligibility levels. To extend coverage to these children, the Congress created the State Children's Health Insurance Program (CHIP) in the Balanced Budget Act of 1997 (P.L. 105-33) under a new Title XXI of the Social Security Act. In 2010, 6 million children were uninsured (Martinez and Cohen 2010).

Federal Legislative History of CHIP

In 1997, Congressional proposals to increase children's coverage ranged from the provision of tax credits to the expansion of Medicaid with uncapped federal financing at an enhanced federal matching rate (Smith and Moore 2010). The legislation that became CHIP gave states flexibility to use either an expansion of Medicaid, referred to as Medicaid-expansion CHIP programs, or to use additional flexibilities to create separate CHIP programs—or a combination of both approaches. Regardless of which approach states used, their CHIP expenditures were to be reimbursed by the federal government at a matching rate higher than Medicaid's—an enhanced Federal Medical Assistance Percentage (E-FMAP) that varies by state but, on average, pays for 70 percent of CHIP spending, compared to 57 percent historically under Medicaid. Unlike Medicaid, federal CHIP funding was capped.

CHIP was structured to differ from Medicaid in several ways. First, while eligible individuals are entitled to Medicaid coverage (including through Medicaid-expansion CHIP programs), there is no individual entitlement to coverage in separate CHIP programs. For example, states can institute enrollment caps and waiting periods in separate CHIP programs, policies that are not permitted in Medicaid without a waiver. In addition, while states with Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no minimum mandatory

income level up to which CHIP programs must extend coverage. Moreover, states with separate CHIP programs have greater flexibility around the design of their benefit packages and enrollee cost-sharing than is available for children in Medicaid. All of these additional flexibilities, particularly in separate CHIP programs, give states greater control, compared to Medicaid, over their CHIP spending. (There are several Medicaid requirements that apply to separate CHIP programs, as described in the Annex to this chapter.)

At the time of CHIP's creation, just how many states would respond to the new federal funding opportunity by extending eligibility to more children was uncertain. By FY 2000, however, every state, territory, and the District of Columbia had children enrolled in CHIP-financed coverage. Another uncertainty was how quickly and effectively states would be able to mount outreach efforts to identify and enroll the eligible population for this new program.

The Balanced Budget Act of 1997 (BBA 97) provided annual federal appropriations for CHIP allotments through FY 2007, totaling approximately $40 billion over the ten-year period from FY 1998 to FY 2007. For the first several years of the program, states' allotments tended to be much larger than their spending. However, as CHIP programs matured and national CHIP spending continued well in excess of the appropriations set in 1997, several states were slated to experience shortfalls of federal CHIP funding (GAO 2007). The Congress intervened to appropriate funding for FY 2006 ($283 million) and again for FY 2007 ($650 million) to prevent these shortfalls.

The original CHIP allotment formula was intended to approximate states' need for CHIP funds, based primarily on the number of low-income children in each state and the number of those children who were uninsured (Czajka and Jabine 2002). However, many states found that the formula did not accurately reflect their need for federal CHIP funding and created large and unexpected fluctuations in their annual CHIP allotments. So as the Congress began to examine how to extend federal CHIP funding past FY 2007, it also explored how to change the allotment formula to provide funding more in line with states' actual CHIP spending.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) extended CHIP appropriations through FY 2013, at much higher levels than under BBA 97.[1] The formula for allotting these funds to states was also overhauled to better target states' actual CHIP spending. CHIPRA made several other changes to the federal CHIP statute, such as requiring separate CHIP programs to cover dental benefits and to ensure any covered mental health benefits had parity with medical benefits.

[1] The 110th Congress passed two bills to "reauthorize" CHIP, which would have provided CHIP funding for FY 2008 through FY 2012 and would have made other changes to both CHIP and Medicaid. Both bills were vetoed. In lieu of being able to provide longer term CHIP funding, the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) was enacted. MMSEA appropriated funds to provide CHIP allotments for FY 2008 and FY 2009 at FY 2007 levels, but only to be available through March 31, 2009. Because shortfalls of federal CHIP funds were still projected to occur in certain states, additional funds besides the allotments were also appropriated. CHIPRA then provided full-year FY 2009 federal CHIP allotments.

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended) extended the program's federal funding by another two years, through FY 2015.

Impact of CHIP

Besides the overall increase in children's coverage, CHIP's impact may also be seen by comparing health insurance changes between 1997 and 2010 in low-income children's health insurance status to low-income adults, who generally did not see comparable eligibility expansions in public programs. Family income at or above 100 but below 200 percent of the federal poverty level (FPL) is the income range for which CHIP coverage is most likely—currently $18,530 to $37,060 for a family of three. Both children and non-elderly adults in this income range experienced declines in private coverage between 1997 and 2010 (Table 3-1). For these adults, the increase in public coverage between 1997 and 2010 did not offset declines in private coverage, and these adults' uninsurance levels *increased* by nine percentage points—from 34.9 percent in 1997 to 43.9 percent in 2010. For children in the same income range, the increase in public coverage between 1997 and 2010 more than offset the decline in private coverage, causing these children's uninsurance rate to *drop* by nine percentage points—from 22.8 percent in 1997 to 13.5 percent in 2010.

Eligibility for CHIP

This section describes eligibility for CHIP, which was designed for low-income children but has also extended coverage to pregnant women, and other adults on a limited basis, as described below.

TABLE 3-1. Sources of Coverage Among Children and Non-elderly Adults with Family Income from 100 through 199 Percent of the Federal Poverty Level (FPL), 1997 and 2010

	Private	Public	Uninsured
Children			
1997	55.0 percent	24.3 percent	22.8 percent
2010	30.8	57.6	13.5
Change	-24.2	+33.3	-9.3
Non-elderly Adults			
1997	52.6	14.6	34.9
2010	34.9	22.5	43.9
Change	-17.7	+7.9	+9.0

Source: National Health Interview Survey (NHIS), Martinez and Cohen 2010.

Note: For this table, the federal poverty level (FPL) is based on the U.S. Census Bureau's poverty thresholds. Children are between the ages of 0 and 17 years, and non-elderly adults are between the ages of 18 and 64. "Public" coverage includes CHIP, Medicaid, and Medicare. Federal surveys such as NHIS do not publish separate results for Medicaid and CHIP enrollment; child enrollment in Medicare is relatively small.

Children

Targeted low-income children eligible for CHIP are those under the age of 19 with no health insurance and who would not have been eligible for Medicaid under the state rules in effect on March 31, 1997.[2] The federal CHIP statute limits states' upper-income eligibility levels to 200 percent FPL or, if higher, 50 percentage points above states' pre-CHIP Medicaid levels. However, states have enough flexibility in how they count applicants' income so that they can effectively expand eligibility to any income level (HCFA 2001). CHIPRA altered the federal CHIP statute so that if a state covers children above 300 percent FPL, the federal funding for those children will be at the regular FMAP rather than the enhanced FMAP, with some exceptions.[3]

As shown for each state in Table 9 of MACStats, states' upper limits for income eligibility in CHIP funded coverage were as follows:

- Two states above 300 percent FPL: New York (400 percent FPL) and New Jersey (350 percent FPL);
- 16 states and the District of Columbia at 300 percent FPL;
- 11 states between 235 and 280 percent FPL;
- 18 states at 200 percent FPL; and
- three states below 200 percent FPL: Idaho (185 percent FPL), Alaska (175 percent FPL), and North Dakota (160 percent FPL).

As shown in Figure 3-1, 7.7 million children were enrolled in CHIP in FY 2010. More than 70 percent (5.5 million) of these children were in a separate program, and the remaining 2.2 million were in a Medicaid-expansion program.[4]

Children in CHIP-financed coverage, including those in Medicaid-expansion programs, are counted separately from children in regular Medicaid-financed coverage. As shown in Table 4 of MACStats, in FY 2010, 7.7 million children were enrolled in CHIP-financed coverage, while Medicaid paid for the coverage of four and a half times that many children (34.4 million).

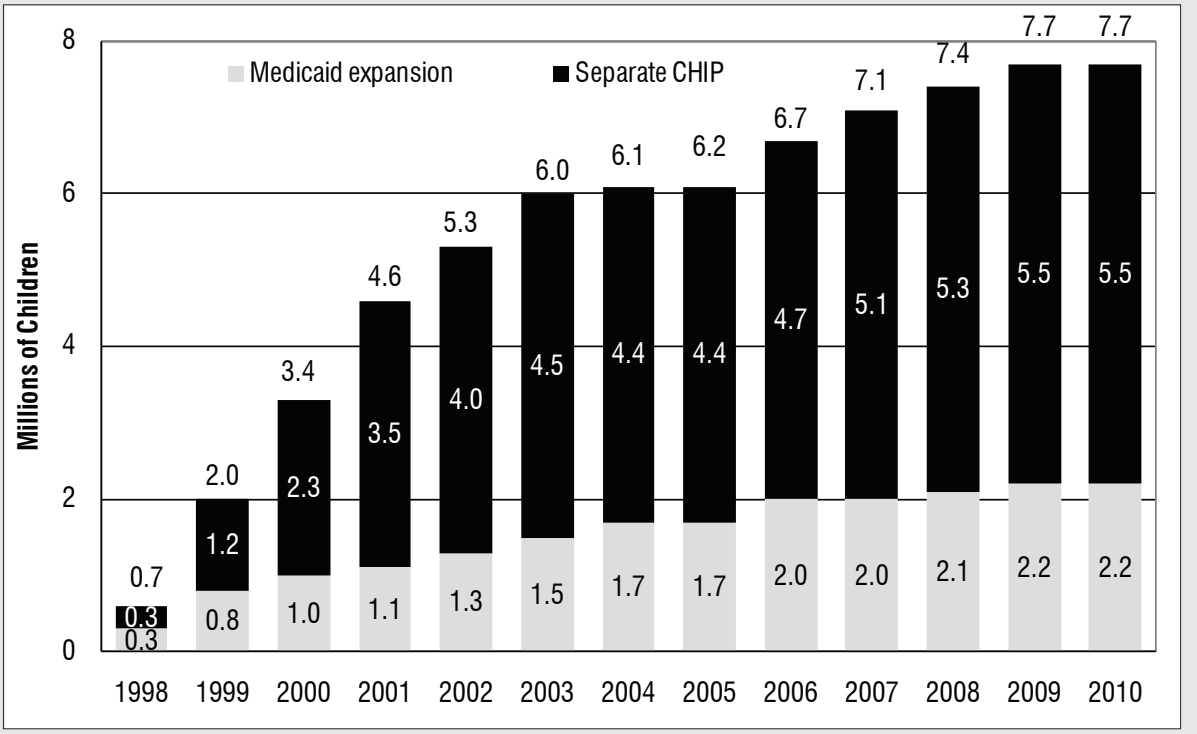
Based on Commission analyses of FY 2010 CHIP data, 90 percent of children enrolled in CHIP-financed coverage were at or below 200 percent FPL, and 98 percent were at or below 250 percent FPL (Table 3-2). Table 4 of MACStats displays these numbers by state. Even in New York, which extends CHIP eligibility to 400 percent FPL, three-quarters of CHIP child enrollees were at or below 200 percent FPL, and 91 percent were at or below 250 percent FPL. Although CHIP in some states may be extended to children in higher-income families, these children are still more likely to be enrolled in a parent's employer-sponsored health insurance, in which case they would be ineligible for CHIP.

[2] In addition, children who live in public institutions or are patients in an institution for mental diseases are ineligible for CHIP coverage. Children of state employees are also ineligible for CHIP, unless (1) annual agency expenditures for employees enrolled in a state employee health plan with dependent coverage (for the most recent state fiscal year) are at least the amount of such expenditures made for state fiscal year 1997 (adjusted for medical inflation) or (2) the state determines that the annual aggregate amount of the applicable premiums and cost-sharing in the state employee plan would exceed 5 percent of the family's annual income.

[3] Exceptions were provided for a state that, as of CHIPRA's enactment date (February 4, 2009), was already above 300 percent FPL (New Jersey) or had enacted a state law to submit a plan for federal approval to go above 300 percent FPL (New York).

[4] A child cannot technically enroll in a combination CHIP program; in a combination state, individual children are enrolled in either the state's separate CHIP program or its Medicaid-expansion CHIP program.

FIGURE 3-1. Child Enrollment in CHIP, FY 1998–2010



Note: Numbers are children ever enrolled during the year, even if only for a month. Components may not add to total due to rounding.
Source: CHIP Statistical Enrollment Data System (SEDS)

For at least some potential CHIP enrollees, most states require waiting periods—that is, minimum periods of uninsurance before individuals can enroll. For example, children must be uninsured for at least three months to enroll in New Jersey's separate CHIP program. States may exempt certain children, such as those with special health care needs or newborns, or those facing special family circumstances, such as a parent's recent job loss (NASHP 2011).

In a separate CHIP program, children have no entitlement to coverage; thus states may impose waiting periods or cap enrollment. For example, in December 2009, Arizona closed its CHIP program to new enrollees (HHS 2011). For Medicaid-expansion CHIP programs, the entitlement to

TABLE 3-2. Child Enrollment in CHIP by Family Income, FY 2010

Family Income as a Percent of Federal Poverty Level (FPL)	Percent of CHIP Child Enrollees
At or below 200 percent FPL	89.8
201–250 percent FPL	8.4
Above 250 percent FPL	1.8
Total	100.0

Note: 200 percent FPL in 2011 is $21,780 for an individual and $7,640 for each additional family member.
Source: MACPAC analysis (February 2011) of CHIP Statistical Enrollment Data System (SEDS), as reported by states.

Medicaid prohibits the use of waiting periods or enrollment caps. According to one analysis, however, 14 states and the District of Columbia had waiting periods for at least some of their Medicaid-expansion CHIP enrollees through the use of Section 1115 waivers (Ross et al. 2009). Section 1115 waivers generally apply to CHIP in the same way as in Medicaid, providing states with flexibility not otherwise permissible by federal law.[5] For additional background information, see the previous chapter's descriptions of 1115 waivers, which also apply to CHIP.

The maintenance of effort provision enacted in PPACA, discussed in Chapter 2, also applies to children in CHIP programs; states will lose all Medicaid funding if their CHIP programs implement eligibility standards or procedures for children that are more restrictive than those in place at PPACA's enactment (March 23, 2010). One of the exceptions to this provision is that a separate CHIP program can institute a waiting list or enrollment cap if otherwise it would exhaust all of its available federal CHIP funding.

Pregnant Women and Unborn Children

Prior to CHIPRA, adult pregnant women could receive CHIP-financed services primarily in one of two ways. First, states could apply for federal approval of a Section 1115 waiver of CHIP program rules in order to extend eligibility to adult pregnant women.[6] Second, CHIP regulations adopted in 2002 permit the coverage of unborn children (CMS 2002), which effectively provides CHIP coverage of pregnant women and is currently used by 13 states.[7]

CHIPRA created a new eligibility pathway for pregnant women, for whom the state can receive the enhanced FMAP from CHIP funds. To cover targeted low-income pregnant women, the state's *Medicaid* program must cover pregnant women up to 185 percent FPL (or, if higher, the level the state had in place on July 1, 2008). Another requirement is that the state's CHIP program cannot impose policies like enrollment caps on targeted low-income pregnant women *or children*. In addition, the upper limit of income eligibility for targeted low-income pregnant women cannot be higher than that of children. Two states have taken up this new option to cover targeted low-income pregnant women in CHIP; in FY 2010, New Jersey enrolled 295 targeted low-income pregnant women, and Rhode Island enrolled 151.

[5] §2107(e)(2)(A) of the Social Security Act, except that CHIP-related waivers cannot be used to waive current-law restrictions on CHIP coverage of childless adults and parents, per §2107(f).

[6] As shown in Table 3 of MACStats, there were 8,103 pregnant women enrolled in CHIP in FY 2010 under Section 1115 waivers, excluding New Jersey and Rhode Island, whose pregnant women were enrolled through the state plan option for targeted low-income pregnant women.

[7] Because the coverage is technically of the unborn child rather than the pregnant woman, the enrollment of these individuals appears in the number of children rather than the number of adults (CMS 2002). In FY 2010, there were 361,069 unborn children enrolled in CHIP, three-quarters of whom were either in California (147,965, 41 percent of national unborn child enrollment) or in Texas (126,772, 35 percent). The other 11 states that covered unborn children in FY 2010 were Arkansas, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Oklahoma, Oregon, Rhode Island, Washington and Wisconsin.

Other Adults

In CHIP's early years, many states were unable to use much of their federal CHIP allotments. This included states whose pre-CHIP Medicaid income-eligibility levels were quite high and that opted not to expand much further. For example, prior to CHIP, Minnesota's Medicaid program already covered children up to 275 percent FPL, currently $50,958 for a family of three; its original CHIP program covered only young children (under age 2) in a very narrow income range—between 275 percent and 280 percent FPL.[8] States received approval for waivers to use their unspent federal CHIP funds to cover adults, although adult coverage is now being phased out of CHIP.

In 2000, the U.S. Department of Health and Human Services (HHS) announced it would approve CHIP waivers to cover certain adults—pregnant women and parents—but not non-pregnant childless adults (HCFA 2000). In 2001, HHS announced greater waiver flexibility, including the use of CHIP funds to cover childless adults. In 2005, legislation prohibited any new states from having CHIP-funded childless adult coverage. CHIPRA terminated CHIP coverage of non-pregnant childless adults altogether after 2009. As shown in Table 3 of MACStats, non-pregnant CHIP enrollees in FY 2010 consisted of 114,095 childless adults in three states—Michigan, New Mexico and Idaho. These childless adults were covered by CHIP only in the first quarter of FY 2010—October through December 2009, after which childless adult CHIP coverage was prohibited. In these three states, childless adults are now covered through Medicaid at the regular FMAP.

CHIPRA also prohibited new states from covering parents with CHIP funds and phases out CHIP coverage of parents altogether by FY 2014. As shown in Table 3 of MACStats, CHIP enrolled 224,499 parents in four states in FY 2010. New Jersey accounted for more than 90 percent of these CHIP-funded parents.

Coverage and Payment of Benefits in CHIP

Depending on state decisions and policies, separate CHIP programs can have greater flexibility to tailor their benefit packages and cost-sharing arrangements to children enrolled in CHIP, who by definition have higher family incomes than children enrolled in Medicaid-financed coverage. This section describes the benefit options available for CHIP state plans under Medicaid-expansion versus separate CHIP programs. It also briefly examines the role of managed care in CHIP.

Children in Medicaid-expansion CHIP programs are protected by federal Medicaid benefits requirements and cost-sharing limitations. They are entitled to all of Medicaid's mandatory services, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, generally without any enrollee cost-sharing.[9]

[8] The state did ultimately obtain waivers to cover parents, although in FY 2010 Minnesota had no CHIP-financed coverage of adults per se; the state covered approximately 5,000 unborn children in FY 2010.

[9] EPSDT is described in Chapter 2. States may obtain Section 1115 waivers to charge premiums and service-related cost-sharing in Medicaid-expansion CHIP programs, which has been done in a handful of states. Sections 1916A and 1937 of the Social Security Act permit some additional flexibility, not described here.

For separate CHIP programs, the federal CHIP statute gives several options for how a state structures its benefit package, generally tied to specified benchmark benefit packages. The benchmark benefit packages for states to choose from are the Blue Cross and Blue Shield standard option available to federal employees, a plan available to state employees, and the HMO plan in the state with the largest commercial, non-Medicaid enrollment. In addition, states can seek approval for a benefit package not tied to these benchmarks; in this case, states design their own benefit package and obtain approval from the HHS Secretary. Many of these benefit packages are called Medicaid look-alikes. All separate CHIP benefit packages are required to cover inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, well-baby and well-child care (including age-appropriate immunizations), and dental services. Separate CHIP programs are not required to cover EPSDT services, although they must cover similar preventive/screening services; differences between EPSDT services and separate CHIP benefit packages are more likely to be found in the treatment of serious and chronic conditions of children and adolescents than in preventive and screening services.

A separate CHIP program can charge premiums, deductibles, coinsurance, and other cost-sharing. However, out-of-pocket cost-sharing is always limited to 5 percent of family income. In addition, no cost-sharing can be charged for preventive or pregnancy-related services, and children with family income below 150 percent FPL are potentially subject to only very limited cost-sharing. One actuarial analysis found that while separate CHIP benefit packages may cover fewer services with higher cost-sharing than Medicaid, they generally cover more services, such as dental, with lower cost-sharing than typical commercial coverage (Watson Wyatt Worldwide 2009).

In FY 2010, three-quarters of all child CHIP enrollees were enrolled in a comprehensive managed care plan, although this varied depending on whether enrollees are in a Medicaid-expansion or separate CHIP program (Table 3-3). For a state-level breakdown in separate CHIP programs and a description of managed care, fee for service, and primary care case management (PCCM), refer to Table 5 of MACStats.

TABLE 3-3. Child CHIP Enrollment in Managed Care Plans, FY 2010

	Medicaid-expansion CHIP		Separate CHIP		Total	
Managed care plan	1,241,441	57%	4,503,711	81%	5,745,152	75%
Fee for service (FFS)	450,253	21	778,354	14	1,228,607	16
Primary care case management (PCCM)	474,256	22	257,708	5	731,964	9
Total	2,165,950	100%	5,539,773	–	7,705,723	100%

Note: For a description of managed care, fee for service, and primary care case management (PCCM), refer to Table 5 of MACStats.
Source: MACPAC analysis (February 2011) of CHIP Statistical Enrollment Data System (SEDS), as reported by states, based on their definitions

Federal Funding for CHIP

States' expenditures under CHIP generally are matched at an enhanced federal matching rate, which requires a state share 30 percent smaller than the regular Medicaid FMAP. For example, under Medicaid, the regular FMAP must be at least 50 percent; for these states, the enhanced FMAP under CHIP is 65 percent. Although it varies by state, the typical federal share of CHIP spending is 70 percent, compared to 57 percent historically for Medicaid.

Unlike Medicaid, however, federal CHIP funds are capped and allotted to states based on a formula, which has changed over the years. In past years, some states exhausted their available federal CHIP funds, for which additional funds generally were appropriated. From FY 1998 through FY 2007, the states, the District of Columbia, and the territories[10] were allotted approximately $40 billion; appropriations for shortfalls that occurred in FY 2006 to FY 2007 amounted to less than $1 billion.[11] CHIPRA changed many aspects of CHIP federal financing for FY 2009 onward. The descriptions that follow are generally based on the current CHIP program, as amended by CHIPRA and PPACA.

Actual federal and state CHIP spending (Figure 3-2) did not always align with federal CHIP appropriations or states' CHIP allotments. This misalignment was also affected by the multi-year availability of federal CHIP allotments. When CHIP began, for example, few states were able to spend their federal allotments, even over the three years for which they were available. While the CHIP allotments began at levels well in excess of CHIP spending, the situation reversed in the 2000s, when programs came to maturity and several states would have experienced shortfalls in the absence of additional Congressional appropriations. The remainder of this section describes CHIP's financing structure.

Federal CHIP Allotments

Prior to CHIPRA, the annual appropriations for federal CHIP allotments ranged from $3.1 billion to $5.0 billion. The following are the national appropriation amounts for CHIP allotments made available by CHIPRA (for FY 2009 to FY 2013) and PPACA (for FY 2014 and FY 2015):

- $10.562 billion in FY 2009;
- $12.520 billion in FY 2010;
- $13.459 billion in FY 2011;
- $14.982 billion in FY 2012;
- $17.406 billion in FY 2013;
- $19.147 billion in FY 2014; and
- $21.061 billion in FY 2015.

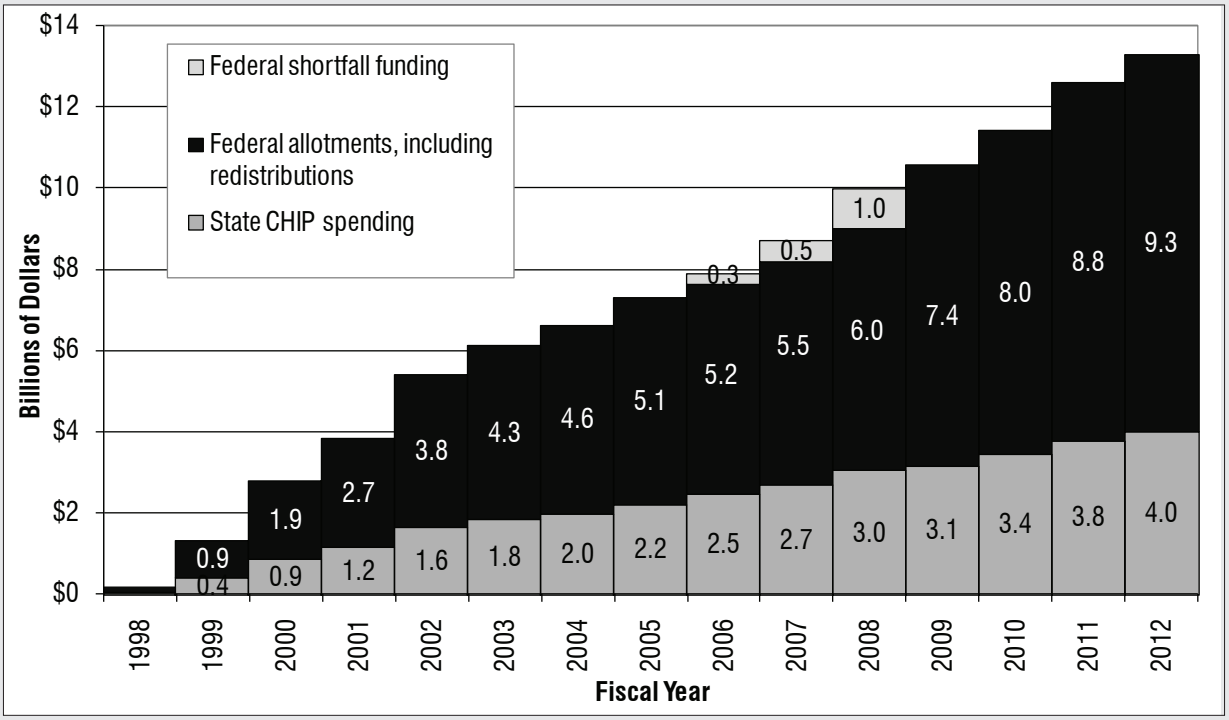
There are currently no appropriations for CHIP allotments beyond FY 2015.

CHIP allotment amounts are calculated for each state and territory. The states and territories will receive those amounts unless the national appropriation is inadequate. Going forward, for odd-numbered years (FY 2011, FY 2013 and FY 2015), the federal allotment for a state will be rebased—that is, it will be based on a new number, the state's prior-year CHIP *spending* plus a state

[10] The Commonwealth of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

[11] As described in footnote 1, MMSEA provided federal CHIP funding for a single year, FY 2008, including $1 billion for shortfalls.

FIGURE 3-2. Federal and State CHIP Spending, FY 1998 to FY 2012



Note: FY 2011 and FY 2012 are based on projections provided by states.
Source: CMS CHIP expenditure reports

growth factor. For even-numbered years (FY 2012 and FY 2014), the allotment will be calculated primarily as the prior-year *allotment* plus a state growth factor. Federal CHIP allotments are now available for two years.

Redistribution of CHIP Funds Among States

If a state does not exhaust its allotment within two years, any remaining balances are made available for redistribution to other states. In the years just prior to CHIPRA, redistribution funds went to states with shortfalls, eliminating or reducing the need for the Congress to appropriate funds to cover projected shortfalls. Since CHIPRA, however, a state is considered to be in shortfall *before* taking into account amounts that might be available to the state through redistribution, as described in greater detail in the next section. Redistribution funds are available for one year. Unexpended redistribution funds are transferred to the bonus fund, as described later.

The CHIPRA Contingency Fund

CHIPRA created a new Child Enrollment Contingency Fund that was appropriated $2.112 billion in FY 2009. Contingency funds are available *only* to states with shortfalls. As previously noted, a state is now considered to be in shortfall—and thus potentially eligible for federal contingency funds—*before* taking into account amounts that might already be available to the state through redistribution.

Prior to CHIPRA shortfall appropriations were based on a state's projected shortfalls for the year, which were reconciled with actual expenditures after the fiscal year ended. Like regular federal CHIP funding, shortfall appropriations had required a state share, based on the enhanced FMAP. Contingency funds, however, do not require state matching, and the amount of federal contingency funds a state receives is not based on the amount of its shortfall. Instead, once a state is determined to be in shortfall, the amount of contingency funds is determined by a complex formula that multiplies:

- growth in the state's CHIP child enrollment above its FY 2008 enrollment (as adjusted by the state's annual growth in child population plus 1 percentage point), by
- the state's per capita expenditures for the children enrolled in FY 2008, increased by annual growth factors, multiplied by the enhanced FMAP.[12]

No contingency funds were ultimately needed for FY 2009 or FY 2010. However, if a state *projects* a shortfall during the fiscal year, CMS and the affected state(s) will be required to calculate the components of the formula to provide the estimated federal contingency funds, even if the end-of-year determination would find the state did not actually experience a shortfall. This circumstance would require the state to return the federal contingency funds it received.

Bonus Payments for Performance

In FY 2009 the Congress appropriated $3.225 billion for CHIP bonus payments. Although these payments are from CHIP appropriations, they are only available to states that (1) increase Medicaid (not CHIP) child enrollment by significant amounts and (2) implement five out of eight specific outreach and retention efforts that are described in the Annex to this chapter. In addition to the initial FY 2009 appropriation, bonus payments may also be funded through unspent national allotment and redistribution amounts.

As shown in the chapter's Annex, in FY 2009, $75.4 million in bonus payments (2.3 percent of the appropriated amount), was awarded to ten states. Fifteen states received $206.2 million in bonus payments in FY 2010, out of $4.2 billion that were available (CMS 2011). Under current law, FY 2013 is the final year for bonus payments.

Looking Forward

CHIP has undergone substantial legislative change over the past few years. The preceding discussion described the impact of those changes on the current program. The remainder of this chapter highlights two future CHIP policy issues—one that is effective in 2014 (CHIP's interaction with exchange coverage) and one that concerns the period after FY 2015, when new federal CHIP funding will not be available under current law.

[12] The growth factor is based on per capita growth as published in the National Health Expenditures.

PPACA authorizes the development of health insurance exchanges, to be operated either by states or the federal government, in every state by 2014. The law defines exchanges as entities that will provide qualified individuals and small businesses with access to private insurers' plans in a comparable way and will identify individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits. Also beginning in 2014, PPACA requires that Medicaid and CHIP programs likewise be able to determine applicants' eligibility for subsidized exchange coverage.

Historically, with respect to CHIP the term "screen and enroll" has referred to the requirement that, if children are determined to be eligible for Medicaid, they cannot be enrolled in CHIP and must be enrolled in Medicaid. A comparable screen-and-enroll provision will apply to exchange coverage beginning in 2014. If a person applying for exchange coverage is found to be eligible for Medicaid or CHIP, the exchange is required to enroll them in that coverage; the person is prohibited from enrolling in subsidized exchange coverage.

The intent of this new screen-and-enroll provision with respect to exchanges is presumably the same as the original: to ensure that children are enrolled in a plan that offers benefits and cost-sharing protections better suited to their family income. However, this will result in cases where children who are eligible for CHIP (or Medicaid) will be prohibited from enrolling in their parents' federally subsidized family coverage through an exchange.[13]

Federal appropriations for CHIP allotments end after FY 2015.[14] If new federal CHIP funding is not made available after FY 2015 and states exhaust their balances, the statute permits CHIP children to enroll in subsidized exchange coverage; however, these children could only enroll in exchange plans with benefits and cost-sharing that the HHS Secretary determines are comparable to the state's CHIP plan. An actuarial analysis of 17 state CHIP benefit packages found that the levels specified for PPACA's subsidized exchange coverage would fall short of all those states' CHIP plans in terms of their benefits and cost-sharing (Watson Wyatt Worldwide 2009).

Although smaller and younger than Medicaid, CHIP provides essential coverage to nearly 8 million uninsured children in low-income, mostly working families. For their CHIP spending, states receive a federal matching rate that is enhanced, compared to Medicaid. While states can structure their CHIP programs to mirror Medicaid's benefits and cost-sharing, they can also tailor their benefit packages and cost-sharing to their enrollees by taking advantage of the CHIP statute's additional flexibility. The complex set of issues facing the CHIP program outlined in this chapter will continue to be part of the Commission's ongoing analyses.

[13] §§1311(d)(4)(f) and 1413(a) of PPACA, and §36B(c)(2)(B) of the Internal Revenue Code, as created by §1401(a) of PPACA. These provisions do not restrict families' ability to enroll their Medicaid- or CHIP-eligible children in their employer's coverage.

[14] For FY 2016 through FY 2019, current law would increase states' enhanced FMAPs by 23 percentage points—up to 100 percent federal match. If no CHIP appropriations are provided for FY 2016 onward, this increased matching rate will cause states to exhaust their remaining federal CHIP balances more quickly.

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Chapter 3 Annex

Federal Medicaid Provisions that Apply to Separate CHIP Programs

Chapter 3 describes how the Congress created CHIP in the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) and gave states greater flexibility in the design of their separate CHIP programs, compared to Medicaid. However, some provisions in the federal Medicaid statute apply to separate CHIP programs as well. Some of these provisions give additional options to separate CHIP programs—for example, to cover legally residing pregnant women and children who have been in the country less than five years. Other provisions extend Medicaid requirements to separate CHIP programs, such as how to pay Federally Qualified Health Centers (FQHCs). This annex describes the Medicaid provisions that apply to separate CHIP programs, as listed in §2107(e)(1) of the Social Security Act.

At CHIP's enactment in BBA 97, the list of Medicaid provisions that applied to separate CHIP programs contained three items. Just before the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), it had four items. As of early 2011, the list contains 15 items. Most of these additions came from CHIPRA, but also from the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) and the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended).

The list below follows the order in the CHIP statute and does not reflect the order in which these provisions were added. The law that added the provision is noted in brackets.

1. **Conflict of interest standards.** Medicaid and CHIP programs must subject current and former state and local employees and contractors who are responsible for a substantial amount of Medicaid or CHIP spending to the same standards that apply to similarly situated individuals at the federal level. [BBA 97]
2. **FQHC flexibility in contracting for dental services.** State Medicaid and CHIP programs cannot prevent a Federally Qualified Health Center (FQHC) from contracting with private-practice dental providers. [CHIPRA]

3. **Advice from designees of Indian Health Programs and Urban Indian Organizations.** In a state where one or more Indian Health Programs or Urban Indian Organizations provide health care services, state Medicaid and CHIP programs must provide a process under which the state seeks advice from these programs and organizations. [ARRA]

4. **Provider and supplier screening, oversight and reporting.** Medicare, Medicaid and CHIP must ensure that health care providers and suppliers meet similar standards set by the HHS Secretary for all three programs. [PPACA]

5. **Express Lane Eligibility (ELE).** In determining whether a child meets one or more Medicaid or CHIP eligibility requirements (e.g., income, household composition, residency), state Medicaid and CHIP programs have the option to rely on findings from designated Express Lane agencies—for example, public agencies that administer Temporary Assistance for Needy Families (TANF), Medicaid, CHIP, Supplemental Nutrition Assistance Program (food stamps), and the National School Lunch Program. [CHIPRA]

6. **Modified Adjusted Gross Income (MAGI).** MAGI is a new federal income-counting methodology, described in Medicaid statute as taxpayers' adjusted gross income plus tax-exempt interest and foreign earned income. The Medicaid definitions and standards regarding MAGI also apply to CHIP, for state programs that use MAGI. [PPACA]

7. **Payments to FQHCs and RHCs.** State Medicaid and CHIP programs must pay for health care services rendered by FQHCs and Rural Health Clinics (RHCs) using a prospective payment system (PPS), generally based on each FQHC's and RHC's inflation-adjusted average Medicaid costs from 1999 and 2000. States may elect to develop a CHIP specific baseline PPS or use an alternate payment methodology, approved by each FQHC and RHC, to pay for services. [CHIPRA]

8. **Disregard of property when determining eligibility.** When state Medicaid and CHIP programs apply asset tests for eligibility, certain assets of Indians are to be excluded. [ARRA]

9. **Limitations on payments.** Conditions are specified under which Medicaid and CHIP cannot pay health care providers, such as when a provider is mandatorily excluded from Medicare or Medicaid because of patient abuse or a program-related crime. [BBA 97]

10. **Conditions for covering certain legally residing pregnant women and children.** Although Medicaid and CHIP coverage can only be provided to most legal non-citizens who have been in the country for five years (and meet all other eligibility criteria), states can choose to cover lawfully residing pregnant women and children without regard to this five-year waiting period. A state may only elect this option for individuals in its separate CHIP program if the state also elected the option for individuals in its Medicaid program. [CHIPRA]

11. **Limitations on provider taxes and donations.** Conditions are specified under which provider taxes and donations may be used to fund the non-federal share of states' Medicaid and CHIP spending. [BBA 97]

12. **Presumptive eligibility for children.** Entities are specified that can determine children's eligibility on a presumptive, or preliminary, basis until the state agency is able to do a full eligibility determination. [P.L. 106-554]

13. **Managed care requirements.** Conditions are specified under which Indians are exempt from mandatory enrollment in a managed care plan and under which other exemptions apply to Indian enrollees, providers and managed care plans. [ARRA] (CHIPRA added a host of other Medicaid managed care provisions unrelated to Indians that now apply to separate CHIP programs, as listed in §2103(f) of the Social Security Act. These provisions are broadly categorized as follows: process for enrollment, termination, and change of enrollment; provision of information to enrollees and potential enrollees; beneficiary protections; quality assurance standards; protections against fraud and abuse; and sanctions for noncompliance.)

14. **Authorization to receive data for eligibility determinations.** Conditions, as well as penalties for noncompliance, are specified under which Express Lane agencies and Medicaid and CHIP programs may exchange information used for eligibility determinations. [CHIPRA]

15. **Coordination with exchanges and Medicaid programs.** Beginning January 1, 2014, exchanges, Medicaid programs, and CHIP programs in each state must coordinate to ensure that individuals who apply through one of the other programs will be enrolled in the appropriate one. [PPACA]

CHIPRA Bonus Payments

In the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3), the Congress appropriated more than $3 billion for CHIP bonus payments. Although these payments are described in the federal CHIP statute and are made from CHIP appropriations, they are only available to states that (1) increase Medicaid (not CHIP) child enrollment by significant amounts, and (2) implement five out of eight specific outreach and enrollment efforts described below. As shown in the table that follows, $75.4 million in bonus payments (2.25 percent of the available amount) was awarded to ten states in FY 2009 and $206.2 million to 15 states in FY 2010.

Eight Enrollment and Retention Efforts

Following is the list of eight enrollment and retention efforts, any five of which could qualify states with significant Medicaid child enrollment increases for CHIPRA bonus payments. To obtain CHIPRA bonus payments, the following efforts must apply to children, not adults, but must apply to children in both Medicaid and CHIP unless noted otherwise.[15]

1. **Twelve months of continuous eligibility.** States may choose to enroll children in Medicaid and CHIP for 12 months, regardless of changes in family income or family status that occur in the interim. There are certain conditions, however, that must still prompt a change in eligibility (e.g., death of the child, the child reaches the age limit).
2. **Liberalization of asset requirements.** States can meet this requirement in a couple of ways. First, they can eliminate altogether any asset test for determining children's eligibility for Medicaid and CHIP. (Only a few states still have asset tests for children.) Second, states with an asset test for children can use administrative verification of those assets. This is where the parent(s) can certify the amount of the family's assets by signature under penalty of perjury, or where the state can verify assets through means besides requiring documentation from the parent(s).
3. **Elimination of in-person interview requirement.** States' application or renewal process may not require a face-to-face interview, unless there are discrepancies or individual circumstances that merit it.
4. **Use of joint application for Medicaid and CHIP.** States may use a single application form and renewal forms that are used by both Medicaid and CHIP. Alternatively, the state Medicaid and CHIP programs may have separate application forms but are able to use either if submitted by an applicant.
5. **Automatic renewal (use of administrative renewal).** States can meet this requirement in a couple of ways. First, when a child's eligibility must be renewed, the state can provide the family with a pre-printed form completed by the state based on information it has on file. In this case, the state can continue the child's coverage, unless provided other information by the family or through the state's own verification efforts, or the state can require the family to confirm the information by returning a signed copy of the pre-populated form with any changes noted on the form. Another option does not involve a pre-printed form,

[15] These descriptions are based on §2105(a)(4) of the Social Security Act; CMS State Health Official (SHO) letter #09-015, CHIPRA Performance Bonus Payments, December 16, 2009, http://www.cms.gov/SMDL/downloads/SHO09015.pdf; and CMS SHO letter #10-008, CHIPRA Performance Bonus Payments, October 1, 2010, https://www.cms.gov/smdl/downloads/SHO10008.pdf.

but relies on *ex parte* redeterminations. This is where the state actually performs an eligibility redetermination based on information on file with the program or other agencies, notifying the family that coverage will continue, unless additional information is needed. To the extent information is not available to complete the redetermination, the family would be contacted only for submitting that additional information.

6. **Presumptive eligibility.** States may permit certain entities (e.g., medical providers, entities that determine eligibility for Head Start) to determine children's eligibility for Medicaid or CHIP on a presumptive, or preliminary, basis until the Medicaid or CHIP agency is able to do a full eligibility determination. Presumptively eligible children can be enrolled for up to two months without a full eligibility determination.
7. **Express Lane Eligibility (ELE).** In determining whether a child meets one or more Medicaid or CHIP eligibility requirements (e.g., income, household composition, residency), state Medicaid and CHIP programs have the option to rely on findings from designated Express Lane agencies—for example, public agencies that administer Temporary Assistance for Needy Families (TANF), Medicaid, CHIP, Supplemental Nutrition Assistance Program (food stamps), and the National School Lunch Program.
8. **Premium assistance.** States have the option to use premium assistance programs to help eligible individuals purchase private insurance through their employer. These programs must be cost-effective—that is, the cost of covering someone through his or her employer-sponsored insurance must not be greater than the cost of direct Medicaid or CHIP coverage. In the states that use premium assistance, most have implemented it through waivers. To qualify a state for CHIPRA bonus payments, however, the premium assistance program must *not* be through a waiver, but through particular Medicaid and CHIP state plan options—that is, those operating under §1906A *or* §2105(c)(10) of the Social Security Act.

TABLE 3A-1. FY 2009 and FY 2010 CHIPRA Bonus Payments

State	FY 2010 Outreach and Enrollment Efforts: 12 Months of Continuous Eligibility	Liberalization of Asset Requirements	Elimination of In-person Interview	Joint Application and Renewal Form	Automatic, Administrative Renewal	Presumptive Eligibility	Express Lane	Premium Assistance	FY 2009 CHIPRA Bonus Payments (millions of dollars)	FY 2010 CHIPRA Bonus Payments (millions of dollars)
AL	✓	✓	✓	✓	✓	–	–	–	$39.8	$55.0
AK	✓	✓	✓	✓	✓	–	–	–	0.7	4.4
CO	–	✓	✓	✓	–	✓	–	✓	–	13.7
IL	✓	✓	✓	✓	✓	✓	–	–	9.5	15.0
IA	✓	✓	✓	✓	–	✓	–	–	–	6.8
KS	✓	✓	✓	✓	–	✓	–	–	1.2	2.6
LA	✓	✓	✓	✓	✓	–	–	–	1.5	3.6
MD	–	✓	✓	✓	✓	–	✓	–	–	10.5
MI	✓	✓	✓	✓	–	✓	–	–	4.7	9.3
NJ	–	✓	✓	✓	✓	✓	✓	–	3.1	8.8
NM	✓	✓	✓	✓	✓	✓	–	–	5.4	8.5
OH	✓	✓	✓	✓	–	✓	–	–	–	12.4
OR	✓	✓	✓	✓	✓	–	–	–	1.6	15.1
WA	✓	✓	✓	✓	–	–	–	✓	7.9	17.6
WI	–	✓	✓	✓	✓	–	–	✓	–	23.1
									$75.4	**$206.2**

Source: HHS 2011, *Connecting Kids to Coverage: Continuing the Progress—2010 CHIPRA Annual Report*, Appendix 3. http://www.insurekidsnow.gov/professionals/reports/chipra/2010_annual.pdf

Medicaid and CHIP Program Statistics: MACStats

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MACStats Table of Contents

Section 1900(b)(3) of the Social Security Act directs the Commission to: "(A) review national and State-specific Medicaid and CHIP data; and (B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews."

Introduction to MACStats

State-level and national information about the Medicaid and CHIP programs can often be difficult to find and is spread out across a variety of sources. The Commission's Medicaid and CHIP Program Statistics (MACStats) pulls key items together in one location and is intended to be used as a reference guide.

In this report, MACStats includes state-specific information about program enrollment, spending, eligibility levels, optional Medicaid benefits covered, and the federal medical assistance percentage (FMAP), as well as an overview of cost-sharing permitted under Medicaid and the dollar amounts of common federal poverty levels (FPLs) used to determine eligibility for Medicaid and CHIP. It also provides information that places these programs in the broader context of state budgets and national health expenditures.

TABLE 1. Medicaid and CHIP Enrollment as a Percentage of the U.S. Population, 2010

The numbers below exclude American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands because data are not available from all sources.

