

# Report to Congress on Medicaid and CHIP

**MARCH 2017**



**MACPAC**

Medicaid and CHIP Payment  
and Access Commission

## About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. The Commission's authorizing statute, 42 U.S.C. 1396, outlines a number of areas for analysis, including:

- payment;
- eligibility;
- enrollment and retention;
- coverage;
- access to care;
- quality of care; and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to Congress by March 15 and June 15 of each year. In carrying out its work, the Commission holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

# Report to Congress on Medicaid and CHIP

**MARCH 2017**



**MACPAC**

Medicaid and CHIP Payment  
and Access Commission

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**March 15, 2017**

The Honorable Mike Pence  
President of the Senate  
S-212 The Capitol  
Washington, DC 20510

The Honorable Paul Ryan  
Speaker of the House  
H-232 The Capitol  
Washington, DC 20515

**Dear Mr. Vice President and Mr. Speaker:**

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to submit the March 2017 *Report to Congress on Medicaid and CHIP*. This year, our March report addresses three critical functions of Medicaid and the State Children's Health Insurance Program (CHIP): health insurance coverage for children, payment to safety-net hospitals, and monitoring access to care under managed care and fee for service.

Chapter 1 of the March 2017 report reprises the Commission's January recommendations for the future of CHIP. CHIP provides comprehensive affordable coverage for more than 8 million children who would otherwise be uninsured because their family incomes are too low to purchase private coverage but too high to qualify for Medicaid. At the core of the nine-recommendation package is an extension of federal CHIP funding through fiscal year (FY) 2022 to assure the stability and continuity of health insurance coverage for low- and moderate-income children at a time of tremendous uncertainty in health insurance markets. This recommendation would also mitigate budget uncertainty for states as federal funding for CHIP ends in the current fiscal year. Supporting recommendations would create new opportunities for states to test innovations that would lead to a more seamless system of children's coverage in the future and make modest changes to existing law to streamline the program and extend certain child health initiatives that are set to expire.

MACPAC also calls on Congress to extend CHIP as soon as possible. State legislatures are now meeting and must make decisions about the structure and financing of their programs. MACPAC has found that if CHIP funding is not renewed, many of the children covered under separate CHIP would become uninsured. Although some of these children may be eligible for private coverage, their families would have to pay considerably more for it than they would under CHIP. Although children in Medicaid-expansion CHIP would not lose coverage, a substantial share of the responsibility to fund this coverage would shift to states.



Chapters 2 and 3 discuss Medicaid disproportionate share hospital (DSH) payments that are intended to offset uncompensated care costs of hospitals that serve a high proportion of low-income patients. These statutorily required analyses present new data on the effects of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) on hospital uncompensated care, noting the decline in states that expanded Medicaid and the continued financial stress on safety-net DSH hospitals nationwide, regardless of expansion status.

Specifically, charity care and bad debt as a share of hospital operating expenses fell by 37 percent in Medicaid-expansion states compared to 6 percent in non-expansion states during the same period. Despite these declines in uncompensated care, the Commission finds that hospitals serving the highest share of low-income patients (known as deemed DSH hospitals) continued to report negative operating margins before DSH payments in both expansion and non-expansion states in 2014. MACPAC is also exploring approaches to ensure that DSH payments are targeted to the hospitals most in need of assistance.

The final chapter of the March report focuses on how states monitor Medicaid beneficiaries' access to health care, an important set of tasks to ensure that the program is achieving its mission. Such information can be used to support assessment of program value, act as a mechanism for accountability, and help identify problems and guide program improvement efforts. The chapter reviews what is known about access to care in Medicaid under fee for service and managed care, describes measures and data that can be used to monitor access for different populations and geographic areas, and concludes with a discussion of key challenges to monitoring and evaluating access.

MACPAC is committed to providing in-depth, non-partisan analyses of all aspects of Medicaid and CHIP. We hope the analyses in the March 2017 report will prove useful to Congress as it considers future policy development affecting Medicaid and CHIP. This document fulfills our statutory mandate to report each year by March 15.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Sara Rosenbaum, JD', with a long horizontal flourish extending to the right.

Sara Rosenbaum, JD  
Chair



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## Executive Summary: March 2017 Report to Congress

In the March 2017 *Report to Congress on Medicaid and CHIP*, the Medicaid and CHIP Payment and Access Commission (MACPAC) addresses three functions central to the roles of Medicaid and the State Children's Health Insurance Program (CHIP) as the source of coverage for almost 90 million people: providing health insurance for children, making payments to safety-net hospitals, and monitoring access to care under managed care and fee for service (FFS).

Chapter 1 of the March 2017 report reprises the Commission's January recommendations regarding the future of CHIP. CHIP provides comprehensive, affordable coverage for more than 8 million children who would otherwise be uninsured because their family incomes are too low to purchase private coverage but too high to qualify for Medicaid. Absent congressional action, no new federal funds will be available after fiscal year (FY) 2017.

At the core of the nine-recommendation package is an extension of federal CHIP funding through FY 2022 to ensure the stability and continuity of health insurance coverage for low- and moderate-income children at a time of tremendous uncertainty in health insurance markets. This recommendation would also mitigate budget uncertainty for states as they plan for the future. Supporting recommendations would create new opportunities for states to test innovations that would lead to a more seamless system of children's coverage in the future, and make modest changes to existing law to streamline the program and extend certain children's health initiatives that are set to expire. The Commission urges Congress to act as soon as possible to extend CHIP funding so that both families and states have assurances that CHIP will be maintained.

Chapters 2 and 3 present the Commission's statutorily required analysis of Medicaid disproportionate share hospital (DSH) payments, which are intended to help offset the uncompensated care costs of hospitals that serve a high proportion of low-income patients. We continue to find little meaningful relationship between the amount of a state's DSH allotments and its hospitals' need for DSH funds. New data on the effects of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) on hospital uncompensated care, presented in Chapter 2, describe declining uncompensated care, particularly in states that expanded Medicaid to the new adult group. But the data also show continued financial distress of many safety-net hospitals across the country, regardless of their state's expansion status. Chapter 3 reviews approaches for improving the targeting of DSH payments and the effects of various approaches to raise the minimum federal eligibility criteria for DSH payments from a 1 percent Medicaid utilization rate to a higher threshold.

The final chapter of the March report focuses on how states monitor Medicaid beneficiaries' access to health care, an important set of tasks to ensure that the program is achieving its mission. Such information can be used to support assessment of program value, act as a mechanism for accountability, and help identify problems and guide program improvement efforts. The chapter reviews what is known about access to care in Medicaid under fee for service and managed care, describes measures and data that can be used to monitor access for different populations and geographic areas, and concludes with a discussion of key challenges to monitoring and evaluating access.

### CHAPTER 1: Recommendations for the Future of CHIP and Children's Coverage

Chapter 1 presents MACPAC's recommendations to Congress on the future of CHIP and children's

coverage. Enacted in 1997 with strong bipartisan support, CHIP is state-administered within federal parameters and jointly financed by states and the federal government. The program operates in every state and U.S. territory. Along with Medicaid, it has been widely credited with helping to reduce the number of uninsured children in the United States to historic lows—from 10 million in 1997 to 3.3 million in 2015. Although the CHIP legislative authorization does not expire, without congressional action, states will not receive any new federal funds for CHIP beyond the current fiscal year.

MACPAC's analysis shows that if CHIP funding is not renewed, 1.1 million children covered under separate CHIP would lose their health coverage. Although some of these children may be eligible for private coverage, their families would have to pay considerably more for it than they would under CHIP. This could create barriers to both needed coverage and access to health and developmental services, which may be unavailable or more costly through other coverage. Children covered by Medicaid-expansion CHIP would not lose coverage but would incur a significant shift in states' obligations to fund their coverage.

The Commission continues to hold that a more seamless system of children's coverage should be developed—a system that would ensure sufficient coverage in terms of both benefits and affordability—to appropriately meet the needs of the nation's children in the future. We also look to states as potential laboratories of innovations for the improvement of children's coverage.

In the short-term, however, two things are clear. First, health insurance markets will likely face substantial changes over the next few years. Second, current funding for CHIP will be exhausted before such changes are fully realized. During this period of uncertainty, the Commission finds that the existing approach to children's coverage should be maintained.

The package of nine recommendations is built around a core recommendation to extend federal funding for CHIP through FY 2022. In addition to the five-year extension of CHIP funding, MACPAC recommends:

- extending the current CHIP maintenance of effort (MOE) provision for three additional years, through FY 2022, to ensure a stable source of health care coverage for children;
- extending the current federal CHIP matching rate through FY 2022 while the MOE is in place;
- establishing new demonstration grants to states to support the development and testing of state-based seamless systems of coverage for low- and moderate-income children;
- ending waiting periods in CHIP and eliminating CHIP premiums for children in families with incomes below 150 percent of the federal poverty level to minimize the potential gaps in children's coverage and reduce uninsurance;
- enabling states to use Express Lane Eligibility permanently to streamline and facilitate the CHIP and Medicaid application process; and
- providing five years of additional funding for grants to support outreach to and enrollment of Medicaid- and CHIP-eligible children, for the Childhood Obesity Research Demonstration project, and for the Pediatric Quality Measures Program—three programs that have been renewed with CHIP in previous years.

## CHAPTER 2: Analyzing Disproportionate Share Hospital Allotments to States

Chapter 2 updates analysis on Medicaid DSH payments, including allotments to states and payments to hospitals. Congress requires MACPAC to report annually on the relationship between DSH allotments to states and three indicators of the

need for DSH funds: (1) changes in the number of uninsured individuals; (2) the amount and sources of hospitals' uncompensated care costs; and (3) the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.

MACPAC continues to find little meaningful relationship between a state's need for DSH funds and the amount of that state's DSH allotments, which are still based on hospitals' spending patterns before federal limits were established in 1992. However, our new analysis shows that hospital uncompensated care is falling much more in states that expanded Medicaid to low-income adults under the ACA than in states that did not expand their programs. As a share of hospital operating expenses, charity care and bad debt fell by 37 percent in Medicaid-expansion states, compared to 6 percent in non-expansion states during the same period. Despite these declines in uncompensated care, we find that the hospitals serving the highest share of low-income patients (known as deemed DSH hospitals) continued to report negative operating margins before DSH payments in both expansion and non-expansion states in 2014.

In Chapter 2, the Commission also discusses the \$2 billion federal DSH allotment reductions currently slated to take effect in FY 2018. As this report goes to press, Congress is debating changes to the ACA and to Medicaid policy more generally—changes that, if implemented, would create a substantially different environment for safety-net providers. At this writing, many different ideas are under discussion, including changes to the ACA coverage expansions, DSH funding, and other policies affecting safety-net providers. The Commission finds it difficult to weigh in on the merits of pending DSH allotment reductions given this uncertainty and the potential for other concurrent changes to the health insurance market that would affect the level of hospital uncompensated care and the ability of these institutions to provide care

to Medicaid beneficiaries and other low-income patients. Although it is difficult to evaluate the cumulative effects of such changes while the debates are ongoing, the Commission will continue examining how policy changes might affect safety-net hospitals and will provide additional analysis and commentary as warranted.

### CHAPTER 3: Improving the Targeting of Disproportionate Share Hospital Payments to Providers

In Chapter 3, MACPAC explores approaches for improving the targeting of DSH payments to providers. Under current law, states are permitted to make DSH payments to virtually any hospital in their state. This flexibility allows states to target DSH payments based on local circumstances, but it leads to a wide variation in the share of hospitals that receive DSH payments in each state.

Chapter 3 analyzes the effects of the current minimum federal eligibility criteria for DSH payments from a 1 percent Medicaid utilization rate to a higher standard. We examine seven different thresholds, including absolute standards that would apply equally across states and relative standards that would vary by state based on their hospitals' average Medicaid or low-income utilization rate. However, because DSH hospitals vary so much in terms of patient mix, mission, and market characteristics, it is difficult to identify a single utilization-based standard applicable to all hospitals that represents a clear improvement over current law.

The chapter concludes with a discussion of other approaches that might be used to better target funding, such as changing the types of uncompensated care that DSH funding can subsidize. In future reports, the Commission plans to further explore policies to improve the targeting of DSH funding to states and providers. MACPAC will also continue to monitor distribution of DSH payments across states and hospitals to



understand how any changes in health insurance coverage for low-income families affect safety-net institutions.

## CHAPTER 4: Monitoring Access to Care in Medicaid

Chapter 4 looks at how states are monitoring access in Medicaid programs. As Medicaid enrollment and spending grow, federal and state governments alike want to ensure that it is effective—that is, that they are paying appropriately for care but also that beneficiaries have sufficient access to necessary care.

The chapter begins by defining access, referencing the framework MACPAC developed in 2011 for examining access to care for enrollees in Medicaid and CHIP. The chapter also reviews what is known about access to care in Medicaid. MACPAC and others have found that Medicaid beneficiaries have much better access to care and higher health care utilization than individuals without insurance, particularly when controlling for socioeconomic characteristics and health status. Medicaid beneficiaries also fare as well, or better, on some access measures compared to individuals with private insurance, although they often experience more difficulty obtaining health care.

There is no single federally mandated method for states to monitor and evaluate access to Medicaid-covered services. However, federal regulations issued in 2015 and 2016 impose access monitoring requirements on state Medicaid FFS programs and on network adequacy requirements in Medicaid managed care, states are now starting to implement policies reflecting the new managed care standards, which will apply beginning July 1, 2018.

The final FFS rule requires states to submit an access monitoring review plan that applies to five categories of services. States must also submit a recent access review with any state plan amendment proposing a reduction or restructuring

of payment rates that could result in diminished access. MACPAC conducted a preliminary review of state plans and found that current monitoring approaches rely primarily on consumer complaint hotlines and advisory committee meetings. In addition, a survey of state practices found that monitoring efforts focused on primary and specialty care, behavioral health, and dental health, and that there was little variation in the number of states collecting data for particular populations.

Many challenges remain in how to most effectively monitor access in both FFS and managed care programs, including data limitations, lack of consistently used standard measures across states and programs, lack of benchmarks to assess adequate access, and administrative constraints. In addition, there is too little information on what initiatives work best for improving access across different populations and for different services. Sharing information across programs—including the associated costs and outcomes—could help to spread the adoption of successful approaches to improving access.

MACPAC will continue its work to assess the performance of Medicaid and CHIP in providing access to services that lead to better health at a reasonable cost. These include monitoring federal and state implementation of data collection and analysis efforts, aspects of Medicaid for which there are no obvious benchmarks to commercial insurance, and the impact of new value-based delivery system models on access to care.

Chapter 1:

# The Future of CHIP and Children's Coverage

# The Future of CHIP and Children's Coverage

## Recommendations

- 1.1** Congress should extend federal CHIP funding for a transition period that would maintain a stable source of children's coverage and provide time to develop and test approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children.
- 1.2** Congress should extend federal CHIP funding for five years, through fiscal year 2022, to give federal and state policymakers time to develop policies and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children.
- 1.3** In order to provide a stable source of children's coverage while approaches and policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the current CHIP maintenance of effort and the 23 percentage point increase in the federal CHIP matching rate, currently in effect through FY 2019, for three additional years, through fiscal year 2022.
- 1.4** To reduce complexity and to promote continuity of coverage for children, Congress should eliminate waiting periods for CHIP. (This recommendation was first made in the Commission's March 2014 report to Congress.)
- 1.5** In order to align premium policies in separate CHIP with premium policies in Medicaid, Congress should provide that children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums. (This recommendation was first made in the Commission's March 2014 report to Congress.)
- 1.6** Congress should create and fund a children's coverage demonstration grant program, including planning and implementation grants, to support state efforts to develop, test, and implement approaches to providing for CHIP-eligible children seamless health coverage that is as comprehensive and affordable as CHIP.
- 1.7** Congress should permanently extend the authority for states to use Express Lane Eligibility for children in Medicaid and CHIP. (The Commission noted its support for this policy in a 2014 letter to the Secretary of HHS [MACPAC 2014c].)
- 1.8** The Secretary of the U.S. Department of Health and Human Services, in consultation with the Secretaries of the U.S. Department of Agriculture and the U.S. Department of Education should, not later than September 30, 2018, submit a report to Congress on the legislative and regulatory modifications needed to permit states to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families.
- 1.9** Congress should extend funding for five years for grants to support outreach and enrollment of Medicaid and CHIP eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures program, through fiscal year 2022.

## Key Points

- The State Children's Health Insurance Program (CHIP) has played an important role in providing insurance coverage and access to health care for low- and moderate-income children since its enactment in 1997. In fiscal year (FY) 2015, about 8.4 million children were enrolled in CHIP.
- CHIP is permanently authorized, but current law only provides federal funding to states through FY 2017. Five states are expected to spend their remaining CHIP allotments by December 2017; 29 states and the District of Columbia are expected to spend their remaining CHIP allotments by March 2018.
- Since funding for CHIP was last renewed by the Medicare and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10), MACPAC's analysis has focused on both what would happen in the current-law scenario under which federal CHIP funding comes to an end, and on the steps that should be taken to meet the health and developmental needs of low- and moderate-income children in the future if federal program funding is extended, including the role of CHIP in providing children's coverage.
- Key findings from this analysis are:
  - CHIP has reduced uninsurance among children in families with incomes below 200 percent of the federal poverty level (FPL).
  - CHIP coverage is more affordable, with respect to both premiums and out-of-pocket cost sharing expenses, for families than either exchange or employer-sponsored coverage.
  - Although most sources of coverage include major medical benefits (i.e., inpatient and outpatient hospital services, physician services, and prescription drugs), CHIP and Medicaid are more likely to cover oral health services, audiology, and hearing aids relative to exchange plans and employer-sponsored insurance.
  - Children with CHIP coverage are more likely to have a usual source of care, including dental care, and more likely to have had a well-child visit in the past year relative to children without insurance.
- It is the Commission's view that the development of a more seamless system of children's coverage is needed. Such a system would provide comprehensive and affordable coverage for low- to moderate-income children, removing the potential for gaps in coverage and care that can affect children as they transition among different sources of publicly and privately financed health insurance.
- Uncertainty about the stability of the coverage market, now heightened by potential action by the 115th Congress on proposals to repeal the law underpinning the workings of the exchange market and change the structure and financing of the Medicaid program, have led the Commission to recommend extending CHIP at this time.

## Key Points (continued)

- The Commission recommends an extension of CHIP funding for five years to ensure that low- and moderate-income children retain access to affordable and comprehensive insurance coverage, maintaining the gain in coverage secured over the past 20 years.
- In order to provide a stable source of children's coverage and give federal and state policymakers time to develop policies and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children, the following changes should be made:
  - fund CHIP through fiscal year 2022; and
  - extend the current CHIP maintenance of effort and 23 percentage point increase in the federal CHIP matching rate for three years, through fiscal year 2022.
- The Commission also recommends creating and funding a children's coverage demonstration grant program to support state efforts to develop, test, and implement approaches to providing CHIP-eligible children with seamless health coverage that is as comprehensive and affordable as CHIP. State innovation will be a key driver in improving the system of coverage for low- and moderate-income children, and federal support of those efforts would ease financial barriers to states that aspire to transform their children's coverage systems.
- The Commission reiterates its support for the elimination of waiting periods in CHIP, aligning separate CHIP premium policies with those of Medicaid, and permanently extending authority for states to use Express Lane Eligibility.
- Finally, the Commission recommends extending funding to support outreach and enrollment of Medicaid- and CHIP-eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures Program. These programs focus on improving aspects of coverage or care for children enrolled in Medicaid or CHIP and have been renewed along with CHIP funding in previous years.

## CHAPTER 1: The Future of CHIP and Children's Coverage

Since its enactment with bipartisan support in 1997, the State Children's Health Insurance Program (CHIP) has played an important role in providing insurance coverage and access to health care for millions of low- and moderate-income children with incomes above Medicaid eligibility levels. During these years, the share of uninsured children in the typical CHIP income range, that is, those with family incomes above 100 percent but below 200 percent of the federal poverty level (FPL), has fallen dramatically—from 22.8 percent in 1997 to 6.7 percent in 2015 (Cohen et al. 2016). In fiscal year (FY) 2015, about 8.4 million children were enrolled in CHIP compared to nearly 37 million children in Medicaid (MACPAC 2016a).

In addition to providing access to affordable coverage, CHIP improves access to care for enrolled children. For example, children with CHIP coverage are more likely than children without insurance to have a usual source of care, including dental care, and more likely to have had a well-child visit in the past year (Harrington et al. 2014). Access to and use of health care services by children with CHIP are generally comparable to that of children with employer-sponsored coverage, although comparisons between these two coverage sources are complex (Cornachione et al. 2016, MACPAC 2012). CHIP also plays an important role in the financial security of low- and moderate-income families. Family spending on children's health care decreases when families gain CHIP or Medicaid coverage. CHIP and Medicaid coverage are also associated with a decreased likelihood that a family has unpaid medical bills and faces household bankruptcy (Wherry et al. 2016).

Congress now faces an important decision regarding the future of the program and its approach to providing a stable, affordable, and adequate

source of coverage to millions of America's children. Although CHIP is permanently authorized, current law provides federal CHIP funding to states only through FY 2017. Since funding for CHIP was last renewed by the Medicare and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10), MACPAC has focused considerable attention on determining what it considers the best approach to take going forward. Our analysis has focused on both what would happen under the current-law scenario under which federal CHIP funding comes to an end, and on the steps that should be taken to meet the health and developmental needs of low- and moderate-income children in the future if federal program funding is extended, including the role of CHIP in providing children's coverage.

MACPAC's deliberations, going back to 2013, have considered CHIP in context: a relatively small program of public coverage, serving children in families whose incomes are too high for Medicaid, but for whom employer-sponsored coverage is unavailable, unaffordable, or inadequate. The Commission's deliberations have assumed that other current coverage sources, including Medicaid and subsidized exchange coverage, remain available for children. For example, we have looked to the possibility of better integrating CHIP with exchange markets given that federal subsidies for such coverage are available to eligible individuals and families with incomes between 100 and 400 percent FPL. Those analyses, however, identified serious concerns about the quality and affordability of exchange coverage as compared to CHIP, concerns that led the Commission to recommend an extension of CHIP in its June 2014 report, and that informed the work of the Commission as it considered policy options for the period ahead.

Now, uncertainty about the stability of the exchange market, further heightened by potential action by the 115th Congress on proposals to repeal the law underpinning the workings of this market and to change the structure and financing of the Medicaid program, have led the Commission to once again recommend extending CHIP. Specifically, as

described in greater detail below, the Commission recommends that funding be extended for a period of five years, through FY 2022. Such an extension would ensure the stability of children's coverage during a time in which the coverage environment could change significantly, and would also be responsive to the pressing concerns of states as they begin budget and policy planning for the next fiscal year and beyond.

The Commission continues to hold that a more seamless system of children's coverage should be developed—a system that would provide comprehensive and affordable coverage for low- to moderate-income children and remove the potential for gaps in coverage and care that can affect children as they transition among different sources of publicly and privately financed health insurance. Such a system would promote greater integration and alignment between Medicaid, CHIP, and other insurance sources and would smooth out transitions that occur when families experience changes in income and employment (e.g., by moderating differences in out-of-pocket spending required for children). In addition, the Commission continues to be troubled by the fact that many low- and moderate-income children do not benefit from the value and security offered by CHIP coverage because CHIP eligibility levels vary widely from state to state (MACPAC 2016b). This means that for families at the same income level, children in some states are eligible for CHIP while children in other states are not. Their families must instead obtain costlier, potentially less comprehensive coverage for the children through other sources.

The Commission's long-range vision looks to a system that ensures sufficient coverage, in terms of both benefits and affordability, to appropriately meet the needs of the nation's children. We also look to states as potential laboratories of innovation for improvements in children's coverage, including alignment of children's coverage with state-focused efforts to organize and improve their health insurance markets to promote coverage and improve population health.

In the short term, however, two things are clear: first, health insurance markets will likely face substantial changes over the next few years. Second, current funding for CHIP will be exhausted before such changes are fully realized. The design of specific solutions to address the shortcomings of children's coverage concerns and weighing the merits and costs of different approaches will require additional time for analysis and planning. Given uncertainty about the future structure of the market for publicly financed health insurance coverage going forward and the urgency of addressing the impending end to CHIP funding, the Commission finds that the existing approach to children's coverage should be maintained while these broader questions are addressed. The Commission urges Congress to act as soon as possible to extend CHIP funding so that both families and states have assurances that CHIP will be maintained during this time of uncertainty.

This report presents the Commission's recommendations on the future of CHIP as well as several companion recommendations to move toward a more seamless system of children's coverage. We begin by summarizing recent work of the Commission that has informed our present deliberations and our conclusions. The analyses and conclusions cover the program's impact on children's coverage, our expectation of the likely scenario should CHIP funding not be renewed, and the relative advantages of CHIP when compared to other sources of coverage. We then present each of the recommendations and its rationale along with our assessment of its implications for the federal government, states, beneficiaries, and providers and plans. Appendix 1A provides an overview of CHIP and Appendix 1B provides state CHIP eligibility and enrollment information.

## MACPAC Analysis and Deliberation

MACPAC has been considering the future of CHIP and children's coverage for a number of years. In 2014, the Commission began thinking more broadly about how to meet the needs of low- and moderate-income children in an evolving coverage environment that under current law includes Medicaid, CHIP, exchange coverage, and employer-sponsored insurance. In its March 2014 report to Congress, the Commission stated its view that regardless of what form children's coverage takes, it must be affordable and offer comprehensive coverage, and it should maintain a program design that allows state flexibility, one of the key features that led to all states adopting CHIP in the late 1990s (MACPAC 2014a). In its June 2014 report, the Commission recommended two years of additional funding, with an expectation that this amount of time would be sufficient to resolve the open questions regarding the longer-term structure of publicly subsidized children's coverage (MACPAC 2014b).

In 2015 and early 2016, the Commission's analysis focused on the following:

- the likely impact on children's insurance status should CHIP funding not be renewed;
- comparisons of out-of-pocket spending between CHIP and both exchange coverage and employer-sponsored insurance;
- analysis of differences in benefits between CHIP and other sources of coverage; and
- an examination of network adequacy under these different types of insurance coverage (MACPAC 2016c, 2015).

Our conclusions based on this work are presented below.

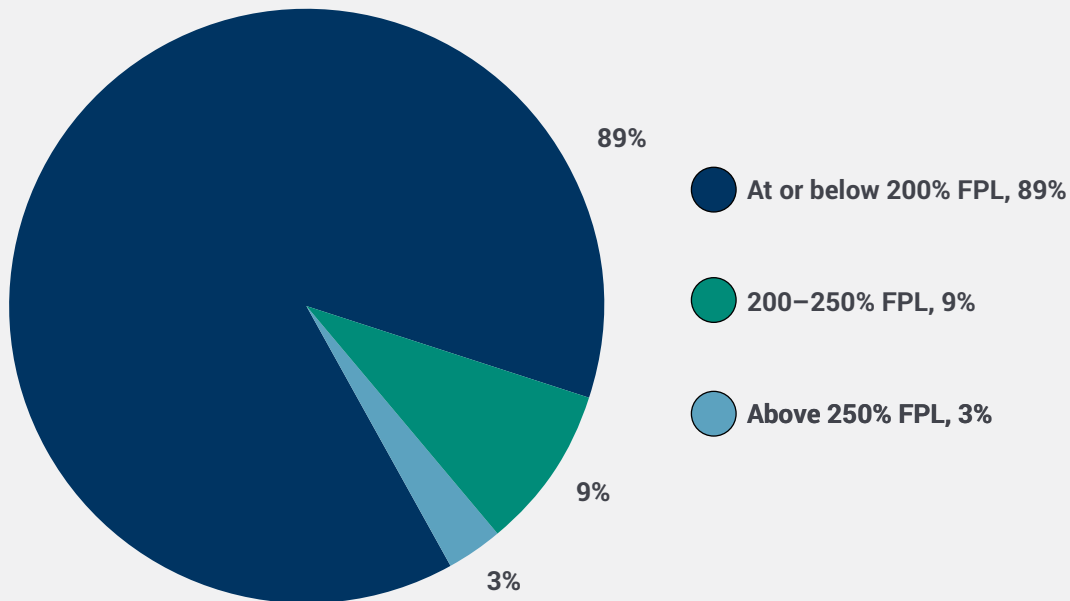
## CHIP has reduced uninsurance among children in families with modest incomes

CHIP was created as part of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). To encourage states to participate, Congress provided them with enhanced federal financing for CHIP and gave them greater flexibility in designing CHIP than they had with Medicaid. In 1997, it was uncertain how many states would respond to this new federal funding opportunity, but by FY 2000, every state and territory (including the District of Columbia) had children enrolled in CHIP-financed coverage. States can design CHIP as an expansion of Medicaid, as a separate program, or as a combination of both. Currently, ten states, including the District of Columbia, and five territories operate CHIP entirely as a Medicaid expansion; two states operate CHIP entirely as separate programs; and 39 states operate a combination program. In states operating a Medicaid-expansion program, federal Medicaid rules generally apply. Of the 8.4 million children enrolled in CHIP-funded coverage in 2015, 3.7 million were enrolled in separate CHIP and 4.7 million in Medicaid-expansion CHIP (MACPAC 2016a).<sup>1</sup> CHIP has enjoyed bipartisan support from Congress, which most recently renewed federal funding for two years, under MACRA, through FY 2017.

CHIP, along with Medicaid, is widely credited with helping to reduce uninsurance among children. Since CHIP's enactment, the share of all children age 0–17 that were uninsured fell about 9 percentage points from 13.9 percent in 1997 to 4.5 percent in 2015.<sup>2</sup> The decline was even greater for those with family incomes at or above 100 percent FPL but below 200 percent FPL (Cohen et al. 2016). Unlike Medicaid, CHIP does not impose on states the requirement to cover children up to a specific income level, and it gives them flexibility in setting income eligibility at levels they deem most appropriate for their coverage market and state environment. Income eligibility levels vary widely across the states, with upper limits currently ranging from 170 percent to 400 percent FPL (MACPAC 2016b). Nevertheless, the vast majority of states (89 percent) set income eligibility at or below 200 percent FPL in FY 2013 (Figure 1-1).



**FIGURE 1-1.** Child Enrollment in CHIP-Financed Coverage, by Family Income as a Percentage of FPL, FY 2013



**Notes:** FPL is federal poverty level. FY is fiscal year. Includes separate and Medicaid-expansion CHIP. In the Statistical Enrollment Data Systems (SEDS), Delaware, Nevada, North Carolina, Oklahoma, South Carolina, and South Dakota reported CHIP enrollees above 200 percent FPL, and Kansas reported CHIP enrollees above 250 percent FPL; however, CHIP in these states is reported only to cover individuals at or below these levels. The numbers here were altered to put all of the enrollees in Delaware, Nevada, North Carolina, Oklahoma, South Carolina, and South Dakota at or below 200 percent FPL and all Kansas enrollees at or below 250 percent FPL. Components may not sum to 100 percent due to rounding. In 2013, in the 48 contiguous states and the District of Columbia, 200 percent FPL was \$22,980 for an individual plus \$8,040 for each additional family member.

**Source:** MACPAC, 2014, analysis of CHIP SEDS data from the Centers for Medicare & Medicaid Services as of March 4, 2014.

## CHIP is more affordable than other sources of coverage

MACPAC's analyses found that for children in the CHIP income eligibility range, CHIP coverage is considerably less costly to families, with respect to both premiums and out-of-pocket cost sharing, than exchange or employer-sponsored coverage (MACPAC 2016c, 2015).<sup>3</sup> For example, in 2015, the combined premiums and cost sharing of separate CHIP in 36 states averaged \$158 per year per child. Most of that spending was for premiums (\$127),

with the remainder being spent on cost sharing (\$31). On average in these 36 states, separate CHIP enrollees faced cost sharing of 2 percent of covered medical benefits, with the plans covering 98 percent—that is, separate CHIP coverage had an effective actuarial value of 98 percent. By contrast, if these same children were enrolled in employer-sponsored insurance, they would have faced an estimated \$891 per year per child in average annual out-of-pocket spending (\$603 for premiums and \$288 in cost sharing), and if enrolled in the second lowest cost silver exchange plan, they would have faced

an estimated \$1,073 per year per child (\$806 for premiums and \$266 in cost sharing). The effective actuarial value averaged 81 percent in employer-sponsored insurance plans and 82 percent in second lowest cost silver exchange plans, with families responsible for the remaining 18 percent to 19 percent through cost sharing (MACPAC 2016c).

While premiums and cost sharing are permitted for children in separate CHIP (capped at 5 percent of family income), they generally are prohibited for children in Medicaid.

## CHIP benefits are generally more generous than those offered by other sources of coverage

MACPAC's comparison of benefits in separate CHIP, Medicaid (including Medicaid-expansion CHIP), exchange plans, and employer-sponsored insurance found that covered benefits vary within each source—between states for Medicaid and CHIP, and among plans for employer-sponsored insurance and exchange plans (MACPAC 2015). Most separate CHIP, Medicaid, exchange, and employer-sponsored insurance plans cover major medical benefits, such as inpatient and outpatient care, physician services, and prescription drugs. Children enrolled in Medicaid-expansion CHIP are entitled to all Medicaid services, including early and periodic screening, diagnostic, and treatment services.

Like Medicaid, separate CHIP covers pediatric dental services. By contrast, dental benefits are offered as a separate, stand-alone insurance product in most exchanges and employer-sponsored coverage, requiring families to pay separate premiums and cover cost sharing expenses. More than half of all employer-sponsored plans (54 percent) do not include pediatric dental coverage. Of the employers that offer separate dental coverage, many require an additional premium (MACPAC 2016d).

CHIP also covers many services important to children's healthy development that are not always available in exchange plans. For example, all separate CHIP and Medicaid programs cover

audiology exams, and 95 percent of separate CHIP programs cover hearing aids. However, only 37 percent of exchange plan essential health benefit benchmarks cover audiology exams, and only 54 percent cover hearing aids (MACPAC 2015). Among employer-sponsored health plans, 34 percent cover pediatric audiology exams and 43 percent cover hearing aids (MACPAC 2015).

The Commission also looked at how CHIP provider networks compare to those of other sources of coverage. Under federal law, CHIP managed care is subject to the same federal provisions that establish standards for Medicaid managed care (§ 2103(f)(3) of the Social Security Act (the Act)). These provisions require states to establish "standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity" (§ 1932(c)(1)(A)(i) of the Act). CHIP regulations also specify that a state must ensure "access to out-of-network providers when the network is not adequate for the enrollee's medical condition" (42 CFR 457.495).

Advocates have suggested that separate CHIP networks are better than Medicaid or exchange plan networks because they are similar to private plan networks or because they are designed specifically for pediatric needs (Hensley-Quinn and Hess 2013, Hoag et al. 2011). However, we found little empirical evidence to either support or refute this assertion.

## Recommendations for the Future of CHIP and Children's Coverage

For much of 2016, the Commission focused its efforts on assessing a range of policy options for the future of CHIP funding and children's coverage. Before deciding on the specific recommendations included in this report, the Commission considered a number of broad options, including: permitting CHIP funding to expire; extending CHIP funding; expanding mandatory Medicaid coverage of children; enhancing exchange coverage; permitting states to use CHIP

funds to purchase exchange coverage; and creating a new waiver authority focused on promoting seamless children's coverage.

In weighing the benefits and drawbacks of the options, the Commission considered several criteria: the effects on coverage, affordability, adequacy of benefits, impact on states and state flexibility, federal and state spending, and simplicity. The Commission drew upon findings from its own analyses as well as those of external policy and health services researchers, such as the evaluation of CHIP mandated by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) (Harrington et al. 2014). The Commission also took into account the views and information offered by stakeholders. From the time the Commission began its deliberation to the time it developed its final recommendations, changes in the policy environment occurred that could significantly alter the coverage context for children. It is important to note that the Commission's recommendations were made in the context of current law, but with the understanding that the incoming Congress is likely to take up proposals to make substantial changes, both to health insurance markets and to Medicaid.

The Commission's recommendations, rationale, and implications are described below. In this recommendation package, the Commission reiterates its 2014 recommendations to eliminate CHIP waiting periods and premiums for children in families with incomes below 150 percent FPL, as well as its prior support for permanently extending Express Lane Eligibility authority. Although the Commission is not recommending any particular offset at this time, the Commission has compiled a list of savings proposals previously identified in legislative proposals, in President's budgets, and by others. It is important to note that the Commission has not analyzed the merits of these proposals or voted on them, and is not endorsing any specific proposal on the list.

## Recommendation 1.1

Congress should extend federal CHIP funding for a transition period that would maintain a stable

source of children's coverage and provide time to develop and test approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children.

### Rationale

This recommendation calls for extending federal CHIP funding because other currently available sources of coverage for CHIP-eligible children do not provide affordable or comprehensive coverage. Extending CHIP ensures that eligible low- and moderate-income children will retain access to affordable insurance coverage, maintaining the gains in coverage secured over the past 20 years.

The Commission has discussed at length the need to develop a seamless, coordinated system of children's coverage rather than indefinitely maintain CHIP as a distinct program. However, uncertainty about other sources of coverage and the approaching exhaustion of federal CHIP funding leads the Commission to conclude that at this time, extending CHIP is the better choice for maintaining children's access to coverage.

CHIP cannot continue in its current state unless federal funding is renewed. If federal CHIP funding is exhausted, the 41 states with separate CHIP will not have to maintain that coverage. Children covered in Medicaid-expansion CHIP will not become uninsured because the maintenance-of-effort (MOE) provision requires states to continue that coverage through FY 2019. However, MOE coverage is funded at the regular Medicaid matching rate, which is lower than the CHIP matching rate for these children, putting new fiscal pressures on states.

MACPAC analysis, published in our March 2015 report to Congress, projected that if federal CHIP funds were exhausted and no new federal funding was provided, 3.7 million children would lose access to separate CHIP, of which an estimated 1.1 million children would become uninsured (MACPAC 2015). The remaining children are projected to obtain coverage from other payers—1.4 million (36.5 percent) through subsidized exchange coverage and 1.2 million (32.6 percent) through a parent's

employer-sponsored insurance. These estimates assumed the availability of Medicaid and subsidized exchange coverage for children, as under current law.

The projected increase in the number of uninsured children is not because such children are not eligible for other coverage, but rather because their families cannot afford it. Among the 1.1 million children projected to become uninsured, 59.1 percent are expected to be eligible for a parent's employer-sponsored insurance but will not enroll because of the high cost of premiums and other out-of-pocket cost sharing. The remaining 40.9 percent of the children expected to become uninsured will be eligible for subsidized exchange coverage (MACPAC 2015). About 63 percent of these families are not expected to have to make additional premium contributions for adding children to their coverage. For the remaining 37 percent of children who will have to make additional premium contributions, these contributions—although lower than would be required for employer-sponsored insurance—are higher than required by CHIP (MACPAC 2015).

Even for those families who are able to pay higher premiums to remain insured, concerns about access remain. The higher level of cost sharing at the point of service that is required by other coverage sources will increase the financial burden on low- and moderate-income families, and this has the potential to impede children's access to care (MACPAC 2016c, MACPAC 2016d).

Under current law, 5 states are expected to spend their remaining CHIP allotments by December 2017 and 29 states and the District of Columbia are expected to spend their remaining CHIP allotments by March 2018.<sup>4</sup> Although current law provides no new CHIP allotments in FY 2018, if states are experiencing shortfalls in their CHIP allotments, they can receive redistribution funds from the unspent CHIP allotments of other states after two years have passed (Appendix 1C). However, the amount of available redistribution funds from FY 2016 unspent allotments is less than in previous years. The current CHIP matching rate is 23 percentage points greater than historical rates, and this has resulted in states spending their federal CHIP allotments faster than in

prior years. For example, in FY 2015, \$12.6 billion in CHIP allotments were unspent, but in FY 2016, \$7.5 billion in CHIP allotments were unspent. In addition, MACRA reduced by one-third the amount of unspent CHIP funding that can be spent in FY 2018. Finally, the child enrollment contingency fund, also available to states that exhaust their CHIP allotments and have CHIP enrollment that exceeds a target level, is not available after FY 2018. Therefore, the Commission urges Congress to act swiftly to renew CHIP funding.

### Implications

**Federal spending.** Extending federal CHIP funding would increase federal spending because of the substantial federal contribution toward covering states' CHIP costs, including the 23 percentage point increase in the CHIP matching rate.

**States.** An extension of federal CHIP funding would permit states to continue providing CHIP-funded coverage to low- and moderate-income children. An extension would help mitigate the risk of increased state Medicaid and uncompensated care spending if CHIP funding was not renewed.

**Enrollees.** An extension of federal CHIP funding would mean that CHIP enrollees could retain their CHIP coverage, unless their circumstances change in ways that affect their eligibility.

**Plans and providers.** Extending CHIP funding would ensure that the plans and providers currently participating in CHIP could continue to provide services to the CHIP-enrolled population without disruption.

### Recommendation 1.2

Congress should extend federal CHIP funding for five years, through fiscal year 2022 to give federal and state policymakers time to develop policies for and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children.

## Rationale

A five-year extension of CHIP funding would provide a longer period relative to the most recent funding renewal, recognizing the considerable work needed to address a more comprehensive approach to children's coverage. It would also ensure that coverage remains available for the vulnerable population of low- and moderate-income children while federal and state policymakers discuss and debate changes in other sources of coverage, including exchange markets and Medicaid.

In its June 2014 report to Congress, the Commission anticipated that a two-year transition period would be sufficient to address concerns regarding the affordability and adequacy of children's coverage. It also stated that if more time was required to ensure that needed reforms were implemented, then an additional extension of CHIP funding should be considered. Meanwhile, the future of other sources of coverage—small group and individual markets—remains unsettled. In addition, Congress is poised to consider substantial changes to Medicaid. At this time, it is not possible to know the precise nature or extent of any such changes, or the timing for instituting them. The recommendation for a five-year extension recognizes the considerable work needed to formulate a more comprehensive approach to children's coverage. A longer-term extension of CHIP will provide a stable source of coverage for low- and moderate-income children while policymakers determine the future of subsidized health insurance.

Extending CHIP for five years also provides budgetary predictability for states. In addition, during this five-year period, states will be key partners in developing new approaches for improving children's coverage systems and may opt to design and implement such strategies. As described below, the Commission also recommends the creation of planning and implementation grants for the development of state-based approaches (see Recommendation 1.6). A five-year CHIP funding extension would provide time for states to implement new approaches and gain experience with them while ensuring a stable source of coverage for

children. These state experiences could inform the development of federal policy.

## Implications

**Federal spending.** Extending federal CHIP funding for an additional five years, along with the accompanying recommendations in this report affecting the MOE and the CHIP matching rate, is projected to increase federal spending. The Congressional Budget Office (CBO) estimates this recommendation would increase net federal spending above the agency's current law baseline by approximately \$13.2 billion over the five-year period of FYs 2017–2021 and approximately \$18.7 billion over the ten-year period of FYs 2017–2026. This estimate reflects congressional budget rules that require the agency to assume in its current-law spending baseline that federal CHIP funding continues beyond FY 2017 at \$5.7 billion each year.

**States.** An extension of federal CHIP funding would permit states to continue providing CHIP-funded coverage to low- and moderate-income children. An extension would help mitigate the risk of increased state Medicaid and uncompensated care spending if CHIP funding were not renewed.

**Enrollees.** An extension of federal CHIP funding would mean that CHIP enrollees could retain their CHIP coverage, unless their circumstances change in ways that affect their eligibility.

**Plans and providers.** Extending CHIP funding would ensure that the plans and providers currently participating in CHIP could continue to provide services to the CHIP-enrolled population without disruption.

## Recommendation 1.3

In order to provide a stable source of children's coverage while approaches and policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the current CHIP maintenance of effort and the 23 percentage point increase in the federal CHIP

matching rate, currently in effect through FY 2019, for three additional years, through FY 2022.

### Rationale

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) put in place an MOE provision effective through FY 2019 that requires states to maintain the CHIP eligibility levels in place on March 23, 2010. The MOE also prohibits states from adopting eligibility and enrollment standards or methodologies that are more restrictive than those in place prior to the enactment of the ACA (§ 2105(d)(3) of the Act). The purpose of this provision is to ensure that children do not lose coverage during a time when changes to other aspects of the program are underway, such as the creation of new eligibility and enrollment systems and the introduction of new methods for making eligibility determinations.

The ACA also increased the federal CHIP matching rate, known as the enhanced federal medical assistance percentage (E-FMAP), by 23 percentage points in FYs 2016–2019. The CHIP matching rate varies by state, currently ranging from 88 percent to 100 percent (Appendix 1D). Eleven states and the District of Columbia have an E-FMAP of 100 percent, 20 states receive an E-FMAP equal to or greater than 90 percent, and 19 have an E-FMAP between 88 percent and 90 percent. Prior to FY 2016, the CHIP E-FMAP ranged from 65 percent to 81 percent.

This recommendation calls for extending the CHIP MOE for three additional years to protect the stability of children's coverage. An extension of the CHIP MOE through FY 2022 is needed given the uncertainty in the coverage environment, the lack of comparable coverage alternatives for children, and the importance of maintaining the gains made in children's coverage. The CHIP MOE will keep coverage for low- and moderate- income children stable during this time of uncertainty and change.

This recommendation also calls for extending the 23 percentage point increase to the federal CHIP matching rate for three years, through FY 2022, to align with the recommended extension of the CHIP MOE. In the Commission's view, a

federal requirement such as the MOE should be accompanied by federal funding.

The Commission is aware of concerns that the increase in the E-FMAP has not resulted in widespread coverage or care improvements for children enrolled in CHIP, suggesting that the matching rate could be restored to its prior level without affecting the number of children covered by CHIP or the quality of that coverage. On the other hand, the increase to the CHIP E-FMAP is believed to have influenced decisions in Florida and Utah in 2016 to expand Medicaid and CHIP coverage to lawfully residing immigrant children without requiring the five-year wait period (CCF 2016). An estimated 1,000 children in Utah and 17,000 in Florida are expected to gain coverage as a result of these policy changes (CCF 2016). Moreover, in July 2016, Arizona, which currently has an E-FMAP of 100 percent, reinstated CHIP, which the state expects to cover approximately 30,000 to 40,000 children (CMS 2016a).

The Commission spent significant time considering approaches for the CHIP MOE and the federal CHIP matching rate, carefully weighing the need for stabilizing children's coverage with the desire to return flexibility to states for the management of their programs. In the course of this discussion, some commissioners raised concerns that if the CHIP MOE requirement was not extended, states would cut eligibility levels in response to budgetary constraints. Others expressed strong reservations about extending the MOE requirement, noting this would give the federal government more authority over the program and limit state flexibility in a program designed to be a federal-state partnership. Several commissioners also argued for reducing the federal CHIP matching rate back to its historical levels, noting both the lack of evidence that the 23 percentage point increase had resulted in significant improvements to children's coverage and the importance of states sharing responsibility for the costs of CHIP.

The Commission considered various phased approaches to modifying the MOE and to reducing the level of the increase to the E-FMAP while

adhering to the principle that any changes to the MOE provision should not lead to reductions in children's coverage levels. However, it was unclear what modifications to the MOE could meet this standard while providing desired flexibility. Ultimately, the Commission concluded that protecting children's coverage should take precedence over promoting state flexibility at this time of great uncertainty in health insurance markets. In the future, when the scope and design of new public approaches to coverage are in place and stable, policymakers may wish to reconsider how to balance these objectives.

### Implications

**Federal spending.** Extending the current CHIP MOE and the 23 percentage point increase in the CHIP E-FMAP through FY 2022 would result in increased federal CHIP spending. As stated above in Recommendation 1.2, the CBO estimates that this recommendation, along with the accompanying recommendations for a five year extension of federal CHIP funding, would increase net federal spending above the agency's current-law baseline by approximately \$13.2 billion over the five-year period of FYs 2017–2021 and approximately \$18.7 billion over the ten-year period of FYs 2017–2026. This estimate reflects congressional budget rules that require the agency to assume in its current law spending baseline that federal CHIP funding continues beyond FY 2017 at \$5.7 billion each year.

Under current law, states would have the opportunity to roll back coverage after FY 2019 and the federal CHIP match would return to its traditional level, reducing federal spending. On the other hand, it is important to note that increased CHIP spending would be offset by reductions in federal spending for Medicaid or subsidized exchange coverage, which many children would have qualified for in the absence of CHIP.