Medicaid and CHIP Enrollment	Administrative Data		Survey Data (NHIS)
	Ever enrolled during the year	Point in time	Point in time
Medicaid	66.7 million	52.9 million	Not available
CHIP	8.1 million	5.4 million	Not available
Totals for Medicaid and CHIP	74.8 million	58.3 million	45.8 million
U.S. Population	**2010 Census**		**Survey Data (NHIS)**
	308.7 million		303.4 million, excluding active-duty military and individuals in institutions
Medicaid and CHIP Enrollment as a Percentage of U.S. Population			
	24.2 percent (74.8/308.7)	18.9 percent (58.3/308.7)	15.1 percent (45.8/303.4)

Notes: Excludes U.S. territories. Enrollment from administrative data includes individuals who received limited benefits. Survey data shown here are 2010 National Health Interview Survey (NHIS), which excludes individuals in institutions such as nursing homes. NHIS point-in-time estimates were as of survey interviews taken between January and June 2010. Administrative data are for fiscal year 2010 (October 2009 through September 2010). By combining administrative totals from Medicaid and CHIP, some individuals may be double-counted, if they were enrolled in both programs during the year. Overcounting of enrollees in the administrative data may occur for other reasons—for example, because a person moves and is enrolled in two states' Medicaid programs during the year. The 2010 census number was as of April 1, 2010, but was also applied in the calculation of the percentage ever enrolled during the year.

Sources: MACPAC analysis based on the following: MACPAC communication with Centers for Medicare & Medicaid Services (CMS) Office of the Actuary; analysis of National Health Interview Survey (NHIS) by the National Center for Health Statistics (NCHS) for MACPAC; Department of Health and Human Services (HHS) *FY 2012 Budget in Brief*; HHS report, *Connecting Kids to Coverage: Continuing the Progress—2010 CHIPRA Annual Report*; and 2010 Census data

Discussion of Table 1: A Guide to Interpreting Medicaid and CHIP Enrollment Numbers

As illustrated in Table 1, published numbers of Medicaid and CHIP enrollment can vary substantially depending on the source of data, the individuals included in those data, and the enrollment period examined. This guide explains why Medicaid and CHIP enrollment numbers such as those in Table 1 can vary so much.

Sources of Data

The sources for Medicaid and CHIP enrollment numbers can be categorized as either administrative data or survey data. Administrative data on Medicaid and CHIP enrollment are discussed in greater detail in Chapter 6 and are the data that states and the federal government compile in the course of administering their Medicaid and CHIP programs. The administrative totals shown in Table 1 were published by the Centers

for Medicare & Medicaid Services (CMS) based on information submitted by state Medicaid and CHIP programs.

Household survey data, as the name suggests, are taken from interviews of individuals, usually from a small selection of the population that is designed to represent the whole. The federal government has a handful of surveys that produce national estimates of Medicaid and CHIP enrollment. Each of these surveys has unique strengths to support analyses that the other surveys cannot. As a result, analysts will sometimes use multiple surveys to create a more complete picture of Medicaid and CHIP enrollees, their demographic characteristics, health, family structure, income, employment situation, and access to care—information often not available from administrative data. States and organizations sometimes conduct their own surveys to obtain estimates for state or local areas. The discussion here uses survey estimates from the federal National Health Interview Survey (NHIS).

Although the only survey estimates provided here are from NHIS, each survey produces different estimates of the number of uninsured and of those enrolled in various types of coverage. This can occur for a number of reasons. For example, the wording of the health insurance questions, the survey mode (e.g., phone interviews, in-person interviews, mail-back forms), and how far back interviewees are asked to recall their health insurance. In addition, surveys tend to undercount Medicaid and CHIP enrollment, and administrative data tend to overcount enrollment. (Overcounting in administrative data may happen when, for example, a person moves and is enrolled in two states' Medicaid programs during the year.) These issues are described in depth in a number of sources, such as the National Academy of Science's *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary,* 2010.

Enrollment Period Examined

Another key consideration that affects Medicaid and CHIP enrollment numbers, even from the same data source, is the enrollment period examined. For example, as shown in Table 1, administrative data found that 66.7 million individuals were ever enrolled in Medicaid during the year, even if for a single month. But if looking at the number enrolled at a point in time during the year, the number of Medicaid enrollees is much smaller—52.9 million.[1] The number enrolled at a point in time will always be smaller than the number ever enrolled over a period of time.

Individuals Included in Data

In spite of examining the same enrollment period—point in time—large differences still exist between the Medicaid/CHIP enrollment reported from the administrative data (58.3 million) and the survey data (45.8 million). Besides surveys' undercount of Medicaid/CHIP enrollment and the administrative data's overcount, different individuals are included in each data source.

[1] Because administrative data are grouped by month, the point-in-time number from administrative data generally appears under a few different titles—average monthly enrollment, full-year equivalent enrollment, or person-years. Average monthly enrollment takes the state-submitted monthly enrollment numbers and averages them over the 12-month period. It produces the same result as full-year equivalent enrollment or person-years, which is the sum of the monthly enrollment totals divided by 12.

Surveys like the NHIS generally interview the noninstitutionalized U.S. civilian population. Active-duty members of the military are excluded, as are individuals living in institutions like nursing homes, which house a disproportionate share of Medicaid enrollees. This causes survey data to produce lower Medicaid/CHIP enrollment numbers.

The administrative totals also include several million individuals who are receiving only limited Medicaid benefits. For example, for some low-income Medicare enrollees, Medicaid helps pay out-of-pocket expenses these individuals would otherwise face. Other limited-benefit Medicaid enrollees include those who receive only family planning services; Medicaid can also pay for limited coverage of emergency services for low-income individuals who are ineligible for Medicaid solely because they are not U.S. citizens, nationals, or qualified aliens. Surveys generally do not count single-benefit plans as health insurance coverage. This is another reason why enrollment numbers from administrative data can be higher than from surveys.

Although surveys may have separate questions about whether individuals are enrolled in Medicaid or CHIP, these estimates are not published separately because many states' CHIP and Medicaid programs use the same name. The separate questions are used to reduce surveys' undercount, not to produce valid estimates separately for each program. Thus, survey estimates generally combine Medicaid/CHIP enrollment into a single category. The combined total from administrative data may overstate total enrollment, to the extent an individual was enrolled in Medicaid and CHIP at different times during the year. This is another reason why Medicaid/CHIP numbers from administrative data may be higher than those from survey data.

Conclusion

Medicaid and CHIP enrollment numbers are available from a variety of sources. Each may produce unique insights into the programs and their enrollees' characteristics; however, the total number of enrollees can vary substantially across the different sources. Much of this is attributable to legitimate differences resulting from the sources of data, the individuals included in the data, and the enrollment period examined. However, as described in Chapter 6, data improvements are necessary and some are under way to ensure the best possible enrollment numbers.

TABLE 2. Medicaid Enrollment by State and Selected Characteristics, FY 2008 (thousands)

	Basis of Eligibility					Dual Eligible Status[1, 2]			Managed Care Participation[3]		
State	Total Medicaid enrollment[1]	Children	Adults	Disabled	Aged	Total dual eligible enrollment	Dual eligibles with full Medicaid benefits	Dual eligibles with limited benefits	Managed care plan with comprehensive benefits	Managed care plan with limited benefits	Primary care case management program
Alabama	**909**	438	147	221	103	**208**	100	108	26	596	436
Alaska	**113**	64	26	16	7	**13**	13	0	0	0	0
Arizona	**1,539**	704	609	142	84	**148**	115	33	1,257	1,258	0
Arkansas	**685**	359	125	132	70	**118**	69	50	0	0	424
California	**10,591**	4,129	4,514	1,154	793	**1,201**	1,175	27	4,090	6,759	0
Colorado	**572**	333	99	85	55	**83**	68	15	181	527	0
Connecticut	**553**	288	131	68	66	**103**	78	25	334	0	0
Delaware	**192**	82	74	23	13	**24**	11	13	141	168	0
District of Columbia	**163**	74	41	38	10	**22**	19	3	106	0	0
Florida	**3,021**	1,525	567	560	369	**601**	349	253	1,953	710	960
Georgia	**1,683**	969	291	286	138	**264**	146	118	1,207	1,500	149
Hawaii	**212**	92	73	26	22	**32**	29	3	162	4	0
Idaho	**205**	125	27	37	16	**31**	22	9	0	143	174
Illinois	**2,390**	1,342	533	345	169	**313**	275	39	177	55	1,469
Indiana	**1,049**	586	221	158	84	**156**	101	55	828	0	84
Iowa	**475**	221	138	74	42	**81**	68	13	8	413	178
Kansas	**355**	199	53	68	36	**63**	47	16	309	0	22
Kentucky	**841**	387	137	244	72	**178**	110	68	165	778	401
Louisiana	**1,055**	555	186	204	110	**180**	107	73	0	0	696
Maine	**344**	120	108	59	57	**92**	53	39	0	0	0
Maryland	**753**	369	183	143	59	**110**	74	35	505	0	0
Massachusetts	**1,489**	432	394	502	160	**255**	248	7	485	391	0
Michigan	**1,919**	1,062	407	313	136	**264**	234	30	1,282	349	0
Minnesota	**808**	391	206	117	93	**132**	120	12	562	0	0
Mississippi	**737**	364	125	171	77	**151**	81	69	0	0	0
Missouri	**988**	525	186	185	92	**172**	156	16	480	272	0
Montana	**110**	60	21	20	10	**18**	16	3	0	0	54
Nebraska	**227**	124	44	36	24	**42**	38	4	40	0	47
Nevada	**260**	145	51	40	24	**40**	22	18	143	229	0
New Hampshire	**148**	89	20	24	15	**29**	21	8	0	0	0

TABLE 2, Continued

State	Basis of Eligibility					Dual Eligible Status[1, 2]			Managed Care Participation[3]		
	Total Medicaid enrollment[1]	Children	Adults	Disabled	Aged	Total dual eligible enrollment	Dual eligibles with full Medicaid benefits	Dual eligibles with limited benefits	Managed care plan with comprehensive benefits	Managed care plan with limited benefits	Primary care case management program
New Jersey	**953**	509	133	199	113	**204**	171	28	683	0	0
New Mexico	**506**	309	102	69	27	**56**	40	16	338	337	0
New York	**4,937**	1,938	1,799	746	454	**737**	659	79	3,405	0	0
North Carolina	**1,684**	873	334	295	182	**314**	250	60	0	90	1,289
North Dakota	**71**	36	15	11	9	**15**	11	4	0	0	39
Ohio	**1,947**	906	492	362	188	**304**	205	98	1,390	0	0
Oklahoma	**723**	408	140	109	65	**114**	95	19	0	624	14
Oregon	**520**	264	119	86	51	**90**	62	28	369	424	7
Pennsylvania	**2,199**	996	432	537	234	**392**	333	59	1,356	1,949	381
Rhode Island	**186**	86	35	44	21	**39**	34	6	114	0	0
South Carolina	**840**	414	198	151	77	**151**	132	19	259	754	105
South Dakota	**120**	70	20	19	10	**21**	14	7	0	120	54
Tennessee	**1,479**	721	304	357	98	**285**	216	68	1,382	1,024	0
Texas	**4,278**	2,681	597	569	431	**626**	385	219	2,006	441	1,016
Utah	**295**	161	82	38	14	**31**	28	3	1	225	0
Vermont	**168**	65	61	24	18	**32**	20	7	0	0	116
Virginia	**866**	461	140	166	99	**171**	119	52	517	0	62
Washington	**1,180**	645	262	184	90	**150**	114	36	827	0	86
West Virginia	**402**	191	59	114	38	**80**	50	30	197	0	28
Wisconsin	**974**	399	287	152	136	**210**	127	16	512	46	0
Wyoming	**78**	51	11	10	6	**10**	7	3	0	0	0
Total	**58,794**	**28,332**	**15,361**	**9,731**	**5,369**	**9,158**	**7,035**	**2,021**	**27,797**	**20,187**	**8,290**

Notes: Numbers reflect individuals ever enrolled during the year, even if for a single month. FY 2008 unavailable for Hawaii; FY 2007 shown instead. Excludes Medicaid-expansion CHIP enrollees and the territories.

Although state-level information is not available, the estimated number ever enrolled in Medicaid (excluding Medicaid-expansion CHIP) is 62.9 million for FY 2009; 67.7 million for FY 2010; 70.4 million for FY 2011; and 71.7 million for FY 2012. These FY 2009-FY 2012 figures include about one million enrollees in the territories. (Source: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, 2010 Actuarial Report on the Financial Outlook for Medicaid, 2010; MACPAC communication with OACT, February 2011.)

1 Components do not sum to totals due to a small number of enrollees with unknown status.

2 Dual eligibles with limited benefits receive Medicaid assistance with Medicare premiums and cost-sharing only.

3 Managed care components should not be summed to obtain a total because individuals are counted in every category for which a payment was made on their behalf during the year. Figures shown here may differ from annual managed care enrollment reports published by CMS from another data source.

Source: Centers for Medicare & Medicaid Services (CMS), Medicaid Statistical Information System (MSIS) data

TABLE 3. CHIP Enrollment by State, FY 2010

State	Program type (as of January 1, 2011)	Children			Adults				Total CHIP enrollment
		Medicaid expansion	Separate CHIP	Total children enrolled	Childless adults[9]	Parents	Pregnant women	Total adults enrolled	
Alabama	Separate	–	137,545	**137,545**	–	–	–	–	**137,545**
Alaska	Medicaid Expansion	12,473	–	**12,473**	–	–	–	–	**12,473**
Arizona[1]	Separate	–	39,589	**39,589**	–	–	–	–	**39,589**
Arkansas	Combination	97,119	3,651	**100,770**	–	NR	–	–	**100,770**
California	Combination	388,740	1,342,865	**1,731,605**	–	–	–	–	**1,731,605**
Colorado	Separate	–	106,643	**106,643**	–	–	3,790	**3,790**	**110,433**
Connecticut	Separate	–	21,033	**21,033**	–	–	–	–	**21,033**
Delaware	Combination	90	12,762	**12,852**	–	–	–	–	**12,852**
District of Columbia	Medicaid Expansion	8,100	–	**8,100**	–	–	–	–	**8,100**
Florida	Combination	1,114	402,235	**403,349**	–	–	–	–	**403,349**
Georgia	Separate	–	248,268	**248,268**	–	–	–	–	**248,268**
Hawaii	Medicaid Expansion	27,256	–	**27,256**	–	–	–	–	**27,256**
Idaho[2]	Combination	19,742	22,466	**42,208**	104	331	–	**435**	**42,643**
Illinois	Combination	157,426	171,678	**329,104**	–	–	–	–	**329,104**
Indiana	Combination	100,887	40,610	**141,497**	–	–	–	–	**141,497**
Iowa	Combination	19,141	44,844	**63,985**	–	–	–	–	**63,985**
Kansas	Separate	–	56,384	**56,384**	–	–	–	–	**56,384**
Kentucky	Combination	50,221	29,159	**79,380**	–	–	–	–	**79,380**
Louisiana	Combination	147,532	9,480	**157,012**	–	–	–	–	**157,012**
Maine	Combination	22,430	10,564	**32,994**	–	–	–	–	**32,994**
Maryland	Medicaid Expansion	118,944	–	**118,944**	–	–	–	–	**118,944**
Massachusetts	Combination	64,906	77,373	**142,279**	–	–	–	–	**142,279**
Michigan[3]	Combination	14,422	55,374	**69,796**	77,657	–	–	**77,657**	**147,453**
Minnesota[4]	Combination	98	5,066	**5,164**	–	–	–	–	**5,164**
Mississippi	Separate	–	95,556	**95,556**	–	–	–	–	**95,556**
Missouri	Combination	57,351	28,910	**86,261**	–	–	–	–	**86,261**
Montana	Combination	–	25,231	**25,231**	–	–	–	–	**25,231**
Nebraska	Medicaid Expansion	47,922	–	**47,922**	–	–	–	–	**47,922**
Nevada	Separate	–	31,554	**31,554**	–	10	646	**656**	**32,210**
New Hampshire	Combination	385	10,245	**10,630**	–	–	–	–	**10,630**
New Jersey[5]	Combination	75,195	112,016	**187,211**	–	204,044	295	**204,339**	**391,550**
New Mexico[6]	Medicaid Expansion	9,654	–	**9,654**	36,334	20,114	–	**56,448**	**66,102**
New York	Separate	–	539,614	**539,614**	–	–	–	–	**539,614**

TABLE 3, Continued

State	Program type (as of January 1, 2011)	Children			Adults				Total CHIP enrollment
		Medicaid expansion	Separate CHIP	Total children enrolled	Childless adults[9]	Parents	Pregnant women	Total adults enrolled	
North Carolina	Combination	64,791	189,101	**253,892**	–	–	–	–	**253,892**
North Dakota	Combination	1,939	5,253	**7,192**	–	–	–	–	**7,192**
Ohio	Medicaid Expansion	253,711	–	**253,711**	–	–	–	–	**253,711**
Oklahoma	Combination	115,909	6,965	**122,874**	–	–	–	–	**122,874**
Oregon[7]	Separate	–	64,727	**64,727**	–	–	–	–	**64,727**
Pennsylvania	Separate	–	273,221	**273,221**	–	–	–	–	**273,221**
Rhode Island[8]	Combination	21,510	1,743	**23,253**	–	–	151	**151**	**23,404**
South Carolina	Medicaid Expansion	52,977	20,461	**73,438**	–	–	–	–	**73,438**
South Dakota	Combination	12,221	3,651	**15,872**	–	–	–	–	**15,872**
Tennessee	Combination	30,090	51,251	**81,341**	–	–	–	–	**81,341**
Texas	Separate	–	928,483	**928,483**	–	–	–	–	**928,483**
Utah	Separate	–	62,071	**62,071**	–	–	–	–	**62,071**
Vermont	Separate	–	7,026	**7,026**	–	–	–	–	**7,026**
Virginia	Combination	81,434	92,081	**173,515**	–	–	3,667	**3,667**	**177,182**
Washington	Separate	–	35,894	**35,894**	–	–	–	–	**35,894**
West Virginia	Separate	–	37,539	**37,539**	–	–	–	–	**37,539**
Wisconsin	Combination	90,220	71,249	**161,469**	–	–	–	–	**161,469**
Wyoming	Separate	–	8,342	**8,342**	–	–	–	–	**8,342**
Total		**2,165,950**	**5,539,773**	**7,705,723**	**114,095**	**224,499**	**8,549**	**347,143**	**8,052,866**

Notes: Except as noted for childless adults, numbers are of individuals ever enrolled during the year, even if for a single month. Except for targeted low-income pregnant women in New Jersey and Rhode Island, all CHIP-funded coverage of adults in FY 2010 was permitted through waivers.

NR = Not reported to CMS, although Arkansas has CHIP-funded coverage of parents.

1 Arizona ended CHIP-funded coverage of parents on September 30, 2009.

2 Idaho ended CHIP-funded coverage of childless adults on December 31, 2009. This population is now covered by Medicaid.

3 Michigan ended CHIP-funded coverage of childless adults on December 31, 2009. This population is now covered by Medicaid.

4 Minnesota ended CHIP-funded coverage of parents on June 30, 2009.

5 New Jersey covers pregnant women under the CHIP state plan option (targeted low-income pregnant women) as of April 1, 2009.

6 New Mexico now covers childless adults under Medicaid.

7 Oregon ended CHIP-funded coverage of childless adults on October 31, 2009. This population is now covered by Medicaid.

8 Rhode Island covers pregnant women under the CHIP state plan option (targeted low-income pregnant women) as of December 9, 2009.

9 Number ever enrolled during the first quarter of FY 2010 (October through December 2009). CHIP-funded coverage of childless adults was prohibited after December 31, 2009.

Sources: Centers for Medicare & Medicaid Services (CMS) analysis for MACPAC of CHIP Statistical Enrollment Data System (SEDS) as of February 2011; Department of Health and Human Services (HHS) report *Connecting Kids to Coverage: Continuing the Progress—2010 CHIPRA Annual Report*; and CMS, *Children's Health Insurance Program Plan Activity as of January 1, 2011*

TABLE 4. Child Enrollment in Medicaid-Financed Coverage by State, and CHIP-Financed Coverage by State and Family Income, FY 2010

State	Medicaid-financed Children[1]	CHIP-financed Children (Medicaid-Expansion and Separate CHIP Coverage)						
	All incomes	At or below 200% FPL		From 200% through 250% FPL		Above 250% FPL		All CHIP children
Alabama	**846,766**	127,118	92.4%	7,889	5.7%	2,538	1.8%	**137,545**
Alaska	**78,034**	12,473	100.0	–	–	–	–	**12,473**
Arizona	**951,092**	39,589	100.0	–	–	–	–	**39,589**
Arkansas	**404,307**	100,770	100.0	–	–	–	–	**100,770**
California	**4,457,183**	1,471,894	85.0	248,611	14.4	11,100	0.6	**1,731,605**
Colorado	**452,636**	101,180	94.9	5,463	5.1	–	–	**106,643**
Connecticut	**282,100**	13,071	62.1	2,378	11.3	5,584	26.5	**21,033**
Delaware	**83,857**	12,852	100.0	–	–	–	–	**12,852**
District of Columbia	**89,402**	7,756	95.8	344	4.2	–	–	**8,100**
Florida	**1,915,980**	403,349	100.0	–	–	–	–	**403,349**
Georgia	**1,098,937**	216,756	87.3	29,511	11.9	2,001	0.8	**248,268**
Hawaii	**114,736**	23,594	86.6	2,716	10.0	946	3.5	**27,256**
Idaho	**169,216**	42,208	100.0	–	–	–	–	**42,208**
Illinois	**2,080,461**	329,104	100.0	–	–	–	–	**329,104**
Indiana	**670,047**	130,772	92.4	10,725	7.6	–	–	**141,497**
Iowa	**293,103**	57,052	89.2	1,329	2.1	5,604	8.8	**63,985**
Kansas	**201,038**	54,713	97.0	1,661	2.9	10	0.0	**56,384**
Kentucky	**490,486**	79,380	100.0	–	–	–	–	**79,380**
Louisiana	**662,861**	151,816	96.7	5,196	3.3	–	–	**157,012**
Maine	**142,931**	32,994	100.0	–	–	–	–	**32,994**
Maryland	**437,840**	55,565	46.7	58,896	49.5	4,483	3.8	**118,944**
Massachusetts	**488,191**	114,465	80.5	18,141	12.8	9,673	6.8	**142,279**
Michigan	**1,188,936**	69,796	100.0	–	–	–	–	**69,796**
Minnesota	**482,352**	4,943	95.7	103	2.0	118	2.3	**5,164**
Mississippi	**618,332**	95,556	100.0	–	–	–	–	**95,556**
Missouri	**548,085**	77,559	89.9	6,510	7.5	2,192	2.5	**86,261**
Montana	**70,175**	25,231	100.0	–	–	–	–	**25,231**
Nebraska	**164,435**	47,922	100.0	–	–	–	–	**47,922**
Nevada	**212,426**	30,381	96.3	895	2.8	278	0.9	**31,554**

TABLE 4, Continued

State	Medicaid-financed Children[1] All incomes	CHIP-financed Children (Medicaid-Expansion and Separate CHIP Coverage) At or below 200% FPL		From 200% through 250% FPL		Above 250% FPL		All CHIP children
New Hampshire	**94,531**	2,155	20.3%	5,459	51.4%	3,016	28.4%	**10,630**
New Jersey	**617,895**	144,630	77.3	25,099	13.4	17,482	9.3	**187,211**
New Mexico	**372,989**	2,730	28.3	6,924	71.7	–	–	**9,654**
New York	**2,080,412**	405,853	75.2	82,621	15.3	51,140	9.5	**539,614**
North Carolina	**1,243,785**	249,707	98.4	1,557	0.6	2,628	1.0	**253,892**
North Dakota	**43,568**	7,192	100.0	–	–	–	–	**7,192**
Ohio	**1,150,356**	253,711	100.0	–	–	–	–	**253,711**
Oklahoma	**477,181**	85,843	69.9	37,031	30.1	–	–	**122,874**
Oregon	**289,123**	62,662	96.8	1,512	2.3	553	0.9	**64,727**
Pennsylvania	**1,228,017**	239,460	87.6	24,907	9.1	8,854	3.2	**273,221**
Rhode Island	**108,321**	20,421	87.8	2,832	12.2	–	–	**23,253**
South Carolina	**485,322**	73,438	100.0	–	–	–	–	**73,438**
South Dakota	**46,994**	15,872	100.0	–	–	–	–	**15,872**
Tennessee	**781,567**	53,416	65.7	27,925	34.3	–	–	**81,341**
Texas	**3,279,846**	928,483	100.0	–	–	–	–	**928,483**
Utah	**237,125**	62,071	100.0	–	–	–	–	**62,071**
Vermont	**72,891**	–	–	3,442	49.0	3,584	51.0	**7,026**
Virginia	**603,166**	173,515	100.0	–	–	–	–	**173,515**
Washington	**705,950**	9,277	25.8	18,211	50.7	8,406	23.4	**35,894**
West Virginia	**247,953**	36,051	96.0	1,488	4.0	–	–	**37,539**
Wisconsin	**520,003**	161,378	99.9	91	0.1	–	–	**161,469**
Wyoming	**58,277**	8,342	100.0	–	–	–	–	**8,342**
Total	**34,441,217**	**6,918,353**	**89.8%**	**644,862**	**8.4%**	**142,508**	**1.8%**	**7,705,723**

Notes: In the lower 48 states and the District of Columbia, 200% of the federal poverty level (FPL) in 2011 is $21,780 for an individual and $7,640 for each additional family member. For additional information, see MACStats Table 19. Numbers are of children ever enrolled during the year, even if for a single month. In Statistical Enrollment Data System (SEDS), Delaware and South Dakota reported some enrollment above 200% FPL, even though their CHIP programs only go up to 200% FPL; the numbers here were altered to put all their enrollees at or below 200% FPL.

1 MACPAC analysis of SEDS, as reported by states, found that 99.5% of Medicaid-financed children were at or below 200% FPL.

Source: MACPAC analysis of CHIP SEDS as of February 2011, as reported by states

TABLE 5. Child Enrollment in Separate CHIP Programs by State and Managed Care Participation, FY 2010

State	Managed Care		Fee for Service		Primary Care Case Management		Total
Alabama	–	–	137,545	100.0%	–	–	**137,545**
Alaska	–	–	–	–	–	–	**0**
Arizona	37,713	95.3%	1,876	4.7	–	–	**39,589**
Arkansas	–	–	3,651	100.0	–	–	**3,651**
California	1,174,931	87.5	167,934	12.5	–	–	**1,342,865**
Colorado	106,643	100.0	–	–	–	–	**106,643**
Connecticut	21,033	100.0	–	–	–	–	**21,033**
Delaware	11,776	92.3	–	–	986	7.7%	**12,762**
District of Columbia	–	–	–	–	–	–	**0**
Florida	385,526	95.8	9,198	2.3	7,511	1.9	**402,235**
Georgia	241,993	97.5	6,209	2.5	66	0.0	**248,268**
Hawaii	–	–	–	–	–	–	**0**
Idaho	–	–	69	0.3	22,397	99.7	**22,466**
Illinois	3,894	2.3	50,282	29.3	117,502	68.4	**171,678**
Indiana	35,442	87.3	5,168	12.7	–	–	**40,610**
Iowa	44,844	100.0	–	–	–	–	**44,844**
Kansas	56,247	99.8	137	0.2	–	–	**56,384**
Kentucky	7,030	24.1	1,796	6.2	20,333	69.7	**29,159**
Louisiana	–	–	9,384	99.0	96	1.0	**9,480**
Maine	–	–	2,126	20.1	8,438	79.9	**10,564**
Maryland	–	–	–	–	–	–	**0**
Massachusetts	25,086	32.4	39,551	51.1	12,736	16.5	**77,373**
Michigan	48,023	86.7	7,351	13.3	–	–	**55,374**
Minnesota	4,252	83.9	814	16.1	–	–	**5,066**
Mississippi	95,556	100.0	–	–	–	–	**95,556**
Missouri	14,374	49.7	14,536	50.3	–	–	**28,910**
Montana	–	–	25,231	100.0	–	–	**25,231**
Nebraska	–	–	–	–	–	–	**0**
Nevada	27,221	86.3	4,333	13.7	–	–	**31,554**
New Hampshire	10,245	100.0	–	–	–	–	**10,245**
New Jersey	109,649	97.9	2,367	2.1	–	–	**112,016**

TABLE 5, Continued

State	Managed Care		Fee for Service		Primary Care Case Management		Total
New Mexico	–	–	–	–	–	–	**0**
New York	538,503	99.8%	1,111	0.2%	–	–	**539,614**
North Carolina	–	–	189,101	100.0	–	–	**189,101**
North Dakota	–	–	–	–	5,253	100.0%	**5,253**
Ohio	–	–	–	–	–	–	**0**
Oklahoma	–	–	6,965	100.0	–	–	**6,965**
Oregon	56,108	86.7	8,226	12.7	393	0.6	**64,727**
Pennsylvania	273,221	100.0	–	–	–	–	**273,221**
Rhode Island	1,743	100.0	–	–	–	–	**1,743**
South Carolina	20,450	99.9	11	0.1	–	–	**20,461**
South Dakota	–	–	1,258	34.5	2,393	65.5	**3,651**
Tennessee	–	–	–	–	51,251	100.0	**51,251**
Texas	928,483	100.0	–	–	–	–	**928,483**
Utah	62,071	100.0	–	–	–	–	**62,071**
Vermont	–	–	722	10.3	6,304	89.7	**7,026**
Virginia	75,360	81.8	14,974	16.3	1,747	1.9	**92,081**
Washington	23,092	64.3	12,500	34.8	302	0.8	**35,894**
West Virginia	–	–	37,539	100.0	–	–	**37,539**
Wisconsin	54,860	77.0	16,389	23.0	–	–	**71,249**
Wyoming	8,342	100.0	–	–	–	–	**8,342**
Total	**4,503,711**	**81.3%**	**778,354**	**14.1%**	**257,708**	**4.7%**	**5,539,773**

Notes: Numbers are of children ever enrolled during the year, even if for a single month.

Categorizations of the types of delivery system are based on states' definitions and/or Statistical Enrollment Data System (SEDS) instructions. According to SEDS instructions to states from the Centers for Medicare & Medicaid Services (CMS), under managed care arrangements, the state contracts with a health maintenance or insurance organization (HMO, HIO) to provide a comprehensive set of services. Under managed care arrangements, enrollees choose a plan and a primary care provider (PCP) who will be responsible for managing their care. Under fee for service, providers submit claims to the state and are paid a specific amount for each service performed. Under primary care case management (PCCM), providers are paid generally on a fee-for-service basis, but PCPs are paid an additional flat monthly management fee.

Source: MACPAC analysis of CHIP SEDS as of February 2011, as reported by states

TABLE 6. Medicaid Spending by State, Category, and Source of Funds, FY 2010 (millions)

State	Benefits			Administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	$4,836	$3,715	$1,121	$158	$88	$70	$4,994	$3,803	$1,191
Alaska	1,208	821	387	96	53	43	1,303	874	429
Arizona	9,380	7,217	2,164	150	80	69	9,530	7,297	2,233
Arkansas	3,881	3,144	737	190	112	78	4,071	3,256	816
California	41,643	25,572	16,072	3,891	2,067	1,824	45,535	27,639	17,896
Colorado	4,028	2,465	1,563	166	90	76	4,194	2,555	1,638
Connecticut	5,528	3,333	2,195	146	85	61	5,674	3,419	2,256
Delaware	1,287	796	491	57	33	24	1,344	830	515
District of Columbia	1,772	1,399	373	128	79	50	1,900	1,477	423
Florida	17,262	11,711	5,551	615	343	272	17,877	12,054	5,823
Georgia	7,711	5,750	1,961	361	211	150	8,072	5,961	2,111
Hawaii	1,361	926	435	67	38	28	1,428	964	463
Idaho	1,345	1,068	278	85	53	32	1,430	1,121	309
Illinois	15,196	9,189	6,008	695	372	323	15,891	9,561	6,331
Indiana	5,879	4,439	1,440	354	188	166	6,233	4,627	1,606
Iowa	3,047	2,211	836	107	62	44	3,153	2,273	880
Kansas	2,408	1,675	733	130	73	57	2,538	1,748	790
Kentucky	5,522	4,415	1,107	147	88	59	5,670	4,504	1,166
Louisiana	6,720	5,326	1,394	198	111	87	6,918	5,438	1,481
Maine	2,266	1,709	557	139	84	55	2,405	1,793	612
Maryland	7,012	4,337	2,674	254	137	117	7,265	4,475	2,791
Massachusetts	11,595	7,181	4,414	628	338	291	12,224	7,518	4,705
Michigan	11,556	8,425	3,132	478	269	209	12,035	8,694	3,341
Minnesota	7,496	4,631	2,865	359	189	170	7,855	4,820	3,036
Mississippi	4,106	3,470	637	110	63	47	4,217	3,533	684
Missouri	7,994	5,899	2,095	318	177	141	8,312	6,076	2,236
Montana	928	729	199	56	32	24	984	762	223
Nebraska	1,595	1,097	498	114	62	53	1,710	1,159	551
Nevada	1,505	953	552	83	49	34	1,588	1,002	586
New Hampshire	1,319	787	532	72	41	31	1,391	828	563
New Jersey	10,163	6,090	4,073	514	273	241	10,677	6,363	4,314
New Mexico	3,457	2,799	658	124	71	53	3,581	2,870	711
New York	50,453	30,721	19,733	1,338	714	624	51,791	31,435	20,356
North Carolina	10,319	7,710	2,610	573	333	240	10,892	8,042	2,850
North Dakota	682	483	199	37	22	15	719	505	214
Ohio	15,122	11,014	4,108	463	254	210	15,585	11,268	4,317
Oklahoma	3,862	2,971	891	227	132	95	4,089	3,103	986

TABLE 6, Continued

State	Benefits			Administration			Total Medicaid		
	Total	Federal	State	Total	Federal	State	Total	Federal	State
Oregon	$3,973	$2,901	$1,072	$296	$152	$144	$4,269	$3,053	$1,216
Pennsylvania	18,634	12,200	6,434	865	474	391	19,500	12,674	6,825
Rhode Island	1,912	1,206	706	83	48	35	1,995	1,254	741
South Carolina	4,992	3,936	1,057	151	87	64	5,143	4,022	1,121
South Dakota	775	569	206	65	43	22	840	612	228
Tennessee	8,441	6,407	2,034	354	190	164	8,795	6,597	2,197
Texas	26,331	18,477	7,854	1,100	587	514	27,431	19,063	8,368
Utah	1,687	1,368	319	118	64	54	1,805	1,432	373
Vermont	1,247	869	378	6	4	3	1,254	873	381
Virginia	6,408	3,938	2,470	253	138	116	6,661	4,075	2,586
Washington	6,989	4,384	2,605	499	273	225	7,488	4,657	2,831
West Virginia	2,539	2,101	438	111	67	44	2,650	2,168	482
Wisconsin	6,432	4,534	1,897	288	149	139	6,720	4,683	2,037
Wyoming	530	331	199	40	24	16	570	355	215
Subtotal (States)	**$382,335**	**$259,394**	**$122,941**	**$17,862**	**$9,769**	**$8,093**	**$400,197**	**$269,163**	**$131,034**
American Samoa	25	13	13	1	0	0	26	13	13
Guam	31	16	15	2	1	1	33	17	16
Northern Mariana Islands	13	7	7	0	0	0	14	7	7
Puerto Rico	1,047	524	524	62	31	31	1,109	554	554
Virgin Islands	44	22	22	4	2	2	48	24	24
Subtotal (States & Territories)	**$383,495**	**$259,975**	**$123,521**	**$17,931**	**$9,804**	**$8,127**	**$401,426**	**$269,778**	**$131,648**
State Medicaid Fraud Control Units (MFCUs)	NA	NA	NA	200	150	50	200	150	50
Medicaid survey and certification of nursing and intermediate care facilities	NA	NA	NA	286	214	71	286	214	71
Vaccines for Children (VFC) program	NA	NA	NA	NA	NA	NA	3,761	3,761	0
Total	**$383,495**	**$259,975**	**$123,531**	**$18,417**	**$10,168**	**$8,249**	**$405,673**	**$273,903**	**$131,769**

Notes: Total federal spending shown here ($273.903 billion) differs from total federal outlays shown in FY 2012 budget documents ($272.771 billion) due to slight differences in the timing of data for the states and the treatment of certain adjustments. Benefits and Administration columns do not sum to Total Medicaid due to the inclusion of VFC in Total Medicaid. Federal spending in the territories is capped; however, they report their total spending regardless of whether they have reached their caps. As a result, federal spending shown here may exceed the amounts actually paid to the territories. The federal share of total Medicaid spending nationally is generally 57 percent; the federal share was higher in FY 2010 due to a temporary increase in states' federal medical assistance percentages (FMAPs) under P.L. 111-5 and P.L. 111-226. State shares for MFCUs and survey and certification are MACPAC estimates based on 75 percent federal match. State-level estimates for these items are available but are not shown here. VFC is authorized in the Medicaid statute but is operated as a separate program; 100 percent federal funding finances the purchase of vaccines for children who are enrolled in Medicaid, uninsured, or privately insured without vaccine coverage. Spending on administration is only for state programs; federal oversight spending is not included.

Sources: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2011 for the states and territories; CMS, FY 2012 *Justification of Estimates for Appropriations Committees* for all other (MFCUs, survey and certification, VFC)

TABLE 7. Total Medicaid Benefit Spending by State and Category, FY 2010 (millions)

State	Total Spending on Benefits	FEE FOR SERVICE									Managed Care and Premium Assistance	Medicare Premiums and Coinsurance	Collections
		Hospital	Physician	Dental	Other Practitioner	Clinic and Health Center	Other Acute	Drugs	Nursing Facility and ICF-MR	Home and Community-based LTSS			
Alabama	**$4,836**	$1,254	$305	$82	$44	$185	$213	$336	$910	$558	$747	$238	-$36
Alaska	**1,208**	324	94	47	17	162	94	46	119	283	0	20	0
Arizona	**9,380**	550	38	4	5	97	281	8	34	13	8,164	189	-3
Arkansas	**3,881**	1,112	276	67	17	237	325	182	774	665	16	269	-59
California	**41,643**	10,351	1,388	556	75	2,196	4,062	1,569	4,984	8,246	6,539	2,176	-498
Colorado	**4,028**	1,284	272	97	0	103	173	138	602	833	462	87	-24
Connecticut	**5,528**	912	70	131	117	218	157	322	1,546	1,268	729	273	-216
Delaware	**1,287**	78	22	29	1	43	50	72	217	146	600	31	-2
District of Columbia	**1,772**	433	55	16	3	93	69	60	274	350	408	30	-20
Florida	**17,262**	4,976	1,089	114	42	212	913	579	3,119	2,226	2,958	1,162	-128
Georgia	**7,711**	2,070	355	41	31	137	194	222	1,226	988	2,235	286	-75
Hawaii	**1,361**	98	7	27	1	28	5	3	11	103	1,085	58	-67
Idaho	**1,345**	293	100	9	42	106	300	61	191	209	33	36	-35
Illinois	**15,196**	7,291	880	186	129	363	752	1,001	2,287	1,756	342	348	-140
Indiana	**5,879**	854	189	167	10	345	221	348	1,475	885	1,274	154	-42
Iowa	**3,047**	730	174	58	58	60	217	104	788	672	133	124	-72
Kansas	**2,408**	449	97	31	4	25	53	76	417	637	569	79	-30
Kentucky	**5,522**	1,532	374	78	42	262	508	299	982	572	752	205	-84
Louisiana	**6,720**	2,764	516	118	0	183	428	632	1,248	823	10	241	-243
Maine	**2,266**	628	100	30	48	143	408	74	296	453	4	111	-29
Maryland	**7,012**	1,168	101	105	13	44	339	172	1,060	1,334	2,527	220	-71
Massachusetts	**11,595**	2,114	314	287	29	287	1,044	345	1,826	1,950	3,204	381	-186
Michigan	**11,556**	1,777	263	58	6	189	277	247	1,686	1,029	5,763	361	-98
Minnesota	**7,496**	729	189	35	168	39	218	138	978	2,314	2,620	160	-93
Mississippi	**4,106**	1,642	298	9	25	77	266	221	1,017	396	0	194	-40
Missouri	**7,994**	3,034	30	15	13	421	354	612	1,039	1,189	1,093	319	-124
Montana	**928**	272	52	19	15	13	90	33	169	235	7	33	-8
Nebraska	**1,595**	392	88	32	6	70	172	90	348	319	107	105	-135
Nevada	**1,505**	422	88	20	11	14	45	61	189	280	289	89	-4
New Hampshire	**1,319**	373	55	22	15	154	81	38	312	259	0	23	-13
New Jersey	**10,163**	2,502	63	22	46	374	724	370	2,587	1,308	1,917	311	-61
New Mexico	**3,457**	570	41	10	41	33	109	9	30	298	2,228	74	14
New York	**50,453**	11,784	361	311	232	1,573	2,193	2,503	10,453	11,675	9,764	1,273	-1,669
North Carolina	**10,319**	3,158	944	321	33	141	601	633	1,727	2,669	270	410	-588
North Dakota	**682**	126	48	10	6	11	17	29	274	153	3	11	-5

TABLE 7, Continued

State	Total Spending on Benefits	FEE FOR SERVICE									Managed Care and Premium Assistance	Medicare Premiums and Coinsurance	Collections
		Hospital	Physician	Dental	Other Practitioner	Clinic and Health Center	Other Acute	Drugs	Nursing Facility and ICF-MR	Home and Community-based LTSS			
Ohio	**$15,122**	$2,723	$317	$44	$60	$95	$325	$820	$3,569	$2,398	$4,526	$384	-$140
Oklahoma	**3,862**	1,247	402	131	29	291	252	244	632	588	174	128	-257
Oregon	**3,973**	347	19	0	28	62	137	90	325	1,183	1,697	120	-34
Pennsylvania	**18,634**	1,910	209	84	9	107	388	222	4,107	2,669	8,531	530	-132
Rhode Island	**1,912**	364	15	14	1	25	507	11	315	77	562	36	-14
South Carolina	**4,992**	1,396	276	101	30	247	229	135	711	595	1,290	161	-181
South Dakota	**775**	240	60	14	2	80	21	34	169	135	2	27	-9
Tennessee	**8,441**	962	28	170	0	30	203	371	849	646	4,933	326	-77
Texas	**26,331**	8,062	1,156	1,280	849	130	1,845	1,277	3,407	3,322	4,930	940	-869
Utah	**1,687**	492	113	33	4	70	64	100	225	221	356	39	-29
Vermont	**1,247**	43	2	0	0	0	61	1	115	6	1,016	6	-3
Virginia	**6,408**	1,120	197	126	25	58	706	132	1,078	1,132	1,672	220	-60
Washington	**6,989**	1,312	193	166	33	382	398	247	717	1,490	1,824	301	-74
West Virginia	**2,539**	511	183	56	13	30	113	155	543	517	323	109	-14
Wisconsin	**6,432**	619	63	51	79	291	366	336	1,066	802	2,581	267	-90
Wyoming	**530**	155	52	13	7	34	23	22	93	127	0	12	-8
Subtotal	**$382,335**	**$89,548**	**$12,621**	**$5,451**	**$2,513**	**$10,571**	**$21,591**	**$15,831**	**$63,117**	**$63,006**	**$91,270**	**$13,689**	**-$6,873**
American Samoa	**25**	0	0	0	0	0	25	0	0	0	0	0	0
Guam	**31**	10	4	0	0	0	9	7	0	0	0	1	0
N. Mariana Islands	**13**	4	0	2	0	1	2	3	0	0	0	0	0
Puerto Rico	**1,047**	0	0	0	0	0	93	0	0	0	954	0	0
Virgin Islands	**44**	39	1	0	0	1	-4	5	2	0	0	0	0
Total	**$383,495**	**$89,600**	**$12,626**	**$5,454**	**$2,513**	**$10,573**	**$21,716**	**$15,846**	**$63,120**	**$63,006**	**$92,224**	**$13,691**	**-$6,873**
Percent of Total, Exclusive of Collections	**–**	**23.0%**	**3.2%**	**1.4%**	**0.6%**	**2.7%**	**5.6%**	**4.1%**	**16.2%**	**16.1%**	**23.6%**	**3.5%**	**–**

Notes: Service category definitions and spending amounts shown here may differ from other CMS data sources, such as the Medicaid Statistical Information System (MSIS). Includes federal and state funds. ICF-MR is intermediate care facility for the mentally retarded; LTSS is long-term services and supports. Hospital includes inpatient, outpatient, mental health facility, critical access hospital, and emergency hospital services, as well as related disproportionate share hospital (DSH) payments. Other practitioner includes nurse midwife, nurse practitioner, and other. Clinic and health center includes non-hospital outpatient clinic, rural health clinic, and federally qualified health center. Other acute includes lab/X-ray; sterilizations; abortions; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings; emergency services for unauthorized aliens; non-emergency transportation; physical, occupational, speech, and hearing therapy; prosthetics, dentures, and eyeglasses; diagnostic screening and preventive services; school-based services; and other care not otherwise categorized. Drugs are net of rebates. Home and community-based (HCB) includes home health, HCB waiver and state plan services, personal care, private duty nursing, case management (excluding primary care case management), rehabilitative services, and hospice. Managed care and premium assistance includes comprehensive and limited-benefit managed care plans, primary care case management (PCCM), employer-sponsored premium assistance programs, and Programs of All-inclusive Care for the Elderly (PACE); comprehensive managed care plans account for the majority of spending in this category (20.5 percent of total benefits, exclusive of collections) followed by limited-benefit plans (2.6 percent) and PCCM, PACE, and premium assistance (which together were 0.4 percent). Collections include third-party liability, estate, and other recoveries.