**States.** This recommendation would require states to maintain CHIP for three additional years within current MOE rules, and would provide states an increase to the federal CHIP matching rate in FYs 2020–2022.

**Enrollees.** Enrollees will continue to have coverage beyond FY 2019, through FY 2022.

**Plans and providers.** Extending the CHIP MOE would ensure that the plans and providers currently participating in CHIP could continue to provide services to the CHIP-enrolled population without disruption.

## Recommendation 1.4

To reduce complexity and to promote continuity of coverage for children, Congress should eliminate waiting periods for CHIP. (This recommendation was first made in the Commission's March 2014 report to Congress.)

### Rationale

States are required to have methods in place to prevent substitution of public coverage for private coverage and some, to satisfy this requirement, stipulate that a child be without private coverage for a specified period of time before enrolling in CHIP. Such waiting periods may not exceed 90 days, and there are several mandatory federal exemptions, resulting in relatively few children being subject to CHIP waiting periods (MACPAC 2014a).<sup>5</sup> As of November 2016, 36 states, including the District of Columbia, do not have waiting periods (CMS 2016b).

In its March 2014 report to Congress, the Commission recommended the elimination of waiting periods, citing four primary reasons. First, eliminating CHIP waiting periods will reduce uninsurance and improve the stability of coverage. This is because waiting periods cause children to be uninsured before they can be eligible for CHIP. Children who are subject to waiting periods are at risk of becoming uninsured and of churning back and forth between CHIP and other coverage, which can disrupt care (MACPAC 2014a).

Second, although CHIP waiting periods were instituted to deter crowd-out of private coverage, it is not clear that they have been effective. The limited research on CHIP waiting periods has reached contradictory conclusions, primarily

because researchers are using different data sources (MACPAC 2014a). In addition, the potential pool of children who might be targeted by this strategy is small—estimates suggest that only a small percentage of uninsured children in the CHIP income range had employer-sponsored coverage in the prior 90 days.

Third, eliminating CHIP waiting periods is consistent with the Commission's goal of more simplified and coordinated policies across various programs. Neither exchanges nor Medicaid require waiting periods, and eliminating CHIP waiting periods would make this aspect of CHIP consistent with those programs. And fourth, eliminating CHIP waiting periods will reduce administrative burden and complexity for families, states, health plans, and providers.<sup>6</sup>

Congressional action to end CHIP waiting periods would be consistent with the trend in state actions on this policy. For example, of the 37 states that began 2013 with CHIP waiting periods, 21 eliminated those waiting periods by 2016 (CMS 2016b). States have eliminated their CHIP waiting periods because of the resulting short-term transitions between exchange coverage and CHIP, to reduce the additional administrative burden on states, and because of the many exemptions (for example, having special health care needs or losing coverage due to a change in parental employment) among those who would otherwise face a CHIP waiting period (Caldwell 2013a).

### Implications

**Federal spending.** This recommendation would increase federal spending in FY 2017 by \$50 million to \$250 million, based on ranges provided by the CBO. Over the five-year period of FYs 2017–2021, this recommendation would increase federal spending by less than \$1 billion.

**States.** Ending the use of CHIP waiting periods would simplify eligibility and reduce the administrative burden associated with determining which children are subject to CHIP waiting periods (as well as the federal and state exemptions). In states currently

using CHIP waiting periods, eliminating these waiting periods could increase state CHIP spending because of the additional months of CHIP coverage. However, at least one state predicted that little additional cost would result from eliminating the CHIP waiting period, considering the administrative cost and burden of administering the policy and the relatively small number of children who would gain additional coverage (Caldwell 2013b).

**Enrollees.** Because many children can be exempted from CHIP waiting periods, the primary impact of eliminating the waiting period would be relieving families of the administrative burden of verifying their exemption and allowing them to avoid any associated delays in coverage. For children who are subject to a CHIP waiting period and not currently exempt, eliminating waiting periods would reduce the risk that they will go uninsured during a transition in coverage.

**Plans and providers.** Eliminating CHIP waiting periods would reduce the administrative burden associated with processing individuals' moves into and out of plans, and can ensure that efforts to improve management of enrollees' care and to measure quality of care are not compromised because of churning.

### Recommendation 1.5

In order to align premium policies in separate CHIP with premium policies in Medicaid, Congress should provide that children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums. (This recommendation was first made in the Commission's March 2014 report to Congress.)

#### Rationale

States are allowed to impose premiums and cost sharing in separate CHIP, but under Medicaid-expansion CHIP, they must adhere to federal Medicaid rules, which allow limited or no premiums and cost sharing. For all children with CHIP coverage, the combined total of premiums and cost sharing may not exceed 5 percent of family income. As of



January 2016, 26 states required premiums and 25 required cost sharing in separate CHIP (Brooks et al. 2016).

When CHIP was enacted, the ability to charge premiums and cost sharing was a key component of the flexibility provided to states. Although CHIP premiums can help to offset state and federal costs of coverage and signal to enrollees the importance of their contribution to the cost of coverage, in practice these premiums are relatively modest, and much lower than typical private coverage premiums. However, even at relatively low levels, premiums can increase uninsurance among children in families with income below 150 percent FPL (MACPAC 2014a).

Eliminating CHIP premiums for families with incomes under 150 percent FPL would reduce uninsurance and align CHIP premium policies with Medicaid policies for lower-income children. Compared to higher-income enrollees, families with incomes below 150 percent FPL are more price sensitive and less likely to take up CHIP coverage for their children when a premium is required (Abdus et al. 2013, Herndon et al. 2008). The CHIP premiums charged in this income range, generally less than \$10 per month, are so small that they would not represent a significant revenue loss to states if they were eliminated—especially as this also removes states' burden in collecting and administering these premiums (Kenney et al. 2007).

This recommendation would affect the eight states that continue to charge CHIP premiums to enrollees in families with incomes below 150 percent FPL. In 2014, MACPAC estimated that there were approximately 110,000 children in families with incomes below 150 percent FPL who would be subject to CHIP premiums (MACPAC 2014a). This recommendation does not call for any change to CHIP's premium policies for families with incomes above 150 percent FPL, which is the income range for the majority of CHIP enrollees subject to premiums.

## Implications

**Federal spending.** CHIP matching funds would be available for any increase in state CHIP spending due to loss of premiums or increased enrollment, up to the point at which states have expended their allotments. CBO estimates that this recommendation would have increased federal spending by less than \$50 million in FY 2017 and by less than \$1 billion over the five-year period of FYs 2017–2021. These are the smallest non-zero ranges provided by CBO. This estimate does not exceed \$1 billion over the ten-year period of FYs 2017–2026.

**States.** Only eight states charge premiums to enrollees in families with incomes below 150 percent FPL for separate CHIP coverage (Brooks et al. 2016). Due to the transition of CHIP-enrolled children below 138 percent FPL from separate CHIP to Medicaid-expansion CHIP, the number of children in families with incomes below 150 percent FPL that are subject to CHIP premiums is shrinking considerably.

Ending the use of CHIP premiums would affect these states in three ways. First, states would lose a small amount of revenue from premiums currently paid by families with incomes under 150 percent FPL. Second, states would likely realize administrative savings associated with no longer collecting these CHIP premiums. The amount of revenue from CHIP premiums obtained from families with incomes below 150 percent FPL is relatively small compared to the administrative costs of collecting them (Kenney et al. 2007). Third, some increased CHIP spending would result from increased enrollment, from children otherwise prevented from enrolling by the premiums.

**Enrollees.** If states no longer charge CHIP premiums to families with incomes below 150 percent FPL, an estimated 110,000 children would be exempted from CHIP premiums. As a result of ending these premiums, additional children might also enroll in CHIP, reducing uninsurance but also private coverage (Abdus et al. 2013, Herndon et al. 2008).

**Plans and providers.** Plans would no longer have to obtain premiums from newly exempted families,

which would reduce administrative burden and increase enrollee retention. Ending CHIP premiums for families with incomes below 150 percent FPL might also increase CHIP enrollment in the eight affected states.

Ending CHIP premiums for families with incomes below 150 percent FPL would not have significant direct effects on providers.

## Recommendation 1.6

Congress should create and fund a children's coverage demonstration grant program, including planning and implementation grants, to support state efforts to develop, test, and implement approaches to providing for CHIP-eligible children seamless health coverage that is as comprehensive and affordable as CHIP.

### Rationale

This recommendation calls for establishing planning and implementation demonstration grants to support interested states in developing and testing models for improved coverage systems that specifically focus on children. Such models could be developed using existing state plan and waiver authorities, such as those available under Sections 1115 and 1332 of the Act.

It is the Commission's view that state innovation will be a key driver in improving the system of coverage for low- and moderate-income children, and that federal support of those efforts is critical. The children's coverage demonstration grant program would ease financial barriers to states wishing to transform their children's coverage system. Developing options for a seamless system of coverage across available coverage sources that ensures CHIP-eligible children have affordable and comprehensive coverage will require resources for research and analysis of markets, needs assessments, stakeholder and expert engagement, as well as legal, regulatory, policy, and cost analyses. Without federal funding, these analyses may not be feasible for states to pursue. Because such activities are typically not eligible for federal match under state

plan authority, states have used waiver authority and grant funding to finance these planning activities.

The models through which states would achieve this goal will provide information on how new systems of children's coverage could be implemented, their effects, and scalability to other states. For example, many states implemented Medicaid managed care delivery systems through demonstrations, which, with increased state experience, have become a permanent feature of the program. Congress has a track record of providing funding to support state planning and implementation efforts to transform health care coverage and delivery, for example:

- States had the opportunity to apply for planning grants to develop state plan amendments for implementing health homes for enrollees with chronic conditions (§ 1945 of the Act).<sup>7</sup> States used these funds to hire contractors; to conduct feasibility studies, consumer and provider outreach, and training; and to develop reporting systems (CMS 2010).
- Some states received federal financial support to transition from institution-based to community-based long-term care systems through the Real Choice Systems Change grant program (Shirk 2007). States used grant funds to develop the necessary regulatory, administrative, program, and funding infrastructure around such transitions, but not to fund services (CMS 2006).<sup>8</sup>
- The State Innovation Model initiative provided grants to states to design and test alternative payment or new service delivery models that would reduce program expenditures while preserving or enhancing the quality of care (§ 1115A(a)(1) of the Act, Spencer and Freda 2016). The model design grant awards were intended to support state planning activities to develop a state health care innovation plan. These activities included stakeholder engagement, analysis of state and federal policy and regulation, and gap analyses of the resources necessary to implement a payment or delivery model (CMS 2012).<sup>9</sup>

## Implications

**Federal spending.** The children's coverage demonstration grant program would likely increase federal spending by the total amount appropriated for the grants. There could also be downstream federal spending effects related to increased enrollment depending on systems of coverage implemented by states under these demonstrations.

**States.** This recommendation would enable states to engage in planning and implementation activities for a more seamless system of children's coverage that they might otherwise have forgone. This recommendation would result in greater state experience with innovative systems of children's coverage and understanding of their effects in participating states.

**Enrollees.** Enrollees in participating states could experience some changes in coverage, including smoother transitions between coverage and less drastic changes in cost sharing and coverage of benefits from one coverage source to another. Enrollees would remain insured and their coverage would remain as comprehensive and affordable as CHIP.

**Plans and providers.** Plans and providers currently participating in coverage sources could continue that coverage without disruption. They may experience some changes related to how much enrollee out-of-pocket costs are allowed and how they are paid, and changes in the delivery of services for children who transition in or out of the plan or practice.

## Recommendation 1.7

Congress should permanently extend the authority for states to use Express Lane Eligibility for children in Medicaid and CHIP. The Commission noted its support for this policy in a 2014 letter to the Secretary of the U.S. Department of Health and Human Services (MACPAC 2014c).

## Rationale

Express Lane Eligibility (ELE) authority allows states to streamline their Medicaid and CHIP application processes and has resulted in favorable gains in coverage and administrative savings. Specifically, ELE permits states to rely on findings from another program designated as an Express Lane agency when making Medicaid and CHIP eligibility determinations (including renewals of eligibility), without regard to differences in rules between the programs for counting income and household composition. Other Express Lane agencies include the Supplemental Nutrition Assistance Program (SNAP), the National School Lunch Program (NSLP), and Head Start. CHIPRA created the state plan option for ELE, authorizing it through FY 2013. Most recently, MACRA extended authority for the ELE option for children in Medicaid or CHIP through September 30, 2017 (it had been scheduled to expire on September 30, 2015).

As of January 1, 2016, eight states use ELE for children at Medicaid enrollment, five states use ELE for CHIP enrollment, seven states use ELE for children at Medicaid renewal, and three states use ELE for CHIP renewal (KFF 2016). A federal evaluation indicated that as of December 2013, nearly 1.4 million children enrolled in Medicaid or CHIP and retained coverage through ELE processes.

Federal evaluations have found that some states reported that implementing ELE resulted in administrative savings, although states generally lacked data to support these findings (OIG 2016, Hoag et al. 2013). For example, one state reportedly saved \$7.3 million between 2011 and 2014, and another state reported that the Medicaid agency saved \$25.77 per initial enrollment and \$5.15 per renewal. Savings were the result of reduced staff time to complete eligibility determinations due to simplified enrollment processes, according to state reports (OIG 2016).

The Commission recommends permanently extending ELE authority because of the favorable enrollment gains and administrative savings reported by states that implemented the ELE policy

option. The ELE option is consistent with MACPAC's view that stability of children's coverage during a period of flux in coverage markets is critical. Streamlined processes, in which enrollment in coverage is not dependent on families supplying or resupplying documentation to states for initial eligibility determinations or renewals, reduce the risk of children losing their coverage for administrative reasons, thus stabilizing their coverage status.

An extension of ELE authority is necessary to allow states to maintain coverage gains. Without an extension, states that have implemented this option would be likely to incur additional costs in reverting to legacy eligibility processes. Should authority for the ELE option expire, the states that have implemented this option could only continue to do so under a Section 1115 waiver.

This recommendation presumes that ELE does not result in additional incorrect eligibility determinations.

## Implications

**Federal spending.** CBO estimates that this recommendation would result in net federal spending of approximately \$400 million over the five-year period of FYs 2017–2021, and approximately \$1.1 billion over the ten-year period of FYs 2017–2026. Increased federal spending is expected to result from increased enrollment and retention of Medicaid- and CHIP-eligible children. This estimate is similar to CBO's estimates of the President's FY 2017 budget (CBO 2016).

**States.** This recommendation would allow states currently using ELE in Medicaid or CHIP to continue to do so, and additional states could adopt the policy. If authority for the ELE option expires, the states that have implemented this option could only continue to do so under a Section 1115 waiver. Otherwise, they would have to revert to non-ELE eligibility processes, which may require states to hire additional staff to conduct eligibility determinations. For example, Louisiana was able to reduce its eligibility workforce by about 200 positions when it implemented ELE without reducing enrollee access

to coverage (Kennedy 2014). Louisiana may need to re-hire many of these staff to process applications and renewals if ELE authority is not extended. In addition, ELE may produce administrative savings for states when compared to traditional enrollment methods (Hoag et al. 2013).

**Enrollees.** Automated ELE processes can increase enrollment of children in Medicaid and CHIP and possibly lead to reductions in churn and uninsurance because it allows states to rely on eligibility findings from other agencies (Hoag et al. 2013). The effect on children enrolled in Medicaid and CHIP of a permanent extension of ELE authority for states, however, will differ depending on their state of residence. Children in states that have implemented ELE will continue to experience a more streamlined eligibility determination or renewal process. Families would not be required to reproduce certain eligibility documentation they had already provided to other agencies. Due to this administrative simplicity, enrollees could experience shorter wait times to enroll in coverage, undergo less churn, and benefit from continuity of care with their medical providers.

**Plans and providers.** If authority for ELE is extended, plans and providers could benefit from a more stable enrollee population with less churn.

## Recommendation 1.8

The Secretary of the U.S. Department of Health and Human Services, in consultation with the Secretaries of the U.S. Department of Agriculture and the U.S. Department of Education, should, not later than September 30, 2018, submit a report to Congress on the legislative and regulatory modifications needed to permit states to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families.

### Rationale

Express Lane authority does not allow other designated assistance programs to consider Medicaid eligibility determination findings. ELE streamlines the application process when families

have applied to partner agencies before applying to Medicaid and CHIP, but not when families apply to Medicaid or CHIP before applying to partner agencies. For example, Colorado allows families to use eligibility findings from the NSLP to facilitate enrollment in CHIP (CMS 2016c). Families that apply for NSLP go through one application process to determine their eligibility for both programs. On the other hand, a family that applies for CHIP first still has to complete a separate application process for NSLP. This creates additional administrative burden for families and for state agencies, which have to gather and verify documentation twice.

In light of the Commission's findings on ELE authority, more information is needed to understand the changes necessary to modify ELE authority so that designated programs can use Medicaid or CHIP eligibility determination information. Specifically, the report should describe the legislative and regulatory changes necessary to allow designated programs to use publicly subsidized health program findings to determine eligibility for other programs. The report should also assess the operational challenges and technical feasibility of this policy, and evaluate the implications of broadening ELE authority.

This recommendation builds on the Commission's recommendation that ELE authority be made a permanent state option. The report would explore how such a policy would reduce administrative burden for families who seek health coverage first, and then seek the support of other designated programs such as SNAP, NSLP, or Head Start. The report should also assess how to reduce administrative burden for states by allowing them to use one eligibility determination for multiple programs no matter which program a family approaches first.

## Implications

**Federal spending.** CBO estimates that a report to Congress would result in negligible federal costs, although the responsibility for such a report would increase the administrative effort for the Secretary, as well as for the Secretaries of Agriculture and Education.

**States.** In completing the report, the Secretary is likely to consult with state agencies that administer Medicaid, CHIP, and other designated ELE programs. States may be asked to provide information on program eligibility requirements, families' eligibility information that is collected by each program's application process, and the changes necessary to use eligibility determination from one program to satisfy application requirements of another.

**Enrollees.** The Secretary's report would not have a direct effect on Medicaid and CHIP enrollees. Over time, however, the report could recommend policies that would streamline the application process and reduce administrative burden for enrollees.

**Plans and providers.** The Secretary's report would not have a direct effect on Medicaid and CHIP managed care plans or health care providers.

## Recommendation 1.9

Congress should extend funding for five years for grants to support outreach and enrollment of Medicaid and CHIP eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures Program, through fiscal year 2022.

### Rationale

The Commission is recommending extending funding for these programs, which in previous years has been renewed along with CHIP funding. These programs focus on improving aspects of coverage or care for children enrolled in Medicaid or CHIP.

**Grants to support outreach and enrollment of Medicaid- and CHIP-eligible children.** In addition to providing a source of coverage for low- and moderate-income children, the enactment of CHIP created incentives for states to proactively search for CHIP- and Medicaid-eligible children who are uninsured and to enroll them in coverage rather than waiting for children and their families to initiate the process. To support such proactive efforts, CHIPRA established outreach and enrollment grants, appropriating \$100 million for FYs 2009–2013.

Funding was most recently renewed under MACRA at \$40 million for FYs 2016–2017. These funds provide support to states, tribes, and community-based organizations for a variety of outreach and enrollment activities. Funds have also supported a national outreach and enrollment campaign (CMS 2016d).

State officials have reported that the CHIPRA outreach and enrollment grants have helped to support their own outreach efforts, which would have to be scaled down without federal funding; these grants have also supported the efforts of community-based organizations that are sometimes coordinated with the state (Harrington et al. 2014). Such grants are needed to maintain the historic successes in finding and enrolling eligible children and in helping them retain coverage at renewal. Arguably, the children who remain uninsured are the hardest to reach and thus sustained efforts are required to encourage them to enroll. Efforts are typically directed at teens, Latino children, children in families with mixed citizenship status, and children in families with mixed eligibility for Medicaid and CHIP (KCMU 2013, Kenney et al. 2010).

Without such funding, reduced attention to outreach could lead to increased uninsurance among children, reversing gains made in recent years. Absent such grants, state spending on outreach and enrollment would be limited by federal law to the 10 percent cap on CHIP administrative spending.

**The Childhood Obesity Research Demonstration project.** The Childhood Obesity Research Demonstration (CORD) was established in CHIPRA to identify health care and community strategies to combat childhood obesity in children age 2–12 who are enrolled in or eligible for Medicaid or CHIP (Dooyema et al. 2013). Funding for this effort was most recently extended under MACRA, at \$10 million for the period of FYs 2016–2017.

In 2015, an estimated 10.8 percent of Medicaid and CHIP enrollees age 0–18 were obese (MACPAC 2016e). One estimate places the annual health care costs for children treated for obesity covered by Medicaid at about \$6,700 per child, compared to

about \$3,700 for those under private coverage. The national cost of childhood obesity is estimated at approximately \$11 billion for children with private insurance and \$3 billion for those with Medicaid (Marder and Chang 2006).

CORD project grantees are evaluating whether multi-level, multi-setting approaches that integrate primary care with public health strategies can improve health behaviors and reduce childhood obesity. For example, the second phase of CORD grants, which began in June 2016, focuses on preventive services to individual children and families in Arizona and Massachusetts, a change from the community-wide public health interventions funded in the first phase.

The demonstration uses a consistent set of outcome and process measures across all projects in addition to measures that are unique to each funded project (Sebelius 2014a). An evaluation is underway and so far suggests favorable outcomes; however, final results will not be available until spring 2017.

The Commission supports continued research into strategies aimed at reducing and preventing childhood obesity among children enrolled in Medicaid and CHIP. Continued federal funding is important to efforts to develop and test strategies to reduce childhood obesity, as well as disseminating results.

**The Pediatric Quality Measures Program.** The 2009 renewal of CHIP funding focused federal attention and resources on measuring the quality of pediatric care. In 2009, the Centers for Medicare & Medicaid Services (CMS) developed a core set of children's health care quality measures for children in Medicaid and CHIP, the first focused effort to measure the quality of publicly funded children's health care in a consistent way on a national level. Since 2010, state participation in reporting the voluntary core set of child health measures has increased; by FY 2014, all 50 states and the District of Columbia reported at least one measure (CMS 2016e, CMS 2011). The number of measures reported by each state has also increased, from a median of 10 in FY 2010 to a median of 16 in FY 2014 (CMS 2016e, CMS 2011). The core set for children's measures has grown from

an initial list of 24 measures in 2010 to 26 measures in 2016 (CMS 2016f).

CHIPRA also established the Pediatric Quality Measures Program (PQMP) to improve and strengthen the initial child core set. In its initial phase, the PQMP funded seven Centers of Excellence, which brought together experts, including researchers, providers, state Medicaid and CHIP officials, and patient and family advocates, to develop and improve pediatric quality measures (AHRQ 2016, Sebelius 2014b). MACRA extended funding of \$20 million over fiscal years 2016 and 2017. Measures developed include prenatal care screening, alcohol and drug screening of depressed adolescents, prevention and appropriateness of asthma-related emergency department use, and identification of children with disabilities. In its current phase, the PMQP is focused on disseminating and implementing the quality measures developed by the Centers of Excellence.

Current PMQP grantees are assessing the feasibility and usability of the measures at the state, health plan, and provider levels (AHRQ 2016). An extension of PQMP funding will allow the Secretary to continue to develop, test, validate, and disseminate new child health quality measures, and to continue revising existing measures for children enrolled in Medicaid and CHIP. In a November 2014 letter to Congress, MACPAC stated that the needed investments in quality measurement are relatively small, but that they are important investments in the program, not only for those whose care is financed by Medicaid and CHIP but also for taxpayers (MACPAC 2014d). In the letter, MACPAC noted several key areas in which ongoing work is needed to build on the progress made to improve quality of care for those with Medicaid and CHIP coverage, including strengthening CMS's capacity to calculate quality measures for states, improving quality measures for individuals with disabilities, and expanding the use of core quality measures in state quality improvement efforts. Continuation of the PQMP could also support efforts to measure and improve care provided to children with special health care needs enrolled in Medicaid and CHIP coverage.

## Implications

**Federal spending.** Extending funding for outreach and enrollment grants, CORD projects, and the PQMP is projected to increase federal spending by \$175 million over five years (FYs 2018–2022). There is also likely to be some associated burden related to administering the grant application process, providing technical assistance to grantees, and overseeing evaluation efforts. Successful project management could not continue without federal administrative support for these programs.

**States.** A funding extension is likely to have different implications for states depending on state interest in these programs. An extension would ensure support for state- and community-based efforts to perform outreach and enrollment activities. States can use CORD grant funds to design and test new interventions to reduce childhood obesity. In addition, an extension of federal support for continued improvement of pediatric quality measures may encourage more states to participate in voluntary reporting. As more states report on more measures, they can use this information to target quality improvement efforts for child health and compare their performance with that of other states.

**Enrollees.** The implications of a funding extension for families and enrollees will differ depending on states' current and future interest in these programs. A funding extension will allow states to continue their outreach, enrollment, and renewal efforts, which help children gain or maintain CHIP coverage. For children in Massachusetts and Texas, which are operating CORD demonstration projects, extended funding could maintain access to project activities such as nutritional counseling and clinic screenings. Extended funding for PQMP is likely to have little direct effect on enrollees, but who likely would benefit indirectly from continued federal focus on improving the quality of children's health care.

**Plans and providers.** Extending funding for these programs could allow plans and providers to use grant funds to undertake outreach and enrollment activities, to partner with states to design and test new strategies to reduce childhood obesity,

to develop new pediatric quality measures, and to revise existing pediatric quality measures. Extended funding would also ensure that plans and providers engaged in these efforts could continue them without disruption. Funding for PQMP could increase administrative burden for health plans, if states implement reporting requirements for new measures in Medicaid and CHIP managed care contracts. On the other hand, increased reporting could shed light on the quality of care plans that providers are providing to enrollees, either by documenting issues or successes.

apparent in the cost savings estimate alone. As such, the list should be viewed with caution.

In the statute creating MACPAC, Congress charges the Commission with reviewing Medicaid and CHIP policies, including their relationship to access and quality of care for Medicaid beneficiaries. Therefore all of the proposals on this list are Medicaid or CHIP policies; in considering policies that increase federal Medicaid or CHIP spending, Congress could choose to enact other proposals affecting spending or revenues, including those from outside CHIP or Medicaid.

## Federal Budget Implications

When making recommendations, the Commission considers the budgetary consequences and consults with the Congressional Budget Office to obtain cost estimates. The Congressional Budget Office estimates that the combined federal costs of MACPAC's recommendations will be approximately \$13.2 billion for the five-year period FY 2017 through 2021, and approximately \$18.7 billion for the ten-year period of FY 2017 through 2026.

Although certain members of MACPAC's congressional committees of jurisdiction have requested that MACPAC recommend budgetary offsets for recommendations that would increase federal spending, the Commission is not prepared to recommend any particular offsets at this time. Instead we have compiled a list of previous savings proposals that have been scored by CBO as well as proposals that have been offered in the President's budget, introduced as legislation, and developed by others (Appendix 1E). The methodology for inclusion of proposals on this list is described in the appendix.

The Commission has not voted on nor has it endorsed any specific proposal on this list. Moreover, MACPAC has not analyzed the merits or effects of these proposals on the availability of coverage to low-income individuals, access to care, or benefits nor their potential impact on states, health plans, providers, or others. Such effects would not be



## Endnotes

<sup>1</sup> CMS believes these totals are accurate. However, according to CMS, reporting challenges in FY 2015 may have impacted separate CHIP and Medicaid-expansion CHIP enrollment totals.

<sup>2</sup> The National Center for Health Statistics reports insurance coverage data collected in the National Health Interview Survey using the age range of 0 through 17 years.

<sup>3</sup> On November 25, 2015, the U.S. Department of Health and Human Services (HHS) released a congressionally mandated study of whether exchange benefits and cost sharing are comparable to separate CHIP (CMS 2015). Consistent with MACPAC's findings, HHS found that no exchange plans are comparable to CHIP with respect to premiums and cost sharing. The HHS study also looked at covered benefits and found that benefit packages in CHIP are generally more comprehensive for dental, vision, and habilitation services and are more comprehensive for children with special health care needs than exchange plans. For benefits typically covered by commercial plans, such as physician, laboratory, and radiological services, HHS found that coverage is similar between CHIP and exchange plans. This is also consistent with MACPAC's prior analyses (CMS 2015, MACPAC 2015).

<sup>4</sup> This MACPAC estimate is based on FY 2017 CHIP allotments.

<sup>5</sup> Children must be exempted from the waiting period if any of the following applies: (1) the additional out-of-pocket premium to add the child to an employer plan exceeds 5 percent of income; (2) a parent is eligible for subsidized exchange coverage because the premium for the parent's self-only employer-sponsored coverage exceeds 9.5 percent of income; (3) the total out-of-pocket premium for employer-sponsored family coverage exceeds 9.5 percent of income; (4) the employer stopped offering dependent coverage (or any coverage); (5) a change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (regardless of potential eligibility for COBRA coverage); (6) the child has special health care needs; or (7) the child lost coverage due to the death or divorce of a parent.

<sup>6</sup> In addition, because most of the states with CHIP waiting periods rely on the federally facilitated exchange, which is generally not able to determine CHIP eligibility where waiting periods exist, CHIP waiting periods are a barrier to streamlined, coordinated eligibility determinations (HHS 2013).

<sup>7</sup> The federal government made \$500,000 in federal matching funds available to states as planning grants to support efforts to develop a state plan amendment (§ 1945(c)(3) of the Act). Twenty states received health home planning grants, and CMS approved 28 state plan amendments from 20 states as of July 2016 (CMS 2016g).

<sup>8</sup> Between 2001 and 2004, grant awards ranged from \$300,000 to \$800,000 to be used over a three- or four-year period; beginning in 2005, fewer grants were awarded, but the grant amounts were larger and generally for a five-year period (CMS 2016h). States had to contribute 5 percent in non-federal share to the total grant award (Shirk 2007). In total, CMS awarded more than \$288 million to states between 2001 and 2010 (CMS 2016h).

<sup>9</sup> In the two grant award phases since 2012, the Center for Medicare & Medicaid Innovation has awarded model design grants ranging from \$750,000 to \$3 million to 36 states and 3 territories. Model design grantees are expected to complete a state health care innovation plan and apply for model testing grants in subsequent rounds of funding (CMS 2016i).

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## Dissenting Statement

I have been asked by the Chair to provide a brief discussion for the record of my reasons for dissenting from the Commission's recommendations that were brought to a vote during the December 15, 2016 meeting. Before doing so I will state that my dissent should not be interpreted as a repudiation of the CHIP program. I support and applaud the important access to health care it has provided to millions of children over the last two decades. Rather, I dissent from the Commission's recommendations for specific Congressional action regarding the future of the program.

**Recommendation 1.1:** I agree that Congress should extend federal CHIP funding for a transition period, during which time alternative approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children can be developed and tested, while maintaining a stable source of children's coverage.

**Recommendation 1.2:** I disagree that the extension should be for five years. The next Congress will undertake comprehensive health care reform and is expected to replace or repeal elements of the ACA. One of the critical failures of the ACA was to integrate CHIP and deliver affordable, high-quality children's coverage to working families. The Commission has discussed and reported the benefit gaps and affordability challenges for children under the ACA in its June 2014, March 2015, and March 2016 reports to Congress. Perpetuating CHIP as a freestanding program means that many families who do not qualify for CHIP will continue to pay higher premiums for less comprehensive exchange coverage. Rather than extending CHIP for five years, Congress should use the upcoming legislative opportunity to ensure there is what the Speaker of the House Paul Ryan has called "a better way" designed specifically for all the children of working families.

**Recommendation 1.3:** I also disagree with the first component of this recommendation, which calls for a five-year extension of the current CHIP MOE. The MOE freezes states in place and renders them unable to adapt to the changing health insurance landscape they confront. It effectively disenfranchises the voters and their representatives in individual states by holding hostage federal funding. States have demonstrated a vibrant capacity to innovate in health care funding and delivery. Regarding the second component, I am entirely opposed to extending the increase to the E-FMAP rate for five years. I find the Commission's rationale unpersuasive. An E-FMAP of 100 percent federalizes what should be a state-directed program and leaves states with no skin in the game. I see no evidence that these billions of dollars of unrestricted funding have produced any meaningful change in children's health outcomes. These funds should be redeployed by Congress for some more useful, well-documented purpose, such as reducing the premiums paid by working families for their children's health care coverage.

**Recommendation 1.6:** I am very supportive of creating and funding a demonstration grant program to support state innovation in children's coverage. Such a demonstration would likely require removal of the MOE requirements.

I support the program improvements and extensions outlined in the Commission's recommendations 1.4, 1.5, and 1.7 through 1.9.

In summary, while I concur with many of the Commission's recommendations in this special report, I am constrained to dissent from the package as a whole. At this point in time, Congress should leverage its current focus on health policy to consider what has enabled CHIP to maintain unwavering bipartisan support for two decades. It should incorporate those success factors—chief among them being a child-

centered focus and state flexibility—into the insurance reforms it seeks to enact in the next session. And it should explicitly and mindfully address the need that all of America's children have for comprehensive, affordable, high-quality health care.

Christopher Gorton, MD, MHSA  
Commissioner

## Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfills this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on CHIP. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

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## The Future of CHIP and Children's Coverage

- 1.1 Congress should extend federal CHIP funding for a transition period that would maintain a stable source of children's coverage and provide time to develop and test approaches for a more coordinated and seamless system of comprehensive, affordable coverage for children.
- 1.2 Congress should extend federal CHIP funding for five years, through fiscal year 2022 to give federal and state policymakers time to develop policies for and to implement and test coverage approaches that promote seamlessness of coverage, affordability, and adequacy of covered benefits for low- and moderate-income children.
- 1.3 In order to provide a stable source of children's coverage while approaches and policies for a system of seamless children's coverage are being developed and tested, and to align key dates in CHIP with the period of the program's funding, Congress should extend the current CHIP maintenance of effort and the 23 percentage point increase in the federal CHIP matching rate, currently in effect through FY 2019, for three additional years, through FY 2022.
- 1.4 To reduce complexity and to promote continuity of coverage for children, Congress should eliminate waiting periods for CHIP. (This recommendation was first made in the Commission's March 2014 report to Congress.)
- 1.5 In order to align premium policies in separate CHIP with premium policies in Medicaid, Congress should provide that children with family incomes below 150 percent of the federal poverty level not be subject to CHIP premiums. (This recommendation was first made in the Commission's March 2014 report to Congress.)
- 1.6 Congress should create and fund a children's coverage demonstration grant program, including planning and implementation grants, to support state efforts to develop, test, and implement approaches to providing for CHIP-eligible children seamless health coverage that is as comprehensive and affordable as CHIP.



1.7 Congress should permanently extend the authority for states to use Express Lane Eligibility for children in Medicaid and CHIP. (The Commission noted its support for this policy in a 2014 letter to the Secretary of the U.S. Department of Health and Human Services.)

1.8 The Secretary of the U.S. Department of Health and Human Services, in consultation with the Secretaries of the U.S. Department of Agriculture and the U.S. Department of Education, should, not later than September 30, 2018, submit a report to Congress on the legislative and regulatory modifications needed to permit states to use Medicaid and CHIP eligibility determination information to determine eligibility for other designated programs serving children and families.

1.9 Congress should extend funding for five years for grants to support outreach and enrollment of Medicaid and CHIP eligible children, the Childhood Obesity Research Demonstration projects, and the Pediatric Quality Measures Program, through fiscal year 2022.

16	Yes
1	No
0	Not Voting

Yes: Burwell, Carte, Cohen, Cruz, Douglas, George, Gold, Gray, Lampkin, Martínez Rogers, Milligan, Retchin, Rosenbaum, Szilagyi, Thompson, Weil

No: Gorton

## APPENDIX 1A: Overview of CHIP

The State Children’s Health Insurance Program (CHIP), created in 1997, is a joint federal-state program established to provide coverage to uninsured children in families whose incomes are too high to qualify for Medicaid. In fiscal year (FY) 2015, 8.4 million children and 4,200 pregnant women received CHIP-funded coverage.<sup>1</sup>

### History and Impact of CHIP

CHIP was created as part of the Balanced Budget Act of 1997 (BBA 97, P.L. 105-33). To encourage states to participate, CHIP provided states with enhanced federal financing and greater flexibility in program design compared to Medicaid. At the time, it was uncertain how many states would respond to this new federal funding opportunity. By FY 2000, however, every state, territory, and the District of Columbia had children enrolled in CHIP-financed coverage.

Since the enactment of CHIP, the number of children lacking health insurance has declined substantially from 10 million children in 1997, many of whom were in working families with incomes just above their states’ Medicaid eligibility levels, to 3.3 million in 2015 (Cohen et al. 2016, Martinez and Cohen 2012). Seventy percent of this decline was due to additional enrollment of children in Medicaid rather than CHIP; however, this increase is often attributed to the availability of a new source of coverage and the new focus, concurrent with CHIP’s passage, on reaching out to eligible uninsured children (Dubay et al. 2007).

Since CHIP’s enactment in 1997, federal funding for the program has been renewed several times, most recently by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10), which extended funding for FYs 2016–2017 (Box 1A-1).

### Key CHIP Design Features

CHIP covered 8.4 million children at a total combined state and federal cost of \$13.7 billion in FY 2015; this makes it a relatively small program compared to Medicaid, which covered 81.0 million individuals with

#### BOX 1A-1. Legislative History of Federal CHIP Funding Renewals

- The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) authorized and funded CHIP for ten years, FYs 1998–2007.
- The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) extended funding through March 31, 2009.
- The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) extended funding through FY 2013.
- The Patient Protection and Affordable Care Act of 2010 (ACA, P.L. 111-148, as amended) extended funding through FY 2015.
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) extended funding through FY 2017.

combined federal and state spending totaling \$556.0 billion that same year (MACPAC 2016a, MACPAC 2016b). As with Medicaid, CHIP is administered by states within federal rules, and states receive federal matching funds for program spending. CHIP, however, differs from Medicaid in a variety of ways.

## Program design

CHIP gives states flexibility to create their programs as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches. For states with Medicaid-expansion CHIP, federal Medicaid rules generally apply. Separate CHIP generally operates under a separate set of federal rules that allows states to design benefit packages that look more like commercial insurance than Medicaid. Under separate CHIP, states may also charge premiums, create waiting periods, and brand and market their programs separately from Medicaid.

As of January 2016, 10 states (including the District of Columbia) and 5 territories ran CHIP as a Medicaid expansion, 2 states operated separate CHIP and 39 states operated a combination program. Of the 8.4 million children enrolled in CHIP-funded coverage during FY 2015:

- 40.0 percent (3.4 million) were children age 0–18 in separate CHIP;
- 56.0 percent (4.7 million) were children in Medicaid-expansion CHIP; and
- 3.9 percent (0.3 million) were unborn children in separate CHIP (Appendix 1B).

Nearly every state that was once categorized as having only separate CHIP now has a combination program. This shift to combination programs is due to the implementation of two provisions of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that required states to move some separate CHIP enrollees into Medicaid:

- a mandatory income disregard equal to 5 percent of the federal poverty level (FPL) that effectively raised Medicaid and CHIP eligibility levels by 5 percentage points; and
- a mandatory transition from separate CHIP into Medicaid of 6- to 18-year-olds in families with incomes between 100 percent and 133 percent FPL (the so-called stairstep children).

**Eligibility.** Individuals who meet Medicaid program criteria (including the criteria for Medicaid-expansion CHIP) are entitled to Medicaid coverage, but there is no individual entitlement to coverage in separate CHIP. Similarly, funding is not open ended.

To be eligible for CHIP, a child must be considered a targeted low-income child, that is, a child under the age of 19 with no health insurance who would not have been eligible for Medicaid under the state rules in effect on March 31, 1997. States may also extend CHIP eligibility to children of state employees.<sup>2</sup>

While Medicaid programs are required by federal law to cover certain populations up to specified income levels, there is no mandatory income level up to which CHIP must extend coverage. State-set upper eligibility limits for children’s CHIP eligibility range from 170 percent FPL in North Dakota (\$41,310 for a family of four in 2016) to 400 percent FPL in New York (\$97,200 for a family of four in 2016). (See Appendix 1B for state CHIP eligibility levels in 2016.) Although many states offer CHIP coverage at higher income levels (generally with higher premiums or cost sharing), 89 percent of the children enrolled in CHIP-financed coverage had incomes at or below 200 percent FPL in FY 2013, and 97 percent were at or below 250 percent FPL (Table 1A-1).

The federal CHIP statute limits states’ upper income eligibility to 200 percent FPL, or, if higher, 50 percentage points above states’ pre-CHIP Medicaid levels. However, prior to the ACA, states had flexibility in how they counted income so they could effectively expand to any income level. The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) amended the CHIP statute

**TABLE 1A-1.** Enrollment in CHIP by Family Income, FY 2013

Family income as a percentage of FPL	Percentage of CHIP enrollees
<b>Total</b>	<b>100.0%</b>
At or below 200 percent FPL	88.8
Above 200 percent through 250 percent FPL	8.6
Above 250 percent FPL	2.6

**Notes:** FY is fiscal year. FPL is federal poverty level.

**Source:** MACPAC 2014.

so that states covering children above 300 percent FPL would receive the regular Medicaid matching rate instead of the enhanced CHIP matching rate (§ 2105(c)(8) of the Social Security Act (the Act)).<sup>3</sup>

In 2015, all but two states had upper income eligibility limits at or above 200 percent FPL, including:

- 23 states covering children with family income from 200 to 249 percent FPL; and
- 26 states (including the District of Columbia) covering children at or above 250 percent FPL.

Under the ACA, states must maintain their 2010 eligibility levels through FY 2019 for children in both separate CHIP (as long as funding exists) and Medicaid (including Medicaid-expansion CHIP), a requirement referred to as the maintenance-of-effort (MOE) provision (§ 2105(d)(3) of the Act).

**Pregnant women and unborn children.** CHIP also funds coverage of pregnant women through a state plan option or through continuation of an existing Section 1115 waiver. Under the CHIP state plan option created in CHIPRA, states may provide comprehensive health care coverage for uninsured, targeted low-income pregnant women (§ 2112 of the Act). To provide this coverage, state Medicaid programs must cover pregnant women with incomes up to 185 percent FPL (or up to the eligibility level the state had in place on July 1, 2008, whichever is higher). The CHIP upper income eligibility limit for pregnant women cannot be higher than the limit set

for children, and states may not impose policies such as enrollment caps on targeted low-income pregnant women or children (§ 2112(b) of the Act). States can also use Section 1115 demonstration waivers to provide CHIP-funded coverage to pregnant women. Four states—Colorado, New Jersey, Rhode Island, and Virginia—enroll pregnant women in CHIP-funded coverage (MACPAC 2016c). Colorado, New Jersey, and Rhode Island use the CHIP state plan option, while Virginia provides the coverage under a Section 1115 waiver.

Under separate CHIP, states may cover pregnant women regardless of immigration status through the unborn child option by revising the definition of the term child in federal regulations to include the period from conception to birth (CMS 2009, 2002). In FY 2015, 15 states provided separate CHIP coverage to approximately 327,000 unborn children (Appendix 1B). Unborn children accounted for the entirety of separate CHIP enrollment in Arkansas, Minnesota, Nebraska, and Rhode Island. The largest enrollments of unborn children in FY 2015 were in California and Texas.

**Waiting periods.** Because there is no individual entitlement to CHIP coverage, states with separate CHIP may use strategies to limit enrollment such as waiting periods, which is the length of time that children must be without employer-sponsored insurance before enrolling in CHIP. Currently, a state's ability to institute new eligibility restrictions is constrained by the MOE provision, but states may continue using waiting periods they previously had in place. In 2016, 15 states had CHIP waiting

periods, down from 37 states in 2013 (CMS 2016, MACPAC 2014). To reduce complexity and to promote continuity of coverage for children, MACPAC recommends that Congress eliminate CHIP waiting periods altogether. (MACPAC 2014).

**Premiums and cost sharing.** States with separate CHIP are also permitted to charge premiums and require cost sharing, which is generally prohibited for children in Medicaid. Thirty states charge premiums or enrollment fees for children enrolled in CHIP, including four states with Medicaid-expansion CHIP. Of these states, 26 charge monthly or quarterly premiums and 4 charge annual enrollment fees. States often charge higher premiums as family income rises. As of January 2016, in states with separate CHIP, premiums ranged from \$12 to \$40 per child, with a median monthly premium of \$17 for children in families with incomes at 151 percent FPL. For families at 251 percent FPL, premiums ranged from \$9 to \$61 per child, with a median monthly premium of \$25 (Brooks et al. 2016).

Twenty-five states with separate CHIP require cost sharing for at least some types of services. For example, 20 states impose cost sharing for non-preventive physician visits, and 20 states have cost sharing for non-emergency use of the emergency department for children with family income at 201 percent FPL (Brooks et al. 2016). States often also require some cost sharing for inpatient hospital visits, emergency room visits, and prescription drugs (Cardwell et al. 2014). CHIP is more likely to charge copayments for services than other forms of cost sharing like deductibles or coinsurance (Bly et al. 2014, McManus and Fox 2014).

Combined expenses for separate CHIP premiums and cost-sharing expenses may not exceed 5 percent of a family's income, although many states have lower caps (Cardwell et al. 2014).

**Covered benefits.** States with separate CHIP can model their plan's benefits on specific private insurance plans, a package equivalent to one of those benchmarks, or Secretary-approved coverage.

Federal rules require that separate CHIP covers dental services, well-baby and well-child care (including age-appropriate immunizations), and emergency services. In 2013, all states covered inpatient and outpatient services, physician services, clinic services, laboratory and X-ray services, and prescription drugs in separate CHIP, although some states applied benefit limits (Cardwell et al. 2014).

The most flexible benefit design option for separate CHIP is Secretary-approved coverage, which is the most common approach. As a result of this flexibility, covered benefits in CHIP differ substantially from state to state. Fourteen states use a Secretary-approved benefit package for separate CHIP that is similar to Medicaid (Cardwell et al. 2014).

Children in Medicaid-expansion CHIP are protected by federal Medicaid benefit 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.

## Financing

CHIP is jointly financed by the states and the federal government. State CHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid's, subject to the cap on their allotment. Spending for FY 2015 totaled \$13.7 billion (\$9.7 billion federal, \$4.0 billion state). Under current law, CHIP allotments are provided through FY 2017.

**CHIP matching rate.** Regardless of program design, state CHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid's. CHIP's enhanced federal medical assistance percentage (E-FMAP) varies by state. In FYs 2016 through 2019, the CHIP matching rate is increased by 23 percentage points from its prior level, ranging from 88 percent to 100 percent. Twelve states have a federal E-FMAP of 100 percent, 20 states receive a federal E-FMAP equal to or greater

than 90 percent, and 19 have a federal E-FMAP between 88 percent and 90 percent. Historically, CHIP matching rates ranged from 65 percent to 81 percent, compared to a 50 percent to 73 percent matching rate for children in Medicaid (Appendix 1D).

**CHIP allotments.** Unlike Medicaid, federal CHIP funding is capped. Federal CHIP funds are allotted to states based on their recent CHIP spending adjusted annually to account for child population growth and medical inflation (Appendix 1C). States have two years to spend each allotment, with unspent funds available for redistribution to other states that experience shortfalls.

States that exhaust their CHIP allotments and have CHIP enrollment that exceeds a target level are also eligible for contingency fund payments in FY 2017, in addition to redistribution funds. MACRA reauthorized payments from the contingency fund through FY 2017, so under current law, contingency funds will not be available starting in FY 2018 (MACPAC 2011).

Without an extension of CHIP funding, when states exhaust their CHIP funding after FY 2017, the ACA's MOE provision requires Medicaid-expansion CHIP to continue those children's Medicaid coverage through FY 2019 at Medicaid's lower federal matching rate. As federal CHIP funding is exhausted, a state's separate CHIP is no longer subject to the MOE; as states close down separate CHIP, most enrollees could qualify for subsidized exchange coverage or employer-sponsored coverage, although some may not enroll and could become uninsured. Under current law, 5 states are expected to spend their remaining FY 2016 and FY 2017 CHIP allotments by December 2017, and 29 states and the District of Columbia, are expected to exhaust their CHIP allotments by March 2018.