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2011

TABLE 8. CHIP Spending by State, FY 2010 (millions)

	Benefits												
	Medicaid-expansion CHIP programs			Separate CHIP and Waivers			Administration			2105(g) Spending	Total CHIP		
State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Federal	Total	Federal	State
Alabama	–	–	–	$157.4	$122.2	$35.2	$8.1	$6.3	$1.8	–	$165.5	$128.4	$37.0
Alaska	$27.2	$18.0	$9.3	–	–	–	1.1	0.7	0.4	–	28.3	18.7	9.6
Arizona	–	–	–	70.1	53.3	16.8	5.9	4.5	1.4	–	76.1	57.8	18.2
Arkansas	82.7	67.0	15.8	18.2	14.7	3.5	5.0	4.1	1.0	–	106.0	85.8	20.2
California	271.1	176.2	94.9	1,452.8	944.4	508.4	101.8	66.2	35.6	–	1,825.7	1,186.8	638.9
Colorado	–	–	–	173.6	112.8	60.8	4.3	2.8	1.5	–	177.8	115.6	62.2
Connecticut	–	–	–	33.5	21.8	11.7	1.8	1.2	0.6	$6.8	35.3	29.7	5.6
Delaware	0.4	0.3	0.1	17.9	11.7	6.3	1.4	0.9	0.5	–	19.7	12.9	6.9
District of Columbia	13.7	10.9	2.9	–	–	–	0.5	0.4	0.1	–	14.3	11.3	3.0
Florida	3.3	2.3	1.1	402.0	275.4	126.7	45.1	30.9	14.2	–	450.4	308.5	141.9
Georgia	–	–	–	273.2	206.6	66.7	24.9	18.8	6.1	–	298.1	225.4	72.7
Hawaii	43.2	29.4	13.8	–	–	–	2.9	2.0	0.9	–	46.2	31.4	14.8
Idaho	18.3	14.4	3.9	22.2	17.5	4.7	2.8	2.2	0.6	–	43.4	34.1	9.3
Illinois	113.3	73.6	39.7	273.5	178.1	95.4	15.2	9.9	5.3	–	402.0	261.7	140.4
Indiana	81.8	62.4	19.4	31.3	23.9	7.5	4.7	3.6	1.1	–	117.8	89.8	28.0
Iowa	25.3	18.9	6.5	62.3	46.4	15.9	8.4	6.3	2.1	–	96.1	71.6	24.5
Kansas	1.8	1.3	0.5	65.8	47.6	18.2	7.2	5.2	2.0	–	74.8	54.0	20.8
Kentucky	102.1	81.4	20.8	48.6	38.8	9.9	3.5	2.8	0.7	–	154.3	122.9	31.4
Louisiana	190.0	146.9	43.1	21.2	16.4	4.8	16.1	12.4	3.6	–	227.2	175.7	51.5
Maine	28.1	21.2	6.9	12.1	9.2	3.0	4.5	3.4	1.1	–	44.6	33.7	10.9
Maryland	237.8	154.6	83.2	–	–	–	8.7	5.7	3.1	–	246.6	160.3	86.3
Massachusetts	230.5	149.8	80.7	224.2	145.7	78.5	9.3	6.0	3.3	–	463.9	301.5	162.4
Michigan	12.5	9.3	3.2	136.1	100.6	35.5	6.8	5.0	1.8	–	155.4	114.9	40.5
Minnesota	0.1	0.0	0.0	23.9	15.6	8.3	0.2	0.2	0.1	3.6	24.2	19.5	4.8
Mississippi	–	–	–	183.3	152.1	31.2	0.4	0.3	0.1	–	183.7	152.4	31.3
Missouri	89.3	67.1	22.2	47.5	35.7	11.8	5.6	4.2	1.4	–	142.4	107.0	35.4
Montana	6.5	5.0	1.5	36.5	28.2	8.3	4.3	3.3	1.0	–	47.3	36.5	10.8
Nebraska	47.2	34.2	13.0	–	–	–	3.5	2.6	1.0	–	50.7	36.7	14.0
Nevada	–	–	–	32.8	21.4	11.4	2.1	1.3	0.7	–	34.8	22.7	12.1
New Hampshire	0.5	0.3	0.2	16.1	10.4	5.6	0.7	0.4	0.2	1.0	17.3	12.2	5.1
New Jersey	135.8	88.3	47.5	662.1	430.7	231.5	66.8	43.5	23.4	–	864.7	562.4	302.4

TABLE 8, Continued

State	Benefits: Medicaid-expansion CHIP programs Total	Medicaid-expansion CHIP programs Federal	Medicaid-expansion CHIP programs State	Separate CHIP and Waivers Total	Separate CHIP and Waivers Federal	Separate CHIP and Waivers State	Administration Total	Administration Federal	Administration State	2105(g) Spending Federal	Total CHIP Total	Total CHIP Federal	Total CHIP State
New Mexico	$96.3	$76.9	$19.4	$190.3	$152.1	$38.1	$2.0	$1.6	$0.4	–	$288.6	$230.6	$57.9
New York	0.2	0.1	0.1	758.3	492.9	265.4	9.8	6.4	3.4	–	768.3	499.4	268.9
North Carolina	182.9	137.8	45.2	283.4	214.2	69.2	10.9	8.2	2.7	–	477.2	360.2	117.0
North Dakota	9.0	6.6	2.3	9.6	7.1	2.5	0.8	0.6	0.2	–	19.4	14.4	5.0
Ohio	350.1	260.4	89.7	–	–	–	4.8	3.6	1.2	–	354.9	264.0	91.0
Oklahoma	139.3	104.6	34.7	7.6	5.7	1.9	3.6	2.7	0.9	–	150.5	113.0	37.5
Oregon	–	–	–	108.7	80.5	28.3	7.6	5.6	2.0	–	116.4	86.1	30.3
Pennsylvania	–	–	–	439.0	300.9	138.2	7.0	4.8	2.2	–	446.0	305.6	140.4
Rhode Island	27.6	18.4	9.1	14.5	9.7	4.8	1.0	0.7	0.3	–	43.1	28.8	14.3
South Carolina	61.9	49.1	12.8	47.6	37.7	9.9	7.3	5.8	1.5	–	116.8	92.5	24.3
South Dakota	18.6	13.8	4.9	6.0	4.4	1.6	1.0	0.8	0.3	–	25.6	18.9	6.7
Tennessee	55.5	42.9	12.7	102.9	78.3	24.6	7.7	5.9	1.8	–	166.1	127.0	39.1
Texas	–	–	–	1,025.7	729.4	296.3	66.0	47.0	19.1	–	1,091.7	776.3	315.4
Utah	–	–	–	66.8	53.6	13.3	7.4	6.0	1.5	–	74.2	59.5	14.7
Vermont	–	–	–	6.5	4.6	1.9	0.5	0.4	0.2	0.5	7.0	5.5	1.5
Virginia	112.6	73.2	39.4	130.8	85.1	45.8	11.1	7.2	3.9	–	254.5	165.4	89.1
Washington	2.0	1.3	0.7	43.4	28.4	15.1	5.0	3.3	1.7	9.8	50.5	42.7	7.8
West Virginia	–	–	–	44.0	36.0	8.0	3.9	3.2	0.7	–	47.9	39.2	8.7
Wisconsin	53.3	38.5	14.8	72.0	51.9	20.1	10.0	7.2	2.8	–	135.3	97.6	37.7
Wyoming	–	–	–	13.4	8.7	4.7	0.8	0.6	0.3	–	14.3	9.3	5.0
Subtotal	**$2,872.0**	**$2,056.1**	**$815.9**	**$7,869.0**	**$5,461.9**	**$2,407.1**	**$542.1**	**$378.4**	**$163.7**	**$21.6**	**$11,283.1**	**$7,918.1**	**$3,365.1**
American Samoa	1.8	1.1	0.6	–	–	–	–	–	–	–	1.8	1.1	0.6
Guam	6.1	4.0	2.1	–	–	–	–	–	–	–	6.1	4.0	2.1
Northern Mariana Islands	1.3	0.8	0.4	–	–	–	–	–	–	–	1.3	0.8	0.4
Puerto Rico	145.5	94.6	50.9	–	–	–	–	–	–	–	145.5	94.6	50.9
Virgin Islands	–	–	–	–	–	–	–	–	–	–	–	–	–
Total	**$3,026.6**	**$2,156.6**	**$870.0**	**$7,869.0**	**$5,461.9**	**$2,407.1**	**$542.1**	**$378.4**	**$163.7**	**$21.6**	**$11,437.7**	**$8,018.5**	**$3,419.2**

Notes: Separate CHIP includes unborn children, who represent some states' only separate CHIP spending, as shown in MACStats Table 9. Federal CHIP spending on administration is generally limited to 10% of a state's total federal CHIP spending for the year. States with a Medicaid-expansion CHIP program may elect to receive reimbursement for administrative spending from Medicaid rather than CHIP funds. Section 2105(g) of the Social Security Act permits 11 qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled children whose family income exceeds 133% of the federal poverty level. Qualifying states covered higher-income children in Medicaid prior to CHIP.

Source: MACPAC analysis of Medicaid and CHIP Budget Expenditure System (MBES/CBES) as of February 2011

TABLE 9. Medicaid and CHIP Income Eligibility Levels as a Percentage of the Federal Poverty Level for Children and Pregnant Women by State, March 2011

As described in *Chapter 3: Overview of the State Children's Health Insurance Program,* states' Medicaid eligibility levels for children under age 19 in effect as of March 31, 1997, continue to be financed by Medicaid. Any expansion above those levels—through expansions of Medicaid or through separate CHIP programs—are financed by CHIP. Adult pregnant women can receive Medicaid- or CHIP-funded services through regular state plan eligibility pathways or Section 1115 waivers; in addition, the unborn children of pregnant women may receive CHIP-funded coverage. Deemed newborns are infants up to age 1 who are deemed eligible for Medicaid or CHIP—with no separate application or eligibility determination required—if their mother was enrolled at time of their birth.

	Medicaid Coverage							Separate CHIP Coverage		Medicaid/CHIP Coverage
	Infants under Age 1		Age 1 through 5		Age 6 through 18			Children		
State	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	Medicaid funded[1]	CHIP funded[1]	CHIP Program Type[2] (as of January 1, 2011)	0-18 years of age	Unborn children	Pregnant women & deemed newborns[3]
Alabama	133%	–	133%	–	100%	–	Separate	300%	–	133%
Alaska	133	175%	133	175%	100	175%	Medicaid Expansion	–	–	175
Arizona	140	–	133	–	100	–	Separate	200	–	150
Arkansas[4]	133	200	133	200	100	200	Combination	–	200%	200
California[5, 6, 7]	200	250	133	250	100	250	Combination	250/300	300	200
Colorado	133	–	133	–	100	–	Separate	250	–	133/200[8]
Connecticut	185	–	185	–	185	–	Separate	300	–	250
Delaware	133	200	133	–	100	–	Combination	200	–	200
District of Columbia	185	300	133	300	100	300	Medicaid Expansion	–	–	300
Florida	185	200	133	–	100	–	Combination	200	–	185
Georgia	185	–	133	–	100	–	Separate	235	–	200
Hawaii	185	300	133	300	100	300	Medicaid Expansion	–	–	185
Idaho[9]	133	–	133	–	100	133	Combination	185	–	133
Illinois[9]	133	–	133	–	100	133	Combination	200	200	200
Indiana	150	–	133	150	100	150	Combination	250	–	200
Iowa[10]	185	300	133	–	100	133	Combination	300	–	300
Kansas	150	–	133	–	100	–	Separate	241	–	150
Kentucky	185	–	133	150	100	150	Combination	200	–	185
Louisiana	133	200	133	200	100	200	Combination	250	200	200
Maine	185	–	133	150	125	150	Combination	200	–	200
Maryland	185	300	185	300	185	300	Medicaid Expansion	–	–	250
Massachusetts[11]	185	200	133	150	114	150	Combination	300	200	185

TABLE 9, Continued

State	Medicaid Coverage: Infants under Age 1 – Medicaid funded[1]	Medicaid Coverage: Infants under Age 1 – CHIP funded[1]	Medicaid Coverage: Age 1 through 5 – Medicaid funded[1]	Medicaid Coverage: Age 1 through 5 – CHIP funded[1]	Medicaid Coverage: Age 6 through 18 – Medicaid funded[1]	Medicaid Coverage: Age 6 through 18 – CHIP funded[1]	CHIP Program Type[2] (as of January 1, 2011)	Separate CHIP Coverage: Children 0-18 years of age	Separate CHIP Coverage: Unborn children	Medicaid/CHIP Coverage: Pregnant women & deemed newborns[3]
Michigan[9]	185%	–	150%	–	100%	150%	Combination	200%	185%	185%
Minnesota[12]	275	280%	275	–	275	–	Combination	–	275	275
Mississippi	185	–	133	–	100	–	Separate	200	–	185
Missouri	185	–	133	150%	100	150	Combination	300	–	185
Montana[9]	133	–	133	–	100	133	Combination	250	–	150
Nebraska	150	200	133	200	100	200	Medicaid Expansion	–	–	185
Nevada	133	–	133	–	100	–	Separate	200	–	133/185[13]
New Hampshire	185	300	185	–	185	–	Combination	300	–	185
New Jersey[9]	185	–	133	–	100	133	Combination	350	–	185/200[14]
New Mexico	185	235	185	235	185	235	Medicaid Expansion	–	–	235
New York	185	–	133	–	100	–	Separate	400	–	200
North Carolina	185	200	133	200	100	–	Combination	200	–	185
North Dakota[15]	133	–	133	–	100	100	Combination	160	–	133
Ohio[16]	133	200	133	200	100	200	Medicaid Expansion	–	–	200
Oklahoma[17]	150	185	133	185	100	185	Combination	200	185	185
Oregon	133	–	133	–	100	–	Separate	300	185	185
Pennsylvania	185	–	133	–	100	–	Separate	300	–	185
Rhode Island[9, 18]	250	–	250	–	100	250	Combination	–	250	185/250[19]
South Carolina	185	200	133	200	100	200	Medicaid Expansion	–	–	185
South Dakota	133	140	133	140	100	140	Combination	200	–	133
Tennessee[20]	185	200	133	200	100	200	Combination	250	250	185
Texas	185	–	133	–	100	–	Separate	200	200	185
Utah	133	–	133	–	100	–	Separate	200	–	133
Vermont[21]	225	–	225	–	225	–	Separate	300	–	200
Virginia[9]	133	–	133	–	100	133	Combination	200	–	133/200[22]
Washington	200	–	200	–	200	–	Separate	300	185	185
West Virginia	150	–	133	–	100	–	Separate	250	–	150
Wisconsin[23]	185	–	185	–	100	150	Combination	300	300	300
Wyoming	133	–	133	–	100	–	Separate	200	–	133

Table 9, Continued

Notes: The federal poverty level (100% FPL) for 2011 in the lower 48 states and the District of Columbia is $10,890 for an individual and $3,820 for each additional family member. For additional information, see MACStats Table 19. Income eligibility levels noted may refer to gross or net income depending on the state. Some states achieve the eligibility levels listed by applying block disregards. Some numbers may differ in practice because of the operation of an income disregard that has not been taken into account. In 1997 many states had different eligibility levels for children aged 6 through 13 and 14 through 18; in such cases, this table shows the 1997 levels for children from age 6 through 13.

1 The eligibility levels listed under 'Medicaid funded' are the Medicaid eligibility thresholds as of March 31, 1997. The eligibility levels listed under 'CHIP funded' are the income levels to which Medicaid has expanded with CHIP funding since its creation in 1997.

2 Under CHIP, states have the option to use an expansion of Medicaid, a separate CHIP program, or a combination of both approaches.

3 Pregnant women can be covered with Medicaid or CHIP funding. When pregnant women are covered under CHIP, it can be through a state plan to targeted low-income pregnant women or a Section 1115 demonstration waiver. Values in this column are for Medicaid covered pregnant women, except where noted.

4 Arkansas increased Medicaid eligibility to 200% FPL through Section 1115 demonstration authority, effective September 1997, which is after the CHIP maintenance of effort date.

5 In California, children through age 18 who are no longer eligible for Medicaid and are converting to the separate CHIP program are covered for one month under the Medicaid expansion program as a bridge while their CHIP enrollment is processed.

6 In 1997 California had an asset test for determining a child's eligibility for Medicaid; there is currently no asset test for children in California, but children from age 6 through 18 from 100 to 133% FPL who would not have been eligible in 1997 because of the asset test are covered in a Medicaid expansion with CHIP dollars.

7 California's county program expanded eligibility to 300% FPL under its separate CHIP program in four counties (three of the four counties have implemented this provision), with all other counties at 250% FPL.

8 Colorado covers pregnant women up to 133% FPL under Medicaid and from 134% through 200% FPL under CHIP through a Title XXI funded 1115 wavier.

9 Idaho, Illinois, Michigan, Montana, New Jersey, Rhode Island, and Virginia Medicaid expansion CHIP programs cover children ages 6 through 18 only.

10 Iowa's Medicaid expansion CHIP program covers infants over 185% through 300% FPL and children ages 6 through 18 from 100% through 133% FPL.

11 Massachusetts has been approved to provide coverage of unborn children up to 225% FPL, although the state has implemented up to 200% FPL.

12 In Minnesota infants are defined as being under age 2. Only infants are eligible for the Medicaid expansion CHIP program.

13 Nevada covers pregnant women up to 133% FPL under Medicaid and from 134% through 200% FPL under CHIP through a Title XXI funded Section 1115 wavier.

14 New Jersey covers pregnant women up to 185% FPL under Medicaid and from 186% through 200% FPL under CHIP through the Title XXI State plan to targeted low-income pregnant women.

15 North Dakota's Medicaid expansion CHIP program consists of children who became eligible for Medicaid when the state eliminated the Medicaid asset tests on January 1, 2002.

16 Ohio has been approved to increase the income threshold to 300% FPL, but the state has not yet implemented the expansion.

17 Oklahoma covers TEFRA children from 0% through 200% FPL as a Medicaid expansion in all age groups. Oklahoma has been approved to increase the income threshold of its separate CHIP program to 300% FPL, but has implemented the expansion up to 200% FPL.

18 In Rhode Island the age range is 1 through 7 and 8 through 18. The state has increased the Medicaid expansion CHIP program income threshold to 300% FPL, but it has not been implemented. The state's separate CHIP program covers unborn children only.

19 Rhode Island covers pregnant women up to 185% FPL under Medicaid and from 186% through 250% FPL under CHIP through the Title XXI State plan to targeted low-income pregnant women.

20 TennCare covers children as a Medicaid expansion group with Title XXI funding, called TennCare Standard, but this Section 1115 demonstration program is currently capped except for children who "rollover" from traditional Medicaid. This includes children with a family income above Medicaid income levels but at or below 200% FPL who are losing TennCare Medicaid eligibility, and children with a family income above 200% FPL but where the child is medically eligible (i.e., uninsurable) to receive TennCare Standard. In January 2007, Tennessee established a separate CHIP program, CoverKids, for children (unborn through age 18) in families with income up to 250% FPL.

21 Vermont's separate CHIP program covers uninsured children between 225% and 300% FPL. Children in this income range who are ineligible under the state's Medicaid Section 1115 waiver are covered under CHIP.

22 Virginia covers pregnant women up to 133% FPL under Medicaid and from 134% through 200% FPL under CHIP through a Title XXI funded Section 1115 wavier.

23 In Wisconsin, children ages 6 through 18 with incomes above 100% through 150% FPL may be enrolled in the Medicaid expansion CHIP program. The state covers unborn children and children from birth through age 18 to 300% FPL under its separate CHIP program.

Sources: MACPAC analysis of the following: CMS *Upper Income Thresholds for Pre-CHIP Medicaid and Children's Health Insurance Programs as of March 4, 2011*; CHIP Statistical Enrollment Data System (SEDS) as reported by states; and MACPAC communication with CMS

TABLE 10. Income Eligibility Levels as a Percentage of the Federal Poverty Level for Non-aged, Non-disabled, Non-pregnant Adults by State, March 2011

States are required to provide Medicaid coverage, at a minimum, at their 1996 Aid to Families with Dependent Children (AFDC) eligibility level. Parents and adults who are not disabled or pregnant may be eligible either through this Medicaid state plan pathway (under Section 1931 of the Social Security Act) or through a Section 1115 waiver. Other adults not otherwise eligible for Medicaid may qualify through a Section 1115 waiver or through a new eligibility pathway permitted under P.L. 111-148, as amended. Jobless and working individuals may qualify at different income levels due to disregards of certain amounts of earned income.

		Parents of Dependent Children				Other Adults	
		Jobless		Working		Jobless	Working
State	Minimum	1931 eligibility	1115 waiver	1931 eligibility	1115 waiver	1115 waiver unless noted otherwise	
Alabama	11%	11%	–	24%	–	–	–
Alaska	54	77	–	81	–	–	–
Arizona	23	100	–	106	–	100%	110%
Arkansas[2]	13	13	–	17	200%	–	200
California[3]	40	100	200%	106	200	200	200
Colorado[4]	28	100	–	106	–	–	–
Connecticut[5]	57	185	–	191	–	56[1]	73[1]
Delaware	22	75	100	120	106	100	110
District of Columbia[6]	28	200	–	207	–	133[1]/200	144[1]/211
Florida	20	20	–	59	–	–	–
Georgia	28	28	–	50	–	–	–
Hawaii[7]	41	100	200	100	200	200	200
Idaho[8]	21	21	–	39	185	–	185
Illinois	25	185	–	191	–	–	–
Indiana[9]	19	19	200	36	200	200 (closed)	200 (closed)
Iowa[10]	28	28	200	83	250	200	250
Kansas	26	26	–	32	–	–	–
Kentucky	34	36	–	62	–	–	–
Louisiana	11	11	–	25	–		–
Maine[11]	36	200	–	200	–	100 (closed)	100 (closed)
Maryland[12]	24	116	–	116	–	116	128
Massachusetts[13]	37	133	300	133	300	300	300
Michigan[14]	32	37	–	64	–	35 (closed)	45 (closed)
Minnesota[15]	35	100	275	121	275	75[1]	75[1]
Mississippi	24	24	–	44	–	–	–
Missouri	19	19	–	37	–	–	–

Table 10, Continued

State	Minimum	Parents of Dependent Children				Other Adults	
		Jobless		Working		Jobless	Working
		1931 eligibility	1115 waiver	1931 eligibility	1115 waiver	1115 waiver unless noted otherwise	
Montana	28%	32%	–	56%	–	–	–
Nebraska	24	47	–	58	–	–	–
Nevada[16]	23	25	–	88	200%	–	–
New Hampshire	36	39	–	49	–	–	–
New Jersey[17]	28	29	200% (closed)	133	200 (closed)	–	–
New Mexico[18]	25	29	200 (closed)	67	408 (closed)	200% (closed)	414% (closed)
New York[19]	46	69	150	75	150	100	100
North Carolina	36	36	–	49	–	–	–
North Dakota	28	34	–	59	–	–	–
Ohio	22	90	–	90	–	–	–
Oklahoma[20]	20	37	200	53	200	200	200
Oregon[21]	30	32	201	40	201	201	201
Pennsylvania	26	26	–	46	–	–	–
Rhode Island[22]	36	110	175	116	181	–	–
South Carolina	13	50	–	93	–	–	–
South Dakota	33	52	–	52	–	–	–
Tennessee[23]	38	70	–	127	–	–	–
Texas	12	12		26	–	–	–
Utah[24]	37	38	150 (closed)	44	150	150 (closed)	150
Vermont[25]	43	77	300	83	300	300	300
Virginia	23	25	–	31	–	–	–
Washington	36	37	–	74	–	–	–
West Virginia	17	17	–	33	–	–	–
Wisconsin[26]	34	200	–	200	–	200 (closed)	200 (closed)
Wyoming	24	39	–	52	–	–	–

Notes: The federal poverty level (100% FPL) in 2011 in the lower 48 states and the District of Columbia is $10,890 for an individual and $3,820 for each additional family member. For additional information, see MACStats Table 19. Reflects income eligibility levels at time of application. The table takes earning disregards, when applicable, into account when determining income thresholds for working adults. For parents, computations are based on a family of three with one earner; for other adults, computations are based on an individual. In some cases, earnings disregards may be time limited and only applied for the first few months of coverage; in these cases, eligibility limits for most enrollees would be lower than the levels that appear in this table. States may use additional disregards in determining eligibility. In some states, the income eligibility guidelines vary by region; in this situation, the income guideline in the most populous region is used. "Closed" indicates that the state was not enrolling new applicants at some point during 2010. In some instances, the state closed the program for the entire year, while in others the state allowed new applicants to enroll in the program as space and funding permitted. Section 1115 waiver coverage may inlcude both Medicaid and CHIP funding.

1 Not funded under a Section 1115 waiver, but through the new Medicaid state plan option that permits coverage of non-disabled, non-pregnant childless adults, as provided by the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148, as amended).

TABLE 10, Continued

2 In Arkansas, adults up to 200% FPL are eligible for more limited subsidized coverage under the ARHealthNetworks waiver program; individuals must have income below the eligibility threshold and work for a qualifying, participating employer.

3 California received approval for a waiver in 2010 that allows the state to continue and potentially expand county-based initiatives serving low-income adults.

4 Colorado expanded coverage to 100% FPL (from 60% FPL) to parents through a Section 1931 expansion on May 1, 2010.

5 Connecticut took up the new PPACA option to cover adults in 2010 and transferred adults from a previously state-funded program to Medicaid.

6 DC took up the new PPACA option and obtained a waiver to cover adults up to 200% FPL in 2010, transferring adults from a previously locally funded program to Medicaid. Adults up to 200% FPL who cannot qualify for Medicaid remain eligible for more limited coverage under the fully District-funded DC HealthCare Alliance program.

7 Hawaii covers adults up to 100% FPL under its QUEST Medicaid managed care waiver program; enrollment in QUEST is closed except for certain groups including individuals receiving Section 1931 Medicaid coverage or General Assistance or those below the old AFDC standards. Adults up to 200% FPL are eligible for more limited coverage under the QUEST-ACE waiver program. Further, adults previously enrolled in Medicaid with incomes between 200-300% FPL can purchase more limited QUEST-NET waiver coverage by paying a monthly premium.

8 Idaho provides premium assistance to adults up to 185% FPL under a waiver; individuals must have income below the eligibility threshold and work for a qualified small employer.

9 In Indiana, adults up to 200% FPL are eligible for limited coverage that resembles a Health Savings Account under the Healthy Indiana waiver program. Enrollment is closed for childless adults.

10 In Iowa, adults up to 250% FPL are eligible for more limited coverage under the IowaCare waiver program.

11 In Maine, childless adults up to 100% FPL are eligible for more limited coverage under the MaineCare waiver program; enrollment is closed.

12 In Maryland, childless adults are eligible for primary care services under the Primary Adult Care waiver program.

13 In Massachusetts, childless adults who are long-term unemployed or a client of the Department of Mental Health with income below 100% FPL can receive more limited benefits under the MassHealth waiver program through MassHealth Basic or Essential. Additionally, adults up to 300% FPL are eligible for more limited subsidized coverage under the Commonwealth Care waiver program.

14 In Michigan, childless adults are eligible for more limited coverage under the Adult Benefit Waiver program; enrollment is closed.

15 In Minnesota, parents up to 275% FPL are eligible for coverage under the MinnesotaCare waiver program. Parents above 215% FPL receive more limited coverage.

16 Nevada provides premium assistance to parents up to 200% FPL under its Check Up Plus waiver program; parents must have income below the eligibility threshold and work for a qualified small business.

17 In New Jersey, parents up to 200% FPL are covered under the FamilyCare waiver program. Waiver enrollment closed in 2010 for parents who do not qualify for Medicaid using an enhanced income disregard.

18 In New Mexico, adults up to 200% FPL are eligible for more limited subsidized coverage under the State Coverage Insurance waiver program. Individuals must have income below the eligibility threshold and work for a participating employer. If they do not work for a participating employer, they can obtain coverage by paying both the employer and employee share of premium costs. Enrollment is closed.

19 In New York, childless adults up to 78% FPL are eligible for the Medicaid (Home Relief) waiver program. Parents up to 150% FPL and childless adults up to 100% FPL are eligible for the Family Health Plus waiver program.

20 In Oklahoma, adults up to 200% FPL are eligible for more limited subsidized coverage under the Insure Oklahoma waiver program. Individuals must have income below the eligibility threshold and also work for a small employer, be self-employed, be unemployed and seeking work, be working disabled, be a full-time college student, or be the spouse of a qualified worker.

21 In Oregon, adults up to 100% FPL are eligible for more limited coverage under the OHP Standard waiver program; enrollment in OHP Standard is closed. The state provides premium assistance to adults up to 201% FPL under its Family Health Insurance Assistance Program waiver program. Income eligibility increased from 185% to 201% effective January 1, 2010. FHIAP is open to open for both individual and employer sponsored insurance, however, the state is only enrolling individuals from the reservation list.

22 In Rhode Island, jobless parents up to 175% FPL are covered under the RIteCare and RIteShare waiver programs.

23 In Tennessee, adults earning up to $55,000 per year are eligible for more limited subsidized coverage under the state-funded CoverTN program. Individuals must have income below the eligibility threshold and be a worker of a qualified business, self-employed, or recently unemployed. To qualify as a business, at least 50% of employees must earn $55,000 or less per year. Once a business qualifies, all eligible employees, regardless of income, may enroll. Enrollment is closed.

24 In Utah, adults up to 150% FPL are eligible for coverage of primary care services under the Primary Care Network waiver program; enrollment is closed. The state also provides premium assistance for employer-sponsored coverage to working adults up to 150% FPL under the Utah Premium Partnership Health Insurance waiver program.

25 In Vermont, 1931 coverage is available up to 77% FPL in urban areas and 73% FPL in rural areas; parents up to 185% FPL and childless adults up to 150% FPL are eligible for the Vermont Health Access Plan waiver program. Additionally, the state offers more limited subsidized coverage to adults up to 300% FPL under its Catamount Health waiver program.

26 In Wisconsin, parents up to 200% FPL are eligible for the BadgerCare Plus waiver program. Childless adults up to 200% FPL are eligible for more limited coverage under the BadgerCare Plus Core Plan waiver program. Enrollment for childless adults is closed.

Source: Georgetown University Center for Children and Families for Kaiser Commission on Medicaid and the Uninsured, *Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults*, February 2011, and MACPAC communication with the authors

TABLE 11. Medicaid Income Eligibility Levels as a Percentage of the Federal Poverty Level for Aged and Disabled Individuals by State, 2010

In most states, enrollment in the Supplemental Security Income (SSI) program for individuals age 65 and older and persons with disabilities automatically qualifies an individual for Medicaid. However, 11 "209(b)" states may use criteria that differ from SSI when determining Medicaid eligibility. In all states, additional people with low incomes or high medical expenses may be covered, at the state's option, through poverty level, medically needy, special income level, and other eligibility pathways.

State	State Eligibility Type[1]	SSI Recipients	209(b) Eligibility Levels	Poverty Level[2]	Medically Needy[3]	Special Income Level[4]
Alabama	1634	75%	–	–	–	224%
Alaska	SSI Criteria	60	–	–	–	147
Arizona	1634	75	–	100%	–	224
Arkansas	1634	75	–	80 Aged only	12%	224
California	1634	75	–	100	66	100
Colorado	1634	75	–	–	–	224
Connecticut	209(b)	–	63%	–	68	224
Delaware	1634	75	–	–	–	187
District of Columbia	1634	75	–	100	64	224
Florida	1634	75	–	88	20	224
Georgia	1634	75	–	–	35	224
Hawaii	209(b)	–	100	100	45	–
Idaho	SSI Criteria	75	–	–	–	224
Illinois	209(b)	–	100	100	100	–
Indiana	209(b)	–	75	–	–	224
Iowa	1634	75	–	–	54	224
Kansas	SSI Criteria	75	–	–	53	224
Kentucky	1634	75	–	–	24	224
Louisiana	1634	75	–	75	11	224
Maine	1634	75	–	100	58	224
Maryland	1634	75	–	–	39	224
Massachusetts	1634	75	–	100	58	224
Michigan	1634	75	–	100	45	224
Minnesota	209(b)	–	53	100	75	224
Mississippi	1634	75	–	–	–	224
Missouri	209(b)	–	85	85	–	131
Montana	1634	75	–	–	69	–
Nebraska	SSI Criteria	75	–	100	44	–

TABLE 11, Continued

State	State Eligibility Type[1]	SSI Recipients	209(b) Eligibility Levels	Poverty Level[2]	Medically Needy[3]	Special Income Level[4]
Nevada	SSI Criteria	75%	–	–	–	224%
New Hampshire	209(b)	–	76%	–	65%	224
New Jersey	1634	75	–	100%	41	224
New Mexico	1634	75	–	–	–	224
New York	1634	75	–	–	85	–
North Carolina	1634	75	–	100	27	–
North Dakota	209(b)	–	83	–	83	–
Ohio	209(b)	–	65	–	–	224
Oklahoma	209(b)	–	79	100	–	224
Oregon	SSI Criteria	75	–	–	–	224
Pennsylvania	1634	75	–	100	47	224
Rhode Island	1634	75	–	100	89	224
South Carolina	1634	75	–	100	–	224
South Dakota	1634	75	–	–	–	224
Tennessee	1634	75	–	–	–	224
Texas	1634	75	–	–	–	224
Utah	SSI Criteria	75	–	100	100	224
Vermont	1634	75	–	–	110	224
Virginia	209(b)	–	80	80	47	224
Washington	1634	75	–	–	75	224
West Virginia	1634	75	–	–	22	224
Wisconsin	1634	75	–	–	66	224
Wyoming	1634	75	–	–	–	224

Notes: In 2011, the federal poverty level (100% FPL) in the lower 48 states and the District of Columbia is $10,890 for an individual and $3,820 for each additional family member. For additional information, see MACStats Table 19. The income eligibility levels may refer to gross or net income depending on the state. The eligibility levels listed in this table are for individuals; the eligibility levels for couples differ for certain categories.

1 In 1634 states, individuals who qualify for Supplemental Security Income (SSI) are automatically eligible for Medicaid. SSI-criteria states, which use the same Medicaid eligibility criteria for their aged and disabled SSI enrollees as are used for the SSI program, require that these individuals apply to the state separately from their application for SSI to determine their Medicaid eligibility. 209(b) states use at least one eligibility criterion more restrictive than the SSI program and may not use more restrictive criteria than those in effect in the state on January 1, 1972; they must also allow individuals with higher incomes to "spend down" to the 209(b) income level shown here by incurring medical expenses.

2 Under the poverty level option, states may choose to provide Medicaid coverage to persons who are aged or disabled whose income is above the SSI or 209(b) level, but at or below the FPL.

3 Under the medically needy option, individuals with higher incomes can "spend down" to the medically needy income level shown here by incurring medical expenses. Some states have a medically needy income standard that varies by location. In these instances, the highest income standard is listed (Connecticut, Louisiana, Michigan, Vermont, and Virginia).

4 Under the special income level option, states have the option to provide Medicaid benefits to people who require at least 30 days of nursing home care up to 300% of the SSI benefit rate (which is 224% of the federal poverty level). The income standard listed in this column may be for institutional services, waiver services, or both.

Source: MACPAC analysis of information from the Centers for Medicare & Medicaid Services (CMS) as of July 2010 and state websites

TABLE 12. Optional Medicaid Benefits by State, August 2010

Although mandatory and optional Medicaid benefits are listed in federal statute, the breadth of coverage (i.e., amount, duration, and scope) varies by state. When designing a benefit, states may elect to place no limits on a benefit, or they may choose to limit a benefit by requiring prior approval of the service, restricting the place of service, or employing utilization controls or dollar caps. For example, while most states cover dental services and some even cover annual dental exams, others limit this benefit to trauma care and/or emergency treatment for pain relief and infection, require that services be provided in a specific setting (such as an emergency room), require that certain services be prior approved, or place dollar caps on the total amount of services an enrollee can receive each year. The result is that the same benefit can be designed and implemented in a number of different ways across states. While this table shows that a benefit is covered, benefit design and coverage of a service can vary greatly from state to state.

Medicaid mandatory benefits are the following:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) for individuals under age 21 (screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by a state)
- Family planning services and supplies
- Federally qualified health center services
- Freestanding birth center services
- Home health services
- Laboratory and X-ray services
- Nursing facility services (for ages 21 and over)
- Nurse midwife services
- Nurse practitioner services
- Rural heath clinic services
- Tobacco cessation counseling and pharmacotherapy for pregnant women
- Non-emergency transportation

The table on the following pages is based on the Social Security Act; Code of Federal Regulations; and CMS, *State Medicaid Benefits as of 8/13/2010.*

TABLE 12, Continued

Benefit	Number of States Providing Benefit	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	IA	KS
Intermediate Care Facility Services for the Mentally Retarded	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Targeted Case Management for Mental Health	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinic Services	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓
Nursing Facility Services (under age 21)	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓
Occupational Therapy	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Optometry Services	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical Therapy	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribed Drugs	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Targeted Case Management	50	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prosthetic Devices	49	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Speech and Language Therapy	49	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospice Care Services	48	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient Psychiatric Services (under age 21)	48	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental Services	46	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Eyeglasses	45	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓
Podiatry Services	45	✓	–	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–
Speech, Hearing and Language Therapy	45	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Audiology Services	43	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓
Inpatient Services in Institutions for Mental Disease (age 65+)	42	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	–	✓	✓	✓	✓	✓
Psychologist Services	42	✓	✓	✓	✓	✓	✓	✓	–	–	✓	✓	✓	✓	–	✓	✓	✓
Emergency Hospital Services	40	–	–	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	–	✓
Dentures	37	✓	✓	–	✓	✓	–	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	–
Preventive Services	37	✓	✓	✓	–	✓	–	✓	–	✓	✓	✓	✓	✓	✓	✓	–	–
Personal Care Services	35	✓	✓	–	✓	✓	–	–	–	✓	✓	–	–	✓	–	–	–	–
Private Duty Nursing Services	33	✓	–	✓	✓	–	✓	–	✓	✓	✓	✓	–	✓	–	✓	–	–
Rehabilitation Services	33	–	✓	✓	–	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	–	–
Diagnostic Services	32	✓	✓	✓	–	–	–	✓	✓	✓	✓	✓	✓	–	✓	✓	–	–
Nurse Anesthetist Services	32	✓	✓	✓	✓	✓	✓	–	–	–	✓	✓	–	–	–	✓	✓	✓
Program of All-Inclusive Care for the Elderly (PACE)	31	–	–	–	✓	✓	✓	–	–	–	✓	–	✓	–	✓	–	✓	✓
Targeted Case Management for Developmental Disabilities	31	✓	–	✓	✓	✓	✓	–	–	–	✓	✓	✓	✓	–	✓	✓	–
Screening Services	30	✓	✓	✓	–	–	–	✓	–	✓	✓	✓	✓	✓	✓	✓	–	–
Chiropractic Services	29	✓	–	–	✓	✓	–	✓	–	–	✓	–	–	✓	✓	✓	✓	–
Critical Access Hospital Services	22	–	✓	✓	✓	–	–	–	–	–	–	✓	✓	–	–	✓	–	–
Respiratory Care (Ventilator) Services	22	✓	✓	✓	✓	–	–	–	–	✓	✓	✓	✓	–	✓	–	–	–
Targeted Case Management for Mental Retardation	18	✓	–	–	–	–	–	✓	–	–	✓	✓	–	–	–	–	–	✓
Primary Care Case Management	14	–	–	–	–	–	✓	–	–	–	–	✓	–	✓	–	–	–	–
Targeted Case Management for HIV/AIDS	14	✓	–	–	–	–	–	–	–	–	–	✓	–	–	–	✓	–	–
Services from Religious Non-Medical Institutions	13	✓	–	✓	–	–	–	–	–	–	–	–	–	–	✓	✓	–	–
Services Related to Tuberculosis	13	–	–	–	–	✓	–	–	–	✓	–	✓	–	–	–	–	–	–
Targeted Case Management for Physical Disabilities	12	✓	–	–	–	✓	–	–	–	–	✓	✓	–	–	–	–	✓	✓
Targeted Case Management for the Medically Fragile	9	–	–	–	–	–	–	–	–	–	✓	✓	✓	–	–	–	–	–
Home and Community Based Services	4	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	✓	–
Targeted Case Management for Traumatic Brain Injury	4	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	✓
Targeted Case Management for Autism	3	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	
Sickle Cell Disease Services	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓
Targeted Case Management for Acquired Brain Injury	2	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–	–
Targeted Case Management for the Technology Dependent	1	✓	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 12, Continued

Benefit	Number of States Providing Benefit	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT	NE	NV	NH	NJ	NM	NY	NC
Intermediate Care Facility Services for the Mentally Retarded	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Targeted Case Management for Mental Health	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinic Services	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nursing Facility Services (under age 21)	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Occupational Therapy	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Optometry Services	50	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical Therapy	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribed Drugs	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Targeted Case Management	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prosthetic Devices	49	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Speech and Language Therapy	49	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospice Care Services	48	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓
Inpatient Psychiatric Services (under age 21)	48	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓
Dental Services	46	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Eyeglasses	45	✓	–	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Podiatry Services	45	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓
Speech, Hearing and Language Therapy	45	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓
Audiology Services	43	–	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient Services in Institutions for Mental Disease (age 65+)	42	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	–	✓	✓
Psychologist Services	42	–	–	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emergency Hospital Services	40	✓	–	–	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	–
Dentures	37	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	–	✓	✓	✓	✓
Preventive Services	37	✓	–	✓	–	✓	–	✓	✓	–	✓	–	✓	✓	✓	–	✓	✓
Personal Care Services	35	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓
Private Duty Nursing Services	33	✓	–	✓	✓	✓	–	✓	✓	–	✓	✓	✓	✓	–	–	✓	✓
Rehabilitation Services	33	–	✓	✓	✓	✓	✓	✓	✓	✓	–	–	–	✓	✓	✓	✓	✓
Diagnostic Services	32	✓	–	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	–	✓	✓
Nurse Anesthetist Services	32	✓	✓	–	✓	–	✓	✓	✓	–	✓	✓	–	✓	–	✓	–	✓
Program of All-Inclusive Care for the Elderly (PACE)	31	–	✓	–	✓	✓	✓	–	–	✓	✓	–	–	–	✓	✓	✓	✓
Targeted Case Management for Developmental Disabilities	31	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	–	✓	–	✓	–	–
Screening Services	30	✓	–	✓	–	✓	–	✓	✓	–	✓	✓	✓	✓	✓	–	✓	✓
Chiropractic Services	29	✓	–	✓	–	✓	–	✓	✓	–	–	✓	–	–	✓	–	✓	✓
Critical Access Hospital Services	22	–	–	✓	–	–	–	✓	–	–	✓	✓	✓	–	–	–	✓	–
Respiratory Care (Ventilator) Services	22	✓	–	–	✓	–	✓	–	–	–	–	✓	✓	–	–	–	–	✓
Targeted Case Management for Mental Retardation	18	–	✓	–	–	✓	–	✓	–	–	–	–	✓	–	–	–	✓	–
Primary Care Case Management	14	–	–	–	–	✓	–	–	–	–	–	–	✓	–	–	–	✓	✓
Targeted Case Management for HIV/AIDS	14	–	✓	✓	✓	✓	–	–	–	–	–	–	–	–	–	–	✓	✓
Services from Religious Non-Medical Institutions	13	–	–	–	–	–	✓	✓	–	–	–	–	–	–	✓	–	–	–
Services Related to Tuberculosis	13	–	✓	–	✓	–	–	✓	–	–	–	–	–	–	–	–	✓	✓
Targeted Case Management for Physical Disabilities	12	–	–	–	–	✓	✓	–	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for the Medically Fragile	9	✓	✓	–	–	–	–	–	–	–	–	–	–	✓	✓	–	–	–
Home and Community Based Services	4	–	–	–	–	–	–	–	–	–	–	–	✓	–	–	–	–	–
Targeted Case Management for Traumatic Brain Injury	4	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓	–	–
Targeted Case Management for Autism	3	–	–	–	✓	–	–	–	–	–	–	–	–	–	–	–	–	–
Sickle Cell Disease Services	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for Acquired Brain Injury	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓
Targeted Case Management for the Technology Dependent	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

TABLE 12, Continued

Benefit	Number of States Providing Benefit	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY
Intermediate Care Facility Services for the Mentally Retarded	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Targeted Case Management for Mental Health	51	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinic Services	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nursing Facility Services (under age 21)	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Occupational Therapy	50	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Optometry Services	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical Therapy	50	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescribed Drugs	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓
Targeted Case Management	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prosthetic Devices	49	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓
Speech and Language Therapy	49	✓	✓	–	✓	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓
Hospice Care Services	48	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient Psychiatric Services (under age 21)	48	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–
Dental Services	46	✓	✓	✓	✓	✓	✓	✓	✓	–	–	✓	–	✓	✓	✓	✓	✓
Eyeglasses	45	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	✓	–
Podiatry Services	45	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	–
Speech, Hearing and Language Therapy	45	✓	✓	–	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓
Audiology Services	43	✓	✓	–	✓	✓	✓	–	✓	✓	–	✓	–	✓	✓	✓	✓	–
Inpatient Services in Institutions for Mental Disease (age 65+)	42	✓	✓	✓	✓	–	✓	–	–	✓	✓	✓	✓	✓	✓	–	✓	✓
Psychologist Services	42	✓	✓	✓	✓	–	–	✓	✓	–	✓	✓	✓	✓	✓	✓	✓	✓
Emergency Hospital Services	40	✓	✓	–	✓	✓	–	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓
Dentures	37	✓	✓	–	✓	✓	✓	–	✓	–	–	✓	–	–	✓	✓	✓	–
Preventive Services	37	✓	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	✓	–
Personal Care Services	35	✓	✓	✓	✓	✓	✓	–	✓	–	✓	✓	–	–	✓	✓	✓	–
Private Duty Nursing Services	33	✓	✓	–	✓	✓	–	✓	–	–	✓	✓	✓	–	✓	✓	✓	–
Rehabilitation Services	33	–	✓	–	–	–	–	✓	–	–	✓	–	✓	✓	✓	✓	✓	✓
Diagnostic Services	32	✓	–	–	–	✓	✓	–	–	–	–	✓	✓	✓	–	–	✓	–
Nurse Anesthetist Services	32	✓	✓	✓	✓	–	–	✓	–	✓	✓	–	–	✓	✓	–	–	✓
Program of All-Inclusive Care for the Elderly (PACE)	31	✓	✓	✓	✓	✓	✓	✓	–	✓	✓	–	✓	✓	✓	–	✓	–
Targeted Case Management for Developmental Disabilities	31	–	✓	✓	✓	–	✓	–	–	–	✓	–	✓	✓	–	✓	✓	–
Screening Services	30	✓	✓	✓	–	✓	–	–	–	–	–	✓	–	✓	–	–	✓	–
Chiropractic Services	29	✓	✓	–	✓	✓	–	✓	✓	–	✓	✓	✓	–	–	✓	✓	–
Critical Access Hospital Services	22	✓	–	✓	✓	✓	–	–	✓	–	–	✓	–	–	✓	✓	✓	✓
Respiratory Care (Ventilator) Services	22	–	✓	–	–	✓	–	–	–	✓	✓	–	–	–	✓	✓	✓	–
Targeted Case Management for Mental Retardation	18	–	✓	✓	–	✓	–	✓	–	–	✓	–	✓	✓	–	✓	–	–
Primary Care Case Management	14	–	–	–	✓	✓	✓	✓	✓	–	✓	–	–	✓	–	–	–	–
Targeted Case Management for HIV/AIDS	14	–	–	–	✓	✓	✓	–	–	–	–	–	–	–	✓	–	✓	–
Services from Religious Non-Medical Institutions	13	–	–	–	✓	✓	–	–	–	✓	✓	–	–	✓	–	–	–	✓
Services Related to Tuberculosis	13	–	–	✓	–	–	–	–	–	–	✓	✓	–	–	–	–	✓	✓
Targeted Case Management for Physical Disabilities	12	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	✓	✓	–
Targeted Case Management for the Medically Fragile	9	–	–	–	–	–	–	–	–	–	–	–	–	–	–	✓	✓	–
Home and Community Based Services	4	–	–	–	–	–	–	–	–	–	–	–	–	–	✓	–	–	–
Targeted Case Management for Traumatic Brain Injury	4	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for Autism	3	–	–	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–
Sickle Cell Disease Services	2	–	✓	–	–	–	–	✓	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for Acquired Brain Injury	2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Targeted Case Management for the Technology Dependent	1	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

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TABLE 13. Maximum Allowable Medicaid Premiums and Cost-Sharing, FY 2011

	At or Below 100% FPL	From 100% through 150% FPL	Above 150% FPL
Exempt Populations	Exempt populations for most types of cost-sharing include children under age 18, pregnant women, beneficiaries receiving hospice care, beneficiaries in nursing facilities and intermediate care facilities for the mentally retarded, certain enrollees in hospitals and other medical institutions, and American Indians who are furnished a Medicaid item or service through an Indian provider or through a contract health service referral.		
Exempt Services	Emergency services and family planning services and supplies are excluded from cost-sharing.		
Cap for Alternative Cost-Sharing	Alternative cost-sharing not permitted. Nominal amounts always apply.	When a state imposes alternative cost-sharing above nominal amounts, the total amount of premiums and cost-sharing may not exceed 5% of a family's monthly or quarterly income.	
Premium	Not permitted	Not permitted	Up to $19 a month, depending on income level and family size. States may charge higher alternative premiums (subject to 5% cap).
Non-Institutional Services	Deductible: Up to $2.50 Copayment: Up to $3.65	Deductible: Up to $2.50 Copayment: Up to 10% of the payment made by the Medicaid agency for the service	Deductible: Up to $2.50 Copayment: Up to 20% of the payment made by the Medicaid agency for the service
Institutional Services	Per admission, the maximum deductible, coinsurance, or copayment charge may not exceed 50% of the payment made by the Medicaid agency for the first day of care.	Per admission, the maximum deductible, coinsurance, or copayment charge may not exceed 50% of the payment made by the Medicaid agency for the first day of care or 10% of the cost of the item or service.	Per admission, the maximum deductible, coinsurance, or copayment charge may not exceed 50% of the payment made by the Medicaid agency for the first day of care or 20% of the cost of the item or service.
Non-Emergency Care Provided in ER	Up to $3.65	Up to $7.30	No limit (subject to 5% cap)
Prescribed Drugs	Preferred and non-preferred copayment: Up to $3.65	Preferred and non-preferred copayment: Up to $3.65	Preferred copayment: Up to $3.65 Non-preferred copayment: Up to 20% of the cost of the drug

Notes: In 2011, the federal poverty level (100% FPL) in the lower 48 states and the District of Columbia is $10,890 for an individual and $3,820 for each additional family member. For additional information, see MACStats Table 19. This table contains fiscal year 2011 numbers, where "nominal" is defined as being up to $2.50 for a monthly deductible or up to $3.65 for a copayment. The table does not reflect amounts that states may have implemented under a Section 1115 waiver.