## Endnotes

- <sup>1</sup> Enrollment data for pregnant women include women covered by the CHIP state plan option and section 1115 waivers.
- <sup>2</sup> A state may elect this option if it can demonstrate that it has consistently contributed to the cost of employee coverage since 1997 with increases for inflation or that its state employee health plan's out-of-pocket costs pose a financial hardship for state employees. The ACA established this state plan option (CMS 2011).
- <sup>3</sup> 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).

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# APPENDIX 1B: Eligibility and Enrollment

TABLE 1B-1. CHIP Eligibility Levels (2016) and Enrollment (FY 2015) by State

State	Program type <sup>1</sup> (as of July 1, 2016)	Children in Medicaid-Expansion CHIP <sup>1</sup>						Children in separate CHIP						Total CHIP-funded child enrollment <sup>4</sup>					
		Infants <1 (% FPL)			Age 1-5 (% FPL)			Age 6-18 (% FPL)			Separate CHIP: Age 0-18 <sup>2</sup>				Total separate CHIP enrollment				
		Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment	Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment	Eligibility <sup>3</sup>	Enrollment								
<b>Total</b>							4,702,185								3,362,642		327,175	3,689,817	8,397,651
Alabama	Combination	-	-	107-141	45,697	142-312	142-312	142-312	87,346	-	-	-	-	-	87,346	-	-	87,346	133,043
Alaska	Medicaid expansion	159-203	159-203	124-203	10,182	-	-	-	-	-	-	-	-	-	-	-	-	-	10,182
Arizona <sup>5</sup>	Combination	-	-	104-133	37,412	148-200	142-200	134-200	1,399	-	-	-	-	-	1,399	-	-	1,399	38,811
Arkansas	Combination	-	-	107-142	108,706	143-211	143-211	143-211	- <sup>6</sup>	209	3,365	3,365	3,365	3,365	3,365	-	-	3,365	112,071
California <sup>7,8</sup>	Combination	208-261	142-261	108-261	1,787,470	262-317	262-317	262-317	2,461	317	122,197	124,658	124,658	124,658	124,658	-	-	124,658	1,912,128
Colorado	Combination	-	-	108-142	23,687	143-260	143-260	143-260	62,446	-	-	62,446	62,446	62,446	62,446	-	-	62,446	86,133
Connecticut	Separate	-	-	-	-	197-318	197-318	197-318	24,884	-	-	24,884	24,884	24,884	24,884	-	-	24,884	24,884
Delaware	Combination	194-212	-	110-133	238	-	<sup>9</sup> 143-212 <sup>9</sup>	134-212 <sup>9</sup>	16,141	-	-	16,141	16,141	16,141	-	-	-	16,141	16,379
District of Columbia	Medicaid expansion	206-319	146-319	112-319	10,676	-	-	-	-	-	-	-	-	-	-	-	-	-	10,676
Florida	Combination	192-206	-	112-133	134,708	-	<sup>9</sup> 141-210 <sup>9</sup>	134-210 <sup>9</sup>	293,386	-	-	293,386	293,386	293,386	-	-	-	293,386	428,094
Georgia	Combination	-	-	113-133	53,906	206-247	150-247	134-247	176,909	-	-	176,909	176,909	176,909	-	-	-	176,909	230,815
Hawaii	Medicaid expansion	191-308	139-308	105-308	27,239	-	-	-	-	-	-	-	-	-	-	-	-	-	27,239
Idaho	Combination	-	-	107-133	8,937	143-185	143-185	134-185	25,576	-	-	25,576	25,576	25,576	-	-	-	25,576	34,513
Illinois	Combination	-	-	108-142	113,105	143-313	143-313	143-313	191,328	208	26,138	217,466	217,466	217,466	208	26,138	217,466	217,466	330,571
Indiana	Combination	157-208	141-158	106-158	69,462	209-250	159-250	159-250	31,098	-	-	31,098	31,098	31,098	-	-	-	31,098	100,560
Iowa	Combination	240-375	-	122-167	21,777	-	<sup>9</sup> 168-302 <sup>9</sup>	168-302 <sup>9</sup>	60,880	-	-	60,880	60,880	60,880	-	-	-	60,880	82,657
Kansas	Combination	-	-	113-133	54	167-238	150-238	134-238	77,085	-	-	77,085	77,085	77,085	-	-	-	77,085	77,139
Kentucky	Combination	-	142-159	109-159	50,926	196-213	160-213	160-213	36,050	-	-	36,050	36,050	36,050	-	-	-	36,050	86,976
Louisiana	Combination	142-212	142-212	108-212	122,878	213-250	213-250	213-250	3,498	209	9,238	12,736	12,736	12,736	209	9,238	12,736	12,736	135,614
Maine	Combination	-	140-157	132-157	13,440	192-208	158-208	158-208	8,870	-	-	8,870	8,870	8,870	-	-	-	8,870	22,310
Maryland	Medicaid expansion	194-317	138-317	109-317	142,327	-	-	-	-	-	-	-	-	-	-	-	-	-	142,327
Massachusetts <sup>10</sup>	Combination	185-200	133-150	114-150	79,299	201-300	151-300	151-300	76,519	200	13,123	89,642	89,642	89,642	200	13,123	89,642	89,642	168,941
Michigan <sup>11</sup>	Combination	195-212	143-212	109-212	29,226	-	-	-	85,302	195	5,171	90,473	90,473	90,473	195	5,171	90,473	90,473	119,699
Minnesota	Combination	275-283 <sup>12</sup>	-	-	474	-	-	-	-	278	3,361	3,361	3,361	3,361	278	3,361	3,361	3,361	3,835
Mississippi	Combination	-	-	107-133	30,819	205-209	144-209	134-209	56,286	-	-	56,286	56,286	56,286	-	-	-	56,286	87,105
Missouri	Combination	-	148-150	110-150	38,600	197-300	151-300	151-300	39,744	300	- <sup>13</sup>	39,744	39,744	39,744	300	- <sup>13</sup>	39,744	39,744	78,344
Montana	Combination	-	-	109-143	16,008	144-261	144-261	144-261	29,253	-	-	29,253	29,253	29,253	-	-	-	29,253	45,261
Nebraska	Combination	162-213	145-213	109-213	55,515	-	-	-	4,613 <sup>14</sup>	197	2,090	6,703	6,703	6,703	197	2,090	6,703	6,703	62,218



**TABLE 1B-1. (continued)**

State	Program type <sup>1</sup> (as of July 1, 2016)	Children in Medicaid-Expansion CHIP <sup>1</sup>										Children in separate CHIP														
		Infants <1 (% FPL)					Age 1-5 (% FPL)					Age 6-18 (% FPL)					Separate CHIP: Age 0-18 <sup>2</sup>					Separate CHIP: Unborn				
		Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment	Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment	Infants <1 (% FPL)	Age 1-5 (% FPL)	Age 6-18 (% FPL)	Enrollment	Eligibility <sup>3</sup>	Enrollment	Total separate CHIP enrollment	Total CHIP-funded child enrollment <sup>4</sup>									
Nevada	Combination	-	-	122-133	17,763	161-200	161-200	134-200	44,145	-	-	-	-	-	44,145	61,908										
New Hampshire	Medicaid expansion	196-318	196-318	196-318	16,651	-	-	-	-	-	-	-	-	-	-	16,651										
New Jersey	Combination	-	-	107-142	100,826	195-350	143-350	143-350	114,365	-	-	-	-	-	114,365	215,191										
New Mexico	Medicaid expansion	200-300	200-300	138-240	17,155	-	-	-	40 <sup>14</sup>	-	-	-	-	-	40	17,195										
New York	Combination	-	-	110-149	235,945	219-400	150-400	150-400	394,787	-	-	-	-	-	394,787	630,732										
North Carolina	Combination	194-210	141-210	107-133	134,413	-	-	138-211	100,237	-	-	-	-	4 <sup>15</sup>	100,241	234,654										
North Dakota	Combination	-	-	111-133	-	148-170	148-170	134-170	4,955	-	-	-	-	-	4,955	4,955										
Ohio	Medicaid expansion	141-206	141-206	107-206	181,100	-	-	-	-	-	-	-	-	-	-	181,100										
Oklahoma	Combination	169-205	151-205	115-205	174,167	-	-	-	208 <sup>16</sup>	205	16,483	16,691	190,858	-	190,858											
Oregon <sup>17</sup>	Combination	133-185	-	100-133	-	186-300	134-300	134-300	115,726	185	6,143	121,869	121,869	-	121,869											
Pennsylvania	Combination	-	-	119-133	64,638	216-314	158-314	134-314	229,704	-	-	229,704	294,342	-	294,342											
Rhode Island	Combination	190-261	142-261	109-261	29,948	-	-	-	1,376 <sup>14</sup>	253	1,376	31,324	31,324	-	31,324											
South Carolina	Medicaid expansion	194-208	143-208	107-208	98,336	-	-	-	-	-	-	-	-	-	98,336											
South Dakota	Combination	177-182	177-182	124-182	12,441	183-204	183-204	183-204	3,775	-	-	3,775	16,216	-	16,216											
Tennessee <sup>19</sup>	Combination	-	-	109-133	17,971	196-250	143-250	134-250	78,731	250	9,513	88,244	106,215	-	106,215											
Texas	Combination	-	-	109-133	336,769	199-201	145-201	133-201	614,417	202	98,437	712,854	1,049,623	-	1,049,623											
Utah	Combination	-	-	105-133	27,762	145-200	145-200	139-200	27,523	-	-	27,523	55,285	-	55,285											
Vermont	Medicaid expansion	237-312	237-312	237-312	4,766	-	-	-	-	-	-	-	4,766	-	4,766											
Virginia	Combination	-	-	109-143	86,551	144-200	144-200	144-200	102,815	-	-	102,815	189,366	-	189,366											
Washington	Separate	-	-	-	-	211-312	211-312	211-312	37,883	193	8,154	46,037	46,037	-	46,037											
West Virginia <sup>20</sup>	Combination	-	-	108-133	15,242	159-300	142-300	134-300	33,036	-	-	33,036	48,278	-	48,278											
Wisconsin	Combination	-	-	101-151	96,973	- <sup>9</sup>	187-301 <sup>9</sup>	152-301 <sup>9</sup>	67,845	301	3,758	71,603	168,576	-	168,576											
Wyoming <sup>21</sup>	Combination	-	-	119-133	- <sup>22</sup>	155-200	155-200	134-200	- <sup>22</sup>	-	-	- <sup>22</sup>	5,649	-	5,649											

**TABLE 1B-1. (continued)**

**Notes:** FY is fiscal year. FPL is federal poverty level. Enrollment numbers generally include individuals ever enrolled during the year, even if for a single month; however, in the event individuals were in multiple categories during the year (for example, in Medicaid for the first half of the year but separate CHIP for the second half), the individual would only be counted in the most recent category. Enrollment data shown in the table are as of July 2016, the most current enrollment data available; states may subsequently revise their current or historical data.

– Dash indicates that state does not use this eligibility pathway.

<sup>1</sup> Under CHIP, states have the option to use an expansion of Medicaid, separate CHIP, or a combination of both approaches. Ten states (including the District of Columbia) are Medicaid expansions and two states are separate CHIP only (Connecticut and Washington). There are combination programs in 39 states; among those, 11 consider themselves to have separate programs but are technically combinations due to the transition of children below 133 percent FPL from separate CHIP to Medicaid (Alabama, Arizona, Georgia, Kansas, Mississippi, Oregon, Pennsylvania, Texas, Utah, West Virginia, Wyoming). Medicaid-expansion CHIP eligibility ranges of 5 percentage points attributable to the mandatory 5 percent disregard are not shown. For states that have different CHIP-funded eligibility levels for children age 6–13 and age 14–18, this table shows only the levels for children age 6–13. For example, Oklahoma offers CHIP-funded Medicaid coverage to children age 6–14 with family income 115–205 percent FPL, and to 14- to 18-year-olds with family income 65–205 percent FPL. Tennessee offers CHIP-funded Medicaid coverage to children age 6–14 with family income from 109–133 percent FPL and 14–19 year olds with family income 29–133 percent FPL.

<sup>2</sup> CHIP eligibility levels as of July 2016.

<sup>3</sup> Separate CHIP eligibility for children birth through age 18 generally begins where Medicaid coverage ends (as shown in the previous columns). For unborn children, there is no lower bound for income eligibility if the mother is not eligible for Medicaid.

<sup>4</sup> Total exceeds the sum of Medicaid expansion and separate CHIP columns due to only total CHIP enrollment being reported for Wyoming.

<sup>5</sup> Arizona closed separate CHIP (KidsCare) to new enrollment in January 2010. The state reinstated the program on September 1, 2016.

<sup>6</sup> Although Arkansas transitioned its Medicaid-expansion CHIP to separate CHIP effective January 1, 2015, the state continued to report enrollment for children age 0–18 years under Medicaid-expansion CHIP.

<sup>7</sup> California has separate CHIP in three counties only that covers children up to 317 percent FPL.

<sup>8</sup> Due to reporting system updates, California CHIP enrollment totals are estimates as a result of the exclusion of certain unborn CHIP enrollees in reporting.

<sup>9</sup> Separate CHIP in Delaware, Florida, Iowa, and Wisconsin covers children age 1–18.

<sup>10</sup> Certain enrollees who should have been assigned to CHIP were assigned to Medicaid beginning in the second quarter of 2014, making FY 2015 totals artificially low.

<sup>11</sup> CHIP-funded Medicaid Michigan enrollees are included in Medicaid enrollment counts rather than in CHIP for FY 2015. Therefore, the CHIP enrollment totals are artificially low and the Medicaid enrollment totals are artificially high. Michigan transitioned its separate CHIP into Medicaid-expansion CHIP effective January 1, 2016.

<sup>12</sup> In Minnesota, only infants (defined by the state as being under age two) are eligible for Medicaid-expansion CHIP up to 283 percent FPL.

<sup>13</sup> Missouri began covering unborn children effective January 1, 2016, however the state has not reported enrollment for this coverage group.

<sup>14</sup> Separate CHIP enrollment figures in Nebraska, New Mexico, and Rhode Island are for the states' §2101(f) coverage group under the Patient Protection and Affordable Care Act. Section 2101(f) required that states provide separate CHIP coverage to children to who lost Medicaid eligibility (including through Medicaid-expansion CHIP) due to the elimination of income disregards under the modified adjusted gross income (MAGI) based methodologies. Children covered under §2101(f) remained eligible for such coverage until their next scheduled renewal or their 19th birthday, or until they moved out of state, requested removal from the program, or were deceased. Coverage under §2101(f) has now been phased out.

**TABLE 1B-1. (continued)**

<sup>15</sup> North Carolina does not provide unborn children separate CHIP coverage. Errors in enrollment data reported are likely due to data quality issues.

<sup>16</sup> Separate CHIP enrollment in Oklahoma is for children enrolled in the state's premium assistance program.

<sup>17</sup> Certain Oregon enrollees who should have been assigned to CHIP were assigned to Medicaid-funded coverage for FY 2014 and FY 2015.

<sup>18</sup> Lack of enrollment for separate CHIP unborn coverage in Rhode Island is likely due to data quality issues.

<sup>19</sup> While Tennessee covers children with CHIP-funded Medicaid, enrollment is currently capped, except for children who roll over from traditional Medicaid.

<sup>20</sup> West Virginia's enrollment totals are artificially high because children who transitioned between CHIP and Medicaid are reported in both programs, rather than the program they were last enrolled.

<sup>21</sup> CMS's FY 2015 children's enrollment report considers these values to be estimates.

<sup>22</sup> Due to inconsistencies between the Statistical Enrollment Data System data and the Centers for Medicare & Medicaid Services' FY 2015 children's enrollment report, we do not report enrollment for Medicaid expansion and separate CHIP. We only report total CHIP enrollment as provided in CMS's FY 2015 children's enrollment report.

**Sources:** Personal communication with CMS staff on December 2, 2016 and December 9, 2016. For numbers of children: MACPAC, 2016, analysis of CHIP Statistical Enrollment Data System from Centers for Medicare & Medicaid Service as of July 1, 2016; MACPAC, 2016, *MACStats: Medicaid and CHIP Data Book, December 2016*, Washington, DC: MACPAC, <https://www.macpac.gov/publication/child-enrollment-in-chip-and-medicaid-by-state/>. For eligibility levels: MACPAC, 2016, *MACStats: Medicaid and CHIP Data Book, December 2016*, Washington, DC: MACPAC, <https://www.macpac.gov/publication/medicaid-and-chip-income-eligibility-levels-as-a-percentage-of-the-federal-poverty-level-for-children-and-pregnant-women-by-state/>.

## APPENDIX 1C: Federal CHIP Allotments

**TABLE 1C-1.** Federal CHIP Allotments by State, FYs 2015–2017 (millions)

State	FY 2015 federal CHIP allotments	FY 2016 federal CHIP allotments <sup>1</sup>	FY 2017 federal CHIP allotments
Alabama	\$172.9	\$457.3	\$319.7
Alaska	23.9	20.4	32.6
Arizona	80.7	123.7	206.4
Arkansas	94.0	174.5	194.4
California	1,744.1	1,995.2	2,668.6
Colorado	157.5	228.3	254.4
Connecticut	48.1	61.9	77.4
Delaware	20.3	38.5	35.3
District of Columbia	20.7	25.6	42.5
Florida	566.0	595.0	686.6
Georgia	410.6	418.2	404.8
Hawaii	46.3	46.3	52.3
Idaho	66.2	66.4	82.9
Illinois	361.4	406.2	547.4
Indiana	162.9	165.7	191.1
Iowa	126.0	147.6	145.7
Kansas	85.1	112.2	124.7
Kentucky	171.9	232.0	268.2
Louisiana	180.1	238.9	358.8
Maine	27.4	32.3	35.7
Maryland	234.3	290.8	295.9
Massachusetts	413.8	535.8	671.3
Michigan <sup>2</sup>	118.6	592.6	264.8
Minnesota	41.1	98.6	115.2
Mississippi	226.2	246.7	316.8
Missouri	163.2	172.9	175.2
Montana	91.7	95.8	103.5
Nebraska	69.7	78.2	72.5

**TABLE 1C-1. (continued)**

State	FY 2015 federal CHIP allotments	FY 2016 federal CHIP allotments <sup>1</sup>	FY 2017 federal CHIP allotments
Nevada	\$43.1	\$63.3	\$70.0
New Hampshire	20.0	39.2	38.2
New Jersey	344.8	406.8	462.9
New Mexico	73.6	122.5	136.0
New York	972.8	1,074.6	1,233.5
North Carolina	395.0	448.2	479.5
North Dakota	21.0	21.2	21.9
Ohio	342.8	352.6	409.3
Oklahoma	173.1	189.2	249.0
Oregon	193.5	211.3	249.8
Pennsylvania	371.1	365.1	527.3
Rhode Island	46.0	65.4	72.8
South Carolina	142.9	162.0	154.2
South Dakota	18.9	23.6	26.9
Tennessee	198.1	213.3	465.0
Texas	1,068.7	1,345.1	1,382.1
Utah	59.1	148.9	131.6
Vermont	15.6	29.3	30.2
Virginia	247.6	265.2	291.1
Washington	129.0	215.3	242.5
West Virginia	55.2	65.4	61.0
Wisconsin	221.2	225.8	224.5
Wyoming	11.4	10.9	12.6
<b>Subtotal</b>	<b>\$11,089.2</b>	<b>\$13,761.9</b>	<b>\$15,716.6</b>
American Samoa	1.7	2.1	2.9
Guam	5.9	8.0	26.6
N. Mariana Islands	1.2	1.0	6.7
Puerto Rico	183.2	179.8	192.5
Virgin Islands	5.0	5.3	6.9
<b>Total</b>	<b>\$11,286.1</b>	<b>\$13,958.3</b>	<b>\$15,952.1</b>

**TABLE 1C-1. (continued)**

**Notes:** FY is fiscal year.

<sup>1</sup> Per statute, FY 2015 and FY 2016 federal CHIP allotments were both based on each state's prior-year federal CHIP spending. In addition, because a 23 percentage point increase in the CHIP matching rate went into effect in FY 2016, the FY 2016 allotments were calculated by increasing federal CHIP spending by each state in FY 2015 as if the 23 percentage point increase in the CHIP matching rate had been in effect in FY 2015. The FY 2016 allotment-increase factor was then applied, which was approximately 5 percent for most states.

<sup>2</sup> In FY 2015, Michigan was poised to exhaust its federal CHIP allotments. As a result, the state requested and qualified for federal CHIP contingency funds totaling \$52.6 million (§ 2104(n) of the Social Security Act (the Act)). Because the contingency fund payment was insufficient to eliminate the state's shortfall, Michigan also qualified for \$61.5 million in redistribution funds (§ 2104(f) of the Act). The combination of contingency and redistribution funds eliminated the state's shortfall. The only other state ever to qualify for contingency funds was Iowa in FY 2011, but Iowa did not then require redistribution funds.

**Sources:** MACPAC, 2016, analysis of Medicaid and CHIP Budget Expenditure System (MBES/CBES) data as of December 13, 2016. Personal communication with Centers for Medicare & Medicaid Services staff on December 8, 2016.

## APPENDIX 1D: CHIP-Enhanced Federal Medical Assistance Percentages

**TABLE 1D-1. CHIP-Enhanced Federal Medical Assistance Percentages by State, FYs 2015–2017**

State	E-FMAPs for CHIP		
	FY 2015 <sup>1</sup>	FY 2016 <sup>2</sup>	FY 2017 <sup>2</sup>
All states (median)	70.8%	93.8%	94.0%
Alabama	78.3	100.0	100.0
Alaska	65.0	88.0	88.0
Arizona	77.9	100.0	100.0
Arkansas	79.6	100.0	100.0
California	65.0	88.0	88.0
Colorado	65.7	88.5	88.0
Connecticut	65.0	88.0	88.0
Delaware	67.5	91.4	90.9
District of Columbia	79.0	100.0	100.0
Florida	71.8	95.5	95.8
Georgia	76.9	100.0	100.0
Hawaii	66.6	90.8	91.5
Idaho	80.2	100.0	100.0
Illinois	65.5	88.6	88.9
Indiana	76.6	99.6	99.7
Iowa	68.9	91.4	92.7
Kansas	69.6	92.2	92.4
Kentucky	79.0	100.0	100.0
Louisiana	73.4	96.6	96.6
Maine	73.3	96.9	98.1
Maryland	65.0	88.0	88.0
Massachusetts	65.0	88.0	88.0
Michigan	75.9	98.9	98.6
Minnesota	65.0	88.0	88.0
Mississippi	81.5	100.0	100.0
Missouri	74.4	97.3	97.3
Montana	76.1	98.7	98.9

**TABLE 1D-1. (continued)**

State	E-FMAPs for CHIP		
	FY 2015 <sup>1</sup>	FY 2016 <sup>2</sup>	FY 2017 <sup>2</sup>
Nebraska	67.3%	88.8%	89.3%
Nevada	75.1	98.5	98.3
New Hampshire	65.0	88.0	88.0
New Jersey	65.0	88.0	88.0
New Mexico	78.8	100.0	100.0
New York	65.0	88.0	88.0
North Carolina	76.1	99.4	99.8
North Dakota	65.0	88.0	88.0
Ohio	73.9	96.7	96.6
Oklahoma	73.6	95.7	95.0
Oregon	74.8	98.1	98.1
Pennsylvania	66.3	89.4	89.3
Rhode Island	65.0	88.3	88.7
South Carolina	79.5	100.0	100.0
South Dakota	66.2	89.1	91.5
Tennessee	75.5	98.5	98.5
Texas	70.6	93.0	92.3
Utah	79.4	100.0	100.0
Vermont	67.8	90.7	91.1
Virginia	65.0	88.0	88.0
Washington	65.0	88.0	88.0
West Virginia	80.0	100.0	100.0
Wisconsin	70.8	93.8	94.0
Wyoming	65.0	88.0	88.0

**Notes:** FY is fiscal year. FMAP is federal medical assistance percentage. E-FMAP is enhanced FMAP. ACA is the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). The E-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.

Enhanced FMAPs for CHIP are calculated by reducing the state share under regular FMAPs for Medicaid by 30 percent. In FYs 2016 through 2019, the E-FMAPs are increased by 23 percentage points. For additional information on Medicaid FMAPs, see <https://www.macpac.gov/subtopic/matching-rates/>.

E-FMAPs for the territories are not included. In FY 2015, all territories had an E-FMAP of 68.5 percent, and in FY 2016 and 2017, 91.5 percent.



**TABLE 1D-1. (continued)**

<sup>1</sup> In FY 2015, states received the traditional CHIP E-FMAP.

<sup>2</sup> Under the ACA, beginning on October 1, 2015, and ending on September 30, 2019, the enhanced FMAPs are increased by 23 percentage points, not to exceed 100 percent, for all states.

**Sources:** Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services, ASPE FMAP reports for 2015, 2016, and 2017, <https://aspe.hhs.gov/basic-report/fy2017-federal-medical-assistance-percentages> (for FY 2017), <http://aspe.hhs.gov/health/reports/2015/FMAP2016/fmap16.cfm> (for FY 2016), <http://aspe.hhs.gov/health/reports/2014/FMAP2015/fmap15.pdf> (for FY 2015).

## APPENDIX 1E: Existing Proposals for Medicaid and CHIP Savings

At the request of some members of MACPAC's congressional committees of jurisdiction, the Commission has compiled a list of Medicaid and CHIP proposals, previously introduced in Congress or developed by others, that are estimated to generate program savings. The Commission has not voted on nor has it endorsed any specific proposal on this list. Moreover, MACPAC has not analyzed the merits or effects of these proposals on the availability of coverage to low-income individuals, access to care, or benefits nor their potential impact on states, health plans, providers, or others. Such effects would not be apparent in the cost savings estimate alone. As such, the list should be viewed with caution.

Sources for identifying cost-saving proposals include:

- legislative proposals (from the 112th, 113th, and 114th Congresses);
- other options that have been scored by the Congressional Budget Office (CBO) since 2010;
- proposals that have been offered in the President's budgets since 2008; and
- recommendations by the Government Accountability Office (GAO) and U.S. Department of Health and Human Services Office of the Inspector General (OIG).

Criteria for inclusion in the table below are:

- the proposal's estimated cost savings are quantified;
- the estimated cost savings do not exceed the estimated increase to federal spending for the Commission's recommendations in this report; and

- the proposal has not already been enacted or implemented.

Given these criteria, we excluded proposals for which savings are not quantified or that generate a level of savings substantially greater than the estimated cost of the Commission's recommendations. We also excluded proposals that are not scorable under Congressional scorekeeping guidelines, which prohibit the counting of budgetary savings when funds are provided in authorizing legislation for administrative or program management activities, including antifraud efforts (CBO 2014). For example, the President's budget for fiscal year (FY) 2017 included non-scorable proposals such as expand funding for Medicaid program integrity (\$0.6 billion in non-scorable savings over 10 years).

In addition, we report estimates as reported in the source notation. The adoption of other policies since these scores were initially developed could result in changes to the estimates if reanalyzed.

In the statute creating MACPAC, Congress charges the Commission with reviewing Medicaid and CHIP policies, including their relationship to access and quality of care for Medicaid beneficiaries. Therefore, all the proposals on this list are Medicaid or CHIP policies. In considering policies that increase federal Medicaid or CHIP spending, Congress could choose to enact other proposals affecting spending or revenues, including those from outside CHIP or Medicaid.

**TABLE 1E-1. List of Existing Proposals Estimated to Generate Medicaid and CHIP Savings**

Proposal	Source of proposal	Estimated savings (over 10 years <sup>1</sup> )	Source of savings estimate <sup>2</sup>
<b>Drug payment policy</b>			
Modify the ACA Medicaid rebate formula for new drug formulations (i.e., line extension drugs)	FY 2017 President's budget	\$6.5 billion <sup>3</sup>	CBO <sup>4</sup>
Exclude brand name and authorized generic drug prices from the Medicaid federal upper limit for drug rebate calculations	FY 2017 President's budget	\$1.0 billion	CBO <sup>4</sup>
<b>Other payment policies</b>			
Require remittances for medical loss ratios of less than 85 percent in Medicaid and CHIP managed care	FY 2017 President's budget	\$6.3 billion	CBO <sup>4</sup>
Permanently extend DSH allotment reductions (current reductions end after FY 2025)	FY 2017 President's budget	\$0.7 billion	CBO <sup>4</sup>
Apply a hospital-specific upper payment limit (UPL) rather than an aggregate UPL	Office of Inspector General (OIG)	\$3.87 billion over five years	OIG
Eliminate graduate medical education supplemental payments in Medicaid	FY 2009 President's budget	\$1.78 billion over five years	FY 2009 President's budget <sup>5</sup>
Eliminate payments for school-based administrative and transportation costs	FY 2009 President's budget	\$3.645 billion over five years	FY 2009 President's budget <sup>5</sup>
<b>Eligibility policy</b>			
Change modified adjusted gross income rules to account for lottery winnings and other lump sum income across multiple months on a prorated basis	H.R. 4725	\$475 million	CBO
Remove state option to increase the limit on home equity that is not considered an asset for aged and disabled eligibility determinations	FY 2009 President's budget	\$480 million over five years	FY 2009 President's budget
<b>Change FMAP for specific services, populations, or other</b>			
Eliminate the newly eligible FMAP for prisoners in correctional facilities	H.R. 4725	\$2.0 billion	CBO

**TABLE 1E-1. (continued)**

Proposal	Source of proposal	Estimated savings (over 10 years <sup>1</sup> )	Source of savings estimate <sup>2</sup>
<b>Change FMAP for specific services, populations, or other (continued)</b>			
Apply a single blended FMAP rate to Medicaid and CHIP (with a four-year transition period)	FY 2013 President's budget	\$17.9 billion	FY 2013 President's budget
Eliminate special Medicaid administrative match rates above the regular 50 percent administrative matching rate	FY 2009 President's budget	\$5.5 billion over five years	FY 2009 President's budget
Reduce the 90 percent FMAP for family planning services to the standard medical matching rate	FY 2009 President's budget	\$3.3 billion over five years	FY 2009 President's budget
Reduce the FMAP for targeted case management services to administrative matching rate rather than medical matching rate	FY 2009 President's budget	\$1.1 billion over five years	FY 2009 President's budget
Reduce the FMAP for qualifying individual program from 100 percent to the state's regular medical matching rate	FY 2009 President's budget	\$200 million over five years	FY 2009 President's budget
<b>Financing changes</b>			
Reduce the safe harbor threshold for provider taxes from 6 percent to 5.5 percent	H.R. 4725	\$4.6 billion	CBO
Reduce the safe harbor threshold for provider taxes from 6 percent to 5 percent	CBO <sup>6</sup>	\$15.9 billion	CBO

**Notes:** ACA is the Patient Protection and Affordable Care Act (P.L. 111-148, as amended). FY is fiscal year. CBO is Congressional Budget Office. DSH is disproportionate share hospital. FMAP is federal medical assistance percentage.

<sup>1</sup> Five-year savings estimates are provided when ten-year estimates are not available.

<sup>2</sup> Cost savings estimates produced by CBO are provided when available. CBO provides budgetary and economic analyses in support of the congressional budget process.

<sup>3</sup> This proposal included a provision to exempt abuse deterrent formulations, which has since been enacted by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-19). This savings estimate has not been updated to reflect this. CBO separately scored the provision to exempt abuse deterrent formulations as adding \$75 million in federal spending over 10 years.

<sup>4</sup> Savings estimates produced by CBO may vary from the source of the proposal due to differences in assumptions.

<sup>5</sup> This proposal was included in the President's FY 2009 budget, which referred to a savings estimate provided in the President's FY 2008 budget.

<sup>6</sup> This proposal was included in CBO's *Options for reducing the deficit: 2017 to 2026* (CBO 2016f).

**Sources:** CBO 2016a, 2016b, 2016c, 2016d, 2016e, 2016f, 2015; OIG 2015; and HHS 2012, 2008.

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Chapter 2:

# Analyzing Disproportionate Share Hospital Allotments to States

# Analyzing Disproportionate Share Hospital Allotments to States

## Key Points

- Analyses presented in this chapter continue to show no meaningful relationship between states' disproportionate share hospital (DSH) allotments and the three factors that Congress has asked the Commission to study:
  - the number of uninsured individuals;
  - the amount and sources of hospitals' uncompensated care costs; and
  - the number of hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations.
- In updating the analyses provided in MACPAC's first DSH report to Congress, published in February 2016, we provide new information about hospital uncompensated care in 2014, after the first year of implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), including the following:
  - Between 2013 and 2014, total hospital uncompensated care for Medicaid-enrolled and uninsured patients fell by about \$4.6 billion (9.3 percent), with the largest declines in states that expanded Medicaid.
  - In both expansion and non-expansion states, deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a high share of Medicaid-enrolled and low-income patients, continued to report negative operating margins before DSH payments.
- We project state-level DSH allotments under current law, which includes a \$2 billion reduction in federal DSH allotments in fiscal year (FY) 2018. The Commission finds that should these DSH allotment reductions take effect:
  - the wide variation in state DSH allotments is likely to persist; and
  - 20 states are projected to have FY 2018 DSH allotment reductions that are larger than the decline in hospital uncompensated care in their state between 2013 and 2014.
- If reductions in federal DSH allotments take effect as scheduled, the Centers for Medicare & Medicaid Services will need to update the methodology for distributing them among states and could use this opportunity to better align state DSH allotments with objective measures of need. Per its statutory authority, the Commission may comment on such proposed changes.
- Given the ongoing congressional debate about the future of the ACA and its many provisions, including the Medicaid expansion to the new adult group, it is difficult to evaluate the merits of pending DSH allotment reductions at this time. As this debate unfolds, the Commission will monitor how potential changes to the ACA—and Medicaid policy more generally—might affect safety-net hospitals and the patients they serve.

## CHAPTER 2: Analyzing Disproportionate Share Hospital Allotments to States

State Medicaid programs are statutorily required to make disproportionate share hospital (DSH) payments to hospitals that serve a high proportion of Medicaid beneficiaries and other low-income patients. The total amount of such payments states make are limited by annual federal DSH allotments, which vary widely by state. DSH payments to hospitals are also limited by the total amount of uncompensated care that hospitals provide to Medicaid-enrolled patients and uninsured individuals.

MACPAC is statutorily required to report annually on the relationship between allotments and several potential indicators of the need for DSH funds:

- changes in the number of uninsured individuals;
- the amount and sources of hospitals' uncompensated care costs; and
- the number of hospitals with high levels of uncompensated care that also provide essential community services for low-income, uninsured, and vulnerable populations.

In this first of two chapters in this report related to DSH policy, we update the analyses provided in MACPAC's first DSH report to Congress, published in February 2016 (MACPAC 2016). As in our first DSH report, we continue to find little meaningful relationship between DSH allotments and the factors that that Congress asked the Commission to study. This is because DSH allotments are largely based on states' historical DSH spending before federal limits were established in 1992.

This year, we provide new information about hospital uncompensated care in 2014, after the first year of implementation of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

Specifically, we find the following:

- Between 2013 and 2014, total hospital uncompensated care for Medicaid beneficiaries and uninsured patients fell by about \$4.6 billion (9.3 percent), with the largest declines in expansion states, that is, states that have expanded Medicaid to adults under age 65 with incomes at or below 138 percent of the federal poverty level (FPL).
- During this period, Medicaid shortfall (the difference between Medicaid payments and hospitals' costs of providing services to Medicaid-enrolled patients) increased by about \$0.9 billion (6.8 percent) due to increased Medicaid enrollment.
- At the same time, hospital uncompensated care for uninsured individuals decreased by about \$5.5 billion (15.2 percent) because of declines in the number of uninsured individuals.
- Although hospital operating margins improved for all types of hospitals in 2014, deemed DSH hospitals, which are statutorily required to receive DSH payments because they serve a particularly high share of Medicaid and low-income patients, continued to report negative operating margins before DSH payments in both expansion and non-expansion states. Total margins (which include revenue not directly related to patient care) were similar between deemed DSH hospitals and other hospital types at about 7 percent, but total margins for deemed DSH hospitals would have been 0 percent without DSH and other government appropriations in 2014.



In addition to expanding insurance coverage under Medicaid and the exchanges, the ACA also included reductions to federal DSH allotments under the assumption that increased health care coverage would lead to reductions in hospital uncompensated care, and lessen the need for DSH payments. The reductions have been delayed several times, but under current law as this report goes to press, the first round of reductions (amounting to \$2 billion or 17 percent) is scheduled to go into effect in fiscal year (FY) 2018, which begins October 1, 2017.<sup>1</sup> Our analysis reflects this current law scenario. We find that the wide variation among states in DSH allotments is likely to persist even after the reductions take effect. Further, we project that in 20 states DSH allotment reductions for FY 2018 will be greater than the decline in hospital uncompensated care reported in 2014.

The Commission is well aware that Congress is currently debating changes to the ACA and to Medicaid policy more generally—changes that, if implemented, would create a substantially different environment for safety net providers. At this writing, many different ideas are under discussion including changes to the ACA coverage expansions, DSH funding, and other policies affecting safety-net providers. The Commission finds it difficult to weigh in on the merits of pending DSH allotment reductions given this uncertainty and the potential for other concurrent changes to the health insurance market that would affect the level of hospital uncompensated care and the ability of these institutions to provide both inpatient and outpatient services to Medicaid beneficiaries and low-income patients. Although it is difficult to evaluate the cumulative effects of such changes while the debates are ongoing, the Commission will continue examining how policy changes might affect safety-net hospitals and will provide additional analysis and commentary as is warranted.

In the next chapter, we turn to analysis related to the Commission's observation in its 2016 report

that DSH allotments and payments should be targeted to the states and hospitals that both serve a disproportionate share of Medicaid and low-income patients and have high levels of uncompensated care, consistent with the original statutory intent. Our analysis in Chapter 3 considers approaches to improve the targeting of DSH funding within states, regardless of whether DSH allotment reductions take effect.

## Current DSH Allotments and Payments

Current DSH allotments vary widely among states and reflect the evolution of federal DSH policy over time. Since 1981, state Medicaid agencies have been required to “take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs” when setting Medicaid hospital payments (§ 1902(a)(13)(A)(iv) of the Social Security Act (the Act)). In 1987, Congress began requiring states to make DSH payments to certain hospitals that serve the highest share of low-income patients, referred to as deemed DSH hospitals (§ 1923(b) of the Act). When DSH spending increased rapidly in the early 1990s, Congress enacted state-specific caps on the amount of federal funds that could be used to make DSH payments. Congress also limited the maximum amount of DSH payments a hospital could receive to the hospital's actual costs of uncompensated care for services provided to Medicaid and uninsured patients (Box 2-1). Additional background information about the history of DSH payment policy is included in Chapter 1 and Appendix A of MACPAC's first DSH report (MACPAC 2016).

## BOX 2-1. Glossary of Key Medicaid Disproportionate Share Hospital Terminology

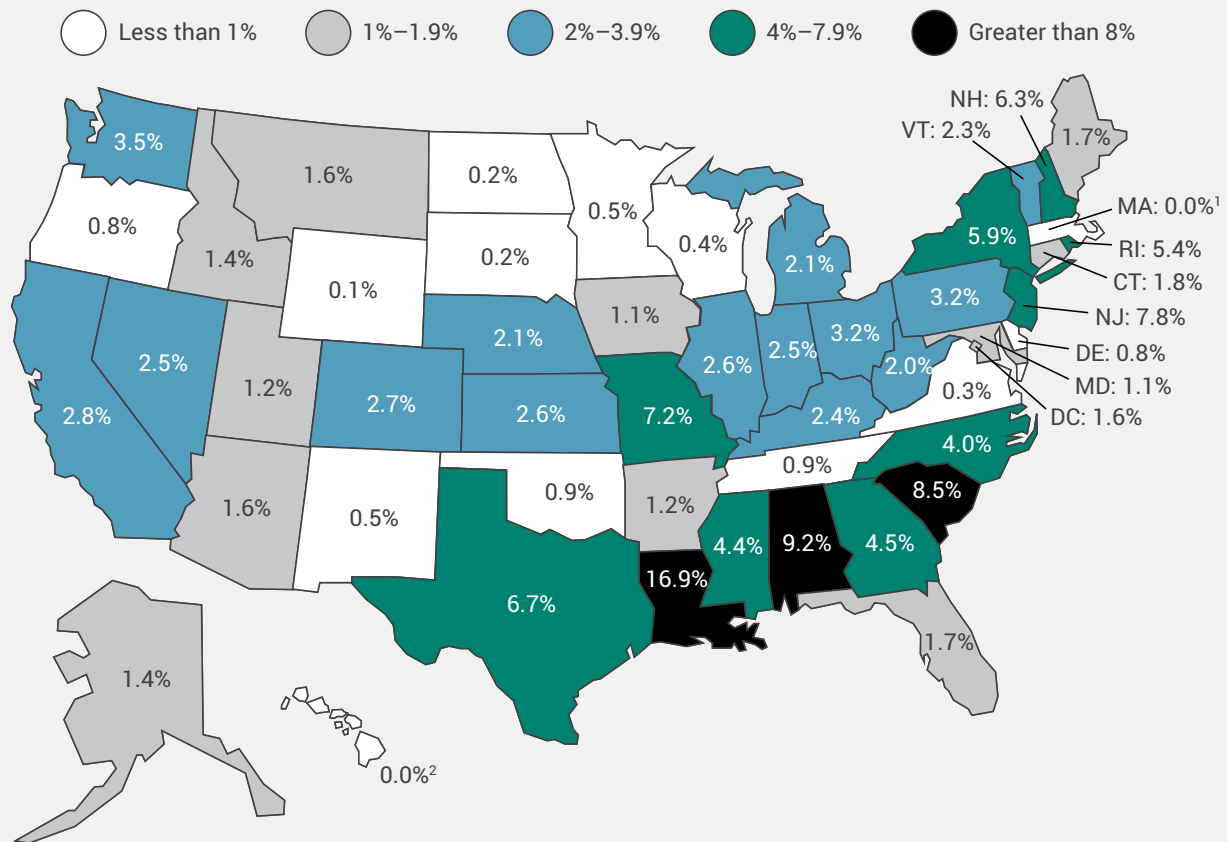
- **DSH hospital**—A hospital that receives disproportionate share hospital (DSH) payments and meets the minimum statutory requirements to be eligible for DSH payments: a Medicaid inpatient utilization rate of at least 1 percent and at least two obstetricians with staff privileges that treat Medicaid enrollees (with certain exceptions).
- **Deemed DSH hospital**—A DSH hospital with a Medicaid inpatient utilization rate of at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or a low-income utilization rate that exceeds 25 percent. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Social Security Act (the Act)).
- **State DSH allotment**—The total amount of federal funds available to a state for Medicaid DSH payments. If a state does not spend the full amount of its allotment in a given year, the unspent portion is not paid to the state and does not carry over to future years. Allotments are determined annually and are generally equal to the prior year's allotment adjusted for inflation (§ 1923(f) of the Act).
- **Hospital-specific DSH limit**—The total amount of uncompensated care for which a hospital may receive Medicaid DSH payment, equal to the sum of Medicaid shortfall and unpaid costs of care for the uninsured for allowable inpatient and outpatient costs.

In FY 2015, a total of \$11.9 billion in federal funds was allotted to states for DSH payments, and states spent a total of \$10.6 billion in federal funds on DSH payments. (States spent \$18.7 billion in state and federal funds combined.)

Today, the distribution of allotments across states largely reflects the patterns of states' DSH spending in 1992, before federal limits were established. For example, FY 2015 DSH allotments

ranged from less than \$15 million in six states (Delaware, Hawaii, Montana, North Dakota, South Dakota, and Wyoming) to more than \$1 billion in three states (California, New York, and Texas). In 2015, state and federal DSH spending as a share of total Medicaid benefit spending ranged from less than 1 percent in 13 states to 16.9 percent in Louisiana (Figure 2-1). Nationally, DSH spending accounted for 3.5 percent of total Medicaid benefit spending in FY 2015.

**FIGURE 2-1. DSH Spending as a Share of Total Medicaid Benefit Spending by State, FY 2015**



**Notes:** DSH is disproportionate share hospital. FY is fiscal year.

<sup>1</sup> Massachusetts does not make DSH payments because its Section 1115 demonstration allows the state to use DSH funding for the state’s safety-net care pool instead.

<sup>2</sup> Hawaii did not report DSH spending in FY 2015, but it has reported DSH spending in prior years.

**Source:** MACPAC, 2016, analysis of CMS-64 Financial Management Report net expenditure data as of May 24, 2016.

In 2012, about half of U.S. hospitals received DSH payments (Table 2-1). Although public teaching hospitals in urban settings received the largest share of total DSH funding, more than half (54 percent) of rural hospitals also received DSH payments, including many critical access hospitals which receive a special payment designation from Medicare because they are small and often the only provider in their geographic area. Many states also make DSH payments to institutions

for mental diseases (IMDs), which are not eligible for Medicaid payment for services provided to individuals age 21–64 but are eligible for DSH funding. In 2012, Maine made DSH payments exclusively to IMDs, and four states (Arkansas, Maine, Maryland, and North Dakota) made more than half of their DSH payments to IMDs.

To better understand the role DSH funding plays in the operation of various types of hospitals,

**TABLE 2-1.** Distribution of DSH Spending by Hospital Type, SPRY 2012

Hospital characteristics	Number of hospitals			Total DSH spending (millions)
	DSH hospitals	All hospitals	DSH hospitals as percent of all hospitals	
<b>Hospital type</b>				
Short-term acute care hospitals	1,865	3,386	55%	\$13,495
Critical access hospitals	565	1,331	42	312
Psychiatric hospitals	129	502	26	2,123
Long-term hospitals	32	430	7	53
Rehabilitation hospitals	32	249	13	10
Children's hospitals	47	81	58	269
<b>Urban/rural classification</b>				
Urban	1,681	4,164	40	14,879
Rural	989	1,815	54	1,384
<b>Hospital ownership</b>				
For-profit	432	1,750	25	972
Non-profit	1,506	2,954	51	5,202
Public	732	1,275	57	10,089
<b>Teaching status</b>				
Non-teaching	1,921	4,866	39	4,632
Low-teaching hospital	392	662	59	2,172
High-teaching hospital	357	451	79	9,458
<b>Total</b>	<b>2,670</b>	<b>5,979</b>	<b>45%</b>	<b>\$16,263</b>

**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year. High-teaching hospitals have an intern/resident-to-bed ratio (IRB) greater than or equal to 0.25 and low-teaching hospitals have an IRB less than 0.25. Total DSH spending includes state and federal funds. Excludes 12 DSH hospitals that did not submit a Medicare cost report.

**Source:** 2017, analysis for MACPAC of 2012 Medicare cost reports and 2012 Dobson, DaVanzo, & Associates and KNG Health, Medicaid DSH audits.

MACPAC profiled seven DSH hospitals during the summer and fall of 2016 (Box 2-2). In this chapter and the one that follows, we provide qualitative information gleaned from interviews to complement our quantitative analyses.

Medicare also makes DSH payments to hospitals but its policies differ on which hospitals qualify

and how much funding they receive. In this report, references to DSH payments refer to Medicaid DSH payments only, unless otherwise specified. Changes in the Number of Uninsured Individuals

Medicaid DSH payments are intended to offset the uncompensated care costs of hospitals that serve a high proportion of low-income patients, including

## BOX 2-2. Disproportionate Share Hospital Profiles

Federal policy gives states considerable discretion in determining which hospitals may receive disproportionate share hospital (DSH) payments. To complement our quantitative analyses and better understand the different types of hospitals that receive DSH payments, MACPAC contracted with the Urban Institute to profile seven DSH hospitals during the summer and fall of 2016. Interviews with DSH hospital executives focused on the role of DSH funding at the hospital, the relationship between DSH payments and other sources of hospital funding, and the role of these DSH hospitals in their communities.

For this project, we sought out a variety of hospitals located in different states to reflect the diversity of hospitals that receive Medicaid DSH payments. We profiled the following hospitals:

- Parkland Hospital in Dallas, Texas, is a 770-bed county-owned hospital that is part of the larger Parkland Health and Hospital System. It is the primary teaching hospital for the University of Texas Southwestern Medical Center.
- MetroHealth Hospital in Cleveland, Ohio, is a 397-bed county-owned hospital that is part of an integrated health system with more than 20 sites. The system serves as a teaching hospital for Case Western Reserve University.
- Santa Clara Valley Medical Center in San Jose, California, is a 574-bed county-owned hospital that is part of the Santa Clara Valley Health and Hospital System. Santa Clara Valley Medical Center is a teaching hospital that has its own residency program as well as a long-standing affiliation with Stanford University Medical School.
- Vidant Medical Center in Greenville, North Carolina, is a 909-bed non-profit hospital that is the flagship facility for Vidant Health System, a regional system that serves 29 counties in eastern North Carolina. Vidant Medical Center is the only hospital in Greenville and is the primary teaching hospital for East Carolina University's Brody School of Medicine.
- Henry Ford Hospital in Detroit, Michigan, is a 491-bed non-profit hospital that is the flagship facility of the Henry Ford Health System, which is composed of seven hospitals and one of the nation's largest group practices, the Henry Ford Medical Group. Henry Ford Hospital is also the primary teaching hospital for Wayne State University.
- Northeastern Vermont Regional Hospital in St. Johnsbury, Vermont, is a 25-bed non-profit critical access hospital in rural Vermont. Northeastern Vermont Regional Hospital is the only hospital within 40 miles of St. Johnsbury, Vermont.
- Connecticut Children's Medical Center in Hartford, Connecticut, is a 187-bed non-profit children's hospital and the primary pediatric teaching hospital for the University of Connecticut School of Medicine. It is the only freestanding children's hospital in the state.

The complete [profiles](#), which are available on MACPAC's website, illustrate the importance of DSH funds to these institutions and the different circumstances under which these hospitals operate (MACPAC 2017).

those without health insurance. Therefore, a state's uninsured rate may be a useful indicator of its need for DSH funds.

The national uninsured rate declined by 1.3 percentage points between 2014 and 2015, resulting in a total decrease of about 4 percentage points since 2013. According to the Current Population Survey, 29 million people (9.1 percent of the U.S. population) were uninsured for the entire calendar year in 2015, compared to 33 million people (10.4 percent of the U.S. population) in 2014 and 41.8 million (13.3 percent of the population) in 2013 (Barnett and Vornovitsky 2016).<sup>2</sup>

These decreases reflect increases in both private and publicly funded coverage, and are likely due to the availability of new coverage options under the ACA, including both Medicaid expansions and exchange coverage. Since 2014, the share of the U.S. population covered at some point in the year by private coverage (including individual insurance purchased through a health insurance exchange) increased 1.2 percentage points to 67.2 percent in 2015, and the share of the population covered at some point by publicly funded coverage (including Medicaid) increased 0.6 percentage points to 37.1 percent in 2015 (Barnett and Vornovitsky 2016).<sup>3</sup>

While the uninsured rate declined in all states between 2013 and 2015, states that expanded their Medicaid programs to low-income adults under the ACA had larger declines than those that did not. For states that expanded Medicaid in 2014, the decline in the number of uninsured individuals was larger between 2013 and 2014 than between 2014 and 2015 (Barnett and Vornovitsky 2016).

Hospital admissions data provide additional insight about the changes in the number of uninsured patients admitted to hospitals. In 2013, 2.1 million uninsured patients were admitted to the hospital, accounting for about 6 percent of all hospital admissions. By the second quarter of 2014, uninsured hospital stays had fallen by about half in states that had expanded Medicaid but were not

statistically different in states that did not expand Medicaid (Nikpay et al. 2016). Comparing full-year discharge data for 28 states, we found a larger reduction in uninsured hospital stays between 2013 and 2014 in states that expanded Medicaid (50 percent reduction) than in states that did not (6 percent reduction).<sup>4</sup>

## Changes in the Amount of Hospital Uncompensated Care

The ACA coverage expansions are having different effects on the two types of hospital uncompensated care costs that Medicaid DSH payments subsidize: unpaid costs of care for uninsured individuals and Medicaid shortfall, defined as the difference between a hospital's costs of serving Medicaid-enrolled patients and the total amount of Medicaid payment received for those services. As the number of uninsured individuals declines, unpaid costs of care for uninsured individuals are declining substantially, particularly in states that have expanded Medicaid. However, as the number of Medicaid enrollees increases, Medicaid shortfall is also increasing.

Below we review the change in uncompensated care between 2013 and 2014 for both types of uncompensated care. Definitions for the various types of uncompensated care vary among data sources, complicating comparisons and our ability to fully understand how individual hospitals are being affected (Box 2-3). We estimated state-level unpaid costs of care for uninsured individuals using charity care and bad debt data reported on Medicare cost reports, which also include charity care and bad debt for patients with insurance.<sup>5</sup> We estimated Medicaid shortfall using national estimates from the American Hospital Association (AHA) annual survey because timely and reliable state-level data on Medicaid shortfall were not available at the time of analysis. One limitation of the AHA annual survey is that it includes hospital

costs for provider taxes and other contributions toward the non-federal share of Medicaid payments, which are not part of the DSH definition of Medicaid shortfall (Nelb et al. 2016). In MACPAC's 2016 DSH report, the Commission commented extensively on the limitations of available data on Medicaid shortfall and recommended that the U.S. Department of Health and Human Services

collect additional data to improve transparency and accountability (MACPAC 2016).

## BOX 2-3. Definitions and Data Sources for Uncompensated Care Costs

### Data sources

- **American Hospital Association (AHA) annual survey**—An annual survey of hospital finances that provides aggregated national estimates of uncompensated care for community hospitals.
- **Medicare cost report**—An annual report on hospital finances that must be submitted by all hospitals that receive Medicare payments (that is, most U.S. hospitals). Medicare cost reports define hospital uncompensated care as bad debt and charity care.
- **Medicaid disproportionate share hospital (DSH) audit**—A statutorily required audit of a DSH hospital's uncompensated care to ensure that Medicaid DSH payments do not exceed the hospital-specific DSH limit, which is equal to the sum of Medicaid shortfall and the unpaid costs of care for uninsured individuals for allowable inpatient and outpatient costs. About half of U.S. hospitals were included on DSH audits in 2012, the latest year for which data are available.

### Medicare cost report components of uncompensated care

- **Charity care**—Health care services for which a hospital determines the patient does not have the capacity to pay and either does not charge the patient at all or charges the patient a discounted rate below the hospital's cost of delivering the care. The amount of charity care is the difference between a hospital's cost of delivering the care and the amount initially charged to the patient.
- **Bad debt**—Expected payment amounts that a hospital is not able to collect from patients who, according to the hospital's determination, have the financial capacity to pay.

### Medicaid DSH audit components of uncompensated care

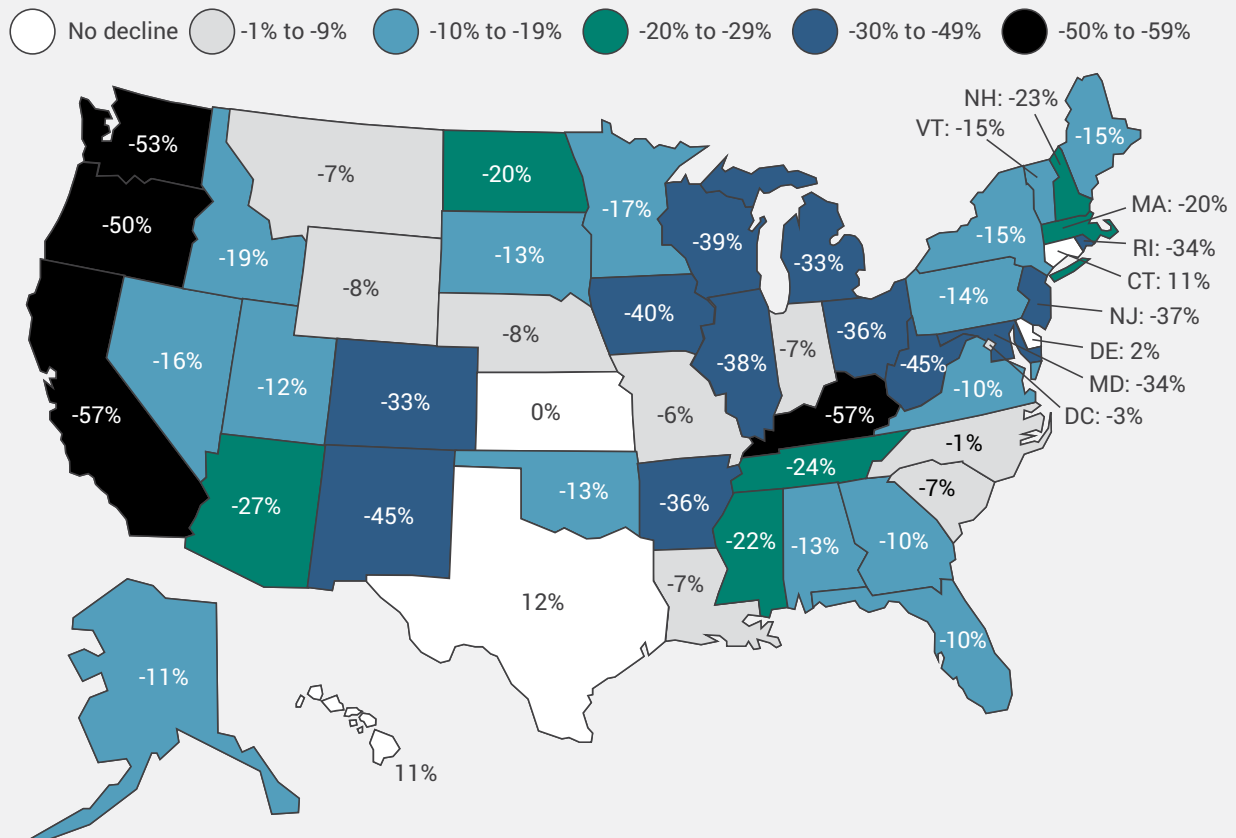
- **Unpaid costs of care for uninsured individuals**—The difference between a hospital's costs of serving individuals without health coverage and the total amount of payment received for those services. This includes charity care and bad debt for individuals without health coverage and generally excludes charity care and bad debt for individuals with health coverage.
- **Medicaid shortfall**—The difference between a hospital's costs of serving Medicaid-enrolled patients and the total amount of Medicaid payment received for those services (under both fee-for-service and managed care, excluding DSH payments but including other types of supplemental payments).

## Unpaid costs of care for uninsured individuals

Between 2013 and 2014, total hospital charity care and bad debt fell by \$5.5 billion nationwide. As a share of hospital operating expenses, charity care and bad debt fell about 20 percent nationally (from 4.4 percent in 2013 to 3.5 percent in 2014).

However, the decline in uncompensated care was not evenly distributed among states: hospitals in five states reported increases in charity care and bad debt as a share of hospital operating expenses, and hospitals in four states reported declines that were greater than 50 percent (Figure 2-2).

**FIGURE 2-2. Percent Decline in Uncompensated Care as a Share of Hospital Operating Expenses by State, 2013–2014**



**Note:** Medicare cost reports define uncompensated care as charity care and bad debt.

**Source:** MACPAC, 2017, analysis of Medicare cost reports.



Changes in hospital uncompensated care between 2013 and 2014 were not clearly related to changes in the number of uninsured individuals in each state during that period. For example, in both California and Connecticut, the uninsured rate fell by about one quarter between 2013 and 2014, but in California, charity care and bad debt as a share of hospital operating expense fell by more than half, while in Connecticut, charity care and bad debt increased. Connecticut expanded Medicaid coverage for low-income adults in 2010, so this may explain why hospitals in the state did not report a decline in uncompensated care in 2014. In addition, Medicare cost reports do not distinguish between bad debt for uninsured individuals and for individuals with health insurance. The latter may be increasing as more individuals enroll in health plans with large copayments and deductibles (Bogarty et al. 2016).

In general, states that did not expand Medicaid to low-income adults under the ACA reported smaller declines in hospital unpaid costs of care for uninsured individuals. As a share of operating expenses, charity care and bad debt fell by 6 percent in states that did not expand Medicaid in 2014 but by 37 percent in states that did expand Medicaid.<sup>6</sup>

Other researchers have also found larger reductions in uncompensated care costs in states that have expanded Medicaid. For example, a substate analysis using Medicare cost report data found that hospitals located in regions within a state with larger than expected gains in Medicaid coverage reported larger declines in charity care and bad debt than those in regions of the state with lower Medicaid enrollment (Dranove et al. 2015). Another multivariate analysis intended to isolate the effects of Medicaid expansion on hospital uncompensated care found that expansion of Medicaid was associated with a decline of \$2.8 million in average charity care and bad debt per hospital (Blavin 2016).

## Medicaid shortfall

According to the AHA annual survey, Medicaid shortfall for all hospitals increased by \$0.9 billion between 2013 and 2014 (from \$13.2 billion to \$14.1 billion), despite the fact that the overall Medicaid payment-to-cost ratio increased from 89.8 percent to 90.0 percent (AHA 2016a, 2016b, 2015). Because the AHA survey reports that Medicaid payment rates increased slightly, the increase in Medicaid shortfall is likely due to increases in Medicaid patient volume in states that expanded Medicaid.

State- and hospital-specific data on Medicaid shortfall in 2014 are not yet available, but interviews with DSH hospital executives in states that have expanded Medicaid suggest that increased Medicaid enrollment is increasing Medicaid shortfall (MACPAC 2017). However, these interviews also highlighted the limitations of available data on Medicaid shortfall (Box 2-4). In particular, data from Medicare cost reports do not include all Medicaid payments and costs (MACPAC 2016). Medicaid DSH audit data provide more complete information on Medicaid shortfall for DSH hospitals, but 2014 Medicaid DSH audits will not be available until 2019.<sup>7</sup>

According to 2012 DSH audits (the most recent available), Medicaid shortfall varies widely by state. DSH hospitals in the 10 states with the lowest Medicaid payment-to-cost ratios received total Medicaid payments before DSH payments that covered 81 percent of their costs of care for Medicaid-enrolled patients, and DSH hospitals in the 10 states with the highest Medicaid payment-to-cost ratios received Medicaid payments before DSH payments that covered 109 percent of the Medicaid costs.<sup>8</sup> Estimates of Medicaid shortfall calculated using DSH audits are generally lower than those reported on the AHA annual survey because the AHA annual survey includes the cost of provider taxes and other contributions used to finance the non-federal share of Medicaid payments (Nelb et al. 2016).

## BOX 2-4. Limitations of Current Measures of Medicaid Shortfall

The Commission has previously noted that costs are an imperfect measure of payment adequacy and that cost-based payments may not promote efficiency. The experience of the seven hospitals profiled by MACPAC during the summer and fall of 2016 sheds light on the limitations of current measures of Medicaid shortfall (MACPAC 2017).

For some of the DSH hospitals we profiled, the amount of Medicaid shortfall reported by hospital executives was greater than that reported on DSH audits because of differences in the accounting of provider contributions to the non-federal share of Medicaid payments, such as provider taxes or local government contributions. For example, Santa Clara Valley Medicaid Center in California reported a 91 percent Medicaid payment-to-cost ratio on its 2012 DSH audit. However, hospital executives noted that the hospital's net payment-to-cost ratio, after accounting for provider taxes and local government contributions, was less than 50 percent. Like several other California counties, Santa Clara County pays for the state share of most Medicaid services provided at its affiliated public hospital through intergovernmental transfers. Other hospitals we profiled also contributed toward the non-federal share of DSH and other supplemental payments, but did not contribute toward the non-federal share of their base Medicaid payment rates.

Executives at MetroHealth Hospital in Cleveland, Ohio, also noted that their Medicaid shortfall would be higher if the hospital were less efficient. MetroHealth executives reported that their current Medicaid payment-to-cost ratio was about 85 percent, but they estimated that it would be around 75 percent if the hospital had not adopted various efficiency strategies to reduce its costs.

## Hospitals with High Levels of Uncompensated Care That Also Provide Essential Community Services

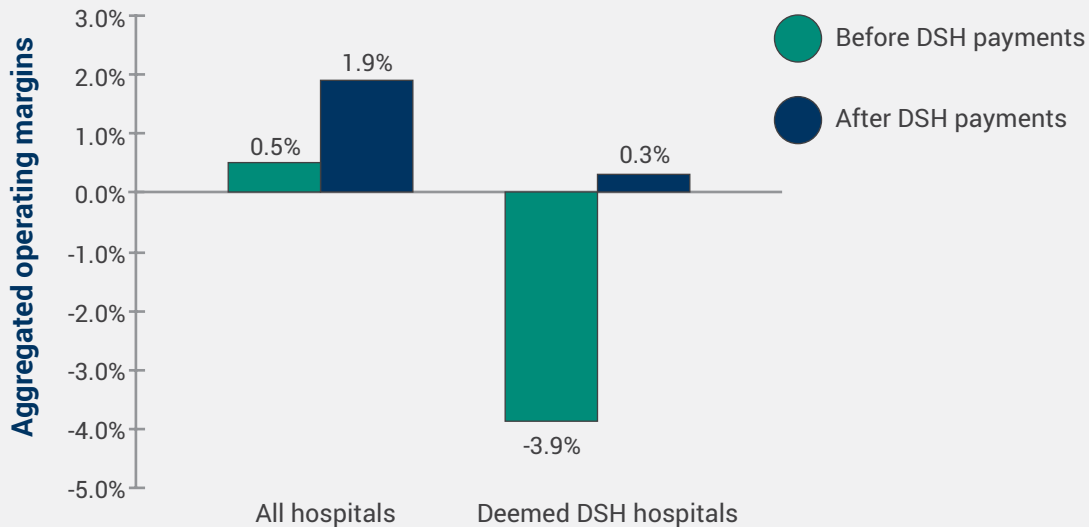
States are required to make DSH payments to deemed DSH hospitals, which serve a high share of Medicaid and low-income patients. In 2012, about 12 percent of U.S. hospitals met the deemed DSH standards and these hospitals received \$10.6 billion in DSH payments (65 percent of all DSH payments in 2012). These hospitals are particularly reliant on DSH payments to offset operating losses and maintain access to care for Medicaid and other low-income patients in their communities.

Below we examine how the ACA coverage expansions are affecting the financial status of deemed DSH hospitals. We also identify the extent

to which deemed DSH hospitals provide what the statute calling for MACPAC's study calls essential community services.

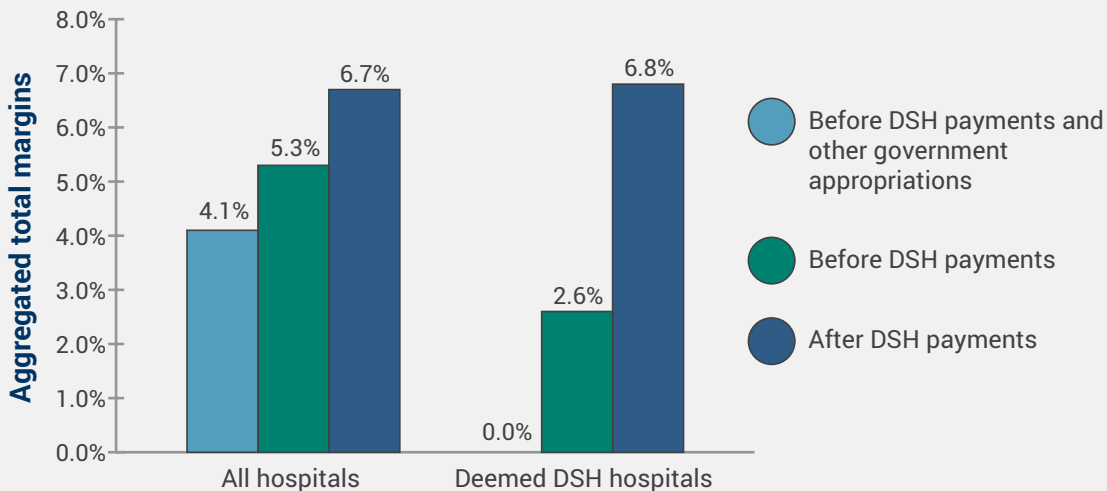
### Deemed DSH hospital finances

In 2014, deemed DSH hospitals reported lower operating margins than other hospitals in the aggregate, and they reported negative operating margins before DSH payments (Figure 2-3). However, deemed DSH hospitals reported total margins after DSH payments at levels similar to all hospitals (Figure 2-4). Total margins include revenue not directly related to patient care and assess overall hospital profitability. Much of the other revenue reported by deemed DSH hospitals was non-DSH government appropriations, such as local funding used to support public hospitals. Before DSH and other government appropriations, total margins for deemed DSH hospitals were 0.0 percent in the aggregate in 2014.

**FIGURE 2-3. Aggregate Hospital Operating Margins Before and After DSH Payments, 2014**


**Notes:** DSH is disproportionate share hospital. Operating margins measure income from patient care divided by net patient revenue. Operating margins before DSH payments in 2014 were estimated using 2012 DSH audit data. Analysis excluded outlier hospitals reporting operating margins greater than 1.5 times the interquartile range from the first and third quartiles. Deemed DSH status was estimated based on available Medicaid and low-income utilization data. For further discussion of this methodology and limitations, see Appendix 2B.

**Source:** MACPAC, 2017, analysis of 2014 Medicare cost reports and 2012 DSH audit data.

**FIGURE 2-4. Aggregate Hospital Total Margins Before and After DSH Payments, 2014**


**Notes:** DSH is disproportionate share hospital. Total margins include revenue not directly related to patient care, such as investment income, parking receipts, and non-DSH state and local subsidies to hospitals. Total margins before DSH payments in 2014 were estimated using 2012 DSH audit data. Other government appropriations include state or local subsidies to hospitals that are not Medicaid payments. Analysis excluded outlier hospitals reporting total margins greater than 1.5 times the interquartile range from the first and third quartiles. Deemed DSH status was estimated based on available Medicaid and low-income utilization data. For further discussion of this methodology and limitations, see Appendix 2B.

**Source:** MACPAC, 2017, analysis of 2014 Medicare cost reports and 2012 DSH audit data.

Between 2013 and 2014, operating margins for deemed DSH hospitals improved by 1.9 percentage points compared to the improvement in hospital operating margins for all hospitals of 1.6 percentage points. Deemed DSH hospitals in expansion states reported a larger improvement in aggregate hospital operating margins (2.2 percentage points) than deemed DSH hospitals in states that did not expand Medicaid (1.6 percentage points). Even so, deemed DSH hospitals in Medicaid expansion states reported lower aggregate operating margins in 2013, and thus reported lower aggregate operating margins in 2014 (-1.8 percent) than deemed DSH hospitals in non-expansion states (2.6 percent).<sup>9</sup>

Hospital margins are an imperfect measure of a hospital's financial health, and the data that are available to calculate hospital margins from Medicare cost report data have several limitations. Hospital margins are affected by many factors other than payer mix, such as hospital prestige, regional market concentration, managed care penetration, and hospital costs (Bai and Anderson 2016). Comparisons of Medicare cost report data and hospital financial statements for a subset of safety-net hospitals suggest that revenues and costs are not always reported consistently; this inconsistency results in discrepancies for individual hospitals, but when hospital data is aggregated for larger groups of hospitals, margins are more similar between these different data sources (Sommers et al. 2016).

## Essential community services

Many deemed DSH hospitals provide low-income and other vulnerable patients a range of important services that are not available at most hospitals. The Protecting Access to Medicare Act of 2014 (P.L. 113-93) requires that MACPAC's DSH analyses provide data identifying hospitals with high levels of uncompensated care that also provide access to essential community services. Given that the concept of essential community services is not defined elsewhere in Medicaid statute or regulation,

MACPAC has developed a working definition based on the types of services suggested in the statute calling for MACPAC's study and the limits of available data (Box 2-5).

Among the 746 deemed DSH hospitals identified in 2012, 669 (90 percent) provided at least one of the included services. About two-thirds (489 hospitals) provided two of these services and slightly fewer than half (352 hospitals) provided three or more of these services. In comparison, a smaller share of non-deemed hospitals provided three or more of these services (30 percent).

To better understand the types of services that are directly and indirectly supported through DSH funding, we asked a number of DSH hospital executives about how they used DSH funding (Box 2-6). The diverse uses of DSH funding in different communities underscore the challenge of identifying a single list of hospital services that are essential for all low-income populations across the country.

Consistent with trends in the hospital industry at large, many of the hospitals we profiled were part of larger health systems that provided extensive outpatient services.<sup>10</sup> According to MACPAC's analysis of 2012 community benefit reports for non-profit hospitals submitted to the Internal Revenue Service (IRS), 31 percent of non-profit DSH hospitals were part of multihospital organizations, which is similar to the share of non-DSH hospitals that were part of multihospital organizations in 2012 (34 percent). However, under current DSH rules, the maximum amount of DSH funding hospitals are eligible to receive is based on care provided within the hospital setting and does not take into account costs and revenue from the health systems that DSH hospitals are part of.

### **BOX 2-5. Identifying Hospitals with High Levels of Uncompensated Care that Provide Essential Community Services for Low-Income, Uninsured, and Other Vulnerable Populations**

The statute requires that MACPAC provide data identifying hospitals with high levels of uncompensated care that also provide low-income, uninsured, and vulnerable populations access to essential community services, such as graduate medical education and the continuum of primary through quaternary care, including the provision of trauma care and public health services. Based on the types of services suggested in the statute and the limits of available data, we included the following services in our working definition of essential community services:

- burn services;
- dental services;
- graduate medical education;
- HIV/AIDS care;
- inpatient psychiatric services (through a psychiatric subunit or stand-alone psychiatric hospital);
- neonatal intensive care units;
- obstetrics and gynecology services;
- substance use disorder services; and
- trauma services.

We also included deemed DSH hospitals that were designated as critical access hospitals and those that were the only children's hospital within a 15-mile radius (measured by driving distance). See Appendix 2B for further discussion of this methodology and its limitations.

## **DSH Allotment Projections**

MACPAC is required to project future DSH allotments and compare them to the measures that Congress asked us to study. Below we describe projected DSH allotments for FY 2018 and compare pending DSH allotment reductions to changes in state levels of hospital uncompensated care. Under current law, DSH allotments are scheduled to be reduced beginning in FY 2018 in the following annual amounts:

- \$2.0 billion in FY 2018;
- \$3.0 billion in FY 2019;
- \$4.0 billion in FY 2020;
- \$5.0 billion in FY 2021;
- \$6.0 billion in FY 2022;
- \$7.0 billion in FY 2023;
- \$8.0 billion in FY 2024; and
- \$8.0 billion in FY 2025.

DSH allotment reductions will be applied against unreduced DSH allotments, which, as noted at the beginning of this chapter, vary widely by state and are largely based on states' historical DSH spending in 1992, before federal limits were established. For example, unreduced FY 2018 federal DSH allotments average \$408 per uninsured individual, but vary by state from less than \$100 per uninsured individual in five states to more than \$1,000 per

uninsured individual in nine states.<sup>11</sup> Much of this variation is projected to persist even if DSH allotment reductions take effect as scheduled in FY 2018, because only one-third of DSH allotment reductions are based on the number of uninsured in a state. Compared on a per capita basis, reduced DSH allotments range from less than \$100 per uninsured individual in nine states to more than \$1,000 per uninsured individual in six states.

## **BOX 2-6. Services Supported by Disproportionate Share Hospital Payments**

Because disproportionate share hospital (DSH) funding is fungible, executives at the seven hospitals MACPAC profiled reported using DSH funds directly and indirectly for different purposes, including the following:

- offsetting hospital uncompensated care costs for Medicaid-enrolled patients and uninsured individuals;
- supporting the development of particular programs for low-income patients, such as programs to address infant mortality, substance use disorders, and social determinants of health; and
- supporting the financial stability of their overall health system, including a hospital's ability to employ physicians and maintain access to care in the outpatient setting.

State policies appeared to affect the types of uncompensated care that DSH funding was used to support. For example, executives from hospitals in states that had not expanded Medicaid reported higher levels of unpaid costs of care for the uninsured, and those from hospitals in states with lower base Medicaid payment rates reported higher levels of Medicaid shortfall.

Market contexts also appeared to shape some hospital executives' views about the role of DSH funding for their institutions. Executives from the two profiled hospitals that were the sole provider in their region noted that DSH funds enabled their institutions to support their capacity to provide services that they felt would otherwise not be financially viable in their region (e.g., birthing services at Northeastern Vermont Regional and trauma services at Vidant Medical Center). Hospital executives in profiled hospitals that were not the only hospital in their urban market noted that DSH allowed them to support services to low-income patients that other hospitals in their markets did not provide.

All but one of the DSH hospitals that we profiled were part of larger health systems that provided extensive outpatient care and other services in their community. In 2016, for example, Parkland Hospital provided 20 times as many outpatient clinic visits as inpatient hospital stays. Northeastern Vermont Regional Medical Center is not part of a health system and provides fewer outpatient visits itself, but it recently partnered with rural health clinics, federally qualified health centers, a designated mental health agency, and various social service providers to form the Caledonia Southern Essex Accountable Health Community (MACPAC 2017).

## BOX 2-7. Factors Used in Disproportionate Share Hospital Health Reform Reduction Methodology

The Centers for Medicare & Medicaid Services (CMS) Disproportionate Share Hospital Health Reform Reduction Methodology (DHRM) applies five factors to calculate state disproportionate share hospital (DSH) allotment reductions. The total amount by which allotments must be reduced is specified in statute (\$2 billion in FY 2018), and the DHRM provides a model for how these reductions may be distributed across states.

- The **low-DSH factor** allocates a smaller proportion of the total DSH allotment reductions to low-DSH states based on the size of these states' DSH allotments relative to their total Medicaid expenditures.
- The **uninsured percentage factor** imposes larger DSH allotment reductions on states with lower uninsured rates relative to other states. One-third of DSH reductions are based on this factor.
- The **high volume of Medicaid inpatients factor** imposes larger DSH allotment reductions on states that do not target DSH payments to hospitals with high Medicaid volume. The proportion of state DSH payments made to hospitals with Medicaid inpatient utilization that is one standard deviation above the mean (the same qualifying criteria used for deemed DSH hospitals) is compared among states. One-third of DSH reductions are based on this factor.
- The **high level of uncompensated care factor** imposes larger reductions on states that do not target DSH payments to hospitals with high levels of uncompensated care. The proportion of DSH payments made to hospitals with above-average uncompensated care as a proportion of costs for Medicaid beneficiaries and uninsured individuals is compared among states. This factor is calculated using DSH audit data, which defines uncompensated care costs as the sum of Medicaid shortfall and unpaid costs of care for uninsured individuals. One-third of DSH reductions are based on this factor.
- The **budget neutrality factor** is an adjustment to the high Medicaid and high uncompensated care factors that accounts for DSH allotments that were used as part of the budget neutrality calculations for coverage expansions under Section 1115 waivers in four states and the District of Columbia (see note). Specifically, funding for these coverage expansions is excluded from the calculation of whether DSH payments were targeted to high Medicaid or high uncompensated care hospitals.

**Note:** Four states—Indiana, Maine, Massachusetts, and Wisconsin—and the District of Columbia meet the statutory criteria for the budget neutrality factor.

Complete state-by-state estimates of DSH allotments and their relationship to the state-by-state data that Congress requested are provided in Appendix 2A.

### Reduced DSH allotments

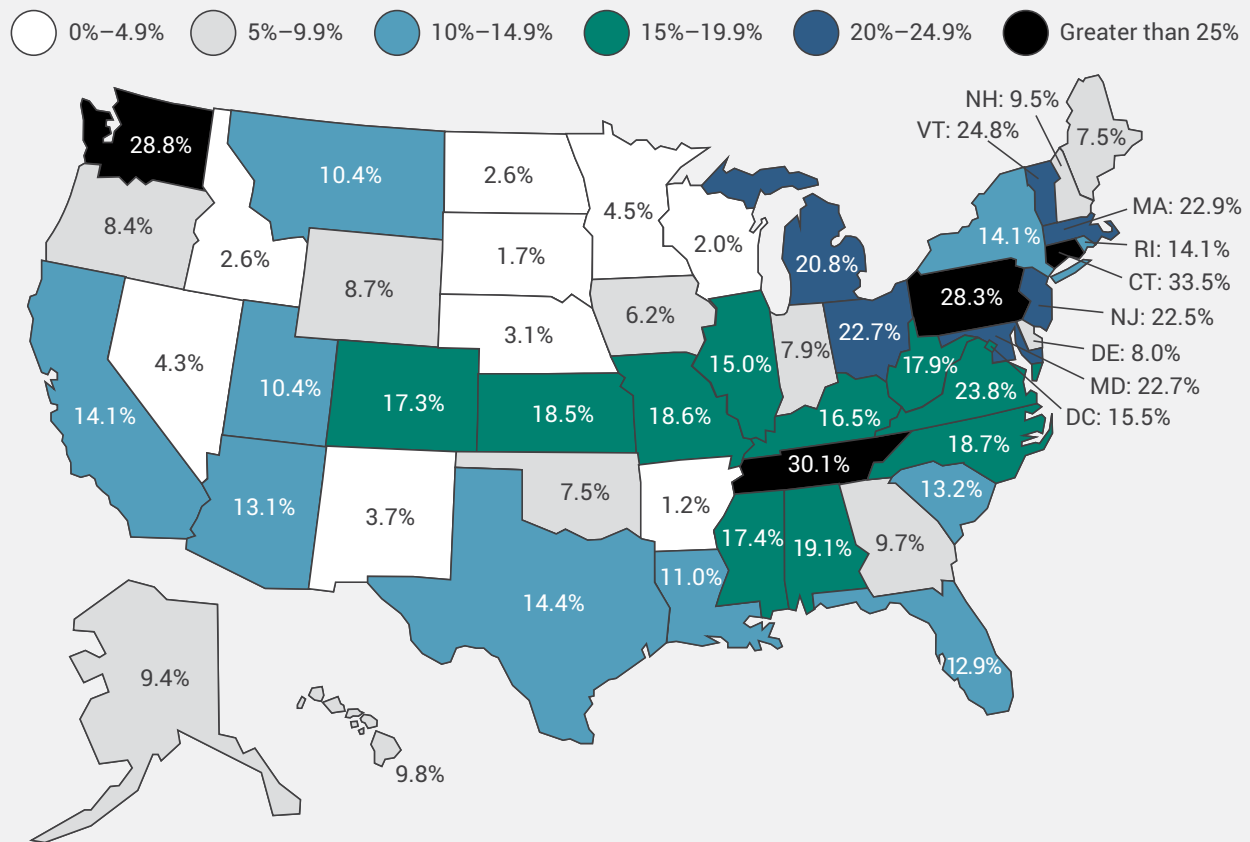
To estimate reduced DSH allotments for FY 2018, we modeled the DSH Health Reform Methodology (DHRM) that was developed by the Centers for

Medicare & Medicaid Services (CMS) to implement allotment reductions originally scheduled to go into effect in FYs 2014 and 2015, before the reductions in DSH allotments were delayed to FY 2018 (CMS 2013). This methodology uses five factors to implement the statutory requirements, which require CMS to apply greater DSH reductions to states with lower uninsured rates and states that do not target their DSH payments to high-need hospitals, among other criteria (Box 2-7). Although CMS may modify this reduction methodology in future years, the DHRM incorporates all of the statutory requirements for DSH allotment reductions and is thus a reasonable starting point for estimating future DSH allotment reductions.<sup>12</sup> We used the same methodology to

project FY 2018 DSH allotments in our 2016 DSH report, but our projections in this report differ slightly because more current data are available.

We estimate that the \$2 billion in federal DSH allotment reductions currently scheduled for implementation in FY 2018 will have widely varying effects on individual state allotments, with state allotment reductions ranging from 1.2 percent to 33.5 percent (Figure 2-5).<sup>13</sup> Because the reduction methodology is only partially based on the current size of state allotments, the states with the largest allotments today are not necessarily the ones that will see their allotments reduced by the greatest percentage.

**FIGURE 2-5. Projected Decrease in State DSH Allotments as a Percentage of Unreduced Allotments by State, FY 2018**



**Notes:** DSH is disproportionate share hospital. FY is fiscal year.

**Source:** Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of Medicare cost reports, Medicaid DSH audits, and the U.S. Census Bureau 2015 American Community Survey.



## Comparison of DSH allotment reductions to changes in levels of uncompensated care

Pending DSH allotment reductions are premised on the assumption that increased health coverage would lead to reductions in uncompensated care. The amount of pending FY 2018 DSH allotment reductions (\$2.0 billion federal, \$3.6 billion state and federal) is smaller than the national reduction in uncompensated care between 2013 and 2014 (\$5.5 billion reduction in charity care and bad debt; \$4.6 billion reduction after accounting for the increase in Medicaid shortfall). However, because the levels of uncompensated care and DSH allotment reductions are not distributed evenly among states, the projected allotment reduction in some states is greater than the state's decline in uncompensated care. In 20 states, the projected FY 2018 DSH allotment reduction (including state and federal funds) is greater than the state's decline in

charity care and bad debt between 2013 and 2014 (Table 2-2).<sup>14</sup> Among these states are 11 states that did not expand Medicaid, where the decline in hospital uncompensated care was lower than expected, and 17 states with historically large DSH allotments, which receive larger reductions under the low-DSH factor of the allotment reduction formula initially proposed by CMS.

Non-expansion states are more likely to have DSH allotment reductions greater than the decline in their states' total level of hospital uncompensated care. Although the DSH allotment reduction methodology initially proposed by CMS applies smaller reductions to states that did not expand Medicaid (because they have higher uninsured rates), hospitals in these states experienced little change in uncompensated care between 2013 and 2014.

In states where DSH allotment reductions are larger than the decline in hospital uncompensated

**TABLE 2-2. States with Projected DSH Allotment Reductions for FY 2018 Greater than Declines in Uncompensated Care between 2013 and 2014**

State characteristics	Total	Projected FY 2018 DSH allotment reductions that are greater than the decline in hospital uncompensated care between 2013 and 2014	
		Number of states	Percentage of total states
<b>Expansion status as of December 31, 2014</b>			
Medicaid expansion states	27	9	33%
Non-Medicaid expansion states	24	11	46
<b>Low-DSH status</b>			
Low-DSH states	17	3	18
Non-low-DSH states	34	17	50
<b>All states and the District of Columbia</b>	<b>51</b>	<b>20</b>	<b>39%</b>

**Notes:** DSH is disproportionate share hospital. FY is fiscal year. Low-DSH states are defined in statute as states with FY 2000 DSH expenditures that were less than 3 percent of total state Medicaid medical assistance expenditures for FY 2000. Projected DSH allotment reductions include state and federal funds. Uncompensated care is based on Medicare cost reports, which define uncompensated care as charity care and bad debt.

**Source:** Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of Medicare cost reports, Medicaid DSH audits, and the U.S. Census Bureau 2015 American Community Survey.

care, DSH allotment reductions will likely result in a net loss of overall funding for hospitals. We do not know how states will distribute DSH funding reductions among their hospitals, and we do not

know how DSH hospitals will respond to reduced funding (Box 2-8).<sup>15</sup>

### **BOX 2-8. Responses to Previous Reductions in Medicaid Disproportionate Share Hospital Funding**

Some hospitals that MACPAC profiled experienced recent reductions in disproportionate share hospital (DSH) payments as a result of changes to state DSH policies and responded in different ways.

At Parkland Hospital in Dallas, a public hospital, DSH payments fell by 14 percent between 2015 and 2016 as a result of a change in Texas's DSH policy, which resulted in the distribution of more DSH funding to privately owned hospitals. Parkland executives reported that they were seeking additional non-DSH supplemental payments through Texas's Section 1115 demonstration to help make up for the loss of DSH funding.

At MetroHealth Hospital in Cleveland, DSH payments fell from \$33 million in 2012 to \$11.7 million in 2015 (a 60 percent decline) because of a change in Ohio's formula for distributing DSH payments and also because MetroHealth's total amount of uncompensated care fell as a result of Ohio's Medicaid expansion. Between 2012 and 2015, MetroHealth reported a \$5 million increase in non-DSH supplemental payments because increased Medicaid enrollment increased the payments that the hospital was eligible to receive under Ohio's upper payment limit program. However, hospital executives also reported that they may need to consider strategies to offset lost revenue by increasing their share of commercially insured patients.

Executives at both hospitals said that they might need to cut services or staff if DSH funding is further reduced (MACPAC 2017).

## **Conclusion**

Early evidence suggests that the ACA coverage expansions are reducing the number of uninsured individuals and levels of uncompensated care, especially in states that have expanded Medicaid. However, even in Medicaid expansion states, deemed DSH hospitals, which serve a particularly high share of Medicaid beneficiaries and low-income patients, report negative operating margins before DSH payments.

Although the Commission cannot evaluate the merits of pending DSH allotment reductions at this

time, the analyses in this chapter raise concerns about the appropriate distribution of reductions among states. Not only do current DSH allotments vary widely based on states' historical spending, but declines in hospital uncompensated care are also not evenly distributed among states and hospitals. The DSH allotment reduction methodology initially proposed by CMS in 2013 does not fully account for this state-by-state variation. However, if reductions take effect in FY 2018 as scheduled, CMS will need to update this methodology and could use this opportunity to better align state DSH allotments with objective measures of need. In the Commission's view,

Medicaid DSH payments should be better targeted to the states and hospitals that serve a disproportionate share of Medicaid beneficiaries and low-income patients and that have higher levels of uncompensated care, consistent with the original statutory intent. The next chapter in this report presents the Commission's analyses of various approaches to improve the targeting of DSH payments within states, regardless of whether DSH allotment reductions take effect.

## Endnotes

<sup>1</sup> The DSH allotment reductions included in the ACA were initially scheduled to take effect in FY 2014, but they have been delayed several times.

<sup>2</sup> The national estimates of the number of uninsured individuals that we provide in Chapter 2 do not match the state-level estimates of the number of uninsured provided in Appendix 2A because of different data sources used. National estimates of the number of uninsured come from the Current Population Survey, a monthly survey of households by the U.S. Census Bureau that is the preferred source for national analyses. State-level data come from the American Community Survey, which has a larger sample size and is the preferred source for subnational analyses (Census 2016). There are a variety of ways to count the number of uninsured individuals. Estimates in this chapter reflect the number of people without health insurance for the entire calendar year.

<sup>3</sup> In the Current Population Survey, a monthly survey of households conducted by the U.S. Census Bureau for the U.S. Bureau of Labor Statistics, estimates of health insurance coverage are not mutually exclusive. People can be covered by more than one type of health insurance during the year.

<sup>4</sup> Hospitalization statistics for 2014 are based on MACPAC's analysis of state inpatient databases for the following 28 states that submitted complete information to the Healthcare Cost and Utilization Project: Arizona, California, Colorado, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Michigan, Minnesota, Missouri,

Nebraska, Nevada, New Jersey, New York, North Carolina, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Washington, West Virginia, and Wisconsin.

<sup>5</sup> According to MACPAC's analysis of 2012 Medicare cost reports and DSH audits for hospitals with matching data, approximately 81 percent of charity care and bad debt reported on 2012 Medicare cost reports for DSH hospitals was reported as unpaid costs of care for uninsured individuals on 2012 Medicaid DSH audits. The remaining 19 percent of uncompensated care reported on Medicare cost reports is likely due to charity care and bad debt provided to patients with health insurance.

<sup>6</sup> For our analyses of 2014 Medicare cost report data, Medicaid expansion states are those that expanded Medicaid to low-income adults with family incomes at or below 138 percent of the FPL before December 31, 2014. States that expanded Medicaid after 2014 are considered non-expansion states in these analyses.

<sup>7</sup> Centers for Medicare & Medicaid Services (CMS) regulations permit states to submit DSH audits approximately three years after a state plan rate year ends so that all claims can be included and audits can be completed; CMS posts DSH audit data on its website after its review, typically about five years after the state plan rate year ends.

<sup>8</sup> Analysis of Medicaid payment-to-cost ratios is limited to DSH hospitals with complete DSH audit data and excludes institutions for mental diseases (IMDs). Total Medicaid payments include base Medicaid payments for services and non-DSH supplemental payments.

<sup>9</sup> One potential reason hospitals in states that expanded Medicaid had lower operating margins than hospitals in states that did not expand Medicaid is the substantial regional variation in hospital margins, which predates the ACA coverage expansions. For example, in 2013, the median hospital in northeastern states reported a net loss of \$236 per adjusted discharge in 2013, while the median hospital in western states reported a net profit of \$45 per adjusted discharge (Bai and Anderson 2016).

<sup>10</sup> For example, between 2002 and 2008, the share of physician practices owned by hospitals grew from about 20 percent to more than 50 percent (Kocher and Sahni 2011).

<sup>11</sup> In this example, unreduced FY 2018 DSH allotments are compared to the number of uninsured individuals in 2015, the year from which the latest data is available. Complete state-by-state data on the relationship between DSH allotments and the number of uninsured for 2013–2015 are provided in Appendix 2A.

<sup>12</sup> According to the fall 2016 publication of the Unified Agenda of Regulatory and Deregulatory Actions, CMS was expected to release a proposed rule to update the DSH allotment reduction methodology in January 2017, but this proposed rule has not yet been published (OIRA 2016).

<sup>13</sup> For states that currently are not spending their full DSH allotment, DSH allotment reductions will have a smaller effect on DSH spending.

<sup>14</sup> Excluding state funds, 17 states have projected federal DSH allotment reductions for FY 2018 greater than the state's decline in charity care and bad debt between 2013 and 2014. This analysis does not include Medicaid shortfall, which increased between 2013 and 2014.

<sup>15</sup> In MACPAC's February 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*, we modeled two scenarios for how states might respond to pending DSH allotment reductions: (1) a proportional reduction model that assumed states would apply a proportional reduction in DSH payments to each hospital, and (2) a strategic model that assumed states would redistribute DSH payments to minimize future reductions under the DSH allotment reduction methodology initially proposed by CMS. We found that the incentives created by the reduction methodology would encourage states to distribute remaining DSH funds to deemed DSH hospitals, which are required to receive DSH payments because they serve a high share of Medicaid and low-income patients. However, CMS may change the reduction methodology in the future, and it remains to be seen whether the incentives created by the reduction methodology are powerful enough to overcome the state-level factors that currently affect DSH payment decisions.