As first authorized in the Deficit Reduction Act of 2005 (P.L. 109-171), alternative cost-sharing allows states to target cost-sharing above nominal levels to specific groups of enrollees, provided their family income is above 100% FPL.

Sources: Sections 1916 and 1916A of the Social Security Act; 42 CFR Part 447; MACPAC communication with Centers for Medicare & Medicaid Services (CMS)

TABLE 14. Federal Medical Assistance Percentages (FMAPs) and Enhanced FMAPs (E-FMAPs) by State, FY 2011

State	FMAPs for Medicaid		Enhanced FMAPs for CHIP
	First quarter of FY 2011 (includes temporary increase)	Fourth quarter of FY 2011 (regular formula level)	FY 2011
Alabama	78.00%	68.54 %	77.98%
Alaska	62.46	50.00	65.00
Arizona	75.93	65.85	76.10
Arkansas	81.18	71.37	79.96
California	61.59	50.00	65.00
Colorado	61.59	50.00	65.00
Connecticut	61.59	50.00	65.00
Delaware	64.38	53.15	67.21
District of Columbia	79.29	70.00	79.00
Florida	67.64	55.45	68.82
Georgia	75.16	65.33	75.73
Hawaii	67.35	51.79	66.25
Idaho	79.18	68.85	78.20
Illinois	61.88	50.20	65.14
Indiana	76.21	66.52	76.56
Iowa	72.55	62.63	73.84
Kansas	69.68	59.05	71.34
Kentucky	80.61	71.49	80.04
Louisiana	81.48	63.61	74.53
Maine	74.86	63.80	74.66
Maryland	61.59	50.00	65.00
Massachusetts	61.59	50.00	65.00
Michigan	75.57	65.79	76.05
Minnesota	61.59	50.00	65.00
Mississippi	84.86	74.73	82.31
Missouri	74.43	63.29	74.30
Montana	77.99	66.81	76.77
Nebraska	68.76	58.44	70.91
Nevada	63.93	51.61	66.13
New Hampshire	61.59	50.00	65.00
New Jersey	61.59	50.00	65.00
New Mexico	80.49	69.78	78.85
New York	61.59	50.00	65.00

TABLE 14, Continued

State	FMAPs for Medicaid: First quarter of FY 2011 (includes temporary increase)	FMAPs for Medicaid: Fourth quarter of FY 2011 (regular formula level)	Enhanced FMAPs for CHIP: FY 2011
North Carolina	74.98%	64.71%	75.30%
North Dakota	69.95	60.35	72.25
Ohio	73.71	63.69	74.58
Oklahoma	76.73	64.94	75.46
Oregon	72.97	62.85	74.00
Pennsylvania	66.58	55.64	68.95
Rhode Island	64.22	52.97	67.08
South Carolina	79.58	70.04	79.03
South Dakota	70.80	61.25	72.88
Tennessee	75.62	65.85	76.10
Texas	70.94	60.56	72.39
Utah	80.78	71.13	79.79
Vermont	69.96	58.71	71.10
Virginia	61.59	50.00	65.00
Washington	62.94	50.00	65.00
West Virginia	83.05	73.24	81.27
Wisconsin	70.63	60.16	72.11
Wyoming	61.59	50.00	65.00
American Samoa	50.00	55.00	65.00 first two quarters / 68.50 thereafter
Guam	50.00	55.00	65.00 first two quarters / 68.50 thereafter
Northern Mariana Islands	50.00	55.00	65.00 first two quarters / 68.50 thereafter
Puerto Rico	50.00	55.00	65.00 first two quarters / 68.50 thereafter
Virgin Islands	50.00	55.00	65.00 first two quarters / 68.50 thereafter

Notes: The federal government's share of most Medicaid service costs is determined by the FMAP, with some exceptions. For Medicaid administrative costs, the federal share does not vary by state and is generally 50%. The enhanced FMAP determines the federal share of both service and administrative costs for CHIP, subject to the availability of funds from a state's federal allotments for CHIP.

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

FMAP = 1 - (State per capita income^2 / U.S. per capita income^2 * 0.45)

Exceptions include the District of Columbia (set in statue at 70%) and the territories (set in statute at 50% until the third quarter of FY 2011, when they will increase to 55% under section 2005(c) of P.L. 111-148, as amended). Other exceptions apply to certain services, providers, or situations (e.g., services provided through an Indian Health Service facility receive an FMAP of 100%). Enhanced FMAPs are calculated by reducing the state share under regular FMAPs by 30%. States are currently receiving a temporary FMAP increase that was included in P.L. 111-5 and later extended by P.L. 111-226. It runs for 11 quarters, from the first quarter of FY 2009 through the third quarter of FY 2011, subject to certain requirements. FMAPs for the second and third quarters of FY 2011(ending June 30, 2011) have not yet been published, but will phase down from their first quarter levels and return to their regular formula levels in the fourth quarter.

Source: Federal Register notices from the Department of Health and Human Services and section 2005(c) of P.L. 111-148, as amended

TABLE 15. Medicaid as a Share of States' Total Budgets and State-Funded Budgets, State FY 2009

State	Total Budget (Including State and Federal Funds)				State-funded Budget			
		Total Spending as a Share of Total Budget				State-funded Spending as a Share of State-funded Budget		
	Dollars (billions)	Medicaid	Elementary and secondary education	Higher education	Dollars (billions)	Medicaid	Elementary and secondary education	Higher education
Alabama	$19.760	25.5%	25.0%	20.7%	$12.929	14.2%	31.6%	24.3%
Alaska	13.524	7.5	10.0	7.5	10.482	3.2	11.0	7.4
Arizona	27.080	29.4	23.9	11.7	16.840	11.9	32.7	15.6
Arkansas	18.193	19.7	17.7	16.8	12.768	7.5	21.3	23.8
California	195.476	20.6	23.6	7.7	122.386	10.0	29.6	7.9
Colorado	28.806	14.1	25.7	14.9	22.359	8.4	30.7	16.2
Connecticut	25.799	20.9	14.6	10.8	23.472	22.9	14.1	10.8
Delaware	8.741	12.3	23.7	4.1	7.485	7.2	25.7	4.4
District of Columbia	NA	NA	NA	NA	NA	NA	NA	NA
Florida	60.674	26.2	19.5	9.3	40.849	15.2	22.7	13.5
Georgia	38.970	19.5	24.2	14.9	27.493	8.1	27.8	21.0
Hawaii	11.822	11.3	21.3	11.1	9.903	4.5	23.4	13.0
Idaho	6.314	22.8	27.4	8.2	4.010	10.7	37.7	12.8
Illinois	46.469	30.9	23.9	6.3	33.216	20.4	27.1	8.1
Indiana	25.719	21.8	28.1	7.3	16.659	9.7	34.5	11.2
Iowa	17.477	17.9	17.6	25.6	11.446	10.9	23.2	34.7
Kansas	13.960	17.4	26.4	16.6	10.165	8.9	32.1	18.7
Kentucky	24.057	22.9	19.7	23.7	15.824	8.6	25.5	31.5
Louisiana	25.654	24.0	18.9	10.6	14.703	9.4	25.8	17.5
Maine	8.092	29.9	17.6	3.5	5.314	12.8	22.7	5.2
Maryland	31.797	19.5	20.3	14.7	24.038	11.0	23.1	18.4
Massachusetts	48.993	17.7	13.0	9.3	45.588	19.0	11.2	9.9
Michigan	45.759	23.0	28.9	4.9	29.249	10.9	37.8	7.0
Minnesota	29.897	22.2	25.5	10.4	22.334	13.6	31.3	13.8
Mississippi	16.328	26.4	19.0	16.6	9.616	10.9	25.6	25.6
Missouri	23.094	32.4	22.6	5.6	16.809	24.3	25.8	7.7
Montana	5.526	15.2	15.8	9.9	3.699	5.4	19.7	13.6
Nebraska	9.139	17.6	15.1	22.7	6.573	9.1	16.9	28.7
Nevada	9.039	14.7	20.6	9.6	6.767	7.0	23.9	12.8
New Hampshire	4.978	26.5	22.4	5.2	3.296	18.6	28.7	7.4

TABLE 15, Continued

State	Total Budget (Including State and Federal Funds)				State-funded Budget			
		Total Spending as a Share of Total Budget				State-funded Spending as a Share of State-funded Budget		
	Dollars (billions)	Medicaid	Elementary and secondary education	Higher education	Dollars (billions)	Medicaid	Elementary and secondary education	Higher education
New Jersey	$46.677	20.7%	24.1%	8.4%	$35.889	12.1%	29.1%	10.8%
New Mexico	15.505	20.5	19.6	17.5	10.559	7.2	24.1	21.3
New York	121.571	26.7	21.5	7.0	83.146	13.4	27.1	10.0
North Carolina	43.090	24.9	22.5	13.5	31.234	13.0	26.5	18.5
North Dakota	3.941	14.1	14.0	22.7	2.579	6.6	16.6	29.6
Ohio	57.794	24.3	21.7	5.2	47.452	23.5	22.8	6.3
Oklahoma	21.430	18.5	15.4	16.5	11.578	11.6	22.2	26.8
Oregon	24.524	14.3	15.7	9.5	18.610	5.8	17.4	11.2
Pennsylvania	62.644	30.8	19.7	3.8	41.819	18.9	24.5	5.5
Rhode Island	7.101	25.8	14.9	3.3	4.830	15.1	17.6	4.8
South Carolina	21.074	23.0	17.0	21.0	13.696	8.9	20.6	27.8
South Dakota	3.546	21.7	16.7	19.0	2.150	11.1	18.3	26.6
Tennessee	29.118	25.4	17.0	12.8	18.086	15.9	22.2	19.0
Texas	89.965	7.5	31.0	11.4	58.863	4.0	39.7	17.2
Utah	11.795	14.6	25.5	11.3	8.832	5.8	27.8	14.7
Vermont	5.617	19.6	26.2	1.6	4.149	9.5	32.6	2.2
Virginia	40.024	15.2	18.0	16.3	32.946	8.8	19.3	17.1
Washington	33.714	21.4	24.6	13.3	25.568	14.0	28.3	17.5
West Virginia	20.447	11.9	10.6	8.7	16.623	3.3	11.0	9.4
Wisconsin	38.442	15.4	18.6	12.5	28.733	7.0	20.3	13.4
Wyoming	7.648	7.0	11.7	5.3	6.222	3.5	12.9	6.3
All states	**$1,546.804**	**21.1%**	**21.7%**	**10.4%**	**$1,089.836**	**12.2%**	**25.7%**	**13.3%**

Notes: Information for the District of Columbia was not collected by the National Association of State Budget Officers (NASBO). Total budget includes federal and all other funds. State-funded budget includes state general funds, other state funds, and bonds. Medicaid, elementary and secondary education, and higher education represent the largest total budget shares among functions broken out separately by NASBO. Functions not shown here are transportation, corrections, public assistance, and all other. Medicaid spending amounts exclude administrative costs and include Medicare Part D "clawback" payments. Total and state-funded budget shares should be viewed with caution because they reflect varying state practices. For example, Connecticut and Massachusetts report all of their Medicaid spending as state-funded spending; in Connecticut this is due to the direct deposit of federal funds into the State Treasury. In addition, some functions—particularly elementary and secondary education—may also be funded outside of the state budget by local governments.

Source: NASBO, *2009 State Expenditure Report*

TABLE 16. National Health Expenditures by Type and Payer, 2009

	DOLLARS (billions)							
Type of Expenditure	Total	Medicaid	CHIP	Medicare	Other public	Out of pocket	Private insurance	Other private
National health expenditures	$2,486.3	$373.9	$11.1	$502.3	$317.6	$299.3	$801.2	$180.8
Hospital	759.1	136.1	3.1	220.4	77.9	24.4	265.9	31.2
Physician and clinical	505.9	39.9	2.9	109.4	37.7	47.9	237.7	30.3
Dental	102.2	7.1	0.8	0.3	1.5	42.5	50.0	0.1
Other professional	66.8	4.5	0.2	13.7	2.1	17.7	24.7	3.9
Home health	68.3	24.3	0.0	29.8	2.1	6.0	5.0	1.0
Other non-durable medical products	43.3	0.0	0.0	2.8	0.0	40.5	0.0	0.0
Prescription drugs	249.9	20.0	1.5	54.8	12.0	53.0	108.6	0.0
Durable medical equipment	34.9	4.3	0.1	7.4	0.5	18.6	4.0	0.0
Nursing care facilities and continuing care retirement communities	137.0	45.0	0.0	28.0	6.8	39.8	10.5	6.8
Other health, residential, and personal care	122.6	64.4	0.9	4.6	22.9	8.9	5.8	15.0
Administration	163.0	28.3	1.6	31.0	13.1	0.0	89.0	0.0
Public health activity	77.2	0.0	0.0	0.0	77.2	0.0	0.0	0.0
Investment	156.2	0.0	0.0	0.0	63.6	0.0	0.0	92.6

TABLE 16, Continued

Type of Service	Total	SHARE OF TOTAL						
		Medicaid	CHIP	Medicare	Other public	Out of pocket	Private insurance	Other private
National health expenditures	100%	15.0%	0.4%	20.2%	12.8%	12.0%	32.2%	7.3%
Hospital	100	17.9	0.4	29.0	10.3	3.2	35.0	4.1
Physician and clinical	100	7.9	0.6	21.6	7.5	9.5	47.0	6.0
Dental	100	7.0	0.7	0.3	1.5	41.6	48.9	0.1
Other professional	100	6.8	0.3	20.5	3.1	26.6	37.0	5.8
Home health	100	35.6	0.0	43.7	3.1	8.8	7.4	1.4
Other non-durable medical products	100	0.0	0.0	6.5	0.0	93.5	0.0	0.0
Prescription drugs	100	8.0	0.6	21.9	4.8	21.2	43.4	0.0
Durable medical equipment	100	12.4	0.2	21.3	1.4	53.3	11.4	0.0
Nursing care facilities and continuing care retirement communities	100	32.8	0.0	20.4	5.0	29.1	7.7	5.0
Other health, residential, and personal care	100	52.5	0.8	3.7	18.7	7.3	4.7	12.3
Administration	100	17.3	1.0	19.0	8.0	0.0	54.6	0.0
Public health activity	100	0.0	0.0	0.0	100.0	0.0	0.0	0.0
Investment	100	0.0	0.0	0.0	40.7	0.0	0.0	59.3

Notes: Nursing care facilities and continuing retirement communities and other health, residential, and personal care reflect new data and methods as of 2011. In prior releases, Medicaid accounted for about 40% of nursing home expenditures and about three-quarters of other personal health care expenditures. Other professional covers services provided in establishments operated by health practitioners other than physicians and dentists, including those provided by private-duty nurses, chiropractors, podiatrists, optometrists, and physical, occupational and speech therapists, among others. Other non-durable medical products covers the "retail" sales of non-prescription drugs and medical sundries. Durable medical equipment covers "retail" sales of items such as contact lenses, eyeglasses and other ophthalmic products, surgical and orthopedic products, hearing aids, wheelchairs, and medical equipment rentals. Nursing care facilities and continuing care retirement communities covers nursing and rehabilitative services provided in freestanding nursing home facilities that are generally provided for an extended period of time by registered or licensed practical nurses and other staff. Other health, residential, and personal care includes spending for Medicaid home and community-based waivers, care provided in residential facilities for people with intellectual disabilities or mental health and substance abuse disorders, ambulance services, school health, and worksite health care.

Sources: Office of the Actuary (OACT), Centers for Medicare & Medicaid Services, as of January 2011 and OACT, *Quick Definitions for National Health Expenditure Accounts (NHEA) Categories*, 2011

TABLE 17. Historical and Projected National Health Expenditures by Payer for Selected Years, 1970–2019

	DOLLARS (billions)						
	Total	Medicaid and CHIP	Medicare	Other public	Out of pocket	Private insurance	Other private
Historical							
1970	$75	$5	$8	$15	$25	$15	$6
1975	134	13	16	26	37	30	10
1980	256	26	37	44	58	69	20
1985	444	41	72	68	96	131	37
1990	724	74	110	108	139	234	59
1995	1,027	145	184	142	146	327	82
2000	1,378	203	224	176	202	458	113
2001	1,495	229	247	195	209	501	114
2002	1,637	254	265	213	223	559	123
2003	1,772	276	282	231	237	612	133
2004	1,895	298	311	243	249	654	140
2005	2,021	317	340	253	264	697	150
2006	2,152	315	403	267	272	734	161
2007	2,283	336	431	282	289	764	181
2008	2,391	353	466	301	298	791	182
2009	2,486	385	502	318	299	801	181
Projected							
2010	2,600	427	534	323	288	845	182
2011	2,710	466	549	343	297	864	191
2012	2,852	501	586	359	309	895	201
2013	3,025	540	620	381	325	944	215
2014	3,302	634	656	401	322	1,065	224
2015	3,538	684	685	427	338	1,161	244
2016	3,796	737	723	458	354	1,258	266
2017	4,045	780	771	488	374	1,346	286
2018	4,298	836	828	520	410	1,398	306
2019	4,572	896	891	552	439	1,467	325

TABLE 17, Continued

	SHARE OF TOTAL						
	Total	Medicaid and CHIP	Medicare	Other public	Out of pocket	Private insurance	Other private
Historical							
1970	100%	7.1%	10.3%	20.1%	33.4%	20.6%	8.5%
1975	100	10.1	12.2	19.7	28.0	22.8	7.3
1980	100	10.2	14.6	17.4	22.8	27.0	8.0
1985	100	9.2	16.2	15.2	21.6	29.5	8.3
1990	100	10.2	15.2	15.0	19.2	32.3	8.2
1995	100	14.1	17.9	13.9	14.3	31.8	8.0
2000	100	14.8	16.3	12.8	14.7	33.2	8.2
2001	100	15.3	16.5	13.1	14.0	33.5	7.6
2002	100	15.5	16.2	13.0	13.6	34.2	7.5
2003	100	15.6	15.9	13.1	13.4	34.5	7.5
2004	100	15.7	16.4	12.8	13.1	34.5	7.4
2005	100	15.7	16.8	12.5	13.1	34.5	7.4
2006	100	14.7	18.7	12.4	12.6	34.1	7.5
2007	100	14.7	18.9	12.4	12.7	33.4	7.9
2008	100	14.8	19.5	12.6	12.5	33.1	7.6
2009	100	15.5	20.2	12.8	12.0	32.2	7.3
Projected							
2010	100	16.4	20.6	12.4	11.1	32.5	7.0
2011	100	17.2	20.3	12.7	11.0	31.9	7.0
2012	100	17.6	20.5	12.6	10.8	31.4	7.0
2013	100	17.9	20.5	12.6	10.8	31.2	7.1
2014	100	19.2	19.9	12.2	9.7	32.2	6.8
2015	100	19.3	19.3	12.1	9.5	32.8	6.9
2016	100	19.4	19.0	12.1	9.3	33.1	7.0
2017	100	19.3	19.1	12.1	9.3	33.3	7.1
2018	100	19.4	19.3	12.1	9.5	32.5	7.1
2019	100	19.6	19.5	12.1	9.6	32.1	7.1

Note: Historical data were released in 2011 and reflect changes in methods, definitions, and source data that were made to NHE estimates in a comprehensive revision; projections data were released in 2010 and have not yet been updated to reflect the comprehensive revision.

Sources: Office of the Actuary, Centers for Medicare & Medicaid Services, *National Health Expenditures by Type of Service and Source of Funds,* as of January 2011 for historical; *National Health Expenditure (NHE) Amounts by Type of Expenditure and Source of Funds*, as of September 2010 for projected

TABLE 18. Characteristics of Individuals by Source of Health Insurance, 2010

	ALL AGES					AGE 0-18				
	Total all ages	Private	Medicaid/ CHIP	Medicare	Uninsured	Total age 0-18	Private	Medicaid/ CHIP	Medicare	Uninsured
Health Insurance Coverage	**303.4 million**	**60.8%****	**15.1%**	**14.0%****	**16.2%**	**78.8 million**	**54.4%****	**34.4%**	**0.2%****	**8.8%****
Gender										
Male	**49.0%****	48.7%**	43.9%	43.1%	55.6%**	**51.2%**	51.0%	51.2%	52.7%	53.0%
Female	**51.0****	51.3**	56.1	56.9	44.4**	**48.8**	49.0	48.8	47.3	47.0
Family Income										
<100% of Poverty	**15.1****	3.9**	48.4	12.8**	27.2**	**21.9****	4.2**	48.6	55.6	29.8**
100 – 199% of Poverty	**18.7****	10.5**	31.7	22.7**	33.8	**22.9****	12.9**	34.0	40.2	38.8
200+% of Poverty	**66.2****	85.6**	20.0	64.5**	39.0**	**55.2****	82.8**	17.4	*	32.2**
Race/Ethnicity										
Hispanic	**16.0****	9.6**	28.7	7.1**	30.8	**22.6****	12.4**	35.0	27.4	36.3
White, Non-Hispanic	**64.6****	74.7**	42.0	78.7**	46.5**	**54.9****	69.9**	36.1	*	39.2
Black, Non-Hispanic	**12.2****	8.8**	22.6	9.9**	14.6**	**14.1****	9.1**	21.8	44.6	13.0**
Other races and multiple races	**7.0**	6.9	6.7	4.3**	8.2	**8.3**	8.5	7.1	*	11.5
Health Status										
Excellent/Very good	**66.0****	72.7**	58.1	38.8**	58.7	**82.3****	89.3**	72.2	44.9**	78.0**
Good	**24.1****	2.0**	26.4	33.4**	30.1**	**15.6****	9.9**	23.7	35.8	20.0
Fair/Poor	**9.9****	6.4**	15.5	27.7**	11.3**	**2.1****	0.8**	4.1	19.3	2.0**
Place of Residence										
Large MSA	**53.9**	55.8**	49.1	46.8	52.1	**53.7****	58.0**	47.6	68.4	50.6
Small MSA	**30.6**	29.9	31.3	32.9	31.3	**31.0**	28.4	32.8	31.6	33.2
Not in MSA	**15.4****	14.2**	19.6	20.3	16.6	**15.3****	13.6**	19.6	0.0	16.2

TABLE 18, Continued

	AGE 19-64					AGE 65 AND OVER				
	Total age 19-64	Private	Medicaid/ CHIP	Medicare	Uninsured	Total 65 and over	Private	Medicaid/ CHIP	Medicare	Uninsured
Health Insurance Coverage	**186.1 million**	**64.9%****	**8.5%**	**3.1%****	**22.5%****	**38.5 million**	**54.1%****	**7.8%**	**94.4%****	**1.0%****
Gender										
Male	**49.2%****	48.7%**	33.4%	45.5%**	56.2%**	**43.3%****	43.8%**	32.3%	42.7%**	45.2%
Female	**50.8****	51.3**	66.6	54.5**	43.8**	**56.7****	56.2**	67.7	56.7**	54.8
Family Income										
<100% of Poverty	**13.2****	3.7**	49.5	30.3**	26.8**	**9.6****	4.4**	39.9	9.5**	22.5**
100 – 199% of Poverty	**16.3****	8.7**	28.1	30.4	33.0**	**21.3****	16.1**	28.5	21.3**	33.8
200+% of Poverty	**70.5****	87.6**	22.5	39.3**	40.2**	**69.1****	79.5**	31.7	69.2**	43.7
Race/Ethnicity										
Hispanic	**15.2****	9.7**	19.7	9.2**	29.7**	**7.3****	3.3**	19.2	6.7**	43.1**
White, Non-Hispanic	**65.7****	74.1**	50.1	68.3**	47.8	**79.5****	87.9**	52.4	80.7**	30.2**
Black, Non-Hispanic	**12.2****	9.3**	24.3	18.7**	14.9**	**8.5****	5.5**	20.3	8.3**	9.6**
Other races and multiple races	**7.0**	6.9	5.9	3.9**	7.5	**4.6****	3.2**	8.1	4.3**	17.1
Health Status										
Excellent/Very good	**63.9****	71.2**	40.7	15.8**	55.6**	**42.5****	46.7**	20.7	42.4**	39.8**
Good	**25.7****	22.6**	30.5	29.6	31.7	**33.9**	34.0	30.2	34.0	30.6
Fair/Poor	**10.4****	6.1**	28.8	54.5**	12.6**	**23.6****	19.3**	49.1	23.6**	29.6**
Place of Residence										
Large MSA	**55.1**	57.2**	50.5	40.4**	52.3	**48.6**	43.6**	55.8	47.7**	66.0
Small MSA	**30.2**	29.6	29.5	34.9	31.0	**32.2**	34.9**	26.4	32.6	25.5
Not in MSA	**14.7****	13.2	20.0	24.7	16.7	**19.2**	21.5	17.8	19.7	*

Notes: Totals of health insurance coverage may add to more than 100% because individuals may have multiple sources of coverage. Not all types of coverage (e.g., military) are displayed. Private health insurance coverage excludes plans that paid for only one type of service, such as accidents or dental care. Medicaid/CHIP health insurance coverage also includes persons covered by other public programs, excluding Medicare (e.g., other state-sponsored health plans). A person was defined as uninsured if he/she did not have any private health insurance, Medicare, Medicaid/CHIP, state-sponsored or other government-sponsored health plans, or military plan. A person was also defined as uninsured if he/she had only Indian Health Service (IHS) coverage or had only a private plan that paid for one type of service, such as accidents or dental care. MSA is a metropolitan statistical area with a population size of 50,000 or more persons. Large MSAs have a population size of 1,000,000 or more; small MSAs have a population size between 50,000 and 1,000,000. Poverty status is based on family size and 2009 family income. In 2009, 100% of poverty using Census' poverty threshold was $17,098 for a family of three. The family income results exclude the 12% of respondents with unknown poverty status.

* Sample size is not sufficient to support published estimates.

** Difference from Medicaid/CHIP is statistically significant at the 95 percent confidence level.

Source: Analysis of National Health Interview Survey (NHIS) by the National Center for Health Statistics (NCHS) for MACPAC; the estimates for 2010 are based on data collected from January through June, based on household interviews of a sample of the civilian noninstitutionalized population

TABLE 19. Income as a Percentage of the Federal Poverty Level (FPL) for Various Family Sizes, 2011

ANNUAL

States		Family Size 1	2	3	4	Amount for each additional family member
Lower 48 states and DC	100% FPL	$10,890	$14,710	$18,530	$22,350	$3,820
	133% FPL	14,484	19,564	24,645	29,726	5,081
	150% FPL	16,335	22,065	27,795	33,525	5,730
	185% FPL	20,147	27,214	34,281	41,348	7,067
	200% FPL	21,780	29,420	37,060	44,700	7,640
	250% FPL	27,225	36,775	46,325	55,875	9,550
	300% FPL	32,670	44,130	55,590	67,050	11,460
	400% FPL	43,560	58,840	74,120	89,400	15,280
Alaska	100% FPL	$13,600	$18,380	$23,160	$27,940	$4,780
	133% FPL	18,088	24,445	30,803	37,160	6,357
	150% FPL	20,400	27,570	34,740	41,910	7,170
	185% FPL	25,160	34,003	42,846	51,689	8,843
	200% FPL	27,200	36,760	46,320	55,880	9,560
	250% FPL	34,000	45,950	57,900	69,850	11,950
	300% FPL	40,800	55,140	69,480	83,820	14,340
	400% FPL	54,400	73,520	92,640	111,760	19,120
Hawaii	100% FPL	$12,540	$16,930	$21,320	$25,710	$4,390
	133% FPL	16,678	22,517	28,356	34,194	5,839
	150% FPL	18,810	25,395	31,980	38,565	6,585
	185% FPL	23,199	31,321	39,442	47,564	8,122
	200% FPL	25,080	33,860	42,640	51,420	8,780
	250% FPL	31,350	42,325	53,300	64,275	10,975
	300% FPL	37,620	50,790	63,960	77,130	13,170
	400% FPL	50,160	67,720	85,280	102,840	17,560

MONTHLY

States		Family Size 1	2	3	4	Amount for each additional family member
Lower 48 states and DC	100% FPL	$908	$1,226	$1,544	$1,863	$318
	133% FPL	1,207	1,630	2,054	2,477	423
	150% FPL	1,361	1,839	2,316	2,794	478
	185% FPL	1,679	2,268	2,857	3,446	589
	200% FPL	1,815	2,452	3,088	3,725	637
	250% FPL	2,269	3,065	3,860	4,656	796
	300% FPL	2,723	3,678	4,633	5,588	955
	400% FPL	3,630	4,903	6,177	7,450	1,273
Alaska	100% FPL	$1,133	$1,532	$1,930	$2,328	$398
	133% FPL	1,507	2,037	2,567	3,097	530
	150% FPL	1,700	2,298	2,895	3,493	598
	185% FPL	2,097	2,834	3,571	4,307	737
	200% FPL	2,267	3,063	3,860	4,657	797
	250% FPL	2,833	3,829	4,825	5,821	996
	300% FPL	3,400	4,595	5,790	6,985	1,195
	400% FPL	4,533	6,127	7,720	9,313	1,593
Hawaii	100% FPL	$1,045	$1,411	$1,777	$2,143	$366
	133% FPL	1,390	1,876	2,363	2,850	487
	150% FPL	1,568	2,116	2,665	3,214	549
	185% FPL	1,933	2,610	3,287	3,964	677
	200% FPL	2,090	2,822	3,553	4,285	732
	250% FPL	2,613	3,527	4,442	5,356	915
	300% FPL	3,135	4,233	5,330	6,428	1,098
	400% FPL	4,180	5,643	7,107	8,570	1,463

Note: The federal poverty levels (FPLs) shown here are based on the Department of Health and Human Services (HHS) 2011 federal poverty guidelines, which differs slightly from the Census Bureau's federal poverty *thresholds*, which are used mainly for statistical purposes. According to HHS, the separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period.

Source: 2011 HHS Federal Poverty Guidelines

TABLE 20. Federal Legislative Milestones for Medicaid and CHIP

Year	Legislative Milestone and Highlighted Provisions
1965	Medicaid is enacted (P.L. 89-97) as Title XIX of the Social Security Act (SSA) to provide health coverage for certain groups of low-income people; establishes Medicaid as an individual entitlement with federal-state financing. Medicare also enacted as Title XVIII of the SSA. ▶ Establishes link between Medicaid eligibility and receipt of Aid to Families with Dependent Children (AFDC) for families with dependent children under age 18 considered deprived of parental support due to the death, continued absence, incapacity or unemployment of the principal family earner in a two-parent household ▶ Requires hospital payments to be based on "reasonable cost"
1967	Social Security Amendments of 1967 (P.L. 90-248) limit Medicaid eligibility to the ''medically needy,'' those with income below 133–1/3 percent of the AFDC maximum payment level for a given family size in a state. ▶ Requires states to "assure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." ▶ Establishes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under 21 ▶ Allows Medicaid beneficiaries to use Medicaid-participating providers of their choice
1971	Public Law 92-223 allows states to cover services in intermediate care facilities (ICFs), including for the mentally retarded (ICFs-MR).
1972	Social Security Amendments of 1972 (P.L. 92-603) repeal "maintenance of effort," allowing states to reduce expenditures from one year to the next. Supplemental Security Income (SSI) program is created to federalize cash assistance for the aged, blind, and permanently and totally disabled. SSI recipients are entitled to Medicaid coverage. ▶ Requires that payments to nursing facilities and intermediate care facilities be on a reasonable cost-related basis ▶ Requires that payments for inpatient hospital services do not exceed customary charges
1977	Departments of Labor and Health, Education, and Welfare Appropriations Act for FY 1977 (P.L. 94-439) enacts the Hyde Amendment, prohibiting federal Medicaid payments for abortions except when the life of the mother is endangered and in cases of rape and incest.
1980	Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) enacts the Boren Amendment to remove the requirement on Medicaid state plans to pay nursing facilities according to Medicare cost principles. ▶ Requires Medicaid payments to be "reasonable and adequate" to meet the costs of "efficiently and economically operated" facilities

TABLE 20, Continued

Year	Legislative Milestone and Highlighted Provisions
1981	Omnibus Budget Reconciliation Act of 1981 (P.L. 97–35) establishes two new types of Medicaid waivers to experiment with payment under the Medicaid program. ▶ Section 1915(b) freedom-of-choice waivers: Allows states to pursue mandatory managed care enrollment of certain Medicaid populations ▶ Section 1915(c) home and community-based services waivers: Allows states to cover home and community-based long-term care services for the elderly and individuals with disabilities at risk of institutional care ▶ Expands Boren-amendment requirements to hospitals, removing requirement on Medicaid state plans to pay according to Medicare cost principles ▶ Removes "reasonable charges" limitation that was added in 1980 ▶ Allows for additional payments to hospitals serving a disproportionate share of Medicaid and low-income patients (later known as disproportionate share hospitals (DSH))
1982	Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248) expands states' options for imposing cost-sharing requirements on Medicaid beneficiaries and services.
1984	Deficit Reduction Act of 1984 (P.L. 98–369) mandates Medicaid coverage of children born after September 30, 1983, up to age 5, in AFDC-eligible families. ▶ Mandates coverage for AFDC-eligible first-time pregnant women and pregnant women in two-parent unemployed families
1985	Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272) requires Medicaid coverage for all remaining AFDC-eligible pregnant women. ▶ Requires hospice payments to be in the same amounts and using the same methodology as Medicare and allowing for a separate room and board payment for hospice patients residing in nursing facilities or ICFs
1986	Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) requires states to cover treatment of emergency medical conditions for unauthorized immigrants otherwise eligible for Medicaid. ▶ Gives states the ability to cover pregnant women and infants (under 1 year of age) with income up to 100 percent of the federal poverty level (FPL) at their option
1987	Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) requires that payment methods for nursing facilities take into account the cost of complying with new quality requirements. ▶ Phases out the distinction between skilled nursing facilities (SNFs) and ICFs, upgrades quality-of-care requirements, and revises monitoring and enforcement ▶ Adds Section 1923 of the SSA, strengthening DSH requirements and outlining DSH payment methods ▶ Gives states the option of covering pregnant women and children under the age of 1 in families with income up to 185 percent FPL ▶ Allows states to cover children up to age 8 in families below 100 percent FPL

TABLE 20, Continued

Year	Legislative Milestone and Highlighted Provisions
1988	Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) requires states to phase in coverage for pregnant women and infants with incomes below 100 percent FPL. ▶ Establishes special eligibility rules for institutionalized persons whose spouse remains in the community to prevent "spousal impoverishment" ▶ Establishes the Qualified Medicare Beneficiary group (QMBs) requiring states to pay premiums, deductibles and cost-sharing for dual eligibles with incomes up to 100 percent FPL Family Support Act of 1988 (P.L. 100-485) requires states to extend 12 months transitional Medicaid coverage to families leaving AFDC rolls due to earnings from work. ▶ Requires states to cover two-parent unemployed families meeting AFDC income and resource (asset) standards
1989	Omnibus Budget Reconciliation Act of 1989 (OBRA, P.L. 101–239) requires states by April 1, 1990, to provide Medicaid coverage to pregnant women and to children up to age 6 in families with income up to 133 percent FPL (or, if higher, the income level the state had at enactment). ▶ Adds requirement to 1902(a)(30)(A) (previously established only by regulation) that payments be sufficient to attract enough providers to ensure that covered services will be as available to Medicaid beneficiaries as they are to the general population ▶ Establishes specific reporting requirements for payment rates for obstetrics and pediatrics, to allow the Secretary of the Department of Health and Human Services ("the Secretary") to determine the adequacy of state payments for these services ▶ Requires coverage and full reimbursement of "reasonable cost" of federally qualified health centers (FQHCs) ▶ Requires room and board payment for hospice patients residing in nursing facilities equal to 95 percent of the Medicare nursing facility rate ▶ Expands EPSDT benefit for children under 21 to include otherwise optional diagnostic and treatment services not covered under state Medicaid program for adult beneficiaries
1990	Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) requires states to phase in Medicaid coverage for all poor children under age 19 born after September 30, 1983, by the year 2002. ▶ Establishes the prescription drug rebate program requiring "best price" rebates to states and federal government ▶ Modifies the Boren Amendment to require that the cost of implementing 1987 nursing home quality reforms be taken into account ▶ Creates additional flexibility in design of DSH payment methods ▶ Establishes the Specified Low-income Medicare Beneficiary (SLMB) eligibility group, allowing states to pay Medicare Part B premiums for enrollees with incomes 120 percent to 135 percent FPL
1991	Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) restrict the use of provider donations and provider taxes as non-federal share. ▶ Prohibits HCFA from restricting intergovernmental transfers (IGTs) of state or local tax revenues ▶ Places national and state-specific ceilings on special payments to DSH hospitals

TABLE 20, Continued

Year	Legislative Milestone and Highlighted Provisions
1993	Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) places hospital-specific ceilings on DSH payments. ▶ Establishes standards for state use of formularies to limit prescription drug coverage ▶ Strengthens prohibitions against transferring assets with the purpose of qualifying for Medicaid nursing home coverage; requires recovery of nursing home payments from beneficiary estates ▶ Establishes Vaccines for Children (VFC) program to use federal Medicaid funds to pay for vaccines provided to public health clinics and enrolled private providers
1996	Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L.104–193) repeals the AFDC program and replaces it with block grants to states (Temporary Assistance for Needy Families, TANF), severing welfare link to Medicaid; enrollment/termination of Medicaid is no longer automatic with receipt/loss of welfare cash assistance. ▶ Establishes Section 1931 family coverage category, requiring states to extend Medicaid eligibility to families meeting July 16, 1996, AFDC eligibility criteria and allowing higher income eligibility thresholds ▶ Bars full-benefit Medicaid coverage for legal immigrants who enter the U.S. after August 22, 1996, and who have been in the country less than five years; coverage after the 5-year bar is allowed at state option
1997	Balanced Budget Act of 1997 (P.L. 105-33) permits states to require most Medicaid beneficiaries to enroll in managed care plans without obtaining a Section 1915(b) waiver. ▶ Requires Medicaid managed care payments to be actuarially sound ▶ Creates the State Children's Health Insurance Program (CHIP), providing federal matching funds to states to expand health insurance coverage for children above states' Medicaid eligibility levels ▶ Repeals OBRA 89 requirements for state reporting on obstetric and pediatric payments ▶ Repeals the Boren amendment, and instead requires state agencies to use a public process to determine payment rates for inpatient hospitals, nursing facilities, and ICF-MRs ▶ Begins phase-out of cost-based reimbursement for FQHCs and RHCs and adds supplemental payments for difference between Medicaid managed care and fee-for-service payments ▶ Limits state DSH allotments to 12 percent of their total annual Medicaid expenditures
1999	Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113) slows phase-out of cost-based reimbursement for FQHCs and RHCs. ▶ Increases DSH allotments for several states Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) allows states to cover working disabled individuals with incomes above 250 percent FPL and impose income-related premiums on such individuals.

TABLE 20, Continued

Year	Legislative Milestone and Highlighted Provisions
2000	Breast and Cervical Cancer Treatment and Prevention Act of 2000 (P.L. 106–354) allows states to provide Medicaid coverage to uninsured women who are screened by the Centers for Disease Control and Prevention early detection program and found needing treatment for breast or cervical cancer, regardless of income or resources, at enhanced CHIP federal matching rates. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (P.L. 106-554) directs the Secretary to issue regulations tightening upper payment limits (UPLs). ▶ Creates a new prospective payment system for FQHCs and RHCs and establishes a floor for payments based on 100 percent of the average cost of services provided ▶ Modifies DSH funding amounts
2003	Jobs and Growth Tax Relief Reconciliation Act of 2003 (P.L. 108-27) raises state-specific DSH allotments for FY 2004 for all states and through FY 2009 for low-DSH states.
2005	Deficit Reduction Act of 2005 (P.L. 109-171) permits states to use "benchmark" coverage for certain populations, instead of the regular Medicaid benefits package. ▶ Permits states to increase copayments for non-emergency services ▶ Increases penalties for assets transferred at less than fair market value to qualify for nursing home cares ▶ Changes the basis of the federal upper limit (FUL) for Medicaid payment of multiple source drugs from lowest published price to average manufacturer price (AMP), improving collection of rebates on physician administered
2009	Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) extends CHIP appropriations through 2013. ▶ Phases out coverage of parents by 2014 ▶ Establishes the Medicaid and CHIP Payment and Access Commission (MACPAC) to review state and federal Medicaid and CHIP access and payment policies and to make recommendations to the Congress, the Secretary, and the states on issues affecting Medicaid and CHIP populations ▶ Improves collection of rebates on physician-administered drugs ▶ Makes children's hospitals eligible for the 340B discount drug program requiring drug manufacturers to offer Medicaid the lowest price paid by any other purchaser of the drug American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) includes temporary FMAP increase for 2009 and 2010.

TABLE 20, Continued

Year	Legislative Milestone and Highlighted Provisions
2010	Patient Protection and Affordable Care Act of 2010 (PPACA, P.L. 111-148, as amended) expands eligibility to include nearly all individuals under age 65 with incomes up to 133 percent FPL based on modified adjusted gross income (MAGI). ▶ Increases some primary care payment rates provided by certain physicians to 100 percent of the Medicare payment rates for 2013 and 2014 ▶ Extends CHIP funding an additional two years through 2015 ▶ Prohibits Medicaid payments for health care-acquired conditions ▶ Establishes a new Center for Medicare and Medicaid Innovation to support pilot programs for innovative payment and delivery arrangements in Medicare and Medicaid ▶ Establishes the Federal Coordinated Health Care Office to improve the integration between Medicaid and Medicare with regard to dual eligible populations ▶ Includes funding for bundled payments demonstrations, global payment demonstrations for safety-net hospitals, pediatric accountable care organization demonstrations, and a demonstration project to provide Medicaid payment to institutions for mental disease in certain cases P.L. 111-226 extends ARRA FMAP increase through June 30, 2011.

CHAPTER 4

Examining Access to Care in Medicaid and CHIP

Section 1900(b)(1) of the Social Security Act: MACPAC shall – (A) review policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP') affecting access to covered items and services, including topics described in paragraph (2).

Chapter Summary

Drawing on earlier research and ongoing efforts to measure access to care, the Commission has developed an initial framework for examining access that takes into account the characteristics and complex health needs of Medicaid and CHIP populations, as well as program variability across states. Our approach aims to help shape our future work on monitoring and evaluating access to services for Medicaid and CHIP enrollees. This framework will also serve as the basis for our work to develop an early-warning system (EWS) to identify areas with provider shortages and other factors that adversely affect, or could potentially adversely affect, access to care for, or the health status of, Medicaid and CHIP enrollees.

The Commission's framework, which focuses initially on primary and specialty care providers and services, has three main elements: enrollees and their unique characteristics, availability of providers, and utilization. Factors associated with enrollee characteristics such as geographic location, cultural diversity, and program eligibility should be accounted for along with income levels and health care needs. Availability of providers is also a significant factor affecting access and is influenced by overall supply and provider participation. Utilization encompasses whether and how services are used, the affordability of services, and how easily enrollees can navigate the health care system. In addition, the Commission will evaluate overall access in terms of the appropriateness of services and settings for care; efficiency, economy, and quality of care; and overall health outcomes.

Using this initial framework, a set of measures will be identified and monitored to provide an understanding of where access levels exist today and allow the Commission to track trends moving forward. We also intend to identify federal and state policies relevant to Medicaid and CHIP that provide promising opportunities for enhancing appropriate access. We expect our access framework to evolve to address new health care practice patterns, changing program needs, and new Commission priorities.

CHAPTER 4

Examining Access to Care in Medicaid and CHIP

One of the key tests of the effectiveness of a health care coverage program is whether it provides access to appropriate health care services in a timely manner and whether those services promote health improvements. The Commission is charged with examining access to care and services for Medicaid and CHIP enrollees. As a first step in undertaking this effort, the Commission has reviewed research to measure and assess access to care for Medicaid and CHIP enrollees.

In order to fulfill its charge, the Commission needs an approach for evaluating access to health care services that considers the complex characteristics and health needs of the Medicaid and CHIP populations, as well as program variability across states. Based on a review of the literature on measuring access, the Commission has tailored its approach to take into account the needs of the Medicaid and CHIP populations, the distinct features of the Medicaid and CHIP programs, and the priorities inherent in the Commission's statutory charge. This chapter lays out how the Commission will start to assemble the data and analyses necessary to examine access to care.

While addressing access to care within Medicaid and CHIP is a primary charge of the Commission, there are a number of other important reasons for monitoring health care access, including understanding whether providers are available to enrollees as well as whether or not enrollees appropriately use and receive high-quality and efficient care. Examining access will help the Commission determine whether or not the programs are positively affecting the health outcomes of enrollees.

Federal and state governments want and expect to purchase high-quality and appropriate care for their Medicaid and CHIP enrollees. Section 1902(a)(30)(A) of the Medicaid statute directs that, "A State plan for medical assistance must…provide such methods

and procedures related to the utilization of, and payment for, care and services under the plan… as may be necessary…to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." A common definition for access has yet to be adopted by states or the federal government for evaluating access to services for Medicaid and CHIP enrollees. A monitoring system could help policymakers understand whether they are purchasing value in the form of efficient and high-quality care for their enrollees.

Lastly, the framework will also serve as the basis for the Commission's charge to create an early-warning system (EWS) to identify areas with provider shortages and other factors that adversely affect, or that could potentially adversely affect, access to care for, or the health status of, Medicaid and CHIP enrollees.

The Commission's Framework for Examining Access to Care for Medicaid and CHIP Enrollees

Drawing on earlier work and ongoing efforts to examine access to care in the overall health system, the Commission has developed its initial framework to help shape our future work on access. The Annex to this chapter provides a historical overview of 30 years of research on defining and measuring access to care. The framework takes into account the important developments in defining and measuring access achieved by health services researchers and leading health policy organizations. The framework incorporates notions of appropriate services in appropriate settings to maximize the value and quality of care received. The impact of services received, namely the health outcomes of care, is also included in the Commission's approach. Finally, the Commission intends for its measures of access to be useful in diagnosing reasons for poor access and to assist state and federal policymakers in evaluating policy choices while being responsive to the programmatic needs of Medicaid and CHIP.

The framework is also tailored to reflect Medicaid and CHIP policies, special characteristics of the programs' enrollees, and factors these populations may face when seeking and obtaining appropriate care. For example, transportation and translation services are important supports for Medicaid enrollees and should be considered when examining access for these populations. Sensitive to the wide variability in state programs and their enrolled populations, the framework considers state and subgroup estimates in important areas where state policies or population needs are likely to differ substantially. At the same time, the Commission must be realistic about resource constraints and data limitations, and focus on measures likely to be most revealing of important barriers to access and shortfalls in program performance. Finally, the Commission's framework will seek to address access questions from both the federal and state perspectives.

The initial framework presented here focuses on primary and specialty care providers and services and does not specifically address hospital, ancillary, long-term care or other services and supports.

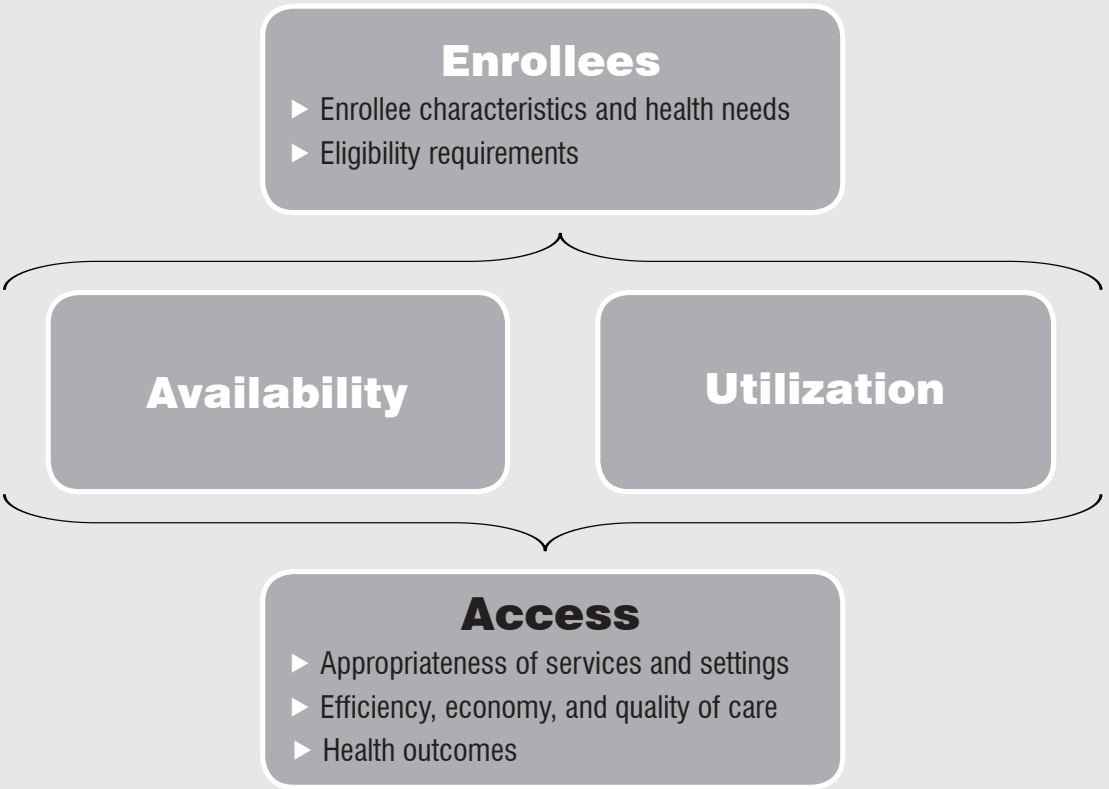
Access to care for these critical services will be addressed in future work.

As Figure 4-1 shows, the Commission's access framework has three main elements: enrollees and their unique characteristics, availability, and utilization.

- **Enrollees.** Medicaid and CHIP enrollees differ from the general population in terms of their demographic characteristics, health needs, and how they qualify for coverage.
- **Availability.** Provider availability for Medicaid and CHIP populations is influenced by a community's health care delivery system and the distribution of providers (its health care workforce and institutional resources), as well as state policies and providers' responses to those policies (provider payment, provider participation rates, willingness to accept Medicaid, and workforce issues such as scope of practice).
- **Utilization.** Realizing that insurance coverage may not guarantee the use of services, utilization focuses on whether available services are used, the affordability of these services for the enrollee, the enrollee's ability to navigate the health care system (including wait times and transportation), and the enrollee's experiences with the health care system.

Analysis incorporating these three components will serve as the basis for evaluating access, allowing the Commission to determine whether Medicaid and CHIP enrollees have adequate access to health care services that are economical and produce positive outcomes.

FIGURE 4-1. The Commission's Access Framework



The remainder of this section addresses each of the elements of the Commission's framework in turn: Medicaid and CHIP enrollees' distinctive characteristics; availability of providers; and aspects of utilization. This section concludes with a discussion on evaluating access in terms of appropriateness, efficiency, quality, and health outcomes.

Unique Characteristics of Enrollees

Medicaid and CHIP serve an important role in the health insurance market. As discussed in earlier chapters, these programs serve low-income populations who would otherwise experience considerable financial barriers to obtaining health services. Characteristics of Medicaid and CHIP enrollees that should be accounted for in monitoring access include:

- lower incomes and assets;
- discontinuous eligibility;
- geographic location;
- complex health care needs;
- cultural diversity;
- level of health literacy; and
- state variation in composition of enrollees.

Each of these considerations is reviewed immediately following.

Lower incomes and assets

Eligibility requirements for Medicaid and CHIP are complex and vary across state programs and subgroups covered. Those eligible for Medicaid and CHIP must meet income and, in some cases, asset tests that vary by state. Forty-eight percent of Medicaid enrollees have incomes at or below 100 percent of poverty—a much higher share than for the population covered by private insurance.[1] Approximately 90 percent of children enrolled in CHIP are at or below 200 percent federal poverty level (FPL) ($37,060 for a family of three in 2011).[2] Medicaid and CHIP enhance financial accessibility to health care for those enrolled and limit the financial burden of high health care costs on enrollees. Even though enrollment in Medicaid and CHIP provides coverage, limits on covered services and cost-sharing requirements may still create financial barriers to access for these low-income individuals. Additional research is needed to determine the impact that service and cost-sharing limits may have on limiting access to care or encouraging inappropriate use of services by enrollees.

Discontinuous eligibility

Turnover in eligibility status within enrolled populations has been an issue historically for both Medicaid and CHIP. One study, using data from the Medical Expenditure Panel Survey, found that nationwide, 20 percent of adults on Medicaid disenrolled within six months of initial enrollment and 43 percent of adults disenrolled within 12

[1] Analysis of 2010 National Health Interview Survey (NHIS) by the National Center for Health Statistics (NCHS) for MACPAC. NHIS uses poverty thresholds as calculated by the Census Bureau. One hundred percent of poverty was $11,136 income for an individual and $17,378 for a family of three in 2010.

[2] MACPAC analysis as of February 2011 of CHIP Statistical Enrollment Data System (SEDS), as reported by states.

months (Sommers 2009). Turnover can be a function of changes in enrollee income levels that can affect eligibility or issues with renewal. This has important effects on timeliness and continuity of care that should be considered when assessing access within Medicaid and CHIP. Medicaid also accepts enrollment when care is needed and retroactively covers some services, unlike private insurance.

Geographic location

Studies have shown that individuals and families with lower incomes and providers tend to be unevenly distributed within inner city areas (Adams 2001). In addition, Medicaid and CHIP enrollees are somewhat more likely to live in rural areas: 20 percent of Medicaid and CHIP enrollees live outside metropolitan statistical areas (MSAs), compared to 15 percent of the general population, as shown in Table 18 of MACStats. Provider supply has been shown to be a particular issue in areas where many enrollees reside and one compounded by other factors that make providers less likely to participate in Medicaid and CHIP.

Complex health care needs

Medicaid enrollees are more likely to report fair or poor general health and mental health status than individuals with private insurance, as shown in Figure 4-2 for adults at or below 138 percent of FPL. These results may be compounded by the fact that even among adults at or below 138 percent FPL, a greater proportion of Medicaid and CHIP enrollees have lower incomes than the privately insured (Holahan et al. 2010). Therefore, the needs associated with chronic illness, behavioral health needs, cognitive impairment, physical or intellectual disabilities—and other special needs that require access to services that are less common within the general population—must be accounted for in monitoring access to services within Medicaid and CHIP. Because children constitute half of all Medicaid enrollees and most CHIP enrollees, access measures specific to the health care needs of children also are critical, including measures targeted to unique program benefits like Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) for children under age 21. Forty-one percent of U.S. births are covered by Medicaid; thus measures of access to appropriate prenatal care are also important (CHCS 2010).

Cultural diversity

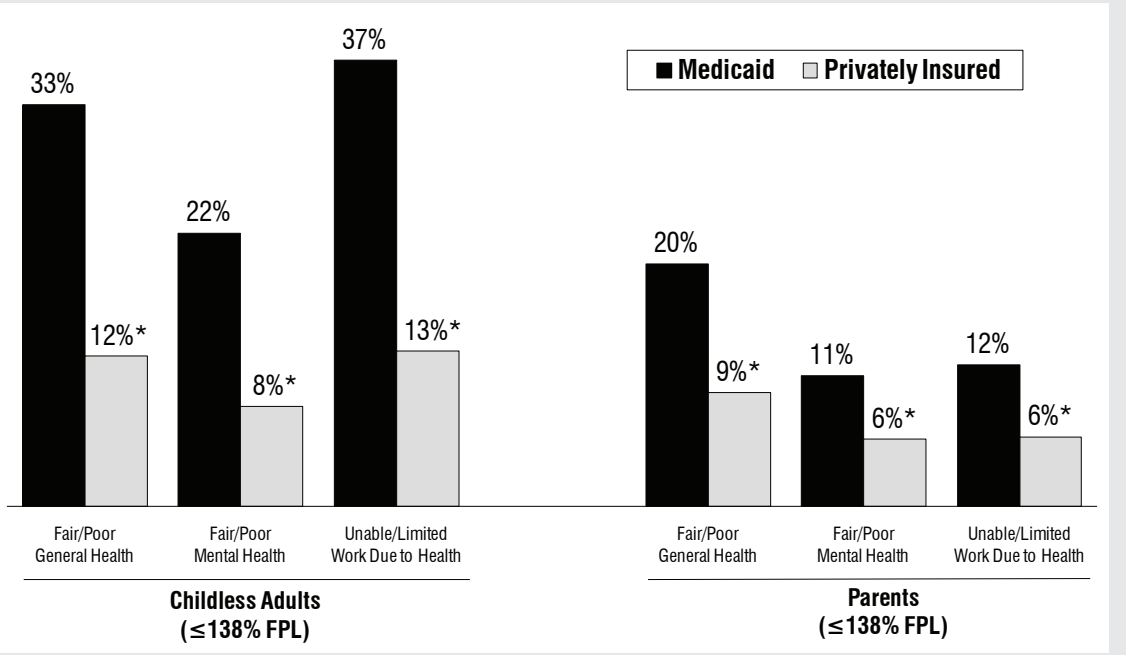
Medicaid and CHIP enrollees are culturally and ethnically diverse. As shown in Table 18 of MACStats, among Medicaid and CHIP enrollees, Whites account for 42 percent of all eligible individuals, Hispanics 29 percent, African Americans 23 percent, and "other races" 7 percent.[3] In addition, many speak English as a second language. These characteristics make access to culturally competent care and translation services particularly important for ensuring effective access.

Level of health literacy

Health literacy—the ability to read, understand and act on health care information—is likely to be a challenge for Medicaid and CHIP enrollees, as it has been found to be more problematic among those with low incomes, nonwhites, individuals over 60, and those with chronic disease. Individuals

[3] Whites, African Americans, and "other races" shown here are Non-Hispanic. Hispanics may be of any race.

FIGURE 4-2. Health Status of Low-Income Adults: Medicaid Enrollees Compared to Persons with Private Insurance, 2005–2006



*p<0.05, statistical significance denotes difference with Medicaid.

Note: FPL is federal poverty level. In 2011, 138% of FPL is $15,028 for an individual. Adults are 19-64 years of age.

Source: Holahan et al. 2010

with low health literacy are less likely to understand written and oral information given by providers and insurers; act upon necessary procedures and directions such as medication and appointment schedules; and navigate the health system to obtain needed services (Potter and Martin 2005a, b).

State variation in composition of enrollees

Subject to federal standards and requirements, both Medicaid and CHIP are state-administered, with substantial flexibility granted to states in program design and administration. Because of program differences across states, national statistics on access may obscure important variations across states. Variability among eligibility categories further complicates monitoring because health care needs and spending likely vary in systematic ways across different eligibility groups.

Availability

Availability focuses on whether care and providers are accessible to the Medicaid and CHIP populations. There are two key factors that influence the availability of providers: provider supply and provider participation. Overall, the availability of providers is greatly influenced by a community's health care delivery system and the distribution of providers (its health care workforce and institutional resources), as well as state policies and providers' responses to those policies

(provider payment, provider participation rates, willingness to accept Medicaid, and workforce issues such as scope of practice). Each of these factors is explained in more detail below, including commonly used measures for quantifying impact on access. Key questions about provider availability that the Commission intends to explore include:

- How many and what kinds of health professionals and institutional providers practice in areas where Medicaid and CHIP enrollees reside?
- How many of these providers participate in the programs and what does this mean in terms of whether there are sufficient providers available to deliver the services Medicaid and CHIP enrollees require?
- What settings are used by Medicaid and CHIP enrollees for receiving care (e.g., clinics, private physician offices, hospitals, emergency departments [EDs])?
- Does provider availability and the mix of participating providers differ between managed care and fee for service?
- What policies and practices exist at the federal and state levels to assure appropriate availability of providers, such as payment to providers and payment methodologies, and how well do they appear to work?

Provider supply

Providers, particularly physicians and other health care professionals, are unevenly distributed across the country. Research shows that physicians disproportionately locate in densely populated areas where incomes are high and demand for care is well financed by existing levels of coverage (Brasure 1999, Fossett and Perloff 1999). Although providers move to some areas with lower (but not the lowest) provider-to-population ratios, they have a tendency to go to areas with higher per capita income and lower unemployment (Ricketts and Randolph 2008). In addition, historical disincentives to choose primary care practice over other specialties are likely to continue, and thus increase the challenges in attracting primary care physicians to communities with limited economic resources (Steinwald 2008, Reinhardt 2002).

Provider-to-population ratios are often used as measures of provider supply. These ratios remain the measure most widely used to assess the supply of health professionals available to the general population. Within public insurance programs, participation rates help gauge provider supply relative to that which is available to the general population. More refined calculations take into account not just physical distance to providers' offices but also travel time given major travel routes, the availability of public transportation, and service needs of the underlying population. Analysis of data from 2005 to 2007 suggests that adults under age 65 enrolled in Medicaid disproportionately live in geographic Health Professional Shortage Areas (HPSAs) compared to other areas. (Hoffman et al. 2011).[4] Located in HPSAs, federally qualified health centers (FQHCs)

[4] The Health Resources and Services Administration (HRSA) defines HPSAs as areas with shortages of primary medical care, dental or mental health providers which may be geographic (a county or service area), demographic (low-income population) or institutional (comprehensive health center, FQHC or other public facility). However, as required by the Patient Protection and Affordable Care Act of 2010 (PPACA), HRSA is currently engaged in negotiated rulemaking to develop a new approach to the HPSA designation, with a target date of July 1, 2011 for the release of the negotiated rulemaking committee's report.

play an important "safety net" role by providing primary care services in these underserved urban and rural communities.

Provider participation

Medicaid enrollees disproportionately rely on providers at community health centers (CHCs) and hospital outpatient departments (OPDs) for primary care services; on a national level, patients with Medicaid or CHIP accounted for a higher percentage of primary care visits to CHCs (44 percent) and OPDs (31 percent) than to physician offices (13 percent) (Hing and Uddin 2008). Safety-net hospitals are also an important source of care for Medicaid enrollees; more than a third of discharges (36 percent) and a quarter of outpatient visits (26 percent) were for Medicaid patients (Cummings et al. 2009).

Of office-based primary care physicians in 2009, only 65 percent were accepting new Medicaid patients, as compared to 74 percent and 88 percent for Medicare and private insurance patients, respectively.[5] Physicians report greater difficulties referring Medicaid patients for specialty consultation than they do for patients with Medicare or private insurance. A 2006 survey indicated that 49 percent of office-based physicians reported difficulties with referring Medicaid patients for specialty consultations, compared with 13 percent reporting such difficulties for patients with Medicare and 16 percent for privately insured patients.[6]

In a 2004-2005 Community Tracking Study Physician Survey, physicians reported that inadequate payment was the most common reason for providers not to accept Medicaid patients, followed by the administrative burden of billing Medicaid, delays in payment, capacity constraints, and high clinical burden (Cunningham and May 2006). Physicians also voice concerns about malpractice. Although there is little research on this issue, studies have not found that people with Medicaid or CHIP coverage are more likely to sue than others (Baldwin et al. 1992, Mussman et al. 1991).

Measures of provider participation typically reflect the share of available providers who agree to participate in the program (potentially collected through surveys and claims-based analyses) and the concentration of patients across providers. Several surveys currently collect physician participation rates in Medicaid and CHIP across the country. Table 4A-1 in the Chapter Annex summarizes several examples of these surveys, as well as their respective definitions for "participating," survey purpose and design, periodicity, and response rates.

Provider participation measures often fail to distinguish between providers who may treat a few Medicaid enrollees and those who treat a substantial number (PPRC 1991). Further, the types of health professionals included in measures differ (e.g., how obstetricians/gynecologists who provide primary care to some women are counted). These inconsistencies can limit the validity of comparisons of provider participation across studies.

States often require managed care plans that participate in Medicaid and CHIP to meet formal

[5] Analysis of 2009 National Ambulatory Medical Care Survey (NAMCS) by the National Center for Health Statistics (NCHS) for MACPAC.

[6] Analysis of 2006 NAMCS by NCHS for MACPAC.

standards of network adequacy for their provider panels. Most states have established minimum ratios for primary care practitioners to enrollees, including some that require plans to demonstrate provider-to-population ratios equivalent to those observed in the fee-for-service sector. States are also requiring plans to meet certain standards with regard to the distance or travel time to reach services, both for urban and rural areas. Such standards are more developed for primary care physicians than for specialists; plans and providers report greater difficulty developing adequate specialty care networks and making successful referrals for specialty care (Gold et al. 2003).

Table 4-1 summarizes potential measures of availability of providers that the Commission intends to explore further.

Utilization of Services

The third component of the Commission's evolving framework on access focuses on the way enrollees use services when available and how they perceive their experiences with obtaining care and interacting with their providers. Utilization is "realized access" or how services are actually used by individuals. Our framework includes three factors that encompass utilization of services by Medicaid and CHIP enrollees: (1) what services are used, (2) the affordability of services, and (3) how easily enrollees can navigate the health system and their experiences. Each of the three factors is discussed in a subsection below. Key questions regarding utilization of services by Medicaid and CHIP that the Commission intends to explore include:

- Do enrollees have a usual source of care?
- How do patterns of service use differ for different subpopulations?
- Are the services needed by Medicaid and CHIP enrollees affordable?
- How do enrollees perceive the quality of care they receive and their providers' ability to communicate with them?
- What policies and procedures exist at the federal and state levels that can ensure that utilization is appropriate and prevent the over, under, and misuse of health services?

TABLE 4-1. Potential Measures of Provider Availability

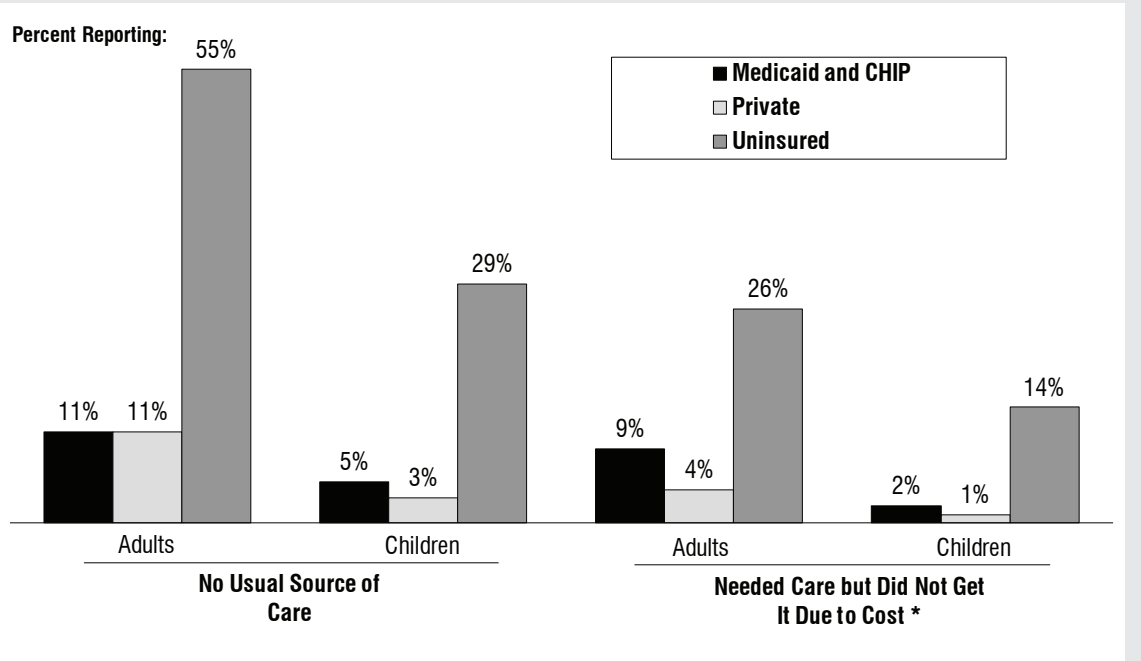
Availability Factors	Potential Measures
Provider Supply	▶ Medically underserved area (MUA) and HPSA designations ▶ Area provider-to-population ratios ▶ Providers available within standard travel time and distance
Provider Participation	▶ Share of providers participating, by specialty ▶ Providers accepting new patients ▶ Provider entry/exit from the program ▶ Patient load per provider

Interpreting measures of utilization from the perspective of access is a challenge because use is affected by many factors, only some of which policymakers and program administrators can control. Utilization measures can take the form of absolute standards such as prenatal care, relative performance (how do Medicaid and CHIP enrollees compare with the general population?), trend analysis (is performance getting worse or better?), or subgroup analysis (which groups within Medicaid and CHIP have more difficulty than others using services and, therefore, warrant special attention?).

Services used

As already discussed, access to health services traditionally is defined by measures that include having a usual source of care and whether any services are used. Figure 4-3 shows that children and adults with Medicaid and CHIP are equally likely as those with private insurance to report no usual source of care. More than half of the uninsured adults (55 percent), however, reported not having a usual source of care compared to 11 percent of adults with Medicaid and CHIP or private insurance. Results were similar for those who reported that they did not get needed care because of cost (KCMU 2011). These averages do not take into consideration differences in the health needs and use of services by various subpopulations or variations by state. Although the differences in these types of measures may not be sufficient on their own, such measures create signals that a particular geographic or population group may experience problems accessing health care.

FIGURE 4-3. Access to Care: Medicaid and CHIP Enrollees Compared to Persons with Private Insurance, 2009



* In the past 12 months

Note: Respondents who said their usual source of care was the emergency room were included among those not having a usual source of care.

Source: KCMU 2011, data from 2009 NHIS

Affordability of services

Health insurance coverage is an important factor in reducing financial barriers to using health care. Insured individuals generally and those in public programs like Medicaid and CHIP have substantially better access to care than those without insurance (IOM 2009). Still, affordability remains a potential problem for Medicaid and CHIP enrollees because of their health needs and relatively low incomes. Out-of-pocket costs due to cost-sharing requirements and restrictions on benefits can be important influences on receipt of health care (Newhouse 2001). For people with low incomes, even limited cost-sharing has been shown to reduce use of services (Hudman and O'Malley 2003). One recent study examined increases in prescription drug copayments for privately insured patients and found that individuals living in low-income areas were less likely to continue taking their medications than people in high-income areas (Chernew et al. 2008).

Measures that define affordability within the context of Medicaid and CHIP should be program-specific, reflecting federal benefit requirements, cost-sharing limits, and areas of state discretion. Under Medicaid, cost-sharing historically has been very limited due to the very low incomes of enrollees as well the promotion of early access to primary and preventive services; thus, financial barriers have tended to be associated with whether, and to what degree, states cover benefits that are optional (e.g., dental services for adults). Developing affordability measures that capture cost-sharing burdens and the coverage of optional benefits, particularly for enrollees with potentially high health care needs for whom "nominal" copays can result in a large total obligation, is particularly important (Selden et al. 2009).

System navigation and patient experiences

System navigation relates to the "fit" between the patient and service delivery. Whether or not available services are well-targeted is important for all users of the health care system. For example, available office hours (including night and weekend coverage) and appointment scheduling policies (same day appointments) are important features of the delivery system that have been shown to influence access to care and the inappropriate use of emergency rooms (MASG 1994). Availability of transportation can also affect receipt of care, particularly for those without cars or who live in areas less well served by public transportation. Given the racial and ethnic diversity of Medicaid and CHIP enrollees, access to providers that patients believe understand their needs is important. Language facility and translation services are also important for reaching subgroups of Medicaid and CHIP enrollees. The experience of moving large numbers of people into Medicaid managed care reinforced the importance of educating enrollees in the program about their choices, how they can obtain services, and the providers available to them; not providing this information impedes access to care (Coughlin et al. 2008, Gold and Mittler 2000, Ku et al. 2000, Gold et al. 1996, Rowland and Lyons 1987).

Many of these types of measures are captured in patient surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), in which adults are asked to report on the care they and/or their children receive. Some state Medicaid

agencies use CAHPS and CAHPS-like measures to gauge member satisfaction with both managed care and fee-for-service arrangements. For example, Medicaid HMO enrollees reported that they usually or always got care without long waits (80 percent) compared to privately insured (86 percent) or Medicare (87 percent) patients (Table 4-2). Medicaid HMO enrollees also gave their health plan a higher overall rating (59 percent) compared to privately insured (38 percent) or Medicare (53 percent) patients.

Surveys can also inform policymakers on how well enrollees with particular health problems (e.g., chronic conditions) understand how to manage their conditions and other questions regarding aspects of care that relate to their specific needs. Administrative records on complaints are another source for measuring patient experiences. "Secret shopper" studies can provide other information, such as the wait time for an available appointment and flexibility to accommodate patient needs. Table 4-3 provides examples of measures for the three utilization factors.

The final discussion in this presentation of the Commission's access framework addresses evaluation criteria.

Evaluating Access

The Commission's framework provides a foundation for our future efforts to monitor access to care for Medicaid and CHIP enrollees. Yet provider availability and use of services by themselves do not necessarily result in optimal enrollee access—or more importantly—optimal

TABLE 4-2. Select CAHPS Health Maintenance Organization (HMO) Member Satisfaction Measures, 2009

Measure	Commercial	Medicare	Medicaid
Consumer and Patient Engagement and Experience			
Rating of Health Plan: Rating of 9 or 10	38.3%	59.0%	52.5%
Rating of Health Care: Rating of 9 or 10	48.7	56.2	47.0
Getting Needed Care: Usually or Always	85.4	89.1	75.0
Getting Care Quickly: Usually or Always	86.4	86.7	79.5
How Well Doctors Communicate: Usually or Always	93.4	93.5	87.0
Personal Doctor: Rating of 9 or 10	63.2	73.3	60.1
Specialist: Rating of 9 or 10	61.8	69.3	60.5
Customer Service: Usually or Always	84.5	86.5	79.5

Note: The data reported to and by National Committee for Quality Assurance (NCQA) only includes data collected from managed care plans. Comparisons among the populations need to be viewed with caution because important differences between the commercial, Medicare and Medicaid populations may affect the results (i.e., health status and benefit designs of the different programs).

Source: NCQA 2010

TABLE 4-3. Potential Measures of Utilization

Utilization Factors	Potential Measures
Services Used	▶ Percentage of enrollees receiving a particular service (e.g., specialty care, pharmacy services, well child visits, prenatal care) ▶ Percentage of enrollees with a usual source of care
Affordability of Services	▶ Coverage of optional benefits ▶ Actuarial measures of benefit package design and potential out-of-pocket costs
System Navigation and Patient Experiences	▶ Appointment waiting times ▶ Complaints ▶ Percentage of enrollees experiencing delays in getting care ▶ Rate of managed care plan selection vs. auto-assignment ▶ Enrollee reports on provider communication with patients: ▷ Clarity of instructions ▷ Language ▷ Understanding of care management (if chronically ill)

health outcomes for an individual or for the program population overall. Even with health coverage, positive outcomes are not guaranteed and the potential for overuse, underuse, and misuse of services still exists. In its work on access, the Institute of Medicine (IOM) emphasized that use of services is not the ultimate goal but instead that the appropriate use of services enhances the impact of health care on outcomes. This focus ultimately on health outcomes has been articulated in national efforts over the past decade to monitor quality and the performance of the health care system (Berwick et al. 2008, IOM 2001).

To reflect this orientation in evaluating access to health services, the Commission has identified three key evaluative components: (1) the appropriateness of services and settings, (2) efficiency, economy, and quality of care, and (3) impact on health outcomes. Our overall analysis of access to care within Medicaid and CHIP will incorporate these three components. Each is discussed below.

Appropriateness of services and settings

Appropriateness of services focuses specifically on the use or nonuse of services that are well accepted as indicative of health care quality. Overuse and misuse of services are also important factors when examining appropriate use of services. In addition, if health care services are not used, it could reflect lack of availability, but it also could indicate a lack of care-seeking behavior by enrollees or that care is misdirected towards less

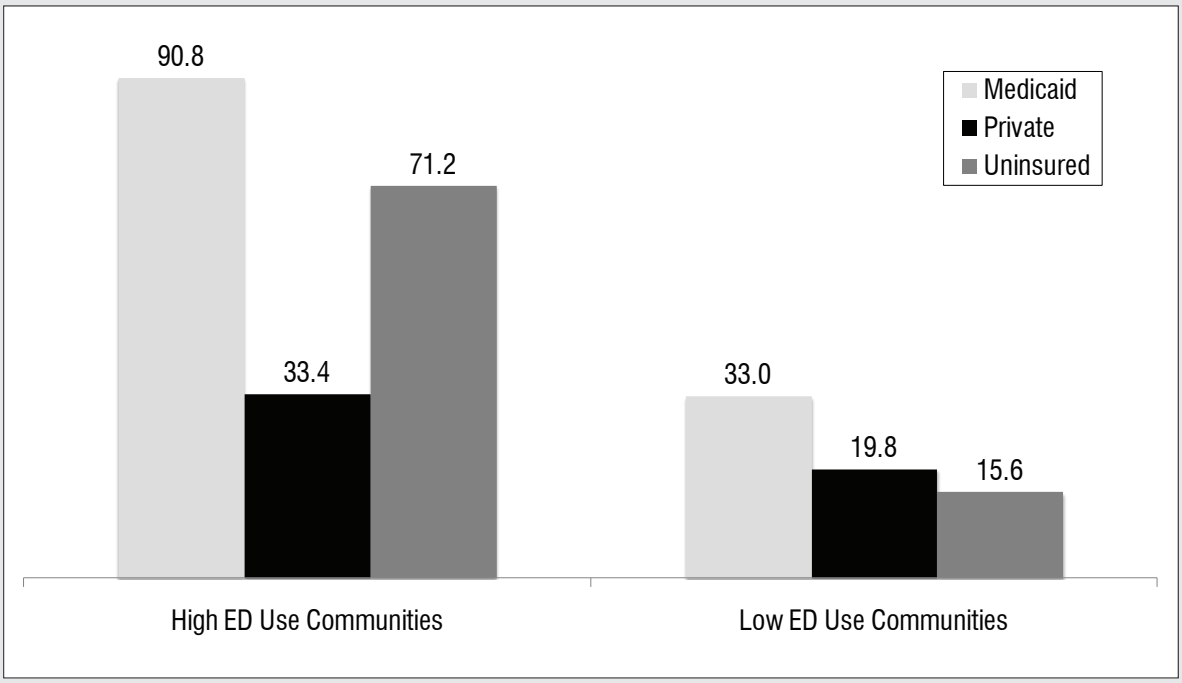
effective modes of care. Personal responsibility also must be considered, as effective care may be available but not sought or overused by enrollees. Indicators of appropriateness of services and settings may include examining rates of use for recommended preventive services; hospitalization rates for conditions that are viewed as avoidable with adequate access to primary care; hospital readmission rates for conditions potentially avoidable with appropriate ambulatory care; and adequacy of prenatal care.

ED visits are a prime example of care that may not always be delivered in the most appropriate setting. Figure 4-4 shows that, after adjusting for self-reported health status, demographics, and the capacity of local EDs and primary care providers, Medicaid enrollees had a greater number of ED visits per 100 persons than did those with private insurance or no coverage (Cunningham 2006). Unmeasured health and related factors may be part of the explanation for the differences in ED use among Medicaid enrollees compared to the uninsured and those privately insured. More research is needed to determine what is driving these patterns of different ED utilization rates and whether its use was appropriate.

Efficiency, economy, and quality of care

As discussed in Chapter 5, there are many definitions of efficiency in health care and little agreement about which is preferable. There is limited additional guidance on this language, particularly the meaning of efficiency, economy, and quality of care, leaving states with the task of developing the standards or methodologies

FIGURE 4-4. Emergency Department (ED) Visit Rates by Coverage Type, 2003



Note: High ED use communities are defined as the 25 percent of Community Tracking Study (CTS) communities with the highest number of ED visits per 100 people. Low ED use communities are defined as the 25 percent of CTS communities with the lowest number of ED visits per 100.

Source: Cunningham 2006

that give meaning to the statutory requirements. Further, because Medicaid continues to be one of the nation's largest payers of health coverage, it is critical that payment policies support high-quality, efficient care (Bachrach 2010).

Regarding quality, over the past decade there have been many concerted efforts to expand the use of standardized measures for quality improvement (Lipson et al. 2009). The National Committee for Quality Assurance (NCQA) has created a set of state-level quality measures for selected conditions called the Healthcare Effectiveness Data and Information Set (HEDIS). These data are collected voluntarily from more than 1,000 health plans across the country and many state Medicaid agencies require managed care plans that serve Medicaid enrollees to report the data. However, these quality measures are not collected for individuals who receive their care in non-managed-care settings, such as fee for service, making comparisons across delivery systems difficult. At a national level, the Medical Expenditure Panel Survey (MEPS) contains select quality-of-care measures that can be used to draw comparisons among individuals with private coverage, public coverage, and individuals without coverage. Select MEPS quality-of-care measures are included in Table 4-4 below.

Health outcomes

Purchasers of health care services want to be assured that they are paying for high-quality care that will produce positive health outcomes. This concept is applicable to all purchasers of health services, whether in the private or public sectors. State and federal governments also have a vested interest in obtaining the best possible outcomes for their enrollees. While

TABLE 4-4. Select Medical Expenditure Panel Survey Quality-of-Care Measures, 2008

Measure	<65, Public Insurance Only	< 65, Any Private Insurance	<65, Uninsured
Percent of adults age 18 and over with diabetes who reported having a hemoglobin A1C measurement at least once in past year	63.5	75.4*	57.1
Percent of adults advised to quit smoking	65.1	62.9	51.1*
Percent of children age 2 – 17 with a dental visit in the past year	40.5	56.5*	25.9*

* $p < .05$, Statistical significance denotes difference with <65, Public Insurance Only population.

Note: Uninsured refers to persons uninsured during the entire year. Public and private health insurance categories refer to individuals with public or private insurance at any time during the period; individuals with both public and private insurance and those with Tricare (Armed Forces-related coverage) are classified as having private insurance.

Comparisons among the populations need to be viewed with caution because there are important differences between individuals with private and public coverage and those with no coverage that may affect the results (i.e., health status and benefit designs of the different programs).

Source: Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey, 2008

everyone can agree that health outcomes are an important output of health-related services, it is more difficult to reach agreement as to which outcomes are most important and how best to obtain them. Recognizing the complexity of this undertaking, the Commission intends to examine the impact of access on health outcomes for Medicaid and CHIP enrollees more closely in the future.

Looking Forward

The development of a framework for examining access to care in Medicaid and CHIP is the Commission's first step towards fulfilling its charge related to access. Using this initial framework, adapted as needed, we will first identify a set of measures that are feasible to collect and monitor over time. This set of measures should incorporate a combination of availability and utilization measures. Further, we will start to assemble data and information to examine what is known about access to care in the Medicaid and CHIP programs. After understanding where access levels exist today on both the national and state levels, we will have the ability to monitor the impact of future changes identified either through the EWS or broader Commission analysis.

We are well aware that limitations in available and timely data are a major challenge for conducting realistic and appropriate monitoring of access in Medicaid and CHIP. Although many sources of data are available at the national level, far fewer sources are available at the state level and these are often inconsistent or out of date. Because analysis at the state level is important, given the wide variation of Medicaid and CHIP programs across the country, the Commission's ongoing plans are to work with states and learn from their experiences and best practices.

The Commission will also assess policy interventions available at the state and federal levels with the potential to affect access for Medicaid and CHIP enrollees. For example, in terms of provider supply and availability, the supply and distribution of health professionals are not within the direct control of most Medicaid and CHIP programs but both have a significant effect on how well the programs function. Changing the number, mix, and geographic distribution of health professionals is a major challenge facing these programs.[7] The Commission plans to examine the interplay of supply and overall participation of providers and track the recent efforts to increase and reshape the health care workforce in undersupplied areas. This research will help us to identify opportunities for enhancing access within Medicaid and CHIP. Closely related to provider supply, the Commission intends to examine payment policies as well as interventions to reduce administrative burdens that can discourage provider participation, as discussed in Chapter 5.

Regarding use of services, the Commission plans to gain a better understanding of differences that exist between services used by Medicaid and CHIP child and adult enrollees, their counterparts who are uninsured, and those with private insurance.

[7] PPACA mandated the development of a multi-stakeholder Workforce Advisory Committee charged with recommending a national workforce strategy with an emphasis on primary care and location in MUAs. Commission members were appointed on September 30, 2010, although the Commission has not yet received funding.