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# APPENDIX 2A: State-Level Data

TABLE 2A-1. Current and Projected State DSH Allotments, FYs 2017–2018 (millions)

State	Fiscal year 2017		Fiscal year 2018 unreduced allotment		Fiscal year 2018 reduced allotment		Difference (unreduced less reduced)		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal	Percent reduction
<b>Total</b>	\$21,408.4	\$12,026.9	\$21,614.6	\$12,141.9	\$18,015.9	\$10,141.9	\$3,598.7	\$2,000.0	-16.6%
Alabama	481.2	337.6	486.1	341.1	393.2	275.9	92.9	65.2	-19.1
Alaska	44.7	22.4	45.2	22.6	40.9	20.5	4.3	2.1	-9.4
Arizona	160.5	111.2	162.2	112.3	140.9	97.6	21.3	14.7	-13.1
Arkansas	68.0	47.4	68.7	47.8	67.8	47.2	0.9	0.6	-1.2
California	2,407.1	1,203.6	2,431.8	1,215.9	2,088.9	1,044.5	342.8	171.4	-14.1
Colorado	203.0	101.6	205.1	102.6	169.5	84.8	35.6	17.8	-17.3
Connecticut	439.2	219.6	443.6	221.8	294.8	147.4	148.8	74.4	-33.5
Delaware	18.3	9.9	18.5	10.0	17.0	9.2	1.5	0.8	-8.0
District of Columbia	96.1	67.2	97.0	67.9	82.0	57.4	15.0	10.5	-15.5
Florida	359.4	219.6	363.1	221.8	316.1	193.1	47.0	28.7	-12.9
Georgia	434.6	295.1	439.1	298.1	396.5	269.2	42.6	28.9	-9.7
Hawaii	19.5	10.7	19.7	10.8	17.8	9.8	1.9	1.1	-9.8
Idaho	25.2	18.0	25.5	18.2	24.8	17.8	0.7	0.5	-2.6
Illinois	460.1	236.0	464.8	238.5	394.9	202.6	69.9	35.9	-15.0
Indiana	351.6	234.7	355.2	237.1	327.1	218.3	28.1	18.7	-7.9
Iowa	76.2	43.2	77.0	43.7	72.2	41.0	4.8	2.7	-6.2
Kansas	80.6	45.3	81.4	45.8	66.4	37.3	15.0	8.4	-18.5
Kentucky	225.9	159.2	228.2	160.8	190.6	134.3	37.6	26.5	-16.5
Louisiana	1,175.3	732.0	1,175.3	732.0	1,045.4	651.1	129.8	80.9	-11.0
Maine	179.1	115.3	180.9	116.5	167.3	107.7	13.6	8.8	-7.5
Maryland	167.4	83.7	169.1	84.6	130.8	65.4	38.3	19.2	-22.7
Massachusetts	669.7	334.9	676.6	338.3	521.6	260.8	154.9	77.5	-22.9
Michigan	446.6	290.9	451.1	293.9	357.4	232.9	93.7	61.0	-20.8
Minnesota	164.0	82.0	165.7	82.8	158.3	79.1	7.4	3.7	-4.5
Mississippi	224.3	167.4	226.6	169.1	187.3	139.8	39.3	29.4	-17.4
Missouri	822.9	520.1	831.3	525.4	676.5	427.6	154.8	97.8	-18.6

**TABLE 2A-1. (continued)**

State	Fiscal year 2017			Fiscal year 2018 unreduced allotment			Fiscal year 2018 reduced allotment			Difference (unreduced less reduced)		
	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Federal	Total (state and federal)	Percent reduction
Montana	\$19.0	\$12.5	\$19.2	\$12.6	\$17.2	\$11.3	\$2.0	\$1.3	\$2.0	\$1.3	-10.4%	
Nebraska	59.9	31.1	60.5	31.4	58.6	30.4	1.9	1.0	1.9	1.0	-3.1	
Nevada	78.5	50.8	79.3	51.3	75.9	49.1	3.4	2.2	3.4	2.2	-4.3	
New Hampshire	351.5	175.8	355.1	177.6	321.3	160.7	33.8	16.9	33.8	16.9	-9.5	
New Jersey	1,413.5	706.8	1,428.0	714.0	1,107.0	553.5	321.0	160.5	321.0	160.5	-22.5	
New Mexico	31.4	22.4	31.8	22.6	30.6	21.8	1.2	0.8	1.2	0.8	-3.7	
New York	3,527.0	1,763.5	3,563.1	1,781.5	3,062.3	1,531.1	500.8	250.4	500.8	250.4	-14.1	
North Carolina	484.3	323.9	489.2	327.2	397.8	266.1	91.4	61.1	91.4	61.1	-18.7	
North Dakota	21.0	10.5	21.2	10.6	20.6	10.3	0.6	0.3	0.6	0.3	-2.6	
Ohio	715.7	446.0	723.0	450.6	559.1	348.4	163.9	102.2	163.9	102.2	-22.7	
Oklahoma	66.3	39.8	67.0	40.2	62.0	37.2	5.0	3.0	5.0	3.0	-7.5	
Oregon	77.1	49.7	77.9	50.2	71.4	46.0	6.5	4.2	6.5	4.2	-8.4	
Pennsylvania	1,190.0	616.2	1,202.2	622.5	862.3	446.5	339.9	176.0	339.9	176.0	-28.3	
Rhode Island	139.9	71.4	141.3	72.1	121.4	62.0	19.9	10.1	19.9	10.1	-14.1	
South Carolina	504.3	359.6	509.4	363.2	442.0	315.2	67.4	48.1	67.4	48.1	-13.2	
South Dakota	22.1	12.1	22.3	12.2	21.9	12.0	0.4	0.2	0.4	0.2	-1.7	
Tennessee	81.7	53.1	81.7	53.1	57.2	37.1	24.6	16.0	24.6	16.0	-30.1	
Texas	1,868.7	1,049.9	1,887.9	1,060.6	1,616.9	908.4	270.9	152.2	270.9	152.2	-14.4	
Utah	30.8	21.5	31.1	21.8	27.9	19.5	3.2	2.3	3.2	2.3	-10.4	
Vermont	45.4	24.7	45.8	25.0	34.5	18.8	11.3	6.2	11.3	6.2	-24.8	
Virginia	192.4	96.2	194.3	97.2	148.1	74.0	46.3	23.1	46.3	23.1	-23.8	
Washington	406.2	203.1	410.4	205.2	292.0	146.0	118.4	59.2	118.4	59.2	-28.8	
West Virginia	103.2	74.1	104.3	74.9	85.6	61.4	18.7	13.4	18.7	13.4	-17.9	
Wisconsin	177.4	103.8	179.2	104.8	175.7	102.8	3.5	2.1	3.5	2.1	-2.0	
Wyoming	0.5	0.2	0.5	0.3	0.5	0.2	0.0	0.0	0.0	0.0	-8.7	

Notes: DSH is disproportionate share hospital. FY is fiscal year. Unreduced allotments for FY 2017 and FY 2018 are projected from FY 2016 allotments. Projected allotment reductions assume that federal DSH allotments are reduced by \$2 billion in FY 2018 as specified under current law and are calculated based on the DSH Health Reform Methodology that the Centers for Medicare & Medicaid Services initially developed to apply reductions to FY 2014 DSH allotments.

0.0 indicates a non-zero amount less than \$0.05 million.

Source: Dobson DaVanzo & Associates and KING Health, 2017, analysis for MACPAC of FY 2016 DSH allotments, Congressional Budget Office projections of the Consumer Price Index for All Urban Consumers, 2012 Medicaid DSH audits, 2012 Medicare cost reports, and the U.S. Census Bureau 2015 American Community Survey.

**TABLE 2A-2. Number of Uninsured and Uninsured Rate by State, 2013–2015**

State	2013			2014			2015			Difference (2015 less 2013)	
	Number (thousands)	Percentage of state population	Number (thousands)	Percentage of state population	Number (thousands)	Percentage of state population	Number (thousands)	Percentage of state population	Number (thousands)	Percentage of state population	
<b>Total</b>	<b>45,181</b>	<b>14.5%</b>	<b>36,670</b>	<b>11.7%</b>	<b>29,758</b>	<b>9.4%</b>	<b>-15,423</b>	<b>-5.1%</b>			
Alabama	645	13.6	579	12.1	484	10.1	-161	-3.5			
Alaska	132	18.5	122	17.2	106	14.9	-26	-3.6			
Arizona	1,118	17.1	903	13.6	728	10.8	-390	-6.3			
Arkansas	465	16.0	343	11.8	278	9.5	-187	-6.5			
California	6,500	17.2	4,767	12.4	3,317	8.6	-3,183	-8.6			
Colorado	729	14.1	543	10.3	433	8.1	-296	-6.0			
Connecticut	333	9.4	245	6.9	211	6.0	-122	-3.4			
Delaware	83	9.1	72	7.8	54	5.9	-29	-3.2			
District of Columbia	42	6.7	34	5.3	25	3.8	-17	-2.9			
Florida	3,853	20.0	3,245	16.6	2,662	13.3	-1,191	-6.7			
Georgia	1,846	18.8	1,568	15.8	1,388	13.9	-458	-4.9			
Hawaii	91	6.7	72	5.3	55	4.0	-36	-2.7			
Idaho	257	16.2	219	13.6	180	11.0	-77	-5.2			
Illinois	1,618	12.7	1,238	9.7	900	7.1	-718	-5.6			
Indiana	903	14.0	776	11.9	628	9.6	-275	-4.4			
Iowa	248	8.1	189	6.2	155	5.0	-93	-3.1			
Kansas	348	12.3	291	10.2	261	9.1	-87	-3.2			
Kentucky	616	14.3	366	8.5	261	6.0	-355	-8.3			
Louisiana	751	16.6	672	14.8	546	11.9	-205	-4.7			
Maine	147	11.2	134	10.1	111	8.4	-36	-2.8			
Maryland	593	10.2	463	7.9	389	6.6	-204	-3.6			
Massachusetts	247	3.7	219	3.3	189	2.8	-58	-0.9			
Michigan	1,072	11.0	837	8.5	597	6.1	-475	-4.9			
Minnesota	440	8.2	317	5.9	245	4.5	-195	-3.7			
Mississippi	500	17.1	424	14.5	372	12.7	-128	-4.4			
Missouri	773	13.0	694	11.7	583	9.8	-190	-3.2			



**TABLE 2A-2. (continued)**

State	2013			2014			2015			Difference (2015 less 2013)	
	Number (thousands)	Percentage of state population	Number (thousands)	Percentage of state population	Number (thousands)	Percentage of state population	Number (thousands)	Percentage of state population	Number (thousands)	Percentage of state population (percentage point change)	
Montana	165	16.5%	143	14.2%	119	11.6%	-46	-4.9%			
Nebraska	209	11.3	179	9.7	154	8.2	-55	-3.1			
Nevada	570	20.7	427	15.2	351	12.3	-219	-8.4			
New Hampshire	140	10.7	120	9.2	83	6.3	-57	-4.4			
New Jersey	1,160	13.2	965	10.9	771	8.7	-389	-4.5			
New Mexico	382	18.6	298	14.5	224	10.9	-158	-7.7			
New York	2,070	10.7	1,697	8.7	1,381	7.1	-689	3.6			
North Carolina	1,509	15.6	1,276	13.1	1,103	11.2	-406	-4.4			
North Dakota	73	10.4	57	7.9	57	7.8	-16	-2.6			
Ohio	1,258	11.0	955	8.4	746	6.5	-512	-4.5			
Oklahoma	666	17.7	584	15.4	533	13.9	-133	-3.8			
Oregon	571	14.7	383	9.7	280	7.0	-291	-7.7			
Pennsylvania	1,222	9.7	1,065	8.5	802	6.4	-420	-3.3			
Rhode Island	120	11.6	77	7.4	59	5.7	-61	-5.9			
South Carolina	739	15.8	642	13.6	523	10.9	-216	-4.9			
South Dakota	93	11.3	82	9.8	86	10.2	-7	-1.1			
Tennessee	887	13.9	776	12.0	667	10.3	-220	-3.6			
Texas	5,748	22.1	5,047	19.1	4,615	17.1	-1,133	-5.0			
Utah	402	14.0	366	12.5	311	10.5	-91	-3.5			
Vermont	45	7.2	31	5.0	24	3.8	-21	-3.4			
Virginia	991	12.3	884	10.9	746	9.1	-245	-3.2			
Washington	960	14.0	643	9.2	468	6.6	-492	-7.4			
West Virginia	255	14.0	156	8.6	108	6.0	-147	-8.0			
Wisconsin	518	9.1	418	7.3	323	5.7	-195	-3.4			
Wyoming	77	13.4	69	12.0	66	11.5	-11	-1.9			

Source: Barnett, J.C., and M.S. Vormovitsky, 2016, *Health insurance coverage in the United States: 2015*, Current Population Reports, P60-257(RV), Washington, DC: U.S. Census Bureau, <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>.

**TABLE 2A-3. State Levels of Uncompensated Care, 2013–2014, and Projected FY 2018 DSH Allotment Reductions by State**

State	Total hospital uncompensated care costs, 2013		Total hospital uncompensated care costs, 2014		Difference in total hospital uncompensated care costs (2014 less 2013)		Projected FY 2018 DSH allotment reductions (millions)	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)	Total (state and federal)	Federal
	\$36,428	4.4%	\$30,901	3.5%	\$-5,527	-0.9%	\$3,598.7	\$2,000.0
Alabama	579	5.9	568	5.1	-11	-0.8	92.9	65.2
Alaska	102	4.2	94	3.7	-8	-0.5	4.3	2.1
Arizona	738	4.8	541	3.5	-197	-1.3	21.3	14.7
Arkansas	346	5.3	226	3.4	-120	-1.9	0.9	0.6
California	3,756	3.9	1,708	1.6	-2,048	-2.2	342.8	171.4
Colorado	411	3.3	288	2.2	-123	-1.1	35.6	17.8
Connecticut	158	1.8	223	2.0	65	0.2	148.8	74.4
Delaware	76	2.4	82	2.5	5	0.0	1.5	0.8
District of Columbia	67	1.8	68	1.8	1	0.0	15.0	10.5
Florida	2,747	6.5	2,668	5.9	-80	-0.6	47.0	28.7
Georgia	1,413	7.2	1,443	6.4	30	-0.7	42.6	28.9
Hawaii	39	1.2	45	1.3	7	0.1	1.9	1.1
Idaho	144	3.7	125	3.0	-19	-0.7	0.7	0.5
Illinois	1,681	4.9	1,116	3.0	-565	-1.9	69.9	35.9
Indiana	1,026	5.1	963	4.7	-63	-0.4	28.1	18.7
Iowa	302	3.9	187	2.3	-115	-1.6	4.8	2.7
Kansas	242	3.3	257	3.3	15	0.0	15.0	8.4
Kentucky	550	4.5	241	1.9	-309	-2.6	37.6	26.5
Louisiana	742	6.0	718	5.5	-23	-0.4	129.8	80.9
Maine	188	3.9	170	3.3	-18	-0.6	13.6	8.8
Maryland	769	5.2	526	3.4	-243	-1.7	38.3	19.2
Massachusetts	608	2.4	501	1.9	-107	-0.5	154.9	77.5
Michigan	958	3.4	662	2.3	-296	-1.1	93.7	61.0
Minnesota	278	1.7	247	1.4	-31	-0.3	7.4	3.7
Mississippi	468	6.0	396	4.7	-72	-1.3	39.3	29.4
Missouri	889	4.6	870	4.3	-19	-0.3	154.8	97.8
Montana	159	4.6	155	4.2	-4	-0.3	2.0	1.3
Nebraska	210	3.7	199	3.4	-11	-0.3	1.9	1.0
Nevada	174	3.7	172	3.1	-2	-0.6	3.4	2.2

**TABLE 2A-3. (continued)**

State	Total hospital uncompensated care costs, 2013		Total hospital uncompensated care costs, 2014		Difference in total hospital uncompensated care costs (2014 less 2013)		Projected FY 2018 DSH allotment reductions (millions)	
	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses	Total (millions)	Share of hospital operating expenses (percentage point change)	Total (state and federal)	Federal
New Hampshire	\$ 187	4.6%	\$ 150	3.5%	\$ -38	-1.0%	\$ 33.8	\$ 16.9
New Jersey	1,127	6.4	911	4.0	-216	-2.4	321.0	160.5
New Mexico	291	6.0	170	3.3	-121	-2.7	1.2	0.8
New York	2,102	3.3	1,869	2.8	-233	-0.5	500.8	250.4
North Carolina	1,416	6.1	1,453	6.0	36	-0.1	91.4	61.1
North Dakota	104	3.1	88	2.5	-16	-0.6	0.6	0.3
Ohio	1,388	3.5	915	2.3	-473	-1.3	163.9	102.2
Oklahoma	480	5.1	454	4.5	-27	-0.7	5.0	3.0
Oregon	414	4.8	237	2.4	-177	-2.4	6.5	4.2
Pennsylvania	793	1.9	709	1.7	-83	-0.3	339.9	176.0
Rhode Island	165	4.8	110	3.2	-56	-1.6	19.9	10.1
South Carolina	735	6.6	721	6.2	-14	-0.4	67.4	48.1
South Dakota	104	3.0	97	2.6	-7	-0.4	0.4	0.2
Tennessee	472	3.8	521	2.9	49	-0.9	24.6	16.0
Texas	4,133	7.1	4,998	8.0	864	0.9	270.9	152.2
Utah	295	5.1	275	4.5	-19	-0.6	3.2	2.3
Vermont	48	2.2	42	1.9	-6	-0.3	11.3	6.2
Virginia	898	5.1	846	4.6	-52	-0.5	46.3	23.1
Washington	593	3.4	306	1.6	-286	-1.8	118.4	59.2
West Virginia	294	5.2	169	2.9	-125	-2.4	18.7	13.4
Wisconsin	492	2.7	315	1.6	-177	-1.0	3.5	2.1
Wyoming	80	5.9	88	5.5	9	-0.5	0.0	0.0

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. Uncompensated care is calculated using Medicare cost reports, which define uncompensated care as charity care and bad debt. Projected allotment reductions for FY 2018 assume that federal DSH allotments are reduced by \$2 billion in FY 2018 as specified under current law and are calculated based on the DSH Health Reform Methodology that the Centers for Medicare & Medicaid Services initially developed to apply reductions to FY 2014 DSH allotments. 0.0 indicates a non-zero amount less than \$0.05 million or 0.05 percent.

**Source:** Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of FY 2016 DSH allotments, Congressional Budget Office projections of the Consumer Price Index for All Urban Consumers, 2012 Medicaid DSH audits, Medicare cost reports, and the U.S. Census Bureau 2015 American Community Survey.

**TABLE 2A-4. Deemed DSH Hospitals Providing at Least One Essential Community Service by State, 2012**

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
<b>Total</b>	<b>5,979</b>	<b>2,670</b>	<b>45%</b>	<b>746</b>	<b>12%</b>	<b>669</b>	<b>11%</b>
Alabama	115	84	73	7	6	7	6
Alaska	25	4	16	1	4	1	4
Arizona	107	37	35	37	35	33	31
Arkansas	97	4	4	1	1	1	1
California	401	46	11	43	11	37	9
Colorado	97	72	74	14	14	14	14
Connecticut	41	33	80	5	12	4	10
Delaware	12	2	17	2	17	2	17
District of Columbia	13	8	62	6	46	6	46
Florida	249	70	28	39	16	34	14
Georgia	166	130	78	27	16	16	10
Hawaii	25	17	68	3	12	3	12
Idaho	51	22	43	6	12	4	8
Illinois	203	52	26	43	21	36	18
Indiana	168	49	29	11	7	10	6
Iowa	123	7	6	3	2	3	2
Kansas	151	57	38	12	8	10	7
Kentucky	116	104	90	28	24	24	21
Louisiana	215	77	36	34	16	26	12
Maine	39	1	3	0	0	0	0
Maryland	58	13	22	7	12	7	12
Massachusetts	104	0	0	0	0	0	0
Michigan	167	113	68	12	7	11	7
Minnesota	144	50	35	16	11	16	11
Mississippi	113	48	42	14	12	13	12
Missouri	148	91	61	23	16	22	15
Montana	64	49	77	5	8	5	8
Nebraska	99	29	29	14	14	12	12
Nevada	53	23	43	4	8	3	6
New Hampshire	30	16	53	2	7	2	7
New Jersey	97	72	74	24	25	23	24
New Mexico	53	19	36	13	25	12	23
New York	192	174	91	22	11	21	11
North Carolina	133	54	41	18	14	18	14
North Dakota	49	3	6	1	2	1	2
Ohio	225	177	79	14	6	13	6
Oklahoma	150	51	34	13	9	13	9
Oregon	60	57	95	9	15	9	15
Pennsylvania	228	200	88	37	16	34	15

**TABLE 2A-4. (continued)**

State	Number of hospitals (all)	DSH hospitals		Deemed DSH hospitals		Deemed DSH hospitals that provide at least one essential community service	
		Number	Percent	Number	Percent	Number	Percent
Rhode Island	15	13	87%	2	13%	1	7%
South Carolina	84	62	74	11	13	10	12
South Dakota	62	24	39	18	29	18	29
Tennessee	143	67	47	19	13	16	11
Texas	573	178	31	83	14	81	14
Utah	57	38	67	2	4	2	4
Vermont	16	13	81	1	6	1	6
Virginia	111	28	25	8	7	6	5
Washington	100	50	50	10	10	10	10
West Virginia	63	52	83	13	21	11	17
Wisconsin	144	13	9	5	3	4	3
Wyoming	30	17	57	4	13	3	10

**Notes:** DSH is disproportionate share hospital. Excludes DSH hospitals that did not submit a Medicare cost report (n = 12). Deemed DSH hospitals are statutorily required to receive DSH payments because they serve a high share of Medicaid and low-income patients. Deemed DSH status was estimated based on available Medicaid and low-income utilization data. Our working definition of essential community services includes the following services: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, substance use disorder services, and trauma services. For further discussion of the methodology and limitations, see Appendix 2B.

**Source:** Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of 2012 DSH audits, 2012 and 2014 Medicare cost reports, and the American Hospital Association annual survey.

**TABLE 2A-5. Share of Hospital Beds and Medicaid Days Provided by Deemed DSH Hospitals by State, 2012**

State	Number of hospital beds						Number of Medicaid days (thousands)					
	All hospitals		DSH hospitals		Deemed DSH hospitals		All hospitals		DSH hospitals		Deemed DSH hospitals	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
<b>Total</b>	<b>663,575</b>		<b>377,901</b>	<b>57%</b>	<b>126,977</b>	<b>19%</b>	<b>21,656</b>		<b>13,535</b>	<b>62%</b>	<b>6,971</b>	<b>32%</b>
Alabama	11,607		10,163	88	941	8	645		628	97	121	19
Alaska	1,264		503	40	278	22	85		32	38	24	29
Arizona	12,967		5,890	45	5,890	45	719		495	69	495	69
Arkansas	7,837		840	11	354	5	223		32	14	26	12
California	60,940		7,115	12	6,058	10	2,433		529	22	442	18
Colorado	8,428		6,721	80	1,952	23	451		414	92	187	41
Connecticut	7,339		6,754	92	1,185	16	454		383	84	90	20
Delaware	2,057		269	13	269	13	123		1	1	1	1
District of Columbia	2,528		1,732	69	1,071	42	139		96	69	57	41
Florida	46,134		18,239	40	11,464	25	1,481		905	61	702	47
Georgia	18,264		15,480	85	3,854	21	568		552	97	231	41
Hawaii	2,126		2,056	97	292	14	75		75	100	19	26
Idaho	2,715		1,709	63	790	29	101		71	70	41	41
Illinois	26,465		9,784	37	7,247	27	1,346		659	49	461	34
Indiana	14,902		5,167	35	2,505	17	372		160	43	109	29
Iowa	6,896		1,120	16	562	8	288		95	33	60	21
Kansas	7,423		3,791	51	1,923	26	74		61	82	51	69
Kentucky	12,348		11,790	95	4,163	34	90		88	98	32	35
Louisiana	14,983		6,949	46	3,017	20	355		182	51	96	27
Maine	2,771		51	2	0	0	124		1	1	0	0
Maryland	10,930		2,299	21	1,504	14	338		72	21	45	13
Massachusetts	17,173		0	0	0	0	1,024		0	0	0	0
Michigan	20,719		17,127	83	2,884	14	373		319	86	87	23
Minnesota	9,549		5,591	59	2,086	22	335		261	78	162	48
Mississippi	9,948		5,570	56	1,875	19	435		275	63	152	35
Missouri	15,495		11,374	73	2,346	15	600		409	68	145	24
Montana	2,516		2,104	84	170	7	69		69	99	8	12
Nebraska	4,848		3,202	66	1,894	39	125		116	93	83	66

**TABLE 2A-5. (continued)**

State	Number of hospital beds						Number of Medicaid days (thousands)					
	All hospitals			Deemed DSH hospitals			All hospitals			Deemed DSH hospitals		
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Nevada	5,131	57%	2,946	19%	984	19%	251	84%	210	96	38%	
New Hampshire	2,303	34	793	15	352	15	32	31	10	6	18	
New Jersey	19,178	90	17,201	29	5,503	29	382	89	341	142	37	
New Mexico	3,848	54	2,069	27	1,023	27	72	60	43	25	35	
New York	38,276	95	36,511	15	5,880	15	1,208	89	1,080	363	30	
North Carolina	18,559	64	11,907	27	5,046	27	942	74	701	342	36	
North Dakota	2,295	21	477	1	25	1	81	32	26	0	0	
Ohio	26,734	90	24,166	17	4,478	17	578	93	535	192	33	
Oklahoma	9,976	54	5,389	17	1,702	17	464	64	299	107	23	
Oregon	5,330	95	5,066	25	1,337	25	270	100	270	99	36	
Pennsylvania	32,001	95	30,360	17	5,548	17	522	98	514	206	39	
Rhode Island	2,626	79	2,081	24	642	24	64	70	44	27	42	
South Carolina	10,420	88	9,203	22	2,276	22	180	97	175	72	40	
South Dakota	2,562	67	1,727	38	986	38	78	93	73	48	62	
Tennessee	15,878	73	11,652	23	3,709	23	432	86	372	244	57	
Texas	58,493	49	28,643	24	14,086	24	1,270	75	947	703	55	
Utah	4,543	76	3,448	4	185	4	132	94	124	13	10	
Vermont	940	84	791	36	343	36	39	96	37	20	51	
Virginia	14,758	45	6,582	12	1,822	12	382	65	247	127	33	
Washington	10,247	56	5,749	15	1,499	15	333	63	209	48	14	
West Virginia	5,735	93	5,319	37	2,121	37	208	99	206	111	54	
Wisconsin	11,275	14	1,539	6	657	6	268	27	72	43	16	
Wyoming	1,295	69	892	15	199	15	26	73	19	4	16	

**Notes:** DSH is disproportionate share hospital. Excludes DSH hospitals that did not submit a Medicare cost report (n = 12). Deemed DSH status was estimated based on available Medicaid and low-income utilization data. For further discussion of the methodology and limitations, see Appendix 2B.

**Source:** Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of 2012 DSH audits and 2012 Medicare cost reports.

**TABLE 2A-6. FY 2018 Reduced and Unreduced DSH Allotment per Uninsured Individual by State, 2013–2015**

State	FY 2018 federal DSH allotment (millions)		FY 2018 federal DSH allotment per uninsured individual					
	Unreduced	Reduced	Unreduced			Reduced		
			2013	2014	2015	2013	2014	2015
<b>Total</b>	<b>\$12,141.9</b>	<b>\$10,141.9</b>	<b>\$ 268.7</b>	<b>\$ 331.1</b>	<b>\$ 408.0</b>	<b>\$ 224.5</b>	<b>\$ 276.6</b>	<b>\$ 340.8</b>
Alabama	341.1	275.9	528.8	588.9	704.3	427.7	476.3	569.7
Alaska	22.6	20.5	171.2	184.5	213.2	155.0	167.1	193.1
Arizona	112.3	97.6	100.4	124.3	154.3	87.3	108.0	134.0
Arkansas	47.8	47.2	102.9	139.4	172.4	101.6	137.7	170.2
California	1,215.9	1,044.5	187.1	255.1	366.5	160.7	219.1	314.9
Colorado	102.6	84.8	140.7	189.1	237.1	116.3	156.3	196.0
Connecticut	221.8	147.4	666.1	903.9	1,053.7	442.7	600.7	700.3
Delaware	10.0	9.2	121.0	140.2	184.2	111.3	129.0	169.5
District of Columbia	67.9	57.4	1,617.5	1,987.1	2,719.5	1,366.8	1,679.1	2,298.0
Florida	221.8	193.1	57.6	68.4	83.3	50.1	59.5	72.6
Georgia	298.1	269.2	161.5	190.1	214.7	145.8	171.6	193.9
Hawaii	10.8	9.8	118.8	149.9	198.2	107.2	135.2	178.8
Idaho	18.2	17.8	70.9	83.4	101.1	69.1	81.2	98.5
Illinois	238.5	202.6	147.4	192.6	264.9	125.2	163.7	225.0
Indiana	237.1	218.3	262.5	305.6	377.7	241.8	281.4	347.8
Iowa	43.7	41.0	176.1	231.2	281.9	165.1	216.8	264.3
Kansas	45.8	37.3	131.5	157.0	175.6	107.2	128.0	143.2
Kentucky	160.8	134.3	261.1	439.3	615.1	218.1	366.9	513.7
Louisiana	732.0	651.1	974.6	1,089.6	1,341.5	867.0	969.2	1,193.3
Maine	116.5	107.7	792.2	872.1	1,053.8	732.6	806.5	974.5
Maryland	84.6	65.4	142.6	182.6	217.3	110.3	141.2	168.0
Massachusetts	338.3	260.8	1,369.6	1,546.6	1,787.3	1,055.9	1,192.5	1,378.0
Michigan	293.9	232.9	274.2	351.3	492.6	217.2	278.3	390.3
Minnesota	82.8	79.1	188.3	261.1	338.0	179.8	249.4	322.8
Mississippi	169.1	139.8	338.3	398.8	455.2	279.6	329.6	376.2
Missouri	525.4	427.6	679.8	757.3	901.1	553.2	616.3	733.3
Montana	12.6	11.3	76.3	87.8	106.2	68.4	78.7	95.2



**TABLE 2A-6. (continued)**

State	FY 2018 federal DSH allotment (millions)		FY 2018 federal DSH allotment per uninsured individual					
	Unreduced		Unreduced			Reduced		
	Unreduced	Reduced	2013	2014	2015	2013	2014	2015
Nebraska	\$ 31.4	\$ 30.4	\$ 150.2	\$ 175.1	\$ 204.1	\$ 145.5	\$ 169.6	\$ 197.7
Nevada	51.3	49.1	90.0	120.2	146.3	86.1	115.1	140.0
New Hampshire	177.6	160.7	1,268.3	1,474.1	2,129.4	1,147.6	1,333.7	1,926.6
New Jersey	714.0	553.5	615.5	739.6	925.8	477.1	573.3	717.7
New Mexico	22.6	21.8	59.1	75.9	100.8	57.0	73.1	97.1
New York	1,781.5	1,531.1	860.6	1,050.1	1,290.5	739.7	902.5	1,109.1
North Carolina	327.2	266.1	216.8	256.4	296.7	176.3	208.5	241.3
North Dakota	10.6	10.3	145.1	186.2	184.4	141.3	181.3	179.6
Ohio	450.6	348.4	358.2	471.7	603.8	277.0	364.8	466.9
Oklahoma	40.2	37.2	60.3	68.8	75.4	55.8	63.7	69.8
Oregon	50.2	46.0	87.9	131.2	179.1	80.6	120.2	164.1
Pennsylvania	622.5	446.5	509.4	584.7	776.2	365.4	419.4	556.8
Rhode Island	72.1	62.0	600.8	934.8	1,213.5	516.3	803.4	1,042.9
South Carolina	363.2	315.2	491.5	566.2	694.2	426.5	491.2	602.3
South Dakota	12.2	12.0	131.7	149.5	142.6	129.5	147.0	140.2
Tennessee	53.1	37.1	59.9	68.4	79.6	41.9	47.8	55.6
Texas	1,060.6	908.4	184.5	210.1	229.8	158.0	180.0	196.8
Utah	21.8	19.5	54.1	59.5	69.9	48.5	53.3	62.6
Vermont	25.0	18.8	554.6	812.5	1,054.0	417.2	611.2	793.0
Virginia	97.2	74.0	98.1	110.0	130.2	74.7	83.8	99.2
Washington	205.2	146.0	213.7	319.3	438.5	152.1	227.2	312.0
West Virginia	74.9	61.4	293.6	479.6	692.7	240.9	393.6	568.4
Wisconsin	104.8	102.8	202.4	251.0	325.0	198.4	246.1	318.6
Wyoming	0.3	0.2	3.3	3.7	3.8	3.0	3.3	3.4

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. Projected allotment reductions for FY 2018 assume that federal DSH allotments are reduced by \$2 billion in FY 2018 as specified under current law and are calculated based on the DSH Health Reform Methodology that the Centers for Medicare & Medicaid Services initially developed to apply reductions to FY 2014 DSH allotments. Excludes DSH hospitals that did not submit a Medicare cost report (n = 12).

**Sources:** Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of 2012 DSH audits, 2012 and 2014 Medicare cost reports, and the American Hospital Association annual survey. Barnett, J.C., and M.S. Vornovitsky, 2016, *Health insurance coverage in the United States: 2015*, Current Population Reports, P60-257(RV), Washington, DC: U.S. Census Bureau, <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>.

**TABLE 2A-7. FY 2018 Reduced and Unreduced DSH Allotment as a Percentage of Hospital Uncompensated Care by State, 2014–2015**

State	FY 2018 federal DSH allotment (millions)		FY 2018 federal DSH allotment as a percentage of hospital uncompensated care in the state			
	Unreduced	Reduced	Unreduced		Reduced	
			2013	2014	2013	2014
<b>Total</b>	<b>\$12,141.9</b>	<b>\$10,141.9</b>	<b>33%</b>	<b>39%</b>	<b>28%</b>	<b>33%</b>
Alabama	341.1	275.9	59	60	48	49
Alaska	22.6	20.5	22	24	20	22
Arizona	112.3	97.6	15	21	13	18
Arkansas	47.8	47.2	14	21	14	21
California	1,215.9	1,044.5	32	71	28	61
Colorado	102.6	84.8	25	36	21	29
Connecticut	221.8	147.4	141	99	93	66
Delaware	10.0	9.2	13	12	12	11
District of Columbia	67.9	57.4	102	100	86	85
Florida	221.8	193.1	8	8	7	7
Georgia	298.1	269.2	21	21	19	19
Hawaii	10.8	9.8	28	24	25	21
Idaho	18.2	17.8	13	15	12	14
Illinois	238.5	202.6	14	21	12	18
Indiana	237.1	218.3	23	25	21	23
Iowa	43.7	41.0	14	23	14	22
Kansas	45.8	37.3	19	18	15	15
Kentucky	160.8	134.3	29	67	24	56
Louisiana	732.0	651.1	99	102	88	91
Maine	116.5	107.7	62	68	57	63
Maryland	84.6	65.4	11	16	9	12
Massachusetts	338.3	260.8	56	67	43	52
Michigan	293.9	232.9	31	44	24	35
Minnesota	82.8	79.1	30	34	28	32
Mississippi	169.1	139.8	36	43	30	35
Missouri	525.4	427.6	59	60	48	49
Montana	12.6	11.3	8	8	7	7

**TABLE 2A-7. (continued)**

State	FY 2018 federal DSH allotment (millions)		FY 2018 federal DSH allotment as a percentage of hospital uncompensated care in the state			
	Unreduced	Reduced	Unreduced		Reduced	
			2013	2014	2013	2014
Nebraska	\$ 31.4	\$ 30.4	15%	16%	14%	15%
Nevada	51.3	49.1	29	30	28	29
New Hampshire	177.6	160.7	95	119	86	107
New Jersey	714.0	553.5	63	78	49	61
New Mexico	22.6	21.8	8	13	7	13
New York	1,781.5	1,531.1	85	95	73	82
North Carolina	327.2	266.1	23	23	19	18
North Dakota	10.6	10.3	10	12	10	12
Ohio	450.6	348.4	32	49	25	38
Oklahoma	40.2	37.2	8	9	8	8
Oregon	50.2	46.0	12	21	11	19
Pennsylvania	622.5	446.5	79	88	56	63
Rhode Island	72.1	62.0	44	66	37	56
South Carolina	363.2	315.2	49	50	43	44
South Dakota	12.2	12.0	12	13	12	12
Tennessee	53.1	37.1	11	10	8	7
Texas	1,060.6	908.4	26	21	22	18
Utah	21.8	19.5	7	8	7	7
Vermont	25.0	18.8	52	60	39	45
Virginia	97.2	74.0	11	11	8	9
Washington	205.2	146.0	35	67	25	48
West Virginia	74.9	61.4	25	44	21	36
Wisconsin	104.8	102.8	21	33	21	33
Wyoming	0.3	0.2	0	0	0	0

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. Projected allotment reductions for FY 2018 assume that federal DSH allotments are reduced by \$2 billion in FY 2018 as specified under current law and are calculated based on the DSH Health Reform Methodology that the Centers for Medicare & Medicaid Services initially developed to apply reductions to FY 2014 DSH allotments. Excludes DSH hospitals that did not submit a Medicare cost report (n = 12).

0 indicates a non-zero amount less than 0.5 percent.

**Source:** Dobson DeVanzo & Associates and KNG Health, 2017, analysis for MACPAC of 2012 DSH audits, Medicare cost reports, and the American Hospital Association annual survey.

**TABLE 2A-8. FY 2018 Reduced and Unreduced DSH Allotment per Deemed DSH Hospital Providing at Least One Essential Community Service by State, 2012**

State	FY 2018 federal DSH allotment (millions)		FY 2018 federal DSH allotment per deemed DSH hospital (millions)		FY 2018 federal DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Unreduced	Reduced	Unreduced	Reduced	Unreduced	Reduced
<b>Total</b>	<b>\$12,141.9</b>	<b>\$10,141.9</b>	<b>\$16.3</b>	<b>\$13.6</b>	<b>\$18.1</b>	<b>\$15.2</b>
Alabama	341.1	275.9	48.7	39.4	48.7	39.4
Alaska	22.6	20.5	22.6	20.5	22.6	20.5
Arizona	112.3	97.6	3.0	2.6	3.4	3.0
Arkansas	47.8	47.2	47.8	47.2	47.8	47.2
California	1,215.9	1,044.5	28.3	24.3	32.9	28.2
Colorado	102.6	84.8	7.3	6.1	7.3	6.1
Connecticut	221.8	147.4	44.4	29.5	55.5	36.9
Delaware	10.0	9.2	5.0	4.6	5.0	4.6
District of Columbia	67.9	57.4	11.3	9.6	11.3	9.6
Florida	221.8	193.1	5.7	5.0	6.5	5.7
Georgia	298.1	269.2	11.0	10.0	18.6	16.8
Hawaii	10.8	9.8	3.6	3.3	3.6	3.3
Idaho	18.2	17.8	3.0	3.0	4.6	4.4
Illinois	238.5	202.6	5.5	4.7	6.6	5.6
Indiana	237.1	218.3	21.6	19.8	23.7	21.8
Iowa	43.7	41.0	14.6	13.7	14.6	13.7
Kansas	45.8	37.3	3.8	3.1	4.6	3.7
Kentucky	160.8	134.3	5.7	4.8	6.7	5.6
Louisiana	732.0	651.1	21.5	19.1	28.2	25.0
Maine	116.5	107.7	N/A	N/A	N/A	N/A
Maryland	84.6	65.4	12.1	9.3	12.1	9.3
Massachusetts	338.3	260.8	N/A	N/A	N/A	N/A
Michigan	293.9	232.9	24.5	19.4	26.7	21.2
Minnesota	82.8	79.1	5.2	4.9	5.2	4.9
Mississippi	169.1	139.8	12.1	10.0	13.0	10.8
Missouri	525.4	427.6	22.8	18.6	23.9	19.4
Montana	12.6	11.3	2.5	2.3	2.5	2.3
Nebraska	31.4	30.4	2.2	2.2	2.6	2.5

**TABLE 2A-8. (continued)**

State	FY 2018 federal DSH allotment (millions)		FY 2018 federal DSH allotment per deemed DSH hospital (millions)		FY 2018 federal DSH allotment per deemed DSH hospital providing at least one essential community service (millions)	
	Unreduced	Reduced	Unreduced	Reduced	Unreduced	Reduced
Nevada	\$ 51.3	\$ 49.1	\$12.8	\$12.3	\$17.1	\$16.4
New Hampshire	177.6	160.7	88.8	80.3	88.8	80.3
New Jersey	714.0	553.5	29.7	23.1	31.0	24.1
New Mexico	22.6	21.8	1.7	1.7	1.9	1.8
New York	1,781.5	1,531.1	81.0	69.6	84.8	72.9
North Carolina	327.2	266.1	18.2	14.8	18.2	14.8
North Dakota	10.6	10.3	10.6	10.3	10.6	10.3
Ohio	450.6	348.4	32.2	24.9	34.7	26.8
Oklahoma	40.2	37.2	3.1	2.9	3.1	2.9
Oregon	50.2	46.0	5.6	5.1	5.6	5.1
Pennsylvania	622.5	446.5	16.8	12.1	18.3	13.1
Rhode Island	72.1	62.0	36.0	31.0	72.1	62.0
South Carolina	363.2	315.2	33.0	28.7	36.3	31.5
South Dakota	12.2	12.0	0.7	0.7	0.7	0.7
Tennessee	53.1	37.1	2.8	2.0	3.3	2.3
Texas	1,060.6	908.4	12.8	10.9	13.1	11.2
Utah	21.8	19.5	10.9	9.7	10.9	9.7
Vermont	25.0	18.8	25.0	18.8	25.0	18.8
Virginia	97.2	74.0	12.1	9.3	16.2	12.3
Washington	205.2	146.0	20.5	14.6	20.5	14.6
West Virginia	74.9	61.4	5.8	4.7	6.8	5.6
Wisconsin	104.8	102.8	21.0	20.6	26.2	25.7
Wyoming	0.3	0.2	0.1	0.1	0.1	0.1

**Notes:** FY is fiscal year. DSH is disproportionate share hospital. N/A is not applicable. Projected allotment reductions for FY 2018 assume that federal DSH allotments are reduced by \$2 billion in FY 2018 as specified under current law and are calculated based on the DSH Health Reform Methodology that the Centers for Medicare & Medicaid Services initially developed to apply reductions to FY 2014 DSH allotments. Excludes DSH hospitals that did not submit a Medicare cost report (n = 12). Deemed DSH status was estimated based on available Medicaid and low-income utilization data. Our working definition of essential community services includes the following services: burn services, dental services, graduate medical education, HIV/AIDS care, inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital), neonatal intensive care units, obstetrics and gynecology services, substance use disorder services, and trauma services. For further discussion of the methodology and limitations, see Appendix 2B.

**Source:** Dobson DaVanzo & Associates and KNG Health, 2017, analysis for MACPAC of 2012 DSH audits, 2012 and 2014 Medicare cost reports, and the American Hospital Association annual survey.

## APPENDIX 2B: Methodology and Data Limitations

MACPAC used data from several different sources to analyze and describe Medicaid disproportionate share hospital (DSH) payments and their relationship to factors such as uninsured rates, uncompensated care, and DSH hospitals with high levels of uncompensated care that provide access to essential services. We also modeled DSH allotment reductions and simulated DSH payments under a variety of scenarios. Below we describe the data sources used in this analysis and the limitations associated with each one, and we review the modeling assumptions we made for our projections of DSH allotments and payments.

### Primary Data Sources

#### DSH audit data

We used 2012 DSH audit reports, the most recent data available, to examine historic DSH spending and the distribution of DSH spending among a variety of hospital types. These data were provided by the Centers for Medicare & Medicaid Services (CMS) on an as-filed basis and may be subject to change as CMS completes its internal review of state DSH audit reports.

Overall, 2,682 hospitals receiving DSH payments are represented in our analyses of DSH audit data. We did not include DSH audit data provided by states for hospitals that did not receive DSH payments (30 hospitals were excluded under this criterion). Some hospitals received DSH payments from multiple states; we combined the data for duplicate hospitals so that each hospital would only appear once in the dataset.

#### Medicare cost reports

We used Medicare cost report data to examine uncompensated care for all hospitals in each state. A hospital that receives Medicare payments must file an annual Medicare cost report, which includes a range of financial and non-financial data about hospital performance and services provided. We excluded hospitals in U.S. territories, religious non-medical health care institutions, and hospitals participating in special Medicare demonstration projects (87 hospitals were excluded under these criteria). These facilities submit Medicare cost reports but do not receive Medicare DSH payments.

We linked DSH audit data and Medicare cost report data to create descriptive analyses of DSH hospitals and to identify deemed DSH hospitals. Hospitals were matched based on their CMS certification number (CCN). A total of 2,670 DSH hospitals were included in these analyses. We excluded 12 DSH hospitals without matching Medicare cost reports.

When using Medicare cost reports to analyze hospital operating margins, we excluded hospitals with operating margins that were more than 1.5 times the interquartile range above the highest quartile or below the lowest quartile (677 hospitals were excluded under this criterion). Operating margins are calculated by subtracting operating expenses (OE) from net patient revenue (NPR) and dividing the result by net patient revenue:  $(NPR - OE) / NPR$ . Total margins, in contrast, include additional types of hospital revenue, such as state or local subsidies and revenue from other facets of hospital operations (e.g., parking lot receipts).

## Working Definition of Essential Community Services

The statute requires that MACPAC's analysis include data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education and the continuum of primary through quaternary care, including the provision of trauma care and public health services.

In this report, we use the same working definition to identify such hospitals that was used in MACPAC's February 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*. This working definition is based on a two part test:

- Is the hospital a deemed DSH hospital?
- Does the hospital provide at least one essential service?

### Deemed DSH hospital status

According to the Social Security Act (the Act), hospitals must meet one of two criteria to qualify as a deemed DSH hospital: (1) a Medicaid inpatient utilization rate greater than one standard deviation above the mean for hospitals in the state or (2) a low-income utilization rate greater than 25 percent (§ 1923(b)(1) of the Act). Because deemed DSH hospitals are statutorily required to receive DSH payments, we excluded from our analysis hospitals that did not receive DSH payments in 2012.

Calculation of the Medicaid inpatient utilization rate threshold for each state requires data from all hospitals in that state, and we relied on Medicare cost reports to make those calculations and to determine which hospitals exceeded this threshold. A major limitation of this approach is that Medicaid inpatient utilization reported on

Medicare cost reports does not include services provided to Medicaid enrollees that were not paid for by Medicaid (e.g., Medicare-funded services for individuals who are dually eligible for Medicare and Medicaid). However, the Medicaid DSH definition of Medicaid inpatient utilization includes services provided to anyone who is eligible for Medicaid, even if Medicaid is not the primary payer. Thus, our identification of deemed DSH hospitals may omit some hospitals with high utilization by dually eligible beneficiaries and overstate the extent to which hospitals with low utilization by dually eligible beneficiaries (e.g., children's hospitals) exceed the threshold.

The low-income utilization rate threshold for deemed DSH hospitals is the same for all states (25 percent), so we were able to use Medicaid DSH audit data to determine whether hospitals met this criterion. However, about one-quarter of DSH hospitals did not provide data on the rate of low-income utilization on their DSH audits, and these omissions limited our ability to identify all deemed DSH hospitals.

### Provision of essential services

Because the term essential community services is not otherwise defined in statute or regulation, we identified a number of services that could be considered essential community services using available data from 2014 Medicare cost reports and the 2014 American Hospital Association (AHA) annual survey (Table 2B-1). Services were selected for inclusion if they were directly mentioned in the statute requiring this report or if they were related services mentioned in the cost reports or the AHA annual survey.

**TABLE 2B-1. Essential Community Services by Data Source**

Service type	Data source
Burn services	Medicare cost reports
Dental services	American Hospital Association annual survey
Graduate medical education	Medicare cost reports
HIV/AIDS care	American Hospital Association annual survey
Inpatient psychiatric services (through psychiatric subunit or stand-alone psychiatric hospital)	Medicare cost reports
Neonatal intensive care units	American Hospital Association annual survey
Obstetrics and gynecology services	American Hospital Association annual survey
Substance use disorder services	American Hospital Association annual survey
Trauma services	American Hospital Association annual survey

For this report, for the sake of inclusiveness, any deemed DSH hospital providing at least one essential community service was included in our analysis. We also included certain hospital types if they were the only hospital in their geographic area to provide certain types of services. These hospital types included critical access hospitals because they are often the only hospital within a 25-mile radius. In addition, we included children's hospitals that were the only hospital within a 15-mile radius (measured by driving distance).

## Projections of DSH Allotments and DSH Spending

### Unreduced DSH allotments

Preliminary DSH allotments for fiscal year (FY) 2016 were provided by CMS, and unreduced DSH allotments for subsequent years were estimated based on projections of the Consumer Price Index for All Urban Consumers (CPI-U) in the Congressional Budget Office's August economic baseline (CBO 2016). Unreduced allotments increase each year based on the CPI-U for all states except Tennessee, whose DSH allotment is specified in statute (§ 1923(f)(6)(A)(vi) of the Act).

### DSH allotment reductions

MACPAC contracted with Dobson DaVanzo & Associates and KNG Health to develop a model for estimating DSH allotment reductions. The model uses the DSH Health Reform Methodology that CMS initially developed to apply reductions to FY 2014 DSH allotments (CMS 2013). Although CMS may apply a different reduction methodology for future year DSH reductions, the methodology developed for this report reflects the current statutory requirements and is therefore a reasonable starting point for estimating FY 2018 DSH allotment reductions.

We used a variety of data sources to estimate the factors used in CMS's methodology (Table 2B-2). Our current estimates of DSH allotment reductions do not fully represent the effects of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) because 2014 data are not available for every factor. Specifically, we used 2012 data for the uncompensated care factor because hospital-specific Medicaid shortfall data are not yet available for 2014.



**TABLE 2B-2. Data Sources for Factors Used in the DSH Allotment Reduction Model**

DSH allotment reduction factor	Data source (year)
Low DSH	Specified in statute (N/A)
Uninsured percentage	American Community Survey (2014)
High volume of Medicaid inpatients	Medicare cost reports (2014)
High level of uncompensated care	DSH audits (2012)
Budget neutrality	Financial Management Group, CMS (2014)

**Notes:** DSH is disproportionate share hospital. N/A is not applicable. CMS is the Centers for Medicare & Medicaid Services.