Our examination of service use will extend to unique subgroups such as persons with disabilities and dual eligibles, and our analyses will take into account differences in need and use that may exist because of health status and socioeconomic status and delivery system (e.g., fee for service vs. managed care). We also plan to review data about the availability of recommended levels of care (e.g., recommended preventive services, appropriate use of ED) as one aspect of understanding the appropriateness of services and settings.

Medicaid and CHIP managed care is also an area that the Commission intends to examine. As shown in Table 2 of MACStats, in FY 2008, almost half of all Medicaid enrollees (and a higher portion of CHIP enrollees) were in a risk-based health plan. Given the important role of managed care in Medicaid and CHIP, the Commission plans to employ access measures and approaches that will examine this in the future. We aim to develop a monitoring system on access that reflects the full range of how enrollees get their health care in Medicaid and CHIP and how federal and state policies relevant to Medicaid and CHIP may create positive or negative outcomes in both fee for service and managed care environments.

Realizing that policies available to influence enrollee access may differ across Medicaid and CHIP programs, particularly within managed care, the Commission will work with states and provide guidance on efforts for improving access.

Possible areas for in-depth analysis include:

- how benefits are designed or modified at the state level, including cost-sharing, and their potential impacts on access to care;
- use of EDs, including the impact of patient characteristics and behaviors, provider office hours and locations, appropriateness of use, and comparisons of use by Medicaid and CHIP enrollees with uninsured and privately insured individuals;
- differences between providers who participate in Medicaid and CHIP and those who do not;
- access to specialty services and whether differences exist between individuals in managed care and fee-for-service arrangements; and
- the types of resources available to states to address access to care in managed care settings.

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Chapter 4 Annex

Defining Access: Evolution of Research Approaches

To better understand key issues in monitoring access, the Commission reviewed 30 years of work related to the topic. This review indicated that over time the concept of access has been adapted and enlarged to answer new questions and concerns as health care practice patterns and individuals' health care needs have changed. While initial work on access was developed to support research on utilization of health care services, definitions and frameworks on access have evolved and become multi-dimensional. Over time, aspects such as the fit between providers and patients, the appropriateness of services used, and health outcomes have been incorporated into access frameworks. Today greater emphasis is placed on the link between the use of the right services to achieve desired outcomes and the factors that support or hinder access than envisioned in earlier definitions. The Commission's framework takes into consideration these important elements.

Utilization as a Measure of Access

The first definitions of access to care were developed to analyze the use of health services, with a focus on its determinants (Aday and Andersen 1981, Andersen and Aday 1978). Access was defined as "those dimensions which describe the potential and actual entry of a given population group to the health services delivery system" (Aday et al. 1980, p. 26). Researchers distinguished three kinds of factors that influence utilization: (1) health needs both clinically defined and self-perceived; (2) predisposing variables such as age, sex, personal characteristics, and health care preferences as related to those needs; and (3) enabling variables like provider availability, transportation, income, and health insurance status, which determine whether potential need (as defined by the first two) is translated into "realized access"—the actual use of health services.

A second body of early research identified "usual source of care" as critical to using health care effectively, anticipating the current concept of "medical homes," that is, a designated point of contact within the health care system to help patients coordinate their care (Berki and Ashcraft 1979). Penchansky and Thomas elaborated on the concept by distinguishing "5 As" in access: (1) *availability*, sufficient personnel and

technology resources to meet the needs of the client; (2) *accessibility*, the geographic ease with which the client can reach the physician's office; (3) *accommodation*, whether care is organized in ways that meet the client's needs (e.g., office hours, appointments, telephone access); (4) *affordability*, as it relates to the client's willingness and ability to pay; and (5) *acceptability*, whether the client is comfortable with the characteristics of the provider (Penchansky and Thomas 1981). This conceptualization characterized access as a function of "the fit between characteristics and expectations of the providers and the clients" (McLaughlin and Wyszewianski 2002). Such concepts form a foundation for current interest in patient-centered care and reinforce the point that insurance coverage (as Medicaid and CHIP provides) enables but does not guarantee access to care if other essential ingredients are missing.

Adding Appropriate Use and Outcomes to the Definition

In the early 1990s the Institute of Medicine (IOM) sought to refine the definition of access to care to address more fully concerns related to the implications of resource constraints on the ability to secure an adequate level of care. IOM expressed concern that receipt of needed health care services was persistently below recommended levels and also highly uneven across population subgroups. Analysis of access was tied not just to use of services but to use of the "right" services, that is, those likely to achieve desired goals and outcomes.

IOM defined access as the: "Timely use of personal health services to achieve the best possible health outcomes" (IOM 1993). IOM identified three kinds of barriers to access: (1) *structural barriers* related to supply and organization of care (and transport to that care); (2) *financial barriers* related to insurance coverage and continuity, provider payments, and benefits and cost-sharing; and (3) *personal barriers* such as acceptability, culture, language, attitudes, education and income. The first two barriers are most susceptible to policy intervention, although the third can be influenced by the way health care systems are designed to accommodate the characteristics and preferences of patients.

The major emphasis in IOM's work focused on elaborating the links between use and outcomes, which could support more nuanced measures of access to appropriate services. In particular, IOM proposed that access measurement should include a focus on how appropriateness, efficiency, provider quality, and patient adherence mediate between use and the ability to achieve desired health goals across populations on an equitable basis. The mere use of services was no longer a sufficient endpoint. More and different kinds of information were needed to determine whether these services used improved health. Health outcomes have now become a strong focus in IOM's investigations.

Including Quality and System Performance in Evaluating Access

More recently, work on access by IOM and others has emphasized looking more broadly at quality and the performance of the health care system (Berwick et al. 2008, IOM 2001). That health care services may be overused, underused, and misused is now widely recognized (McGlynn et al. 2003). Further, there are wide variations in practice patterns across geographic areas. (NHPF 2010,

MedPAC 2009, Fisher et al. 2003, Wennberg 1984). It is unclear how much of this variation can be explained by differences in health status or shifting costs across payers (Zuckerman et al. 2010, Gold 2004).

In the 1990s the Physician Payment Review Commission (PPRC) monitored access for Medicare and Medicaid beneficiaries using a multi-dimensional framework that included measures to assess potential barriers to provider participation; the way health plans structured provider networks and delivery of services; appropriate use of care; and patient experiences (PPRC 1996, Docteur et al. 1996). Similarly, Gold and colleagues developed a framework linking different kinds of access measures to potentially relevant policy interventions (Gold et al. 2006, Gold et al. 2004).

TABLE 4A-1. Selected Surveys Examining Provider Participation in Medicaid and CHIP

Survey and Administering Organization	Variables Related to Participation	Purpose	Design, Response Rate, and Periodicity
National Ambulatory Medical Care Survey(NAMCS) National Center for Health Statistics	Physician accepting new Medicaid patients Percent of patient care revenue from Medicaid Physician reporting difficulty referring patients for specialty consultation (2003-2006, and 2012)	To collect information about office-based physician practices, patient visits, and the adoption of electronic medical records in ambulatory care settings	Nationally representative probability sample of physicians In-person survey with 59 percent response rate[1] Conducted annually In 2011 a question on acceptance of new Medicaid patients will be added to the NAMCS Electronic Medical Record Supplement, a mail survey which has complemented the core in-person NAMCS survey since 2008. Sample size for the mail survey (approximately 10,000 physicians) will support state-level estimates of Medicaid participation for all physicians. Response rate is expected to be comparable to the 68 percent response rate observed for the 2010 mail survey.
Health Tracking Physician Survey 2008 Center for Studying Health System Change	Physician accepting all, most, some, or no new Medicaid patients Percent of patient care revenue from Medicaid Reasons why physician accepting only some or no new Medicaid patients ▶ Billing Requirements ▶ Delayed Payment ▶ Inadequate Payment ▶ Practice has enough patients ▶ High clinical burden Scored as Very, Moderately, Not Very, or Not At All Important	To track a variety of physician and practice dimensions, from basic demographic characteristics, practice organization and career satisfaction to insurance acceptance, compensation arrangements and charity care provision	Nationally representative probability sample of physicians Mail survey 62 percent response rate[2]

TABLE 4A-1, Continued

Survey and Administering Organization	Variables Related to Participation	Purpose	Design, Response Rate, and Periodicity
Population Group HPSA Designation Surveys State Primary Care Offices under guidance from Health Resources and Services Administration, HHS	Physician accepts Medicaid patients Percent of practice patients insured by Medicaid Percent of practice patients offering self-payment using a sliding fee scale based on income or ability to pay Usual elapsed time between request and appointment for ▶ a new patient ▶ established patient	To request HPSA designation for primary care, dental, or mental health services	100 percent sample of physicians in candidate service areas Survey methods vary across states 67 percent response rate or higher required by HRSA Designated areas are required to field survey every three years
Group Practice Survey American Medical Association	Percent of practice patients insured by Medicaid ▶ 0-25 percent ▶ 26-50 ▶ 51-75 ▶ 76-100	To track general demographic and administrative data on group practices of three or more physicians	100 percent sample of all group practices Telephone survey ~100 percent response rate[3] with ~45 percent completion rate for Medicaid participation variable Updated annually
Survey of Physician Participation in Medi-Cal 2008 Bindman et al., University of California San Francisco, sponsored by The California HealthCare Foundation	Practice accepting: ▶ Any new FFS Medi-Cal patient ▶ Any new Medi-Cal managed care (HMO) patient Percent of practice patients insured by Medi-Cal	To determine the level of physician participation in Medi-Cal	Probability sample representative of California physicians Survey mailed in conjunction with licensure renewal applications through the Medical Board of California 60 percent response rate

TABLE 4A-1, Continued

Survey and Administering Organization	Variables Related to Participation	Purpose	Design, Response Rate, and Periodicity
Texas Physician Survey Texas Medical Association	Physician accepting: ▶ All new: ▶ A limited number of new: ▶ No new: ▷ Medicaid patients ▷ CHIP patients	To identify emerging issues, track the impact of practice and economic changes, assess physician priorities, and develop data to support Texas Medicaid Association advocacy efforts	100 percent sample of all physicians in Texas 2010 survey conducted in a series of email modules ~ 20 percent response rate Conducted biennially
Secret Shopper Survey of Primary Care Physicians NORC at the University of Chicago sponsored by Office of the Assistant Secretary for Planning and Evaluation, HHS	Physician accepting new Medicaid patients Wait time for appointment	To monitor provider participation in different insurance programs and assess access differences by insurance status	Probability sample of primary care physicians in 9 states Sample sizes allow state-level estimates On-going study, response rates not yet available One-time study

Notes:

1 Based on proportion of eligible physicians who responded to the survey in 2008 (1,334). Eligible physicians (2,229) defined as office based, principally engaged in patient care, non-federal. Excludes anesthesiologists, pathologists, and radiologists. Eligible physicians were screened from an initial sample of 3,319.

2 Based on proportion of eligible physicians who responded to the survey in 2008 (4,720). Eligible physicians (7,642) defined as providing patient care at least 20 hours per week, non-federal, and excluding: specialists not involved in patient care; physicians in training; and graduates of foreign medical schools with temporary licenses to practice in U.S. Screened from an initial sample of 10,250.

3 Approximately 105,000 practice locations representing 370,000 affiliated physicians.

CHAPTER 5

Examining Medicaid Payment Policy

Section 1900(b)(2)(A) of the Social Security Act: MACPAC shall review and assess payment policies under Medicaid and CHIP, including i) the factors affecting expenditures for items and services in different sectors, including the process for updating hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees; (ii) payment methodologies; and (iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries.

Chapter Summary

Medicaid is an important payer of health care services in the U.S., and like other payers, Medicaid seeks to advance payment policies that promote delivery of efficient, high-quality care. The program's unique characteristics such as its diverse population with wide-ranging health care needs, federal-state financing, and cost-sharing limitations for enrollees raise a number of challenges and considerations for developing effective payment policies.

Currently, no sources exist that systematically and comprehensively explain how states determine Medicaid payments or evaluate whether or not payments meet statutory requirements and promote value-based purchasing—ensuring access to appropriate, efficient, high-quality care at the appropriate time and in the appropriate setting. Lack of timely and reliable sources of data is also a major challenge for payment analysis. The Commission intends to develop a balanced and data-driven approach to payment evaluation that takes these multiple objectives into account and that is appropriate for the Medicaid program.

Medicaid payment policies are developed by each state with federal review limited to the general principles set forth in Section 1902(a)(30)(A) of the Social Security Act. This provision requires that provider payments be consistent with efficiency, economy, quality, and access and safeguard against unnecessary utilization. With the flexibility afforded them under federal law, states have taken a variety of different approaches to Medicaid payment. There are many questions regarding the relationship of these payment policies to access and quality and the potential role for payment innovations that best address efficiency and economy while assuring access to appropriate, high-quality services.

In this chapter we begin our initial assessment of Medicaid payment policy and outline plans for future work. Here we focus on fee-for-service (FFS) payment for hospital and physician services, highlighting federal statutory and regulatory changes that have shaped FFS payment and the resulting variation in state payment methods. We also identify considerations for evaluating Medicaid payment policy and outline our analytic approach.

CHAPTER 5

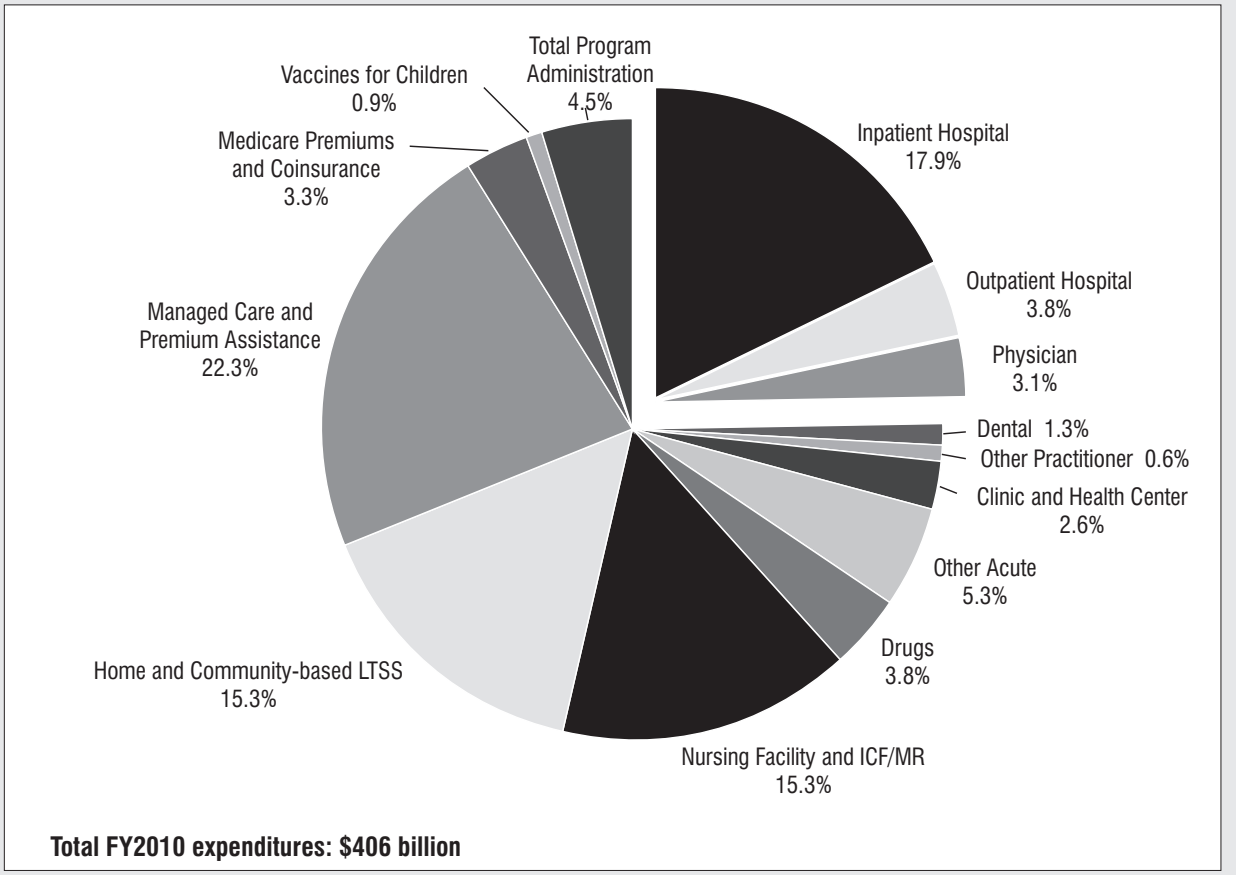
Examining Medicaid Payment Policy

The Medicaid program is a major payer for health care services in the U.S., accounting for 15 percent of total health care spending in 2009 (OACT 2010). In FY 2010 state and federal Medicaid expenditures totaled $406 billion. Medicaid is a particularly dominant payer for obstetrics, pediatrics, behavioral health, and long-term services and supports (Quinn et al. 2007). Medicaid is also a major source of revenue for safety-net providers, accounting for 35 percent of public hospital revenue and 37 percent of community health center revenue, while children's hospitals, representing less than 5 percent of all hospitals, provide about 40 percent of all inpatient hospital care for children covered by Medicaid (NAPH 2010, Rosenbaum et al. 2010, NACH and AAP 2007). Given Medicaid is a major payer and a significant expense for federal and state governments, examining payment methods and levels across states is an important undertaking. In this chapter the Commission begins an initial assessment of Medicaid payment policy and outlines our approach for future work.

The Aims of Payment Policy

With per capita U.S. spending on health care far exceeding that of other developed countries and lower indicators of health status, many health care payers are questioning whether they are getting value for their dollars invested (Farrell et al. 2008, OECD 2008). Promoting value-based purchasing, access to the appropriate amount of efficient, high-quality care, at the appropriate time and in the appropriate setting, is a fundamental goal of payment policy. Medicaid and other payers such as Medicare and commercial plans struggle with how to achieve this goal. At times, payment policies have created incentives to provide a greater volume of services rather than to improve overall value. The Medicaid program is unique in many respects; however, the program is still subject to the same underlying medical cost drivers that other payers struggle to control, such as medical practice patterns and new, high-cost technologies.

FIGURE 5-1. Distribution of Medicaid Spending, FY 2010



Note: See Tables 6 and 7 in MACStats for information on the categories of spending shown here. Collections from third-party liability, estate recovery, and other recoveries ($7 billion) are distributed proportionately among benefit categories. Percentages in MACStats Table 7 differ because that table includes benefits spending only.

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2011

Medicaid Provider and Program Characteristics Important for Analysis of Payment

Although Medicaid is not alone in pursuing value-based purchasing, the program's characteristics make achieving this goal more challenging. These include:

- **Population.** Medicaid covers a diverse population with wide-ranging health care needs including children, low-income Medicare beneficiaries, and individuals with disabilities. As a result, the range of issues surrounding payment for services that Medicaid must consider is more extensive than for other payers.
- **Benefits**. Medicaid covers a broad range of services compared to other payers, reflecting the diverse needs of its enrollees. For example, Medicaid makes payments for long-term services and supports (LTSS), transportation services, and certain therapies, which other payers generally do not cover. As a result, a broad array of providers serves the Medicaid population (Box 5-1).

- **Role in health care markets.** Medicaid is a major payer for services such as LTSS, obstetrics, pediatrics, and mental health services, as well as for safety-net providers such as public hospitals and community health centers. Since Medicaid is a dominant payer for these services, Medicaid's payment decisions strongly influence where and how these services are delivered.
- **Cost-sharing limits.** Serving a low-income population, states are limited in their ability to require copayments and deductibles, tools that other payers use to manage utilization.
- **Federal-state financing.** States are required to contribute funding, and in some cases states require local governments to contribute a portion. Medicaid costs are generally highest when state revenues are at their lowest. States are required to balance their budget on an annual or biennial basis. Significant budget constraints lead states to consider payment changes, including reductions in payment levels.

The Commission will consider these factors when evaluating Medicaid payment policies. In an era of state budget deficits and with states increasingly looking to cut provider rates for potential savings, understanding the relationship of Medicaid payment to the principles of efficiency, economy, quality, and access is critical. Otherwise, states risk encouraging over-utilization and/or overpayment of some services and providers while underpaying others, supporting inefficient service delivery models, or impeding access to medically necessary, quality care.

BOX 5-1. Examples of Medicaid Provider Types[1]

Acute Care	Long Term Services and Supports	Other Service Providers
Ambulance/Air Ambulance	Home Health	Case Management
Advanced Practice Nurse	Hospice	Durable Medical Equipment
Certified Nurse Midwife	Intermediate Care Facility	Independent Laboratory
Children's Hospital	Nursing Facility	Interpreter
Community Mental Health Center	Personal Assistant	Pharmacy
Dental Hygienist		School District
Dentist		Physical Therapist
Federally Qualified Health Center		Occupational Therapist
Hospital		Speech Therapist
Physician		Transportation
Physician Assistant		
Public Health Agency Clinic		
Rural Health Clinic		

[1] State Medicaid programs may include many more discrete provider types such as optician, geneticist, psychologist, physician's assistant, etc.

The Commission's Approach to Examining Payment in Medicaid

In the Medicaid program, state flexibility to develop payment policies has led to significant variation in payment methods, reflecting individual state policy decisions, geographic differences in costs, and practice patterns. Moreover, there is no easily accessible source of state payment methods, no comprehensive analysis of which are more or less effective, and no uniform data that permit meaningful comparisons of payment levels. The Commission's efforts to examine Medicaid payment, therefore, must begin with a thorough understanding of the current payment landscape. Both the amount of payments that states make to providers and the methods that states use to distribute payments are important to consider, as is identification of those policies that most efficiently and effectively promote the provision of quality health care services to Medicaid enrollees. The Commission will work closely with states to understand their individual payment policies across various providers.

The Commission's analytic work plan includes an examination of both existing and emerging fee-for-service (FFS) and managed care payment systems and an identification of data to evaluate state payments against the principles of efficiency, economy, quality, and access set forth in Section 1902(a)(30)(A) of the Social Security Act (the Act). Our goal is to identify payment policies that account for the complexity of Medicaid enrollees and the Medicaid marketplace, and encourage access and quality while controlling the rate of Medicaid spending.

In this initial discussion we focus on Medicaid FFS payments for hospital and physician services. These services comprise a large share of Medicaid spending, as shown in Figure 5-1 and affect a large number of providers in the Medicaid program. Additionally, these services have been the subject of many federal and state policies focused on improving cost-containment and enrollees' access to care. In future reports the Commission will broaden its examination of Medicaid payment, including examination of LTSS and managed care, as well as payments to federally qualified health centers (FQHCs), rural health clinics (RHCs), and other types of providers (Box 5-2).

In this chapter the Commission:

- highlights major federal statutory and regulatory developments that have shaped FFS payment for hospitals and physicians, beginning with the foundational statutory payment requirement for all Medicaid services;
- outlines differences in current state payment policies that have resulted from flexibility under federal policy and reflect differing costs and delivery systems; and
- introduces our analytic approach to evaluating Medicaid payment policies and begins to identify the data to assess the effectiveness of Medicaid payment policies.

Medicaid Managed Care. The Commission understands that managed care plays an increasing role in Medicaid service delivery, with payments to managed care organizations (MCOs) comprising over 20 percent of Medicaid spending (Figure 5-1). Medicaid managed care is an important factor to consider in evaluating Medicaid payment

BOX 5-2. Topics for Future Consideration

In this initial discussion of Medicaid payment, the Commission focuses on FFS payment policy for hospitals and physician services. The Commission will consider the following subjects, in addition to others, in future reports:

- Long-term services and supports (LTSS), both institutional care and home and community-based services
- Federally qualified health centers (FQHCs), rural health clinics (RHCs), and other safety net providers
- Prescription drugs and pharmacy services
- Dental services
- Medicaid managed care organizations (MCO)
- State Medicaid financing, including general and dedicated revenues such as provider taxes
- State approaches to accounting for and organizing Medicaid expenditures through intergovernmental transfers (IGTs) and certified public expenditures (CPEs), and implications for provider payments
- Program integrity efforts and opportunities
- Emerging Medicaid payment models

and access issues. The chapter provides a brief description of managed care payment issues (Box 5-6), and future reports will examine these issues in greater depth.

State Financing. The Commission recognizes that the manner in which states finance their share of Medicaid program operations influences overall Medicaid payment policies. State approaches include the use of general revenues, dedicated revenue sources such as provider taxes, and the use of intergovernmental transfers (IGTs) and certified public expenditures (CPEs) from local governments, including government providers, to distribute and account for their expenditures. We intend to address how these state financing approaches relate to Medicaid payment policy.

The Foundation of Medicaid Payment for All Services

Section 1902(a)(30)(A) of the Act is the foundational statutory provision that governs federal review of state payment methodologies for all services covered by Medicaid. Added in 1968, the original provision addressed only efficiency, economy, and quality as aims of Medicaid payment. In 1989, the Congress amended the statute to incorporate the "equal access provision," previously only included in federal regulation, which identified access as a specific aim of payment (Omnibus Budget Reconciliation Act of 1989, OBRA 89, P.L. 101-239).[2] The statute now reads as follows:

[2] When the "equal access" provision was codified, the phrase "in the geographic area" was added (P.L. 101-239).

> *[A State plan for medical assistance must] (A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in Section 1396b (i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; …*

This provision has several fundamental aims that are not easily reconciled with each other: to assure that payments promote efficiency, quality, and economy; to avoid payment for unnecessary care; and to develop payment policies that promote access within geographic areas as measured by the availability of providers comparable to those available to the general population. States have flexibility in the development of payment policies consistent with these aims.

Federal regulations implementing the 1989 amendments have not been issued. A brief recently filed by the U.S. Solicitor General indicated the Administration's intent to issue such regulations in response to numerous developments related to state Medicaid provider payment policies. [3]

The key statutory and regulatory provisions that govern Medicaid payment policy today, and a timeline of major federal legislative and regulatory developments, which helps to inform these governing provisions, are outlined in the Annex to this chapter.

Payment for Hospital Services

Medicaid, including both FFS and managed care, accounted for approximately 18 percent of hospital discharges and spending nationally in 2008 (AHRQ 2011, CMS 2011). Federal payment policy for hospital services has evolved since the earliest days of the Medicaid program. Key elements have included:[4]

- early requirements to pay based on costs, mirroring Medicare;
- the Boren Amendment, which de-linked Medicaid payment from Medicare and expanded state flexibility in developing Medicaid payment policy—and its repeal, which further expanded state flexibility;
- upper payment limits based on Medicare payment levels; and
- disproportionate share hospital (DSH) payments for uncompensated costs.

Within these broad requirements states have flexibility in how they pay for hospital services. In some cases state flexibility has led to payment innovation. However, questions have emerged regarding the extent to which Medicaid payments are consistent with the principles of efficiency, economy, quality, and access.

[3] Brief for the United States as Amicus Curiae in the case of *Maxwell-Jolly v. Independent Living Center of Southern California, Inc., et al.*, U.S. Court of Appeals for the Ninth Circuit, December 2010.

[4] These elements, with the exception of DSH, also apply to institutional providers other than hospitals (e.g., nursing facilities).

The Boren Amendment

From the program's enactment, Medicaid payment policy had a particular focus on payment to hospitals and other institutional providers. In 1965, the federal statutory requirement for Medicaid payment was included in Section 1902(a)(13) of the Act, which required payment of the "reasonable cost" of inpatient hospital services.[5] During this period Medicaid hospital payment policies mirrored Medicare's and, using a process known as "retrospective cost reimbursement," states reimbursed hospitals for their reported cost of providing care.

After years of efforts to rein in hospital payments, and in response to states' demand for greater flexibility over hospital payment policy,[6] the Congress moved to de-link Medicaid payment from Medicare. Through the Omnibus Budget Reconciliation Acts of 1980 and 1981, the Congress amended Section 1902(a)(13) to broaden state payment discretion, requiring that state payment systems be "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities." These changes are known as "The Boren Amendment."

Repeal of the Boren Amendment

In the years following the amendment's enactment, many states developed new hospital payment methods. However, as costs continued to escalate and the number of providers that were paid less than the full amount of their reported costs increased, so did the number of lawsuits brought by providers against states. The suits alleged that state payment methods failed to meet the Boren Amendment's reasonableness and adequacy tests. Increasingly, states came to oppose the Boren Amendment language that had removed the Medicare payment standard. While the Boren Amendment provided more flexibility, it had a standard for sufficiency of payment, and states struggled to interpret and comply with this standard. The Congress revised the Boren Amendment as part of the Balanced Budget Act of 1997, replacing the reasonable and adequate standards with a more general requirement for a public process to determine institutional provider payments. The 1997 legislation required that states publish the proposed methodology and rates and provide an opportunity for public review and comment. These requirements remain in effect today and give providers and other stakeholders a role in Medicaid payment policy development.

Upper Payment Limits—Regulations to Promote Efficiency and Economy

Prior to the Boren Amendment, the reasonable cost requirements had essentially tied Medicaid payments to Medicare. When the Boren Amendment removed the link to Medicare, the concept of Medicare payments as an upper limit on Medicaid payment took on increased importance as a means of preventing Medicaid payment policies that would actually exceed Medicare. The statutory basis for a federal policy that would assure this upper limit was Section 1902(a)(30)(A), the Medicaid efficiency and economy statute. In 1981,

[5] The "reasonable cost" requirement was extended to nursing facilities and intermediate care facilities by the Social Security Amendments of 1972 (P.L. 92-603).

[6] Amicus brief submitted by the Solicitor General in the case of *Belshe vs. Orthopaedic Hospital* (accessed at: http://www.justice.gov/osg/briefs/1996/w961742w.txt).

BOX 5-3. Supplemental Payments and Medicaid Payment Policy

Some states make substantial payments to providers above what they pay for individual services through Medicaid rates. These additional payments fall into two categories: Disproportionate share hospital (DSH) payments to hospitals serving low-income patient populations, which accounted for nearly $18 billion (including federal matching funds) in FY 2010,[7] and "UPL supplemental payments," which comprise the difference between total base payments for services and the maximum payment level allowed under the UPL for those services. These payments are an important source of Medicaid funding for various providers. In many states, such payments may be particularly important for safety-net providers, who are more dependent on Medicaid payment as a source of revenue and less able to rely on other revenue sources to offset uncompensated care.

Because DSH and UPL payments are generally paid in lump sums, their impact on Medicaid rates for services is difficult to isolate. As a result, it is difficult to compare actual payment rates among providers, either within or across states. The Commission intends to evaluate the role of supplemental payments for providers that treat significant numbers of Medicaid enrollees and the uninsured and the impact of these payments on efficiency, economy, quality, and access.

the Secretary of Health and Human Services issued a new "upper payment limit" (UPL) regulation that prohibited states from paying "more in the aggregate for inpatient hospital services or long-term care services than the amount that would be paid for the services under the Medicare principles of reimbursement."[8]

The UPL regulations, which have been modified several times, afford states flexibility in calculating the UPL. The limit is aggregated over each provider type and class (private, state-owned, and other governmental). As a result, state payments to any individual hospital can exceed that hospital's upper limit as long as the aggregated payments to hospitals in that provider class are within the overall Medicare UPL.

Payments to Disproportionate Share Hospitals

As states were given broader discretion over hospital payment, the Congress became concerned that this shift might threaten hospitals serving large numbers of Medicaid beneficiaries and the uninsured. In response, the Congress in 1981 required states to "take into account" the situation of hospitals serving a disproportionate share of low-income patients when designing payment systems (42 U.S.C. Section 1396a (a)(13)(A)(iv)). In 1987 the Congress further strengthened the requirement to ensure the financial stability of "disproportionate share hospitals" (DSHs) by requiring states to make additional payments to such hospitals (42 U.S.C. Section 1396r-4). At first the amount of payments that could be made was left open-

[7] Based on information reported by states in the CMS-64 expenditure form for FY 2010. CMS now requires states to report the total amount of UPL payments and is working with states to improve data accuracy.

[8] HCFA 1981. The Senate had proposed similar language for inclusion in the Boren Amendment itself, but the provision was not included by the conference committee (U.S. House 1981). In earlier deliberations the Senate Finance Committee stated that "the Secretary would be expected to continue to apply current regulations that require that payments made under state plans do not exceed amounts that would be determined under Medicare principles of reimbursement." (U.S. Senate 1979, HCFA 2001).

ended. The Congress has since refined the DSH program on several occasions, most significantly in 1991 when it enacted state-specific caps on the amount of DSH funds that could be allocated, and in 1993 when it enacted hospital specific limits equal to the actual cost of uncompensated care to Medicaid enrollees and uninsured individuals.[9] In 2010, in response to anticipated increases in health insurance coverage, the Congress reduced state DSH allotments to account for an expected decrease in uncompensated care in Section 1203 of the Health Care and Education Reconciliation Act (P.L. 111-152) that followed the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148). DSH payments are intended to improve the financial stability of safety-net hospitals and to preserve access to necessary health services for low-income patients.

Current Hospital Payment Landscape

With the flexibility afforded them under federal law, states have developed a variety of payment methods for both inpatient and outpatient hospital services.

Inpatient payment methods

States have selected and CMS has approved a wide range of payment methods for hospital inpatient services. Some states use payment methods that reimburse hospitals based on their reported costs, while others pay for the number of days that a patient is in the hospital. Still others have adopted payment methods based on diagnosis related groups (DRGs), a classification system adopted by Medicare in 1983. DRGs group patients according to diagnosis, type of treatment, age, and other relevant criteria.[10] Under Medicare's inpatient hospital prospective payment system, hospitals are paid a fixed amount for treating patients in a single DRG category, regardless of the actual cost of care for the individual. As a result of receiving a fixed payment amount, hospitals have incentives to provide care more efficiently. The shift to DRGs is considered among Medicare's most successful payment reforms—better aligning payments with patients' acuity needs, reducing the number of inpatient days, and slowing growth in Medicare hospital spending (Mayes and Berenson 2006, Bachrach 2010). On the other hand, DRGs have been criticized for potentially creating incentives to discharge patients prematurely (Qian et al. 2011, Kahn et al. 1991).

In general, existing state payment methods for inpatient hospital services can be grouped into these three broad categories (Quinn and Courts 2010):

- **Payment based on DRGs**. Thirty-two states pay hospitals a fixed amount per discharge, with outlier payments for especially costly cases. However, among states using DRGs, multiple DRG algorithms are used.

[9] See, for example, the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66; Balanced Budget Act of 1997, Pub. L. No. 105-33; Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173; and in 1991, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234).

[10] In 2007 Medicare adopted a new and more refined DRG system, Medicare Severity-Diagnosis Related Groups (MS-DRG) that recognizes the severity of illness and resource usage associated with illness severity. Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services. 2007. Medicare program; Changes to the hospital inpatient prospective payment systems and fiscal year 2008 rates. Federal Register 72, no.162 (August 22): 47130-48175.

- **Per diem.** Nine states pay hospitals a per diem amount, typically the same amount for each inpatient day.
- **Cost reimbursement**. Five states pay for inpatient services based on each individual hospital's reported costs.

Outpatient hospital payment

Similar to those used for inpatient services, payment methods for outpatient services include payment based on reported costs; payment based on the volume of services provided; and, in a few cases, payment based on the bundle of services commonly associated with a particular patient condition. States usually take one of four broad approaches to FFS payment for hospital outpatient services (Quinn and Courts 2010):

- **Cost reimbursement**. Twenty-two states pay for outpatient services based on each individual hospital's reported costs.
- **Ambulatory patient classification (APCs) groups**. Eight states employ the APC system used by Medicare, in which individual services are classified into one of 833 APCs based on clinical and cost similarity. All services within an APC have the same payment rate. A single visit may have multiple APCs and multiple separate payments (MedPAC 2007).
- **Enhanced ambulatory patient groups (EAPGs)**. Three states have adopted EAPGs for outpatient care. EAPGs bundle ancillary and other services commonly provided in the same medical visit; payment is based on the complexity of a patient's illness.
- **Other fee schedules**. Eighteen states pay for most outpatient services using other fee schedules.

Recent Hospital Payment Provisions

PPACA includes a number of Medicaid hospital payment provisions that aim to improve quality, address access to care issues, and test new health care delivery approaches through a variety of demonstrations. Many of these approaches, such as bundled payments and accountable care organizations (ACOs), are also being tested in Medicare. Effective July 1, 2011, Section 2702 of PPACA prohibits state Medicaid agencies from paying for services that relate to health care-acquired conditions (HCACs), preventable conditions resulting from treatment. On February 17, 2011, the Secretary of HHS issued a proposed rule that defines HCACs for the Medicaid program (CMS/HHS 2011). The proposed rule examines current state policies that address HCACs and reviews and considers the conditions identified in Medicare regulations on this policy, which became effective in 2008. The proposed rule would also grant states the flexibility to expand beyond the conditions identified by Medicare regulations.

PPACA authorizes the following demonstration projects to test various payment models:

- **Bundled payments.** Section 2704 authorizes a four-year demonstration for up to eight states, beginning January 2012, to evaluate the use of bundled payments for improving integration of care around Medicaid enrollees' hospitalization. This demonstration will focus on certain conditions for which the quality of care could be improved.

- **Medicaid global payments for safety-net hospitals**. Section 2705 establishes the Medicaid Global Payment System Demonstration Project, for up to five states to operate between FY 2010 and FY 2012, which will transition eligible safety-net hospital systems or networks from FFS payment structures to global capitated payment models.
- **ACOs for pediatric providers.** Section 2706 authorizes eligible pediatric providers to form ACOs and share in financial incentives. The demonstration begins January 1, 2012 and ends December 31, 2016.

PPACA also created the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models while preserving or enhancing the quality of care furnished to individuals.

Hospital Payments and the Principles of Efficiency, Economy, Quality, and Access

The nature of the various hospital payment methodologies used by states leads to questions regarding the extent to which they are consistent with the principles of efficiency, economy, quality, and access. Individual state decisions in applying these methodologies can affect their effectiveness. For example, states use a variety of DRG-based methods. Although in Medicare, DRGs have been effective in relating payments to patient acuity and in slowing growth in hospital spending, it is uncertain to what extent the different DRG-based methods reflect the complexity of the Medicaid population (Quinn 2008). On the other hand, some states' inpatient hospital payment methods are based on costs or per diem payment. Other payers, including Medicare, have largely abandoned these methods because they encourage greater utilization of services. Escalating costs for hospital services and the extent to which inpatient care could be provided more appropriately and efficiently in other clinical settings also remain to be addressed.

Many states have recently taken steps to evaluate how they pay for hospital care and have explored adopting payment methods intended to better balance efficiency, economy, quality, and access. In doing so, many states have noted that they lack information and data on the effectiveness of these various methods, including those created by PPACA, as well as other state efforts to refine their payment policies. Thus, evaluating hospital payment policy begins with a deeper understanding of these state-level details as well as the identification of data suitable for drawing informed conclusions about the effectiveness of these policies.

Payments for Physician Services

Medicaid physician services are covered medical services provided by physicians in a variety of settings including clinics, community health centers, and private offices.[11] The Medicaid statute also authorizes payment for services provided by other health care professionals such as certified nurse practitioners and nurse-midwives, and states have differing requirements as to what extent

[11] The Medicaid provisions of the Social Security Act define "physician" based on the Medicare definition in Section 1861(r)(1) "as a doctor of medicine or osteopathy legally authorized to practice medicine."

BOX 5-4. Safety-Net Providers Serve as a Major Source of Care for Medicaid Enrollees

Safety-net providers serve a substantial number of uninsured and Medicaid patients. These providers typically include public hospitals, community health centers, community behavioral health centers, local health departments, and other clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites are also safety-net providers.

Because they serve a higher proportion of Medicaid enrollees as well as a higher proportion of uninsured people, safety-net providers are particularly affected by Medicaid payment policies. Nationally, 35 percent of public hospital revenues and 37 percent of community health center revenues are from Medicaid (NAPH 2010, Rosenbaum et al. 2010). In the case of some individual providers, these percentages are much higher. Additionally, because they often serve a higher proportion of uninsured individuals, these providers are generally less able than other payers that serve a more insured population to absorb costs of uncompensated care. As a result, the following policies have been adopted to address these providers' financial stability:

- **Payments to disproportionate share hospitals (DSHs).** The DSH program was established in 1987 for hospitals serving a disproportionate share of uninsured and Medicaid individuals. DSH payments are in addition to payments hospitals receive for Medicaid-covered services. They are intended to improve the financial stability of safety-net hospitals and to preserve access to necessary health services for low-income patients.
- **Required payment methodology for FQHCs and RHCs.** Community health centers and clinics in rural areas meeting certain requirements qualify for special reimbursement for health care services covered by Medicaid. Although the Congress has changed the payment methodology over time, state Medicaid programs generally reimburse these health centers based on service costs. Most recently, the Consolidated Appropriations Act of 2001 (P.L. 106-554) established a prospective payment methodology based on service costs in a base year and trended forward using factors included in statute.
- **Discounted outpatient prescription drugs.** The 340B program was established in 1992 to provide eligible safety-net providers access to discounted prescription drug pricing for outpatient services.[12] Discounted pricing is not available for inpatient services.

As the Commission begins to examine the relationship of Medicaid payments to the statutory principles of efficiency, economy, quality, and access, it will conduct analyses of these safety-net providers and their impact on patient populations.

[12] The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992 (P.L. 102-585), which is codified as Section 340B of the Public Health Service Act.

these professionals are paid based on physician fee schedules. States generally have flexibility under federal law to determine payment to physicians, and there is no UPL comparable to that for institutional providers. Faced with difficult tradeoffs to balance budgets, states frequently consider and implement changes in physician fee levels. In state fiscal year 2010 for example, 20 states reduced physician payments, while 8 states increased them (KFF 2010). These changes—payment reductions in particular—often lead to questions regarding the adequacy of Medicaid payments. In some cases, physicians and other providers have gone to the federal courts to contest payment reductions (Box 5-5).

Statutory Requirements for Access to Obstetrical and Pediatric Services

In addition to the requirements included in Section 1902(a)(30)(A), OBRA 1989 included a provision, for "assuring adequate payment levels for obstetrical and pediatric services." This additional requirement was intended to address access concerns as a result of eligibility expansions for children and pregnant women in the 1980s (Mitchell 1991).[13] Under this provision, states were required to demonstrate compliance with the equal access provision for pediatric and obstetrical services. This is the only time in the history of the Medicaid program that states were statutorily required to report measures to demonstrate compliance with the equal access provision.

This provision required states to submit annual Medicaid state plan amendments (SPAs) that specified payment rates for obstetrics and pediatrics as well as "additional data as will assist the Secretary in evaluating the State's compliance with such requirement" in order to be considered compliant with the requirements of Section 1902(a)(30)(A). As part of this requirement, in March 1990 the Health Care Financing Administration (HCFA) (now known as the Centers for Medicare & Medicaid Services) issued draft instructions and standards for demonstrating access to pediatric and obstetrical care, including requirements for data at a sub-state level:

1. At least 50 percent of obstetrical practitioners and at least 50 percent of pediatric practitioners are full Medicaid participants or there is full Medicaid participation at the same rate as Blue Shield participation;[14]
2. Medicaid FFS payment rates are equal to at least 90 percent of the average FFS amount of private insurers; or
3. Other documentation of equal access, including other measures of participation, recipient surveys, or equal visit utilization rates (PPRC 1993).

States relied on these draft instructions to demonstrate compliance through their Medicaid State Plans, though they generally found it difficult to measure access based on the proposed requirements. In its 1992 annual report to the Congress, the Physician Payment

[13] Statutes expanding eligibility for pregnant women and children include: Deficit Reduction Act of 1984 (P.L. 98-369), Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), Omnibus Budget Reconciliation Act (OBRA) of 1986 (99-509), OBRA 1987 (100-203), Medicare Catastrophic Coverage Act of 1988 (100-360), and OBRA 1989 (P.L. 101-239) that required state Medicaid programs to cover pregnant women and children under 6 up to and including 133 percent of the Federal Poverty Level. OBRA 1989 also expanded EPSDT services for children under age 21.

[14] Full participation means accepting all Medicaid patients who present themselves for care.

BOX 5-5. Federal Court Activity on Medicaid Payment Adequacy

As states increasingly turn to provider payment rate reductions to address budget issues, providers are turning to the courts to assert that these reductions are not consistent with requirements under Section 1902(a)(30)(A) of the Social Security Act. In many cases, courts have noted that providers did not have the right to sue under this section, but several federal appellate courts have found that the providers were entitled to challenge these payment reductions. A consistent theme among most cases is that state rate-setting based solely on budget constraints is particularly vulnerable to challenge under Section 1902(a)(30)(A).

Many of these cases address whether the reductions adversely affect enrollees' access to care and meet the "equal access" requirement that payments "are sufficient to enlist enough providers." Court decisions are split as to whether Section 1902(a)(30)(A) requires states to demonstrate that the payment rates produce a certain result (e.g., sufficient provider supply) or to follow a certain process to assure that payments are consistent with this provision. The focus of these cases has been on whether overall payment levels, and not payment methods, meet these requirements.

Recently, the Supreme Court has agreed to hear arguments in a case involving Medicaid provider payment reductions, Independent Living Center of Southern California v. Maxwell-Jolly (2010). The court will consider whether the Supremacy Clause confers on beneficiaries and providers the right to challenge the sufficiency of Medicaid provider payments under Section 1902(a)(30)(A).

Review Commission (PPRC) noted that the draft instructions were insufficient to provide HCFA with the ability to enforce the statute and that "HCFA could help the states meet this requirement by developing measures of access appropriate to the Medicaid population and providing technical assistance to implement appropriate monitoring systems." In its 1993 report, PPRC reported that state Medicaid programs generally lacked the data required to make the required assurances. For example, few were able to identify physicians who did not participate in Medicaid and proprietary fee information for private payers was not accessible. According to the report, one state's officials resorted to calling every pediatrician, family physician, and obstetrician in the State to identify the percent of participation (PPRC 1993).

In 1997, the Congress repealed the provision. At the time of its repeal, a State Medicaid Director letter noted the significant administrative burden on both states and HCFA in complying with these requirements.[15]

Inter-State Variability in Physician Payments

In general, states have broad flexibility to determine payments for physician services. State Medicaid programs, like Medicare and commercial payers, typically pay physicians and other clinicians using a fee schedule (Mayes and Berenson 2006). These fee schedules are often based on the concept of "relative value," whereby various physician services or procedures have different values based on the resources involved in performing a

[15] A September 17, 1997 letter from HCFA to State Medicaid Directors noted that "we realize the difficulties that were encountered in obtaining data needed for the Ob/Ped SPAs."

TABLE 5-1. Medicaid Fee Indices for Office Visits, 2010

State	Fee Index	State	Fee Index	State	Fee Index	State	Fee Index
US	1.00	ID	1.47	MO	0.94	PA	0.95
AL	1.12	IL	0.94	MT	1.67	RI	0.51
AK	2.77	IN	0.82	NE	1.16	SC	1.28
AZ	1.43	IA	1.13	NV	1.16	SD	1.10
AR	1.01	KS	1.33	NH	1.06	TX	0.91
CA	0.67	KY	1.13	NJ	0.93	UT	1.07
CO	1.33	LA	1.24	NM	1.34	VT	1.35
CT	1.44	ME	1.04	NY	0.96	VA	1.27
DE	1.70	MD	1.24	NC	1.43	WA	1.29
DC	1.76	MA	1.25	ND	2.35	WV	1.17
FL	0.79	MI	0.74	OH	1.02	WI	0.99
GA	1.07	MN	0.69	OK	1.55	WY	1.70
HI	0.96	MS	1.48	OR	1.21		

Note: Indices are based on the weighted sum of the ratios of each state's fee for a given service to the fee's national average, using Medicaid expenditure weights derived from claims files. A more detailed methods section is included in the Annex to the chapter.

Source: Urban Institute 2010 Medicaid Physician Survey

procedure or service. Resources include physician work, practice expense, and liability insurance. If one procedure is more complex and time consuming than another, then this procedure code will be given more "value." Alternatively, some Medicaid programs pay a percentage of the physician's charges, with those charges usually subject to audit for reasonableness.

While fee schedules are the predominant method of payment, the basis for each fee schedule varies, and there is considerable variation in fees across states. Recent analysis conducted for the Commission demonstrates this variation for office visits.[16] The data in Table 5-1 show each state's FFS payment rates for office visits relative to the national Medicaid average, represented as an index value of 1.00. (For example, Arkansas' fees are one percent higher than the national average while Wisconsin's are one percent lower than the national average.)

These data illustrate the variation in physician payments for Medicaid services, which reflect many factors in delivering care in different parts of the U.S. and state policy decisions on fee levels. Office visit payments in the highest paying state are more than five times higher than those in the lowest paying state. It should be noted that these data include FFS rates only. Similar comparison data for Medicaid managed care payments are not readily available. This is our initial review of physician fee levels, and the Commission intends to conduct additional analyses in the future including to compare Medicaid fees to those of other payers (e.g., commercial, Medicare).

[16] Office visit CPT codes included in the index include the following: 99203: Office Visit, New Patient, 30 Minutes; 99204: Office Visit, New Patient, 45 Minutes; 99213: Office Visit, Established Patient, 15 Minutes; 99214: Office Visit, Established Patient, 25 Minutes.

Recent Legislative Activity Regarding Medicaid Physician Payment

Section 1202 of the Health Care and Education Reconciliation Act (P.L. 111-152) that followed PPACA requires states to pay 100 percent of the Medicare payment rate for primary care services provided by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine participating in Medicaid during calendar years 2013 and 2014. The law provides 100 percent federal funds for the difference between a state's primary care payment amount in Medicaid and the Medicare payment amount during these two years. Primary care services, as defined in the statute, include certain categories of procedure codes as well as services related to immunization administration.[17] Medicaid managed care plans must also make payments to physicians consistent with the new minimum payment amounts.

PPACA also included other provisions that will affect physicians and encourage changes in the health care delivery system through payment policy changes. Many of these provisions were highlighted earlier in our discussion of hospital payment policy. One such change in Section 2703 of PPACA, Health Homes for Individuals with Chronic Conditions, allows states (beginning in January 2011) to implement health homes for Medicaid enrollees with certain chronic conditions such as asthma, diabetes, substance abuse, mental health conditions, and heart disease. These "homes" are designated providers or a team of health professionals including (but not limited to) physicians who coordinate and manage these enrollees' care, including making any necessary referrals to specialists. This provision authorizes separate payments to providers for this care management and allows states to receive higher federal match (90 percent) for up to two years.

Physician Payments and the Principles of Efficiency, Economy, Quality, and Access

State and federal policy makers are faced with significant questions regarding the link between physician payment and issues of access and quality. For example, while the physician office visit data presented earlier show geographic variation in payments, it is unclear how these payments affect efficiency, economy, quality, and enrollees' access to care. Evaluating these effects requires additional data and analysis.

We plan to continue and expand our analysis of physician payment issues in the coming year. We will also examine data sources available to the Commission for this analysis. As the repeal of the OBRA 1989 requirements demonstrated, the collection of data for evaluating physician payment and for assessing the link between payment and access is challenging. The wide variation in physician payments, the requirement to pay 100 percent of the Medicare amount for primary care services, and recent federal court involvement in Medicaid payment (Box 5-5) underscore the need to evaluate payment policies. The Commission also intends to explore new and emerging payment approaches such as health homes, bundled payments, and quality incentives.

[17] Procedure codes include those for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under Section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and services related to immunization administration for vaccines and toxoids.

BOX 5-6. Medicaid Managed Care Payment

In an effort to slow Medicaid spending and improve access to care, many states looked to various forms of managed care in the 1990s as a mechanism for delivering services to enrollees (GAO 1993). One of these forms, risk-based managed care, relies on health plans assuming financial risk for providing a defined group of services to enrollees for a fixed rate. According to CMS, almost half of all Medicaid enrollees (and a higher portion of CHIP enrollees) were in a risk-based health plan in 2009. Twenty-five states had more than fifty percent of their Medicaid enrollees in these types of plans in 2009.

Most states establish payment rates for different demographic groups and usually adjust for age, sex, geographic region, maternity care, and program carve-outs that address services not typically covered by insurers (e.g., behavioral health). To set managed care rates, some states use FFS claims data, while an increasing number of states use encounter data (data which capture health services delivered in a risk-based environment). To fine-tune payments more precisely, some states also adjust rates based on enrollees' anticipated health care spending, called "risk adjustment." Health status data are gathered from FFS medical claims or encounter data.

Federal regulations do not include standards for the type, amount, or age of the data used by states to set managed care payment rates. However, Section 1903(m)(2)(A) of the Act requires that states' payment rates be actuarially sound. In 2002 CMS issued regulations requiring that Medicaid managed care rates be developed in accordance with generally accepted actuarial principals and practices, be appropriate for the population and services, and be certified by qualified actuaries (42 CFR 438.6(c)(1)(i)(2009)). The regulations also require states to submit documentation to CMS that demonstrates compliance with requirements and includes a description of the rate-setting methodology and the data used to set rates. A recent study by the Government Accountability Office (GAO), however, found that CMS's oversight of states' compliance with actuarial soundness requirements and data quality for rate setting was inconsistent and could be improved (GAO 2010).

Looking Forward

The Medicaid payment landscape has been shaped by decades of federal and state efforts to maintain state flexibility around payment policy while containing spending and monitoring access to care. Despite these efforts, the Medicaid program still faces a number of significant policy questions that will guide the Commission's efforts in the coming years. The most fundamental questions include:

- What is the relationship of payment to access and quality?
- Which payment innovations best address efficiency and economy while promoting access to quality services and appropriate utilization?

The Commission will begin to answer these questions by creating a baseline of information that includes state payment policies across providers for both FFS and Medicaid managed care. Currently there is no easily accessible source of state payment methods, and the Commission intends to work with states in this endeavor. After establishing this preliminary understanding of the Medicaid payment landscape, the Commission will consider the following types of analyses:

- Evaluate the impact of the required increase in primary care fees and consider how these payment increases should be passed on to Medicaid managed care plans and from plans to providers.
- Evaluate the impact of particular payment policies for improving efficiency, economy, and quality and increasing availability of providers as appropriate.
- Examine the impact of state financing approaches and supplemental payments on providers, payment policy, and states' ability to adopt payment innovations.

This work will help inform the Congress, states, and CMS regarding those payment policies and innovations that might best promote access to necessary and higher-quality services while slowing the growth of health care spending. However, our ability to assess the extent to which these policies are successful is complicated by variability in payment methods, underlying costs, delivery systems, and practice patterns. Evaluation of payment will vary by provider type and must also account for program integrity and the extent to which inappropriate utilization or fraud occurs.

Moving forward, the Commission will be examining program integrity issues along with other determinants of efficiency, economy, quality, and access. The Commission intends to develop a balanced and data-driven approach to payment evaluation that is appropriate for the Medicaid program.

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Chapter 5 Annex

BOX 5A-1. Key Statutory and Regulatory Provisions Governing Medicaid Payment

Medicaid Provider Payment Provisions under the Social Security Act

Public process for determination of institutional payment rates	1902(a)(13)(A)
Hospice payment requirements and room and board payments for hospice patients in nursing facilities or ICFs-MR	1902(a)(13)(B)
Primary care physician payments equal to Medicare for 2013-2014	1902(a)(13)(C)
Procedures for making nursing facility payment data and methodologies available to the public	1902(a)(28)(C)
Payment methods and procedures to safeguard against unnecessary utilization, consistent with efficiency, economy, and quality, and provide access equal to the general population	1902(a)(30)(A)
Audit requirement to ensure proper payments if payments are based on costs	1902(a)(42)
Authority to provide non-emergency transportation through a competitively bid broker contract	1902(a)(70)(B)
Payment for inpatient hospital services to children under the age of 6 in disproportionate share hospitals	1902(s)
Payment for services provided by Federally Qualified Health Centers and Rural Health Clinics	1902(bb)
Upper limits based on customary charges for inpatient hospitals and based on Medicare payment for diagnostic tests; also rebate requirement for outpatient drugs	1903(i)
Payments for Medicaid managed care organizations	1903(m)
Payment to hospital providers of nursing facility services	1913
Payment for Indian Health Service providers	1911
Competitive bidding for laboratory services and medical devices	1915(a)(1)(B)
Payment for inpatient hospital services provided by disproportionate share hospitals	1923
Payment and rebate requirements for outpatient drugs	1927
Ceiling on payment amounts for home and community care	1929(e)(1)
Payment for Programs of All-Inclusive Care for the Elderly (PACE)	1934(d)
Payment for health homes for individuals with chronic conditions	1945(c)
Prohibition on payment for health care-acquired conditions	Section 2702 of the PPACA

BOX 5A-1, Continued

Medicaid Provider Payment Regulations

Contracts with health insuring organizations	42 CFR 434.40
Medicaid managed care: Contract requirements	42 CFR 438.6
Medicaid managed care: State Plan requirements	42 CFR 438.50
Payments for reserving beds in institutions	42 CFR 447.40
Restrictions on payments to providers to offset bad debts	42 CFR 447.57
State plan requirements to describe payment policy and methods	42 CFR 447.201
Audits required if payment based on costs	42 CFR 447.202
Documentation of payment rates	42 CFR 447.203
Encouragement of provider participation (equal access)	42 CFR 447.204
Public notice of changes in statewide methods and standards for setting payment rates	42 CFR 447.205
Payment for inpatient hospital and long-term care facility services (including UPLs)	42 CFR 447 Subpart C
Payment adjustments for hospitals that serve a disproportionate number of low-income patients	42 CFR 447 Subpart E
Payment methods for other institutional and non-institutional services (including UPLs)	42 CFR 447 Subpart F
Payment for drugs	42 CFR 447 Subpart I

TABLE 5A-1. Timeline of Major Federal Medicaid Payment Policy Developments

Year	
1965	Social Security Amendments of 1965 (P.L. 89-97) ► Create the Medicaid program as a federal-state partnership codified under Title 19 of the Social Security Act. ► Section 1902(a)(13) requires hospital payments to be based on "reasonable cost."
1968	Social Security Amendments of 1967 (P.L. 90-248) add Section 1902(a)(30)(A), requiring states to "assure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."
1972	Social Security Amendments of 1972 (P.L. 92-603) ► Repeal "maintenance of effort," allowing states to reduce expenditures from one year to the next. ► Require in Section 249 that payments to nursing facilities and intermediate care facilities be on a reasonable cost-related basis. ► Require that payments for inpatient hospital services do not exceed customary charges.
1977	Health Care Financing Administration (HCFA) is created to administer Medicaid and Medicare.
1980	Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) "Boren Amendment" ► Removes requirement to pay nursing facilities according to Medicare cost principles. ► Instead requires payments to be "reasonable and adequate" to meet the costs of "efficiently and economically operated" facilities.
1981	Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) expands Boren Amendment requirements to hospitals, removing requirement to pay according to Medicare cost principles. ► Removes "reasonable charges" limitation from 1902(A)(30)(A). ► Allows for additional payments to hospitals serving a disproportionate share of Medicaid and low-income patients, later known as disproportionate share hospitals ► Permits 1915(b) freedom-of-choice waivers allowing, for example, states to pursue mandatory managed care for certain Medicaid populations.

Table 5A-1, Continued

Year	
1982	Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248) expands states' options for imposing cost sharing requirements on Medicaid beneficiaries and services. ► Establishes a risk-based prospective-payment system for HMOs participating in Medicare and facilitates their participation. ► Requires HHS to submit a plan for prospective payments to hospitals and nursing facilities.
1983	Social Security Amendments (P.L. 98-21) establish a prospective payment system (PPS) for inpatient hospital services based on diagnosis related groups (DRGs).
1985	Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85, P.L. 99-272) requires Medicare disproportionate share hospital adjustments for hospitals serving low-income patients.
1986	COBRA 85 requires that hospice payments be in the same amounts and use the same methodology as Medicare and allow for a separate room and board payment for hospice patients residing in nursing facilities or ICFs.
1987	Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) ► Requires that payment methods for nursing facilities take into account the cost of complying with newly enacted quality requirements. ► Adds Section 1923 of the SSA, strengthening DSH requirements and outlining payment methods.
1988	Regulations establish separate UPLs for state-owned and non-state-owned inpatient hospitals, nursing facilities, and ICFs-MR.
1989	Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) ► Adds requirement to 1902 (a)(30)(A) (previously established only by regulation) that payments be sufficient to attract enough providers to ensure that covered services will be as available to Medicaid beneficiaries as they are to the general population. ► Establishes specific reporting requirements for payment rates for obstetrics and pediatrics to allow the Secretary to determine the adequacy of state payments for these services. ► Requires coverage and full reimbursement of "reasonable cost" of FQHCs. ► Requires room and board payment for hospice patients residing in nursing facilities equal to 95 percent of the nursing facility rate. ► Establishes the Resource-Based Relative Value Scale (RBRVS) for physician payments under Medicare, replacing charge-based payments.

Table 5A-1, Continued

Year	
1990	Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) ▶ Establishes the prescription drug rebate program requiring "best price" rebates to states and federal government. ▶ Modifies Boren to require that the cost of implementing 1987 nursing home quality reforms be taken into account. ▶ Creates additional flexibility in design of DSH payment methods.
1991	Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) ▶ Restrict the use of provider donations and provider taxes as non-federal share. ▶ Prohibit HCFA from restricting IGTs of state or local tax revenues. ▶ Place national and state-specific ceilings on special payments to DSH hospitals.
1992	Veterans Health Care Act of 1992 (P.L. 102-585) creates the 340B Drug Pricing Program providing eligible safety net providers access to discounted prescription drug pricing for outpatient services.
1993	Administration begins approving Section 1115 demonstration waivers under which states expand use of Medicaid managed care. Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) places facility-specific ceilings on DSH payments.
1997	Balanced Budget Act of 1997 (BBA 97) (P.L. 105-33) ▶ Permits mandatory managed care without obtaining a waiver. ▶ Requires managed care payments to be actuarially-sound. ▶ Codifies and reduces state-specific DSH allotments. ▶ Repeals OBRA 89 requirements for state reporting on obstetric and pediatric payments. ▶ Repeals the Boren Amendment and instead requires State agencies to use a public process to determine payment rates for inpatient hospitals, nursing facilities, and ICFs-MR. ▶ Begins phase-out of cost-based reimbursement for FQHCs and RHCs and added supplemental payments for the difference between Medicaid managed care and fee-for-service payments. ▶ Requires HCFA to develop five new Medicare prospective payment systems, including for inpatient rehabilitation hospitals; skilled nursing facilities; home health agencies; outpatient hospitals; and outpatient rehabilitation.

TABLE 5A-1, Continued

Year	
1999	Balanced Budget Refinement Act (BBRA) of 1999 ▶ Slows phase-out of cost based reimbursement for FQHCs and RHCs. ▶ Increases DSH allotments for several states.
2000	The Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act (P.L. 106-554) ▶ Directs the Secretary of HHS to issue regulations tightening upper payment limits (UPLs). ▶ Creates a new PPS for FQHCs and RHCs and establishes a "floor" for payments. ▶ Modifies DSH funding amounts.
2001	Regulations implementing BIPA UPL requirements become final, and ▶ Impose three separate UPL categories (state-owned, non-state government owned, and private) for inpatient hospitals, nursing facilities, and ICFs-MR. ▶ Add parallel UPL requirements for outpatient hospital and clinics.
2002	CMS promulgates regulations to implement actuarial-soundness requirements established in BBA 97. CMS creates the National Institutional Reimbursement Team (NIRT) with responsibility for the review of institutional reimbursement methodologies. CMS creates non-institutional Provider Team (NIPT) to review non-institutional reimbursement, including physicians.
2003	The Congress raises state-specific DSH allotments for FY 2004 for all states and through FY 2009 for "low-DSH states." CMS begins to require states to answer five questions as part of the state plan amendment (SPA) approval process, requiring details on supplemental payment methodologies and UPL calculations.

TABLE 5A-1, Continued

Year	
2005	Deficit Reduction Act (P.L. 109-171) ▶ Changes the basis of federal upper limit (FUL) for multiple-source drugs from lowest published price to "average manufacturer price" (AMP). ▶ Improves collection of rebates on physician-administered drugs. ▶ Adds children's hospitals as a covered entity in the 340B drug discount program. ▶ Includes other drug-related provisions.
2007	Revised UPL regulations would have limited payments to public providers to the cost of providing services. The final regulation was never made effective, however, and was eventually rescinded.
2009	American Recovery and Reinvestment Act of 2009 (P.L. 111-5) includes temporary DSH allotment increase for FY 2009-10.
2010	Medicaid payment provisions under the Patient Protection and Affordable Care Act (P.L. 111-148) ▶ Prohibit Medicaid payments for health care-acquired conditions. ▶ Include funding for bundled payments demonstrations, global payment demonstrations for safety-net hospitals, pediatric accountable care organization demonstrations, and a demonstration project to provide Medicaid payment to institutions for mental disease in certain cases. ▶ Fund (for two years) primary care physician payments that are at least 100% of Medicare. ▶ Establish a new Center for Medicare and Medicaid Innovation to support pilot programs for innovative payment and delivery arrangements in Medicare and Medicaid.

Note: See also Kaiser Family Foundation timeline www.kff.org\medicaid\medicaid_timeline

Methods Used in the Medicaid Physician Fee Survey

The Urban Institute has conducted surveys of Medicaid physician fees since 1993, with the most recent data collected as of December 2010 (Zuckerman et al. 2009, Zuckerman et al. 2004, Norton and Zuckerman 2000). While the surveys include a range of services, the data presented here are only related to office visits.[18] Data were collected from all 49 states and the District of Columbia that have a fee-for-service component in their Medicaid programs (Tennessee does not have a fee-for-service component).

The data collection procedures established in prior survey years were followed, with one notable difference in 2010. Whereas 2008 reimbursement rates were collected through a combination of surveys completed by state Medicaid officials and fee schedules downloaded from state Medicaid websites, in 2010 all 49 states and the District of Columbia provided fee data online, eliminating the need for surveys and saving a tremendous amount of time in the data collection process. Some states adjust their reimbursement rates for specific physician specialties, services, or populations to meet policy objectives. For example, a number of states reimburse physicians at a higher rate for services provided to children. If a state had multiple fees for the same service, a simple average was computed to obtain a single service fee for each state.[19]

After collection, the 2010 data were examined to identify and validate any fees that increased or decreased by a large amount since 2008 and fees that were unusually high or low as compared to the national average for that service. Once analysts had validated the data, they calculated a national average fee for each service. The national average fee is a weighted average of the fee paid by each state, where the weight for each state was the state's share of national Medicaid enrollment (derived from the 2007 Medicaid Statistical Information System, the most recent available data). Last, they constructed a Medicaid Fee Index that measures each state's fees relative to national average Medicaid fees. This index is the weighted sum of the ratios of each state's fee for a given service to the fee's national average, using Medicaid expenditure weights derived from claims files used in prior years of the study. Although the Medicaid Fee Index was computed for all surveyed Medicaid services, the version presented in this Report is based only on four types of office visits.

[18] Office visit CPT codes included in the index include the following: 99203: Office Visit, New Patient, 30 Minutes; 99204: Office Visit, New Patient, 45 Minutes; 99213: Office Visit, Established Patient, 15 Minutes; 99214: Office Visit, Established Patient, 25 Minutes.

[19] Ideally, we would compute each fee as the weighted average of the share of the service billed at each rate in the state. However, computing the correct weights is not possible without state-level claims data.

CHAPTER 6

Improving Medicaid and CHIP Data for Policy Analysis and Program Accountability

Section 1900(b)(3) of the Social Security Act directs the Commission to: "(A) review national and State-specific Medicaid and CHIP data; and (B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews."

Chapter Summary

Medicaid and CHIP data are critical to the work MACPAC is charged to conduct. They are a means to answer policy questions that affect enrollees, states, the federal government, providers, and others. Medicaid and CHIP data are also a means to ensure accountability for taxpayer dollars.

At the federal level, states report data to the Centers for Medicare & Medicaid Services (CMS) on enrollment, service use, and spending in their Medicaid and CHIP programs. They also report information on policies such as eligibility levels and covered benefits. Such federal administrative data can help to answer key policy and accountability questions for Medicaid and CHIP. For example, do enrollees receive appropriate care? Which policy choices most affect that care and its costs? Do federal legislators and administrators have a clear picture of how Medicaid and CHIP dollars are spent?

Issues such as data timeliness, consistency, and availability, however, have presented longstanding challenges. Different Medicaid and CHIP data are collected from states at different times for different purposes, with states reporting some information on their Medicaid and CHIP programs more than once. In addition to these redundancies, there are gaps in some of the data sources created in this process that limit their usefulness.

CMS is taking steps to address Medicaid and CHIP data issues, including developing a plan to modernize its computer and data systems. The Commission encourages the agency to continue these efforts and to seek input from states and other stakeholders. Areas for improvement that the Commission suggests CMS consider include the reporting of encounter data by managed care plans, the timeliness of enrollment and other data, consistency of data across sources, and information about state program policies.

CHAPTER 6

Improving Medicaid and CHIP Data for Policy Analysis and Program Accountability

Although data reported by the states on their Medicaid and CHIP programs provide an important source of information for the Commission in carrying out its statutory duties, the collection of those data is never an end in itself. Instead, it is a means to answer policy questions that affect enrollees, states, the federal government, providers, and others, as well as to ensure accountability for taxpayer dollars.

In this chapter we highlight ways in which existing federal administrative data can help to answer key policy and accountability questions. For example, do enrollees receive appropriate care? Which policy choices most affect that care and its costs? Do legislators and administrators have a clear picture of how Medicaid and CHIP dollars are spent?

We then describe major federal administrative data sources that are used for most national and cross-state analyses of enrollment, service use, and spending in Medicaid and CHIP. Other sources of information on state program policies, such as eligibility levels and covered benefits, are also discussed.

Finally, we note areas where better federal administrative data on Medicaid and CHIP are needed and provide examples of how improvements to these data could allow for better analysis of policy and program accountability issues. These areas include:

- the ability to understand service use among managed care enrollees and children in separate CHIP programs;
- the timeliness and consistency of various data sources; and
- the availability of information on state program policies.

A number of these areas could be addressed through current Centers for Medicare & Medicaid Services (CMS) efforts to modernize its computer and data systems. The Commission encourages the agency to continue its development of a strategic plan for Medicaid and CHIP data, with input from states and other stakeholders. To the extent that decisions about Medicaid and CHIP—including those made by the Congress—are guided by these data, both states and the federal government have an interest in improving their quality.

What are Administrative Data?

In the course of administering the Medicaid and CHIP programs, states and the federal government generate large amounts of data. For example:

- States outline certain program policies (e.g., regarding eligibility levels and covered benefits) in state plan and waiver documents that must be approved by CMS.
- Enrollees report eligibility-related information (e.g., income, age, and other characteristics), some of which may vary by eligibility group and state.
- Claims processing systems generate records of services provided to enrollees and associated payments.
- States complete accounting statements to obtain federal funds for a share of their Medicaid and CHIP costs.

At the state level, Medicaid and CHIP administrative data are maintained in systems and formats that vary across and sometimes within states. For example:

- Multiple states may use the same private company to process claims from providers, but each may require providers to bill for their services using state-specific codes.
- Certain services (e.g., those delivered in schools) may be paid using alternative systems.
- Although federal law requires them to operate under the authority of a single state Medicaid agency, multiple state—and often local—agencies may have responsibility for different program functions such as determinations of eligibility and payments to providers.

At the federal level, most administrative data on Medicaid and CHIP are generated from information reported by states to CMS. For many states, prior to FY 1999 the data reported on spending, enrollment, and service use consisted only of aggregate statistics. Currently reported data provide detailed person-level and claims-level information on Medicaid enrollees,[1] in addition to a variety of aggregate statistics. Looking forward, CMS is considering how to integrate clinical data that could provide information on health outcomes among program enrollees as the implementation of electronic health records and health information exchanges proceeds.[2]

Federal administrative data on Medicaid and CHIP provide a national picture of the programs and some degree of comparable information across states because they have been translated from multiple systems into a standard format. One

[1] Person-level data provide eligibility-related and other information on each enrollee, such as age. Claims-level data provide a record of individual services provided to enrollees.

[2] For a discussion of electronic health records and health information exchanges (which differ from health *insurance* exchanges), see NGA 2009.

of the fundamental purposes of collecting these data is to ensure the appropriateness of federal payments to states for their Medicaid and CHIP programs. At the same time, however, states require their own particular reports and analyses to manage their programs and account to their legislatures. They may consider federal reporting requirements burdensome as they face budget pressures and competing demands. States may also see the data as having little use, except as a benchmark for comparing themselves to others. In light of these issues, the success of efforts to improve the quality and timeliness of federal administrative data on Medicaid and CHIP may depend in part on the ability of CMS to provide states with technical and other assistance, as well as to demonstrate the value of this information for states.

Improvements to federal administrative data could ultimately reduce both state and federal burdens by eliminating redundancies in what is currently reported. They could also allow the federal government, including the Commission, and others to expand or replicate analyses that now are possible only by using administrative data maintained by individual states. This would be particularly valuable as many states find themselves with limited analytic resources due to budget constraints.

What Can Be Learned from Federal Administrative Data?

The Commission acknowledges that states' own administrative data provide a rich picture of their individual Medicaid and CHIP programs. The remainder of this chapter, however, focuses on federal administrative data that attempt to provide comparable information on these diverse programs. Often these data may be the best, and sometimes the only, national source of state-level information on Medicaid and CHIP due to the sample size and other limitations of surveys.

Here we give examples of how federal administrative data can be used to analyze a variety of issues and meet the needs of administrators and legislators—including CMS and the Congress—by providing information on enrollees' access to care, the value received for dollars spent on that care, and the integrity of the programs. Some general uses of the data include:

- **Projections.** For example, historical trends are an important factor for projections of future enrollment and spending under current law and alternative proposals made by the Congressional Budget Office (CBO) and CMS.
- **Analysis of spending growth.** For example, such analyses can show the extent to which growth in spending is due to increases in enrollment versus increases in spending per enrollee.
- **Analysis of service use and spending by enrollee characteristics.** This allows, for example, identification of enrollees who account for a disproportionate share of program spending.
- **Analysis of the quality and appropriateness of care.** For example, receipt of recommended care, such as preventive dental services by children, can be examined.

- **Analysis of program characteristics.** For example, such analyses can assess the extent to which policies such as those regarding care management and coordination may affect program costs and enrollee outcomes.
- **Analysis of billing and utilization patterns.** For example, in addition to states' own efforts, CMS is exploring claims data to identify potential fraud and abuse in the programs.
- **Enhancement of other data sources.** Administrative and survey data sources are being linked with each other to provide a richer picture of Medicaid and CHIP than can be obtained from these sources in isolation.

Access to Care

As noted in Chapter 4, the Commission intends to examine access to care in Medicaid and CHIP on a number of dimensions. Access is also discussed in Chapter 5—along with efficiency, economy, and quality—in the context of payments to providers. With regard to these topics, federal administrative data can shed light on a number of issues.

For example, the data can provide information on the characteristics of Medicaid and CHIP enrollees and the services they use. The data can also provide information on the cost of care for various populations, which affects states' budgets and thus their ability to implement policies that could improve access. Although they account for only about a quarter of Medicaid enrollment, federal administrative data indicate that individuals age 65 and older and persons with disabilities account for about two-thirds of Medicaid spending on benefits (Figure 2-2). Similarly, individuals enrolled in both Medicaid and Medicare ("dual eligibles") account for 15 percent of Medicaid enrollment and about 40 percent of Medicaid spending on benefits (Rousseau et al. 2010). Among non-elderly adults with disabilities enrolled only in Medicaid, mental illness is nearly universal among the highest-cost, most frequently hospitalized individuals (Boyd et al. 2010).

Analyses of service use may seem straightforward at first glance, but they require extensive cross-walking of state-specific information into standard service definitions at the federal level. Although some anomalies remain after this cross-walking occurs, the resulting federal administrative data on Medicaid and CHIP can be used to examine whether enrollees receive recommended care such as preventive dental services; monitor patterns of care among enrollee subgroups such as children in foster care; and identify opportunities for improvement such as potentially avoidable hospital readmissions (GAO 2010, Gilmer and Hamblin 2010, Green et al. 2005). Administrative data sources are also being linked with each other to examine, for example, Medicaid and Medicare service use and spending together for dual eligibles. The Medicare Payment Advisory Commission (MedPAC) has begun examining these linked data on dual eligibles (MedPAC 2010), and this Commission will coordinate its analysis with MedPAC and the Federal Coordinated Health Care Office at CMS.

Value Received for Dollars Spent

Federal administrative data can be used to examine Medicaid and CHIP program spending growth and some of its broad underlying factors. For example, between FY 1975 and FY 2002, about 40 percent of the growth in overall spending for Medicaid benefits was due to a rising number of recipients

and about 60 percent was due to increases in real (inflation-adjusted) treatment costs per recipient (CBO 2006). An analysis of more recent data indicates that, between FY 2000 and FY 2007, growth in overall spending for Medicaid benefits was largely driven by enrollment and—as with other payers—underlying health care inflation; increases in real treatment costs have played a smaller role (Holahan and Yemane 2009).

A more difficult issue to address is whether state spending on Medicaid and CHIP is efficient. Although there are many definitions of efficiency and little agreement about which is preferable, one recent study suggested examining state Medicaid programs in terms of the access, quality, and health outcomes they produce for a given level of spending (Lipson et al. 2010). Federal administrative data sources provide useful information on program spending, but analyzing these data can be complicated for a number of reasons (e.g., the fact that some providers receive both standard and supplemental payments). In addition, the outcomes obtained from federal administrative data—primarily those that measure service use, such as hospital readmissions or receipt of preventive and other recommended care—may be somewhat limited.

In any consideration of Medicaid and CHIP efficiency, the ultimate goal is to identify policies that increase value received for dollars spent on the programs, which may be defined in many ways. This is a particularly difficult task given that other factors—such as enrollee and local health care market characteristics—may also contribute to variation in costs and outcomes. However, to the extent that federal administrative data provide relevant state-by-state information (e.g., provider payment methodologies, efforts to increase fee-for-service or managed care provider networks, changes to covered benefits), they may be a useful resource for examining how policy choices influence both costs and outcomes. Even in cases where federal administrative data do not have the level of detail desired for a particular analysis, they may provide a useful starting point for gathering information from additional sources.

Program Integrity

As noted in Chapter 2, discussions of Medicaid program integrity are often limited to issues of fraud and abuse by Medicaid providers, as well as enrollees. However, a broader view encompasses other issues (e.g., policy development and execution) that affect the ability of states and the federal government to ensure that enrollees receive quality care and that taxpayer dollars are spent appropriately. Many of the federal administrative data sources discussed in this chapter can be used to address a variety of program integrity issues. For example, CMS is working with other federal agencies to supplement existing federal data on Medicaid and CHIP with additional information from states for purposes of identifying, and developing policies to mitigate, fraud and abuse in the programs (CMS 2009).

Federal Sources of Administrative Data

The following section describes major federal sources of administrative data that serve as the basis for most national and cross-state analyses of program enrollment, expenditures, and service use. It also describes those sources that provide information on state program policies, such as

eligibility levels and covered benefits.[3] These sources are summarized in Table 6-1.

Funding for data-related activities at CMS is generally provided by annual appropriations, but dedicated funding may also be provided by the Congress for specified purposes.[4] When states incur Medicaid and CHIP administrative costs for data collection, reporting, and other activities, the federal government reimburses them for a share of the total. For Medicaid, routine activities receive a 50 percent federal match and data systems may be eligible for 75 or 90 percent if certain criteria are met.[5] Administrative costs related to CHIP may receive a federal match that varies by state from 65 to about 80 percent. Administrative costs, however, are limited to 10 percent of a state's annual federal CHIP spending.

Medicaid and CHIP Budget and Expenditure Systems (MBES/CBES)

Financing for the Medicaid and CHIP programs is shared by the federal government and the states. States incur Medicaid and CHIP costs by making payments to providers and managed care plans and by performing administrative activities. They then receive federal reimbursement for a share of their costs by submitting quarterly expenditure reports through an online MBES/CBES maintained by CMS. Actual expenditures for regular Medicaid and Medicaid-expansion CHIP programs are reported on Form CMS-64; actual expenditures for separate CHIP programs are reported on Form CMS-21. Supporting documentation for the amounts on these forms must be readily available for review by CMS as necessary. Projected Medicaid expenditures are reported on Form CMS-37. With a few exceptions, these data provide a comprehensive picture of total federal and state spending on Medicaid and CHIP by major benefit and administrative categories.[6]

Medicaid Statistical Information System (MSIS)

MSIS is a data source compiled by CMS from detailed eligibility and claims information reported by all states since FY 1999. Previously, states were only required to provide aggregate statistics on Medicaid enrollment, service use, and spending in an annual report. Currently, states must submit five MSIS files every quarter: one containing eligibility-related information on each person enrolled in the state Medicaid program (e.g., months of Medicaid enrollment, basis of eligibility, dual enrollment in Medicare, demographics such as age, sex, and race/ethnicity) and four containing information on paid claims for inpatient hospital, institutional long-

[3] Although additional references are cited throughout, descriptions of many federal administrative data sources in this chapter were informed by Borden et al. 2010 and numerous links on the CMS website at www.cms.hhs.gov.

[4] For example, funding for certain data activities related to program integrity is provided through the Health Care Fraud and Abuse Control account (HHS and DOJ 2011).

[5] A recent proposed rule from CMS describes the availability of federal reimbursement for Medicaid data systems under current law (CMS 2010a).

[6] Expenditures not reported through MBES/CBES include amounts for the Vaccines for Children program (which is authorized under the Medicaid statute but otherwise operates as a separate program), State Medicaid Fraud Control Units, and Medicaid survey and certification of nursing and intermediate care facilities.

term care, drugs, and other services (e.g., type of service, place of service, amount paid by Medicaid, and diagnoses). States have the option of reporting information on separate CHIP enrollees in MSIS and about half do so.

Each quarterly file submitted by a state undergoes quality review; those that do not pass are returned to states for correction and resubmission. Known issues that cannot be resolved for a given state (e.g., due to problems associated with upgrades or changes to a computer system) are detailed in a report of data anomalies. Once accepted, CMS processes the MSIS files in a number of ways. For example, it produces state-level statistics for months, quarters, and fiscal years; person-level data files with summary information for each fiscal year; and Medicaid Analytic eXtract (MAX) data files with detailed person-level and claims-level information for each calendar year.

TABLE 6-1. Federal Sources of Administrative Data

Source	Brief Description
Medicaid and CHIP Budget and Expenditures System (MBES/CBES)	Reports (Forms CMS-64, CMS-21, and CMS-37) detailing aggregate spending that are submitted by states to receive federal reimbursement for a share of their Medicaid and CHIP costs.
Medicaid Statistical Information System (MSIS)	Eligibility-related information on each person enrolled in Medicaid, as well as a record of each claim paid for most services an enrollee receives.
Statistical Enrollment Data System (SEDS)	Aggregate statistics on CHIP and child Medicaid enrollment.
Form CMS-416	Aggregate statistics on children receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.
Form CMS-372	Aggregate statistics on enrollees and spending under home and community-based waivers.
Medicaid Drug Rebate System (MDR)	Aggregate statistics on drug utilization and payments for calculating rebates to states from drug manufacturers.
State Medicare Modernization Act (MMA) files	Monthly eligibility-related information on "dual eligibles" enrolled in Medicaid and Medicare used for Medicare Part D purposes.
Incurred But Not Reported Survey System (IBNRS)	Accounting data submitted by states to CMS for its fiscal year Annual Financial Report.
State plan documents	Documents that describe a state's Medicaid and CHIP policies under regular statutory rules.
Waiver documents	Documents that describe a state's Medicaid and CHIP policies under a statutory waiver of certain federal requirements.
Medicaid Managed Care Data Collection System (MMCDCS)	Aggregate statistics on managed care enrollment, along with basic descriptive information on each managed care plan and program within a state.
CHIP Annual Report Template System (CARTS)	Variety of information on CHIP programs such as eligibility and other policies and performance measures regarding receipt of care.

Statistical Enrollment Data System (SEDS)

States report aggregate statistics on CHIP enrollment and child Medicaid enrollment through SEDS. The enrollee data are broken out by separate CHIP, Medicaid-expansion CHIP, and regular Medicaid; age, gender, and race/ethnicity; specified income ranges as a percentage of the federal poverty level; and type of delivery system (fee for service, comprehensive managed care, or primary care case management).

Form CMS-416

Under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for individuals under age 21, states must cover certain periodic screening, vision, dental, and hearing services and any medically necessary service listed in the Medicaid statute, including optional services that are not otherwise covered by the state. States report aggregate statistics for EPSDT by age group on an annual basis via Form CMS-416, including services provided under both fee-for-service and managed care arrangements. Information collected includes the number of: individuals eligible for EPSDT; expected and actual screenings; eligible enrollees receiving at least one screen, referrals for corrective treatment, or dental/oral health service (with specific breakouts that most recently include sealants and non-dentist providers); and blood lead screening tests.

Medicaid Drug Rebate (MDR) System

For purposes of calculating rebates from drug manufacturers through a Medicaid Drug Rebate system at CMS, states are required to report drug utilization and payment information on a quarterly basis. These data are reported by national drug code (NDC), which is a unique number that identifies a drug's manufacturer, product information, and package size and type.

State Medicare Modernization Act (MMA) Files

States report monthly MMA files that contain eligibility-related information on dual eligibles enrolled in Medicaid and Medicare. These data are used to determine Medicare Part D low-income subsidies for dual eligibles and to facilitate their enrollment in prescription drug plans under Part D. In addition, the data are used in the calculation of phased-down state contribution (often referred to as "clawback") payments to the federal government. These payments offset Medicare's cost of assuming primary responsibility for prescription drug coverage for dual eligibles, which had been provided through Medicaid prior to 2006.

Incurred But Not Reported Survey (IBNRS) System

CMS uses IBNRS to prepare its fiscal year Annual Financial Report as required by P.L. 103-356. States submit accounting information for Medicaid and CHIP through IBNRS using two forms (CMS-R199 and CMS-10180) that allow CMS to accrue an accounts payable for the services rendered by providers as of the end of the fiscal year and an accounts receivable for all amounts due to the states from various sources, excluding the federal government.

State Plan Documents

A state plan is a comprehensive written statement that describes the nature and scope of a Medicaid or CHIP program (e.g., regarding state administrative structure and operations, eligibility, covered benefits, payment methods) and must be approved by the federal government in order for a state to receive federal funds. State plans consist of both preprinted material that covers basic requirements and individualized narratives that reflect the characteristics of a particular state's program. As federal requirements and state policies change over time, updates are made via state plan amendments (SPAs). Including attachments, state plans may be hundreds of pages long.

Waiver Documents

The Social Security Act (the Act) contains multiple waiver authorities that allow states flexibility in operating their Medicaid and CHIP programs without regard to certain federal requirements that would otherwise apply.

- Section 1115 of the Act is the demonstration authority applicable to Medicaid and certain other programs under the Act (e.g., cash welfare assistance and child support enforcement under title IV). Under Section 1115 the Secretary of Health and Human Services (HHS) may waive a broad range of Medicaid state plan requirements to enable a state to carry out a demonstration project that is judged to promote the objectives of the program. CHIP requirements can also be waived (Sections 2107(e)(2)(A) and (f) of the Act). Section 1115 waivers have evolved over the years and many states have used savings estimated to accrue under these waivers to finance coverage for populations not otherwise eligible for Medicaid or CHIP. States submit Section 1115 waiver proposals in paper formats. CMS outlines the terms and conditions of approved proposals in documents that are specific to each waiver.
- Section 1915(b) of the Act authorizes the Secretary to waive a more limited set of Medicaid state plan requirements pertaining to freedom of choice of providers, statewide implementation (statewideness), and the provision of comparable benefits (comparability) for enrollees. Section 1915(b) waivers have traditionally been used to require enrollment in managed care and to provide additional benefits, although a waiver is no longer required for mandatory enrollment of most populations. Applications for 1915(b) waivers contain both structured and narrative information and may be submitted through an online system at state option.
- Section 1915(c) of the Act allows the Secretary to waive the Medicaid statewideness and comparability requirements, as well as certain income and asset requirements, in order to provide home and community-based services to enrollees who would otherwise require the level of care provided in a nursing home or other institution. Section 1915(c) waiver applications and renewals are required to be handled through an online system that also collects Form CMS-372 aggregate statistics on enrollees and spending by type of service for each waiver.

Medicaid Managed Care Data Collection System (MMCDCS)

States report information through MMCDCS on an annual basis. CMS uses it to create a managed care enrollment report that provides aggregate enrollment statistics and other basic information for each managed care plan within a state, along with national and state-level summary information. CMS also uses it to create a national summary report that describes the managed care programs within a state, each of which may include several plans.

CHIP Annual Report Template System (CARTS)

CARTS was designed to help states meet a statutory requirement to assess the operation of their CHIP programs each fiscal year and report results to the Secretary of HHS by January 1. A variety of both structured and narrative information is collected. Topics include eligibility and other policies; performance measures regarding receipt of care; enrollment data from SEDS and data on uninsured children from a federal survey; state progress towards meeting goals; budget information; and most recently, dental information of the type reported for Medicaid children in the CMS-416.

Areas Where Improvements Could Be Made

As described in this chapter, Medicaid and CHIP data are collected from states at different times in different formats for different purposes, with states reporting some information on their Medicaid and CHIP programs more than once. In addition to these redundancies, gaps in some of the data sources created in this process limit their usefulness.

At CMS, a Medicaid and CHIP Business Information Solutions (MACBIS) council has been established and is overseeing a project to transform the agency's data strategy and environment (Plewes 2010, Thompson 2010). As part of this effort, the council commissioned a review of existing Medicaid and CHIP data sources and their uses (Borden et al. 2010). CMS has also released a plan for modernizing its computer and data systems, which includes convening a state advisory panel to make recommendations in 2011 on a strategy that lessens burdens on states and other stakeholders but still meets the need for standardized information (CMS 2010b).

CMS activities to inventory its existing data sources provide a valuable starting point for addressing both redundancies and gaps in the information reported by states. The Commission supports these efforts and encourages the agency to continue its development of a strategic plan for Medicaid and CHIP data. Here we note a number of areas for CMS to consider in this process and provide examples of how improvements to federal administrative data could allow for better analysis of policy and program accountability issues.

Managed Care Encounter Data

The federal government currently has little information on the services used by the growing number of Medicaid enrollees in managed care. Under most of these arrangements, a managed care entity receives a single payment to provide a defined set of services. Depending on the definition of managed care that is used, half or more of Medicaid enrollees receive some or all of their services through managed care, which

accounts for nearly a quarter of Medicaid spending on benefits (Box 2-2).