## References

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2013. Medicaid program: State disproportionate share hospital allotment reductions. Final rule. *Federal Register* 78, no. 181 (September 18): 57293–57313. <https://federalregister.gov/a/2013-22686>.

Congressional Budget Office (CBO). 2016. *An update to the budget and economic outlook: 2016 to 2026*. August 23. Washington, DC: CBO. <https://www.cbo.gov/publication/51908>.

Chapter 3:

# Improving the Targeting of Disproportionate Share Hospital Payments to Providers

# Improving the Targeting of Disproportionate Share Hospital Payments to Providers

## Key Points

- Although under current law, states can make disproportionate share hospital (DSH) payments to virtually any hospital in their state, it is the Commission's view that Medicaid DSH payments should be targeted to hospitals that serve a high share of Medicaid-enrolled and low-income patients and have higher levels of uncompensated care, consistent with the original statutory intent.
- We analyzed the hospital and state effects of raising the minimum federal eligibility criteria for DSH payments from a 1 percent Medicaid utilization rate to the following higher standards:
  - an absolute standard that would apply equally across states;
  - a relative standard that would vary by state based on the average Medicaid or low-income utilization rate for hospitals in the state; and
  - the deemed DSH standard, which identifies hospitals that are statutorily required to receive DSH payments.
- Our analysis of 2012 DSH audits and 2014 Medicare cost reports found the following:
  - Most DSH payments went to deemed DSH hospitals, which have the most restrictive eligibility threshold that we analyzed.
  - More than half of states made DSH payments to hospitals with a Medicaid utilization rate of less than 5 percent, which is the most inclusive eligibility threshold we analyzed.
  - Many of the DSH hospitals with low Medicaid utilization rates were critical access hospitals, which are small, rural hospitals that receive a special payment designation from Medicare because they are often the sole provider in their community.
- Because DSH hospitals vary so much in terms of patient mix, mission, and market characteristics, it is difficult to identify a single, utilization-based standard applicable to all hospitals that represents a clear improvement over current law.
- Besides changing which hospitals are eligible for DSH payments, another approach to improving the targeting of DSH payments is to change the way DSH funding is distributed among eligible hospitals.
  - Some policymakers have proposed revising the DSH definition of uncompensated care, which would change the maximum amount of funding DSH hospitals could receive.
  - California recently received approval to test distributing DSH funding as a global payment, which provides incentives to hospitals for providing care to uninsured individuals in the most appropriate and cost-effective settings.

## CHAPTER 3: Improving the Targeting of Disproportionate Share Hospital Payments to Providers

Although the total amount of federal funds available for disproportionate share hospital (DSH) payments is limited by federal allotments, states are permitted under current law to make DSH payments to virtually any hospital in their state. This flexibility allows states to target DSH payments based on local circumstances but it leads to a wide variation in the share of hospitals that receive DSH payments in each state. This flexibility also reduces the share of DSH funding that goes to the hospitals that serve the highest share of Medicaid and low-income patients.

In MACPAC's 2016 *Report to Congress on Medicaid Disproportionate Share Hospital Payments*, the Commission concluded that DSH payments should be better targeted to hospitals that serve a high share of Medicaid-enrolled and low-income patients and that have higher levels of uncompensated care, consistent with the original statutory intent of the law establishing DSH payments (MACPAC 2016). Over the past year, MACPAC has reviewed a range of policy approaches to improve the targeting of DSH payments to providers.

In this chapter, we review current DSH targeting rules and present our findings from the analyses we performed to estimate the effects of raising the minimum federal eligibility criteria for DSH payments from a 1 percent Medicaid utilization rate to a higher standard. We examined seven different utilization-based thresholds, including absolute standards that would apply equally across states and relative standards that would vary by state based on the average Medicaid or low-income utilization rate for hospitals in the state. However,

because DSH hospitals vary so much in terms of patient mix, mission, and market characteristics, it is difficult to identify a single utilization-based standard applicable to all hospitals that represents a clear improvement over current law.

The chapter concludes with a discussion of other approaches that might be used to better target funding, such as changing the types of uncompensated care that DSH funding can pay for. However, because of a lack of hospital-specific data on Medicaid payments, analyses of these approaches are preliminary and it is not possible to model the full implications of these policies at this time. The Commission has previously called for more complete and reliable data on Medicaid payments to hospitals in order to help inform approaches to better target DSH funding and to improve the transparency and accountability of Medicaid payments more generally (MACPAC 2016).

As discussed in Chapter 2, DSH allotments are scheduled to be reduced by \$2 billion (16 percent) in fiscal year (FY) 2018, and Congress is currently debating changes to the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) that could affect hospitals' levels of uncompensated care and need for DSH payments. Such uncertainty makes it difficult to make recommendations about DSH policy at this time. The Commission will be monitoring the debate and will publish additional analyses as warranted. Certainly, if less DSH funding is available in the future, it will be particularly important to target remaining DSH funds to the states and hospitals that need them most.

### Current Targeting of DSH Payments

The Social Security Act (the Act) requires Medicaid hospital payments to take into account "the situation of hospitals which serve a disproportionate number of low-income patients with special needs" (§ 1902(a)(13)(A)(iv) of the Act). The statute does not, however, explicitly

define which hospitals meet this standard. States are permitted to make DSH payments to any hospital that has a Medicaid inpatient utilization rate of 1 percent, which includes virtually all U.S. hospitals.<sup>1</sup> However, they are required to make DSH payments to deemed DSH hospitals, which must meet one of two criteria:

- the hospital has a Medicaid inpatient utilization rate of at least one standard deviation above the average for hospitals in the state that receive Medicaid payments; or
- the hospital has a low-income utilization rate in excess of 25 percent.

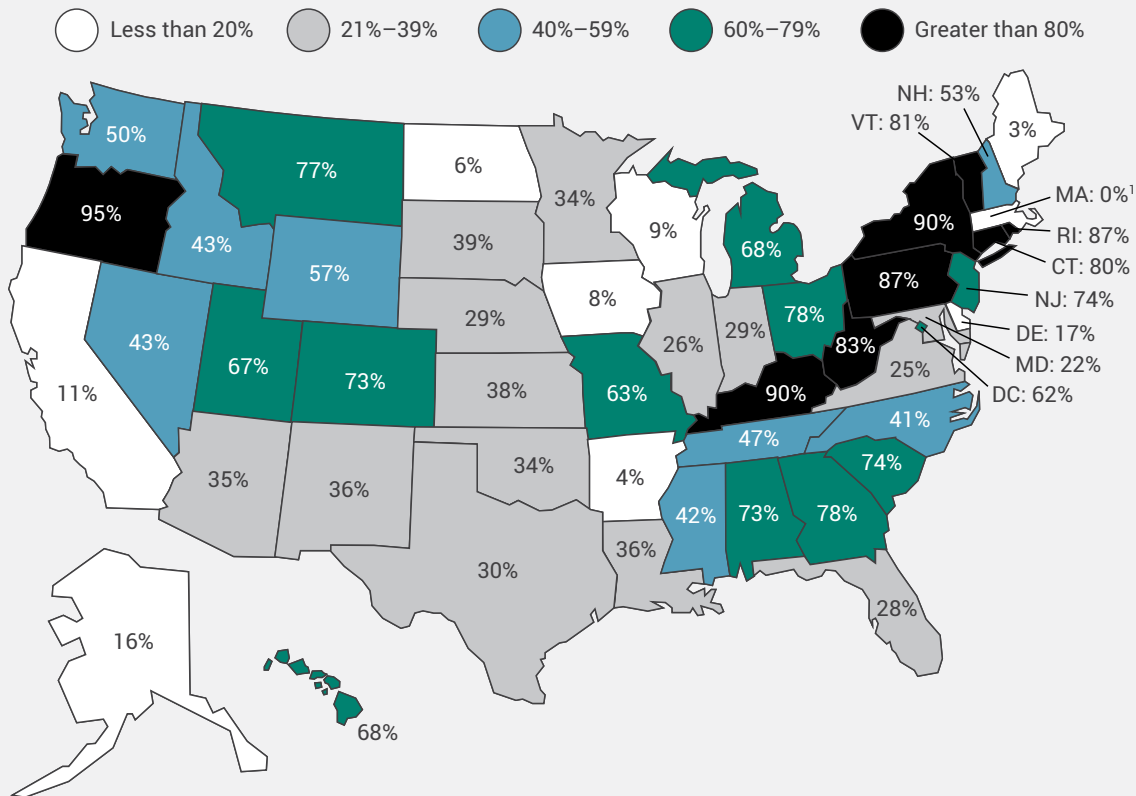
In 2012, about 12 percent of U.S. hospitals met the deemed DSH standards and these hospitals

received \$10.6 billion in DSH payments (65 percent of all DSH payments). However, about half of all U.S. hospitals received DSH payments in 2012, and about one-third of DSH payments were made to hospitals that did not meet the deemed DSH standard.

### Share of hospitals receiving DSH payments

The share of hospitals in each state receiving DSH payments varies widely from state to state (Figure 3-1). For example, in 2012, nine states provided DSH payments to fewer than 20 percent of hospitals in their state while eight states provided DSH payments to more than 80 percent of hospitals in their state.

**FIGURE 3-1. Share of Hospitals Receiving DSH Payments by State, SPRY 2012**



**Notes:** DSH is disproportionate share hospital. SPRY is state plan rate year.

<sup>1</sup> Massachusetts does not make DSH payments because its Section 1115 demonstration allows the state to use DSH funding for the state's safety-net care pool instead.

**Source:** MACPAC, 2016, analysis of 2012 Medicare cost reports and 2012 as-filed Medicaid DSH audits.

In general, states with larger DSH allotments make DSH payments to a greater proportion of hospitals, but there are exceptions. In 2012, the 17 states with the smallest DSH allotments as a share of Medicaid benefit spending (referred to as low-DSH states) made DSH payments to an average of 42 percent of the hospitals in their respective states, but four of these—Hawaii, Montana, Oregon, and Utah—made DSH payments to over 60 percent of their hospitals.<sup>2</sup> Those states not classified as low-DSH states (33 states and the District of Columbia) made DSH payments to an average of 51 percent of the hospitals in their respective states, but California and Maine (both not classified as low-DSH states) made DSH payments to fewer than 20 percent of their hospitals.

The approaches that states use to finance the non-federal share of DSH payments may also affect the share of hospitals that receive DSH payments. In 2012, states that financed DSH payments with above average levels of health care related taxes distributed DSH payments to about twice as many hospitals (as a share of all hospitals in the state) as states that financed DSH payments with lower levels of health care related taxes. States

that financed DSH with above average levels of intergovernmental transfers or certified public expenditures distributed about twice as much DSH funding to public hospitals (as a share of all DSH spending in the state) as states that financed DSH payments with lower levels of local government funding.

### State DSH targeting policies

In addition to complying with minimum federal eligibility standards in making DSH payments, states use their own criteria. Such criteria can be used to determine not only which hospitals are eligible to receive DSH payments but also how much DSH funding eligible hospitals can receive. States' criteria for identifying eligible DSH hospitals vary, but are often related to hospital ownership, hospital type, and geographic factors (Table 3-1). Some states have also established Medicaid and low-income utilization thresholds that are higher than the federal minimum standard but lower than the deemed DSH hospital standard. Information on each state's DSH eligibility criteria can be found in Appendix 3A.

**TABLE 3-1. Number of States Targeting DSH Payments to Selected Hospital Types, 2016**

Hospital type	Number of states
State-owned or public hospitals	36
Psychiatric hospitals or institutions for mental diseases	30
Teaching hospitals	19
Rural or critical access hospitals	15
Children's hospitals	11

**Notes:** DSH is disproportionate share hospital. This analysis shows the number of states that explicitly make certain types of hospitals eligible for DSH payments in their Medicaid state plan. States can also target DSH funding to particular types of providers by establishing different payment methods for different categories of eligible DSH providers.

**Source:** MACPAC, 2017, analysis of Medicaid state plans.

States can also establish different payment methods for different categories of hospitals. For example, many states give priority to a subset of DSH hospitals when distributing DSH payments.

State DSH targeting policies are dynamic and subject to change based on a variety of state and local circumstances, such as the opening or closing of hospitals in certain areas of the state. According to MACPAC's analysis of Medicaid state plan information provided on Medicaid.gov,

34 states submitted 173 Medicaid state plan amendments between 2012 and 2016 to change their DSH policies. These amendments ranged from incremental changes to the amount of DSH funding for particular types of hospitals to changes to the types of hospitals eligible to receive DSH payments. Changes to state DSH payment policies can change DSH payments to particular hospitals even if states' federal DSH allotments are unchanged (Box 3-1).

### **BOX 3-1. Examples of Recent Changes in State Disproportionate Share Hospital Payment Policies**

To complement our quantitative analyses, MACPAC profiled seven disproportionate share hospitals (DSH) during the summer and fall of 2016:

- Parkland Hospital in Dallas, Texas;
- MetroHealth Hospital in Cleveland, Ohio;
- Santa Clara Valley Regional Medical Center in San Jose, California;
- Vidant Medical Center in Greenville, North Carolina;
- Henry Ford Hospital in Detroit, Michigan;
- Northeastern Vermont Regional Hospital in St. Johnsbury, Vermont; and
- Connecticut Children's Hospital in Hartford, Connecticut.

Hospital executives from three of the seven DSH hospitals that we profiled reported recent changes in their states' DSH policies that lowered their DSH payments:

- Parkland Hospital executives reported that Texas's 2014 changes to its DSH targeting policy to make more privately owned hospitals eligible for DSH payments resulted in a 14 percent drop in net DSH payments to Parkland, which is publicly owned.
- MetroHealth Hospital executives reported that Ohio's 2015 change in its methodology for determining the size of DSH payments resulted in a decline of payments for MetroHealth because the new formula de-emphasized hospital unpaid costs of care for uninsured individuals.
- Connecticut Children's Hospital executives reported that their DSH payments were specified as a line item in the state budget and fluctuated from year to year based on budget constraints—from a low of \$10 million in 2012 to a high of \$20 million in 2015, and most recently \$12.5 million in 2016.

More information about the hospitals we profiled can be found in Chapter 2, and the complete [hospital profiles](#) are available on MACPAC's website (MACPAC 2017).

## Effects of Raising the Minimum Federal DSH Eligibility Standard to a Higher Threshold

One approach to improve the targeting of DSH payments to providers is raising the minimum federal eligibility criteria for DSH payments from a 1 percent Medicaid utilization rate to a higher threshold. As noted above, virtually all hospitals meet the current standard.

To inform the discussion of whether to raise the minimum federal eligibility criteria for DSH payments, we analyzed the effects of implementing several different utilization-based thresholds, including both thresholds based on the Medicaid inpatient utilization rate and the low-income utilization rate (Box 3-2). DSH hospitals were identified using 2012 DSH audits and utilization

rates were measured using 2014 Medicare cost reports, the most recent data available.<sup>3</sup> To minimize the effects of missing data and to provide consistent comparisons between the various thresholds, we limited this analysis to short-term and critical access DSH hospitals with complete Medicaid and low-income utilization data for 2014.

We were not able to include institutions for mental diseases (IMDs) in this analysis due to incomplete utilization data, but they may merit special consideration in DSH targeting policy. As discussed above, more than half of states (30) explicitly target DSH payments to IMDs, and in 2012, 26 percent of DSH payments were made to psychiatric hospitals. Federal statute limits the amount of DSH payments that each state can make to IMDs.<sup>4</sup> In addition, IMDs cannot receive Medicaid payment for services provided to individuals age 21–64 (§ 1905(a)(B) of the Act), so the Medicaid utilization rates of IMDs may be lower than the utilization rates of other types of hospitals.

### BOX 3-2. Measures of Medicaid and Low-Income Utilization

The **Medicaid inpatient utilization rate** is the percentage of hospital inpatient days that are attributable to patients who are eligible for Medicaid.

- For Medicaid disproportionate share hospital (DSH) purposes, individuals who are dually eligible for Medicare and Medicaid are included even if their inpatient hospital services are paid for through Medicare. However, because of data limitations, dually eligible individuals are not included in the Medicaid utilization rate thresholds that we analyze in this chapter.
- The Medicaid inpatient utilization rate does not include outpatient days or primary care services provided by the hospital.

The **low-income utilization rate** is a measure of Medicaid and charity care utilization. It is composed of a Medicaid fraction, which is Medicaid revenue divided by total revenue, and a charity care fraction, which is charity care charges divided by total charges.

- The Medicaid fraction includes inpatient and outpatient Medicaid revenue. Medicare revenue for dually eligible beneficiaries is not included.
- The charity care fraction includes only inpatient charges and does not include outpatient charges. Also, bad debt for uninsured patients is not included (although it is an eligible type of uncompensated care for Medicaid DSH purposes).



First, we analyzed the effects of increasing the minimum Medicaid utilization rate standard to a higher absolute standard that would apply equally across states, similar to the current 1 percent Medicaid utilization rate threshold. We examined a 15 percent Medicaid utilization rate threshold (which is similar to the current Medicare DSH standard),<sup>5</sup> and two lower thresholds (5 percent and 10 percent Medicaid utilization). Nationally, the average Medicaid utilization rate was 19 percent in 2014.

Second, we analyzed the effects of using a relative utilization threshold based on the average Medicaid utilization rate within a state. Compared to an absolute standard that applies equally in all states, a relative utilization threshold would vary by state based on the average Medicaid utilization rate for hospitals in that state. Because Medicaid eligibility levels, family incomes, and other factors vary by state, the average Medicaid utilization rate also varies widely— in 2014, it varied from 10 percent in Nebraska and New Hampshire to 32 percent in New Mexico.<sup>6</sup>

Third, we analyzed the effects of applying relative utilization thresholds that are based on the low-income utilization rate, a measure of Medicaid and uninsured utilization that is used to identify hospitals that are statutorily required to receive DSH payments (deemed DSH hospitals). The Medicaid utilization rate accounts for care to Medicaid-enrolled patients only, and the low-income utilization rate accounts for care to Medicaid-enrolled patients as well as care to uninsured patients (as measured by a hospital's charity care charges). We examined two thresholds: (1) above average low-income utilization in the state and (2) above average Medicaid or low-income utilization in the state. In 2014, the average low-income utilization rate was 11 percent, but it varied widely by state, from 5 percent in New Hampshire to 21 percent in the District of Columbia.

Finally, we analyzed the effects of requiring all DSH hospitals to meet the deemed DSH standard, which is a combination of a relative utilization threshold (a Medicaid inpatient utilization rate that is one standard deviation above the average in the state) and an absolute standard (a low-income utilization rate above 25 percent). Deemed DSH hospitals qualify if they meet either the Medicaid or low-income utilization standard.

Below we describe the number and share of DSH hospitals meeting various targeting standards as well as the characteristics of hospitals at various utilization thresholds. We discuss the implications of these findings, including considerations for developing eligibility thresholds based on other measures, which the Commission may explore in future reports.

## Number of hospitals meeting various utilization standards

Of the 2,278 DSH hospitals included in our analysis, we find that the majority would meet most of the higher eligibility thresholds that we analyzed (Table 3-2). Fewer than one-third of the DSH hospitals in our analysis met the deemed DSH standard, but these deemed DSH hospitals received the majority of DSH payments in 2012 (65 percent).

In general, fewer hospitals that currently receive DSH payments would qualify if the minimum eligibility threshold were raised to a higher standard. For example, in 2014, 95 percent of DSH hospitals met the 5 percent Medicaid utilization standard, but only 69 percent of DSH hospitals met the 15 percent Medicaid utilization standard. However, the share of DSH payments affected is lower than the share of DSH hospitals affected. For example, although 69 percent of DSH hospitals had Medicaid inpatient utilization rates above 15 percent, these hospitals received 92 percent of DSH payments in 2012.

**TABLE 3-2. Summary Statistics of DSH Hospitals by Various Targeting Thresholds, 2014**

Summary statistics	Current standard: 1% Medicaid utilization rate	Absolute utilization standards			Relative utilization standards			Deemed DSH standard
		5% Medicaid utilization rate	10% Medicaid utilization rate	15% Medicaid utilization rate	Average Medicaid utilization rate	Average low-income utilization rate	Average Medicaid or low-income utilization rate	
Number of DSH hospitals above threshold (2014)	2,278	2,157	1,922	1,574	1,293	1,326	1,675	634
Share of DSH hospitals	100%	95%	84%	69%	57%	58%	74%	28%
DSH payments to hospitals above threshold, billions (2012)	\$12.6	\$12.5	\$12.3	\$11.6	\$10.8	\$9.4	\$11.4	\$8.2
Share of DSH payments	100%	99%	97%	92%	85%	75%	90%	65%

**Notes:** DSH is disproportionate share hospital. Analysis was limited to short-term and critical access hospitals that received DSH payments in 2012 and reported complete Medicaid and low-income utilization data in 2014 (N = 2,278).

**Source:** MACPAC, 2017, analysis of 2012 DSH audits and 2014 Medicare cost reports.

### Comparison of absolute and relative standards.

In our analyses, more DSH hospitals were affected by the average Medicaid utilization rate standard, a relative threshold, than by the absolute utilization standards. However, the average Medicaid utilization rate nationally was 19 percent in 2014 and was higher than 15 percent in 40 states.

Because average Medicaid utilization rates are typically lower in states that have not expanded Medicaid, fewer hospitals in these states are affected by using a relative threshold than they are by using an absolute threshold. However, low-income utilization rates are less affected by state expansion decisions because they account for both Medicaid and uninsured patient utilization.

**Comparison of Medicaid and low-income utilization rate measures.** Fewer DSH hospitals are affected by the above average low-income standard than by the average Medicaid utilization standard. However, fewer hospitals would be affected if hospitals could qualify by meeting either the average Medicaid utilization standard or the low-income utilization standard. This is due, in part, to the fact that Medicaid and low-income utilization rates are not well correlated.

For example, about 300 DSH hospitals in our analysis had below average low-income utilization rates but above average Medicaid utilization rates. Hospitals in this category included those that primarily treat pregnant women and children, patients who are more likely to be enrolled in Medicaid and less likely to be uninsured.

In addition, about 400 DSH hospitals in our analysis had below average Medicaid utilization rates but above average low-income utilization rates. Hospitals in this category included those that primarily serve adults under age 65 and other demographic categories that are more likely to be uninsured.

### Characteristics of hospitals that meet various utilization standards

We compared the characteristics of DSH hospitals above and below various utilization thresholds (Table 3-3). We identified critical access and teaching hospitals separately, because many states currently apply different DSH targeting standards for these hospital types. We also identified hospitals that provide burn or trauma services, because these quaternary care services are often provided at a loss for the hospital and they are identified in the statute calling for MACPAC to identify hospitals that provide essential community services.

We found that most of the DSH hospitals in our analysis that had Medicaid utilization rates of less than 10 percent were critical access hospitals. Critical access hospitals are small rural hospitals that receive a special payment designation from Medicare because they are often the sole provider in their community. We note that critical access hospitals comprised only about 22 percent of all DSH hospitals in our analysis. Although Medicaid utilization rates are typically higher in rural areas than in urban areas, critical access hospitals report lower Medicaid utilization rates on average than other types of hospitals. Our inability to include patients who are dually enrolled in Medicaid and Medicare in our calculations of Medicaid utilization may contribute to this discrepancy, because dually enrolled patients account for a large share of patients at rural hospitals (Bennett et al. 2014).

In contrast, DSH hospitals providing burn or trauma services and DSH teaching hospitals were more likely to have had above average Medicaid or low-income utilization rates, which means that a smaller percentage of them are likely to be affected by policies that raise the minimum DSH eligibility threshold.

We found that DSH hospitals with above average Medicaid or low-income utilization rates had higher levels of uncompensated care as a

share of operating expenses (3.7 percent) than hospitals with below average Medicaid or low-income utilization rates (2.6 percent) or Medicaid utilization rates below 10 percent (3.1 percent). This finding suggests that raising the minimum eligibility threshold for DSH would target more DSH funds to hospitals that provide higher levels of uncompensated care.

For DSH hospitals above and below the various utilization thresholds we analyzed, hospital margins were not clearly related to Medicaid or low-income utilization rates. Other researchers have also found that hospital margins are affected by

many factors other than patient mix. For example, an analysis of Medicare cost report data for 2013 found that hospital prestige, regional market concentration, managed care penetration, hospital costs, and ownership type were also significantly correlated with hospital margins (Bai and Anderson 2016). In addition, there is substantial regional variation: in 2013, the median hospital in northeastern states reported a net loss of \$236 per adjusted discharge in 2013, while the median hospital in western states reported a net profit of \$45 per adjusted discharge (Bai and Anderson 2016).

**TABLE 3-3.** Characteristics of DSH Hospitals at Various Utilization Thresholds, 2014

Hospital characteristics	Less than 10% Medicaid utilization (n = 356)	Below average Medicaid or low-income utilization (n = 603)	Above average Medicaid or low-income utilization, not deemed (n = 1,067)	Deemed DSH hospitals (n = 608)	All DSH hospitals (N = 2,278)
<b>Hospital type (share of all DSH hospitals at each utilization threshold)</b>					
Critical access hospitals	57.9%	31.2%	20.3%	16.0%	22.0%
Hospitals providing burn or trauma services	25.6	28.4	41.4	51.5	40.6
Teaching hospitals	8.7	20.9	28.1	39.6	29.3
<b>Uncompensated care (aggregate)</b>					
Bad debt and charity care as a share of operating expenses	3.1%	2.6%	3.7%	5.9%	4.3%
<b>Operating margins (median)</b>					
Operating margins before DSH payments	-7.5%	-3.1%	-2.1%	-6.7%	-3.4%
Operating margins after DSH payments	-5.4	-1.5	-0.9	-3.7	-1.5
Total margins (after DSH and revenue not directly related to patient care)	2.5	3.5	4.3	3.2	3.8

**Notes:** DSH is disproportionate share hospital. Deemed DSH hospitals have a Medicaid utilization rate one standard deviation above average or a low-income utilization rate above 25 percent. Total margins include revenue not directly related to patient care, such as investment income, parking receipts, and non-DSH state or local subsidies to hospitals. Analysis is limited to short-term and critical access hospitals that received DSH payments in 2012 and reported complete Medicaid and low-income utilization data in 2014 (N = 2,278). Hospital and utilization categories are not mutually exclusive.

**Source:** MACPAC, 2017, analysis of 2012 DSH audits and 2014 Medicare cost reports.

## Characteristics of states with affected DSH providers

Most states have at least one hospital that would be affected by even small changes to the minimum DSH eligibility threshold (Table 3-4). In general, states that distribute DSH payments more broadly are more likely to be affected by higher utilization thresholds. However, in the states that would be most affected, only a relatively small amount of DSH funds goes to hospitals that do not meet the

various thresholds. For example, although most states (45) have at least one DSH hospital that does not meet the average Medicaid or low-income utilization rate threshold, only 10 percent of DSH payments are made to these hospitals (Table 3-2, above). Moreover, only two states (Alaska and Rhode Island) make more than one-third of their DSH payments to these hospitals.

**TABLE 3-4.** Number of States with at Least One DSH Hospital That Does Not Meet Various Thresholds, 2014

State distribution of DSH payments	Absolute utilization standards			Relative utilization standards			Deemed DSH standard
	5% Medicaid utilization rate	10% Medicaid utilization rate	15% Medicaid utilization rate	Average Medicaid utilization rate	Average low-income utilization rate	Average Medicaid or low-income utilization rate	
Wide DSH distribution states (states that make DSH payments to more than 67% of hospitals) (n = 20)	14	18	19	20	20	20	20
Medium DSH distribution states (states that make DSH payments to 33%–66% of hospitals) (n = 16)	9	14	15	16	16	16	16
Narrow DSH distribution states (states that make DSH payments to less than 33% of hospitals) (n = 13)	5	7	9	10	11	9	11
All states in analysis (N = 49) <sup>1</sup>	28	39	43	46	47	45	47

**Notes:** DSH is disproportionate share hospital. Analysis limited to short-term and critical access hospitals that received DSH payments in 2012 and reported complete Medicaid and low-income utilization data in 2014 (N = 2,278).

<sup>1</sup> Analysis excludes Maine, which makes DSH payments to institutions for mental diseases only, and Massachusetts, which does not make DSH payments.

**Source:** MACPAC, 2017, analysis of 2012 DSH audits and 2014 Medicare cost reports.

One reason so many states have at least one DSH hospital that would be affected by small changes in the DSH eligibility threshold is that many states provide exceptions or have special criteria for certain types of hospitals. For example, in 2016, 15 states targeted DSH payments specifically to critical access hospitals, which, according to our analysis, are more likely to have lower Medicaid utilization rates.

### Implications and topics for future analysis

Although our analyses describe the potential effects of raising the minimum eligibility threshold for DSH payments, they do not point to a clearly superior alternative or answer the normative question of which threshold should be used. DSH hospitals that serve a lower share of Medicaid and low-income patients have less uncompensated care than other DSH hospitals, but they still report low operating margins. In addition, applying a utilization-based standard uniformly to all hospital types may negatively affect critical access hospitals and other hospital types that often are singled out in state policy to ensure access in rural communities or for other, similar reasons.

In future reports, the Commission may explore the effects of using other eligibility criteria, such as implementing different standards for different types of hospital types. In the analysis above, we were not able to include children's hospitals because of missing data, but most of these hospitals have high Medicaid utilization rates and are less likely to be affected by higher utilization thresholds. We were also not able to include rehabilitation and long-term care hospitals. Few rehabilitation and long-term care hospitals receive Medicaid DSH payments, but these hospitals are different from most general acute care hospitals because they provide care only to patients with particular diagnoses.

## Other Approaches for Improving the Targeting of DSH Payments

Changing which hospitals are eligible for DSH payments is not the only way DSH funding can be better targeted; targeting of DSH payments can also be improved by changing the amount of funding that eligible DSH hospitals receive. Below we review two potential approaches that MACPAC has begun to examine:

- changing the DSH definition of uncompensated care, which would change the maximum amount of funding that DSH hospitals can receive; and
- converting DSH payments to a global payment that is based on the quality of care provided instead of being based on the cost.

Because of a lack of timely and reliable hospital-specific data on Medicaid payments, we are not able to fully model the effects of these potential policies at this time. The Congress also is considering policies that would combine Medicaid and Medicare DSH payments (Box 3-3). As data become available, the Commission will continue to explore these and other policy approaches.

### BOX 3-3. Recent Congressional Disproportionate Share Hospital Policy Proposals

As part of larger proposals that make substantial changes to Medicaid and Medicare, members of Congress have proposed combining Medicaid and Medicare disproportionate share hospital (DSH) funding, specifically:

- The House fiscal year (FY) 2017 budget resolution recommends combining Medicaid and Medicare DSH funding into a single uncompensated care fund that would support all providers serving low-income populations, including uncompensated care provided outside the hospital setting. The proposal describes the new pool of funding as a “flexibility fund” but it does not specify whether the funding would be managed by states or the federal government (Committee on the Budget 2016).
- House Speaker Paul Ryan’s white paper, *A Better Way*, included a proposal to combine Medicaid and Medicare DSH payments into a single pool of funding that would be distributed by CMS based on hospital charity care costs reported on Medicare cost reports. Medicaid DSH funds would not be allowed to be used to offset Medicaid shortfall or hospital bad debt expenses, which are included in the current Medicaid DSH definition of uncompensated care (Office of the Speaker of the U.S. House of Representatives 2016).

In 2012, about 49 percent of Medicaid DSH hospitals received Medicare DSH payments. Medicare DSH payments are made to short-term acute hospitals only and are not made to other types of hospitals that receive Medicaid DSH payments, such as critical access hospitals, institutions for mental diseases, and children’s hospitals.

Many important details of these proposals are not known. For example, these proposals do not specify whether states would be required to contribute toward the non-federal share of Medicaid DSH payments or whether Medicaid DSH payments would be federalized, like Medicare. States are more likely to rely on providers and local governments for contributions toward the non-federal share of DSH payments than they are for the non-federal share of other types of Medicaid payments. In 2012, for example, state funds accounted for 62.9 percent of the non-federal share of all Medicaid expenditures but only 36.1 percent of the non-federal share of DSH payments (GAO 2014). Assuming that provider taxes and local government contributions for DSH are returned to providers and public hospitals, then approximately 78.2 percent of net DSH payments were paid for by the federal government in 2012. In comparison, the average federal share for all Medicaid expenditures was 58 percent in 2012 (OACT 2016).

### Changing the DSH definition of uncompensated care

Currently, Medicaid DSH payments to a hospital are limited to the hospital’s unpaid costs for hospital services provided to Medicaid-enrolled and uninsured patients. Some policymakers have proposed expanding this definition to include the

costs of services provided outside the hospital setting, and others have proposed narrowing this definition to exclude payments for Medicaid shortfall and bad debt (Committee on the Budget 2016, Office of the Speaker of the U.S. House of Representatives 2016).

Expanding the DSH definition of uncompensated care to include hospital-provided physician and clinic services could help promote access to outpatient primary and specialty care. Using 2012 Medicaid claims data, we estimate that about 23 percent of hospital patient care costs are not included in the current DSH definition of uncompensated care.<sup>7</sup> Adding these other services to the existing DSH definition would, on average, increase the maximum amount of funding that DSH hospitals could receive by about 30 percent.

Narrowing the DSH definition of uncompensated care to exclude Medicaid shortfall would reduce the potential for duplication between Medicaid DSH payments and base payment rates for Medicaid services and provide more transparency about how much hospitals are paid for Medicaid services. However, the resulting payment cuts could exacerbate financial challenges for hospitals that serve a high share of Medicaid-enrolled patients. In 2012, Medicaid shortfall—the difference between Medicaid payments and hospitals’ cost of care for Medicaid-enrolled patients—accounted for about one-fifth of the total hospital uncompensated care reported on DSH audits. Medicaid shortfall reported on DSH audits includes shortfall for Medicaid-enrolled patients for which Medicaid is not the primary payer, such as patients dually eligible for Medicare and Medicaid.<sup>8</sup>

Further narrowing the DSH definition of uncompensated care to exclude bad debt would target DSH funding based on charity care to uninsured patients. However, it would reduce the maximum amount of DSH funding hospitals could receive by almost half. In 2014, charity care accounted for about half (54 percent) of the uncompensated care reported by DSH hospitals on Medicare cost reports, which is slightly higher than the share reported by non-DSH hospitals (52 percent).

Changes to the DSH definition of uncompensated care would primarily affect hospitals that are already receiving the maximum amount of DSH

funding allowable. In 2012, about 10 percent of DSH hospitals received DSH payments that met or exceeded the total amount of uncompensated care reported on their DSH audits, which is referred to as the hospital-specific limit.<sup>9</sup> About twice as many hospitals would have had DSH payments at or above their hospital-specific limit if Medicaid shortfall were excluded from the DSH definition of uncompensated care (18 percent), and about five times as many hospitals would have had DSH payments at or above their hospital-specific limit if both Medicaid shortfall and bad debt were excluded from the DSH definition of uncompensated care (53 percent). We estimate that expanding the definition of uncompensated care to include care provided outside the hospital setting would reduce the share of DSH hospitals affected by narrowing the DSH definition of uncompensated care (from 18 to 11 percent in the scenario that excludes Medicaid shortfall and from 53 to 46 percent in the scenario that excluded both Medicaid shortfall and bad debt). Because of data lag, this analysis is based on hospital uncompensated care reported on 2012 DSH audits, and we do not know how the coverage expansions implemented as part of the ACA might affect these estimates.

## Converting DSH payments to a global payment

Instead of making DSH payments based on the cost of services provided, DSH payments could be made using other value-based payment methods. In December 2015, California received approval from the Centers for Medicare & Medicaid Services (CMS) for a Section 1115 demonstration to establish a new Global Payment Program (GPP), which combines DSH and other Medicaid funding for uncompensated care into a global payment for certain deemed DSH hospitals in California.

Payments to hospitals participating in the GPP are delinked from hospital uncompensated care and are instead based on a point system that rewards



public health systems when value-based care is provided to uninsured patients. For example, hospitals can earn points for providing traditional inpatient and outpatient services, such as dental care and mental health treatment, and they can also earn points for providing additional patient support services, such as health coaching and technology-based consultations. During the initial years of the demonstration, the point system is based on the relative costs of each service, but in later years of the demonstration, potentially avoidable services, such as emergency room visits, will earn fewer points to encourage hospitals to provide care in the most appropriate and cost-effective setting.

To get a sense of early experience with the GPP, we interviewed hospital executives at one of the hospitals participating in the program, Santa Clara Valley Medical Center in San Jose, California, as part of our work profiling selected DSH hospitals. Hospital executives noted that the GPP helped support clinic services for uninsured patients that were previously not paid for by DSH, but they also expressed concern about whether the hospital would meet its targets and earn its full GPP payments, because payments under GPP are not guaranteed and must be earned (MACPAC 2017). At the time of our interview, in the summer of 2016, California and CMS had recently approved the baselines and targets for the GPP program. These decisions, like those in any value-based payment program, are complex and would need to be re-evaluated if other states adopted a similar approach. The task of measuring the quality of care provided at safety-net hospitals and setting improvement targets is particularly challenging because of the social risk factors that low-income patients face (ASPE 2016).

of the distribution of DSH payments across states and hospitals to understand how any changes in health insurance coverage for low-income families will affect safety-net institutions. We plan to further explore alternative eligibility criteria and the implications of applying different standards to different types of hospitals. We will also continue to monitor the potential effects of changes to the ACA and Medicaid's financing structure on DSH policy. In addition, notwithstanding the limitations of currently available Medicaid payment data, we plan to further explore policies to improve the targeting of DSH funding to states and providers and may also examine proposals to change the amount of funding that DSH hospitals are eligible to receive and the way DSH funding is distributed.

## Next Steps

This is the Commission's second annual report on Medicaid DSH policy. Future reports will present results of the Commission's continued monitoring

## Endnotes

- <sup>1</sup> DSH hospitals are also required to have at least two obstetricians with staff privileges who will treat Medicaid enrollees (with certain exceptions).
- <sup>2</sup> Low-DSH states are those with FY 2000 DSH expenditures that were less than 3 percent of total state Medicaid medical assistance expenditures for FY 2000, including a special exception to include Hawaii (§ 1923(f)(5) and § 1923(f)(6) of the Act).
- <sup>3</sup> Centers for Medicare & Medicaid Services (CMS) regulations permit states to submit DSH audits approximately three years after a state plan rate year ends so that all claims can be included and audits can be completed; CMS posts DSH audit data on its website after its review, typically about five years after the state plan rate year ends.
- <sup>4</sup> Each state's IMD limit is the lesser amount of (1) the DSH allotment the state paid to IMDs and other mental health facilities in FY 1995 or (2) 33 percent of the state's FY 1995 DSH allotment.
- <sup>5</sup> Hospitals are eligible for Medicare DSH payments if their Medicaid and Supplemental Security Income patient utilization rate exceeds 15 percent.
- <sup>6</sup> New Hampshire expanded Medicaid to childless adults on August 15, 2014. As a result, most of the effects of this expansion are not included in the 2014 Medicare cost report data.
- <sup>7</sup> To estimate the share of hospital costs that are not covered by the current DSH definition of uncompensated care, we compared total 2012 fee-for-service claims for inpatient and outpatient hospital services to claims for other types of services that were provided in an inpatient or outpatient setting. This analysis does not include the costs of non-covered services or services for which hospitals do not submit claims.
- <sup>8</sup> For Medicaid DSH purposes, Medicaid shortfall includes the costs of care for all Medicaid-eligible patients, regardless of whether Medicaid is the primary payer. Costs for patients who are dually eligible for Medicaid and Medicare are included, minus any Medicare payments received for those patients (including Medicare DSH payments). In August 2016, CMS proposed a rule to clarify that payment from third-party payers, such as Medicare, should be included in calculations of Medicaid shortfall, but this rule has not yet been finalized (CMS 2016).
- <sup>9</sup> Through the DSH audit process, CMS is currently working with states to recoup DSH payments to hospitals that exceed their hospital uncompensated care costs.

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## APPENDIX 3A. State DSH Targeting Methods

**TABLE 3A-1.** Common Hospital Types Defined and Targeted for DSH Payments by State

State	State-owned or public hospitals	Psychiatric hospitals or institutions for mental diseases	Teaching hospitals	Children's hospitals	Rural or critical access hospitals
Alabama	✓		✓		
Alaska		✓		✓	✓
Arizona	✓				
Arkansas	✓	✓	✓		
California	✓				
Colorado	✓				
Connecticut	✓	✓		✓	
Delaware		✓			
District of Columbia	✓	✓			
Florida	✓	✓	✓	✓	✓
Georgia	✓				✓
Hawaii	✓				
Iowa				✓	✓
Idaho	✓				✓
Illinois	✓	✓			
Indiana	✓	✓			
Kansas	✓	✓	✓		
Kentucky	✓	✓	✓		
Louisiana	✓	✓	✓		✓
Maine		✓			
Maryland		✓			
Massachusetts <sup>1</sup>					
Michigan	✓	✓	✓		✓
Minnesota		✓		✓	
Mississippi	✓		✓		
Missouri					
Montana					
Nebraska	✓	✓	✓	✓	
Nevada	✓				✓
New Hampshire	✓	✓			✓

**TABLE 3A-1. (continued)**

State	State-owned or public hospitals	Psychiatric hospitals or institutions for mental diseases	Teaching hospitals	Children's hospitals	Rural or critical access hospitals
New Jersey	✓	✓	✓		
New Mexico			✓		
New York	✓	✓			
North Carolina	✓	✓	✓		
North Dakota	✓	✓			✓
Ohio				✓	✓
Oklahoma	✓		✓		
Oregon	✓	✓	✓		
Pennsylvania	✓	✓	✓		✓
Rhode Island	✓				
South Carolina	✓	✓			
South Dakota	✓	✓			
Tennessee		✓		✓	
Texas	✓		✓	✓	✓
Utah	✓	✓	✓	✓	✓
Vermont			✓		
Virginia	✓	✓	✓		
Washington	✓			✓	✓
West Virginia	✓	✓			✓
Wisconsin	✓				
Wyoming					

**Notes:** DSH is disproportionate share hospital. This analysis shows the number of states that explicitly make certain types of hospitals eligible for DSH payments in their Medicaid state plan. States can also target DSH funding to particular types of providers by establishing different payment methods for different categories of eligible DSH providers. Categories are not mutually exclusive (e.g., a state targeting state-owned teaching hospitals would be counted as targeting both state-owned hospitals and teaching hospitals).

<sup>1</sup> Massachusetts does not make DSH payments because its Section 1115 demonstration allows the state to use DSH funding for the state's safety-net care pool instead.