All states that contract with managed care plans collect "encounter data" that provide a record of the services furnished to Medicaid enrollees. However, many do not report these data to the federal government in MSIS as required (OIG 2009a). Among states that do report encounter data in MSIS, the quality of the data is largely unknown. CMS recently began a project to explore this issue and provide technical assistance to states. It is also developing a regulation on the submission of encounter data in MSIS.

- If complete managed care encounter data were collected, CMS could directly calculate certain measures reported elsewhere by states. These might include EPSDT statistics reported for children on the CMS-416, as well as certain child and adult quality measures that would otherwise be voluntarily reported by states (HHS 2010b, c).
- To the extent that directly calculated measures could substitute for existing reports, burdens on states could be reduced.
- In addition, federally reported encounter data could be used to make national and cross-state comparisons of the quality of care received by Medicaid and CHIP enrollees whose benefits are delivered through fee-for-service versus managed care systems, which some states already do on an individual basis (Thomson Medstat 2006, Ku et al. 2009).

Information about Enrollees in Separate CHIP Programs

There is currently no requirement for states to report enrollees in separate CHIP programs in MSIS. Only about half of the 44 states with combination or separate CHIP programs choose to do so in addition to their reporting of aggregate enrollment in SEDS (MPR 2010). CMS is developing regulations on separate CHIP reporting but the scope and content of the data have yet to be determined.

- Because children may move between Medicaid and CHIP as their family circumstances change, the lack of person-level data on enrollees in separate CHIP programs hampers analysis of transitions that may leave them uninsured for periods of time.
- A lack of claims-level data on separate CHIP enrollees also prevents detailed examinations of their service use and spending, which may vary in part due to differences between Medicaid and CHIP benefit packages. However, because most children in separate CHIP programs receive services through a comprehensive managed care plan (Table 5 in MACStats), the submission of encounter data would be necessary for this purpose.

EPSDT

As described earlier, Medicaid requires states to cover a broad range of services for enrolled children through the EPSDT benefit; states report annually on EPSDT-related activities via Form CMS-416. With regard to dental services, the Government Accountability Office (GAO) has indicated that CMS-416 data are limited in terms

of the information they provide on utilization and their usefulness for oversight (GAO 2009). CMS recently began collecting additional information on the CMS-416 regarding receipt of dental care; the agency has also convened an EPSDT improvement workgroup.

As with other federal administrative data, there are concerns about the comparability of CMS-416 information across states. For example, states may require different levels of reporting from managed care plans and certain providers (e.g., federally qualified health centers that are paid a flat cost-based amount per visit) (OIG 2009a, Schneider et al. 2005). In addition, methods used by states to determine service use among children in managed care for purposes of CMS-416 reporting are not well documented.

- As noted earlier, if complete managed care encounter data were collected, CMS could directly calculate certain measures reported elsewhere by states. These might include EPSDT statistics reported for children on the CMS-416.
- Improvements in the data used to monitor care, including the CMS-416 or another source such as MSIS, could be used to better target outreach efforts aimed at enrollees in need of services.[7]

Timeliness

Timeliness of federal administrative data on Medicaid and CHIP is a frequently cited concern. Although aggregate expenditures from the CMS-64 and CMS-21 are available with a lag of only a few months, enrollment and other data reported in MSIS take much longer to produce. For example, more than a year after the close of the fiscal year many states do not have complete MSIS data for FY 2009. Without up-to-date federal administrative data on state-level Medicaid enrollment, information collected by outside organizations and through surveys is used as a supplement. However, these data sources may differ in the types of Medicaid enrollees who are counted and in how enrollment is measured (Table 1 in MACStats). CMS plans to conduct a pilot to address data timeliness and to automate checks of data quality; it also plans to address enforcement of timely reporting in future regulations.

- More timely data would give administrators and legislators a clearer picture of the programs as they operate now—rather than as they did two or three years ago.
- In addition to state efforts that make use of their own administrative data, federal efforts to prevent fraud, waste, and abuse could be bolstered by more timely federal administrative data (OIG 2009b).

Consistency

Consistency of information across data sources is an ongoing issue. For example, among states that do report CHIP enrollees (Medicaid-expansion, separate, or both) in MSIS, enrollment figures do not always match those reported in SEDS. In addition, analyses comparing CMS-64 and MSIS spending data have found that even after adjusting for differences in scope and design, MSIS consistently produces lower numbers than the

[7] Despite potential problems with the CMS-416, aggregate statistics on dental and other utilization measures in the CMS-416 might still be more complete than those computed from MSIS in its current form, due to missing or unverified managed care encounter data in MSIS.

CMS-64 (Plewes 2010). Another recent analysis of MAX (a source derived from MSIS) and CMS-64 spending data for long-term services and supports found significant differences between the two (Wenzlow et al. 2008).

These inconsistencies have many possible explanations but they are difficult to document clearly and comprehensively. Historically CMS has not used MSIS data to analyze expenditures reported by states on the CMS-64 (GAO 2006). Further exploration of differences between these two sources could, however, highlight issues relevant for both policy analysis and program accountability.

- For example, CMS could provide useful context for analyses of detailed spending data in MSIS by explicitly identifying settings in which payments are made outside of each state's primary claims processing system (e.g., services delivered in schools, certain services provided in home and community settings) and might therefore be missing from that data source. Although it is well known that MSIS generally excludes supplemental payments that are made to institutional providers such as hospitals, the extent to which other amounts may not be reported in MSIS is less clear.
- In addition, a detailed exploration of differences between the two sources would inform the possibility of using MSIS as the basis for calculating most CMS-64 expenditure amounts. This could reduce state reporting redundancies and make it easier for CMS to connect a state's request for its federal share of Medicaid costs to claims paid by the state.[8] However, a number of other issues (e.g., states' ability to produce MSIS data on a schedule that allows them to receive timely federal reimbursement) would need to be addressed before this could occur.

Information about State Program Policies

A recent report examining data challenges faced by CMS identified the capture of information on state program policies in a more structured (i.e., non-narrative) format as a critical need (Borden et al. 2010). With the exception of 1915(c) and some 1915(b) waivers, these program data are largely submitted, reviewed, and approved in paper or electronic formats that cannot be easily summarized or linked with other data sources. State plans contain hundreds of pages that are stored in paper form in CMS regional offices; although state plan amendments are submitted electronically, they are often stored in paper form. Information on Section 1115 waivers is manually entered into a database that is updated periodically but is not always current.

In order to provide consumers with state-specific information on Medicaid and CHIP eligibility and benefits via the healthcare.gov website, CMS recently abstracted information from Medicaid and CHIP state plan and waiver documents using a set of standardized forms; they then verified the information with states. CMS is considering how it will continue to update this information and how it might expand its efforts to collect Medicaid and CHIP state program policies in a more structured

[8] Currently, if CMS has questions about a request for federal reimbursement on the CMS-64, it must obtain supporting information that will vary by state.

format. In addition, the agency recently rolled out a web-based submission process for states opting to provide a new "health home" benefit for enrollees with chronic conditions (CMS 2010c).

As noted earlier, CMS has efforts underway to modernize its computer and data systems. Ideally, this would include the construction of a fully automated system that directly links data on program policies with data on the populations served by Medicaid and CHIP and the benefits they receive. Realistically, it will take a number of years to implement such changes. In the meantime, existing information can be made more readily available.

- Medicaid state plans are not published in their entirety on the CMS website. The Commission supports plans to do so (HHS 2010a). Current online access to Medicaid state plan information is limited to SPAs.
- CHIP state plans and SPAs are available on the CMS website but they do not always include attachments that elaborate on elements of the state plan and are not always up to date.
- Certain Medicaid and CHIP waiver documents are published online but they are not always complete and up to date.

Increasing access to these data would be beneficial for a variety of reasons:

- The federal government could strengthen its program oversight by providing consistent and comprehensive information on state activities for use by CMS and other agency staff.
- States could more easily learn about the policy choices made by others as they consider their own program changes.
- Analysts could better identify the range of policies in place across states as they examine the number of people who are covered by Medicaid and CHIP, the services they use, and the amount spent on those services.

Looking Forward

The Commission supports efforts by CMS to address redundancies and gaps in the Medicaid and CHIP data reported by states and will continue to monitor and make use of these data in its work. It also encourages the agency to continue its development of a strategic plan for Medicaid and CHIP data with input from states and other stakeholders. Although this chapter has considered administrative data exclusively, the Commission also intends to examine routinely collected survey data that provide information on Medicaid and CHIP enrollees and providers, as well as special studies that collect data for targeted purposes.

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Acronym List

ACO	Accountable Care Organization
ACS	American Community Survey
AFDC	Aid to Families with Dependent Children
AHRQ	Agency for Healthcare Research and Quality
AMP	Average Manufacturer Price
APC	Ambulatory Patient Classification
ARRA	American Recovery and Reinvestment Act of 2009
BBA	Balanced Budget Act
BBRA	Balanced Budget Refinement Act
BRFSS	Behavioral Risk Factor Surveillance System
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARTS	CHIP Annual Report Template System
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMCS	Center for Medicaid, CHIP, and Survey & Certification
CMI	Centers for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPE	Certified Public Expenditure
CPS	Current Population Survey
CPS ASEC	Current Population Survey Annual Social and Economic Supplement
CTS	Community Tracking Study
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
EAPG	Enhanced Ambulatory Patient Group
ED	Emergency Department
E-FMAP	Enhanced Federal Medical Assistance Percentage
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment (i.e., services/benefits)
ER	Emergency Room
ESI	Employer-Sponsored Insurance
EWS	Early-Warning System
FCHCO	Federal Coordinated Health Care Office
FFS	Fee-for-Service

FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FUL	Federal Upper Limit
FY	Fiscal Year
GAO	Government Accountability Office
GDP	Gross Domestic Product
GME	Graduate Medical Education
HCAC	Health Care-Acquired Condition
HCBS	Home and Community Based Services
HCERA	Health Care and Education Reconciliation Act of 2010
HCFA	Health Care Financing Administration (now CMS)
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	United States Department of Health and Human Services
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IBNRS	Incurred But Not Reported Survey System
ICF	Intermediate Care Facility
ICFs/MR	Intermediate Care Facilities for the Mentally Retarded
IGT	Intergovernmental Transfer
IOM	Institute of Medicine
LPR	Lawful Permanent Resident
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MA	Medicare Advantage (also Medical Assistance)
MACBIS	Medicaid and CHIP Business Information Solutions Council
MACPAC	Medicaid and CHIP Payment and Access Commission
MAGI	Modified Adjusted Gross Income
MAX	Medicaid Analytic eXtract
MBES/CBES	Medicaid and CHIP Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System
MCH	Maternal and Child Health
MCO	Managed Care Organization
MDR	Medicaid Drug Rebate
MedPAC	Medicare Payment Advisory Commission
MEPS	Medical Expenditure Panel Survey
MEPS-HC	Medical Expenditure Panel Survey-Household Component
MMA	Medicare Modernization Act
MMCDCS	Medicaid Managed Care Data Collection System
MMIS	Medicaid Management Information Systems
MOE	Maintenance of Effort
MSIS	Medicaid Statistical Information System
MSP	Medicare Savings Program

MUA	Medically Underserved Area
NAMCS	National Ambulatory Medical Care Survey
NAMD	National Association of Medicaid Directors
NASBO	National Association of State Budget Officers
NASHP	National Academy of State Health Policy
NCQA	The National Committee for Quality Assurance
NCSL	National Conference of State Legislatures
NDC	National Drug Code
NGA	National Governors Association
NHE	National Health Expenditure
NHIS	National Health Interview Survey
NHPF	National Health Policy Forum
NIPT	Non-Institutional Provider Team
NIRT	National Institutional Reimbursement Team
NSCH	National Survey of Children's Health
NSCSHCN	National Survey of Children with Special Health Care Needs
OACT	CMS Office of the Actuary
OBRA	Omnibus Reconciliation Act
OIG	Office of Inspector General
OPD	Outpatient Department
PACE	Program of All Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PCP	Primary Care Physician
PERM	Payment Error Rate Measurement
PMPM	Per Member Per Month
PPACA	Patient Protection and Affordable Care Act
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System
QI	Qualifying Individual
QMB	Qualified Medicare Beneficiary
QDWI	Qualified Disabled Working Individual
RBRVS	Resource-Based Relative Value Scale
RHC	Rural Health Clinic
SEDS	CHIP Statistical Enrollment Data System
SFY	State Fiscal Year
SGA	Southern Governors' Association
SIPP	Survey of Income and Program Participation
SLMB	Specified Low-Income Medicare Beneficiary
SPA	State Plan Amendment
SSA	Social Security Act
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TEFRA	Tax Equity and Fiscal Responsibility Act
UPL	Upper Payment Limit

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Authorizing Language from the Social Security Act (42 U.S.C. 1396-1)

MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION

(a) ESTABLISHMENT.—There is hereby established the Medicaid and CHIP Payment and Access Commission (in this section referred to as 'MACPAC').

(b) DUTIES.—

(1) REVIEW OF ACCESS POLICIES FOR ALL STATES AND ANNUAL REPORTS.—MACPAC shall—

(A) review policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP') affecting access to covered items and services, including topics described in paragraph (2);

(B) make recommendations to Congress, the Secretary, and States concerning such access policies;

(C) by not later than March 15 of each year (beginning with 2010), submit a report to Congress containing the results of such reviews and MACPAC's recommendations concerning such policies; and

(D) by not later than June 15 of each year (beginning with 2010), submit a report to Congress containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, MACPAC shall review and assess the following:

(A) MEDICAID AND CHIP PAYMENT POLICIES.—Payment policies under Medicaid and CHIP, including—

(i) the factors affecting expenditures for the efficient provision of items and services in different sectors, including the process for updating payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services;

(ii) payment methodologies; and

(iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries (including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income and other vulnerable populations).

(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services enrollees require to improve and maintain their health and functional status.

(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.

(F) INTERACTION OF MEDICAID AND CHIP PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—The effect of Medicaid and CHIP payment policies on access to items and services for children and other Medicaid and CHIP populations other than under this title or title XXI and the implications of changes in health care delivery in the United States and in the general market for health care items and services on Medicaid and CHIP.

(G) INTERACTIONS WITH MEDICARE AND MEDICAID.— Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.

(H) OTHER ACCESS POLICIES.—The effect of other Medicaid and CHIP policies on access to covered items and services, including policies relating to transportation and language barriers and preventive, acute, and long-term services and supports.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.

(4) CREATION OF EARLY-WARNING SYSTEM.—MACPAC shall create an early-warning system to identify provider shortage areas, as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.

(5) COMMENTS ON CERTAIN SECRETARIAL REPORTS AND REGULATIONS.—

(A) CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to access policies, including with respect to payment policies, under Medicaid or CHIP, the Secretary shall transmit a copy of the report to MACPAC. MACPAC shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress and the Secretary written comments on such report. Such comments may include such recommendations as MACPAC deems appropriate.

(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.

(6) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.

(7) AVAILABILITY OF REPORTS.—MACPAC shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(8) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of MACPAC shall vote on the recommendation, and MACPAC shall include, by member, the results of that vote in the report containing the recommendation.

(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.

(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.

(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—MACPAC shall be composed of 17 members appointed by the Comptroller General of the United States.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of MACPAC shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.

(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under Medicaid or CHIP shall not constitute a majority of the membership of MACPAC.

(D) ETHICAL DISCLOSURE.—The Comptroller General of the United States shall establish a system for public disclosure by members of MACPAC of financial and other potential conflicts of interest relating to such members. Members of MACPAC shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

(3) TERMS.—

(A) IN GENERAL.—The terms of members of MACPAC shall be for 3 years except that the Comptroller General of the United States shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in MACPAC shall be filled in the manner in which the original appointment was made.

(4) COMPENSATION.—While serving on the business of MACPAC (including travel time), a member of MACPAC shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of MACPAC. Physicians serving as personnel of MACPAC may be provided a physician comparability allowance by MACPAC in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to MACPAC in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of MACPAC) and employment benefits, rights, and privileges, all personnel of MACPAC shall be treated as if they were employees of the United States Senate.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of MACPAC, at the time of appointment of the member as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General of the United States may designate another member for the remainder of that member's term.

(6) MEETINGS.—MACPAC shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General of the United States deems necessary to assure the efficient administration of MACPAC, MACPAC may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General of the United States) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal and State departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of MACPAC (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of MACPAC;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of MACPAC.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—MACPAC may secure directly from any department or agency of the United States and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP, information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to MACPAC on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, MACPAC shall—

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

(C) adopt procedures allowing any interested party to submit information for MACPAC's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and nonproprietary data of MACPAC, immediately upon request.

(4) PERIODIC AUDIT.—MACPAC shall be subject to periodic audit by the Comptroller General of the United States.

(f) FUNDING.—

(1) REQUEST FOR APPROPRIATIONS.—MACPAC shall submit requests for appropriations (other than for fiscal year 2010) in the same manner as the Comptroller General of the United States submits requests for appropriations, but amounts appropriated for MACPAC shall be separate from amounts appropriated for the Comptroller General of the United States.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available in such fiscal year to MACPAC to carry out the provisions of this section.

(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.

Additional MACPAC Requirements—Excerpt from Sec. 399V-4 of 42 U.S.C. 280g-15

State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation

The Patient Protection and Accountable Care Act also amended the Public Health Service Act (PHSA) to require MACPAC to "conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) [of Sec. 399V-4 of the PHSA, entitled 'State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation'] to determine the impact of such alternatives on the Medicaid or CHIP programs … and their beneficiaries." Subsection (h) requires that, "[n]ot later than December 31, 2016, the Medicare Payment Advisory Commission [MedPAC] and the Medicaid and CHIP Payment and Access Commission [MACPAC] shall each submit to Congress a report that includes the findings and recommendations of each respective Commission based on [their] independent reviews … , including an analysis of the impact of the alternatives reviewed on the efficiency and effectiveness of the respective programs."

Public Meetings of the Medicaid and CHIP Payment and Access Commission:

September 2010—February 2011

The Commission has convened five public meetings since its first organizational meeting in July 2010. To prepare for public meetings, Commission staff plan agendas (including inviting expert speakers as appropriate) and develop analytic background materials and meeting presentations on specific Medicaid and CHIP policy topics to facilitate the Commission's discussions. Each public meeting concludes with a public comment period.

The presentations and the deliberations in public sessions lay the foundation for the Commission's analytic focus. Based on staff and other expert presentations and public comments, the Commissioners discuss key policy and budgetary questions facing the Medicaid and CHIP programs, review policy options, identify informational needs, and develop analytic work plans to address various topics.

Initial Milestones: Development of Short-Term Priorities

Below is a summary of the major policy issues discussed during the public Commission meetings held between September 2010 and February 2011, as well as preliminary next steps for the Commission's review and possible consideration of inclusion in the June Report or for additional analyses in the latter half of 2011. The Commission coalesced around the three major issues that are addressed in this Report: access to care in Medicaid and CHIP, Medicaid payment policy, and Medicaid and CHIP administrative data for program analysis and accountability. For other topics listed below, such as managed care in Medicaid and CHIP, dual eligibles, and drugs, the Commission developed preliminary analytic work plans and will focus on these issue areas in greater detail at upcoming meetings and in future reports.

Issue Area	Session Topic	Public Meeting Date
Medicaid Payment Policy	Exploring payment issues and provider participation in Medicaid and CHIP	September 23–24, 2010
	Review of the increase in Medicaid payments to physicians for primary care	October 28–29, 2010
	Framework for reviewing payment issues in Medicaid	October 28–29, 2010
	Prudent purchasing in Medicaid: Considering parameters for access and payment	December 9–10, 2010
	Chapter Review: Examining Medicaid payment policy	February 25, 2011
Access to Care in Medicaid and CHIP	Initial review: Access for Medicaid and CHIP enrollees	September 23–24, 2010
	Access to care and the development of the early-warning system	October 28–29, 2010
	Taking stock: Assessing access to care for non-elderly adults under Medicaid	October 28–29, 2010
	Advancing children's access to dental services	December 9–10, 2010
	Developing a framework for an early-warning system on access	December 9–10, 2010
	Chapter Review: Examining access to care in Medicaid and CHIP	February 25, 2011
Medicaid and CHIP Data	CMS initiatives to improve data for program operations and evaluation	October 28–29, 2010
	Review of Medicaid and CHIP administrative data sources	October 28–-29, 2010
	Implications for policy analysis of Medicaid and CHIP administrative data	December 9–10, 2010
	Measuring access to care: Definitions and survey data	December 9-10, 2010
	Chapter Review: Improving Medicaid and CHIP data for policy analysis and program accountability	January 27–28, 2011
	Chapter Review continued: Improving Medicaid and CHIP data for policy analysis and program accountability	February 25, 2011

Issue Area	Session Topic	Public Meeting Date
Managed Care in Medicaid and CHIP	Overview of Medicaid and CHIP managed care models	October 28–29, 2010
	Building an analytic framework for Medicaid and CHIP managed care	December 9–10, 2010
Dual Eligibles	Coordinating care for dual eligibles	September 23–24, 2010
	Overview of dual eligible issues	October 28–29, 2010
	CMS initiatives on dual eligibles	October 28–29, 2010
	Issues in coordinating care for dual eligibles	December 9–10, 2010
Payment for Drugs in Medicaid	Background on payment for drugs in Medicaid	October 28–29, 2010
Other Topics	MACPAC's mission and organizational status	September 23–24, 2010
	Highlighting key priorities at CMS	September 23–24, 2010
	Implementing health reform: New roles for states	September 23–24, 2010
	Data and evaluation priorities at Department of Health and Human Services Assistant Secretary for Planning and Evaluation and the Government Accountability Office	September 23–24, 2010
	Chapter Review: Overview of Medicaid and CHIP in the health care system	February 25, 2011

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MACPAC Consultations with States and Other Stakeholders

The Commission is statutorily charged to collaborate and consult with the Congressional committees that have jurisdiction for MACPAC, states, the Medicare Payment Advisory Commission (MedPAC), and the Federal Coordinated Health Care Office (FCHCO). MACPAC staff maintains active communication with these groups and with several other stakeholders to discuss Medicaid and CHIP-related activities and priorities, including:

- Congressional Committees of Jurisdiction
- Medicare Payment Advisory Commission (MedPAC)
- Federal Coordinated Health Care Office (FCHCO)
- States
- Federal and State Budget Estimate Consultation
- Other Federal Agencies
- Other Stakeholders

Statutorily Required Consultation Activities

Congressional Committees of Jurisdiction: ***(b)(6) AGENDA AND ADDITIONAL REVIEWS.—MACPAC shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding MACPAC's agenda and progress towards achieving the agenda. MACPAC may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such chairmen and members and as MACPAC deems appropriate.***

Working with the Senate Finance and House Energy and Commerce Committees, which have jurisdiction over Medicaid and CHIP, has been a key component of Commission activities. On an ongoing basis, the Commission collaborates with key staff of these Congressional committees, discussing priorities for our analytic work and getting input on the issues discussed in public meetings. Additionally, the Congressional staff members have addressed the Commission and have outlined Congressional priorities. The Commission briefs the staff prior to every public Commission meeting to review the agenda and collect feedback on our

sessions and analytic focus. Lastly, Commission staff has developed a process to provide technical assistance to Congressional staff on policy issues.

The Medicare Payment Advisory Commission: ***(b)(11) CONSULTATION AND COORDINATION WITH MEDPAC.—(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, as appropriate and particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare.***

Addressing dual eligible issues is an important element of the Commission's activities. MedPAC is an independent Congressional agency that advises the Congress on issues affecting the Medicare program, including dual eligibles. The two Commissions have actively collaborated on several policy matters, including dual eligibles. The Chairs and Vice-Chairs of both MACPAC and MedPAC have met to discuss and coordinate policy issues, and the Commission has been briefed by MedPAC staff in a public session on dual eligibles. Plans are in place for ongoing collaboration and coordination regarding data and policy issues—research findings and evolving work plans are critical aspects of these coordination efforts.

Federal Coordinated Health Care Office: ***(b)(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 2081 of the Patient Protection and Affordable Care Act before making any recommendations regarding dual eligible individuals.***

The FCHCO is a new federal agency within the Centers for Medicare & Medicaid Services (CMS) that focuses on policy issues related to individuals who are eligible for both Medicaid and Medicare. The Commission has actively worked with this new office, and the Director of the FCHCO has briefed the Commission on FCHCO priorities and activities. FCHCO is engaged in issues prior to each MACPAC public meeting, and there is ongoing collaboration around analytic work and data development.

State Policy Officials and State-related Associations: **(*b)(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.***

The joint federal-state structure of Medicaid and CHIP requires that state perspectives and insight on emerging trends and policy issues be taken into account as we develop the most sound and rigorous policy analysis for the Congress. The Commission meets regularly with state Medicaid officials and other state-based associations to better understand state Medicaid information and perspectives on emerging trends in the Medicaid and CHIP programs. To that end, the Commission has diligently sought opportunities to collect targeted state data and information and incorporate state perspectives in Commission meeting discussions. Each Commission meeting that has included external speakers has featured current or former state Medicaid and/or CHIP policy officials. In presentations made jointly with Commission staff, state representatives provide examples of how they have addressed aspects of relevant access, payment and

other Medicaid and CHIP issues in their states. Prior to each public meeting, the Commission reviews the agenda with the National Association of Medicaid Directors (NAMD), the National Conference of State Legislatures (NCSL), the National Governors Association (NGA), the Southern Governors' Association (SGA), the National Association of State Budget Officers (NASBO), and the National Academy of State Health Policy (NASHP).

To improve our understanding of states' perspectives in Commission analyses, staff are working with the NAMD and the Robert Wood Johnson Medicaid Leadership Institute Fellows (comprised of State Medicaid Directors) to develop a state consultation and review process for our reports and other materials.

Budget Estimates: ***(10) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, MACPAC shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities, and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations.***

Lastly, the MACPAC authorizing statute requires that the Commission examine the federal, as well as state-specific, budget consequences of all recommendations directly or through consultation with various expert entities. MACPAC has begun discussions with several state-focused organizations about the potential role they could play in assisting us with state policy analysis and cost projections, as appropriate. The Commission is developing an approach to estimate the state-level impacts of recommendations for future reports. The statutory requirement to evaluate state-level impacts reflects the need for analyses that illustrate the diversity among states and their programs. Federal scorekeepers—the Congressional Budget Office (CBO) and the CMS Office of the Actuary—provide separate budget estimates on federal impacts and are not generally required to provide state-specific estimates of changes in federal Medicaid and CHIP policy.

To assist in developing state-specific estimates, MACPAC is establishing a technical advisory group of state organizations, state budget and Medicaid/CHIP officials, and federal scorekeepers. This group will examine the methodological issues for developing state estimates. Such issues include identifying potential areas and policies that could require state-level estimates, determining the data and assumptions needed for these assessments, and examining existing state modeling capabilities used by various government and non-government entities.

Additional Consultation Activities

The Commission recognizes that the Medicaid and CHIP programs touch a broad array of public- and private-sector stakeholders, including but not limited to the federal and state governments, and enrollee, provider, industry, and state organizations. Consequently the Commission makes a concerted effort to keep stakeholders well informed about the Commission's research and analytic agenda. These ongoing dialogues inform the Commission's work on the numerous issues that states, the federal government, providers, and enrollees face with respect to the Medicaid and CHIP programs. These interactions are supplemented by comments that stakeholder groups share during the public comment period at the Commission's public meetings as well as comments submitted through our website.

Other Government Agencies: The Centers for Medicare & Medicaid Services (CMS) administers the federal component of the Medicaid program, and has oversight over all state Medicaid agencies. The Commission's collaboration with CMS is mutually valuable; it contributes to coordination of federal research and policymaking and minimizes redundancy among government initiatives. These collaborations, in addition to briefings before Commission meetings, include ad hoc meetings to discuss specific topics such as demonstration programs, actuarial analysis, and research proposals, particularly with the Center for Medicaid, CHIP and Survey & Certification (CMCS). The Deputy Administrator for CMCS addressed the Commission during public meetings in FY 2010.

Other Stakeholders: Several stakeholder groups with an interest in Medicaid and CHIP have requested meetings with the Commission to discuss their priorities, issues of concern, potential data sources to support Commission analyses, and to review the Commission's research and analytic agenda. We have met with organizations across the spectrum, including beneficiary groups that represent people with chronic illnesses or other special health care needs, associations for hospitals, physicians and other providers, industry groups with a Medicaid market share, and health service research organizations.

Since its initial meeting in July 2010, the Commission has conducted public outreach activities by participating in or speaking as invited guests at meetings hosted by research, government, foundation, academic, and stakeholder organizations.

Commission Members and Terms

Diane Rowland, Sc.D., Chair
Washington, DC

David Sundwall, M.D., Vice Chair
Salt Lake City, UT

Term Expires
December 2011

Richard Chambers
Irvine, CA

Burton Edelstein, D.D.S., M.P.H.
New York, NY

Denise Henning, C.N.M., M.S.N.
Ft. Myers, FL

Judith Moore
McLean, VA

Robin Smith
Awendaw, SC

David Sundwall, M.D.
Salt Lake City, UT

Term Expires
December 2012

Donna Checkett, M.P.A., M.S.W.
Columbia, MO

Patricia Gabow, M.D.
Denver, CO

Mark Hoyt, F.S.A., M.A.A.A.
Desert Hills, AZ

Patricia Riley, M.S.
Brunswick, ME

Diane Rowland, Sc.D.
Washington, DC

Steven Waldren, M.D., M.S.
Kansas City, MO

Term Expires
December 2013

Sharon Carte, M.H.S.
South Charleston, WV

Andrea Cohen, J.D.
New York, NY

Herman Gray, M.D., M.B.A.
W. Bloomfield, MI

Norma Martinez-Rogers, Ph.D., R.N., F.A.A.N.
San Antonio, TX

Sara Rosenbaum, J.D.
Alexandria, VA

Commissioner Biographies

Sharon L. Carte, M.H.S., is Executive Director of the West Virginia Children's Health Insurance Program. From 1992 to 1998, Ms. Carte served as the Deputy Commissioner for the Bureau for Medical Services overseeing West Virginia's Medicaid program. Prior to that she was administrator of several skilled and intermediate care nursing facilities and also worked as Coordinator of Human Resources Development in the West Virginia Department of Health. Ms. Carte's experience includes working with senior centers and aging programs throughout the state of West Virginia and developing policies related to behavioral health and home and community-based services for mentally disabled populations. She received her Master of Health Science degree from The Johns Hopkins University.

Richard Chambers is Chief Executive Officer of CalOptima, a County Organized Health System which provides publicly funded health coverage programs for low-income families, seniors, and persons with disabilities in Orange County, California. CalOptima serves more than 400,000 members through Medicaid, CHIP, and Medicare Advantage Special Needs Plan programs. Before joining CalOptima in 2003, Mr. Chambers spent over 27 years working for the Centers for Medicare & Medicaid Services (CMS). He served as the Director of the Family and Children's Health Programs Group, responsible for national policy and operational direction of Medicaid and CHIP. Prior to that, Mr. Chambers served as Associate Regional Administrator for Medicaid in the San Francisco Regional Office and Director of the Office of Intergovernmental Affairs in the Washington, DC office. He received his Bachelor of Arts degree from the University of Virginia.

Donna Checkett, M.P.A., M.S.W., is Vice President of State Government Relations at Aetna. Prior to that she was the Chief Executive Officer of Missouri Care, a managed Medicaid health plan owned by University of Missouri-Columbia Health Care, one of the largest safety net hospital systems in the state. For eight years Ms. Checkett served as the Director of the Missouri Division of Medical Services (Medicaid), during which time she was the chair of the National Association of State Medicaid Directors and a member of the National Governors Association Medicaid Improvements Working Group. She served as chair of the Advisory Board for the Center for Health Care Strategies, a non-profit health policy resource center dedicated to improving health care quality for low-income children and adults. Ms. Checkett also served as chair of the National Advisory Committee for Covering Kids, a Robert Wood Johnson Foundation program fostering outreach and eligibility simplification efforts for Medicaid and CHIP beneficiaries. She received a Master of Public Administration degree from the University of Missouri-Columbia and a Master of Social Work degree from the University of Texas at Austin.

Andrea Cohen, J.D., is the Director of Health Services in the New York City Office of the Mayor, coordinating and implementing strategies to improve public health and health care services including the administration of Medicaid eligibility processes. She serves on the board of the Primary Care Development Corporation and represents the Deputy Mayor for Health and Human Services on the Board of the Health and Hospitals Corporation, the largest public hospital system in the country. From 2005 to 2009, Ms. Cohen was Counsel with Manatt, Phelps & Phillips, LLP, where she advised clients on issues relating to Medicare, Medicaid, and other public health insurance programs. Prior professional positions include Senior Policy Counsel at the Medicare Rights Center, Health and Oversight Counsel for the U.S. Senate Committee on Finance, and attorney with the U.S. Department of Justice. She received her law degree from the Columbia University School of Law.

Burton L. Edelstein, D.D.S., M.P.H., is a board-certified pediatric dentist and Professor of Dentistry and of Health Policy and Management at Columbia University. He is founding President of the Children's Dental Health Project, a national non-profit policy organization based in Washington, DC, that promotes equity in children's oral health. Dr. Edelstein practiced pediatric dentistry in Connecticut and taught at the Harvard School of Dental Medicine for 21 years prior to serving as a 1996-1997 Robert Wood Johnson Health Policy Fellow in the office of U.S. Senate leader Tom Daschle, with primary responsibility for S-CHIP. Dr. Edelstein worked with the U.S. Department of Health and Human Services on its oral health initiatives from 1998 to 2001, chaired the U.S. Surgeon General's Workshop on Children and Oral Health, and authored the child section of Oral Health in America: A Report of the Surgeon General. His research focuses on children's oral health promotion and access to dental care with a particular emphasis on Medicaid and CHIP populations. He received his degree in dentistry from the State University of New York at Buffalo School of Dentistry, his Master of Public Health degree from the Harvard School of Public Health, and completed his clinical training at Children's Hospital Boston.

Patricia Gabow, M.D., is Chief Executive Officer of Denver Health and Hospital Authority, an integrated public safety-net health care system that is the state's largest provider of care to Medicaid and uninsured patients. Dr. Gabow is a member of the Commonwealth Fund's Commission on a High-Performing Health System and previously served as chair of the National Association of Public Hospitals. She also served on Institute of Medicine committees, including one that addressed the future viability of safety-net providers and another that addressed performance measures and quality improvement. Dr. Gabow joined Denver Health in 1973 as Chief of the Renal Division and is a Professor of Medicine in the Division of Renal Diseases at the University of Colorado Denver School of Medicine. She received her medical degree from the University of Pennsylvania.

Herman Gray, M.D., M.B.A., is President of the Children's Hospital of Michigan and Senior Vice President of the Detroit Medical Center, having served in these roles since 2005. Previously, at the Children's Hospital of Michigan, Dr. Gray served as Chief Operating Officer, Chief of Staff, Pediatric Residency Program Director, and Pediatrics Vice Chief for Education. He also held

positions as Associate Dean for Graduate Medical Education at Wayne State University School of Medicine and Vice president for Graduate Medical Education (GME) at the Detroit Medical Center. In the 1990s, Dr. Gray was the Chief Medical Consultant (Medical Director) for the Michigan Department of Public Health – Children's Special Health Care Services, and later became Vice President and Medical Director of Clinical Affairs for Blue Care Network, a 600,000 member subsidiary of Blue Cross/Blue Shield of Michigan. During the 1980s, he pursued private medical practice in Detroit while acting as a member of the academic faculty at the Children's Hospital of Michigan and Wayne State University. Dr. Gray currently chairs the Detroit Medical Center GME Work Group and serves on the board of trustees of the National Association of Children's Hospitals and Related Institutions, the board of directors of the Child Health Corporation of America, and the American Hospital Association Section for Maternal and Child Health Governing Council. Dr. Gray was named in 2010 as a Top 25 Minority Executive in Healthcare by Modern Healthcare Magazine. He received his medical degree from the University of Michigan in Ann Arbor and an Executive Master of Business Administration from the University of Tennessee.

Denise Henning, C.N.M., M.S.N., is a clinical director for women's health at Collier Health Services, a federally qualified health center in Immokalee, Florida. A practicing nurse-midwife, Ms. Henning provides prenatal and gynecological care to a service population that is predominantly either uninsured or covered by Medicaid. From 2003 to 2008 she was Director of Clinical Operations for Women's Health Services at the Family Health Centers of Southwest Florida, where she supervised midwifery and other clinical staff. Prior to this, Ms. Henning served as a Certified Nurse Midwife in several locations in Florida and as a labor and delivery nurse in a Level III teaching hospital. She is President of the Midwifery Business Network and a chapter chair of the American College of Nurse Midwives. She received her Master of Science degree in Nurse-Midwifery from the University of Florida in Jacksonville and her Bachelor of Science in Nursing from the University of Florida in Gainesville.

Mark Hoyt, F.S.A., M.A.A.A., is a Senior Partner with the Government Human Services Consulting group of Mercer Health & Benefits LLC. The Government specialty group focuses on helping states become more efficient purchasers of Medicaid and CHIP health services and has worked with more than 30 states. Mr. Hoyt joined Mercer in 1980 and since 1987 has worked on government health care projects, including developing strategies for statewide health reform, evaluating the impact of different managed care approaches, and overseeing program design and rate analyses for Medicaid and CHIP programs. Mr. Hoyt is a Fellow in the Society of Actuaries and a member of the American Academy of Actuaries. He received a Master of Arts degree in mathematics from the University of California at Berkeley.

Norma Martinez Rogers, Ph.D., R.N., F.A.A.N., is Professor of the Department of Family Nursing at the University of Texas Health Science Center at San Antonio, where she has served on the faculty since 1996. Dr. Martinez Rogers has held clinical and administrative positions in psychiatric nursing and psychiatric hospitals, including the William Beaumont Army Medical Center in Fort Bliss during Operation

Desert Storm. She has initiated a number of programs at the University of Texas Health Science Center in San Antonio including a support group for women transitioning from prison back into society and the Martinez Street Women's Center, a non-profit organization designed to provide support and educational services to women and teenage girls. Dr. Martinez Rogers is a fellow of the American Academy of Nursing and is President of the National Association of Hispanic Nurses. She received a Master of Science degree in Psychiatric Nursing from the University of Texas Health Science Center at San Antonio and a Doctor of Philosophy degree in Cultural Foundations in Education from the University of Texas at Austin.

Judith Moore is Senior Fellow at the National Health Policy Forum, George Washington University, where she specializes in work related to the health needs of low-income vulnerable populations. Prior to joining the Forum, Ms. Moore held positions in both the legislative and executive branches of the federal government. At the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services), she directed the Medicaid program and the Office of Legislation and Congressional Affairs. Ms. Moore was Special Assistant to the Secretary of the Department of Health, Education and Welfare (now the Department of Health and Human Services) and held positions in the Public Health Service, the Food and Drug Administration, the Agency for Health Care Policy and Research, and the Prospective Payment Assessment Commission. She is co-author of a political history of *Medicaid Politics and Policy*, 1965-2007.

Trish Riley, M.S., is the first Distinguished Visiting Fellow and Lecturer in State Health Policy at George Washington University, following her tenure as Director of the Maine Governor's Office of Health Policy and Finance. She was a principal architect of the Dirigo Health Reform Act of 2003, which was enacted to increase access, reduce costs, and improve quality of health care in Maine. Ms. Riley previously served as Executive Director of the National Academy for State Health Policy and as President of its Corporate Board. Under four Maine governors, she held appointed positions including Executive Director of the Maine Committee on Aging; Director of the Bureau of Maine's Elderly; Associate Deputy Commissioner of Health and Medical Services; and Director of the Bureau of Medical Services, which encompassed planning activities for Medicaid, residential and long-term care, and primary care. Ms. Riley served on Maine's Commission on Children's Health, which planned the state's SCHIP program. She is a member of the Kaiser Commission on Medicaid and the Uninsured and has served as a member of the Institute of Medicine's Subcommittee on Creating an External Environment for Quality and its Subcommittee on Maximizing the Value of Health. Ms. Riley has also served as a member of the Board of Directors of the National Committee on Quality Assurance. She received her Master of Science degree in Community Development from the University of Maine.

Sara Rosenbaum, J.D., is the Harold and Jane Hirsh Professor and founding Chair of the Department of Health Policy, George Washington University School of Public Health and Health Services, a unique center of learning, scholarship, and public service focusing on all aspects of health policy. Professor Rosenbaum has devoted her career to issues of health law and policy

affecting low income, minority, and medically underserved populations. Between 1993 and 1994, Professor Rosenbaum worked for President Clinton, directing the legislative drafting of the Health Security Act and developing the Vaccines for Children program. Professor Rosenbaum also served on the Presidential Transition Team for President-Elect Obama. A graduate of Wesleyan University and Boston University School of Law, Professor Rosenbaum has authored a leading health law textbook as well as more than 350 articles and studies focusing on all phases of health law and health care for medically underserved populations. A holder of numerous awards for her scholarship and service, Professor Rosenbaum is the recipient of the Richard and Barbara Hansen National Health Leadership Award (University of Iowa), a Robert Wood Johnson Foundation Investigator Award in Health Policy Research, and the Oscar and Shoshanna Trachtenberg Award for Scholarship (George Washington University's highest award for scholarship). Professor Rosenbaum is a member of Center for Disease Control and Prevention's Advisory Committee on Immunization Practice (ACIP) and Director's Advisory Committee.

Diane Rowland, Sc.D., is the Executive Vice President of the Henry J. Kaiser Family Foundation and the Executive Director of the Kaiser Commission on Medicaid and the Uninsured. She is also an adjunct Professor in the Department of Health Policy and Management at the Bloomberg School of Public Health of the Johns Hopkins University. She has directed the Kaiser Commission since 1991 and overseen the Foundation's health policy work since 1993. She is a noted authority on health policy, Medicare and Medicaid, and health care for low-income and disadvantaged populations, and frequently testifies as an expert witness before the U. S. Congress on health policy issues. A nationally recognized expert with a distinguished career in public policy and research focusing on health insurance coverage, access to care, and health care financing, Dr. Rowland is an accomplished researcher and has published widely on these subjects. Dr. Rowland is a member of the Institute of Medicine (IOM), a founding member of the National Academy for Social Insurance, Past President and Fellow of the Association for Health Services Research (now AcademyHealth), and a member of the board of Grantmakers in Health. She holds a Bachelor's degree from Wellesley College, a Master of Public Administration from the University of California at Los Angeles and a Doctor of Science degree in health policy and management from the Johns Hopkins University. Dr. Rowland serves as chair of MACPAC.

Robin Smith and her husband Doug have been foster and adoptive parents for children covered by Medicaid, including many special needs children. Her experience with the health care system includes the Medically Fragile Children's Program, an interdisciplinary Medicaid program at the Medical University of South Carolina Children's Hospital, which is a national model partnership between MUSC Children's Hospital, South Carolina Medicaid and the South Carolina Department of Social Services. Ms. Smith serves on the Family Advisory Committee for the Children's Hospital at the Medical University of South Carolina. She has testified at Congressional briefings, presented at the 2007 International Conference of Family Centered Care, and participated in Grand Rounds for medical students and residents at the Medical University of South Carolina. In November 2010

she was awarded the Health Care Hero Award by the Charleston Regional Business Journal.

David Sundwall, M.D., is a Professor of Public Health at the University of Utah School of Medicine, Division of Public Health, where he has been a faculty member for 35 years. He served as Executive Director of the Utah Department of Health and Commissioner of Health for the State of Utah from 2005 through 2010. He currently serves on numerous government and community boards and advisory groups in his home state. Dr. Sundwall served as President of the Association of State and Territorial Health Officials from 2007-2008. He has chaired or served on several committees of the IOM, including those that produced reports on health care quality, the future of emergency care in the U.S., and the U.S. oral health workforce. Prior to returning to Utah in 2005, he was President of the American Clinical Laboratory Association and was Vice President and Medical Director of American Healthcare Systems. Dr. Sundwall's federal government experience includes serving as Administrator of the Health Resources and Services Administration (HRSA), Assistant Surgeon General in the Commissioned Corps of the U.S. Public Health Service, and Director of the Health and Human Resources Staff of the Senate Labor and Human Resources Committee. He received his medical degree from the University of Utah School of Medicine and completed residency in the Harvard Family Medicine Program. He is a licensed physician, board certified in Internal Medicine and Family Practice, and volunteers in a public health clinic one-half day each week. Dr. Sundwall serves as vice chair of MACPAC.

Steven E. Waldren, M.D., M.S., joined the American Academy of Family Physicians (AAFP) in 2004 and serves as Director of its Center for Health Information Technology. His in-depth knowledge of health information systems, programming and software, and medical informatics makes him a qualified expert to lead the Center as it aims to expand its services to thousands more primary care physicians. Dr. Waldren also serves on the board of the Center for Improving Medication Management, a national advocacy organization that educates clinicians and their staff on the best approaches to implementing prescribing technology. He also serves as co-chair of the Ambulatory Care Quality Alliance's Data Aggregation and Health IT Subcommittee. Dr. Waldren earned a Master's degree in health care informatics from the University of Missouri, Columbia, while completing a National Library of Medicine Postdoctoral Medical Informatics Research Fellowship. He completed his family medicine residency at Wesley Family Medicine in Wichita, Kansas, and earned his medical degree from the University of Kansas School of Medicine, Kansas City.

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