**Source:** MACPAC, 2017, analysis of Medicaid state plans.

**TABLE 3A-2. DSH Targeting Policies by State, 2016**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Alabama	73 percent	<ul style="list-style-type: none"> <li>• Teaching hospitals owned by University of Alabama</li> <li>• Acute care public hospitals</li> <li>• Private acute care hospitals that are members of a prepaid health plan, located in counties with between 75,000 and 100,000 people or above 200,000 people without a publicly owned hospital and meet certain Medicaid utilization criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Private acute care hospitals located in counties with 75,000–100,000 people must have an MIUR that exceeds the average MIUR in the state</li> <li>• Private acute care hospitals located in counties with over 200,000 people must have an MIUR that exceeds one-half of the average MIUR in the state</li> </ul>
Alaska	16 percent	<ul style="list-style-type: none"> <li>• Acute care, psychiatric, and specialty rehabilitation hospitals that have entered into agreements with the state agency to participate in one or more of nine state-specific DSH classifications, which primarily target:                             <ul style="list-style-type: none"> <li>– hospitals providing certain psychiatric and substance abuse disorder services</li> <li>– children’s hospitals</li> <li>– rural hospital clinics</li> </ul> </li> </ul>	N/A
Arizona	35 percent	<ul style="list-style-type: none"> <li>• Government-operated hospitals</li> <li>• Privately owned acute care general hospitals meeting certain low-income utilization criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Privately owned acute care general hospitals must have low-income utilization rate (LIUR) exceeding the mean LIUR for private hospitals receiving Medicaid payments in the state, or provide at least 1 percent of total Medicaid days across the state</li> </ul>
Arkansas	4 percent	<ul style="list-style-type: none"> <li>• State-owned teaching hospitals</li> <li>• State-owned psychiatric hospitals</li> </ul>	N/A

**TABLE 3A-2. (continued)**

<b>State</b>	<b>Share of hospitals in state that receive DSH payments (2012)</b>	<b>Hospital types targeted</b>	<b>Medicaid or uninsured utilization criteria</b>
California	11 percent	<ul style="list-style-type: none"> <li>• Government-operated hospitals</li> </ul>	N/A
Colorado	73 percent	<ul style="list-style-type: none"> <li>• Hospitals participating in the Colorado Indigent Care Program (CICP), with prioritization for hospitals that have CICP write-off costs exceeding certain thresholds</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals with CICP write-off costs greater than 750 percent of the statewide average prioritized first</li> <li>• Hospitals with CICP write-off costs greater than 200 percent but less than 750 percent of the statewide average prioritized second</li> </ul>
Connecticut	80 percent	<ul style="list-style-type: none"> <li>• Hospitals serving low-income persons</li> <li>• Psychiatric hospitals</li> <li>• Private and public acute care general short-term hospitals, including those located in distressed economic zones</li> <li>• Public chronic disease hospitals</li> <li>• Private freestanding children’s hospitals</li> </ul>	N/A
Delaware	17 percent	<ul style="list-style-type: none"> <li>• Delaware-owned psychiatric hospitals that meet requirements for serving low-income patients, as well as other hospitals meeting all of the following criteria:                             <ul style="list-style-type: none"> <li>– are non-profit</li> <li>– have a facility located in a Delaware city of over 50,000 people that provides obstetric services to Medicaid enrollees</li> <li>– are enrolled as a provider in fee-for-service Medicaid and CHIP and all participating managed care organizations</li> <li>– meet LIUR criteria</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• For Delaware-owned psychiatric hospitals, at least 60 percent of revenue must be from a combination of public funds, charity care, and bad debts</li> <li>• For other hospitals, LIUR must exceed 15 percent</li> </ul>
District of Columbia	62 percent	<ul style="list-style-type: none"> <li>• Public psychiatric hospitals</li> </ul>	N/A

**TABLE 3A-2. (continued)**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Florida	28 percent	<ul style="list-style-type: none"> <li>• State mental health hospitals</li> <li>• Teaching hospitals</li> <li>• Rural hospitals</li> <li>• Specialty hospitals that receive all of their inpatient clients through referrals or admissions from county public health departments</li> <li>• Children's hospitals</li> <li>• Provider Service Network hospitals</li> <li>• Hospitals qualifying for primary care DSH payments under Florida law</li> </ul>	<ul style="list-style-type: none"> <li>• Private hospitals are targeted differently based on whether or not they have 3,100 or more Medicaid days in the state plan rate year</li> </ul>
Georgia	78 percent	<ul style="list-style-type: none"> <li>• Rural hospitals targeted using separate funding pools</li> </ul>	N/A
Hawaii	68 percent	<ul style="list-style-type: none"> <li>• Governmental providers have a slightly larger pool than non-governmental providers</li> </ul>	N/A
Iowa	8 percent	<ul style="list-style-type: none"> <li>• Children's hospitals</li> <li>• Rural hospitals participating in the rural disproportionate share fund</li> </ul>	N/A
Idaho	43 percent	<ul style="list-style-type: none"> <li>• Idaho has two categories of DSH eligibility: mandatory and deemed, which are defined differently than the federal definition of deemed DSH hospitals. The deemed group receives DSH payments only if the mandatory group has been fully funded. The state targets non-state, government owned hospitals and private hospitals, including rural and critical access hospitals.</li> </ul>	<ul style="list-style-type: none"> <li>• To qualify as a mandatory DSH hospital, a hospital must meet the federal criteria for deemed DSH hospitals</li> <li>• To qualify as a deemed DSH hospital based on Idaho's methodology, a hospital must have an MIUR of at least one percent</li> </ul>
Illinois	26 percent	<ul style="list-style-type: none"> <li>• Public hospitals with an intergovernmental agreement between the state agency and the authorized governmental body for the qualifying hospital</li> <li>• State-owned mental health facilities</li> </ul>	N/A



**TABLE 3A-2. (continued)**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Indiana	29 percent	<ul style="list-style-type: none"> <li>• Municipal hospitals</li> <li>• Hospitals located in Lake County, IN</li> <li>• Private psychiatric hospitals</li> </ul>	N/A
Kansas	38 percent	<ul style="list-style-type: none"> <li>• Targets only deemed DSH hospitals, and pays IMDs and state-owned teaching hospitals out of a separate payment pool</li> </ul>	N/A
Kentucky	90 percent	<ul style="list-style-type: none"> <li>• Acute care hospitals</li> <li>• State university teaching hospital owned and operated by either University of Kentucky or Louisville Medical School</li> <li>• State-owned psychiatric hospitals</li> </ul>	N/A
Louisiana	36 percent	<ul style="list-style-type: none"> <li>• State-operated hospitals</li> <li>• Small rural hospitals</li> <li>• Public or private non-rural community hospitals</li> <li>• Low-income academic hospitals</li> <li>• Hospitals participating in the Low-Income and Needy Care Collaboration program</li> <li>• Private acute general hospitals located outside of Baton Rouge and New Orleans Metropolitan Statistical Area (MSA) meeting criteria related to the ratio of interns and residents to inpatient beds, and Medicaid and low-income utilization</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals qualifying as private acute care general hospitals outside of Baton Rouge and New Orleans MSA must have an MIUR greater than 18.9%</li> </ul>
Maine	3 percent	<ul style="list-style-type: none"> <li>• IMDs</li> </ul>	N/A

**TABLE 3A-2. (continued)**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Maryland	22 percent	<ul style="list-style-type: none"> <li>• Hospitals governed by the Maryland Medicaid waiver do not receive additional payments under DSH because their rates already include a disproportionate share adjustment. Among hospitals not governed by the waiver, hospitals receive the minimum amount of DSH required under federal law, except for:                             <ul style="list-style-type: none"> <li>– freestanding psychiatric hospitals meeting charity care thresholds</li> <li>– freestanding rehabilitation hospitals meeting charity care thresholds</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatric hospitals must have charity care inpatient costs exceeding 40 percent of total inpatient hospital costs</li> <li>• Rehabilitation hospitals must have charity care inpatient costs exceeding 20 percent of total inpatient hospital costs</li> </ul>
Massachusetts <sup>1</sup>	0 percent	<ul style="list-style-type: none"> <li>• Massachusetts does not make DSH payments because its Section 1115 demonstration allows the state to use DSH funding for its safety-net care pool instead</li> </ul>	N/A
Michigan	68 percent	<ul style="list-style-type: none"> <li>• Government-owned or government-operated hospitals receive DSH payments first, and other hospitals can receive payments if there are remaining funds in the allotment period. Other hospitals targeted through payment pools include:                             <ul style="list-style-type: none"> <li>– IMDs</li> <li>– small private rural hospitals</li> <li>– large private urban hospitals</li> <li>– hospitals with an indigent care pool agreement</li> <li>– government hospitals</li> <li>– DRG inpatient and per diem inpatient hospitals</li> <li>– university hospitals with both a college of allopathic medicine and a college of osteopathic medicine</li> </ul> </li> </ul>	N/A

**TABLE 3A-2. (continued)**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Minnesota	34 percent	<ul style="list-style-type: none"> <li>• Hospitals with a contract with the state to provide extended inpatient psychiatric services</li> <li>• Hospitals that received Medicaid fee-for-service payments for 20 transplants in the base year</li> <li>• Hospitals meeting various MIUR thresholds can receive greater adjustments</li> <li>• Children’s hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals with an MIUR greater than the statewide mean can receive additional payment adjustments, which become greater for hospitals that exceed one or three standard deviations.</li> </ul>
Mississippi	42 percent	<ul style="list-style-type: none"> <li>• State-owned teaching hospital located in Hinds County</li> </ul>	N/A
Missouri	63 percent	<ul style="list-style-type: none"> <li>• No particular groups targeted, but children’s hospitals may only qualify if they are federally deemed</li> </ul>	N/A
Montana	77 percent	<ul style="list-style-type: none"> <li>• Hospitals must meet MIUR or LIUR thresholds</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals must have an MIUR equal to or above the mean for all hospitals receiving Medicaid payments in the state or have an LIUR above 20 percent</li> </ul>
Nebraska	29 percent	<ul style="list-style-type: none"> <li>• Children’s hospitals</li> <li>• State-owned IMDs</li> <li>• Non-profit acute care teaching hospitals affiliated with state-owned medical college</li> <li>• Hospitals providing services to low-income persons covered by a county administered general assistance program</li> <li>• Other hospitals that meet MIUR criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals can also qualify for DSH payments if they have an MIUR equal to or above the mean for all hospitals receiving Medicaid payments in the state</li> </ul>

**TABLE 3A-2.** (continued)

<b>State</b>	<b>Share of hospitals in state that receive DSH payments (2012)</b>	<b>Hospital types targeted</b>	<b>Medicaid or uninsured utilization criteria</b>
Nevada	43 percent	<ul style="list-style-type: none"> <li>• Public hospitals targeted separately through different payment methods based on population of the county in which they are located</li> <li>• Private hospitals targeted separately through different payment methods based on population of the county in which they are located</li> </ul>	N/A
New Hampshire	53 percent	<ul style="list-style-type: none"> <li>• Government-owned psychiatric hospitals in which 50 percent or more of revenue is attributable to public funds excluding Medicare, Medicaid, bad debts, and charity care</li> <li>• Critical access hospitals that participate in New Hampshire Medicaid managed care, with an extra payment for critical access hospitals providing essential access to maternity care</li> <li>• Private hospitals that participate in New Hampshire Medicaid managed care</li> </ul>	N/A
New Jersey	74 percent	<ul style="list-style-type: none"> <li>• Hospitals with a contract with the Division of Mental Health and Hospitals to provide services to low-income mentally ill or developmentally disabled beneficiaries</li> <li>• Governmental acute and psychiatric hospitals</li> <li>• Non-state-owned major teaching hospitals</li> <li>• Other hospitals that meet Medicaid, uninsured, and low-income utilization criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals can also qualify for DSH if they have Medicaid, uninsured or low-income utilization greater than 25 percent</li> </ul>
New Mexico	36 percent	<ul style="list-style-type: none"> <li>• Teaching hospitals</li> <li>• PPS hospitals</li> <li>• Hospitals that have had a disproportionate shift in the delivery of services between low-income and Medicaid-covered inpatient days</li> </ul>	N/A

**TABLE 3A-2. (continued)**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
New York	90 percent	<ul style="list-style-type: none"> <li>• State- and county-operated hospitals</li> <li>• Hospitals operated by municipalities with populations greater than 1 million</li> <li>• Private hospitals</li> <li>• State-and private-operated freestanding psychiatric hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• Non-major public hospitals with Medicaid discharges of 40 percent or greater have a separate pool for DSH</li> </ul>
North Carolina	41 percent	<ul style="list-style-type: none"> <li>• To receive DSH, hospitals must meet deemed DSH requirements or state-defined Medicaid revenue or utilization criteria unless they are a psychiatric hospital owned by the government or the University of North Carolina (UNC). Within these parameters, North Carolina targets:                             <ul style="list-style-type: none"> <li>– State-owned IMDs</li> <li>– Hospitals providing services to clients of the Division of Vocational Rehabilitation Services</li> <li>– Hospitals owned or controlled by the UNC health care system</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals in which the sum of Medicaid gross revenues, bad debt, and charity care exceeds 20 percent of total gross patient revenue</li> <li>• Hospital among the top group that accounts for 50 percent of total Medicaid patient days</li> </ul>
North Dakota	6 percent	<ul style="list-style-type: none"> <li>• Hospitals paid using PPS</li> <li>• State-owned psychiatric hospitals</li> <li>• Critical access hospitals</li> </ul>	N/A
Ohio	78 percent	<ul style="list-style-type: none"> <li>• Hospitals with high uncompensated care</li> <li>• Rural and critical access hospitals</li> <li>• Children’s hospitals</li> </ul>	N/A
Oklahoma	34 percent	<ul style="list-style-type: none"> <li>• Private major teaching hospitals</li> <li>• Public hospitals</li> </ul>	N/A
Oregon	95 percent	<ul style="list-style-type: none"> <li>• Inpatient psychiatric hospitals</li> <li>• Public academic medical centers with more than 200 residents or interns</li> </ul>	N/A

**TABLE 3A-2. (continued)**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Pennsylvania	87 percent	<ul style="list-style-type: none"> <li>• Hospitals must be deemed or meet Medicaid utilization criteria. Within that criteria, targets:                             <ul style="list-style-type: none"> <li>– state-operated psychiatric hospitals and non-state operated hospitals targeted separately</li> <li>– acute care general hospitals with higher Medicaid days</li> <li>– rehabilitation hospitals</li> <li>– hospitals that qualify as level I, II, or III trauma centers</li> <li>– hospitals with qualifying burn centers</li> <li>– hospitals providing neonatal intensive care service, a high volume of obstetrical services to Medicaid recipients (rural and nonrural hospitals in this category are targeted separately)</li> <li>– teaching hospitals that provide psychiatric services for Medicaid beneficiaries</li> <li>– critical access hospitals</li> <li>– hospitals meeting criteria for or are designated as sole community hospitals</li> <li>– hospitals providing surgical services to patients with cleft palate and craniofacial abnormalities</li> <li>– hospitals in cities with a per capita income significantly below the statewide average</li> <li>– hospitals that provide a high volume of emergency department visits</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• All non-deemed hospitals must meet specific utilization criteria for their category in order to qualify or receive payment under that category. However, in general, most categories must meet at least one of the following criteria:                             <ul style="list-style-type: none"> <li>– rural or sole community hospital with 75 percent MIUR</li> <li>– Medicaid inpatient days two standard deviations above the statewide mean</li> <li>– located in a county ranked above the 96th percentile for Medicaid utilization for all counties</li> </ul> </li> </ul>
Rhode Island	87 percent	<ul style="list-style-type: none"> <li>• State-operated hospitals that meet deemed DSH standards receive additional payments</li> <li>• Non-government hospitals</li> <li>• Women and infant specialty hospitals</li> </ul>	N/A

**TABLE 3A-2. (continued)**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
South Carolina	74 percent	<ul style="list-style-type: none"> <li>Psychiatric hospitals operated by the South Carolina Department of Mental Health</li> </ul>	N/A
South Dakota	39 percent	<ul style="list-style-type: none"> <li>Hospitals must be deemed or meet MIUR criteria. Within that, South Dakota targets:               <ul style="list-style-type: none"> <li>qualifying acute care hospitals</li> <li>state-owned psychiatric hospitals</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Hospitals that are not federally deemed must have an MIUR exceeding the statewide mean</li> </ul>
Tennessee	47 percent	<ul style="list-style-type: none"> <li>Targets hospitals based on a point system, with points based on Medicaid utilization criteria; hospitals are classified within four groups:               <ul style="list-style-type: none"> <li>hospitals providing essential services such as regional trauma or perinatal centers</li> <li>children’s safety-net hospitals</li> <li>freestanding psychiatric hospitals</li> <li>other essential acute care hospitals</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>To receive DSH payments, hospitals must have at least one point; points are earned by meeting at least one of the following criteria:               <ul style="list-style-type: none"> <li>an MIUR of at least 9.5 percent, and the number of Medicaid days must be greater than average for hospitals in the other essential acute care hospitals group</li> <li>an MIUR of at least 13.5 percent</li> <li>4.5 percent of operating expenses attributable to bad debt, charity care, or medically indigent costs</li> </ul> </li> </ul>
Texas	30 percent	<ul style="list-style-type: none"> <li>All hospitals must have or be in active pursuit of obtaining a trauma facility designation. In addition, hospitals must be federally deemed or meet one of the following criteria:               <ul style="list-style-type: none"> <li>rural hospitals that meet MIUR criteria</li> <li>hospital in an urban county with a population under 290,000 people</li> <li>children’s state-owned teaching hospital, or state chest hospitals</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Rural hospitals can qualify if they if they have an MIUR greater than the statewide mean</li> </ul>

**TABLE 3A-2.** (continued)

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Utah	67 percent	<ul style="list-style-type: none"> <li>• To qualify, hospitals must be federally deemed or be located in a rural county, participate in the Utah Primary Care Network, or meet Medicaid utilization criteria. Within these criteria, Utah targets:               <ul style="list-style-type: none"> <li>– private, general acute care urban hospitals</li> <li>– general acute care rural hospitals</li> <li>– the state psychiatric hospital</li> <li>– the state teaching hospital</li> <li>– children’s hospitals</li> <li>– frontier county hospitals in economically depressed areas</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Except for rural hospitals and hospitals participating in the Utah primary care network, hospitals must be deemed or have an MIUR greater than 14 percent</li> </ul>
Vermont	81 percent	<ul style="list-style-type: none"> <li>• In-state, postgraduate teaching facilities</li> <li>• Hospitals with a large proportion of all statewide inpatient days</li> </ul>	N/A
Virginia	25 percent	<ul style="list-style-type: none"> <li>• Hospitals must be federally deemed or meet MIUR criteria. Within these criteria, Virginia targets:               <ul style="list-style-type: none"> <li>– state-owned teaching hospitals</li> <li>– freestanding psychiatric hospitals</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals that are not federally deemed must have an MIUR of greater than 10.5 percent</li> </ul>
Washington	50 percent	<ul style="list-style-type: none"> <li>• Rural hospitals with fewer than 75 acute beds</li> <li>• Non-rural hospitals providing charity care</li> <li>• Public hospitals</li> <li>• Children’s hospitals</li> <li>• Rural hospitals certified by CMS as a sole community hospital</li> </ul>	N/A
West Virginia	83 percent	<ul style="list-style-type: none"> <li>• Acute care, psychiatric, rehabilitation, or critical access hospitals owned by the state</li> </ul>	N/A



**TABLE 3A-2. (continued)**

State	Share of hospitals in state that receive DSH payments (2012)	Hospital types targeted	Medicaid or uninsured utilization criteria
Wisconsin	9 percent	<ul style="list-style-type: none"> <li>• Hospitals owned by the state or county</li> <li>• Private acute care hospitals</li> </ul>	N/A
Wyoming	57 percent	<ul style="list-style-type: none"> <li>• All hospitals meeting MIUR requirements</li> </ul>	<ul style="list-style-type: none"> <li>• 5 percent MIUR</li> </ul>

**Notes:** DSH is disproportionate share hospital. MIUR is Medicaid inpatient utilization rate. N/A is not applicable. LIUR is low-income utilization rate. IMD is institution for mental diseases. DRG is diagnosis-related group. PPS is prospective payment system. CMS is Centers for Medicare & Medicaid Services. Although the hospital targeting methods and criteria reflect the latest state DSH policies as of December 2016, the share of hospitals receiving DSH is based on 2012 data, meaning that the share of hospitals receiving DSH payments as of December 2016 may be different from what is shown.

<sup>1</sup> Massachusetts does not make DSH payments because its Section 1115 demonstration allows the state to use DSH funding for the state's safety-net care pool instead.

**Source:** MACPAC, 2017, analysis of Medicaid state plans, as-filed 2012 Medicaid DSH audits, and 2014 Medicare cost reports.

Chapter 4:

# Monitoring Access to Care in Medicaid

# Monitoring Access to Care in Medicaid

## Key Points

- Federal and state policymakers alike want to ensure that Medicaid beneficiaries have sufficient access to necessary care. That is, are providers available, to what extent do beneficiaries receive appropriate care, and what are the barriers to receiving services.
- Efforts to monitor access can inform assessment of the program's value, serve as a means of accountability, help identify problems, and guide program improvement.
- MACPAC and others have found that Medicaid beneficiaries have much better access to care and higher health care utilization than those without insurance, particularly when controlling for socioeconomic characteristics and health status. Medicaid beneficiaries fare as well, or better, on some access measures as individuals with private insurance, but they often experience more difficulty obtaining health care.
- There is no single federally mandated method for states to monitor and evaluate access to Medicaid-covered services. However, rules promulgated in 2015 and 2016 require states to monitor access for certain types of services provided under fee for service (FFS) and to include network adequacy requirements in their managed care contracts.
- MACPAC reviewed state access monitoring review plans and found that current monitoring approaches rely primarily on complaint hotlines and advisory committees. Most plans did not define adequate access. However, some states shared information on past efforts to demonstrate that when a problem is identified, the state works to address it.
- MACPAC also surveyed states to learn about their access monitoring activities in FFS Medicaid. Twenty-nine of 37 responding states reported collecting data for one or more of the measures of beneficiary experience accessing covered services; 29 reported collecting data for measures of beneficiary utilization of covered services; and 21 collected data on provider supply measures.
- New network adequacy standards for managed care will apply beginning July 1, 2018. States are now starting to set up their newly required standards and practices.
- States and the federal government face many challenges in monitoring access, including data limitations, inconsistent use of measures, lack of benchmarks for what is considered adequate access, and administrative capacity. States and the Centers for Medicare & Medicaid Services are also interested in learning more about what initiatives work best for improving access across different populations and for different services.

## CHAPTER 4: Monitoring Access to Care in Medicaid

As enrollment and spending in Medicaid grow, federal and state governments want to ensure that they are paying appropriately for care and that beneficiaries have sufficient access to necessary care. One of the key tests of the effectiveness of a health care coverage program like Medicaid is whether it provides access to appropriate and high-quality health care services in a timely manner. That is, are providers available to Medicaid beneficiaries, to what extent do they receive high-quality and efficient care, and what are the barriers to the receipt of such services. Monitoring access to care for Medicaid beneficiaries is a requirement under both fee-for-service (FFS) and managed care programs. And while different strategies may be needed to monitor access under the different delivery systems, findings from both can be used to support assessment of program value, act as a mechanism for accountability, and help identify problems and guide program improvement efforts.

The fundamental purpose of Medicaid is to provide medical assistance, and thus access is central to its purpose. This is seen in multiple provisions of the law including the definition of covered services and design of delivery systems. The key element of the Medicaid statute that created an obligation to ensure access is the so-called equal access provision. Enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239), the equal access provision focuses on the adequacy of provider payments in assuring access, requiring that they be “consistent with efficiency, economy, and quality of care and ... 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” (§ 6402(a) of OBRA 89). Historically, the requirement to “enlist enough providers” had been assessed

primarily through the adequacy of provider payment rates. With increased use of managed care, under which plans, rather than states, pay providers, the focus of ensuring access has shifted from adequate state payments to providers to state contracts with managed care plans. In addition, questions have been raised about meeting the standard of “the extent that such care and services are available to the general population in the geographic area,” given Medicaid’s role in covering services and populations that have no corollary in the private market.

Measuring Medicaid access is not a simple task for both conceptual and practical reasons. First, as discussed in more detail below, access is a multidimensional concept incorporating the need for care, the ability to obtain that care, and the value of the services obtained or not received (MACPAC 2011). Second, there are separate regulatory requirements that specify how access must be monitored under FFS and managed care arrangements. Even so, many beneficiaries receive services under both types of arrangements. Third, the tools needed to monitor patterns of use and barriers to care—timely and complete data, validated measures, and metrics—are not always available. Despite these challenges, sustained and consistent efforts to measure and monitor access can help policymakers understand whether they are in fact providing appropriate access to Medicaid enrollees, if there are particular access issues that should be addressed, and which populations are at risk of access problems.

Because there is no single mandated method for monitoring and evaluating access to services for Medicaid beneficiaries, MACPAC has chosen in this chapter to focus on how states are monitoring access in both their FFS and managed care populations, and how they propose to monitor access in the future. States and managed care plans are currently using multiple datasets and measures to monitor access; new regulations will require many states to expand their efforts to report on access to services they currently do

not monitor. The chapter looks at the monitoring systems themselves and not the findings of those systems; it is not intended to evaluate whether access is adequate or how access affects outcomes of care.

The chapter begins by defining what is meant by access, referencing the framework MACPAC developed in 2011, and the measures and data that can be used to monitor differences over time, across states, and within states. This is followed by a brief review of what is known about access to care in Medicaid, based primarily on recent findings from MACPAC's work comparing access in Medicaid and privately insured populations. The chapter then explains the different federal monitoring requirements and current state practices under FFS and managed care. It concludes with a discussion of key challenges to monitoring and evaluating access.

## Defining Access

As one of its first undertakings in 2011, the Commission developed a framework for examining access to care for enrollees in Medicaid and the State Children's Health Insurance Program (CHIP). This framework was built on many years of research into defining and measuring access to care and was designed to reflect the program policies and special characteristics of enrollee populations, as well as the barriers to receipt of appropriate and necessary care that these populations may face. The framework, which focuses on both primary and specialty care providers and services, has three main elements:

- characteristics of enrollees that affect their need for care and their propensity to seek and use services (such as health status and conditions, geographic location, income, cultural beliefs and practices, and continuity of their insurance coverage);

- availability of providers and services as measured by overall supply of providers and facilities and the willingness of those providers to serve Medicaid enrollees; and
- use of health care services, including whether and how services are used, affordability of services, and how easily enrollees can navigate the health system (MACPAC 2011).

Andersen and Davidson (2007) described four types of access: potential, realized, equitable, and efficient. Potential access includes factors that are necessary, but not sufficient, to obtain care, such as the ability of patients to find providers who will see them, the availability of transportation to the site of care, and the ability of patients to pay for services. Realized access refers to actual receipt of services. Equitable access means that utilization rates are similar to others with similar need. Efficient access is achieved when equitable access is achieved at the lowest possible cost (Andersen and Davidson 2007). Access may differ by geographic area as a function of the health care infrastructure and medical practice patterns, as well as an individual's clinical and perceived need for services. Furthermore, care may be ultimately received but with different levels of difficulty, such as requiring multiple phone calls to schedule an appointment, or long travel times to providers. Quality is a construct separate from access and is related to the achievement of positive outcomes associated with utilization, not whether health care use occurs at all or the difficulties experienced when obtaining care. The analysis in this chapter touches on, but does not consider mechanisms for ensuring quality of care.

## Measuring Access

Assessing the adequacy of access requires specific measures and data. Over the years, numerous access measures have been developed to quantify provider supply, utilization of services, and perceived difficulty or ease of obtaining

services. National surveys collect measures of utilization for specific services; these measures allow the experience of Medicaid beneficiaries to be compared with that of individuals who have private insurance or who are uninsured. Such surveys also gather information on respondents' perceptions of whether they delayed care or did not receive needed care and the reasons respondents did not receive timely services. Administrative datasets are commonly used to compare utilization rates, often for specific services such as preventive care or ongoing treatment for chronic conditions. Provider licensing data and provider association surveys are commonly used to identify the number of providers by geographic area and whether they participate in Medicaid. Access to providers is most commonly measured using the number of health care providers in a geographic area relative to the population in that area.

Although clinical and perceived need, timeliness, difficulty obtaining specific health services, and utilization rates are all subject to variation, standards do exist. Validated metrics can be used to assess access and barriers to access at the population level. Comparisons can be made to other populations, such as privately insured individuals, or to other time periods, such as utilization rates from prior years. Definitions of acceptable access can be based on clinical factors or other benchmarks, such as setting the maximum acceptable travel time to a provider or the minimal number of providers in a managed care network available to see patients.

Different data sources can be used to provide information on the different dimensions of access but all have certain limitations (MACPAC 2012a). Administrative and claims data can be used to measure care that is received but not care that is needed or desired. These data do not usually include measures of social determinants of health such as income, health literacy, race and ethnicity, language spoken, or education that are associated with both the need for health care and the ability to obtain it. Surveys, which are more likely to

contain data on social determinants, typically have smaller sample sizes, provide less detail about the services that are obtained, and are based on self-reports. Information from beneficiary complaint hotlines may identify real and pressing problems but may not be representative of the entire enrollee population.

Data from health plans on their provider networks may accurately represent capacity but may not reflect actual services provided. For example, provider-to-enrollee ratios measure the number of providers from which a beneficiary could theoretically receive health care services. However, if the directories that enrollees use to identify potential providers are not accurate, or if providers in the directory do not accept new patients, then the actual provider-to-enrollee ratio may not be meaningful. One study of Medicaid managed care providers conducted by the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services found that about 33 percent of contracted providers could not be found at the location listed by the plan; another 8 percent said that they were not participating in the plan; and an additional 8 percent were not accepting new patients (OIG 2014a).

There are few datasets that track measures over time that can be used to correlate access with specific clinical outcomes. In addition, the existing measures typically focus on medical care (for example, physician visits) and there are far fewer measures for other types of services, such as long-term services and supports, which are disproportionately important in Medicaid. In theory, access should be measured in terms of achievement of specific metrics (did individuals receive the care they needed with improved health outcomes); in practice, access is primarily monitored using process and outcome measures, and whether they are similar to other populations and if they change over time.

## What Do We Know About Access to Care in Medicaid?

In keeping with its statutory authority to review access policies under Medicaid and CHIP, MACPAC has conducted literature reviews, analyzed survey and claims data, and assessed the potential impact of federal and state legislation and regulations on access to care among Medicaid beneficiaries. For example, a chapter in the June 2013 report discussed what is known about access to care among people with disabilities enrolled in Medicaid coverage (MACPAC 2013). We have analyzed data from large federal household surveys to compare access to care by adults under age 65 and children enrolled in Medicaid to those same age groups that have private insurance and who are uninsured, and have reported our results in *MACStats* and a series of issue briefs (MACPAC 2016a, 2016b, 2016c, 2016d, 2016e, 2016f, 2016g). We have also conducted original analyses using Medicaid administrative data to assess the effect of state Medicaid policies for paying Medicare cost sharing on beneficiary use of services (MACPAC 2015a).

The body of work to date by MACPAC and others shows that Medicaid beneficiaries have much better access to care, and much higher health care utilization, than individuals without insurance, particularly when controlling for socioeconomic characteristics and health status (MACPAC 2012b, 2012c). Medicaid beneficiaries also fare as well as or better than individuals with private insurance on some access measures. Adults with Medicaid are as likely to have a usual source of medical care as those with private coverage. They are also as likely as privately insured individuals to have a physician visit in a given year and to receive some important health care services, such as Pap tests (MACPAC 2016a, 2016b, 2016c, 2016d, 2016e, 2016f, 2016g, NCHS 2016). Low-income adults under age 65 with Medicaid coverage are actually less likely to worry about paying for medical bills than those with private coverage (MACPAC 2016e). Children enrolled in Medicaid or CHIP are more likely to

receive behavioral health care services than those with private insurance.<sup>1</sup>

Although utilization rates for many services are comparable, Medicaid enrollees often experience more difficulty obtaining health care. For example, our analyses show that adults and children with Medicaid coverage have more problems than privately insured individuals in obtaining care, that is, they experience longer wait times for appointments, have more difficulty finding a provider who will treat them, have more trouble obtaining transportation, or have to wait longer at the provider's site of care (MACPAC 2016b, 2016e). Adult Medicaid beneficiaries are less likely to receive mammograms and colorectal tests than the privately insured (MACPAC 2016f). The rates of people with a dental care visit in the past year, an optional benefit for adults but a mandatory benefit for children, are also lower for adults and children covered by Medicaid than for those with private health insurance (MACPAC 2016d, 2016g).

Medicaid beneficiaries, like other low-income individuals, may have lower health literacy, more transportation and child care difficulties, and other factors that affect their ability to access health care. Some of the differences in access between Medicaid-enrolled and privately insured populations may be due to these factors rather than to specific features of Medicaid, such as low provider payment rates or lack of coverage for certain types of services. However, even when comparing similarly situated individuals, some differences remain. For example, Medicaid enrollees have more difficulty than low-income privately insured individuals in finding a doctor who accepts their insurance and making an appointment; Medicaid enrollees also have more difficulty finding a specialist physician who will treat them. Other differences narrow when controlling for income, such as rates of dental visits for children and rates of mammography for women age 50–64 (MACPAC 2016d, 2016f).

People with disabilities, who are represented in the Medicaid population at higher rates than in

the general population, have particular barriers to care, including access to specialist services. Children with special health care needs enrolled in Medicaid or CHIP have more problems obtaining an appointment and finding a doctor who accepts their health insurance than those with special health care needs covered by private insurance (MACPAC 2016b).<sup>2</sup> Adults under age 65 with a disability who are covered by Medicaid are more likely than their privately insured counterparts to report having trouble finding a general doctor, having trouble finding a doctor who would accept their health insurance, and being unable to obtain needed medical care due to cost (MACPAC 2016e).

## Monitoring Access in Fee-for-Service Medicaid

Although managed care is now the dominant delivery system in Medicaid, monitoring access under FFS remains important for several reasons. First, a substantial portion (55 percent) of national Medicaid spending was for services provided under FFS arrangements in fiscal year 2015 (MACPAC 2016a).<sup>3</sup> The use of FFS varies by state—Tennessee and Vermont operate exclusively in a managed care environment, but other states, such as Connecticut and Oklahoma, operate mainly under FFS. Still, even FFS states may use features similar to managed care, such as medical homes and case management services.

Second, the populations that remain in FFS Medicaid, such as children and adults with disabilities, are among the most vulnerable beneficiaries, and ensuring their access to services is particularly important given their high health needs. For example, in Arizona, two-thirds of individuals with disabilities are enrolled in comprehensive managed care, but in West Virginia, less than 2 percent of beneficiaries with disabilities receive services through managed care arrangements.

Third, even in states with high managed care penetration, some services, such as long-term services and supports, dental services, and behavioral health services, are carved out of managed care contracts and provided through FFS arrangements. As a result, many enrollees receive some care under both types of arrangements, and the data needed to monitor access are captured separately for care provided under FFS and managed care.

## Access requirements in FFS Medicaid

Efforts to monitor access to care in FFS Medicaid stem from the provision of the Social Security Act (the Act) requiring that states set Medicaid provider payment rates so that they are “consistent with efficiency, economy, and quality of care” and “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” (§ 1902(a)(30)(A) of the Act). As such, the focus under FFS has primarily been on how changes in payment rates might affect provider participation, as well as on monitoring whether beneficiaries enrolled in FFS have a level of access that is similar to others in their geographic area. Although FFS enrollees may see any participating Medicaid provider who will treat them, payment rates that are too low may discourage providers from treating Medicaid-enrolled individuals, thus impairing these individuals’ access to services.

Until recently, there were no federal regulations to guide states in meeting the equal access provision. This absence of federal guidance led to substantial variation in the processes and standards used by states to monitor and ensure access to care in FFS Medicaid. In some instances, payment rates were determined to be too low to ensure equal access to Medicaid services primarily as the result of lawsuits filed by providers and beneficiaries. On March 31, 2015, in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), the Supreme Court decided that Medicaid providers and



beneficiaries do not have a private right of action to contest state-determined Medicaid payment rates in federal courts, making federal enforcement of the equal access provision that much more important.

On November 2, 2015, the Centers for Medicare & Medicaid Services (CMS) published a final rule describing how states should monitor and report on access to care under FFS Medicaid (CMS 2015a). CMS noted that the goal was to provide a more transparent process for monitoring access to services paid for under FFS arrangements and to allow CMS to make and document informed, data-driven decisions when considering proposed rate reductions and other payment or state program changes that could reduce beneficiaries' abilities to receive needed care. The monitoring requirements also apply to populations receiving services paid on a FFS basis when carved out of managed care as well as those in primary care case management arrangements.

**Access monitoring review plans.** CMS's final 2015 rule required states to submit an access monitoring review plan by October 1, 2016.<sup>4</sup> This plan was to have been developed with the state's medical care advisory committee, as well as provider and beneficiary input, and made available for public comment for at least 30 days. CMS reviewed state plans for compliance with the requirements, but did not formally approve those plans.

The access monitoring review plan applies to five categories of services: primary care services, physician specialist services, behavioral health services, prenatal and postnatal obstetric services, and home health services. The state must also monitor additional services for which the state or CMS has received a significantly higher than usual call volume of access complaints from beneficiaries, providers, or other stakeholders. In addition, states must submit a recent access review with any state plan amendment proposing a reduction or restructuring of payment rates that could result in diminished access. The plans

must also include procedures to periodically monitor access for at least three years after the implementation of a provider rate reduction or restructuring.

The rule includes additional parameters for such plans. For example, they must include the measures, data sources, methods, and thresholds used to analyze access. This analysis must also take into account state-specific delivery systems, beneficiary characteristics, and geography. In making a determination of whether access is sufficient, the plan must consider the following:

- the extent to which beneficiary needs are fully met;
- the availability of care through enrolled providers (by geographic area, provider type, and site of service);
- changes in beneficiary utilization;
- characteristics of the beneficiary population; and
- actual or estimated provider payments from other payers.

When problems with access are identified, states must submit, within 90 days, a plan of corrective action listing specific steps and timelines to address the issues within 12 months. Corrective actions can take a variety of forms, including, but not limited to, increasing provider rates, improving provider outreach, reducing barriers to provider enrollment, providing additional transportation or telehealth services, and improving care coordination (Kvedar et al. 2014).

## Initial review of draft state access monitoring plans in FFS

An initial review of the draft state access monitoring review plans from 49 states shows that the approach to monitoring access varies across states; nevertheless, some common

themes emerged, as noted below.<sup>5</sup> Some states noted in their draft plans that the vast majority of enrollees in their state receive services through managed care entities and commented on the administrative burden of monitoring access for what was sometimes perceived as the small and idiosyncratic population enrolled in FFS Medicaid. It is likely that the approaches outlined in the drafts will change as state access monitoring review plans are finalized and ongoing state efforts to monitor access evolve.

### **Existing state approaches to monitoring access.**

Current state approaches to monitoring access primarily rely on consumer complaint hotlines and advisory committee meetings. Some states also discussed their efforts to address access issues as an indication that once a problem is identified, the state works to address it. For example, a number of states have initiatives designed to improve access through delivery system reforms, such as accountable care organizations and telehealth, or through provider incentives, such as loan repayment programs.

**Baseline data.** Most states reported baseline data across the five required service areas, and some states included data pertaining to additional service areas for which access issues had been identified, such as dental and transportation services. Some states deliver all prenatal and postnatal care or behavioral health services through managed care arrangements, so baseline data for these services were not presented. Baseline data were reported from a variety of sources, such as utilization data from claims, self-reported access measures from beneficiary surveys, and provider enrollment figures. States also differed in the extent to which they included demographic or other enrollee characteristics that would allow them to identify the populations served through FFS arrangements.

**Standards or benchmarks.** Although some states provided trend data or made regional comparisons as part of their baseline reporting, they typically did not provide a standard for what would be

considered adequate access. Overall, only a handful of states included explicit standards or benchmarks for comparisons. For example, a few states set a provider-to-enrollee ratio and others used the ratios in managed care network adequacy requirements. In assessing utilization, a few states compared utilization to individuals with private insurance coverage.

**Provider rate comparison.** A majority of states made comparisons to Medicare payment rates, while a smaller number looked at the rates paid by Medicaid in other, typically neighboring, states. In making the comparison to other states, a number relied on the Medicaid-to-Medicare physician fee index published by researchers at the Urban Institute (Zuckerman et al. 2014). Few states had available private payer data, although those with access to exchange plan data or all-payer claims databases included such comparisons.

**Corrective action plan.** Most states reported little in terms of concrete steps to address access issues when they are discovered, although the plans typically declared the state's intent to work with CMS to address issues within the required time frame. A number acknowledged that any potential access issue would likely require investigation to determine the most appropriate response. For example, one state described the use of a response team to determine the cause of the access issue and to develop a corrective action plan. A few states identified areas for improvement in their review and highlighted the particular steps they would take to investigate and address the issue.

## **Current access monitoring practices in FFS**

To gain a better understanding of the approaches that states take to monitor, assess, and improve access for populations covered under FFS Medicaid, MACPAC contracted with RTI International to conduct a survey of state Medicaid programs. The survey provides MACPAC and others

with additional details beyond those available in the state plans, for example, the types of measures used, the frequency of data collection, and how states use the measures.

The survey asked about state practices that were in effect on May 1, 2016. First, a screener determined which populations were receiving services under FFS Medicaid in the state. The remainder of the survey focused on three aspects of access that states might measure: beneficiary experience accessing covered services, beneficiary utilization of covered services, and provider supply. If applicable, states were asked to report the populations (such as children or adults with disabilities, the elderly, or pregnant women) for which these data were collected. They were also asked whether they were collecting data for specific types of services and providers. These additional details were sought in part to understand where existing efforts align with the

requirements of the new rule. (For a full list of the populations, services, and providers included in the survey, see Appendix 4A, Table 4A-1.) The survey also asked about the types of data collected, the frequency of data collection, and how states used the measures. The survey was fielded from August 8 through September 20, 2016, and 37 states responded.

**Survey findings.** All of the 37 states that responded to the survey provided services on a FFS basis to at least 4 of the 10 populations listed, and 27 of the states provided services on a FFS basis to all of the populations (Table 4-1).

Of the three general types of access measures, 29 of the 37 responding states reported collecting data for one or more of the measure types related to beneficiary experience accessing covered services; 29 responding states reported collecting data for measures of beneficiary utilization of

**TABLE 4-1. Number of States Serving Specific Populations in Fee-for-Service Medicaid, 2016**

Population	Number of states
Non-disabled children	34
Non-disabled adults	32
Individuals age 65 and older	34
Children with physical disabilities	35
Adults with physical disabilities	34
Children with intellectual or developmental disabilities	36
Adults with intellectual or developmental disabilities	35
Children with severe emotional disturbance or substance use disorders	34
Adults with severe mental illness or substance use disorders	33
Pregnant women	30

**Notes:** Data are shown for the 37 responding states.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid fee-for-service beneficiaries' access to care.

**TABLE 4-2. Number of States Collecting Category-Specific Access Measures, 2016**

Access measure	Number of states
Beneficiary experiences accessing covered services	29
Receipt of covered services	26
Receipt of timely covered services	20
Specific barriers to covered services	19
Utilization of covered services	29
Provider supply	21

**Note:** Data are shown for the 37 responding states.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid fee-for-service beneficiaries' access to care.

covered services; and 21 responding states collected data related to provider supply measures (Table 4-2). Thirteen responding states collected data across all five of these areas. (See Appendix 4A, Table 4A-2 for a breakdown of the access measures collected by each state.)<sup>6</sup>

**Populations, services, and providers.** In most areas of measurement, there was little variation in the number of states collecting data for particular populations. In terms of services and providers, states most often collected measures related to primary and specialty care, behavioral health, and dental health. Given prior analyses suggesting that these are areas where access to services may be an issue in FFS Medicaid, monitoring efforts targeting these specific areas would be expected. (See Appendix 4A, Tables 4A-3, 4A-4, and 4A-5 for specific populations, services, and providers for which measures are collected.)

**Beneficiary experience.** Of the 29 states that reported collecting data on beneficiary experience accessing covered services, 26 collected data relating to beneficiary receipt of covered services. Twenty states collected data on the timely receipt of covered services, such as whether enrollees were able to obtain an appointment or find a

provider that accepted Medicaid. Nineteen states collected data on the specific barriers to covered services, for example, the lack of transportation to a provider. Sixteen states collected data for all three beneficiary experience measures.

Across the types of beneficiary experience measures, states focused their efforts on specialty services, primary care, and behavioral health services. Regarding timely receipt of services, states most often collected data on the ability to find a provider and the ability to find one that accepted Medicaid. States were also more likely to collect data related to an individual's inability to secure a usual source of care and the lack of transportation to providers than data related to other potential access barriers.

**Beneficiary utilization of covered services.**

Twenty-nine of the 37 responding states reported that they collected measures of beneficiary utilization. Sixteen collected data for all of the survey populations, 19 collected data for all provider types, and 11 collected data for all service types.

**Provider supply.** Twenty-one states collected provider supply measures for either the state overall or Medicaid FFS populations specifically.

States most commonly collected data on the ratio of participating providers to the population (16 states); provider participation in Medicaid (15 states); and the overall number of providers in the state, but not necessarily those serving Medicaid beneficiaries (15 states). States also tended to focus their efforts on primary care providers and specialty care providers, followed by behavioral health and dental providers.

**Data sources and comparisons.** Across the measures of beneficiary experience and utilization, states most often used claims data, beneficiary surveys, complaint hotline caller logs, and stakeholder meetings to assess the adequacy of enrollee access. In making these assessments, states compared the data to trends from previous years and national Medicaid averages. A number of states also reported these data publicly, while smaller numbers used them to provide feedback to providers or guide corrective action. To assess provider supply in Medicaid and across the state, states most often used provider enrollment data, comparing them to trends from previous years. States used these data to assess the adequacy of access and report publicly, as well as to guide state policy to increase provider supply. (See Appendix 4A, Tables 4A-6, 4A-7, and 4A-8 for sources, uses, and comparisons of the data collected.)

## Monitoring Access in Medicaid Managed Care

Unlike FFS arrangements, in which states pay providers directly and are solely responsible for monitoring access, managed care arrangements involve states contracting with managed care organizations (MCOs), which in turn contract with providers and monitor and enforce access and quality standards. State Medicaid programs approve contracts that describe how access will be monitored and deficiencies corrected, but in most cases do not pay or interact with providers directly. Managed care offers states the opportunity to provide access to appropriate services and

coordinate care for Medicaid enrollees—linking each enrollee with a regular source of primary care, arranging access to a contracted network of providers, and providing support services such as health education. Because managed care plans are paid on a capitated basis, there are risks that these arrangements will incentivize plans to contain costs through limited provider networks or inadequate payment rates that could negate some of the positive aspects of ensuring access to care. States maintain contractual oversight of the plans and have an obligation to ensure that beneficiaries receive the appropriate services and that capitation payments are actuarially sound and made to entities that can provide these services.

### Access requirements in Medicaid managed care

Access to Medicaid services for enrollees in managed care are covered under Sections 1903(m) and 1932 of the Act. MCOs must show the state and the Secretary of the U.S. Department of Health and Human Services (the Secretary) that they have the capacity to serve the expected number of enrollees and provide evidence that the plan offers an appropriate range of services, including access to preventive and primary care services, and maintains a sufficient number, mix, and geographic distribution of providers. The statute also requires that MCOs have procedures in place for monitoring and evaluating the quality and appropriateness of care and services to beneficiaries and that these services reflect the full spectrum of the needs of the populations enrolled under the contract. Medicaid MCOs must also document standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care, adequate primary care, and specialized services capacity (§1932 of the Act).

On May 6, 2016, CMS issued a final rule that amended previous provisions governing network adequacy and access monitoring in MCOs (CMS

2015b). Specifically, the final Medicaid managed care rule includes provisions regarding network adequacy standards for both the state and the MCOs. Under the final rule, states are required to develop—and make publicly available—time and distance network adequacy standards for providers, including primary and specialty care providers (adult and pediatric), obstetrician/gynecologists, behavioral health providers, hospitals, pharmacies, pediatric dental providers, and additional provider types as determined by CMS (42 CFR 438.68). The rule applies to services provided to beneficiaries who are enrolled in managed care, including those who receive some carved-out services, such as behavioral health and dental services, in FFS arrangements.

The Medicaid managed care final rule also lists factors that states must consider in setting standards, including the ability of providers to communicate with limited English proficient enrollees and to accommodate enrollees with disabilities. States should also consider the availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and other evolving and innovative technological solutions (42 CFR 438.68).

States must develop standards for all geographic areas of the state covered by the managed care program, but may allow capitated plans to meet different standards in different parts of the state. For example, a state could require plans to provide primary care within 10 miles or 15 minutes in urban areas of the state, but within 30 miles or 45 minutes in rural areas. States may grant exceptions to its time and distance standards, as long as the exceptions process is set forth in the plan contract and is based on the number of providers in the relevant specialty area who are practicing in the plan’s service area. State time and distance standards must be published on the state’s website and be provided in hard copy and accessible formats upon request. If states create exceptions to network adequacy standards, they must monitor

enrollee access on an ongoing basis (42 CFR 438.68).

The rule also has more specific requirements, such as ensuring that female beneficiaries have direct access to women’s health specialists and timely access to family planning services. Enrollees must also be able to get second opinions from an in-network or out-of-network provider, if necessary. Furthermore, beneficiaries must be permitted to obtain medically necessary services out of network, and out-of-network providers must coordinate with MCOs to ensure that enrollees do not have to pay more for these out-of-network services. Network providers must offer hours of operation no less than those offered to commercial beneficiaries or comparable to Medicaid FFS, and must offer around-the-clock services when medically necessary (42 CFR 438.206).

The provisions of the new managed care final rule will be phased in over a period of time. The new network adequacy standards will apply to plan years beginning on or after July 1, 2018, and states are now starting to set up their newly required standards and practices.

## Current access monitoring practices in managed care

Managed care plans may be in a better position than state officials to monitor beneficiary access to care; their defined population of enrollees and providers provides a ready source for data collection. Furthermore, 33 states either require or recognize health plan accreditation from the National Committee for Quality Assurance (NCQA), which includes consistent data collection and reporting across states and plans. NCQA accreditation requires annual submission of data collected by the Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. HEDIS is a set of state-level quality, access, and effectiveness-of-

care measures for selected conditions, including measures related to the receipt of certain cancer screenings and child immunization rates; CAHPS is a set of beneficiary surveys designed for children and adults that covers a range of topics, including access to care (Toppe 2016).

Because federal regulations did not require specific network adequacy or other access standards before the May 2016 rule, and the new standards are not yet in effect, states vary considerably in what they require in MCO contracts and how the state monitors access once the contracts are in place. Many states have a standard for the maximum distance or travel time allowed to travel to a primary care provider; fewer specify these distances or travel time maximums to specialists (KFF 2016a; KFF 2016b). Standards range from requiring 1 primary care provider for every 100 enrollees to 1 primary care provider for every 2,500 beneficiaries. Additionally, standards are often not specific to certain types of providers or to areas of the state.

States also use different strategies to assess compliance with the access standards established in their managed care contracts. They typically do not use what are called direct tests, such as making calls to providers. A review by the OIG found that most states did not identify any violations of their access standards over a five-year period; the states that found the most violations were those that conducted direct tests of compliance. Among the states that identified violations, most relied on corrective action plans to address the violations, and only six imposed sanctions. Finally, the study found that CMS provided limited oversight of state access standards (OIG 2014b).

## Challenges to Monitoring and Ensuring Access in Medicaid

States monitor access to ensure that Medicaid beneficiaries have adequate access to care and

to provide feedback on where their programs are succeeding and where there are problems requiring attention. These activities also help the federal government assess whether states are using their federal funds in an appropriate manner and make comparisons across states. However, limitations in available and timely data, standard and validated access measures and benchmarks, and administrative capacity are major challenges for states and CMS in monitoring access. In addition, states and the federal government may have different priorities for access monitoring: while CMS may be focused on the need for standard access measures that can be compared across states, states may value measures tailored to their populations and local circumstances that can provide information for program improvement.

### Data limitations

Consistent and detailed data across states and programs are lacking. Many sources of data are available to characterize access at the national level, but far fewer are available at the state level. For example, national household surveys have limited sample sizes at the state level, so few can be used to produce state-level estimates. Administrative or claims data do not contain information on care that is needed but not obtained. In addition, race and ethnicity are not well reported in administrative datasets and often not collected by plans, although the percentage of plans collecting these data is increasing (Escarce et al. 2011). Administrative data also cannot be used to compare measures across payers because the data are generally payer-specific.

The completeness of data may also be a function of delivery system design. States that continue to pay predominantly under FFS may have standardized data that can be used to monitor access for all enrollees. In states with high managed care penetration, contracts with plans may allow states to get more specific data for use in monitoring access. However, plans may collect those data differently, so while states

may have data from all plans, the data are not necessarily comparable, making it difficult to make comparisons across plans, as well as across states.

It is also difficult to assess the sufficiency of Medicaid payment rates without payment data from other states or payers. Private payer data are often considered proprietary and states may not have ready access to them. Furthermore, although Medicare rates may be available for comparison, Medicare providers might not provide services that can be compared to, for example, pediatric dentistry under Medicaid plans.

All-payer claims databases are beginning to become more common, and have the potential to be used to compare Medicaid to privately insured populations. States are also using these databases to compare patterns of care across payers, including the use of emergency department services and differences in specific services for specific conditions by geographic area, race and ethnicity, and other available characteristics of beneficiaries (APCD Council 2017). However, these datasets do not capture the experience of uninsured populations and, like other administrative datasets, they do not contain much information on social determinants of health or need for services (Porter et al. 2014).

## Available measures

Access to care has been studied for decades, and well-established measures that can be used to compare access across states are available, for example, HEDIS measures quality, access, and the effectiveness-of-care measures and the CAHPS beneficiary surveys include data on access to care and satisfaction with providers. Some state Medicaid agencies use CAHPS and similar measures to gauge member satisfaction with Medicaid managed care arrangements and many require participating MCOs to collect and report HEDIS data. These standard measures are useful in comparing broad-based measures, such

as whether individuals saw a physician in the past year, whether they had a usual source of medical care, or whether they reported receiving needed medical care, across states and programs.

However, states vary in their adoption of these measures, in part because there is no federal mandate on their use and in part because their populations and monitoring needs differ. For example, some states have focused on particular populations, such as children, in their use of the CAHPS, while others have adopted the measures more broadly. This inconsistent use of standard measures makes it difficult to compare access across state Medicaid programs. A recent report commissioned by CMS proposed measures that could be used to monitor access in FFS populations across states in compliance with the FFS access rule, primarily using existing data sources and validated measures. The report recommended that states use measures that align with existing data collection activities, including the CMS Core Sets of Adult and Child Health Care Quality Measures for Medicaid and CHIP (otherwise known as the Adult and Child Core Sets), the Transformed Medicaid Statistical Information System (T-MSIS), and the Nationwide Adult CAHPS survey. The report also recommended that states add some new measures based on secret shopper audits as part of their monitoring and contract compliance activities (Kenney et al. 2016).

These broad-based measures, however, may not be sufficient for monitoring Medicaid access for specific services and populations, and in many cases local conditions affect comparisons of even commonly used standard measures. Ideally both types of measures would be used to collect data: standard measures in national data collection activities to identify broad-brush differences in access, but also more specific measures tailored to the needs of specific populations, services, and localities.

CMS acknowledged the need for better and possibly more measures when it issued the



equal access rule, issuing at the same time a request for information, due January 4, 2016, that asked interested parties to share measures and methods to take into account differences in delivery system designs, populations served, and provider networks. For example, CMS noted the need for measures to address the many factors that affect access to Medicaid services, including the following: “level of payment, geographic location, time and distance to the closest provider, workforce, numbers of specialists and other types of providers within the state, lack of knowledge of available resources by beneficiaries, insufficient provider outreach, scope of practice approaches, and other economic and policy factors” (CMS 2015b).

More specific access measures are needed that are relevant to specific localities, populations, and services. Transportation may be more of a barrier to access in some areas, whereas finding a provider willing to treat the beneficiary may be of greater concern in another location. States that allow telehealth may have different distance standards than those that do not. Physical barriers to access, such as width of elevator doors, lack of ramps, or specialized exam tables, may be problematic for people with disabilities but not for other populations. Development of measures of access for services that are not usually covered by other insurers, such as home and community-based services and enhanced behavioral health services, like applied behavioral analysis for autism spectrum disorder, lags behind development of measures of access to more commonly used medical services.

## Lack of benchmarks

A key question in assessing access to care in Medicaid is defining an appropriate comparison. The FFS standard established in the statute—that access be comparable to the general public—is problematic for several reasons. First, many of the populations served by Medicaid are not covered by other insurers, meaning that there is no true

comparison group. Even within Medicaid, given the diverse specific needs of Medicaid enrollees, the large number of services they use, and the wide range of available providers across locations, collecting information on the numerous potential barriers to access may differ across states and programs and therefore not readily allow comparisons.

Second, given the trend in private coverage towards more high-deductible, limited network plans with lower actuarial value, it is not clear that a comparison to this standard would be a measure of sufficient access to care for Medicaid beneficiaries, because many services that are covered by Medicaid are not covered by private insurers or may be available only after high copayments. In addition, state regulations differ with regard to private plans and mandated benefits. As such, private plans in one state may not be similar to those in other states, much less Medicaid programs. Further complicating access monitoring in Medicaid programs is the fact that different Medicaid programs and plans cover different optional services with different restrictions and eligibility rules. For example, state plan dental and behavioral health services differ considerably by state, and the benefits offered in MCOs and waiver services vary even more (MACPAC 2015b, 2015c).

## Administrative capacity constraints

Medicaid agencies at both the state and federal level are often expected to manage a large and diverse set of responsibilities but continue to face staff shortages and resource constraints. In a 2017 survey of state Medicaid agencies, 31 states cited budgetary constraints at the administrative, agency, or state level as an overall issue, with particular inability to fully address program reforms (NAM 2016). CMS also faces budget constraints, staff attrition, and the changing nature of health care program oversight (MACPAC 2014). For example, the new managed care and access rules described earlier create new obligations for agency staff to review all state Medicaid access

monitoring plans, evaluate whether any proposed payment changes will affect access, and review managed care contracts to ensure that capitation rates are actuarially sound.

State and federal Medicaid agencies are also constrained in their ability to collect, analyze, and report data, important functions for monitoring access in Medicaid. A number of states with large managed care populations have also voiced their concerns regarding the burden of monitoring the typically small and sometimes unique populations that continue to receive services in FFS. State capacity to review managed care contracts and ensure that measures of access are appropriate may also be an issue because of competing priorities with other oversight responsibilities and staff expertise with data analysis, access measurement, and managed care contracting.

### Lack of data on effectiveness of interventions to increase access

States and CMS would benefit from greater understanding of effective strategies to increase access to care in Medicaid, yet the outcomes associated with past and ongoing interventions are largely unknown. Many states have worked to improve provider participation by increasing payment rates, reducing paperwork, and creating loan repayment programs. Others have focused on expanding the pool of available providers for certain services, for example, dental hygienists and nurse practitioners, and by expanding use of telehealth. Other access initiatives have focused on increasing office hours and after-hours access, promoting use of non-emergency medical transportation, and providing enabling services such as translation and interpretation (Bodenheimer and Pham 2010, Rowland and Salganicoff 1994).

Some barriers, such as overall provider supply, may be beyond the purview of the Medicaid program, although agencies may be able to work with others

to lessen these barriers. For example, Medicaid programs have collaborated with state licensing boards to change licensing laws or scope of practice regulations to increase overall provider supply, which may also increase the number of providers participating in Medicaid. Medicaid can also work collaboratively to target access barriers for specific populations served through other agencies. For example, Medicaid programs in several states are working with criminal justice systems to enroll individuals prior to their release so they can continue needed health services without interruption (CMS 2016b).

As discussed above, states have undertaken a variety of approaches to increase provider supply; however, little is known as to which approaches are successful, and whether their success differs by provider type or service location. As such, it is difficult for Medicaid administrators to determine which intervention is most appropriate. Sharing information across programs—including the associated costs and outcomes—could help to spread the adoption of successful approaches to improving access.

## Conclusion

States vary considerably in their approaches to monitoring access to care, and these efforts will likely evolve in response to the final rules issued by CMS in 2015 and 2016. But despite measurement and capacity constraints, states and the federal government have an obligation to ensure that Medicaid beneficiaries have sufficient access to services. Increasing the ability to monitor access to care, and increased attention to doing so, also increases transparency and accountability for program spending. This oversight, both by CMS and by state agencies, can and should be further strengthened with more timely and consistent data collection and program evaluation.

Given its statutory charge, MACPAC will continue its work to assess the performance of Medicaid

and CHIP relative to the fundamental goal of providing access to appropriate and effective services that lead to better health at a reasonable cost. The Commission will continue to follow state activities that put FFS monitoring plans into action and work with MCOs to implement the managed care rule. We will also monitor developments to improve data collection and analysis that have the potential to provide timely and important information and are consistent with the administrative resources of the states and federal government, such as the implementation of the T-MSIS. We will continue our examination of areas within the Medicaid program for which there are no obvious benchmarks to commercial insurance and where traditional measures of access are not easily applied. And as states develop and implement new value-based delivery system models in their Medicaid and CHIP programs, the Commission will consider their impact on access to care.

## Endnotes

- <sup>1</sup> This analysis does not control for need for services.
- <sup>2</sup> Children with special health care needs are identified through a series of questions that ask about the following: the need for or use of medicines prescribed by a doctor; the need for or use of more medical care, mental health, or education services than is usual for most children; being limited in or prevented from doing things most children can do; the need for or use of special therapy, such as physical, occupational, or speech therapy; and the need for or use of treatment or counseling for emotional, developmental, or behavioral problems. Parents or other respondents who responded yes to any of the initial questions in the sequence were then asked to respond to up to two follow-up questions about whether the health consequence was attributable to a medical, behavioral, or other health condition lasting or expected to last at least 12 months. Children with positive responses to all of the follow-up questions for at least one of the five health consequences were identified as having a special health care need.
- <sup>3</sup> This figure represents spending in managed care and premium assistance, and includes comprehensive and limited-benefit managed care plans, primary care case management, employer-sponsored premium assistance programs, and Programs of All-Inclusive Care for the Elderly. Comprehensive plans account for over 90 percent of spending in the managed care category. Managed care also includes rebates for drugs provided by managed care plans and managed care payments associated with the primary care physician payment increase, Community First Choice option, and preventive services with U.S. Preventive Services Task Force Grade A or B, and Advisory Committee on Immunization Practices vaccines.
- <sup>4</sup> States were initially required to submit their access monitoring review plan, including the first review of the sufficiency of access, by July 1, 2016. A subsequent rule delayed the submission until October 1, 2016 (CMS 2016a).
- <sup>5</sup> Two states—Vermont and Tennessee—were exempt from developing plans because they have no FFS enrollment in their Medicaid programs. The basis for exemption is for states to confirm that 100 percent of the population is enrolled in managed care and that they have no FFS volume

for the services subject to ongoing review. Only Tennessee and Vermont were able to provide confirmation of this (Silanskis 2016).

<sup>6</sup> Five states (Alaska, New Jersey, New Mexico, Vermont, and West Virginia) did not report collecting any of these types of measures. It may be that because the reference date for our survey was prior to the requirement for the development of an access monitoring review plan, these states were not yet doing anything specific to monitor access in their FFS Medicaid programs. It may also be that the survey questions did not adequately capture their existing monitoring efforts. As discussed above, each of these states (except for Vermont, which was exempt based on its high level of managed care-like enrollment) submitted an access monitoring review plan to CMS outlining its approach to ongoing access monitoring.

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## APPENDIX 4A: Summary Tables from State Survey on Measuring Access to Care in Fee-for-Service Medicaid

**TABLE 4A-1.** Categories of Populations, Services, and Provider Types Used in Access-to-Care Survey, 2016

Populations	Services	Provider types
<ul style="list-style-type: none"> <li>• Non-disabled children</li> <li>• Non-disabled adults</li> <li>• Individuals age 65 and older</li> <li>• Children with physical disabilities</li> <li>• Adults with physical disabilities</li> <li>• Children with intellectual or developmental disabilities</li> <li>• Adults with intellectual or developmental disabilities</li> <li>• Children with severe emotional disturbance or substance use disorders</li> <li>• Adults with severe mental illness or substance use disorders</li> <li>• Pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care</li> <li>• Specialty care</li> <li>• Child developmental screening</li> <li>• Behavioral health</li> <li>• Prenatal and postpartum care and services</li> <li>• Home health services</li> <li>• Long-term services and supports</li> <li>• Dental care and services</li> <li>• Emergency department services</li> <li>• Pharmacy services</li> <li>• Any covered service (specific service(s) not measured)</li> <li>• Other services</li> </ul>	<ul style="list-style-type: none"> <li>• All providers</li> <li>• Primary care providers</li> <li>• Specialty care providers</li> <li>• Behavioral health providers</li> <li>• OB/GYN providers</li> <li>• Home health providers</li> <li>• Dental care providers</li> <li>• Other providers</li> </ul>
<p><b>Applies to following questions:</b></p>	<p><b>Applies to following questions:</b></p>	<p><b>Applies to following questions:</b></p>
<ul style="list-style-type: none"> <li>• Screener for populations served by fee for service</li> <li>• Beneficiary receipt of covered services</li> <li>• Beneficiary receipt of timely services</li> <li>• Specific barriers to obtaining services</li> <li>• Beneficiary utilization</li> <li>• Provider supply</li> </ul>	<ul style="list-style-type: none"> <li>• Beneficiary receipt of covered services</li> <li>• Beneficiary receipt of timely services</li> <li>• Specific barriers to obtaining services</li> <li>• Beneficiary utilization</li> </ul>	<ul style="list-style-type: none"> <li>• Beneficiary receipt of timely services</li> <li>• Specific barriers to obtaining services</li> <li>• Beneficiary utilization</li> <li>• Provider supply</li> </ul>

**Notes:** To gain a better understanding of the approaches that states take to monitor, assess, and improve access for populations covered under fee-for-service Medicaid, MACPAC contracted with RTI International to conduct a survey of state Medicaid programs. The survey asked about state practices that were in effect on May 1, 2016. The survey also asked about the types of data collected, the frequency of data collection, and how states used the measures. The survey was conducted from August 8 through September 20, 2016, and 37 states responded.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid fee-for-service beneficiaries' access to care.

**TABLE 4A-2.** Specific Access-to-Care Measures, by Category, Collected by Each State in FFS Medicaid, May 1, 2016

State (N = 37) <sup>1</sup>	Total number of access measures collected per state	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply	Other types of access measures <sup>2</sup>
		Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services			
<b>States collecting any measure of access in category</b>	N/A	26	20	19	29	21	12
Alabama	6	✓	✓	✓	✓	✓	✓
Alaska <sup>3</sup>	N/A						
Arkansas	1				✓		
California	3		✓		✓	✓	
Colorado	5	✓	✓	✓	✓	✓	
Connecticut	6	✓	✓	✓	✓	✓	✓
Delaware	2	✓			✓		
District of Columbia	4	✓			✓	✓	✓
Georgia	4	✓	✓	✓	✓		
Idaho	5	✓	✓	✓	✓	✓	
Indiana	4		✓	✓	✓	✓	
Iowa	6	✓	✓	✓	✓	✓	✓
Kentucky	4			✓	✓	✓	✓
Louisiana	2	✓		✓			
Maine	5	✓	✓	✓	✓	✓	
Maryland	3	✓			✓		✓
Michigan	4	✓	✓	✓	✓		
Minnesota	2				✓	✓	
Missouri	2	✓			✓		
Montana	6	✓	✓	✓	✓	✓	✓
Nevada	2	✓					✓
New Hampshire	2				✓	✓	
New Jersey <sup>3</sup>	N/A						
New Mexico <sup>3</sup>	N/A						
New York	4	✓			✓	✓	✓
North Carolina	3	✓	✓	✓			



**TABLE 4A-2. (continued)**

State (N = 37) <sup>1</sup>	Total number of access measures collected per state	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply	Other types of access measures <sup>2</sup>
		Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services			
Oklahoma	5	✓	✓	✓	✓	✓	
Oregon	5	✓	✓	✓	✓		✓
Rhode Island	2	✓			✓		
South Carolina	6	✓	✓	✓	✓	✓	✓
South Dakota	5	✓	✓	✓	✓	✓	
Utah	4	✓	✓		✓	✓	
Vermont <sup>3</sup>	N/A						
Virginia	4	✓	✓		✓	✓	
Washington	6	✓	✓	✓	✓	✓	✓
West Virginia <sup>3</sup>	N/A						
Wyoming	5	✓	✓	✓	✓	✓	

**Notes:** FFS is fee for service. N/A is not applicable. A blank cell indicates that the state does not collect data for the access measure type in question.

<sup>1</sup> The table excludes the 14 states that did not participate in the survey.

<sup>2</sup> These states provided varying levels of detail about other types of access measures they collected. Many indicated sources of data (e.g., member surveys, call centers) rather than types of measures. In some cases, the measure provided might fit within one of the categories specified in the survey, for example, measures of cultural competency could be considered a type of barrier to covered care. However, lacking information about how the measures were defined, we did not attempt to categorize them according to our standard survey categories, but rather entered them in the “other” category.

<sup>3</sup> State did not report collecting any of these types of measures.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries’ access to care.

**TABLE 4A-3. Number of States Measuring Access to Care, by Category, for Specific FFS Medicaid Population, May 1, 2016**

State (N = 37) <sup>1</sup>	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
<b>States collecting any measure of access in category</b>	<b>26</b>	<b>20</b>	<b>19</b>	<b>29</b>	<b>21</b>
Non-disabled children	22	15	10	25	17
Non-disabled adults	19	14	10	23	18
Individuals age 65 and older	20	16	13	25	16
Children with physical disabilities	20	15	11	26	16
Adults with physical disabilities	21	16	13	25	17
Children with intellectual or developmental disabilities	21	17	13	25	16
Adults with intellectual or developmental disabilities	21	15	13	24	16
Children with severe emotional disturbance or substance use disorders	20	16	12	24	15
Adults with severe mental illness or substance use disorders	20	15	12	24	16
Pregnant women	21	14	11	23	17
Other populations <sup>2</sup>	7	4	4	4	4

**Notes:** FFS is fee for service.

<sup>1</sup> The table excludes the 14 states that did not participate in the survey.

<sup>2</sup> States reported collecting measures for the following other populations: all populations; all enrolled participants; populations that varied by the specific measure type; a random sample of beneficiaries enrolled in primary care case management; all Consumer Assessment of Healthcare Providers and Systems survey respondents; all populations eligible for integrated care management and patient centered medical homes; and pregnant women.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

**TABLE 4A-4. Number of States Measuring Access to Care under FFS Medicaid, by Category, for Specific Type of Service, May 1, 2016**

Type of service (N = 37) <sup>1</sup>	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply <sup>2</sup>
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
<b>States collecting any measure of access in category</b>	<b>26</b>	<b>20</b>	<b>19</b>	<b>29</b>	<b>21</b>
Primary care	17	12	9	24	N/A
Specialty care	18	13	8	23	N/A
Child developmental screenings	12	6	2	15	N/A
Behavioral health, including mental health, and alcohol and other substance use disorder treatment services	16	10	7	22	N/A
Prenatal and postpartum care and services	12	7	5	16	N/A
Home health services	11	5	5	19	N/A
Long-term services and supports	13	5	6	16	N/A
Dental care and services	16	9	6	22	N/A
Emergency Department services	10	4	4	15	N/A
Pharmacy services	10	4	4	14	N/A
Any covered services (not specified)	6	3	4	10	N/A
Other covered services <sup>3</sup>	5	2	0	2	N/A

**Notes:** FFS is fee for service. N/A is not applicable.

<sup>1</sup> The table excludes the 14 states that did not participate in the survey.

<sup>2</sup> States were not asked what type of services for which they collected provider supply measures.

<sup>3</sup> States reported the following other service types: categories as reported in HEDIS; measures specific to a category of service or a provider type related to an access concern or compliant; and data on the utilization of inpatient hospitals and all services on an as-needed basis.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

**TABLE 4A-5.** Number of States Measuring Access to Care under FFS Medicaid, by Category, for Specific Provider Type, May 1, 2016

Provider type (N = 37) <sup>1</sup>	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services <sup>2</sup>	Receipt of timely covered services	Specific barriers to covered services		
<b>States collecting any measure of access in category</b>	26	20	19	29	21
All provider types	N/A	12	12	19	8
Primary care providers	N/A	17	15	27	18
Specialty care providers	N/A	17	14	26	18
Behavioral health, including mental health and alcohol and other substance use treatment providers	N/A	16	14	26	16
OB/GYN providers	N/A	14	13	24	14
Home health providers	N/A	14	13	23	15
Dental care providers	N/A	16	13	26	16
Other provider types <sup>3</sup>	N/A	1	0	2	3

**Notes:** FFS is fee for service. N/A is not applicable.

<sup>1</sup> The table excludes the 14 states that did not participate in the survey.

<sup>2</sup> States were not asked what type of services for which they collected measures of receipt of covered services.

<sup>3</sup> States reported collecting measures on the following other provider types: pediatricians and maternity providers; all providers as needed; and information for health homes.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

**TABLE 4A-6. Number of States Using Specific Data Source to Collect Information about Access-to-Care Measures under FFS Medicaid, by Category, May 1, 2016**

Data source (N = 37) <sup>1</sup>	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
<b>States collecting any measure of access in category</b>	<b>26</b>	<b>20</b>	<b>19</b>	<b>29</b>	<b>21</b>
Claims and administrative data	25	15	7	28	N/A
Provider surveys <sup>2</sup>	7	4	4	6	7
Beneficiary surveys	17	14	10	7	N/A
Complaint hotline call logs	14	10	7	N/A	N/A
Stakeholder advisory meetings	17	12	8	N/A	N/A
LTSS ombudsman data	8	5	1	N/A	N/A
Other ombudsman data	5	4	1	N/A	N/A
Registries <sup>3</sup>	N/A	N/A	N/A	8	N/A
Provider enrollment data	N/A	N/A	N/A	N/A	20

**Notes:** FFS is fee for service. N/A is not applicable. LTSS is long-term services and supports.

<sup>1</sup> The table excludes the 14 states that did not participate in the survey.

<sup>2</sup> Provider surveys include state-conducted provider survey data.

<sup>3</sup> The registries category includes data from vaccination and cancer registries.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

**TABLE 4A-7. Number of States Measuring Access to Care under FFS Medicaid, by Category, for Specific Purpose, May 1, 2016**

Purpose Total (N = 37) <sup>1</sup>	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
<b>States collecting any measure of access in category</b>	26	20	19	29	21
To assess adequacy of access	19	16	15	23	15
To report information publicly	15	11	8	14	11
To provide feedback to providers	9	8	9	11	5
To make decisions about provider payment incentives	8	4	4	8	3
To guide corrective actions	11	7	7	11	9
Other uses	9	4	2	6	3

**Notes:** FFS is fee for service.

<sup>1</sup> The table excludes the 14 states that did not participate in the survey.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

**TABLE 4A-8. Number of States Reporting Measures Used to Assess Adequacy of Access to Care under FFS Medicaid, by Access-to-Care Measure Category, May 1, 2016**

Purpose Total (N = 37) <sup>1</sup>	Beneficiary experiences accessing covered services			Utilization of covered services	Provider supply
	Receipt of covered services	Receipt of timely covered services	Specific barriers to covered services		
<b>States collecting any measure of access in category</b>	26	20	19	29	21
Trends from previous year <sup>2</sup>	16	13	10	20	12
Regional comparisons <sup>3</sup>	7	8	4	11	6
Managed care comparisons <sup>4</sup>	7	5	2	8	1
National Medicaid averages <sup>5</sup>	12	10	6	11	1
Other states	6	4	4	4	2
Other comparisons <sup>6</sup>	1	0	1	1	0
No comparisons made	2	2	2	1	6

**Notes:** FFS is fee for service.

<sup>1</sup> The table excludes the 14 states that did not participate in the survey.

<sup>2</sup> Same state, same population, different years of data.

<sup>3</sup> Comparing regions within the state, such as urban vs. rural, or different zip codes.

<sup>4</sup> Comparing FFS populations with Medicaid managed care populations.

<sup>5</sup> Comparing data to national Medicaid averages.

<sup>6</sup> Types of comparisons reported included using Southeastern benchmarks as a comparison for assessment, data from Truven to determine comparison groups, and subpopulations as comparison groups.

**Source:** RTI International, 2017, survey for MACPAC of state approaches to measuring and monitoring Medicaid FFS beneficiaries' access to care.

# Appendix



# Authorizing Language from the Social Security Act (42 USC 1396)

## 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 dually 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.—

- (A) IN GENERAL.—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.

(B) REVIEW AND REPORTS REGARDING MEDICAID DSH.—

- (i) IN GENERAL.—MACPAC shall review and submit an annual report to Congress on disproportionate share hospital payments under section 1923. Each report shall include the information specified in clause (ii).
- (ii) REQUIRED REPORT INFORMATION.—Each report required under this subparagraph shall include the following:
  - (I) Data relating to changes in the number of uninsured individuals.
  - (II) Data relating to the amount and sources of hospitals' uncompensated care costs, including the amount of such costs that are the result of providing unreimbursed or under-reimbursed services, charity care, or bad debt.
  - (III) Data identifying hospitals with high levels of uncompensated care that also provide access to essential community services for low-income, uninsured, and vulnerable populations, such as graduate medical education, and the continuum of primary through quaternary care, including the provision of trauma care and public health services.
  - (IV) State-specific analyses regarding the relationship between the most recent State DSH allotment and the projected State DSH allotment for the succeeding year and the data reported under subclauses (I), (II), and (III) for the State.
- (iii) DATA.—Notwithstanding any other provision of law, the Secretary regularly shall provide MACPAC with the most recent State reports and most recent independent certified audits submitted under section 1923(j), cost reports submitted under title XVIII, and such other data as MACPAC may request for purposes of conducting the reviews and preparing and submitting the annual reports required under this subparagraph.
- (iv) SUBMISSION DEADLINES.—The first report required under this subparagraph shall be submitted to Congress not later than February 1, 2016. Subsequent reports shall be submitted as part of, or with, each annual report required under paragraph (1)(C) during the period of fiscal years 2017 through 2024.

- (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 dually 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 dually 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 USC 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.

## Biographies of Commissioners

**Sara Rosenbaum, JD (Chair)**, is founding chair of the Department of Health Policy and the Harold and Jane Hirsh Professor of Health Law and Policy at The George Washington University Milken Institute School of Public Health. She also serves on the faculties of The George Washington Schools of Law and Medicine. Professor Rosenbaum's research has focused on how the law intersects with the nation's health care and public health systems, with a particular emphasis on insurance coverage, managed care, the health care safety net, health care quality, and civil rights. She is a member of the National Academy of Medicine (formerly the Institute of Medicine), and has served on the boards of numerous national organizations, including AcademyHealth. Professor Rosenbaum is a past member of the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices and also serves on the CDC Director's Advisory Committee. She has advised Congress and presidential administrations since 1977 and served on the staff of the White House Domestic Policy Council during the Clinton administration. Professor Rosenbaum is the lead author of *Law and the American Health Care System*, published by Foundation Press (2012). She received her law degree from Boston University School of Law.

**Marsha Gold, ScD (Vice Chair)**, is an independent consultant and senior fellow emerita at Mathematica Policy Research, where she previously served as a lead investigator and project director on research in the areas of Medicare, Medicaid, managed care design, delivery system reform in both public and private health insurance, and access to care. Other prior positions include director of research and analysis at the Group Health Association of America, assistant professor with the Department of Health Policy and Administration at The University of North Carolina, and director of policy analysis and program evaluation at the Maryland Department of Health and Mental Hygiene. Dr. Gold is on the editorial board

of *Health Affairs and Health Services Research*. She received her doctorate of science in health services and evaluation research from the Harvard School of Public Health.

**Brian Burwell** is vice president, community living systems, at Truven Health Analytics in Cambridge, Massachusetts. Mr. Burwell conducts research and provides consulting services, policy analysis, technical assistance in financing and delivery of long-term services and supports, and data analysis related to integrated care models for dually eligible beneficiaries and managed long-term services and supports. He has been with Truven Health Analytics and its predecessor companies for 30 years. Mr. Burwell received his bachelor of arts degree from Dartmouth College.

**Sharon Carte, MHS**, recently retired as executive director of the West Virginia Children's Health Insurance Program, having served there since 2001. From 1992 to 1998, Ms. Carte was deputy commissioner for the Bureau for Medical Services, overseeing West Virginia's Medicaid program. Previously, she was an administrator of skilled and intermediate care nursing facilities and a coordinator of human resources development in the West Virginia Department of Health. Ms. Carte's experience includes work with senior centers and aging programs throughout West Virginia as well as with policy issues related to behavioral health and long-term services and supports for children. She received her master of health science from the Johns Hopkins University School of Hygiene and Public Health.

**Andrea Cohen, JD**, is vice president, office of transformation, at NYC Health + Hospitals, the largest public hospital system in the country. Previously, she served as senior vice president for program at the United Hospital Fund, directing the Fund's program work and overseeing grant-making and conference activities. From 2009 to 2014, she was the director of health services in the New York City Office of the Mayor, where she coordinated and developed strategies to improve public health and



health services. Prior positions include counsel with Manatt, Phelps & Phillips, LLP; senior policy counsel at the Medicare Rights Center; health and oversight counsel for the U.S. Senate Committee on Finance; and trial attorney with the U.S. Department of Justice. She received her law degree from Columbia University School of Law.

**Gustavo Cruz, DMD, MPH**, is an oral health policy consultant and senior advisor to Health Equity Initiative, a professional membership organization in New York City that brings together community leaders and professionals in diverse fields to promote innovations in health equity. He also serves as resident advisor to the dental public health residency at Lutheran Medical Center and as adjunct associate professor in the Department of Epidemiology and Health Promotion at New York University College of Dentistry (NYUCD). Dr. Cruz was a Robert Wood Johnson Foundation Health Policy Fellow in 2009–2010, working in the office of the Secretary of the U.S. Department of Health and Human Services. Subsequently, he served as chief of the Oral Health Branch, Bureau of Health Professions, at the Health Resources and Services Administration. He previously served as director of public health and health promotion at NYUCD and as governing faculty of New York University's master's degree program in global public health. Dr. Cruz has conducted numerous research studies on the oral health of U.S. immigrants, oral health disparities, oral and pharyngeal cancers, and access to oral health care among underserved populations, as well as on the effects of race, ethnicity, acculturation, and culturally influenced behaviors on oral health outcomes and health services utilization. He received his degree in dentistry from the University of Puerto Rico and his master of public health from Columbia University's School of Public Health. He is a diplomate of the American Board of Dental Public Health.

**Toby Douglas, MPP, MPH**, is senior vice president for Medicaid solutions at Centene Corporation. Before joining Centene, he was an independent consultant and senior advisor for Sellers Dorsey,

assisting organizations involved with Medicaid, health insurance exchanges, and Medicare. Previously, Mr. Douglas was a long-standing state Medicaid official, serving for 10 years as an executive in California Medicaid. He served as director of the California Department of Health Care Services and was director of California Medicaid for six years, during which time he also served as a board member of the National Association of Medicaid Directors and as a State Children's Health Insurance Program (CHIP) director. Earlier in his career, Mr. Douglas worked for the San Mateo County Health Department in California, as a research associate at the Urban Institute, as a consultant on pharmacy utilization with Kaiser Permanente Consulting, and as a VISTA volunteer. He received his master of public policy and master of public health from the University of California, Berkeley.

**Leanna George** is the parent of a teenager with a disability who is covered under Medicaid and a child covered under CHIP. A resident of Benson, North Carolina, Ms. George serves on the Johnston County Consumer and Family Advisory Committee, which advises the Board of the County Mental Health Center. She also serves on the Alliance Innovations Stakeholders Group, which advises a Medicaid managed care organization and the state of North Carolina about services and coverage for developmentally disabled enrollees, and on the Client Rights Committee of the Autism Society of North Carolina, a Medicaid provider agency.

**Christopher Gorton, MD, MHSA**, is the president of public plans at Tufts Health Plan, a non-profit health plan in Massachusetts, Rhode Island, and New Hampshire. Previously, Dr. Gorton was chief executive officer (CEO) of a regional health plan that was acquired by the Inova Health System of Falls Church, Virginia. Other positions have included vice president for medical management and worldwide health care strategy for Hewlett Packard Enterprise Services and president and chief medical officer for APS Healthcare, a behavioral health plan and care management organization based in Silver Spring, Maryland. After beginning his career as a practicing

pediatrician in federally qualified health centers in Pennsylvania and Missouri, Dr. Gorton served as chief medical officer in the Pennsylvania Department of Public Welfare. Dr. Gorton received his degree in medicine from Columbia University's College of Physicians and Surgeons and his master of health systems administration from the College of Saint Francis in Joliet, Illinois.

**Herman Gray, MD, MBA**, is president and CEO of United Way for Southeastern Michigan. Prior to assuming this post in September 2015, he served as executive vice president for pediatric health services for the Detroit Medical Center, a position he accepted after eight years as CEO and president of the Detroit Medical Center Children's Hospital of Michigan. At Children's Hospital of Michigan, Dr. Gray also served as chief operating officer, chief of staff, and vice chief of education in the department of pediatrics. He also served as vice president for graduate medical education (GME) at the Detroit Medical Center and associate dean for GME at Wayne State University School of Medicine. Dr. Gray has served as the chief medical consultant at the Michigan Department of Public Health, Children's Special Health Care Services, as well as vice president and medical director of clinical affairs at Blue Care Network, a subsidiary of Blue Cross Blue Shield of Michigan. He has received the Michigan Hospital Association Health Care Leadership Award and *Modern Healthcare's* Top 25 Minority Executives in Healthcare Award and is a member of the board of trustees for the Skillman Foundation. He received his medical degree from the University of Michigan and his master of business administration from the University of Tennessee, and he completed his pediatrics training at the Children's Hospital of Michigan/Wayne State University.

**Stacey Lampkin, FSA, MAAA, MPA**, is an actuary and principal with Mercer Government Human Services Consulting, where she leads actuarial work for several state Medicaid programs. She previously served as actuary and assistant deputy secretary for Medicaid finance and analytics at Florida's Agency for Health Care Administration and as an actuary

at Milliman. She has also served as a member of the Federal Health Committee of the American Academy of Actuaries (AAA), as vice chairperson of AAA's Uninsured Work Group, and as a member of the Society of Actuaries project oversight group for research on evaluating medical management interventions. Ms. Lampkin is a fellow in the Society of Actuaries and a member of the AAA. She received her master of public administration from Florida State University.

**Charles Milligan, JD, MPH**, is CEO of UnitedHealthcare Community Plan of New Mexico, a Medicaid managed care organization with enrolled members in all Medicaid eligibility categories (including dually eligible beneficiaries and adults in Medicaid expansion programs) that provides somatic, behavioral, and managed long-term services and supports. Mr. Milligan is a former state Medicaid and CHIP director in New Mexico and Maryland. He also served as executive director of the Hilltop Institute, a health services research center at the University of Maryland at Baltimore County, and as vice president at The Lewin Group. Mr. Milligan directed the 2005–2006 Commission on Medicaid and has conducted Medicaid-related research projects in numerous states. He received his master of public health from the University of California, Berkeley, and his law degree from Harvard Law School.

**Sheldon Retchin, MD, MSPH**, is executive vice president for health sciences and CEO of The Ohio State University Wexner Medical Center in Columbus. Dr. Retchin's research and publications have addressed costs, quality, and outcomes of health care as well as workforce issues. From 2003 until his appointment at Ohio State in 2015, he served as senior vice president for health sciences at Virginia Commonwealth University (VCU) and as CEO of the VCU Health System, in Richmond, Virginia. Dr. Retchin also led a Medicaid health maintenance organization with approximately 200,000 covered lives through which, for 15 years, he and his colleagues helped manage care for 30,000 uninsured individuals in the Virginia Coordinated Care program.

Dr. Retchin received his medical degree from The University of North Carolina School of Medicine and his master of science in public health from The University of North Carolina School of Public Health.

**Norma Martínez Rogers, PhD, RN, FAAN**, is a professor of family nursing at The University of Texas Health Science Center at San Antonio. She has held clinical and administrative positions in psychiatric nursing and at psychiatric hospitals, including the William Beaumont Army Medical Center in Fort Bliss during Operation Desert Storm. She is dedicated to working with those who face health disparities in the health care system and is the founder and president of the National Latino Nurse Faculty Association. She has initiated a number of programs at The University of Texas Health Science Center, including a mentorship program for retention of minorities in nursing education. She was a founding board member of the Martínez Street Women's Center, a non-profit organization that provides support and educational services to women and teenage girls. Dr. Martínez Rogers is a fellow of the American Academy of Nursing and a past president of the National Association of Hispanic Nurses. She received her master of science in psychiatric nursing from The University of Texas Health Science Center at San Antonio and her doctorate in cultural foundations in education from The University of Texas at Austin.

**Peter Szilagyi, MD, MPH**, is professor of pediatrics, executive vice chair, and vice chair for research in the Department of Pediatrics at the Mattel Children's Hospital at the University of California, Los Angeles (UCLA). Prior to joining UCLA, he served as chief of the division of general pediatrics and professor of pediatrics at the University of Rochester and as associate director of the Center for Community Health within the University of Rochester's Clinical Translational Research Institute. His research has addressed CHIP and child health insurance, access to care, quality of care, and health outcomes, including the delivery of primary care with a focus on immunization delivery, health care financing, and children with chronic disease. From 1986–2014

he served as chairman of the board of the Monroe Plan for Medical Care, a large Medicaid and CHIP managed care plan in upstate New York. He is editor in chief of *Academic Pediatrics* and has served as the president of the Academic Pediatric Association. Dr. Szilagyi received his medical and public health degrees from the University of Rochester.

**Penny Thompson, MPA**, is principal of Penny Thompson Consulting, LLC, and provides strategic advice and solutioning services in the areas of health care delivery and payment, information technology development, and program integrity. Previously, she served as deputy director of the Center for Medicaid and CHIP Services at the Centers for Medicare & Medicaid Services (CMS). Ms. Thompson has held senior positions in management consulting and information technology companies, and was director of health care strategy and planning for Hewlett Packard's health care business unit. In addition, she previously served as CMS's director of program integrity and as chief of the health care branch within the Office of Inspector General at the U.S. Department of Health and Human Services. Ms. Thompson received her master of public administration from The George Washington University.

**Alan Weil, JD, MPP**, is editor-in-chief of *Health Affairs*, a multidisciplinary peer-reviewed health policy journal, in Bethesda, Maryland. He is an elected member of the National Academy of Medicine and served six years on its Board on Health Care Services. He is a trustee of the Consumer Health Foundation and a member of the Kaiser Commission on Medicaid and the Uninsured. He previously served as executive director of the National Academy for State Health Policy, director of the Urban Institute's Assessing the New Federalism Project, executive director of the Colorado Department of Health Care Policy and Financing, and assistant general counsel in the Massachusetts Department of Medical Security. He received a master's degree from Harvard University's John F. Kennedy School of Government and a law degree from Harvard Law School.

## Biographies of Staff

**Annie Andrianasolo, MBA**, is the executive assistant. She previously held the position of special assistant for global health at the Public Health Institute and was a program assistant for the World Bank. Ms. Andrianasolo has a bachelor of science in economics and a master of business administration from Johns Hopkins Carey Business School.

**Amy Bernstein, ScD, MHSA**, is a policy director and contracting officer. She manages and provides oversight and guidance for all MACPAC research, data, and analysis projects, including statements of work, research plans, and all deliverables and products. She also directs and conducts policy analyses. Her previous positions have included director of the Analytic Studies Branch at the U.S. Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics and senior analyst positions at the Alpha Center, the Prospective Payment Assessment Commission, the National Cancer Institute, and the Agency for Healthcare Research and Quality (AHRQ). Dr. Bernstein earned a master of health services administration from the University of Michigan School of Public Health and a doctor of science from the School of Hygiene and Public Health at Johns Hopkins University.

**Kirstin Blom, MIPA**, is a principal analyst. Before joining MACPAC, Ms. Blom was an analyst in health care financing at the Congressional Research Service (CRS). Before that, Ms. Blom worked as a principal analyst at the Congressional Budget Office, where she estimated the cost of proposed legislation on the Medicaid program. Ms. Blom has also been an analyst for the Medicaid program in Wisconsin and for the U.S. Government Accountability Office (GAO). She holds a master of international public affairs from the University of Wisconsin, Madison.

**James Boissonnault, MA**, is chief information officer. Prior to joining MACPAC, he was the

information technology (IT) director and security officer for OnPoint Consulting. At OnPoint, he worked on several federal government projects, including projects for the Missile Defense Agency, the U.S. Department of the Treasury, and the U.S. Department of Agriculture. He has nearly two decades of IT and communications experience. Mr. Boissonnault holds a master of arts in Slavic languages and literatures from The University of North Carolina and a bachelor of arts in Russian from the University of Massachusetts.

**Madeline Britvec** is MACPAC's research assistant. Prior to joining MACPAC, she held internships at the U.S. Chamber of Commerce, International Bridges to Justice, and CBS Detroit. Ms. Britvec holds a bachelor of arts in economics and applied statistics from Smith College.

**Kacey Buderl, MPA**, is an analyst. Prior to joining MACPAC, she worked in the Center for Congressional and Presidential Studies at American University and completed internships in the office of U.S. Senator Ed Markey and at the U.S. Department of Health and Human Services (HHS). Ms. Buderl holds a master of public administration and a bachelor of arts in political science, both from American University.

**Kathryn Ceja** is director of communications. Previously, she served as lead spokesperson for Medicare issues in the Centers for Medicare & Medicaid Services (CMS) press office. Prior to her tenure in the press office, Ms. Ceja was a speechwriter for the Secretary of the U.S. Department of Health and Human Services as well as the speechwriter for a series of CMS administrators. Ms. Ceja holds a bachelor of arts in international studies from American University.

**Benjamin Finder, MPH**, is a senior analyst. His work focuses on benefits and payment policy. Prior to joining MACPAC, he served as an associate director in the Health Care Policy and Research Administration at the District of Columbia Department of Health Care Finance

and as an analyst at the Henry J. Kaiser Family Foundation. Mr. Finder holds a master of public health from The George Washington University, where he concentrated in health policy and health economics.

**Moira Forbes, MBA**, is a policy director focusing on payment policy and the design, implementation, and effectiveness of program integrity activities in Medicaid and CHIP. Previously, she served as director of the division of health and social service programs in the Office of Executive Program Information at HHS and as a vice president in the Medicaid practice at The Lewin Group. At Lewin, Ms. Forbes worked with every state Medicaid and CHIP program on issues relating to program integrity and eligibility quality control. She has extensive experience with federal and state policy analysis, Medicaid program operations, and delivery system design. Ms. Forbes has a master of business administration from The George Washington University and a bachelor's degree in Russian and political science from Bryn Mawr College.

**Martha Heberlein, MA**, is a principal analyst. Prior to joining MACPAC, she was the research manager at the Georgetown University Center for Children and Families, where she oversaw a national survey on Medicaid and CHIP eligibility, enrollment, and renewal procedures. Ms. Heberlein holds a master of arts in public policy with a concentration in philosophy and social policy from The George Washington University and a bachelor of science in psychology from James Madison University.

**Angelica Hill, MA**, is the communications and graphic design specialist. Prior to joining MACPAC, she worked as the membership and programming coordinator for the Public Access Corporation of the District of Columbia (DCTV) and held a similar position at Women in Film and Video. Ms. Hill holds a master of arts in producing for film and video from American University and a bachelor of arts in communications from Howard University.

**Kayla Holgash, MPH**, is an analyst focusing on payment policy. Prior to joining MACPAC, Ms. Holgash worked as a senior research assistant in the Department of Health Policy and Management at The George Washington University and as a health policy legislative intern for U.S. Senator Charles Grassley. Before that, she served as the executive manager of the Health and Wellness Network for the Homewood Children's Village, a non-profit organization in Pittsburgh, Pennsylvania. Ms. Holgash holds a master of public health from The George Washington University and a bachelor of science in public and community health from the University of Maryland.

**Joanne Jee, MPH**, is the congressional liaison and a principal analyst focusing on CHIP and children's coverage. Prior to joining MACPAC, she was a program director at the National Academy for State Health Policy, where she focused on children's coverage issues. Ms. Jee also has been a senior analyst at GAO, a program manager at The Lewin Group, and a legislative analyst in the HHS Office of Legislation. Ms. Jee has a master of public health from the University of California, Los Angeles, and bachelor of science in human development from the University of California, Davis.

**Allissa Jones** is the administrative assistant. Prior to joining MACPAC, she worked as an intern for Kaiser Permanente, where she helped coordinate health and wellness events in the Washington, DC, area. Ms. Jones holds a bachelor of science with a concentration in health management from Howard University.

**Ielnaz Kashefipour, MPP**, is a senior analyst focusing on Medicaid and children's coverage. Prior to joining MACPAC, she worked as a health insurance specialist for the Center for Consumer Information and Insurance Oversight at CMS. Ms. Kashefipour has also worked as a policy associate at the American Academy of Pediatrics and at the National Association of Community Health Centers. Ms. Kashefipour has a master of public policy from the University of California, Los Angeles, and a

bachelor of arts in Near Eastern studies from New York University.

**Nevena Minor, MPP**, is a senior analyst. Prior to joining MACPAC, Ms. Minor was deputy director of the American Psychiatric Association's Department of Reimbursement Policy, focusing on Medicaid and Medicare policies affecting access to care for mental health and substance use disorders. She was also head of the federal affairs division of the American Congress of Obstetricians and Gynecologists, leading its work on physician payment and reproductive, maternal, and child health. Before that, Ms. Minor held several positions at the Heart Rhythm Society. She has a master's degree in public policy with a concentration in health policy from The George Washington University and a bachelor of arts in sociology from Dickinson College.

**Jessica Morris, MPA**, is a principal analyst focusing on Medicaid data and program integrity. Previously, she was a senior analyst at GAO with a focus on Medicaid data systems. She also was a management analyst at the Department of Veterans Affairs, a presidential management fellow at the Pittsburgh VA Medical Center, and a legislative correspondent in the U.S. Senate. Ms. Morris has a master of public administration from The George Washington University and a bachelor of arts in political science and communications from the State University of New York at Cortland.

**Robert Nelb, MPH**, is a senior analyst focusing on issues related to Medicaid payment and delivery system reform. Prior to joining MACPAC, he served as a health insurance specialist at CMS, leading projects related to CHIP and Medicaid Section 1115 demonstrations. Mr. Nelb has a master of public health and a bachelor's degree in ethics, politics, and economics from Yale University.

**Kevin Ochieng** is MACPAC's IT specialist. Before joining MACPAC, Mr. Ochieng was a systems analyst and desk-side support specialist at American Institutes for Research, and prior to

that, an IT consultant at Robert Half Technology, where he focused on IT system administration, user support, network support, and PC deployment. Previously, he served as an academic program specialist at the University of Maryland University College. Mr. Ochieng has a bachelor of science in computer science and mathematics from Washington Adventist University.

**Chris Park, MS**, is a principal analyst. He focuses on issues related to managed care payment and Medicaid drug policy and has lead responsibility for MACStats. Prior to joining MACPAC, he was a senior consultant at The Lewin Group, where he provided quantitative analysis and technical assistance on Medicaid policy issues, including managed care capitation rate-setting and pharmacy-reimbursement and cost-containment initiatives. Mr. Park holds a master of science in health policy and management from the Harvard School of Public Health and a bachelor of science in chemistry from the University of Virginia.

**Ken Pezzella, CGFM**, is the chief financial officer. He has more than 10 years of federal financial management and accounting experience in both the public and private sectors. Mr. Pezzella also has broad operations and business experience, and is a proud veteran of the U.S. Coast Guard. He holds a bachelor of science in accounting from Strayer University and is a certified government financial manager.

**Brian Robinson** is MACPAC's financial analyst. Prior to joining MACPAC, he worked as a business intern at the Joint Global Climate Change Research Institute, a partnership between the University of Maryland and Pacific Northwest National Laboratory. Mr. Robinson holds a bachelor of science in accounting from the University of Maryland.

**Anne L. Schwartz, PhD**, is executive director. She previously served as deputy editor at *Health Affairs*; vice president at Grantmakers In Health, a national organization providing strategic advice

and educational programs for foundations and corporate giving programs working on health issues; and special assistant to the executive director and senior analyst at the Physician Payment Review Commission, a precursor to the Medicare Payment Advisory Commission (MedPAC). Earlier, she held positions on committee and personal staff for the U.S. House of Representatives. Dr. Schwartz earned a doctorate in health policy from the School of Hygiene and Public Health at Johns Hopkins University.

**Kristal Vardaman, MSPH**, is a principal analyst focused on long-term services and supports and on high-cost, high-need populations. Previously, she was a senior analyst at GAO and a consultant at Avalere Health. Ms. Vardaman holds a master of science in public health from The University of North Carolina at Chapel Hill and a bachelor of science from the University of Michigan. She currently is pursuing a doctorate in public policy from The George Washington University.

**Ricardo Villeta, MBA**, is deputy director of operations, finance, and management with overall responsibility for operations related to financial management and budget, procurement, human resources, and IT. Previously, he was the senior vice president and chief management officer for the Academy for Educational Development, a private non-profit educational organization that provided training, education, and technical assistance throughout the United States and in more than 50 countries. Mr. Villeta holds a master of business administration from The George Washington University and a bachelor of science from Georgetown University.

**Eileen Wilkie** is the administrative officer and is responsible for coordinating human resources, office maintenance, travel, and Commission meetings. Previously, she held similar roles at National Public Radio and the National Endowment for Democracy. Ms. Wilkie has a bachelor's degree in political science from the University of Notre Dame.








Advising Congress on  
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